Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES REPORTED AS INSTITUTIONALIZED BY AETNA U.S. HEALTHCARE FOR THE PERIOD JANUARY 1,1996 TO SEPTEMBER 30,1998

JUNE GIBBS BROWN
Inspector General

JULY 1999
A-03-99-00003

OFFICE OF INSPECTOR GENERAL

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July 7, 1999

Common Identification Number A-03-99-00003

Sandra Harmon-Weiss, M.D.
Core Government Programs
Aetna US Healthcare
980 Jolly Road (U22B)
Blue Bell, Pennsylvania 19422

Dear Dr. Harmon-Weiss:

This final report presents the results of our review of Medicare payments for beneficiaries reported as institutionalized by Aetna US Healthcare, Inc. (AUSHC). The AUSHC receives enhanced monthly capitation payments for institutionalized beneficiaries who must reside in facilities designated as institutions and meet a qualifying 30-day residency period. The objective of our review was to determine if payments received by AUSHC for 1,742 beneficiaries reported in institutional status from January 1, 1996 to September 30, 1998 were appropriate.

We based our review on a random sample of 100 Medicare beneficiaries. Our review found that AUSHC incorrectly reported 12 Medicare beneficiaries in institutional status during our audit period resulting in overpayments of $13,823. The AUSHC continued to report two of the 12 beneficiaries as institutionalized after our audit period. Six beneficiaries did not meet the qualifying 30-day residency requirement. Six beneficiaries resided in facilities that did not meet the definition of an institution.

As a result, we recommend that AUSHC: (1) refund $108,655 representing overpayments from January 1, 1996 to September 30, 1998, (2) refund $5,338 representing overpayments received after September 30, 1998 for two beneficiaries that continued to be erroneously identified as institutionalized, and (3) strengthen internal control procedures to ensure errors do not occur in the future.

On June 22, 1999, AUSHC responded to a draft of this report. The AUSHC concurred with each of our draft recommendations. We modified our second recommendation based on information provided in AUSHC's response. Except for beneficiary identity information, the plan's written response is included as APPENDIX B.

BACKGROUND

The AUSHC administers a Medicare managed care program that provides health benefits in southeastern Pennsylvania under the brand name of AUSHC Golden Medicare Plan. The Medicare benefits are provided through a risk-based contract with the Health Care Financing Administration (HCFA).

Risk-based plans are paid a monthly per-capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk-based plans assume full financial risks for all care provided to Medicare beneficiaries. An HMO provides at least all Medicare covered services to its members in return for the monthly capitation payment from the government and sometimes an additional fee paid by the enrollee.

Monthly payments to HMOs are adjusted for the expected costs of each individual. The HCFA assigns weights by risk class of beneficiaries based on age, sex, disability and special status. Special status beneficiaries receive hospice, end-stage renal disease (ESRD), and/or institutional services. They also include beneficiaries classified as working aged or eligible for Medicaid.

A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized. The HCFA requires risk-based HMO's to submit a list of enrollees meeting the institutional status requirements monthly. The advance payments are subsequently adjusted to reflect the enhanced reimbursement for institutional status. For example, in 1998 AUSHC received a monthly advance of $641.15 for each non-Medicaid female, 75-79 years of age, residing in a non-institutional setting in Philadelphia, Pennsylvania. The Medicare monthly payment to AUSHC for similar beneficiaries residing in institutional settings was $1,370.95.

Requirements for institutional status are met if a Medicare beneficiary has been a resident of a qualifying institution for a minimum of 30 consecutive days prior to the first day of the current reporting month. Temporary absences of less than 15 days are permitted for hospitalization or therapeutic leave as long as a bed is being held and paid on behalf of the beneficiary.

Prior to January 1998, HCFA defined an institution qualifying for a higher capitation payment as "nursing homes, sanatoriums, rest homes, convalescent homes, long-term care hospitals and domiciliary homes." The HCFA's Operational Policy Letter Number 54, issued July 24, 1997, revised the definition of an institution for the purpose of receiving the higher institutional payment effective January 1998. According to the revised definition, to qualify for institutional status an enrolled member must be a resident of one of the following title XVIII (Medicare) or title XIX (Medicaid) certified institutions: a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital, rehabilitation hospital, a long-term care hospital or a swing-bed hospital.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine if 1,742 beneficiaries reported in institutional status from January 1, 1996 to September 30, 1998 for which AUSHC received enhanced capitation payments were institutionalized (1) for the qualifying 30-day residency period, and (2) in facilities designated as institutions for the purpose of institutional status.

To achieve our objective, we first reviewed AUSHC's internal controls, focusing on its procedures for verifying the institutional status of Medicare beneficiaries. We then selected a random sample of 100 beneficiary records from the universe of 1,742 Medicare beneficiaries reported as institutionalized by AUSHC for the period January 1, 1996 through September 30, 1998. From AUSHC, we obtained the name, address, phone number, and contact person of the institutions where the beneficiaries in our sample were purported to have resided. We forwarded confirmation requests to 76 institutions to confirm that the 100 beneficiaries in our sample were institutionalized for the periods AUSHC reported to HCFA.

Based on the responses received from the institutions, we identified those Medicare beneficiaries who were incorrectly reported in institutional status. For each error, we calculated the Medicare overpayment by subtracting the non-institutional payment that AUSHC should have received from the institutional payment actually received. We projected the estimated value of Medicare overpayments to the population of 1,742 beneficiaries. Our statistical analysis is shown in Appendix A.

Our review was conducted at AUSHC's office in Blue Bell, Pennsylvania and our office in Philadelphia, Pennsylvania between December 1998 and April 1999.

RESULTS OF REVIEW

MEDICARE OVERPAID AT LEAST $108,655 FOR BENEFICIARIES INCORRECTLY REPORTED BY AUSHC AS INSTITUTIONALIZED

The AUSHC incorrectly reported the institutional status of 12 Medicare beneficiaries in our sample and received overpayments of $13,823. As a result, we estimate, with 95 percent confidence, that AUSHC received at least $108,655 for the beneficiaries in the population incorrectly classified as institutionalized during the audit period. The AUSHC continued to report two of the 12 beneficiaries as institutional after our audit period. The overpayments occurred for the following reasons:

The 30-day qualifying residency requirement was not met.

Six beneficiaries did not meet the qualifying 30-day residency period. The AUSHC reported five beneficiaries as institutionalized who did not complete the 30-day residency requirement. The

AUSHC reported four of these beneficiaries more than one month after the beneficiary was discharged. The remaining beneficiary had a temporary hospital stay that exceeded the 15 days permitted. The overpayment for these six beneficiaries was $4,024.

The facility did not meet the definition of an institution.

Six beneficiaries resided in facilities that did not meet the definition of an institution. Five beneficiaries reported as institutional were residents of personal care homes in 1998 in violation of HCFA's Operational Policy Letter Number 54. Personal care homes are licensed by the Commonwealth of Pennsylvania's Department of Public Welfare as a premise that provides assistance or supervision in matters such as dressing, bathing, diet, etc. Residents of personal care homes do not require the services of a long-term care facility (Pennsylvania Code, Title 55, Chapter 2620.3). Two of these five beneficiaries were reported as institutional after our audit period. One beneficiary never resided at an institution during our audit period. The beneficiary received home care services during the month in question from a company with a similar name to a AUSHC known nursing home. The overpayment for these six beneficiaries was $9,799.

INTERNAL CONTROLS

During our audit period, AUSHC did not have sufficient controls for reporting the institutional status of Medicare beneficiaries. The AUSHC records confirm that the six beneficiaries did not meet the residency requirements and were incorrectly reported. Their records do not indicate that a correction to HCFA was initiated. The AUSHC policies and procedures require that the type of facility be verified on a monthly basis. In some cases, AUSHC did not verify the type of facility.

CONCLUSION AND RECOMMENDATIONS

Our review found that AUSHC incorrectly reported 12 Medicare beneficiaries in institutional status. As a result, AUSHC received Medicare overpayments of $13,823. The AUSHC continued to report two of the 12 beneficiaries as institutional after our audit period. Six beneficiaries did not meet the qualifying 30-day residency requirement. Six beneficiaries resided in facilities that did not meet the definition of an institution.

As a result, we recommend that AUSHC:

(1) refund $108,655 representing overpayments from January 1, 1996 to September 30, 1998,

(2) refund $5,338 representing overpayments received after September 30, 1998 for two beneficiaries that continued to be erroneously identified as institutionalized, and

(3) strengthen internal control procedures to ensure errors do not occur in the future.

THE AUSHC RESPONSE AND OIG COMMENTS

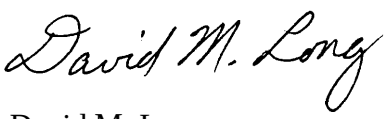
The AUSHC concurred with each of our draft recommendations. We modified our second recommendation based on information provided in AUSHC's response regarding two beneficiaries in our sample for which the plan continued to erroneously receive institutionalized payments after September 30, 1998.

*** *** ***

Final determinations as to actions to be taken on all matters will be made by the HHS official below. The HHS action official will contact you to resolve the issues in the audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time. Should you have any questions please direct them to the HHS official.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), reports issued by Office of Inspector General, Office of Audit Services to the Department's grantees and contractors are made available, if requested, 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 the common identification number in all correspondence relating to this report.

Sincerely yours,



David M. Long
Regional Inspector General
for Audit Services

HHS Official

Regional Administrator
Health Care Financing Administrator
Suite 216
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106

APPENDIX A

VARIABLE APPRAISAL OF STATISTICAL SAMPLES

	Institutional Status Errors
Universe (Beneficiaries)	1,742
Sample Size	100
Nonzero Items	12
Value of Nonzero Items	$13,823
Mean	138.23
Standard Deviation	470.55
Standard Error	45.68
Skewness	4.19
Kurtosis	21.44
Point Estimate	$240,792
Projection at the 90 Percent Confidence Level	
Lower Limit	$108,655
Upper Limit	$372,930
Precision Amount	$132,137
Precision Percent	54.88

Aetna US Healthcare

APPENDIX B

Sandra R. Harmon-Weiss, M.D.
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Blue Bell, PA 19422

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June 22,1999

David Long
Regional Inspector General for Audit Services
Suite 316
150 S. Independence Mall West
Philadelphia, PA 10106

Dear Mr. Long:

Common Identification Number A-03-99-00003
Contract # H3931

Enclosed is our response to your draft report dated May 24, 1999 for review of Medicare payments for beneficiaries reported as institutionalized for the period of January 1, 1996 to September 30, 1998. We appreciate the opportunity to respond to your comments. Our comments are as follows in respect to each of your points.

1. Refund of $108,655 representing overpayments from January 1, 1996 to September 30, 1998.

   - Aetna U.S. Healthcare will reimburse the Health Care Financing Administration for overpayments identified in item 1 of your letter. (See also item 3 re: corrective actions)

2. Review of the status of the two beneficiaries identified as institutional after September 30, 1998 to identify and refund any additional overpayments.

   - The two beneficiaries identified as a part of your institutional audit that were reported as institutionalized after September 30, 1998 are as follows:
     - HIC # , was a resident in an assisted living facility and was reported in October, 1998; November, 1998; January, 1999; and February, 1999.
     - HIC # ., was a resident in an assisted living facility and was reported in, November, 1998; December, 1998; January, 1999; February, 1999; April,1999; and May, 1999.

Please advise us of the appropriate additional payment required for the above named beneficiaries.

3. Strengthen internal control procedures to ensure errors do not occur in the future.

Aetna U.S. Healthcare has reviewed your findings and is in the process of implementing procedure changes that will help further strengthen the reporting process. These enhanced procedures will include the following:

- Enhanced written procedures to ensure process consistency in utilizing the institutional database;
- Newly introduced procedures that address self-reporting of over and under discrepancies;
- Formalized procedures for using fax confirmation sheets to and from facilities;
- Procedures to assure appropriate record retention;
- Newly introduced procedures for tracking institutions that are not responding timely or appropriately which will be sent to provider network staff for follow up with the facility (educational component also prescribed);
- Revision of fax cover page to clarify non-institutional status for assisted living or independent living.

Aetna U.S. Healthcare relies on the accuracy of the information provided by each institution on the type of stay for each beneficiary monthly. Certain facilities have had a lack of understanding of the clarification HCFA released in July of 1997 concerning institutional definitions. Aetna U.S. Healthcare does provide each institution with these definitions of what type of stay meets HCFA's definition. As noted above, we have further strengthened these procedures.

We recently met with the HCFA Director of Beneficiary Services. As part of the meeting, we expressed our concern with the limited time frame the plan has in which to verify institutional status at the end of each calendar month. We strongly urge a revision in policy that will allow more time for plans to review, verify, and report this information. The recommendation would further strengthen the oversight and improve accuracy of plan submissions.

Finally, we have enclosed a copy of our revised institutional manual in which all process revisions described above are tabbed. The enclosed internal manual contains proprietary and confidential commercial information of Aetna U.S. Healthcare Inc. and is not subject to disclosure under the Freedom of Information Act. Should you have any further questions please feel free to contact Mitchell Goldberg at 215-775-7012.

Sincerely,

Sandra Harmon-Weiss MD

Sandra Harmon-Weiss, MD
Core Government Programs

\Sandy\OIG Long 6-22-99

Attachment