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

REGION V
OFFICE OF
INSPECTOR GENERAL

September 22, 2006

Report Number: A-05-06-00031

Ms. Michelle Delegram
Executive Associate Director of Finance
Scott & White Health Plan, Inc.
2401 South 31st Street
Temple, Texas 76508

Dear Ms. Delegram:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' report entitled "Duplicate Medicare Payments to Cost-Based Health Maintenance Plan Scott & White Health Plan for Fiscal Years 2002, through 2004." 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.

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If you have any questions or comments about this report, please do not hesitate to call me at (312) 353-2618 or Stephen Slamar at (312) 353-7905 or through email at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-06-00031 in all correspondence.

Sincerely yours,

for

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Randy Ferris
Regional Administrator
CMS – Region 6
1301 Young Street, Suite 714
Dallas, TX 75202

Fiscal Intermediary
Ms. Marti Mahaffey
President and COO
Trailblazer Health Enterprises, LLC
P.O. Box 660156
Dallas, Texas 75266-0156

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE PLAN SCOTT & WHITE HEALTH PLAN FOR THE FISCAL YEARS 2002, THROUGH 2004

Daniel R. Levinson
Inspector General

September 2006
A-05-06-00031

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 HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Scott & White Health Plan (SWHP) is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare & Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. SWHP receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs that SWHP expects to incur to provide Medicare covered services to enrollees. SWHP claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on SWHP's annual Medicare reimbursement statement that compares its actual costs claimed to the total of the monthly interim payments.

The governing regulations for costs claimed for the Medicare payments made to cost-based HMOs are contained in Federal regulations (42 CFR § 417.532 and § 417.576) and the Medicare Managed Care Manual, Chapter 17, Subchapter B.

Trailblazer Health Enterprises, LLC (Carrier) is the Medicare Carrier through which Medicare payments and adjustments are processed for SWHP.

Under cost-based arrangements, there is a potential for duplicate Medicare payments. This occurs when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee-for-service claim submitted directly by the medical service provider to Medicare. SWHP was at risk for such duplicate payments because it had a contracted agreement with Scott and White Clinic (Clinic) to deliver medical services to SWHP's Medicare enrollees. To provide such services, the Clinic sub-contracted with certain physicians and paid for their services based on an established fee schedule. Since SWHP's Medicare cost report included the Clinic's payments to contracted physicians, Medicare had already paid for the Clinic's medical services covered by the agreement with SWHP. Consequently, any medical service claim paid by the Clinic and also paid by Medicare as a direct fee-for-service claim to either the Clinic or its contracted providers was a duplicate Medicare payment. The Medicare Managed Care Manual, Chapter 17, Subchapter B, requires cost-based HMOs like SWHP to establish a system to preclude and detect such duplicate payments for its medical service providers.

OBJECTIVE

Our objective was to determine whether medical services provided for SWHP's enrollees by the Clinic and its contracted providers were reimbursed under SWHP's Medicare cost report and also through the Medicare fee-for-service payment system.

SUMMARY OF FINDINGS

The Clinic received duplicate Medicare payments of $122,130 because SWHP's internal control procedures for detecting duplicate Medicare fee-for-service billings by the Clinic and its contracted providers relied on a manual analysis of the individual Explanation of Medicare Benefits (EOMB) received from the Medicare Carrier for any SWHP Medicare enrollee. An EOMB is generated each time a Medicare beneficiary receives an allowable medical service that Medicare reimburses on a fee-for-service basis. However, due to the significant volume of EOMBs that SWHP receives each month, its control procedures were unable to detect every duplicate payment. The Clinic and its contracted providers submitted Medicare fee-for-service claims for 3,173 services that had been reimbursed through SWHP's Medicare cost report. As a result, Medicare paid twice for those medical services.

RECOMMENDATIONS

We recommend that SWHP work cooperatively with the Carrier to:

- recover the $122,130 duplicate Medicare fee-for-service payments made to the Clinic and its contracted providers and

- develop a more efficient and effective system to preclude and detect duplicate payments.

AUDITEE'S RESPONSE

SWHP agreed with our findings and will adjust their next cost report to correct the overpayments. SWHP does not believe that their internal control system failed in detecting the duplicate payments. They believe that they are unable to detect some duplicate payments because the Carrier is not sending EOMBs for all the services that were paid for on a fee-for-service basis.

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INTRODUCTION

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Scott & White Health Plan (SWHP) is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare & Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. SWHP receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs SWHP expects to incur to provide Medicare covered services to enrollees. SWHP claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on SWHP's annual Medicare reimbursement statement that compares its actual costs claimed to the total of the monthly interim payments.

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Trailblazer Health Enterprises, LLC (Carrier) is the Medicare carrier that processes Medicare payments and adjustments for SWHP.

Under cost-based arrangements, there is a potential for duplicate Medicare payments. This occurs when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee-for-service claim submitted directly by the medical service provider to Medicare. SWHP was at risk for such duplicate payments because it had a contracted agreement with a related party, Scott and White Clinic (Clinic), to deliver medical services to SWHP's Medicare enrollees. To provide such services, the Clinic sub-contracted with certain physicians, and paid for their services based on an established fee schedule. Since SWHP's Medicare cost report included the Clinic's fee schedule payments to contracted physicians, Medicare has already paid for the Clinic's related medical services covered by the agreement with SWHP. Consequently, any medical service claim paid by the Clinic and also paid by Medicare as a direct fee-for-service claim to either the Clinic or its contracted providers is a duplicate Medicare payment. The Medicare Managed Care Manual, Chapter 17, Subchapter B, requires cost-based HMOs like SWHP to establish a system to preclude and detect such duplicate payments for its medical service providers.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether medical services provided for SWHP's enrollees by the Clinic and its contracted providers were reimbursed under SWHP's Medicare cost report and also through the Medicare fee-for-service payment system.

Scope

We reviewed Medicare fee-for-service payments made to the Clinic and its contracted providers for fiscal years 2002 through 2004 as part of a nation-wide review of potential overpayments made to capitated providers of cost-based HMOs. Due to the limited scope of our audit, we did not review overall internal control structures at SWHP, the Clinic or its contracted providers. However, we created a database specifically designed to identify duplicate payments, which was a specific test of the internal controls SWHP had in place to preclude and detect such payments.

The database was constructed at our field office in Lansing, Michigan. We conducted telephone conference meetings with SWHP key personnel and obtained necessary audit documentation through regular and electronic mailings during the five months between December 2005 and March 2006. We performed limited onsite work during the month of April 2006.

The audit was conducted in accordance with generally accepted government auditing standards.

Methodology

To accomplish the objective, we:

- reviewed applicable Federal laws and regulations and Medicare guidelines;
- reviewed and obtained an understanding of the contracts between SWHP and the Clinic, and between the Clinic and its contracted providers;
- created a database of CMS fee-for-service claims paid to the Clinic and its contracted providers for covered services delivered to SWHP's enrollees;
- obtained and reviewed databases of the Clinic costs related to services provided to SWHP's enrollees and payments made to the Clinic's contracted providers on a primary basis;
- obtained and reviewed databases of adjustments processed by SWHP; and
- validated our database.

In order to create our database of duplicate payments, we used CMS's HMO Group enrollment files to identify health insurance claim numbers for SWHP's enrollees from January 2002 through December 2004. We then matched these numbers against CMS's National Claims History Archive of Carrier Claims for the same time period. We requested and utilized SWHP's enrollee information, which included starting and ending enrollment dates. To create

our database, we extracted Medicare fee-for-service claims with a service date after the beginning enrollment dates and excluded those with a service date after the ending enrollment date. We obtained the Employer Identification Numbers (EINs) for the Clinic and its contracted providers. The resulting database was then compared to a database of the Clinic's costs for services provided to SWHP's enrollees and payments made to the Clinic's contracted providers.

SWHP had duplicate payment detection policies and procedures in place that reviewed the Carrier's Explanation of Medicare Benefits (EOMB) and compared the information to its database of payments. If Medicare paid for the same service, SWHP made an adjustment equal to the amount that Medicare paid. SWHP provided their payment adjustments, which we used to reduce our database of potential fee-for-service duplicate payments.

To validate our database, we selected various random judgmental samples of payments and presented the samples to SWHP.

FINDINGS AND RECOMMENDATIONS

Due to weakness in SWHP's internal controls for detecting duplicate Medicare fee-for-service billings by the Clinic and its contracted providers, the Clinic and its contracted providers received duplicate payments totaling $122,130. For the fiscal years 2002 through 2004, we determined that the Clinic and its contracted providers submitted 3,173 lines of fee-for-service claims to Medicare that had been reimbursed under its contracted arrangement with SWHP. Since the Clinic's actual costs and payments made to the Clinic's contracted providers were included on SWHP's final Medicare settlement cost report, Medicare fee-for-service payments to the Clinic and its contracted providers resulted in $122,130 of duplicate payments for the same medical services.

Responsibility for Detecting Duplicate Payments

The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in the Federal regulations (42 CFR § 417.532 and 42 CFR § 417.576). Based on a per-capita rate for each Medicare enrollee, HMOs receive monthly interim payments from CMS to cover the reasonable costs incurred to provide Medicare-covered services to their enrollees. These reasonable costs may include payments made by the HMO directly to the Clinic, who render Medicare services to the HMO's enrollees. The actual costs incurred by the HMOs are claimed on their annual certified Medicare cost report, and a final settlement is made based on a comparison of the actual costs claimed to the total of the monthly interim payments. An additional payment on a fee-for-service basis to the provider would represent a duplicate payment.

The legislative authority requiring the detection of duplicate payments is specified in the Medicare Managed Care Manual, Chapter 17, Subchapter B, entitled "Duplicate Payment

Detection for Cost Contracting Health Care Prepayment Plans (HCPP) and HMO/Competitive Medical Plans (CMP)" and states:

> "Several entities may have jurisdiction over the processing and payment of Part B bills for your members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent that HCPPs and HMOs/CMPs establish a system to preclude or detect duplicate payments."
>
> . . . "Duplicate payment detection is the responsibility of the HCPP or HMO/CMP, not the carrier."

Weakness in Internal Controls Related to Detecting Duplicate Payments

We attribute the Clinic's and its contracted providers' duplicate payments primarily to a weakness in SWHP's internal controls for detecting Medicare fee-for-service billings. SWHP's procedures for detecting Medicare fee-for-service billings rely on a manual analysis of the individual Explanation of Medicare Benefits (EOMB) received from the Medicare Carrier on behalf of SWHP's Medicare enrollees. An EOMB is generated each time a Medicare beneficiary receives an allowable medical service that Medicare reimburses on a fee-for-service basis. Due to the significant volume of EOMBs SWHP receives each month, its control procedures were unable to detect every duplicate payment. Although we believe that the Clinic and its contracted providers should have had billing controls to detect and prevent duplicate payments, SWHP, as a cost-based HMO, is ultimately responsible to ensure that the Medicare reimbursements contained in its final cost report settlement are not duplicated by fee-for-service claims submitted directly to Medicare by its contracted Clinic.

RECOMMENDATIONS

We recommend that SWHP, work cooperatively with the Carrier to:

- recover the $122,130 duplicate Medicare fee-for-service payments made to the Clinic and its contracted providers and

- develop a more efficient and effective system to preclude and detect duplicate payments.

AUDITEE'S RESPONSE

SWHP agreed with our findings and will adjust their next cost report to correct the overpayments. SWHP does not agree that their internal control system failed in detecting the duplicate payments. They believe that they are unable to detect some duplicate payments because the Carrier is not sending EOMBs for all the services that were paid for on a fee-for-service basis.

APPENDIX

SCOTT & WHITE
HEALTH PLAN

August 28, 2006

Paul Swanson
Department of Health and Human Services
233 North Michigan Avenue
Chicago, Illinois 60601

Report Number A-05-06-00031

Dear Mr. Swanson,

Attached is our response to the draft audit report.

We respectfully request that the following changes be made to the report:
All reference to "Scott" be changed to "SWHP".
In the third paragraph, fourth sentence of the Background in the Executive Summary and Introduction, we request that the phrase "…Medicare had already paid…" be changed to "…Medicare may have already paid…".

Sincerely,

Michelle Delegram

CC: Denise Novak

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SCOTT & WHITE
HEALTH PLAN

August 28, 2006

Paul Swanson
Department of Health and Human Services
233 North Michigan Avenue
Chicago, Illinois 60601

Report Number A-05-06-00031

Dear Mr. Swanson,

This letter is in response to the above referenced report entitled "Duplicate Medicare Payments to Cost - Based Health Maintenance Plan Scott & White Health Plan for Fiscal Years 2002 through 2004."

The Summary of Findings recognizes that the process to check for duplicate claims payments is a completely manual process due to the paper EOMB'S provided by the Carrier. The Findings does not address the possibility that the Carrier failed to provide all the appropriate EOMB'S.

We disagree with the paragraph titled "Weakness in Internal Controls Related to Detecting Duplicate Payments". The Methodology used by SWHP was previously approved by both OIG and CMS. SWHP has proven that it adheres to this Methodology. There is no evidence that the Carrier actually submitted paper EOMB's for the 3,173 services totaling $122,130 and that SWHP's internal controls failed. The services and dollars stated above reflect .06% of total services and .03% of total dollars filed on the cost reports for the 3 year period.

In response to the Recommendations:

- Recover the $122,130 Medicare fee for service payments made to the Clinic and contracted providers.

We will work with CMS to adjust our next cost report to appropriately reflect this overpayment.

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- Develop more efficient and effective system to preclude and detect duplicate payments.

Previous requests made to the carrier to provide an electronic file with tax identification numbers have been futile. We have scheduled a conference call on September 7, 2006 to discuss this issue again. We respectfully request that you notify the Carrier of this Audit report and response and request the Carrier to cooperate with our request to automate this process.

Sincerely,

Michelle Delegram
Associate Executive Director - Finance