DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
Region IX
50 United Nations Plaza, Rm. 171
San Francisco, CA 94102
(415) 437-8360 FAX (415) 437-8372

June 23, 2004

Report Number: A-10-03-00013

Mr. Jack Friedman
Chief Executive Officer
Providence Health Plans
3601 SW. Murray Boulevard, Suite #10
Beaverton, Oregon 97005

Dear Mr. Friedman:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Providence Health Plans' Compliance with Medicare+Choice Prompt Payment Regulations During the Period September 1, 2002 Through February 28, 2003." A copy of this report will be forwarded to the HHS action official named on page 2 for review and any action deemed necessary.

The action official will make final determination as to the actions taken on all matters reported. We request that you respond to the 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 reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-10-03-00013 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

John Hammarlund, Acting Regional Administrator
Centers for Medicare & Medicaid Services, Region X
Department of Health and Human Services
2201 6th Avenue, M/S RX-40
Seattle, Washington 98121

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PROVIDENCE HEALTH PLANS' COMPLIANCE WITH MEDICARE+CHOICE PROMPT PAYMENT REGULATIONS DURING THE PERIOD SEPTEMBER 1, 2002 THROUGH FEBRUARY 28, 2003

JUNE 2004
A-10-03-00013

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

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. Final determination on these matters will be made by authorized officials of the HHS divisions.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the Medicare+Choice (M+C) program. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with the Centers for Medicare & Medicaid Services (CMS). These plans provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers. Federal regulations at 42 CFR § 422 require plans to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers.

OBJECTIVE

Our objective was to determine whether Providence Health Plans (Providence) complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

SUMMARY OF FINDINGS

Providence did not comply with Federal prompt payment regulations. Specifically, it did not (1) pay 95 percent of clean claims[1] within 30 days of receipt, (2) calculate and pay interest on clean claims not paid within 30 days of receipt, and (3) pay or deny all claims within 60 days of receipt. As a result, some noncontracted providers were not paid timely and accurately. These conditions occurred because Providence did not implement adequate procedures to (1) pay or deny claims in a timely manner and (2) process resubmitted claims.

RECOMMENDATIONS

We recommend Providence improve its procedures to ensure that:

1. at least 95 percent of clean claims are paid within 30 days of receipt

2. interest is calculated and paid on clean claims not paid within 30 days

3. all claims are paid or denied within 60 days of receipt

---

[1] A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

PROVIDENCE'S COMMENTS

In its written response to our draft report, Providence concurred with our findings, referring to its commitment and quality improvement efforts to meet the prompt payment requirements. Providence commented that it could identify the reasons the 11 clean claims were not paid within 30 days. Providence also indicated that the number of claims not paid or denied within 60 days of receipt was immaterial relative to the total number of M+C claims processed during the period. Providence's response is included in its entirety as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

During our fieldwork, Providence provided us with nonspecific examples of internal processing delays that may have led to the delay in payment of the 11 clean claims identified. Without knowing the exact cause of each payment delay, Providence may encounter difficulties in ensuring compliance with prompt payment regulations.

Regardless of the materiality of the number of claims not paid or denied within 60 days, prompt payment regulations require payment or denial of all claims within 60 days of receipt. We encourage Providence to continue its quality improvement efforts to ensure that all claims are paid or denied within 60 days.

INTRODUCTION

BACKGROUND

The Medicare+Choice Program

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the M+C program.[2] The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with CMS. These plans, known as M+C organizations, are required to provide enrollees with the same health care services offered under the traditional Medicare program plus additional benefits.[3] These organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers.[4] Claims for services are processed by the M+C organization or through agreements with delegated entities.[5]

Providence Health Plans

Providence is a nonprofit health plan sponsored by Providence Health System, an organization that provides medical services throughout Alaska, Washington, Oregon, and southern California. CMS contracted with Providence as an M+C organization to provide health care coverage to approximately 35,000 Medicare enrollees in Oregon during our audit period.

CMS Reviews

CMS conducts a detailed review of each M+C organization at least once every 2 years. The reviews include internal control and substantive tests of an M+C organization's claims processing systems and compliance with prompt payment provisions. CMS reviewed Providence's claims processing in April 2001 and September 2003 and found it out of compliance with prompt payment regulations. These reviews disclosed that Providence paid less than 95 percent of all clean claims within the required 30 days.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Providence complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

---

[2] The M+C program will be replaced by the Medicare Advantage Program under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, effective January 1, 2006.

[3] Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services.

[4] A noncontracted provider does not have a written agreement with an M+C organization to provide services to an M+C organization's enrollees.

[5] A delegated entity is contracted by an M+C organization to provide administrative or health care services to Medicare-eligible individuals enrolled in the M+C organization's service plan.

Scope

We reviewed selected noncontracted Medicare claims paid or denied by Providence during the period September 1, 2002 through February 28, 2003. Providence paid or denied 19,610 claims for services furnished by noncontracted providers during the period.

Based on the guidance provided to us at the time of our review, we did not review any claims that resulted in payments to enrollees. Further, we did not review the M+C claims processed by Providence's single delegated entity because the number of claims processed was immaterial relative to the total number of claims processed by Providence. We limited our review of internal controls to obtaining an understanding of Providence's claims processing system.

Methodology

To accomplish our objective, we:

- reviewed Federal regulations, policies, and procedures relevant to the prompt payment of noncontracted claims

- consulted with CMS officials to understand CMS's implementation of the M+C program monitoring requirements and prompt payment regulations

- reconciled claims submitted by selected noncontracted providers to claims reported by Providence

To determine whether Providence complied with prompt payment regulations, we separately reviewed the populations of paid claims and claims that did not appear to have been paid or denied within 60 days of receipt. From the population of paid claims, we selected and reviewed a statistical sample of 100 clean claims. For each clean claim that was not paid within 30 days of receipt, we verified that interest was properly calculated and paid to the submitting provider. Additionally, we reviewed each of the 107 claims that, based on a comparison of the receipt dates and paid or denied dates recorded by Providence, did not appear to have been paid or denied within 60 days. For each claim, we analyzed claims history records and other supporting documentation. Appendix A describes our sampling methodology for clean claims in detail.

We performed our audit in accordance with generally accepted government auditing standards. We conducted our fieldwork from October 2002 through March 2004, which included visits to Providence's office in Beaverton, OR.

FINDINGS AND RECOMMENDATIONS

Providence did not comply with Federal prompt payment regulations. Specifically, it did not (1) pay 95 percent of clean claims within 30 days of receipt, (2) calculate and pay interest on clean claims not paid within 30 days of receipt, and (3) pay or deny all claims within 60 days of receipt. As a result, some noncontracted providers were not paid timely and accurately. These conditions occurred because Providence did not implement adequate procedures to (1) pay or deny claims in a timely manner and (2) process resubmitted claims.

FEDERAL REGULATIONS FOR PROMPT PAYMENT

Federal regulations at 42 CFR § 422.100(b) require M+C organizations to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers. The responsibilities for timely payment are clarified in 42 CFR § 422.520:

> (a)(1) …the M+C organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an M+C private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.
> (2) The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B). [Sections 1816 and 1842 refer to Title XVIII of the Social Security Act for Medicare fiscal intermediaries and carriers.]
> (3) All other claims must be paid or denied within 60 calendar days from the date of the request.

A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

PAYMENT OF CLEAN CLAIMS WITHIN 30 DAYS

Providence did not pay at least 95 percent of all clean claims within 30 days of receipt. Our review of a sample of 100 clean claims showed Providence did not pay 11 claims within 30 days of receipt. Based on our sampling results, we determined that Providence paid no more than 94 percent of all clean claims within 30 days. Providence could not specifically identify the reason for the payment delays. See Appendix A for more details of our sampling methodology and results.

INTEREST PAYMENTS ON CLEAN CLAIMS

Providence did not calculate and pay interest on 1 of the 11 clean claims described above. This occurred because Providence did not treat resubmitted claims as new claims. Providence processed the claims as adjustments to previously denied claims, using the original claim numbers. CMS officials informed us that resubmitted claims should be processed as new claims.

As a result, interest should have been calculated and paid on any of these claims that were clean, but not paid within 30 days of receipt.

PAYMENT OR DENIAL OF ALL CLAIMS WITHIN 60 DAYS

Providence did not adequately implement its procedures to ensure that all claims were paid or denied within 60 days of receipt. Of the 19,610 claims processed by Providence during the audit period, 13 were not paid or denied within the required 60 days.

RECOMMENDATIONS

We recommend Providence improve its procedures to ensure that:

1. at least 95 percent of clean claims are paid within 30 days of receipt

2. interest is calculated and paid on clean claims not paid within 30 days

3. all claims are paid or denied within 60 days of receipt

PROVIDENCE'S COMMENTS

In its written response to our draft report, Providence concurred with our findings, referring to its commitment and quality improvement efforts to meet the prompt payment requirements. Providence commented that it could identify the reasons the 11 clean claims were not paid within 30 days. Providence also indicated that the number of claims not paid or denied within 60 days of receipt was immaterial relative to the total number of M+C claims processed during the period. Providence's response is included in its entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

During our fieldwork, Providence provided us with nonspecific examples of internal processing delays that may have led to the delay in payment of the 11 clean claims identified. Without knowing the exact cause of each payment delay, Providence may encounter difficulties in ensuring compliance with prompt payment regulations.

Regardless of the materiality of the number of claims not paid or denied within 60 days, prompt payment regulations require payment or denial of all claims within 60 days of receipt. We encourage Providence to continue its quality improvement efforts to ensure that all claims are paid or denied within 60 days.

OTHER MATTERS

RESPONSIBILITY TO DEVELOP NONCLEAN CLAIMS

Providence did not attempt to develop claims that contained missing or inaccurate information. Although CMS did not question this practice during its onsite reviews, CMS officials informed us that M+C organizations should work with providers to obtain any needed documentation. CMS referred to the guidance for Medicare fiscal intermediaries and carriers, which stresses that organizations should develop claims before denying them. Therefore, Providence should clarify with CMS its responsibilities and level of effort to develop claims.

COMPLIANCE WITH CMS CORRECTIVE ACTION REQUIREMENTS

Providence provided CMS with improper claims processing data. The data contained claims from both contracted and noncontracted providers rather than only noncontracted providers. The inclusion of claims from contracted providers may have distorted the data.

In its April 2001 monitoring review, CMS determined that Providence paid 79 percent of clean claims within 30 days. To monitor Providence's corrective actions, CMS required Providence to provide monthly reports on the timeliness of claims processing. The data indicated that Providence processed 97 percent to 99 percent of claims within 28 days of receipt. As a result, CMS relied on this data and released Providence from further corrective action.

APPENDICES

SAMPLE OF CLEAN CLAIMS
Methodology and Results

Providence paid 15,111 claims for services provided by noncontracted providers during the period September 1, 2002 through February 28, 2003. The number of clean claims was unknown because Providence could not specifically identify its clean claims.

We selected a random sample of claims from the population of paid claims until we identified 100 clean claims. The sampling performed was equivalent to selecting an unrestricted random sample of clean claims. Providence verified that each claim was a clean claim that should have been paid within 30 days.

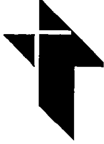
Based on the results of the sample, we are 95-percent confident Providence paid no more than 94 percent of its clean claims within 30 days of receipt. Below are the results of our attribute appraisal.

Sample Results

(Precision at the 90-Percent Confidence Level)

Upper Limit	94.17 percent
Lower Limit	83.83 percent
Standard Error	0.031447 percent
Sampling Error	0.051725 percent

Providence | Health Plans



P.O.Box 4327
Portland, Oregon 97208-4327

June 3, 2004

Lori A. Ahlstrand
Regional Inspector General
DHHS Office of Inspector General
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Re: Report number A-10-03-00013

Dear Ms. Ahlstrand:

I am writing in response to your May 2004 draft report regarding Providence Health Plan's compliance with Medicare+Choice Prompt Payment Regulations. Overall, we feel that the report presents a balanced summary of your findings and we appreciate the care that your staff showed in compiling the report. I do, however, have some specific comments regarding the report, which are presented below.

Response from Providence Health Plan

Objectives[1]
While objective #2 (compliance with CMS instructions to properly notify enrollees) is a reasonable adjunct to objective #1, my notes and records do not show that #2 was ever specified verbally or in writing as an objective by the OIG staff involved. We are not opposed to the inclusion of objective #2 in the report, but we think the objectives should be consistently stated from the outset.

Payment of Clean Claims within 30 Days
We concur with the finding that Providence did not pay at least 95 percent of all clean claims to noncontracted providers within 30 days of receipt and the finding that Providence paid no more than 94 percent of all clean claims within 30 days.

We do not concur that Providence could not specifically identify the reason for payment delays. During the review process we researched the delayed claims and explained to the OIG staff members that the 11 claims were "pended" for a variety of internal administrative issues, e.g., eligibility confirmation, pricing of out-of-area claims, and set-up of new providers in our system. Providence is committed to continuous quality improvement in all areas including timeliness of claims payments. We monitor our results throughout the year and we are confident in our ability to achieve sustained compliance with the 95 percent standard.

[1] **Office of Inspector General Note** – This paragraph is not applicable because the issue referred to by the auditee is not included in this report.

Interest Payments on clean claims
We concur with the finding that Providence did not pay interest on one of the 11 clean claims described above. This claim was properly denied within the allotted 30 days, but the provider subsequently asked for a reconsideration and Providence then accepted and paid the claim retroactively, based on a revised payment policy. For future situations of this type, we have re-trained our staff to enter resubmitted claims as new claims with a new claim number, avoiding the retroactivity problem.

Payment or denial of all claims within 60 days
We concur with the finding that all claims were not paid or denied within 60 days. We feel, however, that the magnitude of non-compliance is minuscule (just 13 claims out of 19,610, or 0.6 per thousand) and that our ongoing quality improvement efforts will have a positive effect.

Responsibility to develop nonclean claims
As suggested in the report, we have begun discussions with CMS Region X on issues relating to claims development.

Compliance with CMS Corrective Action Requirements
We concur with the finding that Providence made an error in reporting our claim timeliness results to CMS Region X following the April 2001 monitoring review. We have verified that we were tracking the appropriate information at the time, but that we erroneously submitted a report that is compiled for a different purpose. We have also verified that our timeliness results in 2002, following our release from corrective action, were 96.6%.

Thank you for your attention to our comments. Please contact me at (503) 574-6560 if you wish to discuss our response. We look forward to receiving the final report.

Sincerely,

Edward J. Nieubuurt
Director of Regulatory Affairs

Cc: Doug Preussler, OIG
Jack Friedman, CEO, Providence Health Plans
Kerry Slinkard, Medicare Compliance Coordinator, Providence Health Plans
Jennifer Rogalla, CMS Region X