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

REGION V
OFFICE OF
INSPECTOR GENERAL

September 12, 2005

Report Number: A-05-05-00043

Mr. Douglas R. Niska, CPA
Vice President and Corporate Compliance Officer
John Deere Health Plan, Inc.
1300 River Drive
Moline, Illinois 61265

Dear Mr. Niska:

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 Organization Plans for John Deere Health Plan, Inc. for the Fiscal Years 2000 through 2003." 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), Office of Inspector General, Office of Audit Services reports issued to the department's grantees and contractors 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.)

If you have any questions or comments about this report, please do not hesitate to call me or Stephen Slamar, Audit Manager at 312-353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. To facilitate identification, please refer to report number A-05-05-00043 in all correspondence.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures - as stated

**Direct Reply to HHS Action Official**:

Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services - Region V
233 North Michigan Avenue Suite 600
Chicago Illinois 60601

**Fiscal Intermediary**

David Horst
Vice President Medicare Operations
WPS
P.O. Box 8190
Madison, Wisconsin 53708

**Department of Health and Human Services**

**OFFICE OF INSPECTOR GENERAL**

# DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLANS FOR JOHN DEERE HEALTH PLAN, INC. FOR THE FISCAL YEARS 2000 THROUGH 2003

**Daniel R. Levinson**
**Inspector General**

**SEPTEMBER 2005**
**A-05-05-00043**

# *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 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 HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

## *Office of Investigations*

The 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.

## *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. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

# DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLANS FOR JOHN DEERE HEALTH PLAN, INC. FOR THE FISCAL YEARS 2000 THROUGH 2003


**Daniel R. Levinson**
**Inspector General**

**SEPTEMBER 2005**
**A-05-05-00043**

# *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 the information 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. Authorized officials of the HHS divisions will make final determination on these matters.

# EXECUTIVE SUMMARY

## BACKGROUND

John Deere Health Plan, Inc. (Deere) 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. Deere receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs that Deere expects to incur to provide Medicare covered services to enrollees. Deere claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Deere'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 on the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR).

Wisconsin Physician Services (Carrier) is the Medicare Carrier through which Medicare payments and adjustments are processed for Deere.

Under cost-based or capitation 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. Deere was at risk for such duplicate payments because it had a sub-contracted capitation agreement with Metropolitan Medical Laboratories (Metropolitan). Under the agreement, Deere prepays Metropolitan a per-member, per-month dollar amount (capitation payment) to provide medical services to Deere's Medicare enrollees. Since Deere includes the capitation payment on its Medicare cost report, Medicare has already paid Metropolitan for the related medical services covered by the agreement. Consequently, any medical service claim covered by the capitation agreement and also paid by Medicare to Metropolitan, as a direct fee-for-service claim is a duplicate Medicare payment. Pursuant to Medicare Managed Care Manual, Chapter 17, Subchapter B, Deere, as a cost-based HMO, is required 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 Deere's enrollees by Metropolitan were reimbursed under its Medicare capitation agreement and also through the Medicare fee-for-service payment system.

## SUMMARY OF FINDINGS

Metropolitan received duplicate Medicare payments of $78,799 because Deere did not have proper Medicare reimbursement procedures in place for the fiscal years 2000 through 2003. Deere failed to establish required internal controls to detect Medicare fee-for-service billings by Metropolitan. Metropolitan received duplicate Medicare payments by submitting Medicare fee-for-service claims for 8,301 services that were already reimbursed through their capitation

agreement with Deere. As a result, Metropolitan received Medicare payments through the Carrier and capitated payments from Deere.

## RECOMMENDATIONS

We recommend that Deere work cooperatively with Metropolitan and the Carrier to:

- recover the $78,799 duplicate Medicare fee-for-service payments made to Metropolitan and

- develop an efficient and effective system to preclude and detect duplicate payments from Metropolitan.

## AUDITEE'S RESPONSE

Deere agreed with our findings and has taken corrective actions to enhance their duplicate payment policies and procedures.

TABLE OF CONTENTS

**Page**

**INTRODUCTION** ..... 1
BACKGROUND ..... 1

OBJECTIVE, SCOPE, AND METHODOLOGY ..... 1
Objective ..... 1
Scope ..... 2
Methodology ..... 2
**FINDINGS AND RECOMMENDATIONS** ..... 3

Regulations Regarding Cost Based HMO Responsibility to Detect Duplicate Payments ..... 3
Deere's Failure to Detect Duplicate Payments ..... 3

RECOMMENDATIONS ..... 4

AUDITEE RESPONSE..... 4

APPENDIX
JOHN DEERE HEALTH PLAN'S RESPONSE TO DRAFT REPORT ..... A

# INTRODUCTION

## BACKGROUND

John Deere Health Plan, Inc. (Deere) 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. Deere receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs Deere expects to incur to provide Medicare covered services to enrollees. Deere claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Deere'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 Title 42 of the Code of Federal Regulations (CFR) and Medicare Managed Care Manual, Chapter 17, Subchapter B.

Wisconsin Physician Services (Carrier) is the Medicare carrier through which Medicare payments and adjustments are processed for Deere.

Under cost-based or capitation arrangements, duplicate Medicare payments occur when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee for service basis to the medical service provider directly to Medicare. Deere was at risk for such duplicate payments because it had a sub-contracted capitation agreement, which prepaid Metropolitan Medical Laboratories (Metropolitan) a per-member, per-month dollar amount (capitation payment), to provide medical services to Deere's Medicare enrollees. Since Deere includes the capitation payment on its Medicare cost report, Medicare has already paid for Metropolitan medical services covered by the agreement. Consequently, any medical service claim covered by the capitation agreement and also paid by Medicare to Metropolitan as a direct fee-for-service claim is a duplicate Medicare payment. Pursuant to the Medicare Managed Care Manual, Chapter 17, Subchapter B, Deere, a cost-based HMO, is required 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 Deere's enrollees by Metropolitan were reimbursed under its Medicare capitation agreement and also through the Medicare fee-for-service payment system.

## Scope

We reviewed Medicare fee-for-service payments made to Metropolitan for fiscal years 2000 through 2003 as part of a region-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 either Deere or Metropolitan. However, we created a database specifically designed to identify duplicate payments, which was a specific test of the internal controls Deere had in place to preclude and detect such payments.

Our database was constructed in our field office in Lansing, Michigan. Since the database was the primary focus of our work, we did not conduct on-site work at either Deere or Metropolitan. We conducted telephone conference meetings with key personnel of Deere and obtained necessary audit documentation through regular and electronic mailings during May 2005.

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 capitation agreement between Deere and the capitated provider, Metropolitan;
- created a database of CMS fee-for-service claims paid to Metropolitan for covered services provided to Deere's enrollees, representing potential duplicate Medicare payments; and
- validated our database.

In order to create our database of duplicate payments, we used the CMS HMO Group enrollment files to identify health insurance claim numbers for Deere's enrollees from January 2000 through December 2003. We then matched these numbers against the CMS National Claims History Archive of Carrier Claims for the same time period. We requested and utilized Deere'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 Number (EIN) for Deere's sole capitated provider, Metropolitan, to isolate Metropolitan's allowable services, per its capitation contract with Deere. The resulting database represented the duplicate reimbursement made through capitated and fee-for-service payments made to Metropolitan for 8,301 services to Deere's enrollees.

To validate our database, we selected a random judgmental sample of 15 payments were presented to Deere to confirm that all sampled items were duplicate payments. We also presented our entire database to the Medicare claims processor Wisconsin Physician Services (Carrier), that processes claims to determine whether Metropolitan had submitted any subsequent adjustments to the fee-for-service claims in our database. Carrier confirmed that none of the claims in our database were adjusted.

## FINDINGS AND RECOMMENDATIONS

Deere failed to establish necessary internal controls to detect Medicare fee-for-service billings by Metropolitan, which allowed Metropolitan to receive duplicate Medicare payments of $78,799. For the fiscal years 2000 through 2003, we determined that Metropolitan submitted 8,301 lines of fee-for-service claims to Medicare that were already reimbursed under its capitation arrangement with Deere. Since Deere's capitation payments were included on its final Medicare settlement cost report, Medicare payments of Metropolitan's fee-for-service claims resulted in $78, 799 of duplicate payments to Metropolitan for the same medical services.

### Regulations Regarding Cost-Based HMO Responsibility to Detect Duplicate Payments

The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR). HMO's receive monthly interim payments from CMS, based on a per-capita rate for each Medicare enrollee, 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 providers 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."

### Deere's Failure to Detect Duplicate Payments

We attribute Metropolitan's duplicate payments primarily to Deere's failure to establish required internal controls to detect Metropolitan's Medicare fee-for-service billings. Although we believe that Metropolitan should have had controls in its billing process to detect and prevent this condition, Deere, 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 providers. During our audit period,

Deere did not have an effective billing control system to detect duplicate payments.

Subsequent to our audit period, Deere began receiving, a hard copy of the Carrier's Explanation of Medicare Benefits (EOMB) forms for the fee-for-service claims reimbursed to Metropolitan on behalf of Deere enrollees. Deere informed us that the EOMBs are now used in an effort to detect duplicate payments.

## RECOMMENDATIONS

We recommend that Deere, work cooperatively with Metropolitan and the Carrier to:

- recover the $78,799 duplicate Medicare fee for service claims made to Metropolitan and;
- develop an efficient and effective system to preclude and detect duplicate payments from Metropolitan.

## AUDITEE'S RESPONSE

Deere agreed with our findings and has taken corrective actions to enhance their duplicate payment policies and procedures.

# APPENDIX

**JOHN DEERE**
HEALTH

1300 River Drive, Suite 200
Moline, IL 61265
Phone: 309-765-1104 Fax: 309-749-1255
E-mail: BartshRichardL@JohnDeere.com

**Douglas R. Niska, CPA**
**Vice President and Corporate**
**Compliance & Privacy Officer**

22 August 2005

Mr. Paul Swanson
Regional IG for Audit Services
Office of Inspector General, DHS
233 North Michigan, Suite 1360
Chicago, IL 60601

**RE: Report Number A-05-05-00043**

Dear Mr. Swanson:

We are in receipt of the OIG's Report Number A-05-05-00043, issued to John Deere Health Plan, Inc. (JDHP), and this letter is our response as was requested in your cover letter.

JDHP had previously attempted to use electronic CMS data files to detect and identify payments which were made by Carriers but which were also covered by a capitation payment by JDHP to Metropolitan Medical Laboratories. Consistent with the experience of other MCOs, our attempts to use the CMS data were not completely effective at isolating all potential duplicate payments. However, prior to the commencement of your audit, JDHP had implemented a new procedure by which paper EOBs are supplied to JDHP by CMS and then manually entered into a company-developed duplicate payment detection application. Your audit scope covered a period prior to the implementation of this new process.

We appreciate your recommendations and it is our intention to recover the $78,799 in duplicate Medicare fee-for-service payments made to Metropolitan and to adjust these as required in our cost report. In addition to the new process described above, we will meet with Metropolitan and consider the need and feasibility of additional enhancements to prevent duplicates from occurring in the future.

Please feel free to contact me should you have any additional questions.

Sincerely,

Douglas R. Niska

**JOHN DEERE**
HEALTH

1300 River Drive, Suite 200
Moline, IL 61265
Phone: 309-765-1104 Fax: 309-749-1255
E-mail: BartshRichardL@JohnDeere.com

**Douglas R. Niska, CPA**
**Vice President and Corporate**
**Compliance & Privacy Officer**

22 August 2005

Mr. Paul Swanson
Regional IG for Audit Services
Office of Inspector General, DHS
233 North Michigan, Suite 1360
Chicago, IL 60601

**RE: Report Number A-05-05-00043**

Dear Mr. Swanson:

We are in receipt of the OIG's Report Number A-05-05-00043, issued to John Deere Health Plan, Inc. (JDHP), and this letter is our response as was requested in your cover letter.

JDHP had previously attempted to use electronic CMS data files to detect and identify payments which were made by Carriers but which were also covered by a capitation payment by JDHP to Metropolitan Medical Laboratories. Consistent with the experience of other MCOs, our attempts to use the CMS data were not completely effective at isolating all potential duplicate payments. However, prior to the commencement of your audit, JDHP had implemented a new procedure by which paper EOBs are supplied to JDHP by CMS and then manually entered into a company-developed duplicate payment detection application. Your audit scope covered a period prior to the implementation of this new process.

We appreciate your recommendations and it is our intention to recover the $78,799 in duplicate Medicare fee-for-service payments made to Metropolitan and to adjust these as required in our cost report. In addition to the new process described above, we will meet with Metropolitan and consider the need and feasibility of additional enhancements to prevent duplicates from occurring in the future.

Please feel free to contact me should you have any additional questions.

Sincerely,

Douglas R. Niska