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

REGION V
OFFICE OF
INSPECTOR GENERAL

September 29, 2006

Report Number: A-05-06-00030

Ms. Catherine Rubin
Vice President of Financial Reporting
Excellus Health Plan, Inc.
165 Court Street
Rochester, NY 14647

Dear Ms. Rubin:

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 Excellus Health Plan, Inc. 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 e-mail at Stephen.Slamar@oig.hhs.gov. To facilitate identification, please refer to report number A-05-06-00030 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
For Audit Services

Enclosures: as stated

Direct Reply to HHS Action Official:

Jim Kerr, Regional Administrator, CMS – Region 2,
26 Federal Plaza, 38th Floor, New York, NY 10278
Phone: (212) 616-2205, Fax: (212) 264-6189

Fiscal Intermediary

Joli Juodaitis, Medicare Managing Director
Healthnow New York, Inc.
33 Lewis Rd.
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

September 2006
A-05-06-00030

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

Excellus Health Plan (Excellus) 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. Excellus receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs that Excellus expects to incur to provide Medicare covered services to enrollees. Excellus claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Excellus' 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.

HealthNow New York, Inc., (Carrier) is the Medicare Part B Carrier through which Medicare payments are processed for Excellus.

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. Excellus was at risk for such duplicate payments because it had a contracted agreement with Rochester Individual Practice Association, Inc. (RIPA) to deliver medical services to Excellus' Medicare enrollees. To provide such services, Excellus prepays RIPA on a per-member, per-month dollar amount (capitation payment) to deliver medical services to Excellus's Medicare enrollees. Since Excellus includes the Medicare apportioned share of RIPA's capitation payment on its Medicare cost report, Medicare has already paid RIPA 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 RIPA's providers, as a direct fee-for-service claim, is a duplicate Medicare payment.

The Medicare Managed Care Manual, Chapter 17, Subchapter B, requires cost-based HMOs like Excellus 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 Excellus' enrollees by its capitated providers were reimbursed under Excellus' Medicare cost report and also through the Medicare fee-for-service payment system.

SUMMARY OF FINDINGS

Excellus received Medicare overpayments of $539,138 because of weaknesses in Excellus' internal controls. Excellus' procedures to detect Medicare fee-for-service billings by RIPA's providers rely on a manual analysis of the individual Explanation of Medicare Benefits (EOMB) it receives from the Medicare Carriers for any Excellus 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, Excellus's control procedures were unable to detect every duplicate payment made for its Medicare enrollees. Additionally, for certain claim payments that Excellus properly identified as duplicates, its procedures for adjusting the Medicare cost report excluded an adjustment for the Medicare co-payment amount. Consequently, Excellus included within its cost report for reimbursement, claim payments for which RIPA's contracted providers had already been paid through direct Medicare fee-for-service claims. As a result, Medicare overpaid Excellus for 16,999 lines of service totaling $539,138.

RECOMMENDATIONS

We recommend that Excellus work cooperatively with the Carriers to:

- recover the $539,138 in Medicare overpayments made to Excellus, and,

- develop a more efficient and effective system to preclude and detect Medicare overpayments.

AUDITEE'S RESPONSE

While Excellus concurs that there were instances of duplicate payments, they do not believe that they have the necessary information to form an opinion on the total overpayment amount. They believe that they found an error in the 2002 claim sample which needs to be addressed to ascertain the impact on the total amount of duplicate payments and that an 80% reimbursement rate should be applied to the claim costs captured in the annual cost report.

OIG RESPONSE

We believe that Excellus received sufficient information to make conclusions on the duplicate payments presented in our audit findings and to accurately calculate the total amount of duplicate payments. We did not apply the 80% factor to our findings because that percentage applies to payments reported on a specific line of Worksheet M of the Medicare cost report for which Excellus did not record any payments. If Excellus, in addressing our findings, reports the adjustment on line 25 of Worksheet M, we agree that the 80% reimbursement rate would apply, and the amount recorded would be reduced from $539,138 to $431,310.

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INTRODUCTION

BACKGROUND

Excellus Health Plan (Excellus) 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. Excellus receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs that Excellus expects to incur to provide Medicare covered services to enrollees. Excellus claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Excellus' 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.

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The Medicare Managed Care Manual, Chapter 17, Subchapter B, requires cost-based HMOs like Excellus 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 Excellus' enrollees by its capitated providers were reimbursed under Excellus' Medicare cost report and also through the Medicare fee-for-service payment system.

Scope

We reviewed Medicare fee-for-service payments made to RIPA's 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 Excellus or RIPA. However, we determined that Excellus had duplicate payment detection policies and procedures in place that reviewed the Carriers' Explanation of Medicare Benefits (EOMB) and compared the information to its database of payments. If the EOMB indicated that Medicare paid for the same service, Excellus made an adjustment equal to the Medicare reimbursement. We created a database specifically designed to identify duplicate payments, and which tested Excellus' policies and procedures to preclude and detect such payments.

The database was constructed at our field office in Lansing, Michigan. We conducted telephone conference meetings with Excellus 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.

Methodology

To accomplish the objective, we:

- reviewed applicable Federal laws and regulations and Medicare guidelines;
- reviewed and obtained an understanding of the contracts between Excellus and RIPA,
- created a database of CMS fee-for-service claims paid to RIPA's providers for covered services delivered to Excellus' enrollees;
- obtained and reviewed databases of Excellus' fee-for-service value of claims related to services provided to Excellus' enrollees and payments made to RIPA's contracted providers;

- obtained and reviewed databases of adjustments processed by Excellus; 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 Excellus' 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 Excellus' 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 RIPA's contracted providers. The resulting database was then compared to Excellus' fee-for-service value of claims, which includes costs for services provided to Excellus' enrollees and payments made to RIPA's contracted providers. To validate our database, we selected various random judgmental samples of payments and presented the samples to Excellus.

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

FINDINGS AND RECOMMENDATIONS

Due to weaknesses in Excellus' internal controls for detecting and adjusting duplicate Medicare fee-for-service billings by RIPA's contracted providers, Excellus received Medicare overpayments totaling $539,138. For the fiscal years 2002 through 2004, we determined that Excellus included within its Medicare cost report, payments made to RIPA's contracted providers for 16,999 lines of service already paid by Medicare on a fee-for-service basis. The Medicare portion of capitation payments made to RIPA, are included for reimbursement on Excellus' final Medicare settlement cost report. As such, payments made by Medicare to RIPA's contracted providers, on a direct fee-for-service basis, constitute Medicare duplicate payments.

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 RIPA, which renders 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 to Detect Duplicate Payments

We attribute overpayments made to Excellus primarily to a weakness in Excellus' internal controls for detecting and adjusting Medicare fee-for-service billings. Excellus' procedures for detecting Medicare fee-for-service billings rely on a manual analysis of the individual EOMB received from the Medicare Carrier on behalf of Excellus' 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. Excellus' control procedures were unable to detect every duplicate payment. Additionally, for certain claim payments that Excellus properly identified as duplicates, its procedures for adjusting the Medicare cost report excluded an adjustment for the Medicare co-payment amount. Although we believe that RIPA's contracted providers should have had billing controls to detect and prevent duplicate payments, Excellus, 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 RIPA providers.

RECOMMENDATIONS

We recommend that Excellus, work cooperatively with the Carriers to:

- recover the $539,138 in Medicare overpayments made to Excellus and,
- develop a more efficient and effective system to preclude and detect Medicare overpayments.

AUDITEE'S RESPONSE

While Excellus concurs that there were instances of duplicate payments, they do not believe that they have the necessary information to form an opinion on the total overpayment amount.

Specifically, they believe that the sample sizes of duplicate claims provided by OIG were not large enough for them to form an opinion on the three years' errors. Excellus believes that they found an error in the 2002 claim sample that could impact the total amount of duplicate payments. Excellus also believes that an 80% reimbursement rate should be applied to the claim costs captured in the annual cost report.

Excellus concurs with our recommendation to develop a more effective system of duplicate payment detection procedures. They have stated that they will review their current procedures for improvement opportunities.

OIG RESPONSE

We believe that Excellus received sufficient information to make conclusions on the duplicate payments presented in our audit findings. Over the course of the audit, we presented to Excellus over 200 random judgmental lines of errors in several samples that covered the entire audit period. We also gave Excellus the error file containing the lines of payments that were considered duplicates for the three years of our audit period. That data, combined with the EOMBs received from the Carrier, should have provided Excellus with enough information to assess the accuracy of our duplicate payment amount.

We believe that the total amount of duplicate payments was accurately calculated. We performed our calculations using Excellus' database of fee-for-service claims. In doing so, we excluded the co-payment amounts, in their database, which Excellus paid on behalf of their beneficiaries. These co-payments were not claimed on their Medicare cost report. Further, Excellus was aware of our database matching methodology and concurred with it over the course of the audit.

Since the 80% reimbursement rate is applicable to amounts reported on Worksheet M, line 25 of the Medicare cost report, and the Excellus cost reports did not have entries on this line, we did not apply the 80% factor to our findings. If Excellus, in addressing our findings, places the adjustment on line 25 of Worksheet M, we agree that the amount of our findings will be reduced from $539,138 to $431,310.

APPENDIX

Excellus

September 20, 2006

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Attention: Mr. Paul Swanson
Regional Inspector General for
Audit Services

Dear Mr. Swanson:

The purpose of this letter is to respond to the recommendations appearing on pages ii and 4 in your draft report entitled "Duplicate Medicare Payments to Cost-Based Health Maintenance Plan Excellus Health Plan For The Fiscal Years 2002, Through 2004."

HHS OIG Audit Recommendation Bullet 1:
We recommend that Excellus work cooperatively with the Carriers to recover the $539,138 in Medicare overpayments made to Excellus.

Excellus Response:
We will work cooperatively to recover overpayments. However we have some questions and concerns regarding the calculations and findings. While we agree that there were instances of duplicate payments which occurred in fiscal years 2002, 2003, and 2004, we don't have the necessary information to form an opinion regarding the accuracy of the entire overpayment amount reflected in the draft audit report.

It appears that the HHS OIG auditors performed a significant amount of data manipulation, involving large volumes of claims data from both Excellus and CMS. HHS OIG provided Excellus with limited samples (including CMS data fields) of potential duplicate payments identified for 2002. These samples were used to "fine tune" HHS OIG methodology in identifying duplicates and calculating duplicate payment errors. HHS OIG indicated that they used the same methodology in calculating overpayments for 2003 and 2004. However, Excellus does not believe that the size of the sample of claims data provided by HHS OIG (25 lines of service per year) to Excellus to verify their 2003 and 2004 results was adequate. Excellus has requested that HHS OIG supplement the detailed error files provided to Excellus (which currently contain only Excellus-provided data fields) with certain CMS data fields in order for Excellus to better assess the accuracy of HHS OIG's audit conclusions. We have not received this data. Additionally, while reviewing the 2002 claim samples in an attempt to verify the audit results for 2002, Excellus found an error that calls into question the accuracy of the overpayment amount reflected in the draft audit report. We believe this error must be reviewed to ascertain the impact on the overpayment amount reflected in their draft audit report.

Lastly, the Medicare overpayments amount, reflected in the HHS OIG draft audit report, does not appear to take into consideration CMS's 80% reimbursement rate that is applied to claim costs captured in the annual cost report. Therefore, barring potential data/methodology errors, the overpayment amount reflected in the draft audit report should be reduced, at a minimum, by 20%.

It should also be noted that the overpayment identified in the HHS OIG draft audit report represents .52% of the fee-for-service claims expense incurred by Excellus and paid to the RIPA contracted providers for the years subject to audit.

We would ask for further discussion and information sharing on this item.

HHS OIG Audit Recommendation Bullet 2:
We recommend that Excellus work cooperatively with the Carriers to develop a more efficient and effective system to preclude and detect Medicare overpayments.

Excellus Response:
Excellus agrees to review its processes and procedures for detecting Medicare overpayments to determine if there are opportunities for improvement.

We appreciate the opportunity to respond to the findings and recommendations and will make every effort to comply with Federal regulations regarding overpayments.

Sincerely,

Catherine V. Rubin
Vice President Financial Reporting

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Stephen Slamar, Audit Manager
Tammie Anderson, Audit Manager – Advanced Audits Technique Staff
Denise Novak, Senior Auditor
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