DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUN 14 1994

From June Gibbs Brown
Inspector General

Subject Review of Empire Blue Cross Blue Shield's Compliance With the Medicare Secondary Payer Statutory Provisions (A-02-93-01006)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final audit report entitled, "Review of Empire Blue Cross Blue Shield's Compliance With the Medicare Secondary Payer Statutory Provisions."

Our audit was performed at the request of the Health Care Financing Administration (HCFA). The purpose of our audit was to determine Empire Blue Cross Blue Shield's (Empire) compliance with the Medicare secondary payer (MSP) provisions of the Social Security Act, 42 U.S.C. 1395y(b). Our review identified the extent to which HCFA Medicare contractors improperly paid claims as primary payer for individuals subject to the working-aged criteria of the MSP statute when, in fact, the Empire private lines of business should have paid primary for these medical services.

To accomplish our audit objectives, we issued two subpoenas to gain access to relevant private-side records, as well as to gain access to Medicare records maintained by Empire as a HCFA Medicare contractor. Computerized private-side employer group health plan enrollment files, as well as applicable health plan contracts were obtained from Empire and the reliability of the data validated. This data was matched against both the Medicare payment history files maintained by Empire as a Medicare contractor and the HCFA central office Medicare Automated Data Retrieval System payment history files for all other Medicare contractors. The universe of claims created by this data match was refined and the data evaluated through a statistical sample review of claims. As part of this review, we examined Medicare claim documents and analyzed printouts of computerized Medicare, Social Security, and Empire private-side information. For those claims identified as a potentially improper primary payment, we contacted Empire's customers to verify that the working-aged criteria of the MSP provisions were met.

We found that substantial amounts of improper Medicare primary payments were made by HCFA contractors when the Empire private lines of business should have paid primary for these medical services. Using statistical sampling techniques, we estimate that approximately $85 million in improper payments were made during this period for beneficiaries subject to the working-aged criteria of the MSP statute. We were not able to render an opinion on an additional estimated $118 million in potentially improper payments since either Empire customers did not cooperate with our audit or we were unable to contact the customers using the data supplied by Empire.

We found that the majority of the improper payments identified in our review resulted from the inappropriate sale by Empire of secondary coverage rather than primary coverage to their customers. It has been Empire's position that compliance with MSP law was not its responsibility, but rather the responsibility of HCFA and Empire customers. For the remaining identified mistaken payments, although primary coverage was sold, we were unable to verify if a correct primary payment was made by Empire's private side because of Empire's lack of cooperation in providing us valid data in a timely fashion. In addition, we have no assurance that primary payments were made by Empire since documents provided to us under subpoena indicate that Empire may have made secondary payments during the audit period if Empire was aware that Medicare improperly paid a primary payment, even if Empire had a primary coverage plan in effect.

Therefore, we are recommending that HCFA negotiate a reasonable settlement with Empire to recover sums improperly paid by HCFA contractors when the private side of Empire should have paid primary for the medical services, including the estimated $85 million in mistaken payments identified in our audit, as well as the estimated $118 million in additional potential mistaken payments identified on which we could not render an opinion.

This matter has also been reviewed by our Office of Investigations and is being referred to the Department of Justice (DOJ) for their review. Therefore, any recovery action by HCFA should be coordinated with the Office of Inspector General (OIG) and DOJ in order to not compromise any potential criminal or civil action.

In responding to our draft report, HCFA concurred with our findings and recommendation, and agreed to seek repayment of funds from Empire. In computing the repayment amount, HCFA requested that OIG and HCFA staff work together to correlate the results of this report with the HCFA/Social Security Administration (SSA)/Internal Revenue Service (IRS) Data Match results. In this

regard, the OIG will share with HCFA supporting documentation for this report, including data necessary to correlate its results with the HCFA/SSA/IRS Data Match, which will help HCFA staff negotiate a reasonable settlement with Empire to recover sums improperly paid.

We would appreciate your views and the status of any action taken or contemplated on our recommendation within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104. Copies of this report are being sent to other interested departmental officials.

To facilitate identification, please refer to Common Identification Number A-02-93-01006 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF EMPIRE BLUE CROSS BLUE SHIELD'S COMPLIANCE WITH THE MEDICARE SECONDARY PAYER STATUTORY PROVISIONS

JUNE GIBBS BROWN
Inspector General

JUNE 1994
A-02-93-01006

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

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Inspector General

Subject Review of Empire Blue Cross Blue Shield's Compliance With the Medicare Secondary Payer Statutory Provisions (A-02-93-01006)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This report provides you with the results of our final audit of Empire Blue Cross Blue Shield's (Empire) compliance with the Medicare secondary payer (MSP) provisions of the Social Security Act, 42 U.S.C. 1395y(b). At the request of the Health Care Financing Administration (HCFA), we identified the extent to which HCFA Medicare contractors improperly paid claims as primary payer for individuals subject to the working-aged criteria of the MSP statute when, in fact, the Empire private lines of business should have paid primary for these medical services.

To accomplish our audit objectives, we issued two subpoenas to gain access to relevant private-side records, as well as to gain access to Medicare records maintained by Empire as a HCFA Medicare contractor. Computerized private-side employer group health plan (EGHP) enrollment files, as well as applicable health plan contracts were obtained from Empire and the reliability of the data validated. This data was matched against both the Medicare payment history files maintained by Empire as a Medicare contractor and the HCFA central office Medicare Automated Data Retrieval System (MADRS) payment history files for all other Medicare contractors. The universe of claims created by this data match was refined and the data evaluated through a statistical sample review of claims. As part of this review, we examined Medicare claim documents and analyzed printouts of computerized Medicare, Social Security, and Empire private-side information. For those claims identified as a potentially improper primary payment, we contacted Empire's customers to verify that the working-aged criteria of the MSP provisions were met.

We found that substantial amounts of improper Medicare primary payments were made by HCFA contractors when the Empire private lines of business should have paid primary for these medical services. Using statistical sampling techniques, we estimate that approximately $85 million in improper payments were made during the period January 1, 1983, through November 20, 1989, for beneficiaries subject

to the working-aged criteria of the MSP statute. We were not able to render an opinion on an additional estimated $118 million in potential improper payments since either Empire customers did not cooperate with our audit or we were unable to contact the customers using the data supplied by Empire.

We found that the majority of the improper payments identified in our review resulted from the inappropriate sale by Empire of secondary coverage rather than primary coverage to their customers. It has been Empire's position that compliance with MSP statutes was not its responsibility, but rather the responsibility of HCFA and Empire customers. For the remaining identified improper payments, although primary coverage was sold, we were unable to verify if a correct primary payment was made by Empire's private side because of Empire's lack of cooperation in providing us valid data in a timely fashion. In addition, we have no assurance that primary payments were made by Empire since documents provided to us under subpoena indicate that Empire may have made secondary payments during the audit period if Empire was aware that Medicare improperly paid a primary payment, even if Empire had a primary coverage plan in effect.

Therefore, we are recommending that HCFA negotiate a reasonable settlement with Empire to recover sums improperly paid by HCFA contractors when the private side of Empire should have paid primary for the medical services, including the estimated $85 million in mistaken payments identified in our audit, as well as the estimated $118 million in additional potential mistaken payments identified on which we could not render an opinion.

This matter has also been reviewed by our Office of Investigations and is being referred to the Department of Justice (DOJ) for its review. Therefore, any recovery action by HCFA should be coordinated with the Office of Inspector General (OIG) and DOJ in order to not compromise any potential criminal or civil action.

In responding to our draft report, HCFA concurred with our findings and recommendation, and agreed to seek repayment of funds from Empire. In computing the repayment amount, HCFA requested that OIG and HCFA staff work together to correlate the results of this report with the HCFA/Social Security Administration (SSA)/Internal Revenue Service (IRS) Data Match results. In this regard, the OIG will share with HCFA supporting documentation for this report, including data necessary to correlate the results of this report with the HCFA/SSA/IRS Data Match, which will help HCFA staff negotiate a reasonable settlement with Empire to recover sums improperly paid. The HCFA's comments are presented as Appendix I to this report.

INTRODUCTION

BACKGROUND

Since the enactment of Medicare in 1965, the program paid for most health services provided to beneficiaries. Beginning in 1980, however, the Congress enacted legislation that made Medicare the secondary payer in certain cases. As a secondary payer, Medicare is generally responsible for paying allowable residual charges only after a primary payment has been made by an EGHP. By 1987, legislative changes had been enacted that made Medicare the secondary payer to EGHPs for those Medicare beneficiaries who are working aged (65 or older),[1] disabled, or have end stage renal disease.

The intent of the MSP legislation was to reduce Medicare expenditures by shifting health care costs to private insurers, self-insuring employers, and employees. Under MSP provisions, Medicare beneficiaries are free to elect Medicare as their primary coverage instead of primary coverage offered by the employer. In these cases, however, employers cannot offer such employees or their spouses complementary coverage on a secondary payer basis.

The Federal requirements governing MSP are found in section 1862(b) of the Social Security Act [42 U.S.C., section 1395y(b)].

The overall administration of the Medicare program is the responsibility of HCFA. In meeting part of its responsibility, HCFA contracts with private insurance companies (fiscal intermediaries (FI) and carriers) to process and pay Medicare claims. The HCFA's contractors are responsible for ensuring that a Medicare payment is made as a secondary source on behalf of older employees enrolled in EGHPs.

The HCFA has taken many actions and initiatives to assure compliance with the provisions of the MSP legislation. One of these initiatives was a request by HCFA that the OIG perform audits to determine the extent to which HCFA Medicare contractors improperly paid claims as primary payer when the private lines of business of health care insurers should have paid primary for these medical services. One of the private insurers selected by HCFA for audit was Empire.

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[1] For details on specific legislative changes applicable to the working aged during our audit period, January 1, 1983 through November 20, 1989, see Appendix F.

Empire is the nation's largest private not-for-profit health insurer. Founded in 1935, the company serves nearly 10 million individual customers who reside primarily in the 28 eastern counties of New York State. The company also acts as the designated carrier for the Medicare program in 16 downstate counties, and as the Medicare FI throughout New York State.

SCOPE

Our audit was performed at the request of HCFA. The objective of our review was to determine the extent to which HCFA Medicare contractors improperly paid claims as primary payer for individuals subject to the working-aged criteria of the MSP statute when the Empire private lines of business should have paid primary for these medical services.

The audit was conducted in accordance with generally accepted government auditing standards. In conducting this audit, however, our efforts were often impeded by resistance and a lack of cooperation from Empire. We were forced to issue two administrative subpoenas to gain access to relevant private-side records, as well as to gain access to Medicare records maintained by Empire as a HCFA Medicare contractor. The inherent audit risk in dealing with an uncooperative auditee and the substantial dollars involved greatly increased our audit efforts necessary to assess the reliability of the information and data provided to us. When our data reliability assessments did find material errors in the subpoenaed data provided by Empire, extensive delays resulted, as well as the expenditure of substantial additional audit resources needed to validate the replacement information supplied by Empire.

Our review at Empire was conducted in four phases, as follows:

Phase I - We used computer applications to identify from Empire's private-side enrollment files 934,271 individuals potentially subject to the MSP working-aged provisions during the period January 1, 1983 through November 20, 1989. For a detailed description of Phase I, see Appendix A.

Phase II - We used computer applications to match the 934,271 individuals identified in Phase I against both the Medicare payment history files maintained by Empire as a Medicare contractor and against HCFA's MADRS system for all other Medicare contractors. This data match identified approximately $2.8 billion in Medicare expenditures for 13 million claims paid for 327,000 individuals meeting the working-aged criteria of the MSP statute and who were part of an Empire EGHP. Of these payments, about $2.0 billion were made by Empire as a Medicare contractor (71 percent) and about $0.8 billion were made by other Medicare contractors (29 percent). For a detailed description of Phase II, see Appendix B. For a specific breakdown of the data match results, see Appendix C.

Phase III - We performed a probe sample review of 448 randomly selected claims. Based on this review, we designed a plan to perform a stratified statistical sample review of the universe of claims identified in Phase II. For a detailed description of Phase III, see Appendix D.

Phase IV - We performed a stratified statistical sample review of 4,774 claims totaling $28,699,178 which were randomly selected from the universe of approximately 13 million Medicare claims ($2.8 billion) identified in Phase II. We also separately reviewed all 146 claims ($21,608,981) identified in Phase II whose payment exceeded $100,000. During this phase, for each reviewed claim, we examined Medicare claim documents and analyzed printouts of computerized Medicare, Social Security, and Empire private-side information. For those claims identified as a potentially improper primary payment, we contacted Empire's customers (various employers that contracted with Empire for group health coverage) to verify that the working-aged criteria of the MSP provisions were met. For a detailed description of Phase IV, see Appendix E.

Field work for all four phases of the audit was performed at the offices of Empire in New York City during the period May 1989 through September 1993.

FINDINGS AND RECOMMENDATIONS

Our computerized data match of Empire's private-side enrollment files with Medicare payment records covering the period January 1, 1983, through November 20, 1989, showed that substantial amounts of improper Medicare primary payments were made by HCFA contractors when in fact the Empire private lines of business should have paid primary for these medical services. Using statistical sampling techniques, we estimate that approximately $85 million in improper payments were made during this period for beneficiaries subject to the working-aged criteria of the MSP statute. In addition, we were not able to render an opinion on an additional $118 million in potential improper payments because either Empire customers did not cooperate with our audit or we were unable to contact the customers using the data supplied by Empire.

Federal law at 42 U.S.C. 1395y(b) provides for Medicare to be the secondary payer for hospital and other medical claims involving Medicare beneficiaries who are working aged (65 years or older), and who are insured under an EGHP based on either their own employment or that of their spouses. For health care related claims of such individuals, the private insurer is usually the primary payer. Medicare will pay any unpaid balance up to the allowed amount subject to deductibles and copayments.[2]

To determine the extent to which HCFA Medicare contractors improperly paid claims as primary payer for individuals subject to the working-aged criteria of the MSP statute when the Empire private lines of business should have paid primary for these medical services, we reviewed a stratified statistical sample of 4,774 Medicare claims totaling $28,699,178. These claims were randomly selected from the universe of approximately 13 million claims ($2.8 billion) identified in our Empire private side/Medicare data match. We found that 128 of the sample claims were improper payments totaling $869,781.

Using stratified random sampling techniques, we estimate the improper payments for the period January 1, 1983 through November 20, 1989, totaled between $69,767,988 and $100,299,753. The midpoint of the range amounted to $85,033,871. The range shown has a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 17.95.

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[2]See Appendix F for details of changes made to the MSP working-aged provisions during the audit period.

We also separately reviewed all 146 claims of over $100,000 (totaling $21,608,981), and found 1 improper payment valued at $128,992.[3] Combining this improper payment with the $85,033,871 point estimate from our statistical projection yields cumulative improper payments of $85,162,863 (for a detailed breakdown of the results of our sample review, see Appendix G).

Furthermore, we were not able to render an opinion on an additional estimated $117,854,959 in potential improper payments (for a detailed discussion of the calculation of this amount, see Appendix H). In this regard, for 215 of the reviewed claims,[4] all evaluated evidence showed that an improper payment was made, except that we were unable to verify the MSP employment provisions with Empire customers. For 125 of the 215 claims, the employers refused to comply or did not respond at all to our requests for information. For the remaining 90 claims, we were unable to locate the employers using the data supplied to us by Empire nor were we able to locate the employers through alternate means. If we could have substantiated each of these claims as improper payments, the total improper payments for the audit period would total $203,017,822.

We found that the majority of the improper payments identified in our review resulted from the inappropriate sale by Empire of secondary coverage rather than primary coverage to their customers. Specifically, 86 of the 129 identified improper payments (or 67 percent) involved secondary coverage sold by the private side of Empire.[5]

It has been Empire's position that compliance with MSP statutes was not its responsibility, but rather the responsibility of HCFA and Empire customers. For example, in a letter to HCFA's Region II Associate Administrator, dated March 28, 1988, Empire officials stated that Empire's position concerning compliance with the MSP provisions was that "...eligibility determination for employer group members was the responsibility of the group, and not Empire's as insurer." These Empire officials further stated that "...eligibility determination, and adherence to working aged/spousal legislation was an employer group responsibility and that Empire had no obligation to take responsibility for employer compliance with the MSP statutes." Notwithstanding these contentions, Federal law and regulations provide that Empire has primary responsibility for compliance with the MSP statutes.

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[3]These 146 claims had been excluded from our sample universe.

[4]The 215 consisted of 213 claims from the sample of 4,774 claims and 2 claims from the 100 percent review of 146 claims exceeding $100,000.

[5]In dollar terms, $583,307 of the $869,781 in identified improper payments (also 67 percent) involved secondary coverage sold by the private side of Empire. There were no improper payments identified in our additional review of 146 claims which involved secondary coverage sold by the private side of Empire.

In the remaining 43 or 33 percent of 129 identified improper payments,[6] although primary coverage was sold, we were unable to verify, because of Empire's lack of cooperation in providing us valid data in a timely fashion, if a correct payment was made by Empire's private side. In addition, we have no assurance that primary payments were made by Empire since documents provided to us under subpoena indicate that Empire may have made secondary payments during the audit period if Empire was aware that Medicare improperly paid a primary payment, even if Empire had a primary coverage plan in effect.

We believe that HCFA should negotiate a reasonable settlement with Empire to recover sums improperly paid by HCFA contractors when the private side of Empire should have paid primary for the medical services. In this regard, we identified an estimated $85 million in improper payments, as well as another estimated $118 million in potential improper payments on which we could not render an opinion. In making the recovery, HCFA should obtain from Empire the necessary documentation to show if any of the payments were allowable. In this regard, HCFA should consider any documented evidence provided by Empire showing that appropriate primary payments were made by Empire for any of the improper payments identified in our audit. In addition, HCFA should consider any documented evidence obtained by Empire from its customers supporting employment status from its 215 customers that did not cooperate with our audit or that could not be located to develop the extent of improper payments. Furthermore, HCFA should consider any documented evidence provided by Empire showing that any improper payments included in our audit universe and identified by Empire were refunded to the Medicare program.[7]

RECOMMENDATION

We recommend that HCFA:

Negotiate a reasonable settlement with Empire to recover sums improperly paid by HCFA contractors when the private side of Empire should have paid primary for the medical services, including the estimated $85 million in improper payments identified in our audit, as well as the estimated $118 million in additional potential

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[6]The 42 payments totaling $286,474 of the 128 sample improper payments valued at $869,781 (or 33 percent) involved primary coverage sold by the private side of Empire. There was also 1 improper payment of $128,992 identified in our additional review of 146 claims which involved primary coverage sold by the private side of Empire.

[7]We included in our review credits made to Medicare which were included in the claim payment histories used to create our audit universe. We did not review credits posted subsequent to our final Medicare payment history computer extract of August 20, 1990. Recoveries made after this date should be deducted from the total sum of improper payments identified in the audit. The OIG computerized universe of claims is available to HCFA for use in making the settlement.

improper payments identified on which we could not render an opinion. Any recovery action by HCFA should be coordinated with OIG and DOJ in order to not compromise any potential criminal or civil action.

HCFA'S COMMENTS

The HCFA concurred with our findings and recommendation, and agreed to seek repayment of funds from Empire. In computing the repayment amount, HCFA requested that OIG and HCFA staff work together to correlate the results of this report with the HCFA/SSA/IRS Data Match results. The HCFA also provided for our consideration some technical comments.

The HCFA's comments are presented as Appendix I to this report.

OIG'S COMMENTS

To assist HCFA in its efforts to negotiate a reasonable settlement with Empire to recover sums improperly paid, the OIG will share with HCFA supporting documentation for this report, including data necessary to correlate the results of this report with the HCFA/SSA/IRS Data Match. In regards to HCFA's technical comments, we considered these comments in the preparation of this final report.

APPENDICES

Phase I: Review of Empire Private-Side Enrollment Files

The primary objective of Phase I of the audit was to identify individuals covered by Empire private-side EGHPs who were potentially subject to the working-aged provisions of the MSP legislation. During this phase, we obtained through an administrative subpoena computerized EGHP enrollment files, as well as applicable health care contracts and other documentation pertaining to Empire's compliance with the MSP provisions.[8] During this phase we also performed sufficient testing to render an opinion as to the accuracy and completeness of the extracted computer files provided by Empire.[9]

Based on this testing, we obtained reasonable assurance as to the accuracy of the enrollment records supplied by Empire. However, we rendered this opinion only after Empire supplied us with replacement tapes on four separate occasions following the receipt of the subpoenaed tapes.[10]

In regards to completeness, since Empire maintained its records on three completely distinct and differing mainframe data bases - Downstate, Northeast NY, and Healthnet HMO, we limited our review to the Downstate data base which contained an estimated 80 percent of Empire subscribers. Using the files extracted by Empire from the Downstate data base, we were able to identify 1,031,067 individuals potentially subject to the working-aged provisions of the MSP legislation. However, we were not able to identify numerous individuals whose records were not readily accessible and thus were excluded from our review, including:

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[8]For example, claims processing policies and procedures; and correspondence with employers, employer health plans, other insurers, and Federal, State, and local governmental entities.

[9]Since it was not feasible to conduct a review of general and application controls in Empire's computer-based system, other tests and procedures were performed to test the reliability of the data.

[10]Some of the data inaccuracies subsequently corrected by Empire included: incorrect end-of-coverage dates, overlapping coverage periods, subscriber file tapes containing no data, incorrect descriptions on the extract file record layout, invalid data in the "group affiliation" field, no data captured in the "subscriber cross-reference" field, records extracted for 64 year old non-Medicare individuals, and dependent records which did not meet our MSP selection criteria.

- purged subscriber records - It was Empire's policy to purge its computerized subscriber file of any inactive record after 13 months.[11] Although these records were maintained on microfiche, it was not feasible to match these against Medicare records. We were unable to estimate the number of purged records that would have been subject to our selection criteria.

- self-cert subscriber records - Empire had 870 "self-cert" groups for which it maintained no individual subscriber data. For these groups, Empire functioned as a third-party administrator and merely processed the claims sent to them by the insured self-cert group. We estimate that as many as 210,000 additional subscriber records would have met our selection criteria.

- subscriber records with invalid birth dates - Empire identified 113,155 subscriber records that were not subject to extract because the birth date maintained in Empire's file was either invalid or missing. We estimate that about 23,800 or 21 percent of these records would have met our selection criteria.

- subscriber records omitted due to programming errors - Based on our tests for completeness, we estimate that about 19,700 or 2 percent of the records that met our selection criteria were not extracted by Empire due to errors in Empire's programming logic.

Furthermore, in terms of completeness of the data on the extracted files, we found that Empire did not always capture subscriber/dependent Social Security Numbers (SSN) or Health Insurance Claim (HIC) numbers in their records. To facilitate a match between Empire's private-side enrollment records and Medicare paid history files, we evaluated each of the records in order to identify a "Best Number" that could be matched against the HIC identifier on the Medicare files. In this evaluation, we found that the Best Number was the subscriber's or the spouse's HIC number, if the HIC data was captured on the subscriber file. If not, the Best Number was the subscriber's SSN with an "A" suffix added, or for the spouse, the subscriber's SSN with a "B" suffix added.

[11] In some instances, after 30 months.

Our evaluation identified Best Numbers which could be matched against Medicare data bases for 934,271 records[12] or 91 percent of the 1,031,067 reviewed records.[13]

Our computer applications used in Phase I of the audit were run at the National Institutes of Health (NIH) Data Center in Bethesda, Maryland.

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[12]This consisted of 589,307 HICs; 283,298 SSNs + "A" suffix; & 61,666 SSNs + "B" suffix.

[13]For the remaining 96,796 or 9 percent of the records, no HICs or SSNs were maintained in Empire's enrollment files. These records were only identified by an arbitrarily assigned "certificate number." We found that these records generally belonged to three groups that, according to Empire officials, had elected to use certificate numbers to protect the confidentiality of their employees. As a result, however, the subscriber records could not be readily matched to Medicare records.

Phase II: Computer Match of Empire Blue Cross Blue Shield Private-Side Enrollment Files Against Medicare Payment Data

The primary objective of Phase II of the audit was to perform a computerized data match between the Empire private-side enrollment data compiled in Phase I and the Medicare payment data maintained by Empire as a Medicare contractor and by HCFA for all other Medicare contractors (non-Empire).

To accomplish this, we requested from Empire computerized records of all Medicare payments made by Empire during the period January 1, 1983 through November 20, 1989 for the 934,271 beneficiaries identified in Phase I. When our request was met with resistance, we served Empire with an administrative subpoena. In response to the subpoena, Empire provided us with a computer file containing 30.5 million Medicare records valued at $3.0 billion.

For Medicare payments made by contractors other than Empire, we requested from HCFA computerized records of all Medicare payments made by all contractors during the period January 1, 1984 through December 31, 1989[14] for the same 934,271 beneficiaries. In response to our request, HCFA provided us with 13.9 million records ($4.6 billion) extracted from the HCFA MADRS system located in Baltimore, Maryland.[15]

To assist with the data match, HCFA contracted with the Information Systems Technology Corporation (ISTC) of Columbia, Maryland, to provide us programming support. Using computer applications, ISTC identified 5.4 million payments valued at $1.5 billion on the extracted MADRS MSP file that were made by non-Empire Medicare contractors. They then matched these payments[16] to the Empire private-side records and identified 3.1 million records valued at $840 million which were potential improper primary payments. In addition, ISTC matched the Empire private-side records with the payments made by Empire as a

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[14]The time period differs from the Empire request since the first service date captured on the HCFA files was January 1, 1984. Also, HCFA records could only be extracted for full calendar years.

[15]Before performing the actual Empire private side/Medicare data match, we performed tests and other procedures to test the reliability of the computer output received from both the Empire Medicare system and the HCFA MADRS. We did not review general and application controls in the Empire Medicare or MADRS computer systems. In both systems, the data consisted of three types of Medicare records: intermediary inpatient, intermediary outpatient, and carrier records.

[16]They also eliminated services prior to May 1, 1986 for individuals over age 69 who were not subject to the MSP criteria.

Medicare contractor and identified 22.6 million records valued at $2.21 billion which were potentially improperly paid. In total, ISTC identified a universe of 372,680 beneficiaries with 25.7 million Medicare records totaling $3.05 billion. The ISTC work was performed at the HCFA Data Center in Baltimore, Maryland.

To further refine the data compiled by ISTC, we ran additional computer applications at the NIH Data Center in Bethesda, Maryland.[17]

The data match identified approximately $2.8 billion in Medicare expenditures for 13 million claims paid for 327,000 individuals meeting the age criteria of the MSP legislation and who were part of an Empire EGHP. Of these payments, about $2.0 billion were made by Empire as a Medicare contractor (71 percent) and about $0.8 billion were made by other Medicare contractors (29 percent). For a specific breakdown of the data match results, see Appendix C.

[17]These applications eliminated (1) records for Empire intermediary inpatient and outpatient services prior to May 1, 1986 for individuals over age 69 not subject to the MSP criteria, (2) records for non-Empire services rendered after November 20, 1989 (the end of the audit period), and (3) all records which did not contain a Medicare reimbursement amount. Throughout the data match process, other tests and procedures were performed which provided us with reasonable assurance that the computer data generated by ISTC and refined by the OIG was reliable.

Office of Inspector General Universe of Claims Identified From Computer Match of Empire Blue Cross Blue Shield Private-Side Enrollment Files Against Medicare Payment Data

Type of Claim Payment	Claims Processed	Amount of Potential Medicare Improper Payments
Intermediary Inpatient		
Empire Processed	235,714	$1,095,546,749
Other Processed	152,083	481,097,934
Subtotal (a)	387,797	$1,576,644,683
Intermediary Outpatient		
Empire Processed	850,405	$ 110,533,117
Other Processed	406,338	71,585,177
Subtotal (b)	1,256,743	$ 182,118,294
Carrier		
Empire Processed	8,891,927	$ 769,088,535
Other Processed	2,471,097[18]	264,341,610
Subtotal (c)	11,363,024	$1,033,430,145
Totals (a)(b)(c)	13,007,564	$2,792,193,122[19]

[18]This is the number of carrier payments rather than the number of carrier claims processed. The actual number of claims processed was not readily available since MADRS consolidates into one computer record (the "R" payment record) all the data for one or more claims covered by a single carrier payment to a provider or beneficiary.

[19]From the audit universe of 13,007,564 claims totaling $2,792,193,122, we reviewed all 146 claims of over $100,000 (totaling $21,608,981). This left a sample universe of 13,007,418 claims totaling $2,770,584,141.

Phase III: Probe Sample Review

The primary objective of Phase III of the audit was to perform a probe sample review of claims to assist in the development of a plan for performing a statistical sample review of the universe of claims previously identified in Phase II. In this phase, we selected from the sampling frame[20] a simple random sample of 133 beneficiaries without replacement. For these beneficiaries, we reviewed 448 Medicare paid claims which were included in the sampling frame. Although the 448 claims did not represent a simple random sample of claims without replacement, this data was the best data available to develop the sampling plan. Aside from the method of selection, we had no other reason to believe that the 448 claims were not generally representative of the sampling frame.

We allocated the 448 claims into 5 stratum based on the dollar-value of the claim, and into a sixth stratum if the sample item was a MADRS "R" payment record,[21] as shown below:

STRATUM	DESCRIPTION			CLAIMS
1	$0.01	-	99.99	100
2	$100.00	-	899.99	100
3	$900.00	-	3,999.99	121
4	$4,000.00	-	9,999.99	22
5	$10,000.00	-	99,999.99	5
6	MADRS "R" records			100
Total				448

We then reviewed sample claims using the HCFA Medicare contractor, Empire private side, and SSA records readily available to us. Due to time and staffing constraints, we were unable to make employer contacts. Based on this probe review, we estimated that the overall error rate approximated 3 percent (13 errors in 448 sample claims), and estimated that improper payments contained in the sampling frame approximated $143 million.

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[20]The sampling frame consisted of 13,007,564 Medicare claims totaling $2,792,193,122. A detailed breakdown of the sampling frame is found in Appendix C.

[21]An "R" record was a record of payment for one or more Part B claims.

Phase IV: Statistical Sample Review

The primary objective of Phase IV of the audit was to perform a statistical sample review of the universe of 13 million claims identified in Phase II. Using stratified random sampling techniques, we estimated the extent to which HCFA Medicare contractors improperly paid claims as primary payer for individuals subject to the working-aged criteria of the MSP legislation when the Empire private lines of business should have paid primary for these medical services.

Our target population for the audit was all Medicare Part A and Part B claims paid by all Medicare contractors for services rendered during the period January 1, 1983 through November 20, 1989 for beneficiaries covered by an Empire EGHP and meeting all of the working-aged criteria of the MSP legislation. The actual population (sampling frame) identified in Phase II of the audit which differed from the target population in several ways,[22] was comprised of 13,007,418 items (claims or MADRS record type "R" payment records) totaling $2,770,584,141.[23]

To evaluate this population of potential Medicare improper payments, a stratified random sample was utilized. The sample consisted of six strata. The first five strata were based on the dollar-value of the sample item,[24] as follows:

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[22]In summary, the sampling frame did not include Medicare claims: (1) for beneficiaries covered by an Empire EGHP not recorded on Empire's main Downstate database, (2) for beneficiaries whose Empire EGHP coverage was recorded on microfiche, (3) Medicare claims paid by non-Empire Medicare contractors for services rendered during 1983, and (4) Medicare claims valued at $100,000 or more (these high-dollar items - 146 claims in total - were reviewed separately through a 100 percent review). In addition, the sampling frame did include some Medicare claims for individuals that did not meet all of the provisions of the MSP working-aged criteria. For example, the sampling frame was created without consideration of the MSP provision that employers have 20 or more employees. Further explanation about the creation of the sampling frame can be found in Appendix B.

[23]A detailed breakdown of the sampling frame is found in Appendix C.

[24]The population of claims was stratified using the "cumulative square root of f(y)" methodology described in Sampling Techniques, Third Edition, William G. Cochran, John Wiley & Sons, New York, 1977, pp. 129-130.

STRATUM	DOLLAR VALUES
1	$ 0.01 - 99.99
2	$ 100.00 - 899.99
3	$ 900.00 - 3,999.99
4	$ 4,000.00 - 9,999.99
5	$ 10,000.00 - 99,999.99
6	MADRS "R" records

The sixth stratum contained any and all MADRS "R" payment records (records of payments for one or more Part B claims).

The sampling unit was defined as a paid Medicare Part A or Part B claim. Each claim was identified in the frame by a unique claim number. In the sixth stratum, the sampling unit was a Medicare Carrier Part B payment record rather than a claim. This stratum consisted entirely of MADRS "R" records. This payment record sampling unit was considered as a cluster of claims.

The sample size was determined through the use of the sample size estimator resident on Department of Health and Human Services (HHS)-OIG/Office of Audit Services (OAS) microcomputers. Using the data gathered in the probe sample review, the sample was drawn to provide an estimate of precision of +/- 10 percent. Although the number of sampling items selected in each stratum exceeded the minimum sample size of 30 sampling items per stratum required by HHS-OIG/OAS policy, the sampling items in three of the strata (#1, #3, and #6) were increased to a level that would provide reasonable assurance that a minimum number of six sample items with the desired characteristics would appear in the final analysis in each stratum.

Using the Neyman allocation methodology[25] to optimally allocate the number of sample items to the strata, we selected a sample of 4,774 items as shown below:

STRATUM	UNIVERSE	SAMPLE SIZE (ESTIMATOR)	SAMPLE SIZE (ACTUAL)
1	8,237,410	276	600
2	1,840,491	699	699
3	336,827	486	600
4	88,267	975	975
5	33,326	1,300	1,300
6	2,471,097	106	600
		3,842	4,774

To select this sample, all Medicare claims identified in the data match were recorded in one computer file; all MADRS "R" records were located in a separate computer file. The Medicare claim file was sorted in paid amount order (descending) and each claim was sequentially numbered. The ranges of sequential numbers which would correspond to each stratum were identified. Each of the MADRS "R" records was assigned a sequential number.

The sample items were then randomly selected using the approved and validated random number generator resident on HHS-OIG/OAS microcomputers. Each stratum's random numbers were selected independently as if they were separate unrestricted random samples without replacement.

The determination as to whether the sample items were properly paid was based on Federal Medicare law, regulations, and guidelines. For each sample item, we examined Medicare claim documents and analyzed printouts of computerized Medicare, Social Security, and Empire private-side information. For those claims identified as a potentially improper primary payment,[26] we contacted Empire's

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[25]See Sampling Techniques, Third Edition, William G. Cochran, John Wiley & Sons, New York, 1977, p. 98, Theorem 5.7.

[26]We considered claims involving prime insured individuals with Social Security earnings of under $600 as a nonerror.

customers (various employers that contracted with Empire for group health coverage) to verify that the employment provisions of the MSP provisions were met.[27]

Specifically, we determined for each sample claims if:

1. the sample Medicare claim was paid;

2. the beneficiary was covered by an Empire EGHP (which was not a third-party administrator plan) on the day the sample services were rendered;

3. the beneficiary (and where applicable the prime insured spouse) met the work status provisions of the MSP working-aged legislation;

4. the beneficiary (and where applicable the prime insured spouse) met the age provisions of the MSP working-aged legislation;

5. the employer providing the EGHP coverage met the 20 or more employee provision of the MSP working-aged legislation; and

6. Empire's private line of business had not previously paid the claim correctly.

We considered an error to occur if all of these six characteristics were met. The amount of the error was the difference between what Empire should have paid as a primary payment minus what Empire already had paid, not to exceed the Medicare payment.

However, because of the delays and diversions caused by Empire, and Empire's resistance in providing valid records to the OIG, we were unable to fully validate whether the above cited sixth characteristic was met. Therefore, for each claim involving an improper secondary coverage sold by Empire, we considered the error amount to be the Medicare payment. Likewise, because we had no assurance that Empire did not pay secondary, even when they sold primary coverage, we considered the error amount for each claim involving primary coverage to be the full Medicare payment.

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[27]When we were unable to contact Empire customers using data provided by Empire, we used alternate sources such as Social Security records and phone listings to attempt to locate and contact these customers.

History of Medicare Secondary Payer Working-Aged Provisions Applicable During Audit Period January 1, 1983 through November 20, 1989

LAW	EFFECTIVE DATE	LEGISLATIVE REQUIREMENTS
TEFRA (Tax Equity Fiscal Responsibility Act)	1/1/83	-Employers with 20 or more employees. -Medicare is secondary for working beneficiaries age 65-69 and their spouses age 65-69. -Medicare supplemental plans may not be offered.
DEFRA (Deficit Reduction Act)	1/1/85	-Employers with 20 or more employees. -Medicare supplemental plans may not be offered -Medicare is secondary for spouses age 65-69 who have health insurance through employment of the spouse. Spouse who has coverage for beneficiary can be any age up to 69.
COBRA (Consolidated Omnibus Budget Reconciliation Act)	5/1/86	-Employers with 20 or more employees. -Medicare supplemental plans may not be offered -Lifts age 69 cap for beneficiary. -Medicare is secondary for individuals age 65 and older who are entitled to employer group health coverage through their own employment or the employment of a spouse of any age who has coverage on the beneficiary.

Appendix G

Detailed Breakdown of Results of Review

	Reviewed:		Errors:	
	Claims	Dollars	Claims	Dollars
Statistical Sample:				
Improper payments identified	4,774	$28,699,178	128	$ 869,781
Could not render opinion	4,774	$28,699,178	213	1,264,952
Subtotal (a)	4,774	$28,699,178	341	$2,134,733
100% Review of 146 Claims:				
Improper payments	146	$21,608,981	1	$128,992
Could not render opinion	146	$21,608,981	2	254,355
Subtotal (b)	146	$21,608,981	3	$383,347
Totals (a)(b)	4,920	$50,308,159	344	$2,518,080

Determination Of Payments On Which OIG Could Not Render An Opinion

We reviewed a statistical sample of 4,774 claims totaling $28,699,178 and found that for 213 of the sample claims totaling $1,264,952, all evaluated evidence showed that an improper payment was made, except that we were unable to verify the MSP employment provisions with Empire customers. Accordingly, we were not able to render an opinion on these sample claims.

Combining these results with the 128 improper payments ($869,781) previously identified yielded a cumulative potential total of 341 improper payments totaling $2,134,733.

Using stratified random sampling for variables techniques, we estimate that the cumulative potential improper payments for the period January 1, 1983 through November 20, 1989, totaled between $181,076,165 and $224,192,785. The midpoint of the range amounted to $202,634,475. The range shown has a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 10.64.

Subtracting the midpoint for improper payments of $85,033,871 from the midpoint for cumulative potential improper payments of $202,634,475 yielded total payments which we could not render an opinion on of $117,600,604.

We also separately reviewed all 146 claims ($21,608,981) exceeding $100,000 (which were excluded from the sample universe), and found two payments ($254,355) on which we could not render an opinion. Combining these payments with the $117,600,604 identified in our statistical sample review yielded a total amount of $117,854,959 on which we could not render an opinion.

Appendix I

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

APR 25 1994

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: Review of Empire Blue Cross Blue Shield's Compliance With the Medicare Secondary Payer Statutory Provisions (A-02-93-01006)

We reviewed the subject draft report examining Empire Blue Cross Blue Shield's (Empire) compliance with the working aged Medicare secondary payer (MSP) provisions of the Social Security Act.

We agree with the findings in the report and would like to work with OIG staff to correlate the results of this report with Health Care Financing Administration (HCFA)/Social Security Administration/Internal Revenue Service Data Match information. After this analysis is completed, HCFA will seek repayment of funds from Empire. Our technical comments are attached for your consideration.*

Thank you for the opportunity to review and comment on this draft report. Please advise us if you would like to discuss our comments at your earliest convenience.

Attachment

*Auditors Note: We considered HCFA's technical comments in the preparation of this final report.