Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

March 22, 1996

Our Reference: Common Identification No. A-02-94-01036

Mr. Peter S. Moore
Vice President, Medicare Division
Group Health Incorporated
88 West End Avenue
New York, New York 10023

Dear Mr. Moore:

Enclosed for your information and use are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' final report entitled "REVIEW OF GROUP HEALTH INCORPORATED DEMAND PAYMENT RECOVERY PROCEDURES UNDER THE 1989 OMNIBUS BUDGET RECONCILIATION ACT DATA MATCH PROJECT." Our audit covered management controls implemented by GHI during the period July 1992 through September 1994.

The HHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time.

To facilitate identification, please refer to Common Identification Number A-02-94-01036 in all correspondence relating to this audit report.

Sincerely yours,

John Tournour
Regional Inspector General
for Audit Services

2 Enclosures

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF GROUP HEALTH INCORPORATED DEMAND PAYMENT RECOVERY PROCEDURES UNDER THE 1989 OMNIBUS BUDGET RECONCILIATION ACT DATA MATCH PROJECT

JUNE GIBBS BROWN
Inspector General

MARCH 1996
A-02-94-01036

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Our Reference: Common Identification No. A-02-94-01036

Mr. Peter S. Moore
Vice President, Medicare Division
Group Health Incorporated
88 West End Avenue
New York, New York 10023

Dear Mr. Moore:

This report provides you with the results of our "REVIEW OF GROUP HEALTH INCORPORATED DEMAND PAYMENT RECOVERY PROCEDURES UNDER THE 1989 OMNIBUS BUDGET RECONCILIATION ACT DATA MATCH PROJECT." The objective of our audit was to determine if Group Health Incorporated (GHI) had an adequate system to track, adjudicate and collect potential Medicare secondary payer (MSP) claims identified through the 1989 Omnibus Budget Reconciliation Act (OBRA) Data Match Project (DMP). Our audit covered management controls implemented by GHI during the period July 1992 through September 1994.

To accomplish our audit objective, we evaluated management controls implemented by GHI to reasonably assure compliance with the DMP demand payment recovery guidelines established by the Health Care Financing Administration (HCFA) for Medicare Part B carriers. As part of this evaluation, we reviewed a representative sample of 40 finalized and pending DMP recovery cases (potential mistaken payments of $186,148) recorded on HCFA's Mistaken Payments Recovery Tracking System (MPaRTS) as of July 14, 1994. As of this date, MPaRTS identified a total of 2,103 finalized GHI cases ($3.8 million) and 89,387 pending GHI cases ($83.9 million).

We found that GHI's management controls were not fully effective in assuring compliance with HCFA DMP recovery procedures with respect to:

- case file documentation.
- timeliness of the demand and recovery process.

- ☞ timeliness in updating of MPaRTS.

As a result, there was no assurance that DMP demand payments were being tracked, adjudicated and recovered in the most effective and timely fashion. We attribute these conditions primarily to a misunderstanding of HCFA guidelines and instructions, the use of an ineffective manual system of flagging, aging and prioritizing DMP recovery cases, and the need for specific procedures to assure the timely update of MPaRTS data.

We are recommending that GHI: (1) establish procedures to implement the use of the HCFA accountability worksheet or equivalent audit trail documentation needed to reconcile and document the differences between the original potential mistaken payment amounts identified and the actual amount recovered and credited to the Medicare program; (2) establish a computerized tracking system to flag, age and prioritize DMP cases to assure that recoveries to the Medicare trust fund are made in a timely fashion; and (3) establish procedures to assure timely updates of MPaRTS data by contractor staff.

The GHI responded to a draft of this audit report on March 13, 1996. In its response, the carrier generally agreed with our findings, but contended that corrective actions had already been taken at the time of our on-site review in 1994, thus negating our recommendations. The GHI comments to our draft report have been summarized after the recommendations section of this report and have been included as an appendix to this report.

INTRODUCTION

Background

The DMP was authorized by Section 6202 of OBRA 1989, Public Law 101-239, which amended Section 1862(b) of the Social Security Act. This provision was later extended through September 30, 1995, by Section 4203(a) of OBRA 1990, Public Law 101-508. As authorized, the project is intended to identify and recover overpayments made by Medicare when primary health insurance is available through employer group health plans (EGHP) for working beneficiaries and/or beneficiaries with working spouses.

Under the DMP provisions, HCFA was authorized to contact employers to obtain EGHP information. To this end, HCFA contracted with GHI, a health care insurance company. The GHI was responsible for sending questionnaires to employers, through a series of staged mailings, in order to obtain the necessary employee health coverage information. The HCFA used that information to search its Medicare Automated Data Retrieval System (MADRS) to identify potential mistaken Medicare payments.

This potential mistaken payments information was transmitted to Medicare contractors (fiscal intermediaries and carriers) which were responsible for searching their internal files to

determine actual mistaken Medicare payments (demand payments) and issuing demand letters to third party payers for recovery. When recovery activities were completed, the contractors were also responsible for reporting this information to HCFA.

To track mistaken payments and recovery activities on a nationwide basis, HCFA established the MPaRTS system. Under MPaRTS, each Medicare contractor was responsible for updating on a timely basis the status of all potential mistaken payments and corresponding recovery actions.

One of these Medicare contractors was GHI, which, in addition to its role as overall DMP contractor, is a Medicare carrier responsible for Medicare Part B payments and recoveries for Queens County, New York.

Scope of Review

The objective of our audit was to determine if GHI, as a Medicare carrier, had an adequate system to track, adjudicate and collect potential MSP claims identified through the 1989 OBRA DMP. Our audit covered management controls implemented by GHI during the period July 1992 through September 1994.

Our review was performed in accordance with generally accepted Government auditing standards. To accomplish our audit objective, we evaluated management controls implemented by GHI to reasonably assure compliance with the DMP demand payment recovery guidelines established by HCFA for Medicare Part B carriers. As part of this evaluation, we reviewed a representative sample of 40 finalized (closed) and pending (open) DMP recovery cases recorded in MPaRTS as of July 14, 1994.[1] Specifically, we tested a random sample of 30 closed cases (potential mistaken payments of $79,790, demand payments of $23,494) and a judgmentally selected sample of 10 open cases (potential mistaken payments of $106,358, demand payments of $30,206).[2] These cases were selected from a universe of 2,103 closed GHI cases (potential mistaken payments of $3.8 million, demand payments of $1.5 million), and 89,387 open GHI cases (potential mistaken payments of $83.9 million, demand payments of $3.1 million).

Field work was conducted at the Medicare offices of GHI in New York, New York. Our review was performed during the period August 1994 through June 1995.

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[1] *Each case in MPaRTS is identified by a DMP report ID. This report ID covers all Medicare claims for one beneficiary's single period of MSP eligibility.*

[2] *The open cases were initiated by the carrier between May 1993 and February 1994. The closed cases were initiated between July 1992 and February 1994, and were finalized between June 1993 and June 1994.*

FINDINGS AND RECOMMENDATIONS

We found that GHI's management controls were not fully effective in assuring compliance with HCFA DMP recovery procedures. Specifically, we found that improvements could be made in case file documentation procedures, as well as procedures for assuring timely resolution of open cases and timely updating of the HCFA MPaRTS system.

Section 3375 of the HCFA's Medicare Carriers Manual (also referred to as the MSP Recovery Manual), effective January 1, 1992, describes the procedures, responsibilities and requirements to be followed by Medicare carriers in performing MSP and DMP recoveries. For example, these guidelines include: time frames for issuing demand letters and completing the demand letter process; audit trail requirements supporting recovery efforts; reasons for ceasing recovery actions; and specific forms and information to be completed and maintained in the case files.

Case Documentation

We found that GHI's procedures for documenting DMP recovery efforts did not adequately provide for a sufficient audit trail to assure that potential mistaken Medicare payments were being appropriately recovered.

The Medicare Carriers Manual provides that contractors maintain audit trails and specific case file documentation for all recovery attempts and actions. Specifically, Carriers Manual Section 3375.5 (A) requires that "contractors must keep an audit trail on all recovery actions, regardless of whether a recovery was or was not made."[3] Carriers Manual Section 3375.10 describes this audit trail, including specific documentation requirements that must be maintained and linked; for example, an analysis of the difference between the Medicare payment in question and the actual recovered amount. To help document this audit trail, HCFA, in Carriers Manual Sections 3375 (F) and 3375, Exhibit 12, required that the contractors maintain accountability worksheets, which would include a written description of the difference between the identified amount and the recovered amount.

We found that GHI was not using the HCFA accountability worksheet nor equivalent audit trail documentation needed to reconcile and document the differences between the original potential mistaken payment amounts identified and the actual amount recovered and credited to the Medicare program. In our review of 30 cases closed as of July 14, 1994, we noted that the case file documentation generally consisted of a series of source documents, such as claims listings and insurance company explanation of benefits, without a detailed explanation

[3] *Underlining emphasis is included in Carriers Manual.*

of critical decisions made to support the write-off of potential mistaken Medicare payments (in all 30 cases reviewed, all or part of the potential mistaken payments were written-off by GHI).

An audit trail is necessary to support critical decisions made in the recovery process and to allow for effective supervision and audit of the work performed and decisions made. For example, Section 3375.5 of the MSP Carriers Manual provides for specific reasons for ceasing recovery actions against third party payers or employers. In our review of 25 closed cases in which the amount recovered differed from the amount demanded from the EGHP, we found that in 19 of the cases the specific reasoning used to write-off part or all of the demand amount was not documented.[4] When we further performed a detailed examination of all of the documents in the 19 cases, we found that in four of the cases sufficient documentation did not exist for terminating recovery efforts. For example, in one case, GHI inappropriately ceased recovery based on information from the insurer without receiving confirmation from the employer. The insurer indicated the beneficiary was a retiree, but GHI did not confirm this fact with the employer, as required under HCFA guidelines. As a result, there was no assurance that Medicare was receiving the appropriate amounts subject to recovery.

The GHI officials stated that accountability worksheets or equivalent audit trail documentation were not used as a the result of a misunderstanding of HCFA documentation guidelines.

Timeliness of Demand and Recovery Process

We found that GHI was not generally performing DMP demand and recovery actions on a timely basis as defined by HCFA guidelines.

The Medicare Carriers Manual specifies certain prescribed time frames for carrier demand and recovery actions. Specifically, Section 3375.5(A) states that:

- Once a debt has been established, Medicare contractors should complete recovery action (i.e. conduct history search, recover the demand amount, refer case to the regional office or close the case) within 8 months from the date the contractor receives initial notice of the potential mistaken payment.

- If a third party payer has not responded within 60 days of an initial demand letter, the contractor should send a follow-up demand letter.

- If the third party does not respond within 30 days of the second (follow-up) demand letter, the contractor should send a demand letter to the employer.

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[4] *In the remaining six cases, the reasons were documented on slips of paper not appropriately secured to the case file.*

In our review of 40 GHI cases, we found that these three time frame requirements were exceeded in 30 of the cases (75 percent).[5] In more specific terms:

- In 28 of the 40 cases reviewed (10 of 10 open, 18 of 30 closed), recovery actions were not completed within eight months from the issuance of the initial demand notice.[6] Closed cases reviewed took an average of 12.5 months to adjudicate, while open cases were outstanding an average of 14 months, as of September 30, 1994.

- In 12 of the 40 cases (4 open and 8 closed), follow-up letters to insurers were not issued within 60 days of the initial demand letter. The eight closed cases were delayed as long as 130 days (4.3 months) following the 60 days period, and 160 days (5.3 months) from the date of the initial demand letter. The four open cases were delayed as long as 128 days (4.3 months) past the 60 day period and 180 days (6 months) from the initial demand letter date.

- In nine of the 40 cases (4 open and 5 closed), demand letters to employers were delayed as long as 136 days (4.5 months) for closed cases, and as long as 151 days (5 months) for open cases.

We attribute these delays primarily to the absence of an effective tracking system to flag, age and prioritize DMP cases. At GHI, each MSP case worker manually tracked open MSP cases contained in their individual workload of cases. Based on the labor intensive nature of this manual tracking system, and the overall complexity of the tracking guidelines, we believe that an effective computerized tracking system which flags, ages and prioritizes DMP cases is necessary to assure that recoveries to the Medicare trust fund are made in the most timely fashion.

Timeliness of MPaRTS Update

We found that GHI was not generally updating the MPaRTS on a timely basis in accordance with the HCFA guidelines.

The Medicare Carriers Manual Section 3375.14.(B) requires that the MPaRTS be updated by the Medicare contractors within 21 days of completion of research on claims history, and within 10 days of completion of recovery action (partial or full payment).

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[5]The time frame requirements were exceeded in a total of 54 instances (duplicated count), for 30 of the 40 cases reviewed (75 percent). In addition, we noted that in five of these cases (3 closed and 2 open), there was no evidence in the case file that applicable follow-up and employer demand letters were sent.

[6]Due to delays by Region II carriers in issuing initial demand letters in 1993 due to involvement in one specific litigation case in the period October 1992 through January 1993, we did not question any delays incurred by GHI prior to the issuance of its initial demand notices.

In our review of 40 GHI cases, we found that GHI did not update MPaRTS data on a timely basis in 34 cases (85 percent). The GHI officials indicated that delays in updating MPaRTS were the result of limited staff being used to perform other MSP recovery activities. Notwithstanding the above, we believe that maintaining the accuracy and completeness of the MPaRTS database is a critical function. Without the timely updating of the MPaRTS database, HCFA officials are unable to accurately monitor the total dollar amount of initial demands sent and recoveries made by Medicare contractors, and make meaningful management decisions about the DMP and its overall effectiveness.

In conclusion, we believe that without improvements in case file documentation procedures, as well as procedures for assuring timely resolution of open cases and timely updating of the HCFA MPaRTS system, there is no assurance that the Medicare trust funds are receiving the appropriate amounts subject to recovery; that the recoveries are being made in the most timely and effective fashion; and that complete and reliable data is available to HCFA to monitor the DMP recovery effort and make meaningful management decisions about the DMP and its overall effectiveness.

Recommendations

We recommend that GHI:

1. Establish procedures to implement the use of the HCFA accountability worksheet or equivalent audit trail documentation needed to reconcile and document the differences between the original potential mistaken payment amounts identified and the actual amount recovered and credited to the Medicare program.

2. Establish a computerized tracking system to flag, age and prioritize DMP cases to assure that recoveries to the Medicare trust fund are made in a timely fashion.

3. Establish procedures to assure timely updates of MPaRTS data by contractor staff.

The GHI Comments

The GHI responded to a draft of this audit report on March 13, 1996. In its response, GHI generally agreed with our findings. However, the carrier asserted that corrective actions had already been taken at the time of our review in 1994, thus negating our recommendations. The carrier also suggested that our review covered 1992 and 1993 management controls, but not management controls in place at the time of our audit in 1994. Furthermore, the carrier attached to their response to our draft report, for our consideration, a piece of HCFA correspondence regarding the timeliness of DMP recovery actions.

The OIG Response

In its response, the GHI suggested that the audit covered management controls in place in 1992 and 1993, but not in 1994 at the time of the audit. To remedy any possible misunderstanding concerning the scope of audit, we further clarified in this report that the audit specifically covered management controls implemented by GHI during the period July 1992 through September 1994, and we expanded the depth of the scope section of this report.

In addition, GHI contended that corrective actions addressing our findings had already been taken at the time of our on-site review which started in August 1994. Specifically they state that the utilization of accountability worksheets had already begun, the demand and recovery process was timely,[7] and MPaRTS was updated on a timely basis. We disagree. We found no evidence that policies or procedures were implemented at the time of our audit regarding the use of accountability worksheets, the use of a computerized tracking system to flag, age and prioritize DMP cases, or the timely update of MPaRTS. In addition, we found no evidence in any of the reviewed current open cases or the closed cases that these controls were being used. We presented our preliminary findings to GHI officials at the conclusion of our on-site audit work, and it was our understanding that GHI agreed with our findings and agreed to take immediate corrective action.

Lastly, GHI provided for our consideration a piece of correspondence from the HCFA RO clarifying 1993 Data Match Time Frames. At issue were delays by Region II carriers in issuing initial demand letters in 1993 due to involvement in one specific litigation case in the period October 1992 through January 1993. In our audit finding we did not question any delays the carrier might have had in issuing initial demand notices, but rather we analyzed only the timeliness of actions taken to recover Medicare funds after the issuance of the demand notice. It is also our opinion that it is incumbent upon a Medicare carrier to recover overpayments for which demand has been made in a timely fashion and restore the monies to the Medicare trust funds. We believe that delays in the issuance of follow-up letters to employers and insurers and in the recovery of funds and completion of cases noted in our review of open 1994 cases, as well as in the reviewed cases finalized in 1993 and 1994, support our conclusion that improvements in DMP demand and recovery actions were needed to assure that recoveries to the Medicare trust fund were being made in the most timely and effective fashion.

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[7]*GHI asserts that Phase II of the SMART system to flag, age and prioritize was implemented in September 1993 and fully implemented at the time of the OIG review. Although we saw evidence that GHI's computer system was revised (for example, GIII implemented prior to our review an automated demand system in which the system rather than a case worker generated the initial demand notice), we saw no evidence that a computerized tracking system to flag, age and prioritize cases was in place at the time of our review.*

The complete text of GHI's response to our draft report is included as an appendix to this report.

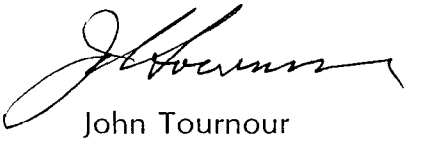
* * * * *

Final determination as to actions taken on all matters reported will be made by the HHS 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 (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are available, if requested, 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).

To facilitate identification, please refer to the referenced common identification number in all correspondence relating to this report.

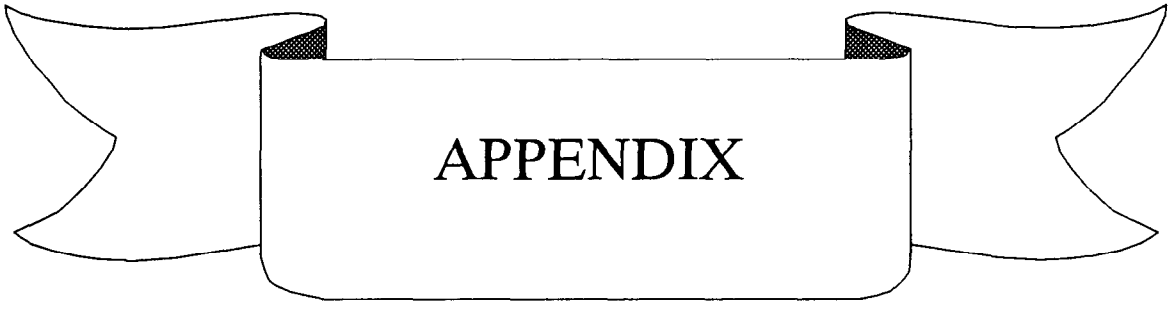
Sincerely yours,



John Tournour
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Alberta Leone
Associate Regional Administrator for Medicare
Health Care Financing Administration, Region II
26 Federal Plaza, Room 3800
New York, NY 10278


APPENDIX

MEDICARE

GROUP HEALTH INCORPORATED
88 West End Avenue • New York, N.Y. 10023

March 13, 1996

Mr. John Tournour
Regional Inspector General
for Audit Service
Office of Inspector General
26 Federal Plaza
New York, NY 10278

Dear Mr. Tournour:

We have received and reviewed your draft report "Review of GHI Demand Payment Recovery Procedures under the 1989 OBRA Act Data Match Project." Our comments are enclosed with this letter.

It is our understanding that these written comments will be incorporated in the final report. We have already taken the opportunity to meet with Mr. Edert, Ms. Diaz and Mr. Jacobs of your staff on February 27, 1996. They were all very helpful in clarifying the information provided in the report.

Please contact me if you have any questions. I may be reached at (212) 721-1300, Ext. 400.

Sincerely,

Peter S. Moore
Vice President

Enclosure

Comments Regarding Draft OIG Audit

General Discussion

As discussed at our meeting with OIG staff on 2/27/96, the review performed by the OIG staff focused on Data Match cases between 1992 and 1993. At the time of the on-site review in 1994, the utilization of an Accountability Worksheet for case files had already begun, the demand and recovery process was timely, and MPaRTS was updated on a timely basis.

In summary, corrective action has already been taken and there currently are no performance problems in the Data Match Recovery area. This is evidenced by our favorable Contractor Performance Evaluation results over the past few years and the results of several special reviews that have been conducted by HCFA Central Office and NY Regional Office in the area. The balance of our comments further describes the procedures that are in place in the specific areas discussed in this OIG review.

Case Documentation

GHI utilizes an Accountability Worksheet for each case. These worksheets include a written description of the difference between the identified amount and the recovered amount where such a difference exists. A detailed explanation of all critical decisions made to support all write-offs of potential mistaken Medicare payments is kept in the case file. Additionally, the SMART system tracks and ages cases while providing a detailed audit trail.

As discussed with the OIG Auditors, Accountability Worksheets were utilized at the time of OIG review, however, the OIG review consisted of cases that began in the 1992 to 1993 time period.

Timeliness of Demand and Recovery Process

In September 1993, we implemented Phase II of the SMART system to flag, age and prioritize Data Match recovery cases. At the time of the OIG review the SMART system was fully implemented, however, the cases included in this OIG review pre-dated Phase II of SMART. Since that time we have been timely in our demand packages and follow up letters. Follow up letters have recently been eliminated per HCFA instruction.

In addition, HCFA issued the attached letter dated December 30, 1993 which discussed time frames for the Data Match recovery process. Paragraph 1 stated that effective with cycle 20, the recovery actions should be completed by the eighth month after the date of receipt. Paragraph two of this letter specifically states that contractors in Regions I, II and III (including GHI) were told to put aside the early cycles in order to deal with the Provident litigation. The six month time frame was not applied for this

workload in FY 1993. It is our opinion that OIG should take this HCFA determination into account for this report.

Timeliness of MPaRTS Updates

Since the time of the OIG audit we have been current in our updates to the MPaRTS system. MPaRTS is updated within 21 days of completion of research on claims history and within 10 days of completion of recovery action (partial or full payment). We currently update MPaRTS at a minimum of once per week and daily when volume warrants.

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
Division of Medicare
Carrier Operations Branch
New York, N.Y. 10278

PROFS DOCUMENT

DATE: December 30, 1993

TO: All Carriers

SUBJECT: DATA MATCH TIME FRAMES

We have had several requests for clarification of the time frames that should be applied to the Data Match recovery process. Cycles 16 - 19 should be completed by May 31, 1994. Starting with cycle 20, the recovery actions should be completed by the eighth month after the date of receipt. Cycle 19 was received in the same quarter as cycles 16-18 and should be treated in the same way. See our letter of December 3, 1993.

Time frames for the completion of cycles 1-15 has been a confusing issue in FY 93. From October 1992 through January 1993 while most contractors in the nation were dealing with the early cycles of the Data Match workload, contractors in Regions I, II and III were instructed to put aside this work in order to deal with the Provident litigation. The six month timeframe which HCFA established shortly after this could not be reasonably applied to contractors which had halted Data Match Work at HCFA's direction. Then at the end of the fiscal year, HCFA instructed contractors to make first demand letters for cycles 1-15 the first priority. Second demand letters were to be worked only if they did not interfere with meeting the first goal. The net result is that the six month timeframe was suspended in Region II for virtually all of FY 93.

The following is our expectations for completing the demand process for cycles 1-15. For those cycles that were included in the automated demand system (SMART for VMS users), the mandated time frames would go into effect for the second and third demand letters as of the implementation of phase II. All first demand letters for cycles 1-15 were mailed by October 1, 1993. A second demand letter should have already been sent on any case where there is no unanswered correspondence. Any second demand letters not yet sent must be processed and mailed immediately. Third demands should be sent based on the appropriate time interval.

Demand amounts should already be entered in MPARTS for all demand letters sent out to date.

If you have any questions, please contact me at (212) 264-3124.

Sincerely,

/s/

Jerry Kerr
Part B MSP Coordinator
Division of Medicare