DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAY 2 2003

TO: Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette
Acting Principal Deputy Inspector General

SUBJECT: Review of Calendar Year 1999 and 2000 Cost Reports Submitted by Scott & White Health Plan to the Centers for Medicare and Medicaid Services for Reimbursement (A-06-02-00034)

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance of the subject final audit report within 5 business days from the date of this memorandum. A copy of the report is attached. We suggest you share this report with the Centers for Medicare and Medicaid Services (CMS), Center for Beneficiary Choices, Health Plan Benefits Group, Division of Cost Plans.

The objectives of our review were to determine whether the costs claimed by Scott & White Health Plan (Plan) – a cost-based health maintenance organization (HMO) were: (1) in accordance with the Medicare cost principles set forth in 42 CFR 417 Subpart O and the HMO Manual, and (2) for services that had already been reimbursed under the Medicare fee-for-service payment system.

Our review showed that the Plan had overstated costs claimed on both its 1999 and 2000 Medicare cost reports by about $8.2 million. Approximately 95 percent of the Plan's 1999 and 2000 costs were for professional services rendered by the Scott & White Clinic (Clinic). The remaining 5 percent of the Plan's costs were for non-clinic costs. We found that the Plan had claimed about $9.2 million of unallowable clinic costs. The remaining net underpayment of about $1 million related to errors in reporting non-clinic costs. Some of the errors we noted were associated with pharmacy cost and had an impact on prior cost reporting periods.

	1999 PLAN COST REPORT	2000 PLAN COST REPORT	TOTAL
Unallowable Clinic Costs	$ 6,519,744	$ 2,724,752	$ 9,244,496
Non-clinic Errors	160,439	(1,175,361)	(1,014,922)
Total Overstated Costs	$ 6,680,183	$ 1,549,391	$ 8,229,574

In addition, the Plan was not in compliance with the financial disclosure requirements for related party administrative costs totaling about $14 million for both 1999 and 2000. The 42 CFR

417.126 requires that an HMO disclose significant business transactions with related parties. The HMO must be able to demonstrate whether the cost of these transactions was less than the cost that would have been incurred with an unrelated party. If the cost incurred using the related party is higher, then the HMO must provide justification that the related party transaction was necessary and proper. As a result, we could not determine the reasonableness of these costs.

During the cost years under review, the Plan was also not in compliance with the HMO Manual on how to process costs claimed for services that were already reimbursed under the Medicare fee-for-service system. The HMO Manual requires the Plan to retrieve the overpayment from the provider and record it as a credit on the Plan's cost report. However, the Plan's procedures were to notify the provider of the duplicate payment and have the provider return the payment to Medicare. In addition, the Plan did not maintain a listing of the duplicate payments to ensure that the Medicare program was properly refunded.

We recommend that the Plan: (1) file an amended 1999 Medicare cost report to decrease the amount claimed by about $6.7 million; (2) file an amended 2000 Medicare cost report to decrease the amount claimed by about $1.5 million; (3) adhere to the reporting requirements for disclosing significant related party transactions; (4) make sure that the duplicate payment controls established in accordance with the HMO Manual are functioning properly; and (5) file amended Medicare cost reports for errors impacting prior years.

The Plan generally concurred with our recommendations and said it is working with CMS to implement them. The Plan stated that it will file an amended Medicare cost report for 2000 and either file an amended cost report for 1999, or make the necessary corrections as part of the ongoing audit process. The Plan also stated that cost years 1997 and 1998 are being addressed in ongoing CMS audits and that cost years prior to 1997 are not subject to reopening. The complete text of the Plan's response is presented as **APPENDIX A** to this report. We modified the final report to address the Plan's comments concerning the reporting requirement regulation and added clarification for a clinic cost report adjustment.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to David A. Dimler, Audit Director, Medicare Managed Care & Contractor Audits, at (410) 786-7102 or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-9206.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

MAY - 7 2003

Report Number A-06-02-00034

Ms. Michelle Delegram
Associate Executive Director – Finance
Scott & White Health Plan
2401 South 31st Street
Temple, Texas 76508

Dear Ms. Delegram:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS) final report entitled, "Review of Calendar Year 1999 and 2000 Cost Reports Submitted by Scott & White Health Plan to the Centers for Medicare and Medicaid Services for Reimbursement." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Report Number A-06-02-00034 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

James R. Farris, M.D.
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF CALENDAR YEAR 1999 AND 2000 COST REPORTS SUBMITTED BY SCOTT & WHITE HEALTH PLAN TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR REIMBURSEMENT

JANET REHNQUIST
Inspector General

MAY 2003
A-06-02-00034

DEPARTMENT OF HEALTH & HUMAN SERVICES | Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

MAY - 7 2003

Report Number A-06-02-00034

Ms. Michelle Delegram
Associate Executive Director - Finance
Scott & White Health Plan
2401 South 31st Street
Temple, Texas 76508

Dear Ms. Delegram:

This final report provides the results of our review of the Calendar Year 1999 and 2000 cost reports submitted by Scott & White Health Plan (Plan) to the Centers for Medicare and Medicaid Services (CMS) for reimbursement. The purpose of this review was to assess whether the costs claimed were: (1) in accordance with the Medicare cost principles set forth in 42 CFR 417 Subpart O and the health maintenance organization (HMO) Manual, and (2) for services that had also already been reimbursed under the Medicare fee-for-service payment system.

Our review showed that the Plan had overstated costs claimed on both the 1999 and 2000 Medicare cost reports by about $8.2 million. Approximately 95 percent of the Plan's 1999 and 2000 costs were for professional services rendered by the Scott & White Clinic (Clinic). The remaining 5 percent of the Plan's costs were for non-clinic costs. We found that the Plan had claimed about $9.2 million of unallowable clinic costs. The remaining net underpayment of about $1 million related to errors in reporting non-clinic costs. Some of the errors we noted were associated with pharmacy cost and had an impact on prior cost reporting periods.

	1999 PLAN COST REPORT	2000 PLAN COST REPORT	TOTAL
Unallowable Clinic Costs	$ 6,519,744	$ 2,724,752	$ 9,244,496
Non-clinic Errors	160,439	(1,175,361)	(1,014,922)
Total Overstated Costs	$ 6,680,183	$ 1,549,391	$ 8,229,574

In addition, the Plan was not in compliance with the financial disclosure requirements for related party administrative costs totaling about $14 million for both 1999 and 2000. The 42 CFR 417.126 requires that an HMO disclose significant business transactions with related parties. The HMO must be able to demonstrate whether the cost of these transactions was less than the cost that would have been incurred with an unrelated party. If the cost incurred using the related party is higher, then the HMO must provide justification that the related party transaction was necessary and proper. As a result, we could not determine the reasonableness of these costs.

During the cost years under review, the Plan was also not in compliance with the HMO Manual on how to process costs claimed for services that were already reimbursed under the Medicare fee-for-service system. The HMO Manual requires the Plan to retrieve the overpayment from the provider and record it as a credit on the Plan's cost report. However, the Plan's procedures were to notify the provider of the duplicate payment, and have the provider return the payment to Medicare. In addition, the Plan did not maintain a listing of the duplicate payments to ensure that the Medicare program was properly refunded.

RECOMMENDATIONS

We recommended that the Plan:

- file an amended 1999 Medicare cost report to decrease the amount claimed by about $6.7 million;
- file an amended 2000 Medicare cost report to decrease the amount claimed by about $1.5 million;
- adhere to the reporting requirements under 42 CFR 417.126 for disclosing significant related party transactions;
- make sure that the duplicate payment controls established in accordance with the HMO Manual are functioning properly; and
- file amended Medicare cost reports for errors impacting prior years.

The Plan generally concurred with our recommendations and said it is working with CMS to implement them. The Plan stated that it will file an amended Medicare cost report for 2000 and either file an amended cost report for 1999, or make the necessary corrections as part of the ongoing audit process. The Plan also stated that cost years 1997 and 1998 are being addressed in ongoing CMS audits and that cost years prior to 1997 are not subject to reopening. The complete text of the Plan's response is presented as **APPENDIX A** to this report. We modified the final report to address the Plan's comments concerning the reporting requirement regulation and added clarification for a clinic cost report adjustment.

INTRODUCTION

BACKGROUND

The Plan is a cost-based HMO under contract with CMS to provide health services on a prepayment basis to enrolled Medicare members. Under a cost-based arrangement, CMS makes an interim payment each month to the Plan based on a per capita rate for each Medicare member. The interim payments are reconciled with the HMO's annual cost report. For contract years

1999 and 2000, the Plan claimed $6.8 million and $6.9 million, respectively, for additional Medicare costs over the amounts received as interim payments. The CMS contracts with auditors to review the Medicare cost reports. During the audit period, the Plan's 1999 cost report was under review by CMS contracted auditors.

Cost-based HMOs are paid the reasonable cost incurred in providing Medicare covered services. The allowable costs are determined in accordance with the principles set forth in 42 CFR 417 Subpart O, the HMO Manual (currently referred to as the Medicare Managed Care Manual), the Provider Reimbursement Manual (PRM), and generally accepted accounting principles.

The Plan is affiliated with the Clinic and Scott & White Memorial Hospital (Hospital). The Plan contracts with the Clinic to provide all professional services to its members and pays the Clinic for these services on a capitation basis. The Plan makes adjustments to the capitation payment for professional services paid directly by the Plan. These adjustments are referred to as "chargebacks." The Plan also entered into a contractual agreement with the Hospital to provide hospital services to the Plan members. The Hospital files claims for services provided to Medicare members directly with the Medicare fiscal intermediary. The Plan also contracted with the Clinic and the Hospital for certain administrative and management services. The Clinic prepares a cost report annually to determine the costs that should be reflected on the Plan's cost report. This report is not filed with CMS or the fiscal intermediary; it is only used internally. The following calculations are made on the clinic cost report to arrive at the Plan's Medicare costs from the Clinic:[1]

- a cost-to-charge ratio is calculated by dividing total clinic expenses by total clinic revenue,

- health plan cost is determined by multiplying the cost-to-charge ratio by revenue from supplying services to health plan members, and

- Medicare costs are then determined by multiplying health plan costs by the ratio of Medicare revenue to total revenue.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our review were to assess whether the costs claimed were:

- in accordance with the Medicare cost principles set forth in 42 CFR 417 Subpart O and the HMO Manual, and

- for services that had already been reimbursed under the Medicare fee-for-service payment system.

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[1] An independent accounting firm tested this methodology and found it to be a reasonable basis for apportioning clinic costs to the Plan.

Scope and Methodology

Our review was conducted in accordance with generally accepted government auditing standards. Our audit work was performed at the Plan in Temple, Texas and at our Austin and Dallas field offices during the period February 2002 through November 2002.

Cost Report Reviews

To determine whether the costs claimed on the 1999 and 2000 Medicare cost reports were in compliance with Medicare reimbursement rules, we:

- verified the accuracy of the Medicare cost reports and traced cost items to support documentation,
- interviewed the Plan officials regarding costs claimed,
- traced plan administration costs to the general ledgers,
- reviewed the clinic cost reports and traced the expenses and revenues to the working trial balances and verified the overhead step-down allocation,
- reviewed the supporting ledgers for the Medicare charges on the clinic cost report for non-covered services,
- reviewed a judgmental sample of administration expenses, and
- relied on an independent accounting firm's report that tested the methodology of apportioning clinic costs to the Plan.

Duplicate Payment Review

We obtained a database of Medicare fee-for-service paid claims for all the Plan members during 1999. We then obtained a listing from the Plan of all claims included in the Medicare cost report for 1999. We compared the two files to generate a listing of payments for beneficiaries with the same health insurance claim numbers, dates of service, and similar types of procedures. This database match was based on line items, or the individual CMS common procedure coding system codes for each claim. We selected a statistical sample of 30 line items for review. We also selected a sample of 72 Explanation of Medicare Benefits (EOMB) that were sent to the Plan by the fiscal intermediary for 1999 and 2000. The Plan used these EOMBs in its duplicate detection process. For the sampled EOMBs, we reviewed supporting documentation to determine whether any duplicate payments detected were properly refunded.

FINDINGS AND RECOMMENDATIONS

Our review showed that the Plan had overstated costs claimed on both the 1999 and 2000 Medicare cost reports by about $8.2 million. The Plan had claimed about $9.2 million of unallowable clinic costs. The remaining net underpayment of about $1 million related to errors in reporting non-clinic costs.

	1999 PLAN COST REPORT	2000 PLAN COST REPORT	TOTAL
Unallowable Clinic Costs	$ 6,519,744[2]	$ 2,724,752	$ 9,244,496
Non-clinic Errors	160,439	(1,175,361)	(1,014,922)
Total Overstated Costs	$ 6,680,183	$ 1,549,391	$ 8,229,574

In addition, the Plan was not in compliance with the financial disclosure requirements for related party administrative costs totaling about $14 million for both 1999 and 2000. The 42 CFR 417.126 requires that an HMO disclose significant business transactions with related parties. The HMO must be able to demonstrate whether the cost of these transactions was less than the cost that would have been incurred with an unrelated party. If the cost incurred using the related party is higher, then the HMO must provide justification that the related party transaction was necessary and proper. As a result, we could not determine the reasonableness of these costs. The Plan officials were not aware of these disclosure requirements.

During 1999 and 2000, the Plan was also not in compliance with the HMO Manual on how to process costs claimed for services that were already reimbursed under the Medicare fee-for-service system. The HMO Manual requires the Plan to retrieve the overpayment from the provider and record it as a credit on the Plan's cost report. However, the Plan's procedures were to notify the provider of the duplicate payment, and have the provider return the payment to Medicare. In addition, the Plan did not maintain a listing of the duplicate payments to ensure that the Medicare program was properly refunded.

1999 AND 2000 MEDICARE COST REPORTS

Our review showed that the Plan overstated costs claimed on both the 1999 and 2000 Medicare cost reports by about $6.7 million and $1.5 million, respectively:

[2] We added chargebacks to the Plan's cost report for 1999 resulting in an understatement of about $2.3 million that we reported under "Unallowable Clinic Costs." Because this error related to the clinic cost report, we offset the total clinic cost report overstatement of about $8.8 million by the $2.3 million understatement resulting in a net overstatement about $6.5 million.

	1999 PLAN COST REPORT		2000 PLAN COST REPORT		TOTAL	
Unallowable Clinic Costs		$6,519,744		$2,724,752		$9,244,496
Non-Clinic Cost Report Errors:						
Durable Medical Equipment (DME) & Transportation	$ 105,069		($1,522,222)		($1,417,153)	
Posting Errors	137,101		167,972		305,073	
Third Party Revenue	88,127		41,928		130,055	
Chargebacks	-		122,126		122,126	
Unallowable Costs	29,153		23,717		52,870	
Administrative & General (A&G)	(192,877)		-		(192,877)	
Member Months	(6,134)		(8,882)		(15,016)	
Sub-total Non-clinic Errors		160,439		(1,175,361)		(1,014,922)
Total Overstated Costs		$6,680,183		$1,549,391		$8,229,574

Unallowable Clinic Costs

The Plan relied on the clinic cost report for recording the cost of services furnished by the Clinic. According to section 4107 of the HMO Manual, cost data must be accurate and in sufficient detail to determine the HMO's costs. The costs must also be for covered Medicare services. Errors on the clinic cost reports impact the apportionment of Medicare costs on the plan cost reports. The clinic cost reports contained the following errors that resulted in the amount claimed by the Plan being overstated by about $6.5 million in 1999 and about $2.7 million in 2000.

Pharmacy Costs

The Clinic double counted drug costs totaling about $8.6 million in 1999 and about $9.7 million in 2000 in the clinic cost report. These costs were used to derive the cost-to-charge ratio in the clinic cost report. The cost to the Hospital for the drugs dispensed to the Clinic for treating clinic patients was reflected on the pharmacy line of the clinic cost report. The clinic cost for these same drugs was also reflected in the direct clinic cost centers. In addition, the costs included a mark-up used for internal purposes intended to cover any additional costs in dispensing the drugs. When the clinic cost report was prepared, the Clinic should have made an adjustment to remove the drug costs from the pharmacy center to avoid double counting. In addition, in 1999 the Clinic included a portion of the mark-up on drug costs totaling $567,654 in administrative and general costs. These costs are part of the clinic drug costs and should be reclassified to the pharmacy line.

The Clinic also included hospital drug costs totaling about $8 million in 1999 and $10.4 million in 2000 in the pharmacy line of the clinic cost report. These costs were used to derive the cost-to-charge ratio in the clinic cost report. The costs of the pharmaceutical agents used in the treatment of hospital patients mistakenly remained in the pharmacy line.

These costs should have been reclassified to the Hospital when the clinic cost report was prepared.

The Clinic also made similar errors in reporting drug costs for 1996, 1997, and 1998. The Plan advised us that it was submitting proposed audit adjustments to CMS for these cost years to correct drug costs.

Chargebacks

In 1999, the Clinic inappropriately included chargebacks totaling about $24 million for Medicare and commercial members in the clinic cost report. These costs were used to derive the cost-to-charge ratio in the clinic cost report. However, chargebacks should be reported directly on the health plan cost report. The Plan officials did not know the correct treatment of chargebacks until informed by the auditors contracted by CMS. There was no associated revenue for chargebacks at the Clinic. Therefore, these costs should not be included on the clinic cost report. According to Section 4106 of the HMO Manual, cost data must be based on the accrual basis of accounting that requires matching expenses with their related revenue.

Revenues

In 1999, the Clinic did not offset internship expenses by revenue totaling about $11 million received from a university. In addition, the Clinic did not include revenue from the satellite clinics totaling about $19 million on the clinic cost report. The PRM section 2302.5 requires that expenses be offset by related income. The satellite clinics changed billing systems in the spring of 1999. Revenue prior to the conversion was not included in revenue on the clinic cost report.

The Clinic reported revenues on the clinic cost report based on hypothetical revenue (unit times price). The Clinic re-ran the revenues to reflect actual revenues that tied to the Plan's financials as requested by the CMS contracted auditors. Actual revenues were lower than using hypothetical revenues by about $34.5 million in 1999 and $84.9 million in 2000. Revenues were used to derive the cost-to-charge ratio and the Medicare revenues-to-total revenues ratio in the clinic cost report.

Reclassification

The Clinic inappropriately included psychology and laboratory costs under the clinic costs category. These costs totaling about $30 million in 1999 and $2.6 million in 2000 affect the cost-to-charge ratios and should be reclassified to the appropriate psychology and clinical pathology lines on the clinic cost report.

Non-Covered Services

The Clinic inappropriately included Medicare charges totaling $168,487 in 1999 and $156,040 in 2000 for non-covered services on the clinic cost report. Services such as refraction, contact lens fitting, hearing aid exams, blood pressure monitoring, and

preventative medicine were included. Non-covered services were included on the clinic cost report due to lack of communication between the Plan and the Clinic.

The Clinic also inappropriately included charges totaling $488,307 for 1999 and $482,770 for 2000 for psychiatric and dialysis services on the clinic cost reports. These services should be paid directly to the Clinic through the Medicare fee-for-service payment system. However, the charges were included on the clinic cost reports due to lack of communications between the Plan and the Clinic.

Non-Clinic Cost Report Errors

The Plan made errors in reporting costs it incurred directly that were not on the clinic cost report. According to section 4107 of the HMO Manual, cost data must be accurate and in sufficient detail to determine the HMO's costs. As a result of the following errors, the plan cost report was overstated by $160,439 in 1999 and understated by about $1.2 million in 2000.

Durable Medical Equipment and Transportation

The Plan did not match expenses with their related revenue in the period they were earned. This occurred because the Plan reported the expenses based on paid dates and did not establish an incurred but not reported (IBNR) account to adjust to dates of service. Section 4106 of the HMO Manual requires cost data to be based on the accrual basis of accounting. The accrual basis of accounting requires that expenses be matched with their related revenue in the period they are earned, regardless of when they are paid.

For 1999, the Plan reported DME and transportation costs based on paid dates without adjusting for IBNR. In addition, transportation costs included unallowable services. As a result, DME and transportation costs were overstated a net $50,061. The related costs for coinsurance and deductibles were overstated by $34,635.[3] As a result, the amount claimed by the Plan was overstated by $105,069. Unallowable services were included in transportation because the program to exclude such services was not in place in 1999.

For 2000, the Plan also reported DME and transportation costs based on paid dates. In addition, the Plan implemented a new program in 2000 that reduced Medicare DME and transportation costs claimed by non-covered services. However, this program was not verified by the Plan resulting in DME and transportation costs being understated by about $1.9 million. The related coinsurance and deductibles were understated by $394,512.[3] As a result, the amount claimed by the Plan was understated by about $1.5 million.

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[3] Because the Plan officials were unable to provide the related coinsurance and deductibles based on date of service for 1999 and 2000, we applied coinsurance and deductible amounts based on paid dates.

Posting Errors

The Plan inadvertently made posting errors causing the Medicare and commercial costs for certain administrative accounts to be overstated by about $1.1 million in 1999 and about $1.2 million in 2000. As a result, the amount claimed by the Plan was overstated by $137,101 in 1999 and by $167,972 in 2000. According to section 4107 of the HMO Manual, cost data developed by an HMO must be accurate and in sufficient detail to determine the HMO's costs.

- In 1999, the Plan inappropriately posted pharmacy administrative expenses to the state tax premium account. The general ledger was corrected before the books for the year closed, but the Plan officials used the wrong general ledger when preparing the cost report. In addition, the Plan made errors in posting adjustments on the cost report for bank charges and interest expenses.

- In 2000, the Plan inappropriately increased the cost report by double counting contributions and donations, reserves, and income taxes, rather than reducing the cost report by these unallowable costs. In addition, the Plan inappropriately posted audit fees on the wrong worksheet on the health plan cost report.

Third Party Revenue

The Plan did not apply the correct offset to certain administrative and clinic expenses with related revenue. As a result, the amount claimed by the Plan was overstated by $88,127 in 1999 and by $41,928 in 2000.

- The Plan charged the Hospital a fee, based on the plan's estimated costs, to administer the Hospital's self-insurance plan. The Plan offset expenses related to the self-insurance program, but the offset was based on a budgeted fee rather than actual costs associated with the related party agreement. As a result, plan administration was understated by $22,074 in 1999 and overstated by $375,803 in 2000. This occurred because the Plan officials did not run a report on actual costs at yearend for Medicare cost reporting purposes. The offset should be based on actual costs in accordance with the PRM section 1000 which states that costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization.

- In 1999, the Plan did not offset the medical record processing expenses by the revenue generated from individual processing fees. As a result, plan administration was overstated by $33,084. This occurred because the Plan officials were not aware that this offset was required. The PRM section 2302.5 requires that expenses be offset by related income.

- In 1999, the Plan did not offset clinic costs by receivables from subrogation. As a result, claim costs were overstated by $320,749. Subrogation is the assumption by a third party (as a second creditor or insurance company) of another's legal right to collect a debt or damages incurred due to claims not being paid. The Plan initially pays the claim and a follow up is done with the beneficiary of the claim to ensure that a third party is not liable. In 2000, the Plan used paid dates rather than dates of service in calculating the offsetting subrogation. As a result, subrogation was overstated by $34,101. The PRM section 2302.5 requires that expenses be offset by related income. At the time, the Plan officials were not aware that this offset was required.

Chargebacks

In 2000, the Plan reported chargebacks based on paid date rather than dates of service, without any adjustment for IBNR. As a result, chargebacks for Medicare and commercial members were understated by about $4.7 million causing the amount claimed by the Plan to be overstated by $122,126. The Plan used paid dates rather than service dates because the Plan officials were instructed to do so by previous CMS contracted auditors and they did not set up an account to track the IBNR expenses. Section 4106 of the HMO Manual requires cost data to be based on the accrual basis of accounting. Expenses must be matched with their related revenue in the period they are earned, regardless of when they are paid.

Unallowable Costs

The Plan claimed administrative costs that are not allowable under Medicare. As a result, the amount claimed by the Plan was overstated by $29,153 in 1999 and $23,717 in 2000. The Plan officials did not realize that these costs were being included in the cost report. The Plan claimed:

- premium bad debts of $22,750 in 1999 and $5,977 in 2000; such costs are unallowable under Medicare per section 300 of the PRM;

- dental administrative expenses of $76,505 in 1999 and $125,678 in 2000; such costs are unallowable under Medicare per 42 CFR 411.15; and

- donations of $26,814 in 1999; such costs are unallowable under Medicare per section 2102.3 of the PRM.

Administrative & General Costs

In 1999, the Plan did not report A&G costs totaling about $3.4 million for Medicare and commercial members. The A&G costs should have been allocated to all cost components on the Medicare cost report, rather than being included under plan administration. As a result, the amount claimed by the Plan was understated by $192,877. This occurred because the Plan did not identify A&G costs when the Medicare cost report was prepared. According to 42 CFR 417.564, A&G costs that benefit the total enrollment of the HMO and are not

directly associated with furnishing medical care must be apportioned on the basis of a ratio of Medicare enrollees to the total HMO enrollment. In addition, the instructions for prepaid health plan cost reports require A&G to be allocated.

Member Months

The Plan understated member months by 1,274 in 1999 and 1,580 in 2000. As a result, the amount claimed by the Plan was understated by $6,134 in 1999 and by $8,882 in 2000. This occurred because the Plan submitted member month additions and deletions after the submitted cost report was filed with CMS.

COMPLIANCE ISSUES

Financial Disclosure Requirements

The Plan was not in compliance with the financial disclosure requirements for related party administrative costs totaling about $14 million for both 1999 and 2000. As a result, we could not determine the reasonableness of these costs. The 42 CFR 417.126 requires that an HMO disclose significant business transactions with related parties. The HMO must be able to demonstrate whether the cost of these transactions was less than the cost that would have been incurred with an unrelated party. If the cost incurred using the related party is higher, then the HMO must provide justification that the related party transaction was necessary and proper. The Plan did not meet these disclosure requirements.

The HMO must provide a disclosure document, the CMS Form 1318, upon request for intensive reviews such as audits. The Plan did not show on Form 1318, or any other documentation, what the transactions would have cost if they had been with a non-related third party. Even though the plan pays the costs incurred by the Clinic and the Hospital, we have no assurance as to the efficiency of those costs. We have no assurance that the transactions would not have cost less if they had been with a non-related third party. Therefore, the Plan was not in compliance with the financial disclosure requirements.

Duplicate Payment Procedures

Our review of 30 Plan claims that matched items paid by Medicare directly did not reveal any duplicate payments. The claims made by the Plan were for the professional component whereas the payment by Medicare was for primarily hospital facility usage. However, the Plan did not have an adequate system in place to process the duplicates it detected. The Plan did not maintain a listing of the duplicates to ensure that Medicare received a credit. In addition, the Plan was not in compliance with the HMO Manual on how to process costs claimed for services that were already reimbursed under the Medicare fee-for-service system. To resolve a duplicate payment, the HMO is required to:

- contact the physician/supplier or enrollee to retrieve the overpayment;
- record any collections as credits on the cost report;

- notify CMS of unresolved overpayment situations; and
- not return the payment to the carrier.

The Plan's procedures were to notify the Clinic of the duplicate payment, and then the Clinic returns the payment to the carrier. According to a Plan official, the duplicate payment procedures were changed in 2001 to comply with the requirements.

Our review of 72 EOMBs showed that: 58 were for duplicate payments that the Clinic refunded Medicare; 8 were for psychology payments and not detected as duplicates by the Plan; 3 did not require refunds because the patients were not members; 2 were for duplicate payments that were refunded to Medicare after the overpayment was identified in our sample; and 1 was not a duplicate payment.

RECOMMENDATIONS

We recommended that the Plan:

- file an amended 1999 Medicare cost report to decrease the amount claimed by about $6.7 million;
- file an amended 2000 Medicare cost report to decrease the amount claimed by about $1.5 million;
- adhere to the reporting requirements under 42 CFR 417.126 for disclosing significant related party transactions;
- make sure that the duplicate payment controls established in accordance with the HMO Manual are functioning properly; and
- file amended Medicare cost reports for errors impacting prior years.

Auditee's Comments

The Plan generally concurred with our recommendations and said it is working with CMS to implement them. The Plan stated that it will file an amended Medicare cost report for 2000 and either file an amended cost report for 1999, or make the necessary corrections as part of the ongoing audit process. The Plan also stated that cost years 1997 and 1998 are being addressed in ongoing CMS audits and that cost years prior to 1997 are not subject to reopening.

The Plan expressed concerns regarding certain adjustments. Specifically, the Plan stated that:
(1) our adjustments did not reflect an add-on to the 1999 plan cost report for chargebacks;
(2) revenue from the satellite clinics was already included on the 1999 clinic cost report; and
(3) Medicare revenues for non-covered services were not included on the 1999 and 2000 clinic

cost reports. The Plan stated that a basis for dialysis and psychiatric services (non-covered services) was not included. The Plan required more detail information for the basis of our adjustment concerning the dialysis and psychiatric services.

The Plan also noted that the draft report sited the reporting requirement regulation that applies to the Medicare+Choice program and not to Medicare cost plans. In addition, the Plan believes that CMS discontinued Form 1318 formerly used to disclose the justification for related party costs, but will research the issue further. Also, the Plan believes that it had adequate duplicate payment procedures and that our sampling revealed no duplicate payments.

The complete text of the Plan's response is presented as **APPENDIX A** to this report.

Office of Inspector General's Response

We modified our draft report to add clarification for the chargeback adjustment, and address the Plan's comments concerning the reporting requirement regulation. However, we did not change our recommended adjustments to the 1999 and 2000 Medicare cost claims based on the information provided by the Plan. In response to the Plan's concerns regarding certain adjustments:

- We added clarification in the final report to show that we added chargebacks to the 1999 plan cost report resulting in an understatement of about $2.3 million that we reported under "Clinic Cost Report Errors." This understatement offset an overstatement of about $8.8 million resulting in a net overstatement of about $6.5 million for clinic cost report errors.

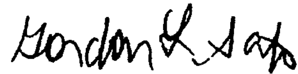
- We disagree with the Plan concerning the satellite revenue. The clinic cost report used by the Plan to prepare the 1999 Medicare cost report under review did not include revenue from the satellite clinics totaling about $19 million. This was due to the billing system conversion in the spring of 1999. However, the Clinic prepared a subsequent clinic cost report with the revenue added that we used to compute our adjustment.

- We disagree with the Plan concerning non-covered services. The clinic cost reports that were used by the Plan to prepare the 1999 and 2000 Medicare cost reports under review included Medicare revenues for non-covered services. We will provide under a separate cover more detail information for the basis of our adjustment concerning dialysis and psychiatric services.

We modified the final report to include the appropriate reporting requirement regulation for Medicare cost plans. However, CMS did not discontinue the use of Form 1318. Under the reporting requirements, Form 1318 is no longer required to be submitted as a regular annual submission. However, this form is used in the course of more intensive reviews and must be produced upon request in an audit.

In addition, we continue to believe that during the cost years under review, the Plan's duplicate payment procedures were not adequate. Our review of procedures and a sample of EOMBs revealed duplicates and weaknesses in controls.

Sincerely,



Gordon L. Sato
Regional Inspector General
for Audit Services

APPENDIX A

February 19, 2003

Mr. Gordon L. Sato
Office of Inspector General
Office of Audit Services
1100 Commerce Room 632
Dallas, Texas 75242

Re: Common Identification #: A-06-02-00034

Dear Mr. Sato:

This letter is in response to the OIG's draft report relating to the 1999 and 2000 Scott & White Health Plan ("SWHP" or "Plan") cost reports, forwarded by your office by letter dated January 21, 2003 ("Draft Report"). The Draft Report divides the issues into "clinic" cost report errors, and "non-clinic" errors.

We would like to take this opportunity to point out that many of the findings in the Draft Report related to issues that had already been identified during the CMS audits of our 1997, 1998 and 1999 cost reports. These were almost entirely "clinic" errors. We agreed with the findings identified during those audits, and made those changes in the 2000 cost report that we filed in 2001. The 2000 cost report has not yet been audited by CMS. We also brought those findings to the attention of the OIG auditors, and they have now been included in the OIG's draft report.

Issues identified in annual CMS audits of our 1997-1999 cost reports (principally "clinic" issues) are already being handled as part of those audits in terms of any adjustments to reimbursement. For the one significant "clinic" issue that we discovered during the OIG audit (the pharmacy issue described below), Scott and White promptly advised both OIG and CMS, and made arrangements with CMS for appropriate adjustments to the cost reports that were in the process of being audited or had been settled. As noted below, we therefore accept the recommendations made by OIG on most items, and in most cases have implemented them already. Apart from "clinic" issues, which were self-identified to OIG by Scott and White, the "non-clinic" issues identified in the OIG report resulted in a net favorable impact to Scott and White of over $1 million.

CLINIC COST REPORT ERRORS

Pharmacy Costs
Due to an oversight, the Scott and White Clinic ("Clinic") costs for pharmacy and related costs were overstated on the internal Clinic pro forma report that is employed in preparing the Plan

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Temple, Texas 76508
(254) 298-3000
(800) 321-7947

3000 Briarcrest, Suite 422
Bryan, Texas 77802
(979) 268-7947
(800) 791-8777

American Plaza
200 W. Highway 6, Suite 101
Waco, Texas 76712
(254) 776-5468
(800) 684-7947

Old Town Square
One Chisholm Trail, Suite 110
Round Rock, Texas 78681
(512) 310-3012
(800) 758-3012

cost report. The original query to us by the OIG did not address this as a particular concern, but rather only asked how we ensure that pharmaceutical costs claimed related to patient care. Upon investigating that question, Scott & White discovered that pharmacy costs had been inadvertently overstated and set about to determine the extent of the overstatement. Scott & White determined that the issue dated back to 1996, the time of the conversion from an HCPP to a cost contract and a time of significant computer system conversions for the Hospital and Clinic. Scott & White informed the OIG of the overstatement, ascertained and proposed to the OIG and CMS the amount of the necessary adjustments, and worked with the OIG to determine the appropriate handling.

Attached are a letter to Shellae Louden of CMS relating to the pharmacy issue for 1996 (Attachment 1), letters to Shellae Louden of CMS for 1997 and 1998 (Attachment 2), and a letter to Brenda Kyle of Kearney & Co. for 1999 (Attachment 3). Kearney and Co. is the outside entity that has contracted with CMS to conduct the Medicare audit of SWHP for the 1999 cost year. These letters propose additional adjustments to the aforementioned cost reports to correct the pharmacy issue. The letters were sent in June of 2002, prior to the completion of the OIG fieldwork, and very shortly after we informed the OIG of the error. The letter to Ms. Louden for the 1996 cost year also included a check and a request for reopening, since the cost report for 1996 had already been settled. In subsequent correspondence from the CMS Division of Cost Plans, we were informed that the 1996 cost report would not be reopened, since the statutory timeframe for reopening had passed and neither Scott & White nor CMS could waive that requirement. However, CMS did accept the proffered refund.

We feel that this finding was self-disclosed as described above.

Chargebacks
Chargebacks are payments for professional services provided by someone other than professionals employed by Scott & White Clinic. Claims made for these services by non-Scott & White providers are paid by the Plan and invoiced to the Clinic. Clinic capitation payments are reduced in the following month to reflect the amount of chargebacks in the preceding month. The Clinic does not charge for these services, but does incur the cost.

The issue of chargebacks has no clear guidance in the regulations governing Cost Plans. Historically, the chargebacks have been included as Clinic costs since the Clinic was at risk for payment of those services. That handling had been acceptable to CMS-contracted auditors for cost reports prior to 1997. During the audits of the 1997 and 1998 Plan cost reports it was recommended by the CMS-contracted audit firm, Tichenor & Associates, that chargebacks be handled on the Plan cost report instead of through the related party costs from the Clinic. The reasoning for the recommendation was that since the Clinic apportions cost based on revenue (a traditional Medicare methodology) and there is no Clinic revenue associated with the chargeback services (the Clinic does not generate a charge for these services), the chargebacks would be more appropriately handled on the Plan cost report.

While we agreed with the reasoning, and applied it to the 2000 cost year filing made in June 2001, the 1999 report (which was filed prior to the Tichenor recommendation) had not yet been

adjusted to reflect this change at the time of the OIG audit. We brought this issue to the OIG's attention and provided the data to make the appropriate adjustments to the 1999 report prior to its being settled. The Draft Report does not reflect an add-on to the Plan cost report for chargebacks. In any refiling or adjustments to the 1999 cost report, this add-on will be addressed.

The Draft Report further states that chargebacks should be accounted for on an accrual basis in order to properly match revenues with expenses. A true accrual methodology would be to include known amounts on a date of service basis with an additional accrual for IBNR at the end of the accounting period. While neither the date of service nor the cash basis of accounting provides a true accrual basis of accounting for chargebacks, the date of service basis does appear to be the most appropriate method.

Revenues
The Draft Report notes that the Clinic (on its internal pro forma report used to prepare the Plan's cost report) did not include an expense reduction for revenues received from a university in 1999. This related to services supplied to the university and Scott and White Hospital by the Clinic. This issue was addressed by an audit adjustment previously proposed during the 1999 CMS audit, and is accepted by SWHP.

The Draft Report also states that in 1999 the Clinic did not include revenue from the satellite clinics totaling about $19 million on the Clinic cost report. However, Clinic revenue from the satellite clinics was included in determining the apportionment of costs on the Plan's filed cost report. It was also included in 2000.

Again, the clinic "cost report" is simply an internal document, which is used within Scott and White to aid in the preparation of the Plan's cost report that is filed with CMS. During the course of the OIG fieldwork, many adjustments and cost report iterations of the clinic "cost report" were requested by the OIG and made available by us to the OIG staff. One of the iterations involved converting the revenue-based apportionment statistics from a revenue proxy to actual revenue (see further discussion below). In performing those calculations and creating the resulting cost report, there was a report provided to the OIG auditors that inadvertently excluded the satellite clinic revenue. That was corrected and again submitted to the OIG staff for review. The satellite clinic revenue was not omitted from the data included in the Plan cost report that was actually filed with CMS in either 1999 or 2000.

The Draft Report further notes that revenues were reported on the clinic cost report based on hypothetical revenue (unit times price), and that actual revenues were lower by about $34.5 million in 1999 and $84.9 million in 2000. However, this methodology did not result in an overpayment to the Plan, but rather slightly understated the costs for which Medicare reimbursed the Plan. (The revenue statistic is used to apportion costs. Therefore, it is the relative size rather than the absolute size of revenues that is important for this purpose.)

After the 1993 cost plan audit, the Plan commissioned the audit firm that had performed the audit, Bland & Co., to study whether actual revenue or a revenue proxy (unit times price) was

more appropriate. The concern was using actual revenue did not allow for a sufficient audit trail because, at the time, there was not a mechanism in place to capture all relevant pricing of a given procedure throughout the year. On the basis of that report, the revenue proxy had been used ever since for apportioning Clinic cost between Health Plan/Senior Care members and other patients. During the course of fieldwork by Kearney & Co. on the 1999 cost report audit, it was recommended that we discontinue that methodology and employ actual revenue. By 1999, record keeping had improved so that all relevant pricing throughout the year was now captured and available for audit. The resulting apportionment of costs was actually modestly more beneficial to Medicare using the revenue proxy as opposed to actual revenue. The difference in reimbursement, in any event, is small. Because actual revenue is more accurate, however, and it can now be adequately captured and audited, it is currently being employed as the statistic, as the OIG apparently suggests should be done.

Again, this issue was brought to the attention of the OIG by Scott and White, which had already taken the steps described above.

Reclassification
Laboratory costs had been included in the Clinic that generated the revenue. During the 1997 and 1998 fieldwork conducted by Tichenor & Associates, it was advised that all of the lab costs and associated revenues should be separately identified and reported on the lab line of the Clinic cost report for proper transfer to the Plan cost report. Since the revenue was identifiable and the costs were buried in the Clinic generating the revenue, a cost-to-charge ratio was utilized to identify those costs and move them to the lab line. This reclassification was reflected on the 2000 filed report, which was prepared after the Tichenor audit findings were revealed.

Psychology costs were again included in the Clinic that generated the revenue. During the 1999 audit fieldwork conducted by Kearney & Co., it was advised that the psychology costs should be handled similarly to the laboratory costs discussed above.

Both of these findings have been applied prospectively from the date that the recommendations were made by the Medicare audit firms, which recommendations were furnished by the Plan to the OIG auditors.

Non-Covered Services
The Draft Report states that in 1999 the Clinic inappropriately included Medicare charges of $168,487 for noncovered services. On further review, it appears that in 1999 the Clinic excluded revenues in the amount of $458,772 from the revenue statistics in the clinic cost report (which is used internally to prepare the Plan cost report). The excluded revenues consisted of revenues relating to both Medicare and non-Medicare patients. The figure of $458,772 was composed of: optical services (mainly refractions, in the amount of $149,380), dialysis services ($87,417), psychotherapy services ($183,250), and other services ($38,275). These services were deemed not to be covered. The basis for the coverage determination was the Medicare Physician Fee Schedule governing the period. The Medicare portion of the $458,772 was $168,487. The Plan believes that the non-Medicare revenues should not have been excluded, but the Medicare revenues should have been excluded (which, in fact, occurred) so that there will be no

apportionment of cost to the program. Appropriate modifications will be made during the audit process with the CMS contractor.

The Draft Report states that in 2000 the Clinic inappropriately included Medicare charges of $156,040 for noncovered services. On further review, it appears that in 2000 the Clinic excluded revenues in the amount of $440,141 from the revenue statistics in the clinic cost report (which is used internally to prepare the Plan cost report). The excluded revenues consisted of revenues relating to both Medicare and non-Medicare patients. The figure of $440,141 was composed of: optical services (mainly refractions, in the amount of $124,964), dialysis services ($56,324), psychotherapy services ($223,818), and other services ($35,035). These services were deemed not to be covered. The basis for the coverage determination was the Medicare Physician Fee Schedule governing the period. The Medicare portion of the $440,141 was $156,040. The Plan believes that the non-Medicare revenues should not have been excluded, but the Medicare revenues should have been excluded (which, in fact, occurred) so that there will be no apportionment of cost to the program. Appropriate modifications will be made in an amended cost report.

The Plan acknowledges that certain services should be billed directly to the Part B Carrier and not incorporated in the cost reimbursement claimed through the cost contract cost report, and the Plan endeavors to do so. Summary data provided by OIG, however, does not indicate a basis for the $488,307 for 1999 and $482,770 for 2000 for dialysis and psychiatric services that are claimed to have been included in the clinic apportionment of cost. Without more detailed information, the Plan is unable to comment on this finding or make any appropriate corrections.

NON-CLINIC COST REPORT ERRORS

Durable Medical Equipment and Transportation

In 1999 and 2000, Durable Medical Equipment and Transportation was based on paid date. OIG states that Durable Medical Equipment and Transportation should be accounted for based on date of service or incurred date. This suggested change affects coinsurance, deductible, costs and statistics for both Durable Medical Equipment and Transportation. It should be noted that this issue was discussed during the CMS audits for 1997, 1998 and 1999 and those auditors determined the paid date was acceptable for both costs and apportionment statistics. However, the Plan will agree with this finding by the OIG.

Posting Errors

In 1999, the Plan understated pharmacy outpatient costs and overstated Plan administration costs due to a post closing reclassification between these two expense accounts that occurred before publishing the audited financial statement. The cost report was compiled before the reclassification was made. Due to an oversight, the cost report was never updated with the reclassified expenses. In addition, costs for bank charges and interest expenses were inappropriately adjusted. These errors were identified during the CMS audits of 1997, 1998 and 1999. We agreed with those findings and made these changes in the 2000 cost report, and informed OIG of them during the OIG audit.

In 2000, the Plan made a posting error relating to contributions and donations, reserves and income taxes. We agree with this correction. However, we do not agree that the Plan posted audit fees on the wrong schedule. Audit fees increased plan costs via Worksheet G because audit expenses for cost report certification purposes were not realized until after 2000.

Third Party Revenue
In 1999 and 2000, the Plan estimated the cost to provide services and collected a fee to administer the Clinic and Hospital's self-insured plan. The fee that was collected was offset against expenses related to the self-insured program. The fee structure was reviewed during the CMS audits of 1997, 1998 and 1999. No exception was documented.

In 1999, the Plan did not offset medical record processing expenses by revenue generated from individual processing fees. In addition, the Plan did not offset Clinic costs with subrogation applicable to Clinic costs. CMS auditors identified these issues during the 1997, 1998 and 1999 audits. The Plan agreed with those findings and made changes in the 2000 cost report that we filed. They have been corrected in the prior year audits as well, including 1999.

Chargebacks
In 2000, the chargebacks were based on paid date. Our response on this issue is above under Clinic Cost Report Issues, Chargebacks section.

Unallowable Costs
During the 1997 and 1998 Plan cost reports, it was recommended by the audit firm, Tichenor & Associates that several costs were unallowable. These costs included premium bad debts, donations and dental administrative expenses. The Plan agreed with Tichenor. We brought this issue to the OIG's attention and provided the data to make the appropriate adjustments to the 1999 report.

Administrative & General Costs
In 1999, the Plan did not allocate A&G costs to all cost components. When the Plan contract first began we were informed by CMS audit staff that A&G allocation was not appropriate for the Plan. Therefore it was a practice of the Plan not to allocate A&G costs. Tichenor & Associates recommended the allocation after the CMS 1997 and 1998 audit. Additionally, CMS came out with further guidance on the issue and the Plan started allocating A&G in the 2000 cost report that we filed.

Member Months
The Plan requests member months from CMS in preparation of the cost reports. Any change that occurred was due to the Plan submission of member month additions and deletions after the cost report was filed with CMS. The Plan agrees with this audit finding.

COMPLIANCE ISSUES

Financial Disclosure Requirements
The draft report states that SWHP was not in compliance with the financial disclosure requirements for related party administrative costs. The draft audit report cites 42 CFR §422.516 as the basis for this requirement. The draft audit report also states that an HMO is obligated to disclose this information on CMS Form 1318.

In response to this point, SWHP first notes that §422.516 is a regulation that applies to the Medicare+Choice program, not to Medicare Cost plans, such as SWHP, which are subject to the requirements of Part 417, not Part 422, of CMS's Medicare regulations.

In addition, SWHP notes that CMS Form 1318 is not a current CMS reporting requirement. CMS Form 1318 was developed to fulfill the reporting requirements of Section 1318 of the Public Health Service Act, which applies to federally qualified HMOs. We contacted the office within CMS that administers CMS's responsibilities under the Paperwork Reduction Act. Those responsibilities include assuring that all reporting requirements undergo review and approval by the Office of Management and Budget (OMB) and that the reporting forms contain the current OMB approval number. After we were unable to locate CMS Form 1318 as one of the approved reporting forms on OMB's website, we inquired with CMS about the approval status of CMS Form 1318. The CMS office administering its responsibilities under the Paperwork Reduction Act told us that CMS had dropped this filing requirement. Thus, CMS Form 1318 is no longer required to be completed and submitted to CMS.

We also note that OMB's implementing regulations (5 CFR §1320.6), which apply to all government agencies, provide that no person shall be subject to any penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. The copy of this form provided to SWHP by your auditors did not contain an OMB control number.

We are continuing to review this situation and will comply with any reporting requirements that are applicable.

Duplicate Payment Procedures
SWHP has had in effect duplicate payment procedures since the inception of the HCPP and later the Cost contract (Attachments 4 and 5). The duplicate payment procedures in place prior to 2001 involved detection of the duplicate payments and reimbursement sent directly to Medicare by the provider of service. Site visits performed by the Regional CMS office staffs in 1998, 2000 and 2002 reviewed the procedure in place for detection of duplicate payments and no recommendations were made by the regional CMS staff to revise the procedure previously in place.

We disagree with the statement that the Plan did not have an adequate system in place to process the duplicates it has detected. The OIG audit sampling revealed no duplicate payments.

In September 2001, SWHP revised its duplicate payment procedures to comply with the HMO Manual on how to process costs claimed for services that were already reimbursed under the Medicare fee-for-service system. The current SWHP policy/procedure (Attachment 6) involves contacting the contracted physician/supplier to retrieve the overpayment; recording the collections as credits on the cost report; and notifying CMS regional office of any unresolved overpayment situations. Thus, we have implemented the OIG recommendation in this regard, prior to the audit.

The electronic information provided by the CMS intermediary is inadequate to perform an automated reconciliation. Information provided by the CMS intermediary on the electronic report does not contain all necessary information needed to match payment information in the Plan system. As a result, in order for the Plan to comply with CMS requirements for detection of duplicate payments it must manually compare copies of Medicare EOMB's received from the carrier against claims paid.

Recommendations
SWHP generally concurs with the recommendations of the Draft Report, and will address the specific issues as described above. In summary:

- The Plan will discuss with CMS or the CMS contractor whether it should file an amended Medicare cost report for 1999, or make the necessary corrections for 1999 as part of the ongoing audit process which is already underway for the 1999 cost year.

- The Plan will file an amended Medicare cost report for 2000, since the audit process has not yet begun for the 2000 cost year. The amended return will be filed by March 31.

- The reporting requirement under 42 C.F.R. § 422.516 does not apply to the Plan, and it appears that CMS has discontinued the use of Form 1318. However, the Plan will further review this matter.

- Controls over duplicate payments have been implemented.

- As noted above, most of the items identified in the Draft Report are being addressed in ongoing CMS audits for the 1997-1999 cost years. Cost years prior to 1997 are not subject to reopening. The Plan has affirmatively contacted CMS or CMS audit contractors, and has proposed audit adjustments, with respect to the one significant issue (pharmacy costs) that was not already being treated in these audits.

Sincerely,

Michelle Delegram
Associate Executive Director – Finance
Scott & White Health Plan

Pharmacy1

SCOTT & WHITE HEALTH PLAN

June 14, 2002

Ms. Shallae Louden
Office of Financial Management
7500 Security Blvd.
Mail Stop: C3-14-00
Baltimore, MD 21244-1850

Dear Ms. Louden:

Subject: Scott & White Health Plan, H-4564, Request for Reopening FY 1996

We respectfully request that our 1996 cost report be reopened for the issue described below. This report is past the reopening timeframe of three years from the Notice of Program Reimbursement as specified in the regulations. That timeline expired February 25, 2002. However, Scott & White Health Plan will voluntarily waive the application of that three year period for this issue only, for the amounts set forth below, without any admission that there are legal grounds for a reopening beyond the three year period.

The purpose of the reopening request is to correct an error in the determination of Clinic cost included in the Scott & White Health Plan Senior Care cost report. Through internal investigations, we have concluded that certain pharmacy costs were overstated in the Clinic cost report, which is prepared for internal use and which is used to derive the costs claimed on the Senior Care cost report.

Based on the above findings, we propose the following adjustments:

Worksheet	Line	Column	Description	Reported	Adjustment	Adjusted
H	1	4	Amount allowable in cost	80,502,647	(3,209,979)	77,292,668
F	11	4	Reclass Clinical Lab	2,743,793	(6,641)	2,737,332
F	12	5	Reclass Clinical Lab	2,743,793	(6,641)	2,737,332
F	14	4	Reclass Mental Health Svcs	2,214,228	(3,701)	2,210,527
F	14	5	Reclass Mental Health Svcs	2,214,228	(3,701)	2,210,527

The result of these adjustments is an amount due the program of $543,914. This amount is supported in the attached worksheets from the cost report and the revised Clinic one-page cost report. We have also attached a check in this amount payable to CMS.

If you have any questions please call me at 254.724.5627 or email wgalinsky@swmail.sw.org.

Sincerely,

William Galinsky, CPA
Director of Reimbursement

2401 South 31st Street
Temple, Texas 76508
(254) 298-3000
(800) 321-7947

3000 Briarcrest, Suite 422
Bryan, Texas 77802
(979) 268-7947
(800) 791-8777

American Plaza
200 W. Highway 6, Suite 101
Waco, Texas 76712
(254) 776-5468
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Baltimore MD 21244-1850

PS Form 3800, February 2000 See Reverse for Instructions

June 14, 2002

Ms. Shallae Louden
Office of Financial Management
7500 Security Blvd.
Mail Stop: C3-14-00
Baltimore, MD 21244-1850

Dear Ms. Louden:

Subject: Scott & White Health Plan, H-4564, Additional Adjustments FY 1997 and 1998

We respectfully request that additional adjustments be made to the above referenced cost reports. These reports were audited by Tichenor & Associates and are now with CMS pending final settlement.

The purpose of the adjustment requests is to correct an error in the determination of Clinic cost included in the Scott & White Health Plan Senior Care cost report. Through internal investigations, we have concluded that certain pharmacy costs were overstated in the Clinic cost report, which is prepared for internal use and which is used to derive the costs claimed on the Senior Care cost report.

Based on the above findings, we propose the following adjustments to the health plan cost reports:

1997

Worksheet	Line	Column	Description	Reported	Adjustment	Adjusted
G	Any	2	Clinic Pharmacy Cost Reduction – Main Clinic (worksheet E, line 5)	0	(5,317,399)	(5,317,399)
G	Any	2	Clinic Pharmacy Cost Reduction – Clinical Lab (worksheet E, line 8)	0	(11,719)	(11,719)
G	Any	2	Clinic Pharmacy Cost Reduction – Mental Health Services (worksheet E, line 15A)	0	(4,697)	(4,697)

2401 South 31st Street
Temple, Texas 76508
(254) 298-3000
(800) 321-7947

3000 Briarcrest, Suite 422
Bryan, Texas 77802
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(800) 791-8777

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200 W. Highway 6, Suite 101
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Old Town Square
One Chisholm Trail, Suite 110
Round Rock, Texas 78681
(512) 310-3012
(800) 758-3012

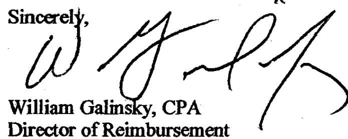
1998

Worksheet	Line	Column	Description	Reported	Adjustment	Adjusted
G	Any	2	Clinic Pharmacy Cost Reduction – Main Clinic (worksheet E, line 5)	0	(7,184,978)	(7,184,978)
G	Any	2	Clinic Pharmacy Cost Reduction – Clinical Lab (worksheet E, line 8)	0	(1,226)	(1,226)
G	Any	5	Clinic Pharmacy Cost Reduction – Mental Health Services (worksheet E, line 15A)	0	(260)	(260)

The results of these adjustments should be included with the other adjustments proposed and handled through the settlement process. This amount is supported in the attached workpapers.

If you have any questions please call me at 254.724.5627 or email wgalinsky@swmail.sw.org.

Sincerely,



William Galinsky, CPA
Director of Reimbursement

CLINIC COST REPORT - SCOTT & WHITE HEALTH PLAN COST APPORTIONMENT

Scott & White Clinic

Pharmacy Revision Difference

@CR_COMP.xls

1997	After Pharm Total Costs	Prior Pharm Total Costs	Difference Total Costs
Clinic Covered Cost (Subtotal)	107,989,715	113,307,114	(5,317,399)
Clinical Pathology Cost	3,691,231	3,702,950	(11,719)
Psychiatry Cost	3,185,184	3,189,881	(4,697)
TOTAL COVERED COST	114,866,130.00	120,199,945.00	(5,333,815)

1998	After Pharm Total Costs	Prior Pharm Total Costs	Difference Total Costs
Clinic Covered Cost (Subtotal)	152,554,405	159,739,383	(7,184,978)
Clinical Pathology Cost	3,369,907	3,371,133	(1,226)
Psychiatry Cost	2,870,893	2,871,153	(260)
TOTAL COVERED COST	158,795,205.00	165,981,669.00	(7,186,464)

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Ms. Brenda Kyle / Kearney + Co
Street, Apt. No.; or PO Box No.
4501 Ford Ave, Suite 1400
City, State, ZIP+ 4
Alexandria, VA 22302

PS Form 3800, February 2000 See Reverse for Instructions

HEALTH PLAN

June 17, 2002

Ms. Brenda Kyle
Kearney and Company
4501 Ford Avenue
Suite 1400
Alexandria, VA 22302

Dear Ms. Kyle:

Subject: Scott & White Health Plan, H-4564, Additional Adjustmer

We respectfully request that you add the following adjustment to our 1999 cost report. Hopefully, this will get us one step closer to finalizing your audit work and that we may begin the settlement process.

The purpose of the request is to correct an error in the determination of Clinic cost included in the Scott & White Health Plan Senior Care cost report. Through internal investigations, we have concluded that certain pharmacy costs were overstated in the Clinic cost report, which is prepared for internal use and which is used to derive the costs claimed on the Senior Care cost report.

Based on the above findings, we propose the following adjustments:

1999

Worksheet	Line	Column	Description	Reported	Adjustment	Adjusted
G	Any	2	Clinic Pharmacy Cost Reduction – Main Clinic (worksheet E, line 5)	0	(8,100,507)	(8,100,507)
G	Any	2	Clinic Pharmacy Cost Reduction – Clinical Lab (worksheet E, line 8)	0	(462,492)	(462,492)
G	Any	5	Clinic Pharmacy Cost Reduction – Mental Health Services (worksheet E, line 15A)	0	(56,808)	(56,808)

The result of these adjustments is an amount due the program of $543,914. This amount is supported in the attached worksheets from the cost report and the revised Clinic one-page cost report. We have also attached a check in this amount payable to CMS.

If you have any questions please call me at 254.724.5627 or email wgalinsky@swmail.sw.org.

Sincerely,

William Galinsky /dar

William Galinsky, CPA
Director of Reimbursement

2401 South 31st Street
Temple, Texas 76508
(254) 298-3000
(800) 321-7947

3000 Briarcrest, Suite 422
Bryan, Texas 77802
(979) 268-7947
(800) 791-8777

American Plaza
200 W. Highway 6, Suite 101
Waco, Texas 76712
(254) 776-5468
(800) 684-7947

Old Town Square
One Chisholm Trail, Suite 110
Round Rock, Texas 78681
(512) 310-3012
(800) 758-3012

391620507
Page 1 of 2

Medicare Summary Notice

June 30, 1999

SCOTT AND WHITE HEALTH PLAN
HMO for
2401 S 31ST STREET
TEMPLE TX 76508-0001

CUSTOMER SERVICE INFORMATION

Your Medicare Number:

If you have any questions, write or call:
Medicare Part B
P.O. Box 660156
Dallas, Tx 75266-0156

Toll-Free: 1-800-442-2620 TX
TTY for hearing impaired: 1-800-516-6684

HELP STOP FRAUD: Be informed - Read your Medicare Summary Notice.

This is a summary of claims processed on 06/17/1999.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section

Deductible Information:

You have met the Part B deductible for 1999.

General Information:

Who pays? You pay. Report Medicare fraud by calling 1-800-447-8477. An example of Medicare fraud would be claims for Medicare items or services you did not receive. If you have any other questions about your claim, please contact the Medicare contractor telephone number shown on this notice.

THIS IS NOT A BILL - Keep this notice for your records.

Your Medicare Number:

General Information (continued):

Under the Privacy Act, Medicare cannot release information about you to anyone without your consent. Written consent can be for one time or on-going. An on-going consent will be valid until you change it. Verbal consent is valid for 30 days. Medicare is required to verify your name, Medicare number and date of birth with the caller. This must be verified again with you. The only information we can give the caller without your prior consent is whether we have received or processed a claim.

You have the right to request an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly if you would like an itemized statement.

Appeals Information - Part B

If you disagree with any claims decision on this notice, you can request an appeal by **December 30, 19**
Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.
2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1
3) Sign here_________________________________ Phone number (____)_____________

CLINIC COST REPORT - SCOTT & WHITE HEALTH PLAN COST APPORTIONMENT

Scott & White Clinic

Pharmacy Revision Difference

@CR_COMP.xls

1999	After Pharm Total Costs	Prior Pharm Total Costs	Difference Total Costs
Clinic Covered Cost (Subtotal)	133,913,152	142,013,659	(8,100,507)
Clinical Pathology Cost	15,674,393	16,136,885	(462,492)
Psychiatry Cost	4,708,639	4,765,447	(56,808)
TOTAL COVERED COST	154,296,184.00	162,915,991.00	(8,619,807)

SWHP

Accounting Policy/Procedure

Subject: Detection of SeniorCare Duplicate Claim Payments

Effective Date: January 1, 1993

☒ New Policy/Procedure ☐ Change ☐ Clarification

Purpose:

To comply with HCFA contractual guidelines regarding detection of duplicate payments of SeniorCare claims to either the physician, supplier, or SeniorCare enrollee.

Procedure:

1. The S&W Clinic Claims Adjudicator receives copies of the Explanation of Medicare Benefits (EOMB) from Medicare.
2. EOMB's are sorted by S&W providers and non-S&W providers.
3. S&W providers:
   a) EOMB's for S&W Clinic providers are researched on the AMISYS system by the claim adjudicators to determine SeniorCare member eligibility. The claim adjudicators also determine whether charges were billed appropriately to SWHP by the Clinic.
   b) If it is determined charges were filed by the Clinic in error to Medicare, a copy of the EOMB (with membership information) is sent to the appropriate Clinic. The Clinic is responsible for generating the refund to Medicare.
4. Non-S&W providers:
   a) EOMB's for non-S&W providers are sorted by date of service and filed alphabetically by patient name.
   b) EOMB'S are compared to the claims payable system to determine if any duplicate payments have been made by SWHP and Medicare.
   c) A report (MCR37R) is generated monthly listing all SeniorCare claims paid by SWHP to non-S&W providers.
   d) The report is researched for any claims where a duplicate payment may have been made (SeniorCare claims paid in full).
   e) When a claim is identified as a possible duplicate payment, the claim and related Medicare EOMB are researched. If Medicare has paid its portion and SWHP has paid the claim in full, a refund/recoup will be requested from the provider of service.

Prepared By: Vernell Labaj

Approved By: **Date:** 1/1/93

Distribution: Carol Medford, Elizabeth Morgan, Michelle Delegram, Brenda Griffith

CM/kf
Claim.pol

Describe the systems/procedures the organization will implement to: (1) avoid duplicate payments of health care services and (2) assure coordination of benefits.

Duplicate payments can arise because there are several entities that have jurisdiction over the processing and payment of Part B bills for Medicare beneficiaries. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent upon you to establish a system to preclude or detect duplicate payments.

Scott and White Health Plan contracts with Scott and White Clinic to provide medical services to all of its enrollees. Scott and White Clinic (Clinic) is a group multi-specialty practice with more than 300 physicians, scientists and other health professionals on staff. SWHP has contracted with the Clinic since 1982 to provide these services. The Health Plan and Clinic have developed a sophisticated method for the Clinic to identify HMO members in their registration and billing system.

Because SWHP pays the Clinic a capitation for all services covered under Medicare Part B, the Clinic automatically "bills" the fee-for-service equivalent of these charges to SWHP thereby creating a zero balance on the patient account. In the event that another entity was to make payment to the Clinic for services covered by the HMO it would create a credit balance on the patient account which would require research and a possible refund to the payor by the Clinic.

It is our understanding that the most common problem with duplicate payments is in the area of referral services. Because the Clinic has numerous secondary and tertiary care providers on staff, it is very rare that SWHP would need to refer to an outside physician. Also, because a copy of the Explanation of Medicare Benefits (EOMB) is sent to an HMO enrollee's HMO, SWHP will review these EOMB's on a routine basis to verify against our information that there was not a duplicate payment.

It is our understanding that we will also receive a report entitled, "Payment Records Posted in Month, Year, HMO Name Update." This report identifies payments made by Medicare for HMO enrollees. These are all services which should be covered by the HMO. Initially, SWHP Claims Processors will manually compare payments on this list to services covered by the HMO to identify any potential duplicate payments. If we determine that this manual review is too cumbersome we will work with Medicare to receive this information by magnetic tape or electronic transmission. We could then develop a program in-house which would run these Medicare records against our HMO payment records to identify any duplicate payments.

SWHP also intends to utilize the newsletter for Medicare enrollees as a method to educate members on the prevention of duplicate payments and procedures to notify SWHP of any duplicate payments. This issue will also be discussed with enrollees at member orientation sessions.

They also review outpatient records on a retroactive basis and are able to identify potential recovery situations.

Procedures - All information obtained is entered into the SWHP membership data base which is tied into the claims processing system. Members having another insurance primary or Workers Compensation or third party liability with claims will be pended and/or denied for manual review.

SWHP provides the Scott and White Clinic and Scott and White Memorial Hospital with this information on a daily basis so that they are able to maintain the same information in their insurance system. Monthly, Scott and White Clinic and Hospital provide SWHP with a magnetic tape listing all changes to their insurance information for SWHP members. This tape is then run against the SWHP insurance information. Any discrepancies are dumped onto a report which is reviewed manually. Any new information is then updated in the SWHP computer system.

SWHP contracts with the Scott and White Clinic and Hospital for their shared Insurance Department to coordinate benefits on behalf of SWHP for members receiving services at Scott and White. On a routine weekly basis the S&W Insurance Department files claims with an enrollee's primary group insurance or Workers Compensation carrier. When these recoveries are received they are refunded on a weekly basis to SWHP.

SWHP currently contracts with Healthcare Recoveries, Inc. (HRI) to identify and recover payment for any third party liability (TPL). In addition to all the methods described above by which SWHP identifies potential TPL claims we transmit electronically to hri claims for members who have had services with specific diagnosis codes on a weekly basis. These diagnosis codes are typically trauma related injuries. HRI then begins a methodical investigation and recovery if appropriate.

Claims Payment Policies - It is SWHP policy that identified Workers Compensation claims are not paid by SWHP and the provider is notified of the Workers Compensation information. Claims from a non-Scott and White providers on members with another group health plan insurance primary, are not paid until SWHP receives an Explanation of Benefits from the primary insurer. Based on prior subrogation experience, SWHP has taken the "pay and chase" route on third party liability as these cases can take up to several years before they are settled and the member can be very inconvenienced due to an outstanding debt.

In the event that a member receives directly a COB or duplicate payment that should have gone to SWHP, SWHP will seek reimbursement directly from the member.

from HCPAA application

FINANCIAL

I. FISCAL SOUNDNESS

A. **Provide in the Documentation independently certified audited financial statements for the HCPP applicant. Applicants must provide audited statements and any management letters for the three most recent fiscal year periods, or if in operation for a shorter period of time, provide for each of the fiscal years. 417.568(b)(1).**

See Pages 271-312.

B. **Provide in the Documentation a copy of the most recent unaudited financial statements of the organization.**

See Pages 313-333.

C. **Provide in the Documentation independently certified audited financial statements of: (1) Guarantors (including medical group(s), individual practice association(s), and parent/sister organization guarantors): and (2) Lenders (organizations providing loans, letters of credit or other similar financing arrangements, excluding banks).**

Attached are the most recent independently certified audited financial statements of the two sponsors of Scott and White Health Plan, Scott and White Clinic and Scott and White Memorial Hospital. See Pages 334-358.

D. **If a applicant is a public corporation or line of business of a public corporation, provide the most recent stockholders letter which includes information pertinent to the HCPP applicant in the Documentation.**

Not applicable

E. **If an applicant has raised capital through public offerings within the last 3 years or anticipates public offering, provide copies of prospectuses in the Documentation.**

Not applicable

II. STATE FINANCIAL REQUIREMENTS. 417.806(c), 417.486(a)(2)

Describe the reserve requirements, any other financial requirements

SCOTT & WHITE HEALTH PLAN
ACCOUNTING/CLAIMS POLICY/PROCEDURE

Subject: **Detection of SeniorCare Duplicate Claim Procedures**

Effective Date: **January 1, 1993**
Revision Date: **January 1, 2000**

Policy Clarification

Purpose: **To comply with HCFA contractual guidelines regarding detection of duplicate SeniorCare claims payments by SWHP and HCFA Intermediary to either the physician, supplier, or SeniorCare enrollee.**

Procedure:

1. **Paper Medicare Summary Notice (EOMB's) from the Medicare intermediary are received daily/weekly by SWHP.**
2. **The claims adjudicator will open the EOMB notices and sort by S&W providers and Non-S&W providers.**
3. **S&W clinic providers:**
   a. **EOMB's for S&W clinic providers are researched on the AMISYS system by the Claim Adjudicator to determine SeniorCare member eligibility. The claim adjudicator will determine whether charges were billed appropriately to SWHP by S&W Clinic facility.**
   b. **If it is determined charges were filed by the S&W Clinic facility in error to Medicare, a copy of the EOMB is sent to S&W Patient Financial Services (PFS) along with a request for a refund to be sent to Medicare for the duplicate payment.**
   c. **An audit will be conducted periodically to determine that the refunds are correctly being sent to Medicare.**

4. **Non S&W contracted Providers:**
   a. **EOMB's for non S&W contracted providers are sorted by date of service and filed alphabetically by Patient name.**
   b. **EOMB's are compared to the claims payable system to determine if SWHP and Medicare have made any duplicate payments.**
   c. **When a claim is identified as a possible duplicate payment, the claim and related Medicare EOMB are researched. If Medicare has paid its portion and SWHP has paid the entire portion of the claim, a copy of the EOMB will be sent to the appropriate provider of service with a request for a refund to be sent to Medicare for the duplicate payment.**

d. An audit will be conducted periodically to determine that the refunds are correctly being sent to Medicare.

d. EOMB's/Summary Notices should be researched thoroughly. SWHP SeniorCare members may receive services from non contracted facilities/physicians and are liable for the balance of Medicare allowable – these charges are appropriate for payment by Medicare.

4. All Medicare EOMBs/Summary Notices will be filed alphabetically by year and maintained for a seven-year time frame.

Prepared By: Vernell Ladrig **Date:** 1/3/00

Approved By: Michelle Delegram **Date:** 1/3/00

Distribution: **Claim Adjudicators** **Michelle Delegram**
Brenda Griffith

IMPORTANT INFORMATION ABOUT YOUR MEDICARE PART B MEDICAL INSURANCE BENEFITS

For more information about services covered by Medicare, please see your Medicare Handbook.

MEDICARE PART B MEDICAL INSURANCE: Medicare Part B helps pay for doctors' services, diagnostic tests, ambulance services, durable medical equipment, and other health care services. Medicare Part A Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care and hospice care. You will be sent a separate notice if you received Part A services or any outpatient facility services.

MEDICARE ASSIGNMENT: Medicare Part B claims may be **assigned** or **unassigned.** Providers who accept **assignment** agree to accept the Medicare approved amount as total payment for covered services. Medicare pays its share of the approved amount directly to the provider. You may be billed for unmet portions of the annual deductible and the coinsurance. You may contact us at the address or telephone number in the Customer Service Information box on the front of this notice for a list of **participating providers** who always accept assignment. You may save money by choosing a participating provider.

Doctors who submit **unassigned** claims have not agreed to accept Medicare's approved amount as payment in full. Generally, Medicare pays you 80% of the approved amount after subtracting any part of the annual deductible you have not met. A doctor who does not accept assignment may charge you up to 115% of the Medicare approved amount. This is known as the Limiting Charge. Some states have additional payment limits. The NOTES section on the front of this notice will tell you if a doctor has exceeded the Limiting Charge and the correct amount to pay your doctor under the law.

YOUR RESPONSIBILITY: The amount in the **You May Be Billed** column is your share of cost for the services shown on this notice. You are responsible for:

- **annual deductible:** the first **$100** of Medicare Part B approved charges each calendar year,
- **coinsurance:** 20% of the Medicare approved amount, after the deductible has been met for the year,
- the amount billed, up to the **limiting charge,** for unassigned claims, and
- charges for services/supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a NOTE on the front will tell you.

If you have supplemental insurance, it may help you pay these amounts. If you use this notice to claim supplemental benefits from another insurance company, make a copy for your records.

WHEN OTHER INSURANCE PAYS FIRST: All Medicare payments are made on the condition that you will pay Medicare back if benefits could be paid by insurance that is primary to Medicare. Types of insurance that should pay before Medicare include employer group health plans, no-fault insurance, automobile medical insurance, liability insurance and workers' compensation. Notify us right away if you have filed or could file a claim with insurance that is primary to Medicare.

YOUR RIGHT TO APPEAL: If you disagree with what Medicare approved for these services, you may appeal the decision. You must file your appeal within **6 months of the date of this notice.** Follow the appeal instructions on the front of the last page of this notice. If you want **help with your appeal,** you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify. You may contact us for the names and telephone numbers of groups in your area. To contact us, please see our Customer Service Information box on the front of this Summary Notice.

HELP STOP MEDICARE FRAUD: Fraud is a false representation by a person or business to get Medicare payments. Some examples of fraud include:

- offers of goods or money in exchange for your Medicare Number,
- telephone or door-to-door offers of free medical services or items, and
- claims for Medicare services or items you did not receive.

If you think a person or business is involved in fraud, you should call Medicare at the Customer Service telephone number on the front of this notice.

INSURANCE COUNSELING AND ASSISTANCE: Insurance Counseling and Assistance programs are located in every State. These programs have volunteer counselors who can give you free assistance with Medicare questions, including enrollment, entitlement, Medigap and premium issues. If you would like to know how to get in touch with your local Insurance Counseling and Assistance Program Counselor, please call us at the number shown in the Customer Service Information box on the front of this notice.

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For more information about services covered by Medicare, please see your Medicare Handbook.

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- **coinsurance:** 20% of the Medicare approved amount, after the deductible has been met for the year,
- the amount billed, up to the **limiting charge,** for unassigned claims, and
- charges for services/supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a NOTE on the front will tell you.

If you have supplemental insurance, it may help you pay these amounts. If you use this notice to claim supplemental benefits from another insurance company, make a copy for your records.

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YOUR RIGHT TO APPEAL: If you disagree with what Medicare approved for these services, you may appeal the decision. You must file your appeal within **6 months of the date of this notice.** Follow the appeal instructions on the front of the last page of this notice. If you want **help with your appeal,** you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify. You may contact us for the names and telephone numbers of groups in your area. To contact us, please see our Customer Service Information box on the front of this Summary Notice.

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- offers of goods or money in exchange for your Medicare Number,
- telephone or door-to-door offers of free medical services or items, and
- claims for Medicare services or items you did not receive.

If you think a person or business is involved in fraud, you should call Medicare at the Customer Service telephone number on the front of this notice.

INSURANCE COUNSELING AND ASSISTANCE: Insurance Counseling and Assistance programs are located in every State. These programs have volunteer counselors who can give you free assistance with Medicare questions, including enrollment, entitlement, Medigap and premium issues. If you would like to know how to get in touch with your local Insurance Counseling and Assistance Program Counselor, please call us at the number shown in the Customer Service Information box on the front of this notice.

Health Care Financing Administration

2743.000-8/98

SAMPLE PROVIDER LETTER

DATE

PROVIDER NAME
PROVIDER ADDRESS
PROVIDER ADDRESS

RE: PATIENT ACCOUT #
DATE OF SERVICE

Dear PROVIDER NAME:

We have received a copy of a Medicare Summary Notice from HCFA indicating payment was made by Medicare for the above services to you. Please research your patient records and as appropriate please refund any overpayment dollars.

A copy of the Medicare Summary Notice is attached.

Please call our offices if you have any questions.

SWHP Claims Dept

Attachment: Medicare Summary Notice

Duplicate Payment
Procedures 3

SCOTT&WHITE
HEALTH PLAN

CLAIMS Policy/Procedure

Subject: **Detection of Duplicate Medicare Payments for SWHP Senior Care Claims**

Effective Date: **September 2001**
April, 2002
January 1, 2003

X Revised Policy

Purpose: **To comply with CMS contractual guidelines regarding detection of duplicate Medicare payments for Senior Care claims for Part B services covered under the Cost Contract, where Scott & White Health Plan acts as the Part B intermediary.**

Procedure:

1. **Paper Medicare Summary Notes (EOMB's) from the Medicare intermediary Trailblazers will be date stamped with receipt date by SWHP.**
2. **Claims adjudicator will sort EOMB notices by S&W providers and Non-S&W providers.**
3. **EOMB claim information will be researched in Amisys system and if it is determined a duplicate payment was made by the CMS intermediary and SWHP, the claim adjudicator will adjust/recoup or request refund from the appropriate claim in Amisys with a CASH or STAT adjustment to subtract the duplicate payment from the provider payment.**
4. **All EOMB's for S&W Clinic claims will be researched. For non S&W providers, only contracted providers where SWHP acts as the Medicare intermediary will be considered for possible duplicate payment.**
5. **All EOMB recoupment documentation will be scanned into Macess and attached to the appropriate claim # for future reference and maintained for the statutatory 7 year time period.**
6. **All recoupments will be entered into an excel spreadsheet by month adjustment/ recoupment was performed. The spreadsheet will track dollars, provider Identification and provider compliance to refund requests.**
7. **A report will be distributed quarterly to Provider Relations Dept summarizing recoupment amd refimd activity and as appropriate Provider Relations will educate providers on appropriate billing practices for Senior Care members.**
8. **Scott & White Health Plan will notify CMS of any unresolved overpayment situations .**
9. **Report XCFAEFJ will be produced identifying all collections for duplicate payments so adjustement can be made on the cost report.**
10. **Procedure only applies to SeniorCare claims where SWHP acts as the Medicare Intermediary.**

Prepared By: Vernell Labaj
Vernell Labaj

Date: January 3, 2003

Distribution: Claims Dept

F:\Policy & Procedures\Rev SrCare Duplicate Payment Detection.doc