



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

REGION V
OFFICE OF
INSPECTOR GENERAL

September 9, 2005

Report Number: A-05-05-00044

Mr. Robert Paskowski
Chief Executive Officer
Arnett Health Plan, Inc.
P.O. Box 6108
Lafayette, Indiana 47903

Dear Mr. Paskowski:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' report entitled "Duplicate Medicare Payments to Cost-Based Health Maintenance Organization Plans for Arnett Health Plan, Inc. for the Fiscal Years 2000, through 2003." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me or Stephen Slamar, Audit Manager at 312-353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. To facilitate identification, please refer to report number A-05-05-00044 in all correspondence.

Sincerely yours,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

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

Fiscal Intermediary

Michael McCarron
President
AdminaStar Federal, Inc.
8115 Knue Road
Indianapolis, Indiana 46250

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DUPLICATE MEDICARE PAYMENTS
TO COST-BASED HEALTH
MAINTENANCE ORGANIZATIONS
PLANS FOR ARNETT HEALTH PLAN,
INC. FOR THE FISCAL YEARS 2000,
THROUGH 2003**



**Daniel R. Levinson
Inspector General**

**SEPTEMBER 2005
A-05-05-00044**

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

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

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DUPLICATE MEDICARE PAYMENTS
TO COST-BASED HEALTH
MAINTENANCE ORGANIZATIONS
PLANS FOR ARNETT HEALTH PLAN,
INC. FOR THE FISCAL YEARS 2000,
THROUGH 2003**



**Daniel R. Levinson
Inspector General**

**SEPTEMBER 2005
A-05-05-00044**

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Arnett Health Plan, Inc. is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare & Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. Arnett receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs Arnett expects to incur to provide Medicare covered services to enrollees. Arnett claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Arnett's annual Medicare cost report that compares its actual costs claimed to the total of the monthly interim payments. The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR).

AdminaStar Federal (Carrier) is the Medicare Carrier through which Medicare payments and adjustments are processed for Arnett.

Under cost-based or capitation arrangements, there is a potential for duplicate Medicare payments. This occurs when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee-for-service claim submitted directly by the medical service provider to Medicare. Arnett was at risk for such duplicate payments because it had sub-contracted capitation agreements with Arnett Clinic, LLC (the Clinic) and American Health Network of Indiana, LLC (AHN). Under these agreements, Arnett prepays the Clinic and AHN a per-member, per-month dollar amount (capitation payment) to provide medical services to Arnett's Medicare enrollees. Since Arnett includes the capitation payment on its Medicare cost report, Medicare has already in effect paid the Clinic and AHN for the related medical services covered by the agreement. Consequently, any medical service claim covered by the capitation agreement and also paid by Medicare to the Clinic and AHN as a direct fee-for-service claim, is a duplicate Medicare payment. Pursuant to the Medicare Managed Care Manual, Chapter 17, Subchapter B, Arnett, as a cost-based HMO, is required to establish a system to preclude and detect such duplicate payments for its medical service providers.

OBJECTIVE

Our objective was to determine whether medical service provided for Arnett's enrollees by the Clinic and AHN were reimbursed under its Medicare capitation agreement and also through the Medicare fee-for-service payment system.

SUMMARY OF FINDINGS

The Clinic and AHN received duplicate Medicare payments of \$111,862 because Arnett did not have proper Medicare reimbursement procedures in place for the fiscal years 2000, through 2003. Arnett failed to establish required internal controls to detect Medicare fee-for-service billings by the Clinic and AHN. The Clinic and AHN received the duplicate Medicare payments

by submitting Medicare fee-for-service claims for 2,291 services that were already reimbursed through capitation agreements with Arnett. As a result the Clinic and AHN received Medicare payments through the Carrier and capitated payments from Arnett.

RECOMMENDATIONS

We recommend that Arnett, work cooperatively with the Clinic, AHN and the Carrier to:

- recover the \$111,862 duplicate Medicare fee-for-service claims made by the Clinic and AHN, and;
- develop an efficient and effective system to preclude and detect duplicate payments from the Clinic and AHN.

AUDITEE'S RESPONSE

Regarding the \$111,862 we identified in our finding, Arnett stated that \$24,042 has already been refunded to Medicare, concurred that \$84,772 represents recoverable duplicate payments and stated that the remaining \$3,048 were billings to incorrect beneficiaries that will be refunded to Medicare. Arnett has taken action to enhance their duplicate payment policies and procedures.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
OBJECTIVE, SCOPE, AND METHODOLOGY	1
Objective	1
Scope	2
Methodology	2
FINDINGS AND RECOMMENDATIONS	3
Regulations Regarding Cost Based HMO Responsibility to Detect Duplicate Payments	3
Arnett’s Failure to Detect Duplicate Payments	3
RECOMMENDATIONS	4
AUDITEE’S RESPONSE	4
APPENDIX	
ARNETT HEALTH PLAN RESPONSE TO DRAFT REPORT	A

INTRODUCTION

BACKGROUND

Arnett is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare & Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. Arnett receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs Arnett expects to incur to provide Medicare covered services to enrollees. Arnett claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Arnett's annual Medicare reimbursement statement that compares its actual costs claimed to the total of the monthly interim payments. The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR) and Medicare Managed Care Manual, Chapter 17, Subchapter B.

AdminaStar Federal (Carrier) is the Medicare carrier through which Medicare payments and adjustments are processed for Arnett.

Under cost-based or capitation arrangements, duplicate Medicare payments occur when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee-for-service basis to the medical service provider directly to Medicare. Arnett was at risk for such duplicate payments because it had sub-contracted capitation agreements, which prepaid Arnett Clinic, LLC (the Clinic) and American Health Network of Indiana, LLC (AHN) a per-member, per-month dollar amount (capitation payment), to provide medical services to Arnett's Medicare enrollees. Since Arnett includes the capitation payment on its Medicare cost report, Medicare has already paid for the Clinic and AHN medical services covered by the agreement. Consequently, any medical service claims covered by the capitation agreement and also paid by Medicare to the Clinic and AHN as direct fee-for-service claims is a duplicate Medicare payment. Pursuant to the Medicare Managed Care Manual, Chapter 17, Subchapter B, Arnett, as a cost-based HMO, is required to establish a system to preclude and detect such duplicate payments for its medical service providers.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether medical services provided for Arnett's enrollees by the Clinic and AHN were reimbursed under its Medicare capitation and agreement and also through the Medicare fee-for-service payment system.

Scope

We reviewed Medicare fee-for-service payments made to the Clinic and AHN for fiscal years 2000, through 2003 as part of a region-wide review of potential overpayments made to capitated providers by cost-based HMOs. Due to the limited scope of our audit, we did not review overall internal control structures at Arnett, the Clinic or AHN. However, we created a database specifically designed to identify duplicate payments, which was a specific test of the internal controls Arnett had in place to preclude and detect such payments.

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

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

Methodology

To accomplish the objective, we:

- reviewed applicable Federal laws and regulations and Medicare guidelines;
- reviewed and obtained an understanding of the capitation agreements between Arnett and the capitated providers, the Clinic and AHN;
- created a database of CMS fee-for-service claims paid to the Clinic and AHN for covered services provided to Arnett's enrollees, representing potential duplicate Medicare payments; and
- validated our database.

In order to create our database of duplicate payments, we used the CMS HMO Group enrollment files to identify health insurance claim numbers for Arnett's enrollees from January 2000, through December 2003. We then matched these numbers against the CMS National Claims History Archive of Carrier Claims for the same time period. We requested and utilized Arnett's enrollee information, which included starting and ending enrollment dates. To create our database, we extracted Medicare fee-for-service claims with a service date after the beginning enrollment dates, and excluded those with service dates after the ending enrollment date. We obtained the Employer Identification Number (EIN) for Arnett's two capitated providers, to isolate the Clinic and AHN's allowable services, per their capitation contracts with Arnett. The resulting database represented the duplicate reimbursement made through capitated and fee-for-service payments made to the Clinic and AHN for 2,291 services to Arnett's enrollees.

To validate our database, we selected a random judgmental sample of 10 payments that we presented to Arnett to confirm that all sampled items were duplicate payments. Arnett confirmed that all sampled items were duplicate payments. We also presented our entire database to the Medicare claims processor, AdminaStar Federal, that processes claims to

determine whether the Clinic and AHN had submitted any subsequent adjustments to the fee-for-service claims in our database. The Carrier confirmed which claims had not been adjusted.

FINDINGS AND RECOMMENDATIONS

Arnett failed to establish the necessary internal controls to detect Medicare fee-for-service billings by the Clinic and AHN, which allowed The Clinic and AHN to receive duplicate Medicare payments of \$111,862. For the fiscal years 2000 through 2003, we determined that the Clinic and AHN submitted 2,291 lines of fee-for-service claims to Medicare that were already reimbursed under the two capitation agreements with Arnett. Since Arnett's capitation payments were included on its final Medicare settlement cost report, Medicare payments of the Clinic and AHN's fee-for-service claims resulted in \$111,862 of duplicate payments to the Clinic and AHN for the same medical services.

Regulations Regarding Cost-Based HMO Responsibility to Detect Duplicate Payments

The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR). HMO's receive monthly interim payments from CMS, based on a per-capita rate for each Medicare enrollee, to cover the reasonable costs incurred to provide Medicare covered services to their enrollees. These reasonable costs may include payments made by the HMO directly to providers who render Medicare services to the HMO's enrollees. The actual costs incurred by the HMOs are claimed on their annual certified Medicare cost report, and a final settlement is made based on a comparison of the actual costs claimed to the total of the monthly interim payments. An additional payment on a fee for service basis to the provider would represent a duplicate payment.

The legislative authority requiring the detection of duplicate payments is specified in the Medicare Managed Care Manual, Chapter 17, Subchapter B, entitled "Duplicate Payment Detection for Cost Contracting Health Care Prepayment Plans (HCPP) and HMO/ Competitive Medical Plans (CMP)" and states:

"Several entities may have jurisdiction over the processing and payment of Part B bills for your members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent that HCPPs and HMO/CMPs establish a system to preclude or detect duplicate payments.

. . . "Duplicate payment detection is the responsibility of the HCPP or HMO/CMP, not the carrier."

Arnett's Failure to Detect Duplicate Payments

We attribute the Clinic and AHN's duplicate payments primarily to Arnett's failure to establish required internal controls to detect the Clinic and AHN's Medicare fee-for-service billings. Although we believe that the Clinic and AHN should have had controls in its billing process to detect and prevent this condition, Arnett, as a cost-based HMO, is ultimately responsible to

ensure that the Medicare reimbursements contained in its final cost report settlement are not duplicated by fee-for-service claims submitted directly to Medicare by its contracted providers.

During our audit period, Arnett received a monthly report from AdminaStar Federal listing all Medicare claims submitted for payment on behalf of its Medicare enrollees. Any Medicare payments to the Clinic or AHN that appeared on the report represented a duplicate payment. For such duplicate payments that Arnett's system detected, they reprocessed the claim and credited the payment amount on their Medicare cost report. Although Arnett's system captured some duplicates, its controls were inadequate to detect and correct all of the duplicate payments.

RECOMMENDATIONS

We recommend that Arnett work cooperatively with the Clinic, AHN and the Carrier to:

- recover the \$111,862 duplicate Medicare fee-for-service claims paid to the Clinic and AHN, and;
- develop an efficient and effective system to preclude and detect duplicate payments from the Clinic and AHN.

AUDITEE'S RESPONSE

Regarding the \$111,862 we identified in our finding, Arnett stated that \$24,042 has already been refunded to Medicare, concurred that \$84,772 represents recoverable duplicate payments, and stated that the remaining \$3,048 were billings to incorrect beneficiaries that will be refunded to Medicare. Arnett has taken action to enhance their duplicate payment policies and procedures.

APPENDIX

August 24, 2004

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, IL 60601

Re: Report Number A-05-05-00044

Dear Mr. Swanson:

We have reviewed the findings and recommendations of this audit and Arnett HMO's responses are as follows:

OIG Findings:

- The Clinic and AHN received duplicate Medicare payments of \$111,862 because Arnett did not have proper Medicare reimbursement procedures in place for the fiscal years 2000 through 2003. Arnett failed to establish required internal controls to detect Medicare fee-for-service billings by the Clinic and AHN. The Clinic and AHN received the duplicate Medicare payments by submitting Medicare fee-for-service claims for 2,291 services that were already reimbursed through capitated agreements with Arnett. As a result, the Clinic and AHN received Medicare payments through the Carrier and capitated payments through Arnett.

Arnett HMO Response:

Arnett HMO concurs with a portion of the findings. Per Arnett HMO records, \$24,042.27 was discovered to have been refunded previously to Medicare by Arnett Clinic. Arnett Clinic is currently working through AdminaStar to have these refunds posted in the CMS database. The refund payment dates range from 2003 to current.

An additional \$3,047.66 was determined by Arnett Clinic to have been billed to the incorrect beneficiary, and has now refunded this money to Medicare.

Arnett HMO concurs with the remaining \$84,772.51 of the findings of this audit.

OIG Recommendations:

- Recover the \$111,862 duplicate Medicare fee-for-service claims made by the Clinic and AHN
- Develop an efficient and effective system to preclude and detect duplicate payments from the Clinic and AHN

Arnett HMO Response:

Arnett HMO has been working with both Arnett Clinic and AHN to research and recover the identified duplicate payments. Through this research we have determined that Arnett Clinic's portion (\$105,745.32) of the findings were determined to be:

- **\$78,655.39 duplicate payments (recovered)**
- **\$24,042.27 refunded to Medicare prior to details of audit available (various dates ranging from 2003 to 2005)**
- **\$ 3,047.66 discovered that the incorrect patient was billed (refunds being made to Medicare by Arnett Clinic directly)**

American Health Network's (AHN) portion (\$6,117.12) of the audit findings was confirmed as duplicates and are in process of recovery.

Arnett HMO has already revised its duplicate payment process with these two providers in the recent past but subsequent to the OIG Audit period. Also, based on the audit findings, we have implemented additional detection processes to prevent duplicate payments by CMS.

Sincerely,

Robert S. Paskowski
Chief Executive Officer
Arnett HMO, Inc



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

Stephen Slamar, Audit Manager

Tammie Anderson, Audit Manager – Advanced Audits Technique Staff

Denise Novak, Senior Auditor

Tom Caughey, Auditor-in-Charge

Kathryn Benson, Auditor

Nanette Sanchez, Auditor