



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

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

November 12, 2004

Report Number: A-02-04-01016

Mr. Dennis T. Gorski
Vice President, Government Programs
HealthNow
1901 Main Street
P.O. Box 80
Buffalo, New York 14240-0080

Dear Mr. Gorski:

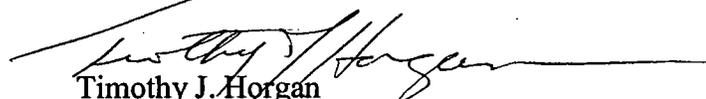
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General report entitled "Review of HealthNow's Compliance with Medicare+Choice Prompt Payment Regulations During the Period August 1, 2003 through January 31, 2004." A copy of this report will be forwarded to the HHS action official named on page 2 for review and any action deemed necessary.

The action official will make final determinations as to actions taken on all matters reported. We request that you respond to the 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 reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR Part 5).

Please refer to report number A-02-04-01016 in all correspondence.

Sincerely yours,


Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures - as stated

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Direct Reply to HHS Action Official:

Mr. James T. Kerr, Regional Administrator
Centers for Medicare & Medicaid Services, Region II
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HEALTHNOW'S
COMPLIANCE WITH MEDICARE+CHOICE
PROMPT PAYMENT REGULATIONS
DURING THE PERIOD
AUGUST 1, 2003 THROUGH JANUARY 31, 2004**



**NOVEMBER 2004
A-02-04-01016**

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:

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OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the Medicare+Choice (M+C) program. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with the Centers for Medicare & Medicaid Services (CMS). These plans, known as M+C organizations, are required to provide the same health care services offered under the traditional Medicare program and may also offer additional benefits to their enrollees. M+C organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers. Claims for services are processed by the M+C organization or through agreements with delegated entities. Federal regulations at 42 CFR § 422 require health plans to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers.

OBJECTIVE

Our objective was to determine whether HealthNow New York, Inc.'s Senior Blue Health Plan (HealthNow) complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

SUMMARY OF FINDINGS

HealthNow substantially complied with Federal prompt payment regulations for claims submitted by noncontracted providers. Specifically, HealthNow paid over 95 percent of clean claims¹ within 30 days of receipt, and paid interest on clean claims that were not paid within 30 days of receipt. However, HealthNow did not pay or deny some claims within 60 days of receipt. This occurred because certain claims were treated as routine correspondence rather than as higher priority claims. Under a policy modification implemented in January 2004, HealthNow's staff now screens incoming correspondence to assure that claims are sent directly to the claims processing unit.

RECOMMENDATION

We recommend HealthNow ensure that all claims are paid or denied within 60 days of receipt.

HEALTHNOW'S COMMENTS

In its written response to our draft report, HealthNow concurred with our findings and recommendations and cited its commitment to meet Federal requirements. The full text of HealthNow's response is presented at Appendix B.

¹ A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

OFFICE OF INSPECTOR GENERAL RESPONSE

We thank HealthNow for the cooperation extended to our audit team and encourage HealthNow to continue its commitment to meet Federal requirements.

INTRODUCTION

BACKGROUND

The Medicare+Choice Program

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the M+C program². The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with CMS. These plans, known as M+C organizations, are required to provide the same health care services offered under the traditional Medicare program and may also offer additional benefits³ to their enrollees. M+C organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers⁴. Claims for services are processed by the M+C organization or through agreements with delegated entities. Federal regulations at 42 CFR § 422 require health plans to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers.

HealthNow Senior Blue Health Plan

HealthNow New York, Inc., a not-for-profit corporation, enters into contracts with governmental and other entities to provide and operate comprehensive health benefit plans for enrolled covered persons. During the audit period, CMS contracted with HealthNow to provide coverage under its Senior Blue Health Plan to approximately 36,300 Medicare enrollees in sixteen New York counties.

CMS Reviews

CMS conducts a detailed review of each M+C organization at least once every two years. The reviews include internal control and substantive tests of M+C organizations' claims processing systems and compliance with prompt payment provisions. CMS reviewed HealthNow's claims processing in August 2000 and July 2002 and found that HealthNow processed 95 percent of clean claims within 30 days of receipt. These CMS reviews, however, disclosed that HealthNow did not meet the requirement to process all other claims within 60 days of receipt.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether HealthNow complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

² The M+C Program will be replaced by the Medicare Advantage Program under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, effective January 1, 2006.

³ Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services.

⁴ A noncontracted provider does not have a written agreement with an M+C organization to provide services to an M+C organization's enrollees.

Scope

We reviewed selected noncontracted Medicare claims paid or denied by HealthNow during the period August 1, 2003 through January 31, 2004. HealthNow paid or denied 21,723 claims for services furnished by noncontracted providers during this period. This included claims resulting in payments to providers and enrollees.

We did not review M+C claims processed by HealthNow's delegated entities⁵ because the number of claims processed was immaterial relative to the total number of claims processed by HealthNow. Finally, we limited our review of internal controls to obtaining an understanding of HealthNow's claims processing system.

Methodology

To accomplish our objective, we:

- reviewed Federal regulations, policies, and procedures relevant to the prompt payment of noncontracted claims
- consulted with CMS officials to understand CMS's implementation of the M+C program monitoring requirements and prompt payment regulations
- obtained an understanding of HealthNow's claims processing system
- reviewed and validated the database of claims submitted by noncontracted providers
- selected samples of claims for further review and
- determined whether HealthNow complied with prompt payment regulations

To determine whether HealthNow complied with prompt payment regulations, we separately reviewed the populations of paid claims and claims that did not appear to have been paid or denied within 60 days of receipt. For the population of paid claims, we reviewed all clean claims. Additionally, we selected and reviewed a statistical sample of 100 claims that, based on a comparison of the receipt dates and paid or denied dates recorded by HealthNow, did not appear to have been paid or denied within 60 days of receipt. For each of the sampled claims, we analyzed claims history records and other supporting documentation.

We performed our audit in accordance with generally accepted government auditing standards. We conducted our audit fieldwork at HealthNow's offices in Buffalo and Binghamton, New York.

⁵ A delegated entity is contracted by an M+C organization to provide administrative or health care services to Medicare-eligible individuals enrolled in the M+C organization's service plan.

FINDINGS AND RECOMMENDATION

HealthNow substantially complied with Federal prompt payment regulations for claims submitted by non-contracted providers. Specifically, HealthNow paid over 95 percent of clean claims within 30 days of receipt and paid interest on clean claims not paid within 30 days of receipt. However, HealthNow did not pay or deny some claims within 60 days of receipt. This occurred because HealthNow's claims processing system did not differentiate claims submitted by its enrollees from routine correspondence. As a result, there were delays in payments to HealthNow's enrollees.

Federal Regulations for Prompt Payment

Federal regulations at 42 CFR § 422.100(b) require M+C organizations to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers. The responsibilities for timely payment are clarified in 42 CFR § 422.520:

- (a)(1) ...the M+C organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an M+C private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.
- (2) The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B). [Sections 1816 and 1842 refer to Title XVIII of the Social Security Act for Medicare fiscal intermediaries and carriers.]
- (3) All other claims must be paid or denied within 60 calendar days from the date of the receipt.

A "clean claim" does not have any defect, impropriety, lack of any substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

Payment of Clean Claims Within 30 Days

HealthNow complied with Federal requirements to pay clean claims within 30 days of receipt. It exceeded the requirement to pay 95 percent of the claims timely and, in fact, paid 96.6 percent of the clean claims within 30 days of receipt.

Payment or Denial of All Claims Within 60 Days

HealthNow generally complied with Federal requirements to pay or deny all claims within 60 days of receipt. Most claims that did not appear to have been paid or denied within 60 days were submitted without the necessary supporting documentation. In these cases, HealthNow timely paid any resubmitted claims.

However, five of the 100 claims selected for review were neither paid nor denied within 60 days. HealthNow officials explained that their enrollees had not submitted these five claims on

claim forms. Therefore, the claims were routed to HealthNow's correspondence unit where they were processed as routine correspondence rather than as higher priority claims. Once the claims were researched, staff forwarded them for processing. As a result, HealthNow's enrollees did not receive timely payments in these five instances. Further details about our sampling methodology and results are presented at Appendix A.

Under a policy modification implemented in January 2004, HealthNow's staff now screens incoming correspondence to assure that all claims are sent directly to the claims processing unit.

RECOMMENDATION

We recommend HealthNow ensure that all claims are paid or denied within 60 days of receipt.

HEALTHNOW'S COMMENTS

In its written response to our draft report, HealthNow concurred with our findings and recommendations and cited its commitment to meet Federal requirements. The full text of HealthNow's response is presented at Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We thank HealthNow for the cooperation extended to our audit team and encourage HealthNow to continue its commitment to meet Federal requirements.

APPENDICES

**SAMPLE OF CLAIMS NOT PAID OR DENIED WITHIN 60 DAYS
METHODOLOGY AND RESULTS**

HealthNow did not pay or deny 597 claims within the required 60-day time frame during the period August 1, 2003 to January 31, 2004. We calculated the number of claims not processed within the required 60-day time frame by comparing the dates claims were received to the dates when the claims were paid or denied, as shown on HealthNow's records.

We selected a simple random sample of 100 claims from the population of claims not paid or denied within 60 days.

Based on our review of the sampled claims, HealthNow paid 95 of the 100 claims within 60 days of receiving the necessary supporting documentation. The remaining five claims were not paid within 60 days of receipt.

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Dennis T. Gorski
Vice President
Government Programs

October 13, 2004

Mr. Timothy J. Horgan
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General, Office of Audit Services
Region II
Jacob K. Javits Federal Building
28 Federal Plaza, Room 3900
New York, New York 10278

RE: Report A-02-04-01016

Dear Mr. Horgan:

I am responding to your letter dated September 30, 2004 that references a draft report entitled "Review of HealthNow's Compliance with Medicare+Choice Prompt Payment Regulations During the Audit Period August 1, 2003 through January 31, 2004. (Report A-02-04-01016).

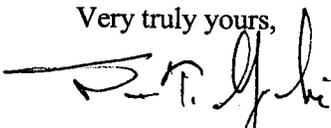
Let me first state that I appreciate the audit team efforts led by Mr. Hirshon and Ms. Webb. These individuals and the rest of the audit team members exhibited professionalism and a spirit of cooperation throughout the audit process, which made for a smoother onsite audit.

In reference to the audit findings, we concur with the one and only audit finding that instructs HealthNow to pay or deny all claims within sixty (60) days of receipt. As cited in the audit findings, HealthNow had identified a deficiency in our prompt pay procedures prior to the onsite audit and took corrective action to ensure compliance with the regulation. This corrective action will resolve the aforementioned deficiency.

Thank you again for the constructive criticism that was offered by this audit process. HealthNow New York is fully committed to the adherence to all Medicare Advantage regulations. Audits such as these provide us with additional opportunities to meet regulation requirements.

Should you have any questions regarding this response, please contact me at 716-887-6027 or via email at gorski.dennis@healthnow.org. Thank you.

Very truly yours,



Dennis T. Gorski
Vice President
Government Programs

DTG/bgl