

REGION IV
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December 29, 2004

Report Number: A-04-04-02005

Walter H. Janke, M.D.
Chief Executive Officer
America's Health Choice
Medical Plans, Inc.
1175 South U.S. Highway 1
Vero Beach, Florida 32962

Dear Dr. Janke:

Enclosed are two copies of the Office of Inspector General (OIG) report entitled *Review of Compliance with Medicare + Choice Prompt Payment Regulations — America's Health Choice Medical Plans, Inc.* A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (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.

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If you have any questions or comments about this report, please do not hesitate to call Mr. Don Czyzewski at (305) 536-5309, extension 10. To facilitate identification, please refer to report number A-04-04-02005 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Charles J. Curtis".

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

Direct Reply to HHS Action Official

Ms. Rose Crum Johnson
Regional Administrator for Medicare
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF COMPLIANCE WITH
MEDICARE + CHOICE PROMPT
PAYMENT REGULATIONS –
AMERICA’S HEALTH CHOICE
MEDICAL PLANS, INC.**



**DECEMBER 2004
A-04-04-02005**

Office of Inspector General

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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 Centers for Medicare & Medicaid Services (CMS). These plans provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers. Federal regulations at 42 CFR § 422 require 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 America's Health Choice Medical Plans, Inc. (America's Health Choice) complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

SUMMARY OF FINDINGS

America's Health Choice did not comply with Federal prompt payment regulations. Specifically, it did not: (1) pay at least 95 percent of clean claims¹ within 30 days of receipt, (2) calculate and pay interest on clean claims not paid within 30 days of receipt, and (3) pay or deny all claims within 60 days of receipt. The results of one sample showed that America's Health Choice did not pay 14 of the 100 reviewed clean claims within 30 days and did not properly calculate and pay interest on those 14 clean claims. The results of a second sample showed that America's Health Choice did not pay or deny 92 of the 100 reviewed claims within 60 days. These conditions occurred because internal monitoring at America's Health Choice was not adequate to ensure policies and procedures were followed. As a result, some noncontracted providers were not paid timely and accurately.

RECOMMENDATIONS

We recommend management of America's Health Choice establish internal monitoring to ensure its policies and procedures are properly implemented so that:

1. at least 95 percent of clean claims are paid within 30 days;
2. interest is calculated and paid on clean claims not paid within 30 days; and
3. all claims are paid or denied within 60 days of receipt.

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.

COMMENTS BY AMERICA’S HEALTH CHOICE

In its written response to our draft report, America’s Health Choice generally concurred with the findings and recommendations. In its response, America’s Health Choice outlined corrective actions it had taken and planned to implement regarding the findings and recommendations. The response provided by America’s Health Choice is included in its entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

We believe the procedures outlined will correct the problems identified in our audit. We encourage America’s Health Choice to follow through in its efforts to ensure that it meets the applicable standards in the prompt payment regulations.

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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 program.² 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 enrollees with the same health care services offered under the traditional Medicare program plus additional benefits.³ These organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers.⁴ Claims for services are processed by the M+C organization or through agreements with delegated entities.⁵

America's Health Choice Medical Plans, Inc.

America's Health Choice is a for-profit Florida health maintenance organization that provides medical services in south Florida. The CMS contracted with America's Health Choice as an M+C organization to provide health care coverage to approximately 15,000 Medicare enrollees in Florida during our audit period.

CMS Reviews

The CMS conducts a detailed review of each M+C organization at least once every 2 years. The reviews include internal control and substantive tests of an M+C organization's claims processing systems and compliance with prompt payment provisions. The CMS reviewed America's Health Choice's claims processing in February 2001 and July 2002 and found it out of compliance with prompt payment regulations. These reviews disclosed that America's Health Choice paid less than 95 percent of all clean claims⁶ within the required 30 days. In January 2004, CMS, in collaboration with Florida Medical Quality Assurance, Inc., performed a focused review. The focused review indicated that America's Health Choice did not comply with prompt payment regulations. Additional details on the CMS reviews are included in Appendix C.

² The Medicare+Choice 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.

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.

⁶ 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed two samples of noncontracted Medicare claims paid or denied by America's Health Choice during the period September 1, 2003, through February 29, 2004. America's Health Choice paid or denied 26,212 claims for services furnished by noncontracted providers during the period. America's Health Choice did not process any claims that resulted in payments to enrollees.

We did not review the claims processed by America's Health Choice's single delegated entity because the number of claims processed was immaterial relative to the total number of claims processed by America's Health Choice. We limited our review of internal controls to obtaining an understanding of America's Health Choice's claims processing system.

We conducted our fieldwork from March through July 2004, which included visits to America's Health Choice's office in Vero Beach, FL.

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;
- reconciled claims submitted by selected noncontracted providers to claims reported by America's Health Choice; and
- reviewed corrective action plans of America's Health Choice that were submitted to CMS relevant to the prompt payment of noncontracted claims.

To determine whether America's Health Choice 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. From the population of paid claims, we selected and reviewed a statistical sample of 100 clean claims. For each clean claim that was not paid within 30 days of receipt, we verified whether interest was properly calculated and paid to the submitting provider. 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 America's

Health Choice, did not appear to have been paid or denied within 60 days. For each claim, we analyzed claims history records and other supporting documentation. Appendices A and B describe in detail our sampling methodologies for clean claims and claims that did not appear to have been paid or denied within 60 days of receipt.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

America's Health Choice did not comply with Federal prompt payment regulations. Specifically, it did not: (1) pay at least 95 percent of clean claims within 30 days of receipt, (2) calculate and pay interest on clean claims not paid within 30 days of receipt, and (3) pay or deny all claims within 60 days of receipt. The results of one sample showed that America's Health Choice did not pay 14 of the 100 reviewed clean claims within 30 days and did not properly calculate and pay interest on those 14 clean claims. The results of a second sample showed that America's Health Choice did not pay or deny 92 of the 100 reviewed claims within 60 days. These conditions occurred because internal monitoring at America's Health Choice was not adequate to ensure policies and procedures were followed. As a result, some noncontracted providers were not paid timely and accurately.

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 request.

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.

PAYMENT OF CLEAN CLAIMS WITHIN 30 DAYS

America's Health Choice did not pay at least 95 percent of all clean claims within 30 days of receipt. Our review of a sample of 100 clean claims showed America's Health Choice did not pay 14 claims within 30 days of receipt. Based on our sample results, we determined that America's Health Choice paid no more than 92 percent of all clean claims within 30 days. See Appendix A for details on the sample results.

This condition occurred because the computer system at America's Health Choice did not forward the claims for payment as intended. The claims did not always go to the payment queue but were suspended in the system. In addition, America's Health Choice did not conduct internal monitoring even though monitoring was required by CMS based on the fiscal year 2002 review. Following the fiscal year 2004 review, CMS required America's Health Choice to report monthly on the timeliness of claims processing. The monthly reporting requirement had not started during our fieldwork.

INTEREST PAYMENTS ON CLEAN CLAIMS

America's Health Choice did not calculate and pay interest on 12 of the 14 clean claims described above and miscalculated the interest on the remaining 2 claims. America's Health Choice did not always pay interest due and used an incorrect interest rate for calculating interest payments. In addition, it did not have adequate monitoring to detect that the procedures were not followed or applied incorrectly.

PAYMENT OR DENIAL OF ALL CLAIMS WITHIN 60 DAYS

America's Health Choice did not pay or deny all its claims within 60 days of receipt. We sampled 100 of the 2,352 claims that did not appear to be paid or denied within 60 days of receipt. Our review of the 100 sampled claims indicated America's Health Choice did not pay or deny 92 claims within 60 days of receipt. Based on our sample results, we estimated that 2,164 claims were not paid or denied within the required 60 days. See Appendix B for details on the sample results. America's Health Choice did not conduct internal monitoring to ensure that all claims were paid or denied within 60 days of receipt.

RECOMMENDATIONS

We recommend management of America's Health Choice establish internal monitoring to ensure its policies and procedures are properly implemented so that:

1. at least 95 percent of clean claims are paid within 30 days;
2. interest is calculated and paid on clean claims not paid within 30 days; and
3. all claims are paid or denied within 60 days of receipt.

COMMENTS BY AMERICA'S HEALTH CHOICE

In its written response to our draft report, America's Health Choice generally concurred with the findings and recommendations. In its response, America's Health Choice outlined corrective actions it had taken and planned to implement regarding the findings and recommendations. The response provided by America's Health Choice is included in its entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We believe the procedures outlined will correct the problems identified in our audit. We encourage America's Health Choice to follow through in its efforts to ensure that it meets the applicable standards in the prompt payment regulations.

APPENDIXES

**SAMPLE OF CLEAN CLAIMS
METHODOLOGY AND RESULTS**

America's Health Choice paid 17,666 claims during the period September 1, 2003, through February 29, 2004 for services provided by noncontracted providers. The number of clean claims was unknown because America's Health Choice could not specifically identify its clean claims. Further, America's Health Choice could not specifically identify its noncontracted claims. We reviewed the database and removed the contracted claims.

We selected a random sample of claims from the population of paid claims until we identified 100 clean claims. The sampling performed was equivalent to selecting an unrestricted random sample of clean claims. America's Health Choice verified that each claim was a clean claim paid to a noncontracted provider that should have been paid within 30 days.

Of the 100 clean claims reviewed, we determined 14 claims were not paid within 30 days of receipt.

Based on the results of the sample, we are 95 percent confident America's Health Choice paid no more than 92 percent of its clean claims within 30 days of receipt. Below are the results of our attribute appraisal.

Sample Results

(Precision at the 90-Percent Confidence Level)

Upper Limit	91.74 percent ⁷
Lower Limit	80.26 percent
Standard Error	0.034874 percent
Sampling Error	0.057362 percent

⁷ For reporting purposes, we rounded to 92 percent.

**SAMPLE OF CLAIMS PAID OR DENIED AFTER 60 DAYS OF RECEIPT
METHODOLOGY AND RESULTS**

America's Health Choice paid or denied 26,208 claims during the period September 1, 2003, through February 29, 2004 for services provided by noncontracted providers. Of these claims, we identified 2,352 claims that appeared to have taken over 60 days to pay or deny. We then selected a random sample of 100 claims from the sub-universe of 2,352 claims and determined that 92 were not paid or denied within 60 days of receipt.

Based on the results of the sample, we estimate America's Health Choice did not pay or deny 2,164 claims within 60 days of receipt. Below are the results of our attribute appraisal.

Sample Results

Point Estimate 2,164

(Precision at the 90-Percent Confidence Level)

Upper Limit 2,255

Lower Limit 2,027

COMPLIANCE WITH CMS CORRECTIVE ACTION REQUIREMENTS

CMS Biennial Monitoring Review 2002

In its July 2002 monitoring review, CMS determined that America's Health Choice paid only six percent of clean claims with 30 days. The CMS required America's Health Choice to revise its policies and procedures for claims processing, to train staff on the revised procedures, and to conduct internal monitoring to ensure revised policies and procedures were followed. Further America's Health Choice must review the clean claims from noncontracted providers for 6 months of the biennial monitoring review (December 1, 2001 - May 31, 2002) to determine if interest should be paid.

CMS Focused Review 2004

In January 2004, CMS, in collaboration with Florida Medical Quality Assurance, Inc., performed a focused review. From the information provided by America's Health Choice, CMS could not determine the actual date the claim was paid, if the claim was clean or unclean, and if the correct amount of interest was paid. The CMS required America's Health Choice to develop more specific policies and procedures for claims processing, and improve its computer system for tracking the claims. In addition, America's Health Choice must develop a monitoring system to make sure that policies and procedures are being implemented correctly. To monitor America's Health Choice corrective actions, CMS required America's Health Choice to provide monthly reports on the timeliness of claims processing.



America's Health Choice
Medical Plans, Inc.
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November 30, 2004

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Office of Audit Svcs.

Department of Health and Human Services
Office of Inspector General
Office of Audit Services -- Region IV
61 Forsyth Street, S.E., Suite 3T41
Atlanta, Georgia 30303

RE: Report Number A-04-04-02005

Dear Mr. Curtis:

This letter is in response to your correspondence dated November 9, 2004 entitled "Review of Compliance with Medicare +Choice Prompt Payment Regulations". As was requested, we have reviewed the report and have compiled our formal response.

As outlined in your draft under "Findings and Recommendations" it was stated that America's Health Choice:

(A) Did not pay at least 95 percent of all clean claims within 30 days of receipt.

Corrective Action Taken:

Through our own internal auditing and use of the guidelines supplied by Centers for Medicare and Medicaid, America's Health Choice has modified its internal claims reviewing system to include monthly auditing of the following items but not limited to:

1. Number of paid claims received as of the last day of the month.
2. Number of paid clean claims received as of the last day of the month.
3. Average number of processing days for paid clean claims.
4. Number of paid unclean claims received as of the last day of the month.
5. Average number of processing days for paid unclean claims.
6. Number of pended paid claims on the last day of each month.

As well as limiting the timeframe that a non-contracted provider has to respond to a request for more information before that claim would then become a denied claim, as was addressed in the Focus Review conducted with the CMS January 2004.

(B) Did not always pay interest due and used an incorrect interest rate for calculating interest payments/did not have adequate monitoring to detect that the procedures were not followed or applied incorrectly.

Corrective Action Taken:

1. Internally in our system the checks for payment are sent to accounts payable on Monday thru Wednesday of each week. To insure accurate interest payments the actual interest computation will be calculated through Friday the day that the checks are mailed. This will be the weekly cycle maintained.

(C) Payment or denial of all claims within 60 days of receipt.

Corrective Action Taken:

America's Health Choice has modified the electronic system used to process claims to closely follow the regulations/guidelines set forth by the CMS. As covered in the Focus Review outline of January 2004, we have implemented an electronic system with benefits loaded for each plan/provider. The updated system will automatically determine the correct payment for each procedure code and specific plan thus increasing the ability to process claims more effectively and accurately. This system update will be completed by year end - 2004.

America's Health Choice has arranged for our outside financial auditors to perform the initial claims audit by December 2004, and will help further develop an auditing system to complement what has already been established by the CMS. The audit will include the review of the corrective actions outlined in this letter and any corrective actions taken as a result of past reviews by CMS.

In conclusion I would like to say that we appreciated working with Ms. Lee and Mr. Carrington. If you have any questions or would like further information please do not hesitate to contact me at (800) 308-9823.

Sincerely,



Walter H. Janke, M.D.
Chief Executive Officer
America's Health Choice Medical Plans, Inc.

WHJ/mrs

ACKNOWLEDGMENTS

This report was prepared under the direction of Charles Curtis. Other principal Office of Audit Services staff who contributed include:

Donald Czyzewski, *Audit Manager*

Kathy Lee, *Senior Auditor*

Mervyn Carrington, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.