



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

REGION V  
OFFICE OF  
INSPECTOR GENERAL

September 22, 2006

Report Number: A-05-06-00029

Mr. Sabin C. Bass  
Senior Vice President – Finance, CFO  
Capital Health Plan, Inc.  
2140 Centerville Place  
Tallahassee, FL 32308

Dear Mr. Bass

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 Plan Capital Health Plan, Inc. for Fiscal Years 2002 through 2004." 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-05-06-00029 in all correspondence.

Sincerely yours,

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

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures - as stated

**Direct Reply to HHS Action Official:**

Roger Perez  
Acting Regional Administrator  
Centers for Medicare and Medicaid Services – Region IV  
Atlanta Federal Center  
61 Forsyth Street, S.W., Suite 4T20  
Atlanta, GA 30303-8909

**Fiscal Intermediary**

First Coast Services Options, Inc.  
Curtis Lord  
CEO  
532 Riverside Ave.  
Jacksonville, FL 32202

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**DUPLICATE MEDICARE  
PAYMENTS TO COST-BASED  
HEALTH MAINTENANCE PLAN  
CAPITAL HEALTH PLAN, INC.  
FOR FISCAL YEARS 2002  
THROUGH 2004**



Daniel R. Levinson  
Inspector General  
September 2006  
A-05-06-00029

# ***Office of Inspector General***

<http://oig.hhs.gov>

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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. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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# *Notices*

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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**

Capital Health Plan, Inc. (Capital) 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. Capital receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs that Capital expects to incur to provide Medicare covered services to enrollees. Capital claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Capital'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 for the Medicare payments made to cost-based HMOs are contained in Federal regulations (42 CFR §417.532 and §417.576) and the Medicare Managed Care Manual, Chapter 17, Subchapter B.

First Coast Service Options, Inc. (Carrier) is the Medicare Carrier through which Medicare payments and adjustments are processed for Capital.

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. Capital was at risk for such duplicate payments because it had a capitation agreement with 10 providers (Providers). Under the agreements, Capital prepays Providers a per-member, per-month dollar amount (capitation payment) to deliver medical services to Capital's Medicare enrollees. Since Capital includes the capitation payment on its Medicare cost report, Medicare has already paid Providers 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 Providers, as a direct fee-for-service claim, is a duplicate Medicare payment. The Medicare Managed Care Manual, Chapter 17, Subchapter B, requires cost-based HMOs like Capital to establish a system to preclude and detect such duplicate payments for its medical service providers.

### **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

Providers received duplicate Medicare payments of \$132,075 because Capital did not have proper Medicare reimbursement procedures in place for the fiscal years 2002 through 2004. Capital failed to establish required internal controls to preclude and detect Medicare fee-for-service billings by Providers. Providers received duplicate Medicare payments by submitting Medicare fee-for-service claims for 3,886 services that were already reimbursed through their capitation agreement with Capital. As a result, Providers received Medicare payments through the Carrier and capitated payments from Capital.

## **RECOMMENDATIONS**

We recommend that Capital work cooperatively with Providers and the Carrier to:

- recover the \$132,075 duplicate Medicare fee-for-service payments made to Providers, and
- develop an efficient and effective system to preclude and detect duplicate payments from Providers.

## **AUDITEE'S RESPONSE**

Capital agreed with our findings and is taking corrective actions to enhance their ability to identify and detect potential duplicate payments. Capital states that the effectiveness of their corrective action is contingent upon their having access to automated physician information that they have previously requested from CMS and its carriers.

## TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	1
Objective.....	1
Scope.....	2
Methodology.....	2
<b>FINDINGS AND RECOMMENDATIONS</b> .....	3
<b>RESPONSIBILITY FOR DETECTING DUPLICATE PAYMENTS</b> .....	3
<b>CAPITAL’S FAILURE TO DETECT DUPLICATE PAYMENTS</b> .....	4
<b>RECOMMENDATIONS</b> .....	4
<b>AUDITEE’S RESPONSE</b> .....	4
<b>APPENDIX</b>	
<b>AUDITEE’S LETTER IN RESPONSE TO THE DRAFT REPORT</b>	



## **INTRODUCTION**

### **BACKGROUND**

Capital Health Plan, Inc. (Capital) 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. Capital receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs Capital expects to incur to provide Medicare covered services to enrollees. Capital claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Capital'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 for Medicare payments made to cost-based HMOs are contained in Federal regulations (42 CFR §417.532 and §417.576) and the Medicare Managed Care Manual, Chapter 17, Subchapter B.

First Coast Service Options, Inc. (Carrier) is the Medicare carrier that processes Medicare payments and adjustments for Capital.

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 to Medicare by the medical service provider. Capital was at risk for such duplicate payments because it had a capitation agreement with 10 providers (Providers). Under the agreements, Capital prepays Providers a per-member, per-month dollar amount (capitation payment) to provide medical services to Capital's Medicare enrollees. Since Capital includes the capitation payment on its Medicare cost report, Medicare has already paid Providers 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 Providers, as a direct fee-for-service claim, is a duplicate Medicare payment. The Medicare Managed Care Manual, Chapter 17, Subchapter B, Capital, requires cost-based HMOs like Capital 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 Capital's enrollees by Providers were reimbursed under Capital's Medicare capitation agreement and also through the Medicare fee-for-service payment system.

## **Scope**

We reviewed Medicare fee-for-service payments made to Providers for fiscal years 2002 through 2004 as part of a nation-wide review of potential overpayments made to capitated providers of cost-based HMOs. Due to the limited scope of our audit, we did not review overall internal control structures at either Capital or Providers. However, we created a database specifically designed to identify duplicate payments, which was a specific test of the internal controls Capital had in place to preclude and detect such payments.

We constructed our database in our field office in Lansing, Michigan. We conducted telephone conference meetings with key personnel of Capital and obtained necessary audit documentation through regular and electronic mailings during the five months between December 2005 and April 2006. We performed limited onsite work during the month of May 2006.

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 agreement between Capital and its capitated Providers;
- created a database of CMS fee-for-service claims paid to its capitated Providers for covered services delivered to Capital's enrollees, representing potential duplicate Medicare payments; and
- validated our database.

In order to create our database of duplicate payments, we used CMS's HMO Group enrollment files to identify health insurance claim numbers for Capital's enrollees from January 2002 through December 2004. We then matched these numbers against CMS's National Claims History Archive of Carrier Claims for the same time period. We requested and utilized Capital'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 a service date after the ending enrollment date. We obtained the Employer Identification Number (EIN) for the Providers. The resulting database represented the duplicate reimbursement made through capitated and fee-for-service payments made to Providers for 3,886 services to Capital's enrollees.

To validate our database, we selected a random judgmental sample of approximately 50 payments and presented the sample to Capital. Capital confirmed that all sampled items were duplicate payments.

## **FINDINGS AND RECOMMENDATIONS**

Capital failed to establish necessary internal controls to detect Medicare fee-for-service billings by its Providers, which allowed the Providers to receive duplicate Medicare payments of \$132,075. For the fiscal years 2002 through 2004, we determined that Providers submitted 3,886 lines of fee-for-service claims to Medicare that had been reimbursed under its capitation arrangement with Capital. Since Capital's capitation payments were included on its final Medicare settlement cost report, Medicare payments to its Providers, which were made on a fee-for-service basis, resulted in \$132,075 of duplicate payments to these Providers for the same medical services.

### **Responsibility for Detecting Duplicate Payments**

The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in the Federal regulations (42 CFR §417.532 and §417.576). HMOs 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 HMOs/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."

## **Capital's Failure to Detect Duplicate Payments**

We attribute the Providers' duplicate payments primarily to Capital's failure to establish required internal controls to detect Providers' Medicare fee-for-service billings. Although we believe that Providers should have had controls in its billing process to detect and prevent this condition, Capital, 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, Capital did not have an effective billing control system to detect duplicate payments.

Subsequent to our onsite fieldwork, Capital discussed with the Carrier the reasons why they were not receiving a hard copy of the Carrier's Explanation of Medicare Benefits (EOMB) forms for the fee-for-service claims reimbursed to all of its providers on behalf of Capital enrollees. Capital informed us that the Carrier had system edits in place that precluded them from sending EOMBs to Capital. Additionally, Capital informed us that they are working with the Carrier to rectify the situation and that they intend on using EOMBs in an effort to detect duplicate payments in the future.

## **RECOMMENDATIONS**

We recommend that Capital, work cooperatively with Providers and the Carrier to:

- recover the \$132,075 duplicate Medicare fee-for-service claims made to the Providers; and
- develop an efficient and effective system to preclude and detect duplicate payments from Providers.

## **AUDITEE'S RESPONSE**

Capital agreed with our findings and is taking corrective actions to enhance their ability to identify and detect potential duplicate payments. Capital states that the effectiveness of their corrective action is contingent upon their having access to automated physician information that they have previously requested from CMS and its carriers.

# **APPENDIX**

September 6, 2006

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

Mr. Swanson:

This letter will serve as our response to Report Number: A-05-06-00029 issued July 31, 2006 entitled 'Duplicate Medicare Payments to Cost-Based Health Maintenance Plan Capital Health Plan, Inc. for Fiscal Years 2002 through 2004'.

The report indicates Providers received \$132,075 in duplicate Medicare payments by submitting claims for services provided during 2002 – 2004 that were already reimbursed under capitation payments received from Capital Health Plan, Inc. ("CHP").

The report states the reported duplicate payments were the direct result of CHP not having proper Medicare reimbursement procedures in place and not establishing required internal controls to preclude and detect Medicare fee-for-service billings by Providers.

CHP provides several sources of information to Providers to enable an accurate determination of eligibility prior to rendering services or claims submission.

Capitated Providers are provided a detail member listing on a monthly basis. This listing represents the members for which the Provider is receiving a capitation payment. CHP also provides electronic access to eligibility verification for all CHP Providers via 'CHP Connect' – an online portal that a Provider can use to verify eligibility on a real time basis. CHP Member Services staff are available to respond to any questions a Provider may have concerning eligibility or benefits.

CHP has also established the following process for identifying and precluding potential duplicate payments for its Medicare Cost Contract members:

Upon receipt of either a claim or an EOMB from a Provider or a fiscal intermediary (“carrier”), CHP issues instructions to the Provider to return any monies received from CMS as they have already been reimbursed for any services rendered through their contractual relationship with CHP as a Medicare Cost contractor. If a claim is received, it is denied and a letter is issued to the Provider, indicating that CHP is the primary payer and to return any monies received from CMS. The letter also indicates the claim will remain in a denied status until the Provider submits evidence of the refund to CMS. CMS – Pub 75. § 6105 clearly presumes the establishment and success of any controls to identify and preclude potential duplicate payments is dependent upon the receipt of information that would indicate a potential duplicate payment has occurred:

‘...After you receive paid claim information (denial or an EOMB from the carrier), perform several duplicate check functions. If you have not previously paid the claim, file a copy of claims information in the beneficiary's history file. If your duplicate check reveals you have already paid for the service(s):

1. Contact the physician/supplier or enrollee to retrieve the overpayment;
2. Record any collections as credits on the cost report;
3. Notify HCFA of unresolved overpayment situations; and
4. Do not return payment to carrier.’

Unfortunately, as evidenced by the sample items provided by the OIG, CHP rarely received any notification, or information, that would indicate any potential for duplicate payment.

As part of the review CHP was provided a sample of 47 occurrences of potential duplicate claim payments made to Providers for services rendered to members covered under the CHP Medicare Cost Contract. CHP researched its records and verified it had not received a claim or EOMB in 42 (89%) of the occurrences.

Recent discussions with the Carrier revealed that the EOMB distribution feature in the claims processing system was suppressed for H1010 (CHP), supporting our assertion that CHP had not received any notification of potential duplicate payment.

CHP can only take steps to verify duplication of payment when information is provided by either the Provider or a CMS fiscal intermediary (“carrier”), a presumption clearly stated in CMS – Pub 75.

In addition to the process described above, CHP has also attempted to implement additional controls that would establish a process to proactively identify any potential duplicate payments and would serve to mitigate the inherent challenge posed by the absence of any notification of potential duplicate payment through receipt of claims or EOMB’s from the Provider or a Carrier.

Specifically, CHP has made repeated requests – from the carrier as well as the CMS Regional Office – to gain access to the Physician Supplier I.D. numbers reflected in the GROUCH reports. This information would enable CHP to detect potential duplicate payments and correspond with the Provider to direct a refund to CMS.

The Carrier indicated this access must be granted by CMS. Despite repeated requests, access to this information has not been granted. The potential for duplicate payments by Medicare should be greatly reduced effective January 1, 2006 due to the transition, pursuant to the provisions of the Medicare Modernization Act, of CHP from a cost based HMO to an MA/PD plan,

CHP has taken prudent steps to establish controls to detect and preclude duplicate payments, though these controls were largely preempted by the inherent flaws and challenges in the in the claims adjudication and processing for cost – based HMO's.

As a result of this review, the OIG has provided CHP with sufficient information to identify and work with the Providers to recover the payments contained in the report.

CHP will be issuing letters to each of the identified Providers, informing them of the duplicate payments and instructing that refunds be directed to CHP. Recoveries received will be applied as a credited on CHP's final 2005 cost report and any unresolved overpayments will be reported to CMS as required by CMS – Pub 75. § 6105, (3).

Our ability to identify potential duplicate payments made by Medicare to other Providers not listed in the report is contingent upon the provision of information from CMS or its carriers, as described above.

CHP may also, as part of its ongoing efforts to detect and preclude potential duplicate payments, request the assistance of the OIG in obtaining information necessary to aid in the recovery of such payments.

Sincerely,

Sabin C. Bass  
Sr. VP Finance, CFO





*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

Kathryn Benson, Auditor-in-Charge

Lance Lockhart, Auditor