DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date AUG 30 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Review of Incorrect Medicare Payments Made to Uniformed Services Treatment Facilities (A-14-93-00377)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Incorrect Medicare Payments Made to Uniformed Services Treatment Facilities." The Defense Authorization Act (DAA) for Fiscal Year 1993 required that the Inspector General of the Department of Defense (DOD) and the Department of Health and Human Services conduct a joint review to determine the amount to be recovered by the Health Care Financing Administration (HCFA) for incorrect Medicare payments made to Uniformed Services Treatment Facilities (USTF) from October 1, 1986 through December 31, 1989. The DAA also required that, as part of this joint review, we address possible procedures to avoid future billing inaccuracies.

In accordance with the DAA, our objectives were to (1) determine the amount of incorrect Medicare payments and (2) determine if the necessary controls are in place to avoid future billing inaccuracies. To accomplish our objectives, we reviewed Medicare paid claims data for Calendar Years 1987 through 1989 from HCFA's fiscal intermediaries (FI) which serviced the three USTFs involved in this review. We did not verify Medicare paid claims data for the period October 1, 1986 through December 31, 1986 because the computer system, used by the FIs to support a Medicare paid claim during that time period, had undergone major systems changes and the data was unavailable.

The HCFA's claim included three elements: (1) Medicare Part A benefit payments for health care services totaling $36.9 million, (2) a factor for prospective payment system hospital pass-through costs associated with one USTF totaling $3.1 million, and (3) accrued interest, totaling $4.7 million, that the Medicare trust fund was not able to earn because of trust fund expenditures for the incorrect payments. Based on our review of the FIs' Medicare paid claims history file, Medicare made Part A benefit payments totaling $36.8 million. (This amount differs slightly from HCFA's claim because of an adjustment needed in totaling the benefit payments

for one of the USTFs.) However, DOD estimated that only $7.1 million of the $36.8 million in Medicare Part A benefit payments was for covered USTF services.

In addition to verifying Medicare payments to USTFs, we also discussed with HCFA officials possible procedures to avoid future billing inaccuracies. Based on our discussions, we believe that the controls needed to prevent erroneous billing practices and duplicate payments are not in place. As a result, we are recommending that: (1) HCFA and DOD negotiate an equitable settlement based on the audit work performed. In this regard, based on HCFA's claim and the audit work performed, we believe DOD owes HCFA $7,757,603; (2) HCFA work with DOD to clarify the eligibility rules of dually eligible beneficiaries and, if necessary, propose legislation to clarify the law to prevent future duplicate payments; and (3) HCFA work with DOD to establish a formalized periodic data exchange of USTF eligible beneficiary information to avoid future billing inaccuracies.

In response to our draft report, HCFA provided an advance draft of it's comments. The HCFA did not concur with our first two recommendations and concurred with our third recommendation. We acknowledge HCFA's comments and continue to believe that our determination of the amount to be reimbursed by DOD to HCFA is reasonable based on our audit performed in accordance with generally accepted government auditing standards. We also believe that statutory authority may be necessary to prevent duplicate payments from occurring in the future.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-14-93-00377 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INCORRECT MEDICARE PAYMENTS MADE TO UNIFORMED SERVICES TREATMENT FACILITIES

AUGUST 1993 A-14-93-00377

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Principal Deputy Inspector General

Subject Review of Incorrect Medicare Payments Made to Uniformed Services Treatment Facilities (A-14-93-00377)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

The purpose of this final report is to provide you with the results of our review of incorrect Medicare payments made to Uniformed Services Treatment Facilities (USTF). The Defense Authorization Act (DAA) for Fiscal Year (FY) 1993 required that the Inspector General of the Department of Defense (DOD) and the Department of Health and Human Services (HHS) conduct a joint review to determine the amount to be recovered by the Health Care Financing Administration (HCFA) for incorrect Medicare payments made to USTFs from October 1, 1986 through December 31, 1989. The DAA also required that, as part of this joint review, we address possible procedures to avoid future billing inaccuracies.

In accordance with the DAA, our objectives were to (1) determine the amount of incorrect Medicare payments and (2) determine if the necessary controls are in place to avoid future billing inaccuracies. To accomplish our objectives, we reviewed Medicare paid claims data for Calendar Years (CY) 1987 through 1989 from HCFA's fiscal intermediaries (FI) which serviced the three USTFs involved in this review. We did not verify Medicare paid claims data for the period October 1, 1986 through December 31, 1986 because the computer system, used by the FIs to support a Medicare paid claim during that time period, had undergone major systems changes and the data was unavailable.

The HCFA's claim included three elements: (1) Medicare Part A benefit payments for health care services totaling $36.9 million, (2) a factor for prospective payment system (PPS) hospital pass-through costs associated with one USTF, totaling $3.1 million, and (3) accrued interest, totaling $4.7 million, that the Medicare trust fund was not able to earn because of trust fund expenditures for the incorrect payments. Based on our review of the FIs' Medicare paid claims history file, Medicare made Part A benefit payments totaling $36.8 million. (This amount

differs slightly from HCFA's claim because of an adjustment needed in totaling the benefit payments for one of the USTFs.) However, DOD estimated that only $7.1 million of the $36.8 million in Medicare Part A benefit payments was for covered USTF services.

In addition to verifying Medicare payments to USTFs, we also discussed with HCFA officials possible procedures to avoid future billing inaccuracies. Based on our discussions, we believe that the controls needed to prevent erroneous billing practices and duplicate payments are not in place. As a result, we are recommending that HCFA and DOD negotiate an equitable settlement based on the audit work performed. In this regard, based on HCFA's claim and the audit work performed, we believe DOD owes HCFA $7,757,603. In addition, we recommend that HCFA work with DOD to clarify the eligibility rules of dually eligible beneficiaries and, if necessary, propose legislation to clarify the law to prevent future duplicate payments. We also recommend that HCFA work with DOD to establish a formalized periodic data exchange of USTF eligible beneficiary information to avoid future billing inaccuracies.

INTRODUCTION

BACKGROUND

Uniformed Services Treatment Facilities Program

The USTF program is a health benefits program administered by DOD. A USTF is 1 of 10 former Public Health Service hospitals authorized to provide medical care to members of the uniformed services, their beneficiaries, and to retired members and their families. The DOD establishes participation agreements with each USTF to provide services under the program. The agreements contain a list of the services that will be provided by each USTF and the methodology for calculating the payment.

During the first few years of the USTF program, DOD reimbursed the USTFs on a fee-for-service basis. The DOD found that this payment method lacked effective incentives for the USTFs to contain costs. For FY 1987, the Congress imposed a cap on USTF program expenditures by requiring DOD and the USTFs to negotiate fixed-price or capitated payments.

Although the fixed-price agreements have been somewhat effective in controlling certain costs, there was no provision in the agreement to control utilization of services and billing practices. By agreement, individuals were free to participate in the USTF program without formally enrolling, which means they could also choose

to go to a non-USTF provider for medical services. Some military retirees who are eligible to receive medical services from the USTF program are also eligible to receive Medicare benefits. In general, the USTF agreements provided that the USTFs were liable for covered services provided to USTF-eligibles at USTFs (and authorized affiliates). The covered services were set out in the USTF agreements. Nonetheless, it is apparent that the USTFs in question did bill Medicare, and received payment, for services provided to dual eligibles. The services claimed were USTF-covered and noncovered services. With respect to the covered services, the USTFs' claims to Medicare were inconsistent with the terms of the USTF agreements, and with the laws governing the Medicare program.

Prior HHS Office of Inspector General (OIG) Audit Report

In 1989, DOD officials informed us that some of the USTFs billed Medicare for services covered and paid for under the USTF agreements. The DOD officials wanted to know if the Medicare payments were authorized under the circumstances. On December 28, 1989 we issued an audit report entitled, "Payments by Medicare to Uniformed Services Treatment Facilities for Dual Eligible Beneficiaries" (A-14-90-00325). The objectives of this prior review were to (1) determine if Medicare was erroneously billed for services provided to an individual who is covered by both the USTF and Medicare programs and (2) identify, for recovery, duplicate payments involving individuals who are dually eligible for USTF and Medicare services. We reported that the Medicare payments were improper, based on the advice of our Office of General Counsel (OGC), discussions with DOD counsel and our own view that the Congress could not have intended that the Federal Government pay twice for the same services. We recommended that HCFA identify and recover all Medicare payments received on behalf of USTF patients and clarify existing policy to prevent future improper payments.

In response to our report, HCFA obtained estimates of the amounts of Medicare payments owed by 3 of the 10 USTFs. The HCFA estimated that about $33.9 million should be recouped from the following three USTFs: Homewood Hospital Center (Homewood) in Baltimore, Maryland; Brighton Marine Public Health Center (Brighton) in Boston, Massachusetts; and Pacific Medical Center (PMC) in Seattle, Washington. The HCFA informed us that in 1990, demand letters had been prepared to notify the three USTFs of the improper payments and to request repayment. However, the letters were not sent to the USTFs because of ongoing discussions within the Government on how to settle these cases.

Defense Authorization Act

In 1992, the Congress passed the DAA for FY 1993 which provides for reimbursement to HCFA for Medicare overpayments made to USTFs. Up to $40 million will be available to the USTF program to reimburse HCFA for health care provided to eligible retired DOD beneficiaries who are also eligible for Medicare, between October 1, 1986 and December 31, 1989. The DAA requires a joint review by the OIG of DOD and the OIG of HHS to report on the amounts claimed by HCFA as well as the identification of procedures to avoid future billing inaccuracies. The report is to be submitted to the Secretaries of DOD and HHS and to the Committees on Appropriations of the Senate and the House of Representatives.

HCFA's Claim for Reimbursement of Medicare Overpayments

In a memorandum dated April 8, 1993, HCFA provided to the HHS OIG a claim for $44.7 million for Medicare overpayments associated with the USTF program. The data used to support the original claim of $33.9 million was no longer available for two of the three USTFs. Therefore, HCFA recreated the data for those two USTFs and submitted a revised estimate of $44.7 million. See Appendix I to this report for the complete text of HCFA's claim.

SCOPE

Our review was made in accordance with generally accepted government auditing standards. The scope of our review was limited to address the issues stated in the DAA and, therefore, a review of internal controls was not performed. We utilized data from the FIs' claims processing systems. We performed tests of computer processed data for Medicare claims payment amounts by tracing computer file data to supporting documentation.

Through discussions with DOD OIG personnel, we developed an audit approach whereby each OIG office performed verification work within their respective Departments.

The objectives of our review at HHS were to (1) determine the amount of incorrect Medicare payments and (2) address possible procedures to avoid future billing inaccuracies. The DOD OIG performed a concurrent review to ensure that the Medicare payments made to the USTFs were allowable under the USTF agreements.

For our analysis, we utilized computer processing techniques to make a 100 percent verification of Medicare claims payments for dually eligible individuals residing within a 50-mile radius of the three USTFs identified above (Homewood, Brighton, and PMC). We obtained and analyzed Medicare paid claims data for CYs 1987 through 1989 from HCFA's FIs which serviced the three USTFs involved in this review. Although a total of 10 USTFs are in existence nationwide, HCFA informed us that they believed that only these 3 had mistakenly billed Medicare. We focused our review on the three USTFs and did not perform a similar review of the other seven USTFs.

To accomplish our objective, we utilized a HCFA supplied computer file of all DOD eligible individuals within a 50-mile radius of each of the three USTFs. The HCFA had previously received this computer file from DOD USTF program officials. The eligibility file was provided to the FI of each of the three USTFs to match against the Medicare paid claims history file for the CYs 1987 through 1989. We used this information to determine if Medicare made a payment, during CYs 1987 through 1989, on behalf of the individuals that were dually eligible for Medicare and USTF services. Since HCFA did not provide us with Medicare claims paid during the period October 1, 1986 through December 31, 1986, they were not included in the universe of the data matches and, therefore, were not tested for potential overpayments. These claims were not included in the data matches because obtaining 1986 data from the FIs' computer systems would have required additional reprogramming, due to a subsequent change in format for processing.

As mentioned above, the objective of the DOD OIG's concurrent review was to determine the allowability of Medicare payments in accordance with the USTF agreements. In order to rely on DOD's audit work, we conducted tests on a sample of claims that the DOD OIG had processed, and we agreed with their conclusions on allowability of the claims tested. We also validated their statistical projection of Medicare payments made on behalf of dually eligible individuals. (See Appendix II for the appraisal of the statistical sampling results.) As such, we have concluded that DOD's audit work is in consonance with applicable government auditing standards.

We also selected a judgmental sample of claims paid to non-USTF and USTF-affiliated providers located within a 50-mile radius of the USTFs in Baltimore, Maryland and Seattle, Washington--for the period of the review--to determine if there was any indication in the hospital records of referrals from the respective USTFs to these other providers.

The field work was performed by our headquarters staff in Maryland and by our San Francisco, California and Seattle, Washington field office staffs during the period October 1992 through May 1993.

RESULTS OF REVIEW

HCFA's Claim

The HCFA provided the HHS OIG with a claim for Medicare Part A (inpatient hospital care) benefits paid on behalf of the Medicare/USTF eligibles living within a 50-mile radius of each of the three USTFs, during the CYs 1987 through 1989. This was created through a computer operation of matching DOD's file of USTF eligibles and the FIs' files of paid Medicare claims data for each of the three States in which the USTFs are located.

The HCFA claim includes three elements: (1) Medicare Part A benefit payments for health care services rendered, (2) a percentage add-on factor for PPS hospital pass-through costs associated with PMC, and (3) a value for accrued interest the Medicare trust fund was not able to earn because of the trust fund expenditures for these incorrect payments. The following chart summarizes HCFA's claim:

PROVIDER	PART A PAYMENTS	PASS-THRU COSTS	ACCRUED INTEREST	TOTAL
Homewood	$12.8	$ 0	$1.6	$14.4
Brighton	2.8	0	.4	3.2
PMC	21.3	3.1	2.7	27.1
TOTALS (Millions)	**$36.9**	**$3.1**	**$4.7**	**$44.7**

In the memorandum to HHS OIG, HCFA officials stated that they believe the claim is understated for the following three reasons:

- It does not include any Medicare Part B overpayment amounts for noninstitutional providers, such as, physicians, suppliers, etc.

- It does not include any amounts for USTF eligibles outside the 50-mile radius of each USTF involved.

- It does not include any claims paid on behalf of dually eligible individuals from two Part A providers of services affiliated with PMC, which are serviced by a different FI.

The HCFA officials have not supplied us with an estimate of the underclaimed amount or with any auditable documentation evidencing an amount. We, therefore, cannot comment on the amount of any potential underclaim.

HHS OIG Review Results

We reviewed HCFA's claim of $44.7 million which consisted of $36.9 million in Medicare Part A benefit payments, $3.1 million in associated hospital pass-through costs, and $4.7 million for accrued interest. We performed an analysis of the computer data used to obtain HCFA's estimate of $36.9 million for Medicare Part A benefit payments made on behalf of dually eligible individuals. Our verification of the computer data showed that HCFA's claim should be reduced to $36.8 million because of an adjustment needed in totaling the benefit payments for one of the three USTFs. However, our analysis found that while the benefit payment data consisted of Medicare payments to USTF facilities and their affiliated providers, the data also included payments to non-USTF facilities. This determination was made by using the provider number that HCFA assigns to each facility. When the Medicare payments were totaled by provider number, only $14.8 million of the $36.8 million had been paid to USTFs and their affiliated providers. The remaining $22 million was paid to non-USTF providers.

All Inclusive versus Provider Specific Claim

As mentioned above, we found that HCFA's adjusted universe of $36.8 million could be divided into two distinct parts: (1) claims totaling $14.8 million paid to the three USTFs and affiliated providers (provider specific claims) and (2) claims totaling $22 million paid to providers other than the three USTFs and their affiliates.

During the course of our review, HCFA officials indicated their concern about the issue of referrals involving dually eligible individuals. These officials thought that some USTF participants could be receiving covered services at non-USTF or USTF-affiliated providers with or without an official referral being found in the hospital records. As part of our review, we included a judgmental sample of claims from non-USTF and USTF-affiliated providers to test for any indication of a referral from a USTF facility. We selected a judgmental sample of five hospitals within a 50-mile radius of the USTF facilities in both Baltimore, Maryland and Seattle, Washington. We reviewed patient medical records and billing records to

determine if there was any indication that the beneficiary had been referred from the USTFs. Our review of the medical and billing records provided to us by the hospitals showed that a small number of referrals had been made to USTF-affiliated providers for covered services provided to dually eligible individuals. Although the USTF should have paid for the services, Medicare was improperly billed for these services and paid for them. However, the majority of the sample claims showed either no indication of referral or a noncovered service was performed.

We requested a legal opinion from our OGC regarding USTF liability for a dually eligible individual who does not go to a USTF for medical care, but goes to other non-USTF or USTF-affiliated facilities. The legal opinion concluded that Medicare is liable for services provided at non-USTF or USTF-affiliated facilities when the services are not arranged or approved by the USTF. Therefore, although Medicare made payments on behalf of USTF eligibles who went to a non-USTF or USTF-affiliated facility, there appears to be no legal basis to recommend recoupment of those payments.

Based on our review of the all inclusive universe of $36.8 million (adjusted), we believe that the provider specific claims of $14.8 million are the proper universe of potential incorrect Medicare claims based on the agreements negotiated by DOD and the USTFs. These are claims where the dually eligible individual went to a USTF, or affiliated provider, and received medical services.

The remaining $22 million represents claims for dually eligible individuals who did not receive their medical care at the USTF or affiliated provider, but chose to go to a non-USTF provider. According to the USTF agreements and discussions with our OGC personnel, the USTF is liable for payment only if beneficiaries receive their medical care on USTF premises or by a referral to an affiliated USTF facility.

Through discussions with the DOD OIG personnel, we agreed with their conclusions that they limit their review of USTF records to a sample of the universe of $14.8 million of claims paid directly to the three USTFs and affiliated providers under review.

PPS Pass-Through Costs

The claim that HCFA submitted also included a factor for PPS hospital pass-through costs for providers associated with PMC. (The other two USTFs are not paid under PPS.) Under PPS, payments are made to providers for operating costs related to inpatient services connected with each Medicare discharge. Certain costs are excluded from PPS and are reimbursed on a reasonable cost

basis. These costs are referred to as pass-through costs and may include costs, such as, capital expenditures, direct medical education expenses, indirect medical education expenses, and bad debts attributable to Medicare beneficiaries.

We reviewed documentation to support HCFA's claim of a 14.9 percent add-on factor for PPS pass-through costs which they applied to the $21.3 million in claims payments applicable to PMC. The HCFA calculated the 14.9 percent by averaging the 3-year national average for pass-through costs for all PPS hospitals. We agree that this is a reasonable approach and that the percentage is calculated correctly. The 14.9 percent factor should be applied to the total valid PPS payments for PMC.

Accrued Interest

The HCFA's claim also included an accrued interest calculation using an annual rate of 8 percent for income that was lost to the Medicare trust fund because of the overpayments. The interest covers the period from September 1, 1991 through March 31, 1993. We requested a legal opinion from our OGC to determine whether HCFA had a legal basis for including accrued interest as part of its claim. Based on advice provided by our OGC, accrued interest is not allowable under the circumstances of this review. The OGC provided us with the following citations from the regulations and Social Security Act.

The pertinent regulations are found at 42 CFR 405.376. These provisions govern interest charges "...on overpayments to...Medicare providers, suppliers, Health Maintenance Organizations, competitive medical plans, and health care prepayment plans." Subject to the regulations, the general rule requires HCFA to charge interest on overpayments.

Section 1815(d) of the Social Security Act is the statute authorizing the regulation and states that "...whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of...the payment that is due...interest shall accrue on the balance...at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments."

The OGC informed us that there must be evidence that a "final determination" of the amount of the overpayment had been reached in order for the provisions of 42 CFR 376(e) to be applicable. The HCFA provided no evidence that a "final determination" had been reached in regard to the USTF overpayments. Therefore, we conclude that HCFA's claim for accrued interest is not allowable since it does not comply with the provisions of the applicable regulation.

DOD OIG Audit Work

The DOD OIG performed a review of USTF medical records and patient financial data, using statistical sampling techniques, but limited their review to only the specific provider associated with the USTF facility. The following illustration provides the results of their review.

SAMPLE RESULTS

PROVIDER	AUDITED UNIVERSE (Millions)	SAMPLE SELECTED	VALID CLAIMS	NONCOVERED SERVICES	PATIENT NOT SEEN/REFERRED	
Homewood	$ 2.2	136	132	4	0	0
Brighton	.8	180	147	28	2	3
PMC	11.8	380	152	31	124	73
TOTAL	**$14.8**	**696**	**431**	**63**	**126**	**76**

As the above illustration shows, DOD selected a statistical sample of 696 Medicare paid claims and found that 431 were considered valid for recoupment. The 431 claims represent Medicare payments for services authorized in the USTF agreements rendered to DOD eligible patients and are considered valid claims for DOD reimbursement. The remaining claims were not considered valid for recoupment by HCFA, for the following reasons: (1) the services provided were not covered under the USTF agreement (63 claims), (2) the claim was paid to a USTF-affiliated provider, and there was no record that the beneficiary had ever been seen at the USTF (126 claims), or (3) the beneficiary was a USTF patient and had been treated at a USTF-affiliated provider, but there was no record that the USTF had referred the patient (76 claims).

The following illustrates the difference between DOD's universe and HCFA's claim:

HCFA'S CLAIM VS. DOD'S UNIVERSE
(MILLIONS)

PROVIDER	HCFA	DOD	DIFFERENCE
Homewood	$12.8	$ 2.2	$10.6
Brighton	2.8	.8	2.0
PMC	21.3	11.8	9.5
TOTAL	**$36.9**	**$14.8**	**$22.1**

The HCFA's claim includes Medicare payments made to all providers in the State where the USTF is located on behalf of the DOD/Medicare eligible individuals contained on the DOD eligibility file. As previously stated, through discussions with the DOD OIG and associated legal counsel, it was decided that the DOD verification work would be limited to the $14.8 million in claims directly made to the three USTFs and affiliated providers. The results of the DOD OIG review show that DOD owes the Medicare trust fund $7,757,603 for incorrect Medicare payments made to the three USTFs and affiliated providers. The $7,757,603 consists of $7,087,002 in allowable Part A benefits (see Appendix II, page 3) and $670,601 in associated pass-through costs related to PMC.

The DOD OIG review showed that only $7,757,603 ($7,087,002 for benefit payments and $670,601 for pass-through costs) of the total $14.8 million actually involved medical services that were covered under the USTF agreements with the three USTFs under review. The remaining services that were paid by Medicare as covered Medicare procedures remain the liability of the Medicare program. During the course of our review, we conducted sufficient tests of DOD's working papers and statistical sampling appraisal results to concur with the above conclusions.

As a result of the audit work performed, we believe that DOD should reimburse the Medicare program a total of $7,757,603 for incorrect payments made to the three USTFs and affiliated providers.

Controls to Avoid Future Overpayments

In addition to verifying HCFA's claim against USTFs, the DAA contains a provision to also address possible procedures to avoid any future billing inaccuracies. Through discussions with HCFA and DOD personnel, and a review of correspondence on the issue of dually eligible Medicare beneficiaries, it is apparent that there continues to be the potential for billing inaccuracies and duplicate payments to occur, involving two Federal Government agencies. The potential for Medicare mistaken payments and duplicate payments by HHS and DOD occurs when a dually eligible beneficiary receives services in the USTF and Medicare is billed for the service. Also, duplicate payments involving HHS and DOD could occur when a dually eligible beneficiary is enrolled in the USTF program and, therefore, included in the capitation payments, and then independently seeks medical services at a non-USTF facility. When this happens, Medicare is billed and pays the non-USTF facility, and DOD also pays the USTF a full capitation payment for the same beneficiary. So far, no statutory authority exists to prevent this situation from occurring.

Over the last several years, HCFA has experienced difficulties in avoiding making a payment when it involves Medicare secondary payer (MSP) issues. These improper payments, which are very similar to the Medicare payments made inappropriately to USTFs, are made when two or more payers of health services exist. The problem occurs because HCFA does not always have the eligibility information necessary to identify another payer prior to paying the Medicare claim. Without HCFA having a current file of USTF eligible beneficiaries, the potential (from HCFA's perspective) for incorrect Medicare payments resulting in two Federal agencies paying for the same service, will continue to exist.

We understand that DOD is in the process of establishing a standardized managed care plan to encompass all USTF participants who wish to enroll in the plan. We are encouraged that DOD and HCFA program officials have been discussing this plan and made improvements that will help to preclude duplicate payments involving two Federal agencies. The DOD OIG's audit work included a review of controls over patient billings and referrals by the three USTFs reviewed. The audit results indicated that there were now sufficient controls at the three USTFs to prevent future billings of Medicare for USTF covered services. However, based on our experience with MSP issues, we continue to have concerns that the managed care plan alone will not prevent the potential for future inappropriate billing practices. Therefore, we continue to strongly believe that DOD and HCFA should establish a formalized exchange of USTF eligibility information that can be entered into HCFA's Medicare eligibility system to help prevent future inappropriate payments being made by Medicare to USTFs while the beneficiary is actually a member of the USTF managed care program.

CONCLUSIONS AND RECOMMENDATIONS

We reviewed HCFA's claim for Medicare Part A benefit payments totaling $36.9 million, pass-through costs totaling $3.1 million, and accrued interest totaling $4.1 million. Our review disclosed that HCFA's claim of $36.9 million for Part A benefit payments should be reduced to $36.8 million because of an adjustment needed in totaling the benefit payments for one of the USTFs. However, we believe that only the $14.8 million paid to the three USTFs and their affiliates under review is the potential gross liability of DOD. The difference of $22 million is for payments made to providers other than the USTF which, based on USTF agreement, are not the liability of DOD.

Based on the DOD OIG review of these $14.8 million in payments, they estimate that $7,087,002 in Part A benefits represents allowable services under the USTF agreements for which DOD should reimburse the Medicare trust fund. Associated with this is $670,601 in pass-through costs related to PMC. Therefore, based on our review, we conclude that DOD owes HCFA a total of $7,757,603.

RECOMMENDATIONS

1. We recommend that HCFA and DOD negotiate an equitable settlement based on the audit work performed. Based upon HCFA's claim and our audit work, we believe that DOD owes HCFA $7,757,603 for payments inappropriately billed to Medicare by the three USTFs on behalf of dually eligible individuals contained on the DOD eligibility file.

2. We recommend that HCFA continue to work with DOD to clarify the eligibility rules of dually eligible beneficiaries. If necessary, a legislative proposal should be submitted that will clarify the law to define situations where each agency is liable for payment in order to prevent future duplicate payments.

3. We also recommend that HCFA work with DOD to establish a formalized periodic data exchange of USTF eligible beneficiary information to avoid future billing inaccuracies.

HCFA COMMENTS AND OIG RESPONSE

In responding to the recommendations in our draft report, HCFA provided us with an advance draft memorandum of its comments which are summarized below. The complete text of HCFA's draft comments are included as Appendix III to this report.

The HCFA officials concurred with our recommendation concerning establishment of a formalized periodic data exchange. With regard to our recommendation for HCFA to negotiate a reasonable settlement with DOD, HCFA does not concur, stating that they believe a significant part of the overpayment is reimbursable to the Medicare trust fund. Concerning our recommendation to prevent future duplicate payments, HCFA did not concur, and stated that they are presently working with DOD to implement a congressionally mandated managed care plan.

HCFA Comments - Recommendation 1

The HCFA does not concur with this recommendation, stating that we only recognized part of HCFA's claim and that they believe a significant portion is reimbursable. The HCFA believes that a portion of this is for referrals and should be reimbursed to the Medicare trust fund. Additionally, HCFA believes that approximately $800,000 in Medicare payments should be reimbursed by DOD and was not taken into consideration during the audit.

OIG Response

Based on HCFA's claim, $36.8 million was paid by Medicare for health care services provided to dually eligible beneficiaries. Payments totalling $14.8 million were made to USTFs and their affiliates, and payments totaling $22 million were made to non-USTFs. The results of our audit indicate that a portion of the $14.8 million which are for covered USTF services are reimbursable to the Medicare program and should not have been billed to Medicare. The remainder of the $14.8 million was for noncovered services and was correctly billed to the Medicare program. The $22 million in payments made to non-USTF providers is the obligation of the Medicare program unless a referral had been made to that provider from the USTF. In accordance with generally accepted government auditing standards, we performed a judgmental review of a sample of Medicare claims paid to non-USTF providers. Included in this review was a verification of the medical records and patient financial records to determine whether documentation was available to support a referral from the USTF and also a determination of the payment of coinsurance and deductibles in connection with the claims. Our review concluded that there were a small number of referrals. However, we found the majority of these sample claims showed either no indication of referral, or a noncovered service was performed. Therefore, we concluded to our satisfaction that sufficient testing was performed to make the determination that referrals were not routinely made to non-USTF providers.

With regard to the $800,000, we performed our audit in accordance with the provisions contained in title VI of the DAA for FY 1993 which requested that we report ..."solely on the amounts claimed by the Health Care Financing Administration...." The $800,000 was not included in HCFA's claim. Therefore, we could not make a determination that any part of this amount should be reimbursed by DOD to HCFA.

HCFA Comments - Recommendation 2

The HCFA does not concur with this recommendation, stating that HCFA and DOD have already settled this issue through the implementation of a congressionally mandated USTF managed care plan.

OIG Comments

We agree with HCFA that the managed care plan will help prevent billing inaccuracies in the future. However, there is no Medicare statutory authority to prevent a DOD beneficiary enrolled in the USTF program from receiving health care outside the USTF and have that care reimbursed by Medicare. As a result, the potential exists for duplicate payments to occur by both DOD and Medicare on behalf of dually eligible beneficiaries. We believe that the formalized data exchange process between DOD and HCFA will facilitate the identification of this type of duplicate payment. However, new statutory authority may be necessary to preclude future duplicate payments from occurring.

HCFA Comments - Recommendation 3

The HCFA concurs with this recommendation.

OIG Comments to HCFA Technical Comments

We agree with HCFA's comments regarding the application of pass-through costs, and we have corrected the final report accordingly.

We do not agree with HCFA's comment regarding the projecting of payments for the period October 1, 1986 through December 31, 1986. As mentioned in our response to Recommendation 2 above, we conducted our audit in accordance with the requirements set out in the DAA which states that we will report solely on the amounts claimed by HCFA. The HCFA did not provide us with an estimate or supporting documentation of the amount paid by Medicare during this time period. Therefore, we could not make a determination on an amount to be reimbursed by DOD for this period.

In regard to HCFA's technical comment related to its claim for accrued interest, we determined accrued interest to be unallowable based on advice given to us by OIG OGC. The OGC's basis for considering interest to be unallowable was 42 CFR 376(e) and section 1815(d) of the Social Security Act which requires a "final determination" of an overpayment amount.

We are addressing HCFA's technical comment regarding the context in which "three USTFs" and "three USTFs and affiliated providers" are used. Our final report will be corrected.

APPENDICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date: APR 8 1993

Refer to: BPO-CF42

From: Director
Bureau of Program Operations

Subject: Health Care Financing Administration's (HCFA's) Claim for Medicare Overpayments Associated with Uniformed Services Treatment Facilities (USTF) Due from the Department of Defense (DOD)--INFORMATION

To: Assistant Inspector General
for Health Care Financing Audits

The attached Exhibit summarizes HCFA's claim for Medicare Part A overpayments, due from the DOD, for services provided to Medicare/USTF dual eligible beneficiaries during calendar years 1987, 1988 and 1989.

Basis for Claim

In December 1989 the USTFs were notified by DOD to stop billing Medicare for USTF covered services. In addition, the DOD Office of the Inspector General (OIG) notified the Department of Health and Human Services (DHHS) OIG about this unauthorized billing of Medicare by the USTFs. HCFA was then requested by the DHHS OIG to develop the "full potential" USTF overpayment amounts and validate individual claim amounts through the determination process. In order to develop the maximum overpayment amounts, HCFA decided that the data match must be all inclusive and, therefore, not limited to specific providers. Our data matches were conducted using an USTF eligibles tape furnished by the DOD. The methodologies for constructing this tape were developed by Colonel Daniel Holz, the then Director of the USTF Program, under the Assistant Secretary of Defense for Health Affairs.

In this regard, the Defense Authorization Act for Fiscal Year 1993 prevents HCFA from proceeding with making final overpayment determinations and, therefore, we are unable to establish proof of a link showing that a medical service referral had taken place for those claims billed through providers outside of the USTF confines.

HCFA overpayment staff, a staff member from the DHHS Office of the General Counsel and senior corporate officers from Pacific Medical Center (PMC) met on November 2, 1990, to discuss the financial impact that recovery would have on PMC.

James Gore, PMC's Chief Financial Officer and B. Gerald Johnson, Counsel for PMC, estimated that PMC's Medicare overpayment liability, for USTF covered services, would be approximately $18 to $20 million. We wish to note that HCFA's original overpayment estimate for PMC was approximately $19.7 million. This estimate was developed using the all inclusive data match criteria as discussed above.

HCFA's claim, which is all inclusive, is based on USTF covered services as specified in individual agreements with the respective facilities. These USTF facilities include Brighton Marine Hospital (BMH) in Boston, Homewood Hospital Center (HHC) in Baltimore and PMC in Seattle. The claim for BMH is for outpatient services only, as specified in its USTF agreement.

HCFA's claim for HHC includes bills submitted through provider # 21-0009, the Johns Hopkins Health System (JHHS). The JHHS received approximately $900,000 in Medicare Part A payments. A history of the JHHS establishes a close relationship between JHHS and HHC as early as 1986. They formally merged HHC into the JHHS on July 1, 1988. It is our position that the close relationship between the two facilities justifies inclusion of claims submitted through JHHS into our total claim for HHC.

Despite the magnitude of our claim, we consider it to be understated in that it does not include several elements which would increase the amount requested. These excluded elements are:

- All Medicare Part B (non institutional providers, physician, suppliers, etc.) overpayments amounts.
- Amounts for USTF eligibles outside the fifty mile radius of each USTF involved.
- Two providers of service affiliated with PMC.

The claim includes accrued interest, lost by the Medicare Program, due to the mandated delay in HCFA's authorized overpayment determination-making process. This interest, at an annual rate of 8 percent, covers the period from September 1, 1991 through March 31, 1993. In addition, our claim includes a factor for Prospective Payment System (PPS) hospital pass through costs for providers associated with PMC. These pass through costs are based on a 3-year national average of 14.9 percent. The average is used as an expedited method of claiming these costs.

We feel that HCFA's total claim is conservative and it is fair to all parties concerned.

If you have any questions regarding this matter, please contact Bernie Altman on (410) 966-7512 or Bob Scogna on (410) 966-7496.

Carol J. Walton

Attachment

HCFA's Part A Medicare Claim
Due From USTF-DOD

Items	Brighton Marine Hospital	Pacific Medical Center	Homewood Hospital Center	COMBINED TOTALS
Benefits Paid By Medicare	$2,800,000	$21,300,000	$12,800,000	$36,900,000
PPS Providers (Pass Through Costs) (1)	NA	$3,173,700	NA	$3,173,700
(Accrued Interest) (2)	$354,669	$2,698,000	$1,621,333	$4,674,002
Totals	$3,154,669	$27,171,700	$14,421,333	$44,747,702

(1) NA = Not Applicable, PPS Waiver Hospital and/or Outpatient Services

(2) Accrued Interest from 9/1/91 through 3/31/93, Subject to additional amounts beyond 4/1/93

HCFA's Total Claim	$44,747,702

Verification of DOD OIG Sample
Homewood Hospital Center

Design Type: Stratified Random Sample

Stratum Number	Total Claims	Total[1] Value	Sample Size	Sample[1] Value	Accepted Claims	Accepted[1] Value
1	24	$0.437	24	$0.437	23	$0.420
2	2,019	1.381	91	0.061	88	0.052
3	12,851	0.351	21	0.001	21	0.001
Totals	14,894	$2.169	136	$0.499	132	$0.473

Sample Appraisal at the 95 Percent Confidence Level

Lower Bound	Point Estimate	Upper Bound
$1,571,157	$1,933,651	$2,296,145

[1] Figures represent millions

Verification of DOD OIG Sample
Brighton Marine Public Health Center

Design Type: Stratified Random Sample

Stratum Number	Total Claims	Total[2] Value	Sample Size	Sample[2] Value	Accepted Claims	Accepted[2] Value
1	96	$0.170	30	$0.056	11	$0.021
2	178	0.124	30	0.020	20	0.012
3	434	0.151	30	0.011	28	0.010
4	1,010	0.154	30	0.005	29	0.005
5	1,457	0.103	30	0.002	29	0.002
6	4,770	0.097	30	0.001	30	0.001
Totals	7,945	$0.799	180	$0.095	147	$0.051

Sample Appraisal at the 95 Percent Confidence Level

Lower Bound	Point Estimate	Upper Bound
$ 601,862	$ 652,672	$ 703,482

[2] Figures represent millions.

Verification of DOD OIG Sample
Pacific Medical Center

Design Type: Stratified Random Sample

Stratum Number	Total Claims	Total[3] Value	Sample Size	Sample[3] Value	Accepted Claims	Accepted[3] Value
1	251	$ 3.8	100	$1.555	28	$0.334
2	445	3.3	100	0.721	48	0.350
3	711	2.5	75	0.266	35	0.123
4	805	1.2	45	0.076	21	0.037
5	504	0.4	30	0.023	17	0.013
6	4,173	0.4	30	0.003	3	0.000
Totals	6,889	$11.6	380	$2.644	152	$0.857

Sample Appraisal at the 95 Percent Confidence Level

Lower Bound	Point Estimate	Upper Bound
$3,989,141	$4,500,679	$5,012,216

NOTE: The sum of the three point estimates ($1,933,651, $652,672, and $4,500,679) is $7,087,002 and agrees with DOD's statistical estimate.

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[3] Figures represent millions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Review of Incorrect Payments Made to Uniformed Services Treatment Facilities" (USTF), (A-14-93-00377)

To Bryan B. Mitchell
Principal Deputy Inspector General

We have reviewed the above-referenced draft report in which OIG provided the results of its review to quantify incorrect Medicare payments made to USTFs and to assess the extent to which management controls were in place to avoid future billing inaccuracies.

OIG proposed several recommendations to address their findings. We concur with the third recommendation; however, we do not concur with recommendations 1 and 2.

We want to emphasize our concern that all issues be resolved as fairly and equitably as possible in order to protect the integrity the Medicare Trust Funds. Our detailed comments on the report findings and recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please contact us if you would like to discuss our comments and response.

Attachments

U.S. GOVERNMENT PRINTING OFFICE: 1982 - 522-060/5182

Health Care Financing Administration's (HCFA) Comments
on Office of Inspector General (OIG) Draft Report:
"Review of Incorrect Medicare Payments Made to
Uniformed Services Treatment Facilities"
(A-14-93-00377)

Recommendation 1

HCFA and DOD should negotiate an equitable settlement based on the audit work performed. Based upon HCFA's claim and our audit work, we believe that DOD owes HCFA $8,655,281 for payments inappropriately billed to Medicare by the three USTFs on behalf of dually eligible individuals contained on the DOD eligibility file.

HCFA Response

We do not concur. OIG's recommended settlement only recognizes part of HCFA's claim. HCFA's claim included the full potential of benefits paid by Medicare to USTF eligibles (beneficiaries served at USTFs and those referred by USTFs to non-USTF facilities). The direct benefit amount ($36.8 million) was split by OIG into two distinct parts: $14.8 million paid to USTFs (provider specific claims) and $22 million paid to non-USTFs. OIG used the provider number as the basis for this split. (Provider numbers are assigned to USTFs by HCFA.) HCFA's concern is that referrals were made by the USTFs to non-USTF providers and the portion of the $22 million that is for referrals to non-USTFs should be determined and reimbursed to HCFA.

We are not satisfied that adequate audit procedures were performed by OIG to detect or identify possible referrals. OIG relied on a sample of medical records to determine if referrals had been made. We believe this is a highly unreliable method in which to determine whether patients had been referred to affiliate hospitals. We strongly recommend that a confirmation-type or similar procedure be used on the sample patients identified by OIG. This procedure would have required yes or no responses to the question of referral to non-USTF providers and is an essential audit step needed to ensure that the patients were not originally referred to non-USTF institutions. OIG relied on a sample of medical records to determine if referrals had been made. We believe this is a highly unreliable manner in which to determine whether patients had been referred to affiliate hospitals.

OIG states, on page 7, that their review of the medical and billing records provided to them by the hospitals "showed that a small number of referrals had been made to USTF affiliated providers for covered services provided to dually eligible individuals." We question OIG's basis for this statement. OIG reviewed a judgmental sample of medical records provided to them by hospitals for evidence of written referrals. HCFA has been advised, specifically by Pacific Medical Center (PMC), that referrals

are routinely made to non-USTF providers in the normal course of their patient care and not all of these referrals are documented in beneficiaries' medical records. It is unacceptable to HCFA to dismiss $22 million without proper investigation. Therefore, we do not accept this finding.

Additionally, OIG does not mention that it independently obtained information showing that the two providers related to the Seattle USTF (PMC), but serviced by Aetna, received approximately $800,000 in questionable direct payments from Medicare. This amount should be used to adjust HCFA's claim, along with the application of Prospective Payment System (PPS) passthrough costs and accrued interest as it relates to these two providers.

We also concur with OIG's conclusions regarding PPS passthrough costs application.

Recommendation 2

HCFA should continue to work with the Department of Defense (DOD) to clarify the eligibility rules of dually eligible beneficiaries. If necessary, a legislative proposal should be submitted that will clarify the law to define situations where each agency is liable for payment in order to prevent future duplicate payments.

HCFA Response

We do not concur with this recommendation, which implies a present state of confusion regarding which agency will pay for services.

HCFA and DOD have already settled this issue. DOD is about to implement a Congressionally mandated USTF managed care plan, under which only those individuals enrolled in the plan will be eligible for USTF services at DOD expense.

The law (10 USC chapter 55) requires that DOD pay for services furnished by a USTF to dually eligible individuals enrolled in the managed care plan. Medicare must pay for covered services furnished by a USTF to dual eligibles not enrolled in the plan, and for services furnished by providers other than the USTF, except when services furnished by other providers are authorized under the managed care plan.

Military retirees and dependents who are entitled to Medicare have the same opportunity to enroll in a USTF managed care plan as individuals not entitled to Medicare. Only if DOD failed to implement the managed care program, or denied Medicare-military dual eligibles an equal opportunity to enroll, would a problem regarding who should pay for USTF services persist. Also, DOD has assured HCFA that an individual's ability to enroll in the managed care plan will not be affected by his or her medicare entitlement.

Recommendation 3

OIG recommends that HCFA work with DOD to establish a formalized periodic data exchange of USTF eligible beneficiary information to avoid future billing inaccuracies.

HCFA Response

We concur. HCFA and DOD have already initiated discussions regarding data exchange to avoid billing inaccuracies.

TECHNICAL COMMENTS

Page 9, 1st paragraph, PPS passthrough Costs, indicates the 14.9 percent was applied to $36.9 million in claims payment. This should be corrected to say "applied to PMC's all inclusive claim payment of $21.3 million."

OIG should explore the possibility of projecting overpayments made to the USTFs for the period October 1, 1986 through December 31, 1986. The second paragraph on page 5, indicates that the OIG simply ignored this period for potential overpayments to the USTFs due to the fact that data matches were not made available and would require additional reprogramming on the part of the fiscal intermediaries due to changes in format for processing. We believe that a reasonable estimate of the overpayments made to the USTFs should, for this period, be obtained and made a part of HCFA's claim along with passthrough costs and accrued interest.

Actions by Congress and the Office of Management and Budget have prevented HCFA from reaching "final determination" and issuing demand letters. This includes threats of proposed legislation and the formal passage of a mandated directive under Public Law 102-396. Our current claim includes interest at the rate of 8 percent for the period September 1, 1991, through September 30, 1993, unless this issue is resolved before then. The Medicare Trust Funds continue to lose accrued interest as a result of this issue.

We take exception to the statement made in the "Scope" section of the report, page 5, paragraph 4, which states in part ". . . HCFA informed us that they believed that only these three had mistakenly billed Medicare." We do not consider these to be billing mistakes, but a conscious decision on the USTF's part to bill the Medicare program.

Throughout the report, references are made to "three USTFs" and "three USTFs and affiliated providers." Are both of these statements correct in the context in which they are used?

Attached is a copy of a memorandum from the Office of the General Counsel which addresses the various elements in your report and supports HCFA's concerns stated above. This memorandum was originally forwarded to your staff on June 8.