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

REGION V
OFFICE OF
INSPECTOR GENERAL

June 19, 2003

Report Number: A-05-02-00067

Mr. Richard Kramer
Finance Director
Welborn Health Plans, Inc.
421 Chestnut Street
Evansville, Indiana 47713

Dear Mr. Kramer:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS) final report entitled, "Audit of Medicare Cost Reports and Duplicate Payments for Welborn Health Plans for the Fiscal Years 1999 through 2001." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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), OIG, OAS 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).

To facilitate identification, please refer to Report Number A-05-02-00067 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

David Dupre
Acting Regional Administrator
Centers for Medicare and Medicaid Services
233 N. Michigan Avenue, Ste. 600
Chicago, IL 60601-5519

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

AUDIT OF MEDICARE COST REPORTS AND DUPLICATE PAYMENTS FOR WELBORN HEALTH PLANS FOR THE FISCAL YEARS 1999 THROUGH 2001

WELBORN HEALTH PLANS, INC.
EVANSVILLE, INDIANA

JUNE 2003
A-05-02-00067

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

OBJECTIVES

The audit objectives were to determine whether $35,378,132 in costs claimed by Welborn Health Plans, Inc. (Welborn) on its Medicare cost reports were reasonable, allowable and allocable; in accordance with Medicare provider reimbursement principles and guidelines; and whether payments for provider services claimed on Welborn's cost reports were also reimbursed under the Medicare fee-for-service payment system.

FINDINGS

Based on our review, we consider all costs, except the $700 claimed for an unallowable and unallocable retirement party, to be reasonable, allowable, and allocable. We also determined that the Medicare program improperly paid $96,923 in fee-for-service claims submitted by two of Welborn's providers that were already reimbursed for these services through capitated payments. Welborn claimed the capitated payments on its Medicare cost reports. We attribute the duplicate payments to Welborn's failure to establish required internal controls to detect the Medicare fee-for service billings by their providers.

RECOMMENDATIONS

We recommend that Welborn:

- Refund the $700 related to unallowable costs claimed on the FY 2000 cost report.
- Refund the $96,923 of duplicate Medicare fee-for-service payments made to its providers.
- Review its duplicate payment detection policies and assess the effectiveness of the Medicare compliance training provided to participating providers.

AUDITEE'S RESPONSE

In a written response to our draft, Welborn concurred with all of our audit findings and recommendations. In addition, Welborn is working toward correcting and improving current processes that are designed to prevent duplicate payments and unallowable costs from being charged to the Medicare program. The complete text of Welborn's response is presented as Appendix B to this report.

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INTRODUCTION

BACKGROUND

Cost-Based Health Maintenance Organizations (HMO)

Welborn is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare and Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. Under a cost-based arrangement, HMOs are paid the reasonable cost incurred to provide Medicare covered services. Each month, CMS makes an interim payment to the HMO based on a per capita rate for each Medicare member. A final payment is made based on the Plan's final certified cost report.

Under cost-based arrangements, there is a potential for duplicate Medicare payments, if the costs reported on the annual cost reports for beneficiary services are also submitted to Medicare directly by the providers of service. Cost-based HMOs are required to establish a system to preclude and detect duplicate payments. Our audit of Welborn is part of an OIG nationwide review of cost-based Medicare HMOs.

Regulations

The governing regulations for costs claimed on the Medicare cost reports are contained in Title 42 of the Code of Federal Regulations (CFR). The legislative authority requiring the detection of duplicate payments is specified in Section 6105 of the HMO Manual (HCFA Publication 75).

OBJECTIVE, SCOPE, AND METHODOLOGY

Our objectives were to determine whether $35,378,132 in costs claimed by Welborn on its FY 1999 through FY 2001 Medicare cost reports were reasonable, allowable and allocable, in accordance with the applicable Medicare provider reimbursement policy and guidelines, and whether payments for provider services claimed on the cost reports were also reimbursed under the Medicare fee-for-service payment system.

Scope. Costs were claimed by Welborn using pro-forma cost reports (Form HCFA 276-99), which are a series of worksheets and schedules that identify pools of allowable costs, and then adjust, reclassify, and allocate these costs to Medicare through a series of methodologies. The ultimate allocations reflect Welborn's business attributable to Medicare. In relation to costs claimed, our audit procedures traced the amounts claimed on Welborn's cost reports through the established processes to the general ledger support and found the process and the resulting claims generally acceptable. In reaching this conclusion, we judgmentally sampled administrative cost pools and traced the expenses to supporting documentation for the FYs ended 1999 through FY 2000. As cited in the results of audit, we noted one instance of unallowable cost inclusions.

To test for duplicate payments, we used the CMS HMO Group enrollment files to identify Health Insurance Claim (HIC) numbers for Welborn enrollees during January 1999 through December 2001 and matched these numbers against the CMS National Claims History Archive of Carrier Claims for the same time period. The resulting database represented potential erroneous fee-for-service payments for Welborn enrollees. All Medicare fee-for-service claims with a service date after the beginning enrollment date were extracted, and those with a service date after the ending enrollment date were excluded. We obtained Unique Provider Identification Numbers (UPIN) and Provider Identification Numbers (PINs) for Welborn's list of participating providers for the relevant audit period and reduced the database to those services provided by Welborn's participating providers.

Through an initial probe sample and testing of our database, we determined that Welborn had properly adjusted for separate fee-for-service billings for all but two providers. We concentrated our review to the two capitated providers, Southern Indiana Imaging Consultants, Inc. (SIIC) and Welborn Clinic (WC). From our database, we identified a population of 2,983 claimed lines of service for SIIC, totaling $79,696, and a population of 657 claimed lines of service for WC, totaling $17,227. Since our data analysis presumed that any Medicare fee-for-service claim to these providers would be duplicated on Welborn's cost report, we performed an acceptance sample to assure that the developed populations were accurate. We selected a statistical sample of 130 claims and confirmed with Welborn that all of these items represented a duplicate payment.

Methodology To accomplish our objective of reviewing the costs claimed on Welborn's cost reports, we:

- Reviewed applicable laws, regulations, and Medicare guidelines,
- Reviewed and obtained an understanding of internal controls and procedures used by cost-based HMOs,
- Analyzed original working papers used to prepare and support the cost report, and
- Reconciled Welborn claims data to cost report.

We performed our audit in accordance with generally accepted government auditing standards. Our fieldwork was performed at the Welborn offices in Evansville, Indiana, and our field office in Lansing, Michigan, between July 2002 and February 2003.

RESULTS OF AUDIT

Based on our review of $35,378,132 in costs claimed on Welborn's Medicare cost reports for the FY 1999 through FY 2001, we consider $35,377,432 to be reasonable, allocable and allowable, and question the acceptability of $700 for the allocated share of unallowable retirement party expenses. We also determined that the Medicare program improperly duplicated payments of $96,923 for fee-for-service claims by two Welborn providers that were

already reimbursed for these services through capitated payments. Welborn claimed the capitated payments on its FY 1999 through FY 2001 cost reports.

UNALLOWABLE COSTS CLAIMED ON WELBORN'S COST REPORT

Welborn's allowable cost pool for the FY 2000 Medicare cost report contained an unallowable expense of $4,115, for a retirement party that included food and alcohol. The amount allocated to Medicare was $700. The CMS PRM, Chapter 21, Paragraph 02.3 (2102.3), states, in part:

> ….costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities…

Relative to the cited criterion, Welborn could not provide a justification for allocating this non-patient care expense of $700 to the Medicare program. Accordingly, we consider cost claimed of $700 on Welborn's cost report to be unallowable and unallocable.

RECOMMENDATION

We recommend that Welborn refund the $700 related to unallowable costs claimed on the FY 2000 cost report.

DUPLICATE MEDICARE PAYMENTS

During our audit period, inappropriate Medicare fee-for-service billings by two Welborn providers amounted to $96,923. The duplicate Medicare payments resulted when SIIC ($79,696) and WC ($17,227) directly billed Medicare, on a fee-for-service basis, for medical services that were already paid for under a contractual agreement with Welborn. These providers were not supposed to bill Medicare under a fee-for-service basis, which would result in duplicate Medicare reimbursements.

The two providers attributed the inappropriate Medicare fee-for-service billings to internal problems, as follows:

- During the audit period, a new information system was implemented by the hospital where SIIC performed its radiological services. As a result, SIIC encountered problems regarding Welborn's enrollment. SIIC's billing systems were not updated in a timely manner and improper claims were billed to Medicare in the amount of $79,696.

- Although WC's billing personnel are periodically taught that fee-for-service invoices for Welborn beneficiaries, covered by the Medicare capitation contract, should not be sent, the high turnover of billing department personnel, the decentralization of WC departments, and the infrequency of the training sessions contributed to the basic policy

not being followed. Invoices were sent to Medicare for services rendered to cost contract beneficiaries resulting in Medicare overpayments of $17,227.

CMS acknowledged the susceptibility of cost-based HMO's to Medicare duplicate payments and instructed them to take preventive measures, as specified in the HMO Manual (HCFA Publication 75), Section 6105, entitled Duplicate Payment Detection for Cost Contracting HMO/CMP, which 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 upon you to establish a system to preclude or detect duplicate payments….

Although Welborn had Fiscal Intermediary reports and pertinent documentation related to Medicare claims activity and could have detected the inappropriate billings from SIIC and WC, Welborn did not have an adequate mechanism in place to detect and prevent such billings.

RECOMMENDATIONS

We recommend that Welborn:

- Refund the $96,923 of duplicate payments related to the fee-for-service payments made to its capitated providers

- Review its duplicate payment detection policies and assess the effectiveness of the Medicare compliance training provided to participating providers.

AUDITEE'S RESPONSE

In a written response to our draft, Welborn concurred with all of our audit findings and recommendation and indicated that it is working toward correcting and improving current processes that are designed to prevent duplicate payments and unallowable costs from being charged to the Medicare program. The complete text of Welborn's response is presented as Appendix B to this report.

OTHER MATTERS

At the request of CMS, our scope included a specific review of management fees and interest charges that relate to a management services contract extending from the prior audit period, and, are identical, in nature, to the costs that were determined to be unallowable Medicare expenses in the prior audit of Welborn's cost reports. The prior audit was performed by a public accounting firm and covered FY 1996 through FY 1998. We believe the prior auditors applied inappropriate criteria in determining that the management fees and interest charges were unallowable. By applying the appropriate criteria during our review of Welborn's detailed supporting

documentation and by considering the audited financial statements and required public filings with the Securities and Exchange Commission of the contracted service provider, we have determined that similar management fees and interest were included in Welborn's allowable cost pool for our audit period, but are reasonable, allocable and allowable.

APPENDICES

APPENDIX A

SUMMARY OF MEDICARE COSTS CLAIMED BY WELBORN HEALTH PLANS

FOR FISCAL YEARS 1999 THROUGH 2001

Cost Categories	1999 Claimed	2000 Claimed	2001 Claimed	TOTAL Claimed
Non-Provider Costs	13,577,616	13,125,572	13,620,180	40,323,368
Home Health Agency	836,172	666,918	602,384	2,105,474
Hospital (Various Part B & Emergency)	165,635	146,377	96,665	408,677
Part B Deductible	63,947	70,241	131,399	265,587
Plan Administration	513,226	488,195	537,641	1,539,062
Special Administration	94,961	81,962	90,868	267,791
Medicare Bad Debts	14,013	10,888	11,057	35,958
SUBTOTAL	15,265,570	14,590,153	15,090,195	44,945,918
				0
Less: Deductibles	518,213	505,520	494,207	1,517,940
Less: Coinsurance	2,709,117	2,616,156	2,724,574	8,049,846
SUBTOTAL	3,227,330	3,121,676	3,218,780	9,567,786
				0
MEDICARE CLAIMED	12,038,240	11,468,477	11,871,415	35,378,132
				0
UNALLOWABLE AND UNALLOCABLE PER OIG	0	700	0	700
				0
OIG COSTS RECOMMENDED FOR ACCEPTANCE	12,038,240	11,467,777	11,871,415	35,377,432

WELBORN HEALTH PLANS

May 21, 2003

Mr. Stephen Slamar
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Report A-05-02-00067

Dear Mr. Slamar:

Welborn agrees with the audit findings as described in the OAS draft report entitled "Audit of Medicare Cost Reports and Duplicate Payments for Welborn Health Plans for Fiscal Years 1999 through 2001." However, we would like to describe our efforts to correct and improve processes that are on going and designed to prevent duplicate payments and unallowable costs from being charged to the Medicare Program.

First, Welborn believes that current polices and procedures will detect unallowable costs prior to inclusion in future Cost Reports. It appears that the inclusion of a single invoice for expenses not allowed under CMS PRM, Chapter 21 Paragraph 02.3 (2102.3), was an isolated incident. Welborn has taken steps to prevent the inclusion of these costs in the future through increased training of the staff directly involved in the preparation of the cost report.

Welborn Clinic incorrectly directly billed Medicare for $17,227 related to Cost Plan members. We have updated and included in our policy and procedures designed to detect duplicate payments the review of all Medicare FFS payments made to Welborn Clinic against the WHP Medicare Cost eligibility files. This review will serve to allow us to detect and correct these errors when normal cross checks and eligibility procedures fail. Existing procedures at the point of entry in the Clinic have been improved over the last year. At the check-in process, each person is questioned at every visit to determine if their insurance status has changed since their last visit. If the person is Medicare eligible, check-in staff will follow the appropriate procedures to determine if the person is a Cost Plan member or a traditional Medicare enrollee.

Welborn also does extensive validation of the eligibility and claims database used to develop the apportionment statistics. This process will be continued, with specific review of information related to any individual detected in the wrong eligibility category during the review process of Medicare payments to Welborn Clinic.

Finally, with regard to the duplicate payments made to Southern Indiana Imaging Consultants (SIIC.) Welborn believes that certain circumstances unique to this provider contributed to the number over payments detected by the OAS. As the report mentions, the facility where these services took place implemented a new computer system. This caused a temporary interruption

WELBORN HEALTH PLANS

and degradation in the quality of the data fed to the medical billing service used by SIIC. The majority of the claims that resulted in overpayment by CMS, were never submitted to Welborn for adjudication either as the primary or secondary payor nor adjudication as a capitated service. Typically, in our effort to detect duplicate payments, the process has attempted to identify charges for the same service, for the same person on the same day. Because there was no corresponding Welborn service, these hospital based Part B services went undetected. Welborn has revised the effected policy and procedure to include a scan of the data received from the intermediary for all Welborn capitated providers against the Welborn Medicare Cost eligibility files to specifically to detect this type of overpayment situation in the future.

Welborn wishes to thank the OAS staff for assisting us in identifying these deficiencies and for the supporting position documented in the report regarding the 1996-1998 Cost Report audits.

Sincerely,

Richard A. Kramer

Richard A. Kramer
WHP Finance Director

Cc: Mr. Richard B. Perry
Chief Financial Officer
Welborn Clinic

Mr. William Macko
Chief Executive Officer
Welborn Health Plans

ACKNOWLEDGMENTS

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*
Denise Novak, *Senior Auditor*
Jamie Miller, *Auditor*
Chad Anderson, *Auditor*

Technical Assistance
Tammie Anderson, *Advanced Audit Techniques*

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