Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COST REPORTING INTEGRITY FOR COST PLAN H6161

FOR THE PERIOD JANUARY 1, 1998 – DECEMBER 31, 1998

JANET REHNQUIST
INSPECTOR GENERAL

FEBRUARY 2002
A-07-00-02082

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

February 22, 2002
CIN: A-07-00-02082

Mr. Ronald Fahey
Director of Finance
Medical Associates Health Plans, Inc.
700 Locust Street, Suite 230
Dubuque, Iowa 52001

Dear Mr. Fahey:

This report provides the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) review titled, *Medicare Cost Reporting Integrity for Cost Plan H6161 for the Period January 1, 1998 through December 31, 1998*. The purpose of our review was to evaluate costs claimed for reasonableness, allowability and allocability, and to test paid claims data for duplicate claims.

We found the cost reporting process to be generally adequate and that the Medical Associates Health Plans (MAHP) was detecting and adjusting most duplicate payments. There were, however, a small number of claims (totaling $1,006), which were paid by both MAHP and the carriers. We are recommending that MAHP revise the 1998 cost report to eliminate the duplicate payments and continue to closely monitor duplicate claims.

INTRODUCTION

Background

In 1982, Medical Associates developed a Health Maintenance Organization (HMO) named MAHP. The MAHP was incorporated as an Iowa for-profit corporation in 1986 and participates in the Medicare program as a cost based HMO. Under contract with the Centers for Medicare and Medicaid Services [1](CMS), the MAHP is reimbursed under reasonable cost principles for furnishing medical and other health services to MAHP enrollees who are entitled benefits under Part B of the Medicare program.

[1] The contract was signed by the Health Care Finance Administration (HCFA). On June 14, 2001, the Department of Health & Human Services announced that HCFA would be known as the Centers for Medicare and Medicaid Services.

The MAHP's total revenue for calendar year 1998 was $47,833,347 and the net income, per MAHP's financial statements was $1,040,169. The MAHP received total Medicare cost reimbursement for 1998 of $8,116,580, which represented about 17 percent of total revenue for the calendar year. In addition, under its Medicare supplement program, MAHP provided its Medicare enrollees various health care services not covered under the Medicare program. Premiums of $5,991,192 were earned under the Medicare supplement program for 1998.

By emphasizing health promotion and early detection of illness, MAHP brings a full range of health benefits to area employers as well as Medicare enrollees in eastern Iowa, southwest Wisconsin, and northwest Illinois. The MAHP is a licensed HMO in the states of Iowa, Illinois, and Wisconsin.

Objective, Scope and Methodology

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to evaluate the Medicare cost report for reasonableness, allowability and allocability of costs claimed and to test paid claims data for duplicate claims. The MAHP claimed costs of $10,669,799 for the period January 1, 1998 through December 31, 1998.

To accomplish our objective, our audit included the following procedures. 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;
- analyzed certified financial statements,
- traced a sample of payments and invoices to original supporting documentation,
- reconciled the MAHP claims data to cost report, and
- performed a computerized data match comparing Part B Medicare claims from the CMS National Claims History File to Part B claims from the MAHP for the calendar year ended December 31, 1998.

Our audit was conducted at the MAHP, Dubuque, Iowa.

FINDING AND RECOMMENDATIONS

Our review showed the internal control and cost reporting systems were generally adequate and costs claimed were generally allowable. In addition, the MAHP's duplicate claim procedures generally appear to be adequate and functional. We did, however, find duplicate paid claims totaling $1,006.

As required by the CMS contractual agreements, the MAHP has established internal administrative and procedural policy to minimize and control duplicate payments. The MAHP receives Claim Detail Reports from the carriers. In order to identify duplicate payments, a sample of claims is audited against the plans system. The sample consists of every 12th claim received from participating providers and every 50th claim from non-participating providers. When a duplicate payment is found, MAHP performs a target audit of 100 percent on the identified providers past and current Claim Detail Reports. Since an inherent weakness is built in whenever sampling occurs, we believe this is the reason for the duplicate claims that we identified.

Recommendations

We recommend that MAHP revise the 1998 cost report to eliminate the $1,006 duplicate payments and continue to closely monitor for duplicated claims.

Auditee Response

The draft report contained a recommendation that the cost report be revised to eliminate duplicate payments of $4,879. The MAHP responded that they did not agree with the findings in the report and provided additional data on the 109 claims we had identified as duplicate payments. They stated that some of the payments were for co-insurance and/or deductible amounts, and others related to third party payments. The complete text of MAHP's response is at the Appendix to this report.

OIG Comments

After further review, we agree that certain of the payments identified as duplicates were for allowable co-insurance and deductible amounts. We were not able to verify MAHP's position regarding third party payments included in the amount originally questioned. Those amounts remain as questioned costs in this final report.

- - - - -

Final determinations as to the actions taken on all matters reported will be made by the U.S. Department of Health and Human Services action official named below. We request that you respond to the action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5). As such, within ten business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number A-07-00-02082 in all correspondence relating to this report.

Sincerely,

James P. Aasmundstad
Regional Inspector General
For Audit Services

Direct Reply to HHS Action Official:

Mr. Mark Alark
Centers for Medicare & Medicaid Services
Director, Division of Cost Plans
C3-14-00
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Appendix A

MEDICAL ASSOCIATES
HEALTH PLANS

February 4, 2002

Terry Eddleman
HHS OIG Office of Audit Services
601 E. 12th Street
Room 284A
Kansas City, MO 64106

RE: CIN A-07-00-02082

Dear Terry:

We have reviewed the draft of the Medicare Cost Reporting Integrity for Cost Plan H6161 and the November 12, 2001 letter from James Aasmundstad. Medical Associates Health Plans, Inc. does not agree with the findings in the report. John Klatt, Sr. Auditor, provided a copy of the claims he identified as duplicate payments.

Upon our review of these claims, additional documentation was provided to John Klatt to support that the identified claims were not duplicate payments.

If you have any questions or need additional information, please contact me at (563) 584-4841.

Sincerely,

Ronald K. Fahey
Director of Finance

cc: John Klatt

700 Locust Street, Suite 230 P.O. Box 5002 Dubuque, Iowa 52004-5002
319.556.8070 phone 800.747.8900 toll free 319.556.5134 fax