DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

July 8, 2011

Report Number: A-07-11-05010

Mr. James Elmore
Director, Program Management
National Government Services, Inc.
8115 Knue Road
Indianapolis, IN 46250

Dear Mr. Elmore:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Fee-for-Service Payments Made by National Government Services, Inc., for Medicare Advantage Enrollees During Calendar Years 2007 and 2008*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Scott Englund, Audit Manager, at (573) 893-8338, extension 27, or through email at Scott.Englund@oig.hhs.gov. Please refer to report number A-07-11-05010 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS MADE BY NATIONAL GOVERNMENT SERVICES, INC., FOR MEDICARE ADVANTAGE ENROLLEES DURING CALENDAR YEARS 2007 AND 2008

Daniel R. Levinson
Inspector General

July 2011
A-07-11-05010

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with Medicare contractors to process and pay Medicare claims submitted by hospitals. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 revised Medicare Part C. Among its changes, this law renamed the Medicare+Choice program the Medicare Advantage program. Medicare Advantage organizations (MA organizations) receive capitation payments from CMS to arrange and pay for all medically necessary services that are allowable in the traditional Medicare fee-for-service (FFS) program. Under Medicare Part C, Medicare beneficiaries may enroll in Medicare Advantage plans (MA plans) that are offered by MA organizations.

Pursuant to Section 1886(d) of the Act, 42 CFR § 412.1(a) established the prospective payment system (PPS) for Medicare inpatient hospital services. Under the PPS, Medicare contractors will not make Medicare FFS payments for certain inpatient services, such as bed and board, nursing services, and drugs, furnished to Medicare Advantage enrollees.

For inpatient claims, the status of the beneficiary's enrollment in an MA plan on the hospital admission date determines whether the MA organization or the Medicare contractor has payment responsibility. MA organizations have payment responsibility for claims with services that began on or after the Medicare Advantage enrollment date. Medicare contractors have payment responsibility for claims with services that began before the Medicare Advantage enrollment date.

National Government Services, Inc. (NGS), was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 13 contract on March 18, 2008. With this award, NGS acquired Empire Blue Cross's Part A business segment in November 2008.

OBJECTIVE

Our objective was to determine whether Medicare FFS payments made by NGS to hospitals for inpatient services furnished to Medicare Advantage enrollees complied with Federal regulations.

SUMMARY OF FINDINGS

Medicare FFS payments made by NGS to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. NGS made $132,865 in unallowable payments to hospitals for inpatient claims for beneficiaries who were enrolled in MA plans.

NGS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases NGS did not receive an Informational Unsolicited Response (IUR) from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

NGS had not taken action on these 8 improper payments prior to our fieldwork.

RECOMMENDATIONS

We recommend that NGS:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government $132,865 of improper payments from providers and

- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

AUDITEE COMMENTS

In written comments on our draft report, NGS neither agreed nor disagreed with our findings and recommendations. NGS stated that it will not take any action until the final report is issued and that it will defer to CMS on the actions to take regarding our recommendations.

NGS's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in NGS's comments caused us to change our findings or recommendations. We maintain that NGS made unallowable payments to hospitals for inpatient claims for beneficiaries who were enrolled in MA plans.

Due to the age of some of the claims in our review, we urge NGS to reopen the claims in question pending final determination by the CMS action official. This will ensure that the statute of limitations on collecting the overpayment will not expire.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted by hospital inpatient departments.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process hospitals' inpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Medicare Advantage Program

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Managed care organizations include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service organizations. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 revised Medicare Part C. Among its changes, this law renamed the Medicare+Choice program the Medicare Advantage program. Medicare Advantage organizations (MA organizations) receive capitation payments from CMS to arrange and pay for all medically necessary services that are allowable in the traditional Medicare fee-for-service (FFS) program. Under Medicare Part C, Medicare beneficiaries may enroll in Medicare Advantage plans (MA plans) that are offered by MA organizations.

Claims for Inpatient Services

Pursuant to Section 1886(d) of the Act, 42 CFR § 412(a)(1) established the prospective payment system (PPS) for Medicare inpatient hospital services. Under the PPS, Medicare contractors will

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

not make Medicare FFS payments for certain inpatient services, such as bed and board, nursing services, and drugs, furnished to Medicare Advantage enrollees.

Claims for Inpatient Services Provided to Medicare Advantage Enrollees

CMS is responsible for ensuring that Medicare payments are made correctly. Weekly, MA organizations transmit enrollment data to CMS, including information on when each Medicare beneficiary enrolled and/or disenrolled in his or her MA plan. CMS maintains the enrollment data on the Medicare Advantage Prescription Drug system (MARx), a system that is intended to contain data on every Medicare beneficiary enrolled in an MA plan. CMS uses the enrollment data on the MARx to update the enrollment data in the CWF, which is intended to contain eligibility information for every Medicare beneficiary.

When hospitals submit claims for inpatient service, eligibility is verified through the CWF. If the CWF indicates that the beneficiary is a member of an MA plan, the Medicare contractor should deny the claim; however, there are some exceptions. For example, a provider may be reimbursed on an FFS basis for a Medicare Advantage enrollee who elects hospice coverage or who receives a service classified as a national coverage determination.[2] A provider may also be reimbursed for direct graduate medical education costs, indirect medical education costs, and services to Medicare beneficiaries in clinical trials.

For inpatient claims, the status of the beneficiary's enrollment in an MA plan on the hospital admission date determines whether the MA organization or the Medicare contractor has payment responsibility. MA organizations have payment responsibility for claims with services that begin on or after the Medicare Advantage enrollment date. Medicare contractors have payment responsibility for claims with services that begin before the Medicare Advantage enrollment date.

Retroactive Enrollment

A retroactive enrollment occurs when enrollment data are entered in the MARx after the beneficiary's actual enrollment date. For example, if a beneficiary enrolled in an MA plan on January 1, 2007, but the enrollment data were not entered in the MARx until January 30, 2007, the MARx would retroactively list the actual enrollment date as January 1, 2007. The actual enrollment date should then be updated in the CWF.

The CWF generates an Informational Unsolicited Response (IUR) which provides the identifying information regarding the claim submitted for a beneficiary retroactively enrolled in an MA plan. The CWF electronically transmits the IUR to the Medicare contractor that originally processed the claim.

Upon receipt of the IUR, the Medicare contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payments. The Medicare contractor must also generate

[2] A national coverage determination indicates coverage for a new service that was not included in the calculation of the managed care capitation payment.

an adjustment to update or cancel the claim; this adjustment, in turn, updates both the CWF and the contractor history.

National Government Services, Inc.

National Government Services, Inc. (NGS), was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 13 contract on March 18, 2008. With this award, NGS acquired Empire Blue Cross's Part A business segment in November 2008.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare FFS payments made by NGS to hospitals for inpatient services furnished to Medicare Advantage enrollees complied with Federal regulations.

Scope

Our audit included FFS payments made by NGS and Empire Blue Cross for certain inpatient services furnished to Medicare Advantage enrollees who were enrolled in MA plans nationwide for at least 1 month during calendar years (CY) 2007 and 2008. We reviewed internal controls to the extent necessary to accomplish the audit objective.

Methodology

To accomplish our objective, we:

- reviewed Federal regulations related to payment liability for Medicare beneficiaries enrolled in MA plans, as well as program manuals and memorandums, issued by CMS to Medicare contractors, that provided instructions on which claims to pay;

- used the Enrollment Database to identify beneficiaries enrolled in an MA plan during CY 2007;

- obtained inpatient claims data for CYs 2007 and 2008 from the National Claims History and Standard Analytical Files for those beneficiaries enrolled in MA plans;

- identified Medicare FFS inpatient claims for services that began on or after the date that the beneficiary enrolled in the MA plan and before the beneficiary disenrolled from the MA plan;

- eliminated paid claims for enrollees who elected hospice coverage before being admitted to the hospital;

- eliminated paid claims for graduate medical education costs, indirect medical education costs, and costs associated with clinical trials;

- verified, using information in the CWF, both the eligibility of the Medicare beneficiary and the accuracy of the payment amount, and ensured that the payment had not been cancelled;

- provided NGS with detail data regarding 88 claims totaling $1,205,110 that were potentially paid in error, and, after discussing the possible causes of claims that were potentially paid in error with NGS officials:

    - eliminated 60 improper payments totaling $761,395 that had been cancelled and recouped prior to the start of our fieldwork and

    - eliminated 20 payments totaling $309,088 that were properly paid; and

- discussed the results of our review with NGS officials and provided them with details of the 8 claims for which we had identified improper payments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Medicare FFS payments made by NGS to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. NGS made $132,865 in unallowable payments to hospitals for inpatient claims for beneficiaries who were enrolled in MA plans.

NGS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases NGS did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

NGS had not taken action on these 8 improper payments prior to our fieldwork.

FEDERAL REQUIREMENTS

Pursuant to 42 CFR § 412.20(e)(3), inpatient hospital services will not be paid on an FFS basis if "[t]he services are paid for by an [MA organization] … that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the [MA organization's] … Medicare enrollees…."

CMS's manuals instruct hospitals and Medicare contractors about the payment liability for inpatient services for Medicare Advantage enrollees. Section 408 of CMS's *Hospital Manual* states: "If you are a PPS hospital and the patient changes his [Medicare Advantage] status during an inpatient stay, his status at admission determines liability. If he was enrolled in the [MA organization] before admission, the [MA organization] is responsible regardless of whether he disenrolled before discharge." Section 3654.1 of CMS's *Medicare Intermediary Manual* instructs Medicare contractors to "… not make a duplicate payment for the same services [for which] the [MA organization] has paid."

IMPROPER MEDICARE FEE-FOR-SERVICE PAYMENTS

For CYs 2007 and 2008, NGS made 8 improper payments totaling $132,865 for inpatient claims for beneficiaries who were enrolled in MA plans. For example, one payment for $4,036 was made for an inpatient stay beginning on April 11, 2007, for a beneficiary who was enrolled in an MA plan from April 1, 2007, to December 31, 2007.

NGS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases NGS did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan. As a result, NGS was unaware that the improper payments had been made. Therefore it did not initiate overpayment recovery procedures to recoup the original payments, and it did not generate an adjustment to update or cancel the claim in order to update both the CWF and the contractor history.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

NGS had not taken action on these 8 improper payments prior to our fieldwork.

RECOMMENDATIONS

We recommend that NGS:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government $132,865 of improper payments from providers and

- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

AUDITEE COMMENTS

In written comments on our draft report, NGS neither agreed nor disagreed with our findings and recommendations. NGS stated that it will not take any action until the final report is issued and that it will defer to CMS on the actions to take regarding our recommendations.

NGS's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in NGS's comments caused us to change our findings or recommendations. We maintain that NGS made unallowable payments to hospitals for inpatient claims for beneficiaries who were enrolled in MA plans.

Due to the age of some of the claims in our review, we urge NGS to reopen the claims in question pending final determination by the CMS action official. This will ensure that the statute of limitations on collecting the overpayment will not expire.

APPENDIX

APPENDIX: AUDITEE COMMENTS

Medicare

National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

June 7, 2011

Mr. Patrick J. Cogley
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, Missouri 64106

RE: Report Number A-07-11-05010 (during field work known as A-07-10-01091)

Dear Mr. Cogley,
The following is National Government Service's (NGS) response to the Office of Inspector General (OIG) draft report entitled "Review of Medicare Fee-For-Service Payments made by National Government Services, Inc., for Medicare Advantage Enrollees during Calendar Years 2007 and 2008".

NGS was awarded the CMS Parts A and B Medicare Administrative Contractors (MAC) Jurisdiction 13 contract on March 18, 2008. However, with this award, J13 did not acquire the Empire Blue Cross's Part A business segment until November 14, 2008. Prior to that the Empire Blue Cross Part A segment was a legacy Title XVIII contract administered by NGS.

As a MAC, NGS will not take any action until the final report is issued. Once issued, we will defer to CMS on the actions to take regarding the following recommendations.

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government $132,865 of improper payments from providers and

- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

Sincerely,

David A. Marshall
VP of Administrative Services
National Government Services