**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 18, 2011

Report Number: A-07-11-05012

Mr. Bruce Hughes
President and Chief Operating Officer
Palmetto GBA
P.O. Box 100134
Columbia, SC 29202-3134

Dear Mr. Hughes:

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 Palmetto Government Benefit Administrators 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-07-11-05012 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 PALMETTO GOVERNMENT BENEFIT ADMINISTRATORS FOR MEDICARE ADVANTAGE ENROLLEES DURING CALENDAR YEARS 2007 AND 2008

Daniel R. Levinson
Inspector General

July 2011
A-07-11-05012

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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.

Palmetto Government Benefit Administrators (Palmetto) was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 1 contract on October 25, 2007. With this award, Palmetto acquired United Government Services' Part A business segment in August 2008.

## OBJECTIVE

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

## SUMMARY OF FINDINGS

Medicare FFS payments made by Palmetto to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. Palmetto made $977,782 in unallowable payments for inpatient claims for beneficiaries who were enrolled in MA plans.

Palmetto 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 Palmetto 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.

Palmetto had not taken action on these 67 improper payments prior to our fieldwork.

## RECOMMENDATIONS

We recommend that Palmetto:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government $977,782 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, Palmetto concurred with our recommendations and described corrective actions that it had implemented. Palmetto's comments are included in their entirety as the Appendix.

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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.

### Palmetto Government Benefit Administrators

Palmetto Government Benefit Administrators (Palmetto) was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 1 contract on October 25, 2007. With this award, Palmetto acquired United Government Services' Part A business segment in August 2008.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

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

### Scope

Our audit included FFS payments made by Palmetto and United Government Services 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 Palmetto with detail data regarding 98 claims totaling $1,404,296 that were potentially paid in error, and, after discussing the possible causes of claims that were potentially paid in error with Palmetto officials:

    - eliminated 10 improper payments totaling $104,630 that had been cancelled and recouped prior to the start of our fieldwork and

    - eliminated 21 payments totaling $321,884 that were properly paid; and

- discussed the results of our review with Palmetto officials and provided them with the details of the 67 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 Palmetto to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. Palmetto made $977,782 in unallowable payments for inpatient claims for beneficiaries who were enrolled in MA plans.

Palmetto 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 Palmetto 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.

Palmetto had not taken action on these 67 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, Palmetto made 67 improper payments totaling $977,782 for inpatient claims for beneficiaries who were enrolled in MA plans. For example, one payment for $176,736 was made for an inpatient stay beginning on April 5, 2007, for a beneficiary who was enrolled in an MA plan from March 1, 2007, to April 30, 2007.

Palmetto 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 Palmetto did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan. As a result, Palmetto 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.

Palmetto had not taken action on these 67 improper payments prior to our fieldwork.

## RECOMMENDATIONS

We recommend that Palmetto:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government $977,782 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, Palmetto concurred with our recommendations and described corrective actions that it had implemented. Palmetto's comments are included in their entirety as the Appendix.

# APPENDIX

# APPENDIX: AUDITEE COMMENTS

Palmetto GBA.
PARTNERS IN EXCELLENCE.

Bruce W. Hughes
President and Chief Operating Officer

July 12, 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

Reference: Report No. A-07-11-05012

Dear Mr. Cogley:

This letter is in response to the recent Office of Inspector General (OIG) report entitled "*Review of Medicare Payments Fee-for-Service Payments Made by Palmetto GBA for Medicare Advantage Enrollees During Calendar years 2007 and 2008*", addressed to Yvonna Ruff. We appreciate the feedback your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

As stated in the report, in September 2008 Palmetto GBA, LLC (Palmetto) assumed full responsibility as the Medicare administrative contractor for Jurisdiction 1. The audit determined that Palmetto made incorrect payments totaling $977,782 for beneficiaries enrolled in Medicare Advantage Plans. As noted in the report, the payments were made because Palmetto was not able to determine beneficiaries' enrollment status on the CWF at time the payments were made.

Palmetto GBA concurs with the following recommendations:

- **Initiate overpayment recovery procedures to recoup and reimburse to the Federal Government $977,782 for improper payments from providers.**

  *Palmetto GBA Response:*
  All claims identified in the audit have been initiated for recoupment and are scheduled for completion as early as July 13, 2011.

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

  *Palmetto GBA Response*:
  Claims have been cancelled which will update both CWF and the contractor history.

Thank you for providing Palmetto GBA with the opportunity to provide feedback regarding your review. If you have any questions, please do not hesitate to contact me at (803) 763-7130 or Yvonna Ruff at (803) 763-5015.

Sincerely

cc: Steven Smetak, COTR, CMS
Daniel Dion, CMS
Ann Archibald, Palmetto GBA
Mike Barlow, Palmetto GBA
Robin Spires, Palmetto GBA
Sheri Thompson, Palmetto GBA