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

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-04-00035

September 8, 2004

Mr. Mark Richardson
President & CEO
Mount Carmel Health Plan, Inc.
495 Cooper Road, Suite 200
Westerville, Ohio 43081

Dear Mr. Richardson:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Mount Carmel Health Prompt Payment Review." The audit covered the period of April 1, 2003 through September 30, 2003. A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

The action official will make final determination as to the actions taken on all matters reported. 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), 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.)

Please refer to report number A-05-04-00035 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:
Ms. Jacqueline Garner
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MOUNT CARMEL HEALTH PLAN, INC.

PROMPT PAYMENT REVIEW

SEPTEMBER 2004
A-05-04-00035

Office of Inspector General

http://oig.hhs.gov

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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. Final determination on these matters will be made by authorized officials of the HHS divisions.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the Medicare+Choice (M+C) program. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with the Centers for Medicare & Medicaid Services (CMS). These plans provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from non-contracted providers. Federal regulations at 42 CFR require plans to make timely payment to, or on behalf of, plan enrollees for services obtained from non-contracted providers.

OBJECTIVE

Our objective was to determine whether Mount Carmel Health Plan, Inc. complied with M+C prompt payment regulations to timely pay or deny claims submitted by non-contracted providers.

SUMMARY OF FINDINGS

Mount Carmel Health Plan did not comply with one Federal prompt payment regulation. Specifically, it did not pay or deny all claims within 60 days of receipt. As a result, some non-contracted providers were not paid timely and accurately. This condition occurred because Mount Carmel Health Plan did not implement adequate procedures to pay or deny all claims within 60 days of receipt.

Mount Carmel Health Plan substantially complied with Federal prompt payment regulations to pay at least 95 percent of clean claims within 30 days and calculate interest on clean claims not paid within 30 days.

RECOMMENDATION

We recommend that Mount Carmel Health Plan improve its procedures to ensure that all claims are paid or denied within 60 days of receipt.

MOUNT CARMEL HEALTH PLAN'S RESPONSE

Mount Carmel Health Plan is in agreement with the findings contained in the report. They will incorporate the recommendations of this report into their policies, procedures and training in order to continually improve their processes.

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INTRODUCTION

BACKGROUND

The Medicare+Choice Program

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the M+C program[1]. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with CMS. These plans, known as M+C organizations, are required to provide enrollees with the same health care services offered under the traditional Medicare program plus additional benefits[2]. These organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from non-contracted providers[3]. Claims for services are processed by the M+C organization or through agreements with delegated entities[4].

Mount Carmel Health Plan

Mount Carmel Health Plan is a nonprofit health plan. CMS contracted with Mount Carmel Health Plan as an M+C organization to provide health care coverage to approximately 15,500 Medicare enrollees in Ohio during our audit period.

CMS Reviews

CMS conducts a detailed review of each M+C organization at least once every 2 years. The reviews include internal control and substantive tests of an M+C organization's claims processing systems and compliance with prompt payment provisions. CMS reviewed Mount Carmel Health Plan's claims processing in July 1999, July 2001 and August 2003. CMS found MCHP out of compliance with prompt payment regulations during the July 1999 and 2001 reviews. These two reviews disclosed that Mount Carmel Health Plan paid less than 95 percent of all clean claims[5] within the required 30 days. Mount Carmel Health Plan was placed on a corrective action plan for one year after the July 2001 review. CMS reviewed Mount Carmel Health Plan again in August 2003 and no deficiencies were found.

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[1] The Medicare+Choice Program will be replaced by the Medicare Advantage Program under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, effective January 1, 2006.
[2] Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services.
[3] A non-contracted provider does not have a written agreement with an M+C organization to provide services to an M+C organization's enrollees.
[4] A delegated entity is contracted by an M+C organization to provide administrative or health care services for Medicare-eligible individuals enrolled in the M+C organization's service plan.
[5] A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Mount Carmel Health Plan complied with M+C prompt payment regulations to timely pay or deny claims submitted by non-contracted providers.

Scope

We reviewed selected non-contracted Medicare claims paid or denied by Mount Carmel Health Plan during the period April 1, 2003 through September 30, 2003. Mount Carmel Health Plan paid or denied 8,548 claims for services furnished by non-contracted providers during the period.

We limited our review of internal controls to obtaining an understanding of Mount Carmel Health Plan's claims processing system.

Methodology

To accomplish our objective, we:

- reviewed Federal regulations, policies, and procedures relevant to the prompt payment of non-contracted claims;

- consulted with CMS officials to understand CMS's implementation of the M+C program monitoring requirements and prompt payment regulations; and

- reconciled claims submitted by selected non-contracted providers to claims reported by Mount Carmel Health Plan.

To determine whether Mount Carmel Health Plan complied with prompt payment regulations, we separately reviewed the populations of paid claims and claims that did not appear to have been paid or denied within 60 days of receipt. From the population of paid claims, we selected and reviewed a statistical sample of 100 clean claims. For each clean claim that was not paid within 30 days of receipt, we verified that interest was properly calculated and paid to the submitting provider. Additionally, we reviewed each of the 20 claims that, based on a comparison of the receipt dates and paid or denied dates recorded by Mount Carmel Health Plan, did not appear to have been paid or denied within 60 days. For each claim, we analyzed claims history records and other supporting documentation. The appendix describes our sampling methodology for clean claims in detail.

We performed our audit in accordance with generally accepted government auditing standards. We conducted our fieldwork from March 2004 through July 2004, which included visits to Mount Carmel Health Plan's office in Westerville, OH.

FINDINGS AND RECOMMENDATIONS

Mount Carmel Health Plan did not comply with one Federal prompt payment regulation. Specifically, it did not pay or deny all claims within 60 days of receipt. As a result, some non-contracted providers were not paid timely and accurately. This condition occurred because Mount Carmel Health Plan did not implement adequate procedures to pay or deny all claims within 60 days of receipt.

Mount Carmel Health Plan substantially complied with Federal prompt payment regulations to pay at least 95 percent of clean claims within 30 days, calculate interest on clean claims not paid within 30 days.

FEDERAL REGULATIONS FOR PROMPT PAYMENT

Federal regulations at 42 CFR § 422.100(b) require M+C organizations to make timely payment to, or on behalf of, plan enrollees for services obtained from non-contracted providers. The responsibilities for timely payment are clarified in 42 CFR § 422.520:

> (a)(1) …the M+C organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an M+C private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.
> (2) The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816©(2)(B) and 1842(c)(2)(B). [Sections 1816 and 1842 refer to Title XVIII of the Social Security Act for Medicare fiscal intermediaries and carriers.]
> (3) All other claims must be paid or denied within 60 calendar days from the date of the request.

A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

PAYMENT OR DENIAL OF ALL CLAIMS WITHIN 60 DAYS

Mount Carmel Health Plan did not adequately implement its procedures to ensure that all claims were paid or denied within 60 days of receipt. Of the 8,548 claims processed by Mount Carmel Health Plan during the audit period, 12 were not paid or denied within the required 60 days.

RECOMMENDATION

We recommend that Mount Carmel Health Plan improve its procedures to ensure that all claims are paid or denied within 60 days of receipt.

MOUNT CARMEL HEALTH PLAN'S RESPONSE

Mount Carmel Health Plan is in agreement with the findings contained in the report. They will incorporate the recommendations of this report into their policies, procedures and training in order to continually improve their processes.

APPENDICES

APPENDIX A

SAMPLE OF CLEAN CLAIMS METHODOLOGY AND RESULTS

Mount Carmel Health Plan paid 5,436 claims for services provided by non-contracted providers during the period April 1, 2003 through September 30, 2003. The number of clean claims was unknown because Mount Carmel Health Plan could not specifically identify its clean claims.

We selected a random sample of claims from the population of paid claims until we identified 100 clean claims. The sampling performed was equivalent to selecting an unrestricted random sample of clean claims. Mount Carmel Health Plan verified that each claim was a clean claim that should have been paid within 30 days.

Based on the results of the sample, we are 90-percent confident Mount Carmel Health Plan paid over 95 percent of its clean claims within 30 days of receipt. Below are the results of our attribute appraisal.

Sample Results

(Precision at the 90-Percent Confidence Level)

Upper Limit	97.93 percent
Lower Limit	90.07 percent
Standard Error	0.023868 percent
Sampling Error	0.039260 percent

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APPENDIX B

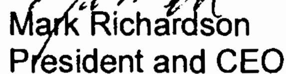
August 17, 2004

Paul Swanson
Regional Inspector General for
Audit Services
Department of Health and Human Services
Region V
233 North Michigan Ave
Chicago, IL 60601

Re: Mount Carmel Health Plan Prompt Payment Review
Report Number A-05-04-00035
Dear Mr. Swanson:

I am writing in response to your August 2004 draft report regarding Mount Carmel Health Plan's compliance with the Medicare + Choice prompt payment regulations. Mount Carmel Health Plan is in agreement with the findings contained in the report. We appreciate the diligence your staff demonstrated in their review of our claims processing operations and the balanced summary presented in this report. We will incorporate the recommendations of this report into our policies, procedures and training in order to continually improve our processes.

Sincerely,



Mark Richardson
President and CEO

Cc: Debra Paver, OIG
Joyce Macek, CMS, Region V

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