DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

May 2, 2012

Report Number: A-02-11-01018

Dr. Robert H. Greenspan
Chief Executive Officer
The New York Hotel Trades Council and Hotel Association
of New York City, Inc., Health Benefits Fund
305 West 44th Street
New York, NY 10036

Dear Dr. Greenspan:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *The New York Hotel Trades Council and Hotel Association of New York City, Inc., Health Benefits Fund Reported Unallowable Costs on its Final 2009 Medicare Cost Report.* 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, or contact Glenn H. Richter, Audit Manager, at (518) 437-9390, extension 227, or through email at Glenn.Richter@oig.hhs.gov. Please refer to report number A-02-11-01018 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Timothy Love, Acting Deputy Director
Center for Medicare
Centers for Medicare & Medicaid Services
Mail Stop C5-01-14
7500 Security Boulevard
Baltimore, MD 21244-1850

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE NEW YORK HOTEL TRADES COUNCIL AND HOTEL ASSOCIATION OF NEW YORK CITY, INC., HEALTH BENEFITS FUND REPORTED UNALLOWABLE COSTS ON ITS FINAL 2009 MEDICARE COST REPORT

Daniel R. Levinson
Inspector General

May 2012
A-02-11-01018

Office of Inspector General

http://oig.hhs.gov

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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.

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 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.

The Medicare Part C program offers beneficiaries managed care options through the Medicare Advantage program. Under the program, CMS contracts with private health insurance plans to provide covered Part B services. Medicare Advantage plans include Health Care Prepayment Plans (HCPP), which are union- or employer-sponsored plans that contract with CMS to provide or arrange for some or all Medicare Part B services.

On a monthly basis, CMS pays HCPPs an interim rate for each Medicare beneficiary enrolled in their plan. Pursuant to 42 CFR § 417.810(b), HCPPs must submit a final cost report to CMS within 120 days after the close of the contract period. CMS reconciles the final reported costs to the previously made interim payments to determine the payment amounts due the HCPPs or the Medicare trust fund, which funds the Part C program. Pursuant to 42 CFR § 417.802, HCPPs are entitled to reimbursement only for costs that are reasonable and allowable.

The New York Hotel Trades Council and Hotel Association of New York City, Inc., Health Benefits Fund (the Fund) is an HCPP that provides Medicare Part B services to eligible New York City hotel industry employees and their families. In addition, the Fund offers non-Medicare services to other plan members. The Fund provides services to plan members at four health centers and contracts with outside providers for services not offered by the health centers.

On its final cost report for calendar year (CY) 2009, the Fund reported Medicare Part B costs totaling $8,204,307 for services provided to 3,180 plan members. CMS requested that we perform a limited scope review to determine if Medicare Part B costs reported by the Fund were for Medicare-eligible services provided to Medicare-eligible plan members, excluded costs for services billed to Medicare by contracted providers, and excluded Medicare coinsurance.

OBJECTIVE

Our objective was to determine whether Medicare Part B costs reported by the Fund on its final CY 2009 cost report were reasonable and allowable.

SUMMARY OF FINDINGS

The Fund's final CY 2009 cost report included Medicare Part B costs totaling $236,943 that were not reasonable and allowable. Specifically, the Fund reported costs for services to plan members that were not Medicare-eligible ($181,189), costs for services that were billed to both the Fund and Medicare by contracted providers ($48,784), and costs for services not eligible for Medicare reimbursement ($6,970).

RECOMMENDATIONS

We recommend that the Fund:

- refund $236,943 to the Federal Government,
- strengthen procedures for verifying plan members' Medicare eligibility,
- establish procedures for verifying that reported Medicare Part B costs do not include services billed to Medicare by contracted providers, and
- ensure that only Medicare-eligible services are included in reported Medicare Part B costs.

FUND COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Fund concurred with our findings related to plan members not eligible for Medicare and services not eligible for Medicare reimbursement, and described steps it had taken to address our related recommendations. The Fund did not concur with our finding related to duplicate payments; however, it stated that it will refund these payments. The Fund's comments appear in their entirety as the Appendix.

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FUND COMMENTS

INTRODUCTION

BACKGROUND

Medicare Program

Pursuant to Title XVIII of the Social Security 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.

Health Care Prepayment Plans

The Medicare Part C program offers beneficiaries managed care options through the Medicare Advantage program. Under the program, CMS contracts with private health insurance plans to provide covered Part B services. Medicare Advantage plans include Health Care Prepayment Plans (HCPP), which are union- or employer-sponsored plans that contract with CMS to provide or arrange for some or all Medicare Part B services.

On a monthly basis, CMS pays HCPPs an interim rate for each Medicare beneficiary enrolled in their plan. Pursuant to 42 CFR § 417.810(b), HCPPs must submit a final cost report to CMS within 120 days after the close of the contract period. CMS reconciles the final reported costs to the previously made interim payments to determine the payment amounts due the HCPPs or the Medicare trust fund, which funds the Part C program. Pursuant to 42 CFR § 417.802, HCPPs are entitled to reimbursement only for costs that are reasonable and allowable.

The New York Hotel Trades Council and Hotel Association of New York City, Inc., Health Benefits Fund

The New York Hotel Trades Council and Hotel Association of New York City, Inc., Health Benefits Fund (the Fund) is an HCPP that provides Medicare Part B services to eligible New York City hotel industry employees and their families. In addition, the Fund offers non-Medicare services to other plan members. The Fund provides services to plan members at four health centers and contracts with outside providers for services not offered by the health centers.

On its final cost report for calendar year (CY) 2009, the Fund reported Medicare Part B costs totaling $8,204,307 for services provided to 3,180 plan members.

CMS requested that we perform a limited scope review to determine if Medicare Part B costs reported by the Fund were for Medicare-eligible services provided to Medicare-eligible plan members, excluded costs for services billed to Medicare by contracted providers, and excluded Medicare coinsurance.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare Part B costs reported by the Fund on its final CY 2009 cost report were reasonable and allowable.

Scope

This review was performed based upon a limited scope request from CMS. Therefore, we did not perform an overall assessment of the Fund's internal control structure. Rather, we reviewed only the internal controls that pertained directly to our objectives.

We conducted fieldwork at the Fund's administrative offices in New York, New York from June through August 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations;
- interviewed the Fund officials to gain an understanding of the Fund's policies and procedures for verifying and reporting Medicare Part B costs;
- reconciled the Fund's CY 2009 Medicare Part B cost report to supporting financial records;
- reviewed the CMS Services, Tracking, Analysis & Reporting System database to determine if the Fund's plan members were Medicare-eligible;
- reviewed the CMS National Claims' History database to determine if CMS paid Medicare claims to providers contracted and paid by the Fund for Medicare-eligible plan members;
- reviewed the Fund's Medicare Part B plan member claims to determine if the services were eligible for Medicare reimbursement;
- verified that costs reported by the Fund excluded Medicare coinsurance; and
- discussed our results with the Fund officials.

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 objectives.

FINDINGS AND RECOMMENDATIONS

The Fund's final CY 2009 cost report included Medicare Part B costs totaling $236,943 that were not reasonable and allowable. Specifically, the Fund reported costs for services to plan members that were not Medicare-eligible ($181,189), costs for services that were billed to both the Fund and Medicare by contracted providers ($48,784), and costs for services not eligible for Medicare reimbursement ($6,970).

UNALLOWABLE COSTS

Plan Members Not Medicare-Eligible

Pursuant to 42 CFR § 406, an individual is entitled to Medicare benefits if he/she has attained age 65, is under the age of 65 with certain disabilities, or is of any age and has end-stage renal disease.

The Fund confirmed that plan members were Medicare-eligible by checking applicants' Medicare cards at the time of enrollment. However, the Fund did not verify Medicare eligibility subsequent to enrollment. The Fund officials stated that, during a conversion to a new computer system, Medicare enrollment information for primary plan members was also assigned to primary plan members' family, regardless of their actual Medicare eligibility. As a result, the Fund reported unallowable costs totaling $181,189.

Duplicate Payments

Pursuant to 42 CFR § 417.802, to be allowable for reimbursement, costs reported by an HCPP must be reasonable. In addition, CMS's *Medicare Managed Care Manual* (the Manual), Pub. No. 100-16, chapter 17, subchapter B, section 300, states that duplicate payment detection is the responsibility of the HCPP. The Manual further states that the HCPP "should perform several duplicate check functions after it receives paid claims information."

The Fund reported unallowable costs, totaling $48,784, for duplicate payments to contracted providers who billed the Fund and Medicare for the same services. To prevent duplicate payments, the Fund's contracts with these providers contain a clause directing the providers not to bill Medicare for the Fund plan members. However, the Fund did not have procedures for verifying that reported Medicare Part B costs did not include services directly billed to Medicare by contracted providers.

Services Not Eligible for Medicare Reimbursement

Pursuant to 42 CFR § 411.15, certain services, including vision and hearing examinations related to the fitting of glasses and hearing aids, cosmetic surgery, and specified immunizations are not eligible for Medicare reimbursement. To prevent the improper billing of excluded services, CMS developed the National Correct Coding Initiative Coding Policy Manual for Medicare

Services, which contains a listing of all procedure codes that may be used to support covered Medicare Part B services.

The Fund reported unallowable costs, totaling $6,970, for services (e.g., placement of an intrauterine device) not eligible for Medicare reimbursement. The Fund officials stated that these errors occurred because staff improperly coded the services.

RECOMMENDATIONS

We recommend that the Fund:

- refund $236,943 to the Federal Government,
- strengthen procedures for verifying plan members' Medicare eligibility,
- establish procedures for verifying that reported Medicare Part B costs do not include services billed to Medicare by contracted providers, and
- ensure that only Medicare-eligible services are included in reported Medicare Part B costs.

FUND COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Fund concurred with our findings related to plan members not eligible for Medicare and services not eligible for Medicare reimbursement, and described steps it had taken to address our related recommendations. The Fund did not concur with our finding related to duplicate payments; however, it stated that it will refund these payments. The Fund's comments appear in their entirety as the Appendix.

APPENDIX

APPENDIX: FUND COMMENTS

THE NEW YORK HOTEL TRADES COUNCIL
HEALTH BENEFITS FUND
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

305 West 44th Street • New York, NY 10036 • (212) 586-6400 • Fax: (212) 581-6107 • www.HotelFunds.org

April 17, 2012

James P. Edert
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Report Number: A-02-11-01018

Dear Mr. Edert:

We are in receipt of the draft report dated March 26, 2012 for the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund for reported unallowable costs on its final 2009 Medicare Cost Report. As per your instructions, below are our responses to the three areas of findings outlined in your report.

Plan Members not Medicare Eligible

As stated in the report, there was an issue that arose during the conversion to a new computer system where plan type for dependents was derived from former Union members (the primary Plan Members). Therefore, if a member had enrolled and assigned the Plan their Medicare benefits, the encounters of their dependents were also included in the Medicare statistics even though they were not Medicare Eligible. The issue also occurred on the inverse, that is, if the primary Plan member was not Medicare eligible but was eligible through other coverage (i.e. Cobra, Retiree Continuation etc.) and the dependents were Medicare eligible and had assigned it to the Plan, those encounters were not originally included the Cost Report Medicare Statistics. We concur with this finding and have corrected the programming issue.

Duplicate Payments

As also noted in the report, the Fund contracts with outside providers to perform services not rendered in the Health Centers. Those contracts contain language prohibiting those providers from billing Medicare for services that are referred by the Fund for Medicare Members. We are not aware of any system or database assessable to us to verify what payments were paid by Medicare to specific providers. Even if such a system was available, there could not be a procedure established to insure that Medicare does not pay for Services the Fund already has. We do not concur

but will return the payments to Medicare. We are in recent receipt from your office of the list of these overpayments by provider which well be utilized to cancel our contracts with these providers as well as attempt recovery.

Services Not Eligible For Medicare Reimbursement

We concur that a few providers improperly coded services as they performed them in the Health Centers. We have instituted routine re-training sessions in proper coding for all medical staff.

Should you have any questions on our response or should you require any additional information, please do not hesitate to contact me. Thank you for your assistance.

Very Truly Yours,

Dr. Robert Greenspan
Chief Executive Officer