Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING FACILITIES IN VIRGINIA GENERALLY RECONCILED ACCOUNT RECORDS WITH CREDIT BALANCES AND REPORTED THE ASSOCIATED MEDICAID OVERPAYMENTS TO THE STATE AGENCY

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Stephen Virbitsky
Regional Inspector General

April 2013
A-03-11-00211

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Virginia, the Department of Medical Assistance Services (State agency) is responsible for administering the Medicaid program.

Providers of Medicaid services submit claims to States to receive compensation. The States process and pay the claims. Pursuant to 42 CFR § 433.10, the Federal Government pays its share (Federal share) of State medical assistance expenditures according to a defined formula.

Credit balances may occur when a provider's reimbursement for services that it provides exceeds the allowable amount or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid and another third-party payer for the same services.

Providers record and accumulate charges and reimbursements for services in each patient's record of account. Providers should reconcile account records containing credit balances to include a review of all charges and payment records, and if the reconciliation identifies a Medicaid overpayment, the provider should report the overpayment to the State. The State must refund the Federal share of the overpayment to CMS (the Act, § 1903(d)(2)(A), and 42 CFR part 433, subpart F).

Effective March 23, 2010, States have up to 1 year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, the overpayment before making an adjustment to refund the Federal share. Except for overpayments resulting from fraud, the State must make the adjustment no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

In general, an overpayment is discovered when a State either (1) notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery or (2) initiates a formal recoupment action. Discovery may also occur when the provider initially acknowledges a specific overpaid amount in writing to the State. If a Federal review (such as an audit) indicates that a State has failed to identify an overpayment, the overpayment is considered discovered on the date the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

Virginia nursing facilities are required to submit quarterly Medicaid credit balance reports showing all identified Medicaid overpayments recorded as credit balances and to refund the

credit balance to the State agency (12 Virginia Administrative Code 30-90-257). Instead of ensuring that providers submit the required quarterly reports, the State agency hired a contractor to visit each nursing facility to determine which credit balances were Medicaid overpayments and report them to the State agency.

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers. In Virginia, the audit focused on nursing facilities.

OBJECTIVES

Our objectives were to determine whether nursing facilities in Virginia reconciled account records with credit balances and reported the associated Medicaid overpayments to the State agency.

SUMMARY OF FINDINGS

Generally, the eight nursing facilities that we sampled reconciled account records with credit balances and reported the associated Medicaid overpayments to the State agency. However, as of September 30, 2011, there were 80 credit balances in accounts for which Medicaid was listed as a payer that these nursing facilities had not reconciled. Of these 80 credit balances, 57 contained Medicaid overpayments and 23 did not. The Medicaid overpayments associated with these 57 credit balances totaled $23,273 ($12,985 Federal share). We estimate that the State agency could realize an additional statewide recovery of $203,760 ($110,869 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in nursing facility accounts.

These nursing facilities did not identify and report all Medicaid overpayments because the State agency based its reconciliation process on contractor reviews every two to three years. Therefore, some nursing facilities did not reconcile account records for more than 1 year.

RECOMMENDATIONS

We recommend that the State agency:

- refund $23,273 ($12,985 Federal share) to the Federal Government for overpayments paid to the selected nursing facilities and

- enhance its efforts to recover additional overpayments estimated at $203,760 ($110,869 Federal share) from our audit period and realize future savings by ensuring that nursing facilities exercise reasonable diligence in reconciling account records with credit balances and reporting the associated Medicaid overpayments on a more timely basis.

STATE AGENCY COMMENTS

The State agency concurred with our findings and recommendations.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Virginia, the Department of Medical Assistance Services (State agency) is responsible for administering the Medicaid program.

Providers of Medicaid services submit claims to States to receive compensation. The States process and pay the claims. Pursuant to 42 CFR § 433.10, the Federal Government reimburses the State for its share (Federal share) of State medical assistance expenditures according to a defined formula.

Credit balances may occur when a provider's reimbursement for services it provides exceeds the allowable amount or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid and another third-party payer for the same services.

Providers record and accumulate charges and reimbursements for services in each patient's record of account. Providers should reconcile account records containing credit balances to include a review of all charges and payment records, and if the reconciliation identifies a Medicaid overpayment, the provider should report the overpayment to the State. The State must refund the Federal share of the overpayment to CMS (the Act, § 1903(d)(2)(A), and 42 CFR part 433, subpart F).

Federal and State Requirements Related to Medicaid Overpayments

Under 42 CFR § 433.312, States are responsible for recovering from providers any amounts paid in excess of allowable Medicaid amounts and for refunding the Federal share to CMS. Effective March 23, 2010, States have up to 1 year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, the overpayment before making an adjustment to refund the Federal share. Except for overpayments resulting from fraud, States must make the adjustment no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

In general, an overpayment is discovered when a State either (1) notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery or (2) initiates a formal recoupment action. Discovery may also occur when the provider initially acknowledges a

specific overpaid amount in writing to the State. If a Federal review (such as an audit) indicates that a State has failed to identify an overpayment, the overpayment is considered discovered on the date the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.[1]

Virginia's Medicaid program defines a credit balance as an excess or overpayment made to a provider as the result of patient billing. The Virginia Administrative Code (VAC) requires that nursing facilities submit quarterly Medicaid credit balance reports showing all identified Medicaid overpayments recorded as credit balances and refund the credit balance to the State agency (12 VAC 30-90-257). Instead of ensuring that providers submit the required quarterly reports, the State agency hired a contractor to visit each nursing facility to determine which credit balances were Medicaid overpayments and report them to the State agency.

Nursing Facilities

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers. In Virginia, our audit focused on nursing facilities.

Nursing facilities are establishments that provide living quarters and care for the elderly or the chronically ill. In addition to receiving payments from Medicaid, nursing facilities may receive payments from Medicare (which are processed by Medicare administrative contractors), other third-party payers (e.g. private insurance companies), and/or the patients themselves. Medicaid, as payer of last resort, pays for the remaining portion of the claim after Medicare, other third-party payers, and the patient portions have been paid.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether nursing facilities in Virginia reconciled account records with credit balances and reported the associated Medicaid overpayments to the State agency.

Scope

Our audit period covered account records with unresolved credit balances as of the quarter ended September 30, 2011, for the eight nursing facilities in our sample. The 80 unresolved Medicaid credit balances[2] totaled $31,796.

We did not review the overall internal control structure of the State agency or the nursing facilities that we sampled. We limited our review of the State agency's internal controls to

[1] 42 CFR § 433.316.

[2] Some account records had more than one unresolved credit balance. The 80 unresolved credit balances in our review were contained in 77 account records. Each credit balance was unresolved for at least 60 days.

determining whether its processes for reviewing nursing facility credit balances and collecting Medicaid overpayments were effective and to determining whether there were backlogs in processing nursing facility adjustments and refunds. We limited our internal control review at the eight sampled nursing facilities to obtaining an understanding of the policies and procedures that the nursing facilities used to review credit balances and report overpayments to the State agency.

From September 2011 through January 2012, we conducted fieldwork at the State agency's offices in Richmond, Virginia, and the eight nursing facilities at various locations throughout Virginia.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations and State agency regulations and policy guidelines pertaining to Medicaid overpayments;

- interviewed State agency personnel responsible for monitoring Medicaid overpayments;

- interviewed contractor personnel who perform Medicaid credit balance procedures for the State agency;

- reviewed the credit balance reports produced by the contractor and compared them to the credit balances found during our review;

- created a sampling frame for the first stage of our sample design consisting of 79 nursing facilities from which we randomly selected 8 nursing facilities using the probability-proportional-to-size methodology (Appendix A);

- reviewed the nursing facilities' policies and procedures for reviewing credit balances and reporting overpayments to the State agency;

- reviewed all account records related to Medicaid accounts for each of the eight nursing facilities;

- reviewed patient payment data, remittance advices, details of patient accounts receivable, and additional supporting documentation for each of the selected account records to determine overpayments that should be reported to the State agency;

- estimated statewide unrecovered Medicaid overpayments associated with unresolved credit balances that should be reported to the State agency;

- determined whether the 8 nursing facilities had taken action, subsequent to our audit period, to report to the State agency the Medicaid overpayments identified in our sample; and

- discussed our audit results with the eight nursing facilities in our sample.

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

Generally, the eight nursing facilities that we sampled reconciled account records with credit balances and reported the associated Medicaid overpayments to the State agency. However, as of September 30, 2011, there were 80 credit balances in accounts for which Medicaid was listed as a payer that these nursing facilities had not reconciled. Of these 80 credit balances, 57 contained Medicaid overpayments and 23 did not. The Medicaid overpayments associated with these 57 credit balances totaled $23,273 ($12,985 Federal share). We estimated that the State agency could realize an additional statewide recovery of $203,760 ($110,869 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in nursing facility accounts.

These nursing facilities did not identify and report all Medicaid overpayments because the State agency based its reconciliation process on contractor reviews every two to three years. Therefore, some nursing facilities did not reconcile account records for more than 1 year.[3]

ACCOUNT RECORDS WITH UNRESOLVED CREDIT BALANCES

As of the quarter ended September 30, 2011, the accounting records for the 8 nursing facilities listed accounts that contained 626 unresolved credit balances totaling $593,838. Although Medicaid had reimbursed the nursing facilities for some portion of these account records, the nursing facilities had not reconciled, or otherwise evaluated, the account records to determine whether the unresolved credit balances contained Medicaid overpayments that should have been returned to the State agency.

Of the 626 unresolved credit balances, 80 credit balances totaling $31,796, or 13 percent, were at least 60 days old, as shown in the table on the following page:

[3] A Federal requirement that providers must report and repay overpayments within a certain time period was added to section 1128J of the Social Security Act by section 6402(a) of the Patient Protection and Affordable Care Act, P.L. No. 111-148. CMS will issue Medicaid regulations in the future to establish Federal policies and procedures to implement the law.

Unresolved Credit Balances At Least 60 Days Old

Time Unresolved	Number of Unresolved Credit Balances	Amount of Unresolved Credit Balances
60–365 days	68	$26,840
1–2 years	10	3,703
More than 2 years	2	1,253
Total	**80**	**$ 31,796**

MEDICAID OVERPAYMENTS NOT REPORTED

Virginia nursing facilities are required to submit quarterly Medicaid credit balance reports showing all identified Medicaid overpayments recorded as credit balances and refund the credit balance to the State agency (12 VAC 30-90-257). However, the State agency did not ensure that nursing facilities submitted the required quarterly reports or refunded the overpayments. Instead, it hired a contractor to visit each nursing facility every two to three years to determine which credit balances were Medicaid overpayments and report them to the State agency.

Under Federal regulations, a State must refund the Federal share of an overpayment to CMS within a specified period after it is discovered. The overpayment would be discovered when the provider acknowledges the overpayment amount on the quarterly report that it submits to the State. The State would refund the Federal share on the quarterly CMS-64 report to CMS.

The State agency's quarterly report is similar to the report that Medicare providers are required to submit under §§ 1815(a), 1833(e), 1866(a)(1)(C), and related provisions of the Act.[4] Both the State agency's quarterly report and Medicare's report notify the appropriate officials that the provider has determined that a credit is due to the applicable Federal program for an overpayment.

Among the nursing facilities in our sample, the practices for reconciling credit balances and identifying and reporting overpayments varied. None of the eight nursing facilities submitted the required quarterly report. Of the eight sampled nursing facilities, only three had policies addressing the review and refund of Medicaid credit balance overpayments.

Of the 80 credit balances that were at least 60 days old, in accounts that listed Medicaid as a payer, 57 contained Medicaid overpayments totaling $23,273 ($12,985 Federal share). The eight nursing facilities acknowledged that the overpayments occurred.

The overpayments occurred because the nursing facilities received duplicate payments and third-party payments and made various billing and accounting errors. Duplicate payments could either be caused by the nursing facilities erroneously generating multiple billings or by Medicaid paying more than once for the same services. Third-party payments resulted from nursing facilities receiving payment from a third-party insurer, such as a commercial insurer or

[4] See Form CMS-838, Medicare Credit Balance Report.

Medicare, for a service paid for by Medicaid. Billing and accounting errors included overstated billings and posting errors.

POLICIES AND PROCEDURES

The State agency had regulations that required nursing facilities to exercise reasonable diligence in reconciling account records with credit balances and to identify and return overpayments that were due the State agency in a timely manner. However, the State agency did not follow its regulations. Instead, the State agency relied on contractor reviews for its reconciliation process. Because the contractor reviews occurred every two to three years, some nursing facilities did not reconcile their account records for more than 1 year.

MEDICAID OVERPAYMENTS AND ESTIMATED PROGRAM RECOVERIES

Of the 80 credit balances in accounts that listed Medicaid as a payer, 57 contained Medicaid overpayments totaling $23,273 ($12,985 Federal share). (See Appendix B for details of our sample results.)

We estimated that the State agency could realize an additional statewide recovery of $203,760 ($110,869 Federal share) from our audit period and obtain future savings by ensuring that nursing facilities exercise reasonable diligence in reconciling account records with credit balances and reporting the associated Medicaid overpayments. (See Appendix B for details of our statewide estimate.)

ACTION TAKEN

After we brought the outstanding credit balances to the nursing facilities attention, they agreed to refund the overpayments. We verified that the nursing facilities had refunded all $23,273 in overpayments to the State agency as of June 14, 2012.

RECOMMENDATIONS

We recommend that the State agency:

- refund $23,273 ($12,985 Federal share) to the Federal Government for overpayments paid to the selected nursing facilities and

- enhance its efforts to recover additional overpayments estimated at $203,760 ($110,869 Federal share) from our audit period and realize future savings by ensuring that nursing facilities exercise reasonable diligence in reconciling account records with credit balances and reporting the associated Medicaid overpayments on a more timely basis.

STATE AGENCY COMMENTS

The State agency concurred with our findings and recommendations. We included the State agency comments in their entirety as Appendix C to this report.

OTHER MATTER

Hospice providers provide palliative care as opposed to curative measures to beneficiaries with a terminal illness. Hospice providers sometimes pay nursing facilities to care for these beneficiaries. The State agency reimburses hospice providers 95 percent of these Medicaid expenses and receives a Federal share.

One nursing facility in our sample had two credit balances with overpayments totaling $1,469 related to duplicate payments it received from a hospice provider for the beneficiary's portion of the cost of hospice care. The State paid the hospice provider $1,396 for these payments and received a Federal share of $698. During our audit, the nursing facility refunded the overpayments to the hospice provider. The hospice provider refunded the overpayments to the State agency by check dated October 11, 2012.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of nursing facilities in Virginia that received a Medicaid payment during the quarter ended March 31, 2011.

SAMPLING FRAME

From Virginia's Medicaid Management Information System, we created a database of all payments made to nursing facilities during the quarter ended March 31, 2011. The database consisted of 113,581 claims with Medicaid payments totaling $194,323,216, representing 270 nursing facilities. We then eliminated all nursing facilities with less than 500 Medicaid claims and out-of-State nursing facilities. The resulting sampling frame of 71,930 claims and Medicaid payments totaling $81,632,485 represented 79 nursing facilities.

SAMPLE UNIT

The primary sample unit was a nursing facility. The secondary sample unit was a credit balance in a provider's account that was at least 60 days old as of September 30, 2011.

SAMPLE DESIGN

We used a multistage sample design based on probability-proportional-to-size weighted by the total number of Medicaid claims submitted by each nursing facility for the quarter ended March 31, 2011. The first stage consisted of a random selection of nursing facilities with probability of selection proportional to the total number of Medicaid claims. Only one of the nursing facilities selected had more than 30 credit balances that were at least 60 days old in account records that listed Medicaid as a payer. Therefore, we selected for review all credit balances in these accounts that were at least 60 days old as of September 30, 2011.

SAMPLE SIZE

We selected eight nursing facilities as the primary units. For the secondary units, we selected from the 8 nursing facilities all Medicaid credit balances in account records that listed Medicaid as a payer, for a total of 80 credit balances in the amount of $31,796.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

The sample selection used probability-proportional-to-size through which we considered the relative sizes of the nursing facilities when selecting the primary sampling units. For the secondary units, we selected all the Medicaid credit balances in account records that listed Medicaid as a payer.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the amount of Medicaid overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS OF MEDICAID OVERPAYMENTS

Nursing Facility	Amount of Actual Overpayments	Federal Share of Overpayments
Nursing Facility 1	$335	$ 168
Nursing Facility 2	130	65
Nursing Facility 3	5	3
Nursing Facility 4	5,550	2,777
Nursing Facility 5	600	316
Nursing Facility 6	1,068	640
Nursing Facility 7	12,949	7,425
Nursing Facility 8	2,636	1,591
Total	**$ 23,273**	**$12,985**

STATEWIDE ESTIMATE OF POTENTIAL SAVINGS[1]

Frame Size for the Selected Nursing Facilities	Value of Frame for the Selected Nursing Facilities	Sample Size	Value of Sample	Number of Overpayments in Sample	Value of Overpayments in Sample	Value of Overpayments in Sample (Federal Share)
80	$31,796	80	$31,796	57	$23,273	$12,985

Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$ 227,033
Lower limit	53,319
Upper limit	400,747

Estimated Value of Overpayments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$123,854
Lower limit	29,956
Upper limit	217,753

[1] The estimated value of overpayments includes the value of overpayments in the sample.

APPENDIX C: STATE AGENCY COMMENTS

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

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RICHMOND, VA 23219

April 17, 2013

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Audit Services, Region III
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150 S. Independence Mall West
Philadelphia, PA 16106

Re: Draft Report Number: A-03-11-00211
Nursing Facilities in Virginia Generally Reconciled Account Records with Credit Balances and Reported the Associated Medicaid Overpayments to the State Agency

Dear Mr. Virbitsky:

The Department of Medical Assistance Services (DMAS) for the Commonwealth of Virginia is in concurrence with the recommendation in the draft report to refund $12,985 (the Federal share of $23,273) to the Federal Government for overpayments related to credit balances to selected nursing facilities as of State Fiscal Year (SFY) 2012. These amounts have already been refunded either by the facilities adjusting claims or sending in a repayment.

DMAS further concurs to enhance efforts to recover overpayments more timely by reminding nursing facilities to reconcile accounts with credit balances and to adjust claims. DMAS has a number of communication opportunities including periodic notifications posted in "GoFileRoom" (an electronic file drawer accessible to nursing facilities) and informational presentations given for nursing facility key personnel.

If there are questions about our responses, please contact William J. Lessard, Jr., Director of the Division of Provider Reimbursement, at William.Lessard@dmas.virginia.gov or 804-225-4593.

Sincerely,

Cynthia B. Jones

Cynthia B. Jones

CBJ/mh