Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ACUTE CARE HOSPITALS IN GEORGIA DID NOT ALWAYS RECONCILE INVOICE RECORDS WITH CREDIT BALANCES AND REPORT 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.

Lori S. Pilcher
Regional Inspector General

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Office of Inspector General

https://oig.hhs.gov

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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 program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the 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 Georgia, the Department of Community Health (State agency) supervises the administration of the program. Within the State agency, the Division of Medical Assistance administers the 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 (invoice record). Providers should reconcile invoice records with 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 pt. 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.

In Georgia, the State's regulations do not require providers to refund Medicaid overpayments within a specific period. However, part I, section 303.8 of Georgia's *Policies and Procedures for Medicaid and PeachCare for Kids* requires providers to submit a quarterly report showing all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

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

OBJECTIVES

Our objectives were to determine whether acute care hospitals reconciled invoice records with credit balances and reported the associated Medicaid overpayments to the State agency.

SUMMARY OF FINDINGS

Seven of the eight acute care hospitals that we sampled did not always reconcile invoice records with credit balances and report associated Medicaid overpayments to the State agency. Of the 123 invoice records with both Medicaid payments and credit balances in our sample, 67 contained no Medicaid overpayments; however, 56 contained Medicaid overpayments totaling $117,238 ($79,156 Federal share). Based on these results, we estimated that the State agency could realize an additional Statewide recovery of $1,037,810 ($710,564 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

The hospitals did not identify and report Medicaid overpayments because the State agency did not require them to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. Also, the State agency did not provide adequate oversight to ensure that providers identified and reported Medicaid overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund $117,238 ($79,156 Federal share) to the Federal Government for overpayments paid to the selected acute care hospitals and

- enhance its efforts to recover additional overpayments estimated at $1,037,810 ($710,564 Federal share) from our audit period and realize future savings by requiring and ensuring that providers exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

In comments on our draft report, the State agency noted that it is in the process of recouping the $117,238 in overpayments, $90,935 of which related to one hospital that had identified $87,902 of the overpayments before our hospital fieldwork began. The State agency stated that OIG failed to take into account the State agency's ongoing process to identify and recoup credit balances, including the time lag from identification to the return of the funds. Furthermore, it noted that its recoupment process was already ongoing at the time of our review for the majority of the $117,238.

The State agency disagreed with the finding that it did not require providers to exercise reasonable diligence in identifying and reconciling credit balances. However, it agreed to implement protocols to improve reconciling invoice records with credit balances.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the State agency that it has made efforts to recoup the overpayments and that some of those efforts were ongoing both prior to and during our audit. However, we evaluated the sampled invoice records as of December 31, 2011, and if there was an amount due to Medicaid related to an invoice record that had a credit balance for at least 60 days, we treated that sample unit as an error. The State should continue its efforts to collect the remainder of the $117,238 and ensure that it returns the Federal share of $79,156 to the Federal Government.

The State agency's plans to put in place additional procedures to ensure that providers properly report Medicaid overpayments should ensure that providers exercise reasonable diligence in reconciling invoice records with credit balances.

TABLE OF CONTENTS

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 program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the 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 Georgia, the Department of Community Health (State agency) supervises the administration of the program. Within the State agency, the Division of Medical Assistance administers the 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.

The State agency's Medicaid policies and procedures define a credit balance as the amount determined to be refundable to Medicaid when a provider receives an improper or excess payment for a claim.[1] 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 (invoice record). Providers should reconcile invoice records with 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 pt. 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.

[1] Part I, section 303.8 of Georgia's *Policies and Procedures for Medicaid and PeachCare for Kids*.

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.[2]

In Georgia, the State agency's regulations do not require providers to refund Medicaid overpayments within a specific period. However, part I, section 303.8 of Georgia's *Policies and Procedures for Medicaid and PeachCare for Kids* requires providers to submit a quarterly report showing all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

Acute Care Hospitals

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

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether acute care hospitals reconciled invoice records with credit balances and reported the associated Medicaid overpayments to the State agency.

Scope

Our audit period covered 632 invoice records with unresolved credit balances[3] as of the quarter ended December 31, 2011. The unresolved credit balances totaled $2,028,933. The 8 sampling frames included 277 invoice records with unresolved credit balances[4] totaling $406,399.

We did not review the overall internal control structure of the State agency or the acute care hospitals. We limited our internal control review to obtaining an understanding of the policies and procedures that the hospitals used to review credit balances and report overpayments to the State agency.

From November 2011 through June 2012, we conducted fieldwork at the State agency's offices in Atlanta, Georgia and the eight hospitals at various locations throughout Georgia.

[2] 42 CFR § 433.316.

[3] The invoice records with these credit balances contained Medicaid payments.

[4] Each credit balance in our sampling frame was unresolved for at least 60 days.

Methodology

To accomplish our objectives, we:

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

- discussed with State agency personnel the State agency's policies and procedures for identifying and recovering Medicaid overpayments;

- created a sampling frame for the first stage of our sample design consisting of 67 acute care hospitals from which we randomly selected 8 (Appendix A);

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

- identified the invoice records in each hospital's accounting records with a Medicaid payment and a credit balance that was at least 60 days old at December 31, 2011;[5]

- reconciled these invoice records to each hospital's total accounts receivables and reconciled the accounts receivables to the hospitals' trial balance;

- selected a random sample of 30 invoice records with a Medicaid payment and a credit balance that was at least 60 days old from the 3 hospitals that had more than 30 such invoice records (Appendix A);

- reviewed all the invoice records with a Medicaid payment and a credit balance that was at least 60 days old from the 5 hospitals that had no more than 30 such invoice records (Appendix A);

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

- estimated the Statewide unrecovered Medicaid overpayments associated with unresolved credit balances that should be reported to the State agency (Appendix B);

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

- discussed our results with the eight hospitals 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

[5] These invoice records were the sampling frames for the second stage of our sample design.

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

Seven of the eight acute care hospitals that we sampled did not always reconcile invoice records with credit balances and report associated Medicaid overpayments to the State agency. Of the 123 invoice records with both Medicaid payments and credit balances in our sample, 67 contained no Medicaid overpayments; however, 56 contained Medicaid overpayments totaling $117,238 ($79,156 Federal share). Based on these results, we estimated that the State agency could realize an additional Statewide recovery of $1,037,810 ($710,564 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

The hospitals did not identify and report Medicaid overpayments because the State agency did not require them to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. Also, the State agency did not provide adequate oversight to ensure that providers identified and reported Medicaid overpayments.[6]

INVOICE RECORDS WITH UNRESOLVED CREDIT BALANCES

As of the end of the most recent quarter, the accounting records for the eight acute care hospitals contained 632 invoice records with unresolved credit balances totaling $2,028,933. Although Medicaid had reimbursed the hospitals for some portion of these invoice records, the hospitals had not reconciled, or otherwise evaluated, the invoice records to determine whether the unresolved credit balances contained Medicaid overpayments that should have been returned to the State agency.

Of the 632 invoice records with unresolved credit balances and a Medicaid payment, 277 totaling $406,399 had unresolved credit balances that were at least 60 days old, as shown in the table below.

Invoice Records With Unresolved Credit Balances

Days Outstanding	Number of Invoice Records	Unresolved Credit Balances
60 – 180 days	145	$333,062
181 – 365 days	55	48,665
1 – 2 years	76	24,640
More than 2 years	1	32
Total	**277**	**$406,399**

[6] 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.

MEDICAID OVERPAYMENTS NOT REPORTED

Part I, section 303.8 of Georgia's *Policies and Procedures for Medicaid and PeachCare for Kids* states that providers are required to submit a quarterly report showing all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems as of the last day of each calendar quarter. The report requires specific information for each credit balance on a claim-by-claim basis, and the State agency uses the report to monitor and recover credit balances due to Medicaid.

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 must refund the Federal share on its 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.[7] 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 hospitals in our sample, the practices for reconciling credit balances and identifying and reporting overpayments varied widely, and some of the hospitals did not report Medicaid overpayments to the State agency. Two out of the eight hospitals in our sample did not submit credit balance reports for calendar year 2011.

Of the 123 invoice records in our sample, 56 contained Medicaid overpayments totaling $117,238 ($79,156 Federal share). We identified Medicaid overpayments at seven of the eight hospitals in our sample. The seven hospitals acknowledged that the overpayments occurred, and we verified that the hospitals had refunded $27,395 ($17,799 Federal share) of the overpayments to the State agency as of the end of our fieldwork.

The overpayments occurred for multiple reasons. Some overpayments occurred when hospitals reduced their initial charges after Medicaid had already paid the initial charges. Hospitals reduced their initial charges when (1) they combined multiple charges to a single invoice, (2) patients qualified for drug replacement programs, or (3) audits identified billing errors.

Overpayments also resulted when Medicaid and other third parties, such as Medicare or commercial insurers, made payments. These overpayments occurred when hospitals received payments from Medicaid and third parties that totaled more than the Medicaid allowable amount for the charges on the invoice record.

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

INEFFECTIVE POLICIES AND PROCEDURES

The hospitals did not identify and report Medicaid overpayments because the State agency did not require them to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. Also, the State agency did not provide adequate oversight to ensure that providers identified and reported Medicaid overpayments. For example, the State agency did not contact the two hospitals in our sample that failed to submit quarterly credit balance reports for any of the quarters ending during the calendar year 2011.

Additionally, the State agency contracted with a vendor to identify and verify potential third party resources for Medicaid members and to identify claims paid that may be the liability of a third party. However, this vendor did not review the quarterly credit balance reports submitted by providers.

MEDICAID OVERPAYMENTS AND ESTIMATED PROGRAM SAVINGS

Of the 123 invoice records with both Medicaid payments and credit balances in our sample, 56 contained overpayments totaling $117,238 ($79,156 Federal share) paid to 7 acute care hospitals. The State agency should refund the Federal share of those overpayments to CMS. (See Appendix B for details of our sample results.)

We estimated that the State agency could realize an additional Statewide recovery of $1,037,810 ($710,564 Federal share) from our audit period and obtain future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting associated Medicaid overpayments. (See Appendix B for details of our Statewide estimate.)

RECOMMENDATIONS

We recommend that the State agency:

- refund $117,238 ($79,156 Federal share) to the Federal Government for overpayments paid to the selected acute care hospitals and

- enhance its efforts to recover additional overpayments estimated at $1,037,810 ($710,564 Federal share) from our audit period and realize future savings by requiring and ensuring that providers exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

In comments on our draft report, the State agency noted that it is in the process of recouping the $117,238 in overpayments, $90,935 of which related to one hospital that had identified $87,902 of the overpayments before our hospital fieldwork began. The State agency stated that OIG failed to take into account the State agency's ongoing process to identify and recoup credit balances, including the time lag from identification to the return of the funds. Furthermore, it

noted that its recoupment process was already ongoing at the time of our review for the majority of the $117,238.

The State agency disagreed with the finding that it did not require providers to exercise reasonable diligence in identifying and reconciling credit balances. However, it agreed to implement protocols to improve reconciling invoice records with credit balances. The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the State agency that it has made efforts to recoup the overpayments and that some of those efforts were ongoing both prior to and during our audit. However, we evaluated the sampled invoice records as of December 31, 2011, and if there was an amount due to Medicaid related to an invoice record that had a credit balance for at least 60 days, we treated that sample unit as an error. The State should continue its efforts to collect the remainder of the $117,238 and ensure that it returns the Federal share of $79,156 to the Federal Government.

The State agency's plans to put in place additional procedures to ensure that providers properly report Medicaid overpayments should ensure that providers exercise reasonable diligence in reconciling invoice records with credit balances.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of acute care hospitals in Georgia that received a Medicaid payment during the quarter ended September 30, 2011.

SAMPLING FRAME

The State agency provided a database of Georgia Medicaid payments for acute care hospitals for the quarter ended September 30, 2011. The database consisted of 143 acute care hospitals with 434,768 claims totaling $312,527,831. We eliminated all hospitals with less than $1 million in paid claims for the quarter ended September 30, 2011. The resulting sampling frame consisted of 67 acute care hospitals with 353,756 claims totaling $286,283,893.

SAMPLE UNIT

The primary sample unit was an acute care hospital. The secondary sample unit was an invoice record with a Medicaid payment and a credit balance that was at least 60 days old as of the date of the most recently ended quarter before we began fieldwork. For all of the hospitals in our sample, this date was December 31, 2011.

SAMPLE DESIGN

We used a multistage sample design. The first stage consisted of a random selection of eight acute care hospitals from the sampling frame. The second stage consisted of a random sample at each of the selected hospitals when the hospital had more than 30 invoice records with Medicaid payments and credit balances. If the hospital did not have more than 30 invoice records with Medicaid payments and credit balances, we selected all of that hospital's invoice records with Medicaid payments and credit balances for review.

SAMPLE SIZE

We selected eight acute care hospitals as the primary units. For the secondary units, we selected a random sample of 30 invoice records from 3 hospitals and all invoice records from the remaining 5 hospitals, for a total of 123 invoice records in the amount of $329,466.

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

For the primary units, we consecutively numbered the acute care hospitals in our sampling frame from 1 to 67. After generating the random numbers, we selected the corresponding frame items. For the hospitals with more than 30 secondary units, we consecutively numbered the invoice records in the sampling frame for each hospital. After generating the random numbers, we selected the corresponding frame items.

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

Hospital	Amount of Actual Overpayments	Federal Share of Overpayments
Hospital 1	$524	$386
Hospital 2	1,426	1,016
Hospital 3	1,670	1,098
Hospital 4	0	0
Hospital 5	878	581
Hospital 6	19,694	14,460
Hospital 7	90,935	60,160
Hospital 81	2,111	1,455
Total	**$117,238**	**$79,156**

STATEWIDE ESTIMATE OF POTENTIAL SAVINGS[2]

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Overpayments in Sample	Value of Overpayments in Sample	Value of Overpayments in Sample (Federal Share)
277	$406,399	123	$329,466	56	$117,238	$79,156

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

Point estimate	$1,155,048
Lower limit	(49,447)
Upper limit	$2,359,542

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

Point estimate	$789,720
Lower limit	(19,141)
Upper limit	$1,598,582

1 In accordance with the Office of Inspector General, Office of Audit Services policy, we did not use the results of stratum eight in calculating the estimated values of overpayments

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

David A. Cook, Commissioner

Nathan Deal, Governor

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December 28, 2012

Lori S. Pilcher
Office of Inspector General
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
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Re: Response to OIG Audit Report – Credit Balances

Dear Ms. Pilcher,

Thank you for allowing the Georgia Department of Community Health (DCH) to review the Health and Human Services Office of Inspector General's draft report A-04-12-04021 related to Hospital Credit Balance processing for Georgia Medicaid. We appreciate the diligence that went into this review, and we welcome the opportunity for external review and improvements in our internal processes.

Summary of OIG Findings and Recommendations

The draft report outlines two OIG findings. These findings are summarized below.

1. Seven of eight acute care hospitals sampled did not always reconcile invoice records with credit balances and report associated Medicaid overpayments to the Department of Community Health (DCH).

2. Providers did not identify and report overpayments because DCH did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed.

These two findings resulted in the following OIG recommendations cited in report.

1. Refund $117,238 ($79,156 Federal share) to the Federal Government for overpayments paid to the selected acute care hospitals.

2. Enhance efforts to recover additional overpayments estimated at $1,037,810 ($710,564 Federal share). Realize future savings by requiring and ensuring that providers exercise

reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

DCH Response

DCH acknowledges that there are always improvements that can be made in most any business process. However, DCH rejects the OIG finding that DCH did not require providers to exercise reasonable diligence in identifying and reconciling credit balances. Additionally, we find that the OIG review largely fails to recognize DCH's ongoing process to identify and recoup hospital credit balances. This includes the time lag from identification to return of those funds. This is evidenced by the fact that the majority of the refund identified was already in process at the time of the OIG review. The DCH response is further explained below.

- Refund of $117,238 ($79,156 Federal share)
  - DCH reviewed the refund of $117,238($79,156 Federal share)
    - The bulk of the $117,237 was in process for retraction by the MMIS vendor. Hospital 7 had correctly reported the bulk of the overpayment ($87,902 out of $90,935) to Medicaid on the 12/31/2011 DMA 710 Form
    - The retraction $87,902 of these funds have been submitted for recoupment. DCH is awaiting a retraction from HP.
    - To ensure non duplication of retraction, a check copy has not been requested simultaneously with the retraction processing.
    - Seven hospitals acknowledged the overpayments and refunded the State $27,395 ($17,799 Federal share).
    - DCH and our TPL vendor will ensure that all remaining overpayments are refunded by the provider to the State.
- Enhance efforts to recover additional overpayments
  - DCH agrees to implement protocols to improve reconciling invoice records with credit balances
    - Implement scorecard of providers to measure self reporting
    - Random sample providers that repeatedly declare $0 credit balances
    - Institute follow-up efforts for non-complying providers to ensure overpayments are refunded to DCH

Refund of $117,238 ($79,156 Federal share) to the Federal Government

Excerpts applicable from Summary of Findings pp. ii of OIG Audit Report:

Seven of the eight acute care hospitals that we sampled did not always reconcile invoice records with credit balances and report associated Medicaid overpayments to the State agency. Of the123 invoice records with both Medicaid payments and credit balances in our sample, 67 contained no Medicaid overpayments; however, 56 contained Medicaid overpayments totaling $117,238 ($79,156 Federal share).

Information and Response:

Based on the sample results of Medicaid overpayments, the bulk of the $117,238 in overpayments was identified at Hospital 7. $90,935 in overpayments or approximately 78% of the identified refunds were contained within this facility. Of the entire overpayments identified 75% were in process for refund to DCH. Per the OIG audit notes, two accounts totaling $87,902 were correctly reported on the 12/31/11 DMA-710 form. The provider has also reported these overpayments to the State on the 3/31/12 DMA-710 form.

DCH and our TPL vendor along with Hospital 7 have made several attempts to resolve these overpayments (Documentation of these attempts is available upon request by HHS OIG). HP paid claims to this provider that should have been paid as secondary, but were paid as primary. The provider contacted HP to notify them of the error. The provider also inquired about the method of refunding the overpayments. HP responded by asking that the provider not send checks because they would reprocess the claims for the overpayments.

Subsequently, the provider also received a quarterly reporting notice from our TPL vendor. The provider contacted DCH with concerns about how they should report their overpayments due to the reprocessing of claims by HP. We advised the provider to allow HP to reprocess the claims and not to submit the overpayments through the TPL vendor credit balance process to avoid a possible duplicate recoupment. In an effort to expedite the refunding of these monies, our TPL vendor will contact DCH to inquire about the status of recoupment and an expected reprocessing timeframe.

As of the end of the OIG fieldwork, seven hospitals have also acknowledged that the identified overpayments occurred, and OIG has verified that the hospitals have refunded $27,395 ($17,799 Federal share).

DCH through our TPL contractor will diligently recover all remaining Medicaid overpayments by:

- Drafting a follow-up credit balance audit letter for review and approval by the State. The letter will contain the following information:
  - Overpayments identified by OIG
  - 30-day timeframe to refund
  - Lockbox information
  - Contact information

- Mailing the audit letter certified, to the attention of the Chief Financial Officer for each institution.

- Following - up via phone call approximately one week from the date that the letter is mailed. If there is no response, or if there is a message left, our vendor will return the phone call within 2 business days. If there is no response after a 3rd attempt, we will instruct our vendor to escalate these issues for DCH involvement.

Enhance Efforts to Recover Additional Overpayments

Excerpts applicable from Summary of Findings pp. ii of OIG Audit Report:

Based on these results, we estimated that the State agency could realize an additional statewide recovery of $1,037,810 ($710,564 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.
The providers did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. Also, the State agency did not provide adequate oversight to ensure that providers identified and reported Medicaid overpayments.

Information and Response:

DCH credit balance audit policy requires providers to routinely report overpayments within 30 days of each quarter close. In June 2012, providers were reminded and instructed to complete the reporting of their overpayments using DMA-710. All reported overpayments are to be submitted on the state DMA-710 form and checks are mailed to the state-owned lockbox. In addition to self-reporting, all providers are targeted, twice a year, for a possible on-site audit review.

To ensure that providers exercise reasonable diligence in reporting Medicaid overpayments, DCH will put in place the following procedures:

- Create a provider bulletin that will educate providers on the audit process, deadlines and reporting requirements. DCH will recommend that this bulletin is published at least twice a year. This will ensure that the proper audit protocols have been communicated to each provider and minimize confusion on the process.

- DCH through our TPL vendor will create a score card for every acute care provider in the State. For each quarter, our TPL vendor will document the reporting of credit balances to the State. If a provider has not reported any overpayments within 30 days of the quarter-close, DCH will instruct our TPL vendor to follow-up via letter and two phone calls to Patient Accounts Director and/or Chief Financial Officer. If a provider does not respond after three attempts, we will request that our TPL vendor escalate the matter to DCH for further follow-up. This procedure will guarantee that every provider responds to the quarterly reporting requirements.

- For every Medicaid overpayment that is reported to DCH, our policy will require that each provider submit their systems - generated, quarter ending, credit balance report along with their DMA-710 form and overpayments. If there are credit balance accounts in question, we will request additional information. We may also randomly select credit balance accounts where overpayments were not identified by the provider, to make certain that there is no refund due. This will ensure that every credit balance account is being reviewed and refunded for specified audit time period.

- For providers that are reporting zero credit balances for any quarter, we will request that the provider submit their systems-generated, quarter-ending credit balance report, along with the DMA-710 form. We will randomly select accounts for a more detailed review. DCH may also request to target those providers for an on-site review.

Again, DCH appreciates the review conducted by the OIG, and we acknowledge areas for improvement and our strategies to accomplish those improvements above. We trust this response letter and the additional detail regarding the status of the recoupments of outstanding hospital credit balances described in this response gives the OIG additional confidence in the hospital credit balance reconciliation process. If you have any questions or concerns about the content of this response, please contact Ms. Lorraine McMillion, Director Third Party Liability, at lmcmillion@dch.ga.gov or (404) 657-9510.

Sincerely,

Jerry L. Dubberly

Jerry Dubberly
Chief, Medicaid Division