DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

June 23, 2009

Report Number: A-06-08-00053

Mr. Albert Hawkins
Executive Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

Dear Mr. Hawkins:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Collaborative Effort To Identify Overlapping Claims for Dual-Eligible Beneficiaries Receiving Medicare Part A and Medicaid Long-Term-Care Services in Texas." 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.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Warren Lundy, Audit Manager, at (405) 605-6183 or through e-mail at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-08-00053 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
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Chicago, Illinois 60601
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COLLABORATIVE EFFORT TO IDENTIFY OVERLAPPING CLAIMS FOR DUAL-ELIGIBLE BENEFICIARIES RECEIVING MEDICARE PART A AND MEDICAID LONG-TERM-CARE SERVICES IN TEXAS

Daniel R. Levinson
Inspector General

(June 2009)
A-06-08-00053

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title 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. For eligible beneficiaries, Medicaid pays a per diem to nursing homes for long-term care.

Pursuant to Title XVIII of the Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. Medicare Part A (hospital insurance) helps cover inpatient care, including hospital stays and up to 100 days in skilled nursing facilities (SNF) for posthospital extended care. Medicare pays the full cost for the first 20 days of a qualified SNF stay but requires a coinsurance payment beginning on the 21st day and continuing through the 100th day. Dual-eligible beneficiaries have Medicare coverage and also are eligible for Medicaid because they have either (1) limited income and resources or (2) high medical expenses that have caused them to spend down their income to Medicaid eligibility limits.

The Medicare-Medicaid Data Match Program (the program) is a collaborative effort initiated by the Centers for Medicare & Medicaid Services (CMS) its key partners are State Medicaid agencies and program safeguard contractors (TriCenturion in Texas). Program contractors analyze Medicare and Medicaid claims data simultaneously to detect patterns of fraud, waste, and abuse that may not be evident when viewed separately. The Texas Health and Human Services Commission (the State agency), which administers Medicaid for the State of Texas, used TriCenturion to identify improper Medicaid payments the State agency made for Medicare coinsurance. However, TriCenturion did not match Medicaid claims for long-term care to Medicare claims for inpatient stays to detect overlapping payments. To assist the State agency, we collaborated with the program partners to expand the program data match TriCenturion performed to identify overlapping payments.

OBJECTIVE

Our objective was to determine whether the State agency paid Medicaid long-term-care providers for the same dates of service for which Medicare paid hospitals and SNFs for dual-eligible beneficiary inpatient stays.

SUMMARY OF FINDINGS

The State agency paid Medicaid long-term-care providers for the same dates of service for which Medicare paid hospitals and SNFs for dual-eligible beneficiary inpatient stays. From records provided by TriCenturion for calendar year 2006, we identified 2,480 Medicaid long-term-care claims with the same dates of service as Medicare inpatient claims. The State agency researched the claims and recovered $417,060 ($253,098 Federal share) in payments for 1,198 of the Medicaid long-term-care claims. For the remaining 1,282 Medicaid long-term-care claims, the State agency determined that the payments were proper. The State agency had not identified

overlapping payments because the program partners did not coordinate a match of Medicaid claims for long-term care to Medicare claims for inpatient stays for the same beneficiary and the same dates of service. In addition, the State agency noted that it could improve its efforts to recover improper payments if the program contractor provided the data match information in a more timely manner.

RECOMMENDATIONS

We recommend that the State agency:

- refund the $253,098 Federal share of improper Medicaid long-term-care payments to the Federal Government;

- continue to obtain from the program contractor periodic listings of Medicare and Medicaid claims with the same dates of service, research the claims, recover inappropriate claim payments having overlapping dates of service, and refund the Federal share of recovered amounts to the Federal Government; and

- work with CMS and the program contractor to continue to improve the data match process through its use of the data fields and encourage the program contractor to provide the data match results in a more timely manner.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations and discussed the actions it would take. The State agency said that the number of Medicaid and Medicare claims with overlapping dates of service may change because the State agency has not completed its reconciliation of the claims. In addition, the State agency disagreed with our finding that the State agency did not identify overlapping payments because it did not request that TriCenturion attempt to do so. The full text of the State agency's comments is included as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We made minor revisions to the report in response to the State agency's comments. We agree that the number of claims with overlapping dates of service may change because the State agency's list of recovered amounts did not always match the service dates of Medicaid claims from TriCenturion's claims data. We reported the amounts of recovered payments provided by the State agency and the number of Medicaid claims from TriCenturion's list of overlapping claims.

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INTRODUCTION

BACKGROUND

Medicaid and Medicare Eligibility

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 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. For eligible beneficiaries, Medicaid pays a per diem to nursing homes for long-term care.

Pursuant to Title XVIII of the Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. Medicare Part A (hospital insurance) helps cover inpatient care, including up to 100 days in skilled nursing facilities (SNF) for posthospital extended care. An SNF is an institution or a distinct part of an institution, such as a skilled nursing home or rehabilitation center, which primarily provides skilled nursing care and related services for patients who require medical or nursing care. Medicare pays the full cost for the first 20 days of a qualified SNF stay but requires a coinsurance payment beginning on the 21st day and continuing through the 100th day.

Dual-eligible beneficiaries are individuals who have Medicare coverage and who also are eligible for Medicaid because they have either (1) limited income and resources or (2) high medical expenses that have caused them to spend down their income to Medicaid eligibility limits.

Medicare-Medicaid Data Match Program

The Medicare-Medicaid Data Match program (the program) is a collaborative effort initiated by CMS. Program contractors analyze Medicare and Medicaid claims data simultaneously to detect patterns of fraud, waste, and abuse that may not be evident when viewed separately. The program allows CMS to identify vulnerabilities in Medicare and Medicaid and work with the States, where appropriate, to take action to protect the Federal share of Medicaid expenditures. The program began as a pilot project in California in 2001 and by 2005 had expanded to nine additional States, including Texas, which began its program in 2003. The Deficit Reduction Act of 2005 amended the Act to require CMS to establish the program nationwide.

Postpayment Reviews of Medicaid Claims

The Texas Health and Human Services Commission (the State agency) administers Medicaid for the State of Texas. Under the program, the State agency coordinated with CMS and TriCenturion, the program safeguard contractor for Texas, to identify instances in which the State Medicaid agency made improper coinsurance payments for SNF stays of dual-eligible

beneficiaries. TriCenturion performed a computer match of Medicare and Medicaid claims and provided the State agency with a quarterly report of claims that appeared to be improper. The State agency used the report to research, and recover from SNF providers, those coinsurance payments verified as improper. During a previous audit of these types of claims, "Review of Texas Medicaid Payments for Medicare Coinsurance of Dual-Eligible Beneficiaries in Skilled Nursing Facilities" (A-06-08-00006), we identified improper coinsurance payments of $119,580 ($72,668 Federal share) that the State agency had not recovered.[1] Although the State agency used TriCenturion to identify improper coinsurance payments, the State agency informed us that TriCenturion did not perform a data match to identify Medicaid claims with per diem payments to nursing homes for long-term care that had the same dates of service as Medicare inpatient claims.

Collaborative Effort

To assist the State agency, we initiated a collaborative effort among the Office of Inspector General (OIG), the State agency, CMS, and TriCenturion. Through this effort, we expanded the program to allow TriCenturion to identify instances in which the same beneficiaries had the same dates of service on Medicare inpatient claims and Medicaid long-term-care claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency paid Medicaid long-term-care providers for the same dates of service for which Medicare paid hospitals and SNFs for dual-eligible beneficiary inpatient stays.

Scope

Using a list of 242,083 records provided by TriCenturion for calendar year 2006, we identified 2,480 long-term-care Medicaid claims that had the same dates of service as Medicare inpatient claims for the same beneficiaries. We excluded claims with overlaps of one day if the last day of Medicare service was the first day of Medicaid service.[2] We did not review the claims in detail, but provided the claims to the State agency for potential recoupment.

We limited our review of internal controls to obtaining an understanding of the State agency's policies and procedures for identifying and recovering potential overpayments to long-term-care facilities for dual-eligible beneficiaries.

We conducted our fieldwork at the State agency in Austin, Texas, from April through November 2008.

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[1]State agency Medicare coinsurance payments are improper when they are not authorized by a Medicare claim.

[2]When the final day of a Medicare claim was a discharge day, Medicare covered incidental costs but not room and board. In these instances, the first day of service on the Medicaid claim was for an admission, and the overlap was proper.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State officials to ascertain State policies and procedures for identifying and recovering improper Medicaid long-term-care payments;
- initiated a collaborative effort among OIG, CMS, the State agency, and TriCenturion;
- held group discussions with the collaboration participants to clarify the purpose of the collaboration, define the roles of each participant, determine timelines for obtaining results, and identify the scope and fields of Medicare and Medicaid claims to include in TriCenturion's data match;
- obtained from TriCenturion Medicare and Medicaid claims with the same dates of service and provided them to the State agency; and
- obtained and reviewed a list of payments recovered by the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

MEDICARE AND MEDICAID CLAIMS FOR THE SAME DATES OF SERVICE

To ensure proper and efficient payment of Medicaid claims, section 1902(37)(B) of the Act requires States to have claim payment procedures that provide for prepayment and postpayment claims review, including review of appropriate data about providers, patients, and the nature of the services for which payments are claimed.

The State agency paid Medicaid long-term-care providers for the same dates of service for which Medicare paid hospitals and SNFs for dual-eligible beneficiary inpatient stays. For calendar year 2006, we identified 2,480 long-term-care Medicaid claims with the same dates of service as Medicare inpatient claims. The State agency researched the claims and recovered $417,060 ($253,098 Federal share) in payments for 1,198 of the Medicaid long-term-care claims. For the remaining 1,282 Medicaid long-term-care claims, the State determined that the payments were proper. The State agency had not identified overlapping payments because the program partners did not coordinate a match of Medicaid claims for long-term care to Medicare claims for inpatient stays for the same beneficiary and the same dates of service.

CONTINUATION OF THE COLLABORATION

The collaboration that was initiated established a process that, if continued, will improve the accuracy of Medicaid payments. However, we learned that opportunities exist to improve the process. During the collaboration, the State agency noted that TriCenturion did not collect two Medicare claim data fields, "days covered" and "days not covered," that would have enabled the State agency to determine whether it had paid for Medicaid long-term-care claims with the same dates of service and beneficiaries as Medicare inpatient claims. As a result, we requested that CMS add collection of the two data fields in the latest program contract for Texas.[3] Collecting this data in the future should allow the State agency to identify and recover Medicaid payments with the same dates of service as Medicare claims. The State agency also noted that more timely receipt of the results of the data match from the program contractor would improve the effort to recover improper payments because (1) when providers need to research a claim, current data is more accessible because, for example, records may be sent to offsite locations after a certain period, and (2) recovering funds from providers with closed contracts is more difficult.

RECOMMENDATIONS

We recommend that the State agency:

- refund the $253,098 Federal share of improper Medicaid long-term-care payments to the Federal Government;

- continue to obtain from the program contractor periodic listings of Medicare and Medicaid claims with the same dates of service, research the claims, recover inappropriate claim payments having overlapping dates of service, and refund the Federal share of recovered amounts to the Federal Government; and

- work with CMS and the program contractor to continue to improve the data match process through its use of the data fields and encourage the program contractor to provide the data match results in a more timely manner.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations and discussed the actions it would take. The State agency said that the number of Medicaid and Medicare claims with overlapping dates of service may change because the State agency has not completed its reconciliation of the claims. In addition, the State agency disagreed with our finding that the State agency did not identify overlapping payments because it did not request TriCenturion to attempt to do so. The State agency said that it was not responsible or in a position to direct TriCenturion's actions. The full text of the State agency's comments is included as the Appendix.

[3]CMS extended TriCenturion's contract for program services, which was set to expire in September 2008, through January 2009. CMS established zone program integrity contractors to replace program safeguard contactors and in February 2009 awarded the contract for zone 4, which includes Texas, to Health Integrity, LLC.

OFFICE OF INSPECTOR GENERAL RESPONSE

We made minor revisions to the report in response to the State agency's comments. We agree that the number of claims with overlapping dates of service may change because the State agency's list of recovered amounts did not always match the service dates of Medicaid claims from TriCenturion's claims data. We reported the amounts of recovered payments provided by the State agency and the number of Medicaid claims from TriCenturion's list of overlapping claims.

APPENDIX

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

June 3, 2009

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Reference Report Number A-06-08-00053

Dear Mr. Sato:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Collaborative Effort to Identify Overlapping Claims for Dual-Eligible Beneficiaries Receiving Medicare Part A and Medicaid Long-Term Care Services in Texas" from the Department of Health and Human Services Office of Inspector General (DHHS-OIG). The cover letter, dated May 5, 2009, requested that HHSC provide written comments, including the status of actions taken or contemplated in response to the report recommendations.

The report identified recommendations for HHSC to consider regarding Medicare and Medicaid claims with overlapping dates of service. These recommendations include: (1) refunding ineligible Medicaid claims payments with overlapping dates of service; and (2) continuing efforts to improve the data matching processes with the Centers for Medicare and Medicaid Services (CMS) and TriCenturion, the program safeguard contractor. This management response includes clarifications to the draft report and comments related to actions taken or planned by HHSC and the Department of Aging and Disability Services (DADS).

Please consider the following clarifications to information provided in the draft report:

- Under 'Summary of Findings' on pages i and ii and under 'Findings and Recommendations' on page 3 states:

  "...we identified 2,480 Medicaid long-term-care claims with the same dates of service as Medicare inpatient claims" and "...in payment for 1,198 of the Medicaid long-term-care claims" and "For the remaining 1,282 Medicaid long-term-care claims...."

DHHS-OIG provided 2006 Medicaid long-term care claims data to DADS for reconciliation purposes. Efforts are on-going between DHHS-OIG auditors and DADS staff to isolate and determine the number of Medicaid and Medicare claims with overlapping dates of service. Once this reconciliation is completed, adjustments to the claim counts identified in the draft report may be necessary.

- Page ii of the 'Executive Summary' states:

  "The State agency had not identified overlapping payments because it did not request that TriCenturion match Medicaid claims for long-term care to Medicare claims for inpatient stays for the same beneficiary and the same dates of service."

  DADS is not responsible or in a position to direct the actions of TriCenturion, a federal contractor. During the course of the audit and under the direction of CMS, TriCenturion expanded its report to identify instances in which the same beneficiaries had the same dates of service on Medicare inpatient claims and Medicaid long-term care claims.

- Under 'Recommendations' on pages ii and 4 states:

  "Continue to obtain from the program contractor periodic listings of Medicare and Medicaid claims with the same dates of service, research the claims, recover payments for long-term care services not rendered, and refund the Federal share of recovered amounts to the Federal Government; and…."

  HHSC proposes modifying the above wording as follows:

  "*…recover inappropriate claim payments having overlapping dates of service, and…."*

Responses to recommendations and details on actions taken or planned follow:

DHHS/OIG Recommendation: *We recommend the State agency refund the $253,098 Federal share of improper Medicaid long-term care payments to the Federal Government.*

HHSC Management Response

Actions Planned: DADS continues to research claims data provided by the auditors. Once claim discrepancies have been resolved, DADS will refund and submit documentation to support the refund of the federal share for improper Medicaid long-term care payments.

Estimated Completion Date: July 31, 2009

Title of Responsible Party: Manager, Third Party Recovery Unit, DADS

DHHS/OIG Recommendation: *We recommend the State agency continue to obtain from the program contractor periodic listings of Medicare and Medicaid claims with the same dates of service, research the claims, recover payments for long-term-care services not rendered, and refund the Federal share of recovered amounts to the Federal Government.*

HHSC Management Response

Actions Planned: DADS has continued to receive periodic listings of Medicare and Medicaid claims with the same dates of service from the program safeguard contractor. DADS is completing implementation of a process to evaluate the listings and to research, recover, and refund the federal share of any inappropriate claims payments.

Estimated Completion Date: Ongoing

Title of Responsible Party: Manager, Third Party Recovery Unit, DADS

DHHS/OIG Recommendation: *We recommend the State agency work with CMS and the program contractor to continue to improve the data match process through its use of the data fields and encourage the program contractor to provide the data match results in a timely manner.*

HHSC Management Response

Actions Planned: DADS will continue to identify potential improvements in the matching process and request that CMS, through its contractor, implement any useful and practical changes that could enhance the effectiveness of the process.

Estimated Completion Date: Ongoing
Title of Responsible Party: Manager, Third Party Recovery Unit, DADS

If you have any questions or require additional information, please contact Penny V. Rychetsky, CIA, CGAP, Internal Audit Director, Department of Aging and Disability Services.

Ms. Rychetsky may be reached by email at Penny.Rychetsky@dads.state.tx.us or by telephone at (512) 438-5638.

Sincerely,

Albert Hawkins