DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

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

May 4, 2010

Report Number: A-06-09-00102

Mr. Eugene Gessow
Director
Department of Human Services
Division of Medical Services
P.O. Box 1437, Slot S401
Little Rock, AR 72203

Dear Mr. Gessow:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Credit Balances at Arkansas Health Center as of June 30, 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Paul Chesser, Audit Manager, at (501) 225-8114 or through email at Paul.Chesser@oig.hhs.gov. Please refer to report number A-06-09-00102 in all correspondence.

Sincerely,

/Patricia Wheeler/
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 and Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CREDIT BALANCES AT ARKANSAS HEALTH CENTER AS OF JUNE 30, 2009

Daniel R. Levinson
Inspector General

April 2010
A-06-09-00102

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security 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. In Arkansas, the Department of Human Services (the State agency) administers the State's Medicaid program.

Credit balances may occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the program payment ceiling or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from the Medicaid program and another third-party payer for the same services. In such cases, the provider should return the existing overpayment to the Medicaid program, which is the payer of last resort.

Section 1903(d)(2)(C) of the Act, implemented at 42 CFR § 433.300(b), states: "... when an overpayment is discovered ... the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment .... [T]he adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made."

Although the State agency does not have any regulations requiring providers to refund Medicaid credit balances within a specific timeframe, the *Manual of Cost Reimbursement Rules for Long Term Care Facilities* contains instructions related to overpayments. Specifically, section 1-12 states that overpayments will be corrected when discovered.

Arkansas Health Center (AHC), located in Benton, Arkansas, is a 350-bed psychiatric nursing home that participates in the Medicaid program. It is one of two State-run nursing homes in Arkansas.

OBJECTIVE

Our objective was to determine whether the Medicaid credit balances recorded in AHC's accounting records for patient services constituted overpayments that should have been returned to the Medicaid program pursuant to Federal and State requirements.

SUMMARY OF FINDING

As of June 30, 2009, AHC's Medicaid accounts with credit balances included 30 overpayments totaling $79,890 ($58,574 Federal share) that had not been returned to the Medicaid program. Because we did not review 76 Medicaid accounts with credit balances equal to or less than $500,

totaling $4,993, we cannot express an opinion on this amount. AHC did not promptly return the overpayments because it did not have a policy that required the unreconciled accounts to be reviewed on a specific schedule or within certain timeframes. Also, AHC was unaware that it should report Medicaid credit balances to the State in a timely manner.

RECOMMENDATIONS

We recommend that the State agency:

- recover from AHC the $79,890 ($58,574 Federal share) in Medicaid overpayments and refund the $58,574 Federal share to the Federal Government;
- work with AHC to determine whether any portion of the $4,993 in remaining credit balances was due to Medicaid overpayments, and, if any credit balances were due to overpayments, collect the overpayments and refund the Federal share to the Federal Government; and
- work with AHC to ensure that future Medicaid credit balances are reviewed and that overpayments are promptly returned to the Medicaid program.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency said that it had identified several credit balance accounts that have been adjusted since our review. The State agency agreed to investigate and reconcile the remaining credit balances identified in the report. Additionally, the State agency agreed to work with AHC to ensure that any future credit balances will be routinely investigated for cause and any Medicaid overpayments will be promptly recouped. The State agency's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

Page

INTRODUCTION....................1

BACKGROUND....................1
Medicaid Program....................1
Federal Reimbursement and State Requirements....................1
Arkansas Health Center....................1

OBJECTIVE, SCOPE, AND METHODOLOGY....................2
Objective....................2
Scope....................2
Methodology....................2

FINDING AND RECOMMENDATIONS....................3

OUTSTANDING CREDIT BALANCE ACCOUNTS WITH MEDICAID OVERPAYMENTS....................3

RECOMMENDATIONS....................3

STATE AGENCY COMMENTS....................4

APPENDIX

STATE AGENCY COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security 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. In Arkansas, the Department of Human Services (the State agency) administers the State's Medicaid program.

Credit balances may occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the program payment ceiling or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from the Medicaid program and another third-party payer for the same services. In such cases, the provider should return the existing overpayment to the Medicaid program, which is the payer of last resort.

Federal Reimbursement and State Requirements

Section 1903(d)(2)(C) of the Act, implemented at 42 CFR § 433.300(b), states: "... when an overpayment is discovered ... the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment .... [T]he adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made."

Although the State agency does not have any regulations requiring providers to refund Medicaid credit balances within a specific timeframe, the *Manual of Cost Reimbursement Rules for Long Term Care Facilities* contains instructions related to overpayments. Specifically, section 1-12 states that overpayments will be corrected when discovered.

Arkansas Health Center

Arkansas Health Center (AHC), located in Benton, Arkansas, is a 350-bed psychiatric nursing home that participates in the Medicaid program. It is one of two State-run nursing homes in Arkansas.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Medicaid credit balances recorded in AHC's accounting records for patient services constituted overpayments that should have been returned to the Medicaid program pursuant to Federal and State requirements.

Scope

As of June 30, 2009, AHC's accounting records contained 109 credit balance accounts that totaled $105,837 and listed Arkansas Medicaid as payer. Of the total, we reviewed the 33 accounts that had credit balances greater than $500, totaling $100,844. After further review, we discovered that three of the accounts did not contain credit balances. We did not review the remaining 76 accounts, which had credit balances equal to or less than $500, totaling $4,993.

Our objective did not require an understanding or assessment of the complete internal control system at AHC. We limited our review of internal controls to obtaining an understanding of the policies and procedures that AHC used to review credit balances and report overpayments to the State Medicaid program.

We performed our fieldwork in August 2009 at AHC in Benton, Arkansas.

Methodology

To accomplish our objective, we:

- researched and reviewed Federal and State requirements pertaining to Medicaid credit balances and overpayments;

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

- reviewed AHC's Resident Aging Schedule to identify all Medicaid credit balances outstanding as of June 30, 2009;

- judgmentally selected for review 33 credit balance accounts (3 of which we later determined did not have credit balances) that were outstanding as of June 30, 2009, and that had credit balances greater than $500;

- reviewed patient payment data, Medicaid claim forms and remittance advices, patient accounts receivable detail, and additional supporting documentation for each of the selected credit balance accounts to determine whether a credit balance was the result of an overpayment;

- calculated the Federal share of overpayments based on Arkansas' Federal medical assistance percentage rates, which ranged from 72.81 percent to 77.62 percent; and

- coordinated our audit with officials from 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

As of June 30, 2009, AHC's Medicaid accounts with credit balances included 30 overpayments totaling $79,890 ($58,574 Federal share) that had not been returned to the Medicaid program.

OUTSTANDING CREDIT BALANCE ACCOUNTS WITH MEDICAID OVERPAYMENTS

As of June 30, 2009, AHC's Medicaid accounts with credit balances included 30 overpayments totaling $79,890 ($58,574 Federal share) that had not been returned to the Medicaid program. Because we did not review 76 Medicaid accounts with credit balances equal to or less than $500, totaling $4,993, we cannot express an opinion on this amount.

AHC did not promptly return the overpayments because it did not have a policy that required the unreconciled accounts to be reviewed on a specific schedule or within certain timeframes. Also, AHC was unaware that it should report Medicaid credit balances to the State agency in a timely manner.

RECOMMENDATIONS

We recommend that the State agency:

- recover from AHC the $79,890 ($58,574 Federal share) in Medicaid overpayments and refund the $58,574 Federal share to the Federal Government;

- work with AHC to determine whether any portion of the $4,993 in remaining credit balances was due to Medicaid overpayments, and, if any credit balances were due to overpayments, collect the overpayments and refund the Federal share to the Federal Government; and

- work with AHC to ensure that future Medicaid credit balances are reviewed and that overpayments are promptly returned to the Medicaid program.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency said that it had identified several credit balance accounts that have been adjusted since our review. The State agency agreed to investigate and reconcile the remaining credit balances identified in the report. Additionally, the State agency agreed to work with AHC to ensure that any future credit balances will be routinely investigated for cause and any Medicaid overpayments will be promptly recouped. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

Division of Medical Services

P.O. Box 1437, Slot S-401 · Little Rock, AR 72203-1437
501-682-1857 · Fax: 501-682-3889 · TDD: 501-682-6789

March 18, 2010

Ms. Patricia Wheeler
Regional Inspector General
For Audit Services
Office of Inspector General
1100 Commerce Street, Room 632
Dallas, TX 75242

Dear Ms. Wheeler:

I have reviewed the draft report entitled "Review of Medicaid Credit Balances at Arkansas Health Center as of June 30, 2009" identified as Report Number A-06-09-00102. The report recommends that the State agency recover a Medicaid overpayment in the amount of $79,890 from the Arkansas Health Center (AHC).

Our initial review identified several credit balances for accounts that have since been adjusted. Because of these adjustments the amount of any credit balance may have changed. In addition to these, Provider Reimbursement is currently working with the AHC and the Department's Division of County Operations to investigate and reconcile the remaining credit balances identified in the report.

The Division of Medical Services (DMS), Provider Reimbursement Unit would appreciate the opportunity to work with CMS in reconciling any changes that may have occurred since the date of your audit including those resulting from our ongoing review. Any unresolved accounts will then be recouped from the AHC and the Federal share reimbursed to CMS.

Additionally DMS will work with AHC to ensure that any future credit balances will be routinely investigated for cause. Any Medicaid overpayments will be promptly recouped.

Sincerely,

Eugene I. Gessow
Director

CC: Randy Helms, Provider Reimbursement
File: Review of Medicaid Credit Balances