Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING FACILITIES IN MISSOURI DID NOT RECONCILE INVOICE RECORDS WITH CREDIT BALANCES AND REPORT THE ASSOCIATED MEDICAID OVERPAYMENTS TO THE STATE AGENCY

Inquires about this report may be address to the Office of Public Affairs at
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Patrick J. Cogley
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 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 Missouri, the Department of Social Services (State agency) supervises the administration of the Medicaid program. Within the State agency, the Missouri HealthNet Division administers 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 (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.

Pursuant to Missouri regulations in *Rules of Department of Social Services*, Division 70, Chapter 3 (13 Code of State Regulations (CSR) 70-3), providers are required to refund Medicaid overpayments within 45 days of notification of an overpayment, or else they may face sanctions. However, there are no Missouri regulations specifically requiring providers to reconcile invoice records with credit balances to determine whether overpayments exist.

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

OBJECTIVES

Our objectives were to determine whether nursing facilities reconciled invoice 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 did not reconcile invoice records with credit balances and report the associated Medicaid overpayments to the State agency. Of the 143 invoice records with both Medicaid payments and credit balances in our sample, 101 contained Medicaid overpayments, but 42 did not. The Medicaid overpayments associated with these 101 invoice records totaled $33,419 ($21,173 Federal share). Based on these results, we estimated that the State agency could realize an additional statewide recovery of $572,703 ($362,967 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. The reconciliation process was at the discretion of the providers, and some providers did not reconcile invoice records for more than 1 year.

RECOMMENDATIONS

We recommend that the State agency:

- refund $33,419 ($21,173 Federal share) to the Federal Government for overpayments paid to the selected nursing facilities and

- enhance its efforts to recover additional overpayments estimated at $572,703 ($362,967 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency described corrective actions that it had taken or planned to take in response to our recommendations.

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 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 Missouri, the Department of Social Services (State agency) supervises the administration of the Medicaid program. Within the State agency, the Missouri HealthNet Division administers 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 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).

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]

Pursuant to Missouri regulations in *Rules of Department of Social Services*, Division 70, Chapter 3 (13 Code of State Regulations (CSR) 70-3), providers are required to refund Medicaid overpayments within 45 days of notification of an overpayment, or else they may face sanctions. However, there are no Missouri regulations specifically requiring providers to reconcile invoice records with credit balances to determine whether overpayments exist.

Nursing Facilities

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers. In Missouri, the 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 (Medicare contractors)), other third-party payers (e.g. private insurance companies), and/or the patients themselves.[2] Medicaid, as payer of last resort, pays for the remaining portion of the claim after the Medicare, other third-party payers, and the patient surplus portions have been paid.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

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

Scope

Our audit period covered 359 invoice records with unresolved credit balances[3] as of the quarter ended September 30, 2011, for the 8 nursing facilities in our sample. The unresolved credit balances totaled $211,754. The 8 sampling frames included 316 invoice records with unresolved credit balances[4] totaling $123,299.

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[1] 42 CFR § 433.316.

[2] The portion of the claim that patients are financially responsible for is referred to as patient surplus.

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

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

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 determining the capabilities of the Medicaid claims processing system in preventing overpayments and determining whether there were backlogs in processing provider adjustments and refunds. We limited our internal control review at the eight sampled providers 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 October 2011 through February 2012, we conducted fieldwork at the State agency's offices in Jefferson City, Missouri, and the eight nursing facilities at various locations throughout Missouri.

Methodology

To accomplish our objectives, we:

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

- interviewed State agency personnel responsible for monitoring Medicaid overpayments;

- created a sampling frame for the first stage of our sample design consisting of 75 nursing facilities from which we randomly selected 8 providers using the probability-proportional-to-size methodology (Appendix A);

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

- determined the providers' total number and associated dollar amount of all invoices with credit balances and reconciled to the providers' accounting records to identify total credit balances with Medicaid payments;

- created a sampling frame for each of the eight selected providers for the second stage of our sample design;

- selected a random sample of 30 invoice records for each of the 4 providers that had more than 30 invoice records and reviewed all invoice records from each of the 4 providers that did not have more than 30 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 statewide unrecovered Medicaid overpayments associated with unresolved credit balances that should be reported to the State agency;

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

- discussed our audit results with the eight providers in our sample; and

- provided the results of our findings to 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 objectives.

FINDINGS AND RECOMMENDATIONS

Generally, the eight nursing facilities that we sampled did not reconcile invoice records with credit balances and report the associated Medicaid overpayments to the State agency. Of the 143 invoice records with both Medicaid payments and credit balances in our sample, 101 contained Medicaid overpayments, but 42 did not. The Medicaid overpayments associated with these 101 invoice records totaled $33,419 ($21,173 Federal share). Based on these results, we estimated that the State agency could realize an additional statewide recovery of $572,703 ($362,967 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. The reconciliation process was at the discretion of the providers, and some providers did not reconcile invoice records for more than 1 year.[5]

INVOICE RECORDS WITH UNRESOLVED CREDIT BALANCES

As of the quarter ended September 30, 2011, the accounting records for the 8 nursing facilities contained 359 invoice records with unresolved credit balances totaling $211,754. Although Medicaid had reimbursed the providers for some portion of these invoice records, the providers 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 359 invoice records with unresolved credit balances, 316 invoice records totaling $123,299, or 88 percent, had credit balances that were at least 60 days old, and some were unresolved for more than 1 year, as shown in the table on the following page.

[5] A Federal requirement that providers must report and repay overpayments within a certain time period was added to section 1128J of the 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.

Table: Invoice Records With Unresolved Credit Balances

Time Unresolved	Number of Invoice Records	Unresolved Credit Balances
60–365 days	308	$115,786
1–2 years	7	$4,833
2–3 years	1	$2,680
Total	**316**	**$123,299**

The providers did not reconcile these invoice records with unresolved credit balances because there was no specific requirement for them to do so.

MEDICAID OVERPAYMENTS NOT REPORTED

Pursuant to Missouri regulations in *Rules of Department of Social Services*, Division 70, Chapter 3 (13 CSR 70-3), providers are required to refund Medicaid overpayments within 45 days of notification of an overpayment, or else they may face sanctions. However, there are no Missouri regulations specifically requiring providers to reconcile invoice records with credit balances to determine whether overpayments exist.

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.[6] 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 widely, and some of the providers did not report Medicaid overpayments to the State agency.

Of the 143 invoice records with both Medicaid payments and credit balances in our sample, 101 contained overpayments totaling $33,419 ($21,173 Federal share). Of the eight nursing facilities in our sample, six had Medicaid overpayments and two did not. The six nursing facilities acknowledged that the overpayments occurred, and we verified that the providers had refunded $9,378 ($5,957 Federal share) of the overpayments to the State agency subsequent to our audit period.

The overpayments occurred because of billing software errors at the Medicare contractors, changes in patient surplus amounts, and billing and accounting errors. Billing software errors were due to the Medicare contractor system incorrectly processing certain therapy codes at an

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

incorrect rate. The patient surplus amounts were due to changes in the patients' incomes. Billing and accounting errors included incorrect adjustments of Medicare crossover claims and incorrect posting of supplemental insurance payments.[7]

INEFFECTIVE POLICIES AND PROCEDURES

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 identify and return overpayments that were due the State agency. The reconciliation process was at the discretion of the providers, and some providers did not reconcile their invoice records for more than 1 year.

MEDICAID OVERPAYMENTS AND ESTIMATED PROGRAM RECOVERIES

Of the 143 invoice records with both Medicaid payments and credit balances in our sample, 101 contained overpayments totaling $33,419 ($21,173 Federal share) paid to 6 nursing facilities. 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 $572,703 ($362,967 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 the associated Medicaid overpayments. (See Appendix B for details of our statewide estimate.)

RECOMMENDATIONS

We recommend that the State agency:

- refund $33,419 ($21,173 Federal share) to the Federal Government for overpayments paid to the selected nursing facilities and

- enhance its efforts to recover additional overpayments estimated at $572,703 ($362,967 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

[7] Individuals who are entitled to both Medicare and some form of Medicaid benefits are known as dual eligibles. After a Medicare contractor pays a Medicare claim for a dual eligible and assesses the Medicare deductibles and coinsurance, the contractor forwards the claim information to the appropriate State's Medicaid program. The State Medicaid program determines, based on the guidelines established in its State plan, whether to pay part or all of the Medicare deductibles and coinsurance and then pays the provider through the usual Medicaid payment system. We refer to such claims as crossover claims.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency described corrective actions that it had taken or planned to take in response to our recommendations.

The State agency's comments are included in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of nursing facilities in Missouri that received a Medicaid payment during the quarter ended March 31, 2011. A nursing facility is identified within Missouri's Medicaid Management Information System (MMIS) as provider type 10 and specialty code 80.

SAMPLING FRAME

From Missouri's MMIS, we created a database of all payments made to nursing facilities during the quarter ended March 31, 2011. The database consisted of 158,781 claims with Medicaid payments totaling $219,743,625, representing 507 providers. We then eliminated all providers with less than 500 Medicaid claims. The resulting sampling frame of 54,710 claims and Medicaid payments totaling $69,424,654 represented 75 nursing facilities.

SAMPLE UNIT

The primary sample unit was a nursing facility. The secondary sample unit was an invoice record with a Medicaid payment and a credit balance in a provider's account that was at least 60 days old as of the date of the most recently ended quarter.

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 provider for the quarter ended March 31, 2011. The first stage consisted of a random selection of providers with probability of selection proportional to the total number of Medicaid claims. The second stage consisted of a simple random sample at each of the selected providers where the provider had more than 30 invoice records with Medicaid payments and credit balances as of the quarter ended September 30, 2012. If the provider did not have more than 30 invoice records with Medicaid payments and credit balances as of the quarter ended September 30, 2012, we selected all of that provider's invoice records with Medicaid payments and credit balances for review.

SAMPLE SIZE

We selected eight nursing facilities as the primary units. For the secondary units, we selected a random sample of 30 invoice records with Medicaid payments and credit balances from 4 providers and all invoice records with Medicaid payments and credit balances from the remaining 4 providers, for a total of 143 invoice records in the amount of $67,310.

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 consecutively numbered the invoice records with Medicaid payments and credit balances in the sampling frame for each provider. 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

Nursing Facilities	Amount of Actual Overpayments	Federal Share of Overpayments
Provider 1	$ 0	$ 0
Provider 2	5,108	3,230
Provider 3	768	486
Provider 4	3,778	2,391
Provider 5	565	359
Provider 6	14,822	9,404
Provider 7	8,378	5,303
Provider 8	0	0
Total	**$33,419**	**$21,173**

STATEWIDE ESTIMATE OF POTENTIAL SAVINGS[1]

Frame Size for the Selected Providers	Value of Frame for the Selected Providers	Sample Size	Value of Sample	Number of Overpayments in Sample	Value of Overpayments in Sample	Value of Overpayments in Sample (Federal Share)
316	$123,299	143	$67,310	101	$33,419	$21,173

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

Point estimate	$606,122
Lower limit	$67,590
Upper limit	$1,144,654

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

Point estimate	$384,140
Lower limit	$42,463
Upper limit	$725,816

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

APPENDIX C: STATE AGENCY COMMENTS

Missouri Department of
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January 8, 2013

Patrick Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Region 0429
Kansas City, MO 64106

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Nursing Facilities in Missouri Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency", Report Number A-07-11-03169. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: The OIG recommends that the State agency refund $33,419 ($21,173 Federal share) to the Federal Government for overpayments paid to the selected nursing facilities.

DSS Response: The State's Third Party Liability (TPL) Fund Recovery contractor has been performing credit balance audits on nursing facilities since May 2011. Based on the detail provided by the OIG, the State has determined that $14,780 has been recovered through the TPL Fund Recovery audits and returned to CMS. For the remaining overpayments of $18,639, the State will request a check from the provider. After the State recovers these payments, the appropriate adjustment will be made to the CMS 64.

Recommendation 2: The OIG recommends that the State agency enhance its efforts to recover additional overpayments estimated at $572,703 ($362,967 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

DSS Response: With the implementation of credit balance audits by the TPL Fund Recovery contractor, the State has realized additional savings during the audit period and after. The State intends to continue pursuing credit balance audits through the TPL

vendor until March 2013, at which time the Recovery Audit Contractor (RAC) for the State will perform credit balance audits.

Please contact Jennifer Tidball, Director, Division of Finance and Administrative Services at 573/751-7533 if you have further questions.

Sincerely,

Brian Kinkade
Interim Director

BK/jc