DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

March 13, 2009

Report Number: A-06-08-00006

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 "Review of Texas Medicaid Payments for Medicare Coinsurance of Dual-Eligible Beneficiaries in Skilled Nursing Facilities." 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-06-08-00006 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
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF TEXAS MEDICAID PAYMENTS FOR MEDICARE COINSURANCE OF DUAL-ELIGIBLE BENEFICIARIES IN SKILLED NURSING FACILITIES

Daniel R. Levinson
Inspector General

(March 2009)
A-06-08-00006

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.

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. 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. Medicaid pays all or part of the Medicare coinsurance for beneficiaries eligible for both Medicare and Medicaid (dual-eligible beneficiaries), depending on their income. Dual-eligible beneficiaries have Medicare coverage and are also 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 Texas Health and Human Services Commission (the State agency) administers the Medicaid program for the State of Texas. For dual-eligible beneficiaries, the State requires that the number of coinsurance days authorized by the Medicare claim match the number of coinsurance days paid by Medicaid.

In an effort to identify and recover improper coinsurance payments, the State agency entered into a cooperative agreement with the Centers for Medicare & Medicaid (CMS) and TriCenturion, the program safeguard contractor (PSC) for Texas. Under the agreement, the PSC generates a quarterly exception report from a comparison of the number of coinsurance days authorized on Medicare SNF claims to the number of coinsurance days paid on Medicaid coinsurance claims for the same individual, provider, and common span of service dates. An exception is a potential overpayment that occurs because the coinsurance days for which Medicaid pays differ from the days for which Medicare authorizes payment.

The report sometimes identifies an exception for which the State has made a coinsurance payment for incorrect dates but the correct number of days; other exceptions occur because of missing documentation. Because not every exception represents an improper Medicaid coinsurance payment, the State agency researches claims identified in the exception report to determine whether Medicaid coinsurance payments should be recouped. According to a State agency official, the agency did not have sufficient staff to research all exceptions and generally prioritized and reviewed first those exceptions with the greatest differences between the number of days Medicare authorized and the number of days billed to Medicaid.

OBJECTIVE

Our objective was to determine whether Medicaid payments made for Medicare coinsurance were proper and, if not, whether the State agency recovered the improper payments.

SUMMARY OF FINDINGS

The State agency made but did not recover $33,809 ($20,551 Federal share) in improper Medicaid coinsurance payments for 54 of the 100 exceptions in our sample. The State agency made proper payments for 46 exceptions. Based on our sample, we estimate that the State agency, prior to the start of our audit, made but did not recover at least $119,580 ($72,668 Federal share) in improper Medicaid coinsurance payments. The improper payments were made because SNF providers submitted inaccurate coinsurance claims and because the State agency misinterpreted Medicare policy related to the date of death of SNF patients. During our audit, the State agency hired additional staff to review exceptions and recovered from SNF providers $28,876 ($17,547 Federal share) in improper payments for 28 of the 54 exceptions in our sample.

RECOMMENDATIONS

We recommend that the State agency:

- refund the $72,668 Federal share of Medicare coinsurance payments to the Federal Government and

- continue to research all exceptions to determine whether additional collections are warranted.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with both of our recommendations and described its plan of action. The State agency added comments related to recoveries made prior to the start of our audit (but not identified until after selection of our sample), suggesting that our estimate of improper payments may be slightly in error. Additionally, the State agency updated the amount of recoveries it has made and commented on its improved procedures for the payment of coinsurance. The full text of the State agency's comments is included as Appendix C.

We did not adjust our estimate of improper payments because our methodology was correct for the sampling frame that was available when we selected our statistical sample, and the State agency agreed to refund the Federal share of our estimate.

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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.

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. 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. Medicaid pays all or part of the Medicare coinsurance for beneficiaries eligible for both Medicare and Medicaid (dual-eligible beneficiaries), depending on their income. Dual-eligible beneficiaries have Medicare coverage and are also 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.

Medicaid Coinsurance Payments

The Texas Health and Human Services Commission (the State agency) administers the Medicaid program for the State of Texas. For dual-eligible beneficiaries, the State agency requires that the number of coinsurance days authorized by the Medicare claim match the number of coinsurance days paid by Medicaid. The State agency requires SNFs to submit the "Medicare/Skilled Nursing Facility Patient Transaction Notice" (Form 3619) to obtain payment for coinsurance related to Medicare SNF services. The Texas "Medicaid Provider Manual for Long-term Care Facilities," effective January 1, 2005, and "Information Letter No. 06-25," dated March 13, 2006, instructed SNFs to submit Form 3619 on or after the 21st day of a qualified stay. To stop coinsurance payments, SNFs must submit another Form 3619 to notify the State agency of a beneficiary's discharge date. Using this process, providers do not have to wait for adjudication of a Medicare SNF claim to seek Medicaid reimbursement for coinsurance. As a result, SNFs receive coinsurance payments on a more timely basis.

Quarterly Exception Reports

In an effort to identify and recover improper coinsurance payments, the State agency entered into a cooperative agreement with the Centers for Medicare & Medicaid Services (CMS) and TriCenturion, the program safeguard contractor (PSC) for Texas. Under the agreement, the PSC

generates a quarterly exception report from a comparison of the number of coinsurance days authorized on Medicare SNF claims to the number of coinsurance days paid on Medicaid coinsurance claims for the same individual, provider, and common span of service dates. An exception is a potential overpayment that occurs because the coinsurance days for which Medicaid pays differ from the days included on Medicare claims. An exception may include several claims for a beneficiary's period of illness.

The report sometimes identifies an exception for which the State has made a coinsurance payment for incorrect dates but the correct number of days; other exceptions occur because of missing documentation. Because not every exception represents an improper Medicaid coinsurance payment, the State agency researches claims identified in the exception report to determine whether Medicaid coinsurance payments should be recouped. According to a State agency official, the State agency did not have sufficient staff to research all exceptions and generally prioritized and reviewed first those exceptions with the greatest differences between the number of days billed on Medicare claims and the number of days Medicaid paid for the same beneficiary. Before we started our audit, the State agency had researched and recovered Medicaid coinsurance payments for 532 of the 1,471 exceptions identified for the first three quarters of calendar year 2005. During our audit, the State agency received the fourth quarter 2005 report and provided us with a list of exceptions that it did not intend to review.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicaid payments made for Medicare coinsurance were proper and, if not, whether the State agency recovered the improper payments.

Scope

For calendar year 2005, we identified 802 exceptions with Medicaid payments totaling $2,518,292. Our review included only PSC-identified exceptions that involved (1) claims that the State had not reviewed and did not intend to review and (2) providers that had an active Medicaid contract with the State agency at the time of our review. We reviewed a stratified random sample of 100 exceptions totaling $359,423.

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 of coinsurance for dual-eligible beneficiaries.

We conducted our fieldwork at the State agency in Austin, Texas, from October 2007 through October 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to ascertain the agency's policies and procedures for identifying and recovering improper Medicaid payments;
- obtained from the State 802 exceptions from calendar year 2005 quarterly exception reports;
- used stratified random sampling, as detailed in Appendix A, to select 100 exceptions from the sampling frame;
- contacted the SNFs in our sample and obtained patient data and Medicare remittance advices; and
- determined whether the exceptions were actually improper payments and calculated the Federal share of those amounts.

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 RECOMMENDATONS

The State agency made but did not recover $33,809 ($20,551 Federal share) in improper Medicaid coinsurance payments for 54 of the 100 exceptions in our sample. The State agency made proper payments for 46 exceptions. Based on our sample, we estimate that the State agency, prior to the start of our audit, made but did not recover at least $119,580 ($72,668 Federal share) in improper Medicaid coinsurance payments. The improper payments were made because SNF providers submitted inaccurate coinsurance claims and because the State agency misinterpreted Medicare policy related to the date of death. During our audit the State agency hired additional staff to review potential overpayments and recovered from SNF providers $28,876 ($17,547 Federal share) of improper payments for 28 of the 54 exceptions in our sample.

SUBMISSION OF INACCURATE CLAIMS

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.

For 41 of the 54 exceptions that were actual Medicaid coinsurance overpayments, the SNFs submitted inaccurate Forms 3619. The State agency relied on the Forms 3619 to authorize coinsurance payments and did not require SNFs to submit a corresponding Medicare remittance advice.[1] SNFs that submitted inaccurate Forms 3619 either provided us with remittance advices that did not support their claims for coinsurance or did not have corresponding Medicare remittance advices. The following three examples illustrate the problems:

- For one exception, the State agency paid $3,651 for 35 days of coinsurance for services provided from April 1 to May 5, 2005. The SNF did not provide a remittance advice corresponding to 12 days of coinsurance, from April 1 to 12. As a result, the State improperly paid $1,251 for the 12 days.

- For another exception, the State agency paid $1,085 for 12 days of coinsurance. The SNF claimed coinsurance from July 29 to August 9, 2005, but the remittance advice did not authorize any coinsurance during that period.

- For a third exception, the State agency paid $7,342 for 77 days of coinsurance for services provided from April 15 to June 30, 2005. The corresponding Medicare claim for services from April 15 to 29 did not authorize any coinsurance days. There were no Medicare claims or remittance advices for services provided from April 30 to June 30. As a result, the State improperly paid $7,342 for 77 days of coinsurance.

The improper Medicaid payments for Medicare coinsurance for these 41 exceptions totaled $32,558 ($19,790 Federal share).

MISINTERPRETATION OF MEDICARE POLICY

CMS "Medicare Benefit Policy Manual," chapter 3, section 20.1, provides that the number of days of care charged to a beneficiary for SNF care services is always in units of full days. The day of death is not counted as a billable day unless death occurs on the date of admission.

For the 13 remaining improper Medicaid coinsurance payments, the State agency paid Medicare coinsurance for days on which beneficiaries had died because it had misinterpreted CMS guidance. In 2006, the State agency issued guidance to SNFs that was in accordance with Medicare requirements and stopped paying coinsurance for the day of death.

The improper Medicaid coinsurance payments for these 13 exceptions totaled $1,251 ($761 Federal share).

RECOVERY OF OVERPAYMENTS DURING OUR AUDIT

After the State agency provided the records of exceptions used for our sampling frame, it hired additional staff to review exceptions. As a result, the State agency reviewed additional claims

[1] A remittance advice is a notice of payments and adjustments that Medicare contractors send to billers, providers, and suppliers to explain reimbursement decisions for processed claims.

and recovered from SNF providers $28,876 ($17,547 Federal share) for 28 of the 54 improper coinsurance payments we identified in our sample. Because the State had not recovered these payments at the start of our audit, we included these overpayments in the estimates based on our statistical sample. In addition, the State recovered $66,757 ($40,514 Federal share) for 126 of the remaining 702 exceptions in our sampling frame.

RECOMMENDATIONS

We recommend that the State:

- refund the $72,668 Federal share of Medicare coinsurance payments to the Federal Government and

- continue to research all exceptions to determine whether additional collections are warranted.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with both of our recommendations and described its plan of action. The State agency also commented that:

- Our estimate of improper payments may be slightly in error because $3,446.31 for 7 of the 54 improper payments identified in our statistical sample was recovered before we began our audit.

- As of February 1, 2009, the State agency had recovered $33,343 for 46 of the 54 improper payments in our sample.

- The State agency improved controls over the payment of coinsurance by requiring that providers report the 20 days of a qualifying stay paid in full by Medicare as part of the authorization process for payment of coinsurance.

The full text of the State agency's comments is included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We believe that our estimate of improper payments is accurate. The sampling frame from which we selected our statistical sample consisted of data presented by the State agency as unrecovered payments. Though the data in our sample included improper payments recovered before we began the audit, the State did not identify the improper payments as recovered until after we had selected our sample. We did not adjust our estimate of improper payments because our methodology was correct for the sampling frame that was available when we selected our statistical sample, and the State agency agreed to refund the Federal share of our estimate.

We commend the State agency for recovering additional improper payments and for improving the process of authorizing coinsurance payments.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was potential overpayments (exceptions) made by the Texas Health and Human Services Commission (the State agency) to skilled nursing facilities for Medicare coinsurance payments during calendar year 2005. An exception occurred when the State agency potentially made a Medicaid coinsurance payment for days that exceeded the number of days for which Medicare paid.

SAMPLING FRAME

The sampling frame was a spreadsheet listing of 802 exceptions by beneficiary with payments totaling $2,518,292 for services in calendar year 2005.

SAMPLE UNIT

The sample unit was an exception for Medicare coinsurance that the State agency did not or would not pursue.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sample by the difference between the number of coinsurance days authorized by Medicare and the number of coinsurance days paid by Medicaid:

- stratum one: 481 exceptions with a 1-day difference, totaling $1,265,057;
- stratum two: 156 exceptions with differences of 2 to 11 days, totaling $527,012; and
- stratum three: 165 exceptions with differences of 12 to 77 days, totaling $726,223.

SAMPLE SIZE

We randomly selected a sample of 100 exceptions: 34 from stratum one and 33 each from stratums two and three.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services, RAT-STATS statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the sample units within each stratum by the "days difference" field and by the "client ID" field. We then numbered each sample unit sequentially, starting with one for each stratum.

We generated 100 random numbers (34 for stratum one and 33 each for stratums two and three) and selected the corresponding sample unit from each stratum.

ESTIMATION METHODOLOGY

We used RAT-STATS to estimate the amount of improper payments based on the dollar value of sample units determined to be improper payments. We reported the estimate of improper payments using the "difference estimator" at the lower limit of the 90-percent two-sided confidence interval.

APPENDIX B

SAMPLE RESULTS AND ESTIMATES

The results of our review are as follows:

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Improper Payments	Value of Improper Payments
1	481	$1,265,057	34	$86,873	25	$2,048
2	156	527,012	33	122,820	17	5,828
3	165	726,223	33	149,730	12	25,933
Total	**802**	**$2,518,292**	**100**	**$359,423**	**54**	**$33,809**

The estimates of improper payments and Federal share are as follows:

	Estimated Improper Payments	Estimated Federal Share
Point Estimate	$186,191	$113,168
Lower Limit	119,580	72,668
Upper Limit	252,802	153,669

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

February 20, 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-06-08-00006

Dear Mr. Sato:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Review of Texas Medicaid Payments for Medicare Coinsurance of Dual-Eligible Beneficiaries in Skilled Nursing Facilities" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated January 23, 2009, requested that HHSC provide written comments, including the status of actions taken or contemplated in response to the report recommendations.

HHSC respectfully submits the following clarifications and updates to the information provided in the draft report:

- Prior to the audit entrance conference on October 24, 2007, the Department of Aging and Disability Services (DADS) had recovered a total of $3,446.31 on 7 of the 54 exceptions in the audit sample. Five were from stratum one and totaled $259.94, and two were from stratum three and totaled $3,186.37 (sample strata are defined in Appendix A of the draft report). The auditors may not have been aware of these recoupments; consequently, the auditor's extrapolation may be slightly in error.

- On page 3, under Findings and Recommendations, the draft report states, "During our audit the state agency hired additional staff to review potential overpayments and recovered from SNF providers $28,876 ($17,547 federal share) of improper payments for 28 of the

54 exceptions in our sample." As of February 1, 2009, DADS has recovered $33,343 of improper payments for 46 of the 54 exceptions in the OIG sample.

- Since DADS does not require the provider to submit the Medicare remittance, it relies totally on the provider to identify the co-insurance days on Form 3619. To address this, beginning on September 1, 2008, DADS requires providers to report the 20 days of qualifying stay paid in full by Medicare on Form 3619. This service period is processed in the DADS Service Authorization System (SAS) as an un-billable service authorization and will prevent any payment by Medicaid when the authorization is activated in SAS. The provider cannot successfully process a Form 3619 for the effective date of Medicare Part A coinsurance (and subsequently cannot bill for the service) until the 20 full days paid by Medicare is established in SAS. This change implemented by the state helps resolve, but will not eliminate, the problem. Receipt of a Medicare contractor-prepared Medicare quarterly exception report that contains more timely and comprehensive information would enable DADS to more fully address the inaccurate claims issue (see additional comments below for more detail).

The report identifies two recommendations for HHSC to consider regarding Medicaid payments made for Medicare coinsurance payments. These recommendations address: (1) recovery of improper Medicaid coinsurance payments; and (2) the need for DADS to continue researching all exceptions identified to determine whether additional collections are warranted. The following management response includes comments related to these recommendations and details related to actions HHSC has taken or planned.

DHHS/OIG Recommendation: *We recommend that the State refund the $72,668 Federal share of Medicare coinsurance payments to the Federal Government.*

HHSC Management Response

Actions Planned: The State will refund the $72,668 Federal share of Medicare coinsurance payments to the Federal Government.

Estimated Completion Date: February 28, 2009

Title of Responsible Parties: Department of Aging and Disability Services
Director of Accounting and Director of Budget

DHHS/OIG Recommendation: *We recommend that the State continue to research all exceptions to determine whether additional collections are warranted.*

HHSC Management Response

Actions Planned: DADS will continue to research all exceptions to determine whether additional collections are warranted.

Estimated Completion Date: Ongoing

Title of Responsible Party: Department of Aging and Disability Services
Manager, Third Party Recovery Unit

Additional Comments

A Medicare contractor performs periodic data matches of Medicare and Medicaid payments in an effort to identify potential SNF overpayments, and reports exception results to DADS. However, the reported information is at least two years old when DADS receives it. Because the information that is reported is not timely, providers do not always have readily available support documentation when DADS requests it. In addition, the data match report does not include some information essential for DADS to determine whether the match represents an actual overpayment, such as Medicare "covered" and "non-covered days."

More timely results and more comprehensive information reported by the Medicare contractor would help ensure providers can readily provide documentation DADS needs to accurately research and resolve these exceptions, and would significantly reduce the time needed by both the provider and 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. You may contact Ms. Rychetsky by email at Penny.Rychetsky@dads.state.tx.us or by telephone at (512) 438-5638.

Sincerely,

Albert Hawkins