Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOUTH CAROLINA PAID HOSPITALS FOR SOME INPATIENT HOSPITAL SERVICES THAT MEDICARE PAID

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Lori S. Pilcher
Regional Inspector General

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Office of Inspector General

https://oig.hhs.gov

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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

South Carolina Medicaid overpaid hospitals $1,056,782 for some of the same inpatient hospital services that Medicare had already paid.

WHY WE DID THIS REVIEW

Medicaid provides health coverage to 8.3 million "dually eligible" low-income seniors and people with disabilities, who are enrolled in both Medicaid and Medicare. However, Medicaid is the payer of last resort and should not pay for medical costs when there is another responsible entity (or program), including Medicare. The Office of Inspector General has consistently identified Medicaid overpayment issues. In this audit, we focused on Medicaid overpayments when Medicare and Medicaid both pay for the same services. We are conducting this audit in multiple States.

Our objective was to determine whether the South Carolina Department of Health and Human Services (State agency) overpaid Medicaid inpatient claims to hospitals that received Medicare payments for the same services.

BACKGROUND

Federal and State Governments jointly fund the Medicaid program. The Medicaid program is intended to be the payer of last resort; that is, all third party insurance carriers, including Medicare, must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual on Medicaid (section 1902(a)(25) of the Social Security Act).

Overpayments occur when the State agency inappropriately pays claims that a third party is responsible for paying. In South Carolina, the State agency administers the Medicaid program.

WHAT WE FOUND

The State agency overpaid some Medicaid inpatient claims from hospitals that had received Medicare payments for the same services. Of the 1,136 overpayments ($2,261,959 Federal share) that we reviewed, the hospitals had refunded 532 prior to our audit. However, the hospitals had not refunded the remaining 604. The overpayments were due to the State's lack of system edits to detect erroneous or incorrect hospital entries in their payment system. As a result, the State agency made Medicaid overpayments to hospitals totaling $1,056,782 ($797,680 Federal share).

WHAT WE RECOMMEND

We recommend that the State agency:

- recover $1,056,782 in Medicaid overpayments,
- refund $797,680 to the Federal Government, and

- correct the system errors that allowed the overpayments to occur.

STATE AGENCY COMMENTS AND OUR RESPONSE

In its comments on our draft report, the State agency concurred with our first and second recommendations and described actions that it had taken or planned to take in regard to these recommendations. However, the State agency did not concur with our third recommendation because it plans to replace its Medicaid Management Information System (MMIS). Nevertheless, the State agency will review the controls currently within its MMIS to ensure that edits are in place to prevent these types of overpayments. The State agency will also continue to use post-payment audits and other means of monitoring inpatient hospital claims for duplicate Medicare-Medicaid payments.

After reviewing the State agency's comments, we believe that its Medicaid payment system should identify and correct duplicate and erroneous hospital information. We agree with the State agency's approaches to both reviewing the controls of its MMIS to ensure that erroneous payments do not recur until it can update its MMIS and continuing the use of post-payment audits, and other inpatient hospital monitoring, to identify duplicate Medicare-Medicaid payments.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicaid provides health coverage to 8.3 million "dually eligible" low-income seniors and people with disabilities, who are enrolled in both Medicaid and Medicare. However, Medicaid is the payer of last resort and should not pay for medical costs when there is another responsible entity (or program), including Medicare. The Office of Inspector General has consistently identified Medicaid overpayment issues. In this audit, we focused on Medicaid overpayments when Medicare and Medicaid both pay for the same services. We are conducting this audit in multiple States.

OBJECTIVE

Our objective was to determine whether the South Carolina Department of Health and Human Services (State agency) overpaid Medicaid inpatient claims from hospitals that had received Medicare payments for the same services.

BACKGROUND

The Medicaid Program

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.

The amount that the Federal Government reimburses to State Medicaid agencies is commonly known as Federal financial participation, or Federal share. It is a specified percentage of Medicaid expenditures determined by the Federal medical assistance percentage, which varies based on a State's relative per capita income.

Medicaid Payer of Last Resort

The Medicaid program is intended to be the payer of last resort; that is, all third party insurance carriers, including Medicare, must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual on Medicaid (section 1902(a)(25) of the Social Security Act (the Act)). Overpayments occur when the State agency inappropriately pays claims that a third party is responsible for paying. When both Medicare and Medicaid coverage apply, Medicare is the primary payer.

The State agency must recover Medicaid payments when Medicaid pays for services for an individual who has Medicare as the primary payer. This payment constitutes an overpayment.

South Carolina Department of Health and Human Services

In South Carolina, the State agency administers the Medicaid program. Within the State agency, the Bureau of Compliance and Performance Review is responsible for identifying Medicaid overpayments. As part of the bureau, the Division of Program Integrity conducts post-payment reviews directed towards reclaiming Medicaid funds that have been wasted through inaccurate, excessive, or duplicate payments.

HOW WE CONDUCTED THIS REVIEW

We reviewed 1,136 Medicaid overpayments for inpatient services that Medicare also paid, totaling $2,954,446 ($2,261,959 Federal share), submitted by 52 hospitals in South Carolina for the 3-year period from January 1, 2007, through December 31, 2009. Our audit population did not include claims in which Medicaid paid for only the deductible, only the coinsurance, or both, for the inpatient stay.

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.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency overpaid some Medicaid inpatient claims from hospitals that had received Medicare payments for the same services. Of the 1,136 overpayments ($2,261,959 Federal share) that we reviewed, the hospitals had refunded 532 prior to our audit. However, the hospitals had not refunded the remaining 604. The overpayments occurred because of the State agency's lack of system edits to detect erroneous or incorrect hospital entries in its payment system. The State agency made its payments on the basis of data it received from the hospitals, which was not always accurate. As a result, the State agency made Medicaid overpayments to hospitals totaling $1,056,782 ($797,680 Federal share).

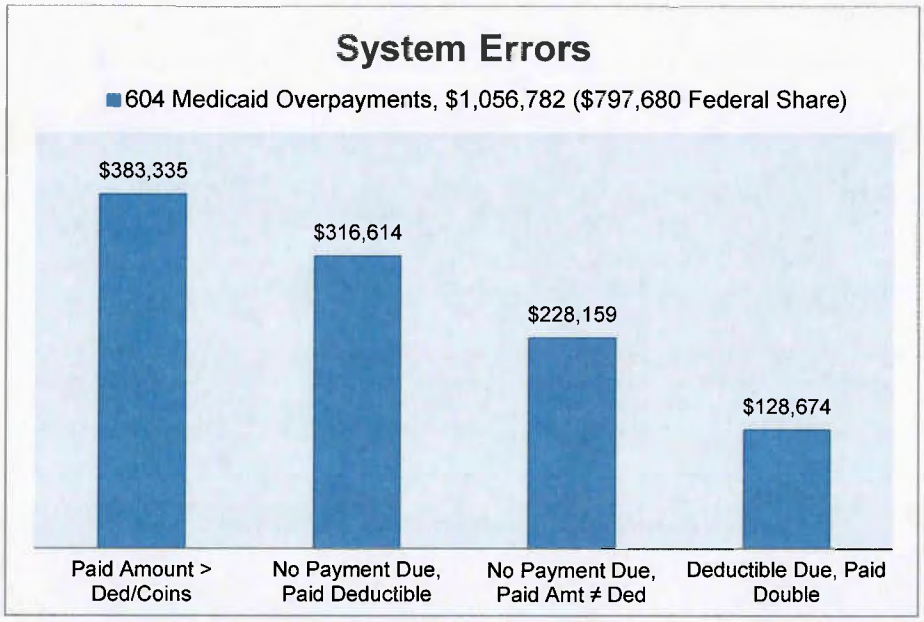
For details on the Federal and State requirements related to the Medicaid overpayments, see Appendix B.

MEDICAID OVERPAYMENTS NOT RECOVERED

The Act provides that the State should refund the Federal portion of any overpayment (§ 1903(d)(2)(A)). An overpayment is the amount paid by a Medicaid agency to a provider that exceeds the amount that is allowable for services furnished under the State plan (42 CFR § 433.304).

The State agency overpaid some Medicaid inpatient claims from hospitals that had received Medicare payments for the same services. Of the 1,136 overpayments we reviewed, the hospitals refunded 532 prior to the start of our audit. However, the hospitals had not refunded the remaining 604 Medicaid overpayments to CMS totaling $1,056,782 ($797,680 Federal share). Of the 604 overpayments, the State paid hospitals:

- an amount greater than the deductible and/or coinsurance for 101 overpayments totaling $383,335,
- a deductible amount when it was not due for 311 overpayments totaling $316,614,
- an amount other than a deductible and/or coinsurance when it was not due for 70 overpayments totaling $228,159, and
- double the deductible amount when the deductible was due for 122 overpayments totaling $128,674.



WHY DID OVERPAYMENTS OCCUR?

The overpayments occurred because the State agency's payment system did not have edits in place to detect erroneous or incorrect hospital entries. The State agency based its payments on data from the hospitals, which was often inaccurate.

When a Medicare payment for the same service was present, the hospitals were required to enter the Medicare information into specified fields on the claims form. The State agency's payment system would then pay the lower of the difference between the Medicaid-allowed amount and the Medicare payment, or the sum of the Medicare coinsurance, blood deductible, and deductible. Because the hospitals were not required to submit a copy of the Medicare

Explanation of Medical Benefits (EOMB) with the Medicaid claims submission, the Medicaid payments were based on the hospital's entries on the claims form for any Medicare related information.

The State agency did not properly monitor the Medicaid payments when it placed full reliance on the hospital entries on the claims form without automated edits or other procedures to validate their accuracy.

RECOMMENDATIONS

We recommend that the State agency:

- recover $1,056,782 in Medicaid overpayments,
- refund $797,680 to the Federal Government, and
- correct the system errors that allowed the overpayments to occur.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency concurred with our first and second recommendations and described actions that it had taken or planned to take in regard to these recommendations. However, the State agency did not concur with our third recommendation because it plans to replace its Medicaid Management Information System (MMIS). Nevertheless, the State agency will review the controls currently within its MMIS to ensure that edits are in place to prevent these types of overpayments. The State agency will also continue to use post-payment audits and other means of monitoring inpatient hospital claims for duplicate Medicare-Medicaid payments.

After reviewing the State agency's comments, we believe that its Medicaid payment system should identify and correct duplicate and erroneous hospital information. We agree with the State agency's approaches to both reviewing the controls of its MMIS to ensure that erroneous payments do not recur until it can update its MMIS and continuing the use of post-payment audits, and other inpatient hospital monitoring, to identify duplicate Medicare-Medicaid payments.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered a population of 1,136 Medicaid overpayments for inpatient services that Medicare also paid, totaling $2,954,446 ($2,261,959 Federal share), submitted by 52 hospitals in South Carolina for the period from January 1, 2007, through December 31, 2009. Our audit population did not include claims in which Medicaid paid for only the deductible, only the coinsurance, or both, for the inpatient stay.

We did not review the overall internal control structure of the State agency or the Medicaid program. Instead, we limited our internal control review to the objective of our audit.

We conducted fieldwork at the State agency in Columbia, South Carolina, and at various hospitals throughout South Carolina.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements and the South Carolina State Medicaid plan,
- discussed the Medicaid overpayment process with State agency officials,
- obtained data for paid Medicaid and Medicare inpatient claims,
- performed a data match of the Medicaid and Medicare inpatient claims for overpayments for the same beneficiary for the same date of service,
- reviewed the matching 1,136 overpayments that had Medicare and Medicaid inpatient claims for the same beneficiary for the same date of service,
- obtained documentation from providers and the State agency to support repayment of Medicaid payments,
- provided State agency officials with a listing of the overpayments for validation,
- calculated the overpayment amount (Federal share), and
- discussed our results with State agency officials.

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 the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

The State or local agency administering a State plan for medical assistance will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan. By law, the Medicaid program is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid (Section 1902(a)(25) of the Act). This means that all third party insurance carriers, including Medicare, must pay before Medicaid processes the claim.

Federal regulations (42 CFR § 433.304) define an overpayment as "... the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for the services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." In instances when Medicaid should not have paid because Medicare was the primary payer, the State agency should recover the Medicaid payments, which are considered overpayments.

Federal regulations, 42 CFR § 433.312(a), also require that the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

STATE REQUIREMENTS

The State agency's *Hospital Services Provider Manual*, section 2, states Medicaid is the "payer of last resort." In addition, section 1, states a provider who has been paid by Medicaid and subsequently receives reimbursement from a third party, including Medicare, must repay to the State agency either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less.

In the State agency's *Hospital Services Provider Manual*, section 3, a hospital must file a claim with Medicare first (when known). The hospital must enter the information from the Medicare EOMB in fields 50, 54, and 60, as well as amounts for value codes 09, 11, A1, B1, C1, A2, B2, C2, and 38, if applicable. These fields provide the Medicare information needed for the State agency to make a Medicaid payment. It further states that claims involving Medicare and Medicaid will be paid the lower of (1) the difference between the Medicaid-allowed amount and the Medicare payment, or (2) the sum of the Medicare coinsurance, blood deductible, and deductible.

APPENDIX C: STATE AGENCY COMMENTS

SOUTH CAROLINA
Healthy Connections
MEDICAID

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January 23, 2014

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Atlanta, Georgia 30303

RE: OIG Report Number: A-04-11-06145

Dear Ms. Pilcher:

Thank you for the opportunity to respond to the Office of Inspector General (OIG) draft report titled *South Carolina Paid Hospitals for Some Inpatient Hospital Services That Medicare Paid*, involving duplicate Medicaid payments to inpatient hospitals where Medicare had already made a payment on the claim. The South Carolina Department of Health and Human Services (SCDHHS) agrees with your determination of the overpayments caused by this situation; however, since the completion of your audit work, we have identified additional refunds which have reduced the amount of the overpayments still outstanding. In addition, we do not agree that the overpayments were "due to the State's lack of system edits to detect erroneous or incorrect hospital entries in their payment system."

This audit was initiated by the OIG in September 2011. After assisting the OIG in validating the information in a sample of the claims under review, we were provided a listing of claims with dates of service from January 1, 2007, through December 31, 2009, where the OIG had identified Medicare as the primary payer, yet had also identified a payment made for the same claim by the South Carolina Medicaid program. Of the 1,136 claims with duplicate Medicare – Medicaid payments, we found that hospitals had refunded the overpayment for 532 claims prior to the OIG's audit. The majority of these refunds were the result of a project we initiated with the South Carolina Recovery Audit Contractor (RAC), to identify and recover duplicate Medicaid payments for patients with Medicare and/or commercial health insurance. The rest of the refunds were the result of SCDHHS's "retro-recovery" processes and credit balance audits that are managed by the agency's Third Party Liability (TPL) contractor. It should be noted that the Medicaid data extracts used by the OIG do not show refunds from providers that occur after claim payment is made. SCDHHS worked with the OIG to identify any prior refunds from providers in our audit records from the RAC and the agency's TPL contractor. Since the conclusion of the

OIG's audit work, we have continued to research claim-level history to make sure we have accounted for all the refunds for these overpayments.

The recommendations from the draft report, and our "statements of concurrence or non-concurrence" for each one, are as follows:

Recommendation #1: The State agency should recover $1,056,782 in Medicaid overpayments.

We concur with that the State should recover the $1,056,782 in Medicaid overpayments; however, some portion of this amount has already been recovered. Since the discovery of the 532 claim refunds, we have identified another 88 claims that had already been refunded by inpatient hospital providers. We were able to identify these provider repayments within the Medicaid retro-recovery system operated by our TPL contractor. According to our calculations, therefore, the final overpayment amount for the claims in question is $860,277.58. However, in order to confirm this, we also will have to obtain detailed information from the OIG audit staff regarding the original estimated overpayment amounts. We also will provide detailed spreadsheets to the audit staff to document our findings.

Recommendation #2: The State agency should refund $797,680 to the Federal Government.

We concur that the State should refund the federal portion $797,680 of the identified overpayments to the Federal government; again, some portion of this amount has already been recovered. Based on our revised estimate of the overpayments in question, the federal share (using 75% of the total) is estimated to be $645,208.19.

Recommendation #3: The State agency should correct the system errors that allowed the overpayments to occur.

We do not concur with recommendation #3. We have had policy and system edits in place since 2006 to provide that the SCDHHS payment for dually eligible recipients is equal to the allowed amount minus the Medicare payment or the sum of the Co-insurance, Deductible, and Blood Deductible, whichever is less. We cannot identify any "system errors" that allowed the overpayments to occur. Based on our review, we find that many if not most of the overpayments were caused by erroneous and duplicate information submitted by providers on the claim. The report states that the agency did not require providers to submit a copy of the Medicare EOMB and therefore did not "properly monitor the Medicaid payments when it placed full reliance on the hospital entries on the claims form without automated edits or other procedures to validate their accuracy." Such a broad statement is not accurate, since there are system edits that do ensure proper payment of claims.

While we do not require the submission of EOMBs, to match each inpatient hospital claim for a dually-eligible beneficiary against a Medicare EOMB form would be an extremely cumbersome, manual process. We do not think this is the intent of the OIG's recommendation in this case.

Regardless, we will review the controls currently within our MMIS to ensure wherever possible that any overpayments caused by a lack of appropriate edits will not re-occur. However, SCDHHS is in the beginning stages of developing a replacement MMIS, and major system changes to our 30 year old legacy system may not be feasible at this time. SCDHHS also will continue to use post-payments audits conducted by the RAC as well as other means to monitor inpatient hospital claims for duplicate Medicare-Medicaid payments.

Once the final amount of the overpayment is established, we will immediately begin the process to recover these funds from the hospitals involved, and will use the assistance of the South Carolina RAC to help verify and collect these overpayments. We will comply with federal requirements to properly remit the federal share to CMS based on the federal financial participation rate applicable during the dates of service for the claims.

Again, thank you the opportunity to respond to the draft audit report. I look forward to working with the OIG Office of Audit Services staff to finalize the results of this audit. Please do not hesitate to call me at 803-898-1050 if you have any questions at this time.

Sincerely,

Kathleen C. Snider, Bureau Chief
Compliance and Performance Review

KCS:m

cc: Byron Roberts, General Counsel, SCDHHS
John Supra, CIO, SCDHHS