Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PROVIDERS DID NOT ALWAYS RECONCILE PATIENT RECORDS WITH CREDIT BALANCES AND REPORT AND RETURN THE ASSOCIATED MEDICAID OVERPAYMENTS TO STATE AGENCIES

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Office of Inspector General

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EXECUTIVE SUMMARY

Providers did not always reconcile patient records with credit balances and report and return the associated Medicaid overpayments to State agencies. On the basis of our reviews of 64 providers in 8 States, we estimated that the States could recover Federal Medicaid overpayments of nearly $17 million.

WHY WE DID THIS REVIEW

Two previous Department of Health and Human Services (HHS), Office of Inspector General (OIG), reports indicated that significant outstanding Medicaid credit balances existed nationwide. Between May 1992 and March 1993, we reported that many State agencies' efforts were inadequate to ensure that, nationwide, providers were identifying the majority of Medicaid credit balances and remitting overpayments in a timely manner. Through 2012, the OIG *Compendium of Unimplemented Recommendations* continued to recommend that the Centers for Medicare & Medicaid Services (CMS) establish a national Medicaid credit balance reporting mechanism and require its regional offices to monitor reporting.

We performed reviews in eight States to update our prior work on Medicaid credit balances. This report summarizes the results of the individual reviews.

The objectives of our reviews in the eight States were to determine whether providers reconciled patient records with credit balances and reported and returned the associated Medicaid overpayments to the State agencies. In each State, our audit included unresolved credit balances as of a quarter that ended between June 2011 and June 2012.

BACKGROUND

Providers of Medicaid services submit claims to States to receive payment. The States process and pay the claims. The Federal Government pays its share (Federal share) of State medical assistance expenditures on the basis of the Federal medical assistance percentage, which varies depending on the State's relative per capita income.

Credit balances generally occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the charges billed, such as when a provider receives a duplicate payment for the same services from the Medicaid program or a third-party payer. CMS does not require States to routinely monitor providers' efforts to identify, report, and return Medicaid credit balances in patient accounts.

On March 23, 2010, section 6402(a) of the Patient Protection and Affordable Care Act (Affordable Care Act) amended the Social Security Act (the Act) to include a requirement that providers must report and return overpayments within a certain time period (the Act § 1128J(d)).

Under the Medicare program, CMS published its proposed rule in 2012 for the reporting and returning of overpayments. CMS proposed that a provider identifies an overpayment if it had actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate

ignorance of the overpayment. CMS stated that this definition gives providers an incentive to exercise reasonable diligence to determine whether an overpayment exists. Without such a definition, some providers might avoid performing activities to determine whether an overpayment exists.

Under the Medicaid program, HHS designated CMS to issue regulations relating to these new provider requirements. CMS has not published a proposed rule for Medicaid providers to report and return overpayments to the State. However, the Act already requires that a State Medicaid agency refund the Federal share of any overpayment to CMS 1 year from the date of discovery of the overpayment (the Act §§ 1903(d)(2)(A) and (C), and 42 CFR § 433.312).

This review of Medicaid credit balances included reviews in eight States and eight providers in each State. In each State, we reviewed acute care hospitals, nursing facilities, or certain noninstitutional providers.

WHAT WE FOUND

Providers did not always reconcile patient records with credit balances and report and return the associated Medicaid overpayments to the State agencies. Of the 1,102 patient records with credit balances that we reviewed in 8 States, 538 did not contain Medicaid overpayments; however, 564 patient records contained Medicaid overpayments totaling $263,582 ($170,371 Federal share). On the basis of these results, we estimated that the eight States in our review could realize an additional recovery of $24,984,165 ($16,833,392 Federal share) from our audit period and could obtain future savings if they enhanced their efforts to recover overpayments in provider accounts.

Generally, providers did not identify, report, and return Medicaid overpayments because the States did not require that providers exercise reasonable diligence in reconciling patient records that had credit balances with charges and payment records to determine whether overpayments existed. There was no requirement that States ensure providers perform reconciliations, and some providers did not reconcile some patient records for more than 6 years.

WHAT WE RECOMMEND

We recommend that CMS issue Medicaid regulations to clarify the requirements of the Affordable Care Act that parallel its proposed Medicare rules and require that States ensure that providers exercise reasonable diligence to identify, report, and return overpayments.

CMS COMMENTS

In its written comments on our draft report, CMS concurred with our recommendation.

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INTRODUCTION

WHY WE DID THIS REVIEW

Two previous Department of Health and Human Services (HHS), Office of Inspector General (OIG), reports indicated that significant outstanding Medicaid credit balances existed nationwide. Between May 1992 and March 1993, we reported that many State agencies' efforts were inadequate to ensure that, nationwide, providers were identifying the majority of Medicaid credit balances and remitting overpayments in a timely manner. Through 2012, the OIG *Compendium of Unimplemented Recommendations*[1] continued to recommend that the Centers for Medicare & Medicaid Services (CMS) establish a national Medicaid credit balance reporting mechanism and require its regional offices to monitor reporting.

We performed reviews in eight States to update our prior work on Medicaid credit balances.

OBJECTIVES

The objectives of our reviews in the eight States were to determine whether providers reconciled patient records with credit balances and reported and returned the associated Medicaid overpayments to the State agencies. This report summarizes the results of the eight individual reviews.[2]

BACKGROUND

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, CMS administers the program. Each State administers its program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its program, it must comply with applicable Federal requirements.

Providers of Medicaid services submit claims to States to receive payment. The States process and pay the claims. The Federal Government pays its share (Federal share) of State medical assistance expenditures based on the Federal medical assistance percentage, which varies depending on the State's relative per capita income.

Medicaid Credit Balances

[1] In 2014, the *OIG Compendium of Unimplemented Recommendations* was renamed *Compendium of Priority Recommendations (Compendium)*. The *Compendium* constitutes OIG's response to a specific requirement of the Inspector General Act of 1978, as amended (section 5(a)(3)). It identifies significant recommendations described in previous *Semiannual Reports to Congress* with respect to problems, abuses, or deficiencies for which corrective actions have not been completed. The 2014 edition also responds to a requirement associated with the Consolidated Appropriations Act of 2014 directing OIG to report its top 25 unimplemented recommendations that, on the basis of the professional opinion of OIG, would best protect the integrity of HHS programs if implemented.

[2] Appendix A contains a list of related OIG reports.

Providers record and accumulate charges and reimbursements for services in each patient's account record. Credit balances generally occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the charges billed, such as when a provider receives a duplicate payment for the same services from the Medicaid program or a third-party payer. CMS does not require States to routinely monitor providers' efforts to identify, report, and return Medicaid credit balances in patient accounts.

On March 23, 2010, section 6402(a) of the Patient Protection and Affordable Care Act (Affordable Care Act) amended the Social Security Act (the Act) to include a requirement that providers must report and return overpayments within a certain time period (the Act § 1128J(d)).

Under the Medicare program, CMS published in 2012 its proposed rule for the reporting and returning of overpayments.[3] CMS proposed that a provider identifies an overpayment if it had actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. CMS stated that this definition gives providers an incentive to exercise reasonable diligence to determine whether an overpayment exists. Without such a definition, some providers might avoid performing activities to determine whether an overpayment exists.

Under the Medicaid program, HHS designated CMS to issue regulations relating to these new provider requirements. CMS has not published a proposed rule for Medicaid providers to report and return overpayments to the State.[4] However, the Act already requires that a State Medicaid agency refund the Federal share of any overpayment to CMS 1 year from the date of discovery of the overpayment (the Act §§ 1903(d)(2)(A) and (C) and 42 CFR § 433.312).

Selected Providers

This multistate review of Medicaid credit balances included reviews in eight States. We reviewed acute care hospitals in Georgia, Ohio, and Texas; nursing facilities in Missouri and Virginia; and certain noninstitutional providers in California, New York, and North Carolina.[5]

HOW WE CONDUCTED THIS REVIEW

We statistically sampled 8 providers from each of the 8 States for a total of 64 providers. At each provider, we identified all patient records with unresolved credit balances as of a quarter that ended between June 2011 and June 2012 (depending on the provider). The 64 providers

[3] 77 Fed. Reg. 9179 (Feb. 16, 2012). On February 17, 2015, CMS announced the extension of the timeline for publication of its final rule until February 16, 2016.

[4] In February 2012, CMS stated that it would develop proposed rules for other stakeholders, including Medicaid, at a later date. 77 Fed. Reg. 9179, 9180 (Feb. 16, 2012).

[5] Appendix B identifies the classification for each type of provider selected for review.

sampled in our reviews had 24,466 patient records[6] with unresolved credit balances totaling $7,594,589. Of these records, we focused our review on 17,851 patient records, totaling $4,755,659, with unresolved credit balances outstanding for at least 60 days.[7] Of the 17,851 patient records, our sample included 1,102 totaling $731,653.

We limited our internal control reviews to obtaining an understanding of the policies and procedures that the providers used to reconcile credit balances and report and return overpayments to the State agency. We accomplished our objective through substantive testing.

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 C contains relevant Federal requirements, Appendix D contains the details of our scope and methodology, Appendix E contains our statistical sampling methodology, and Appendix F contains our sample results and estimates.

FINDINGS

Providers did not always reconcile patient records with credit balances and report and return the associated Medicaid overpayments to the State agencies. Of the 1,102 patient records with credit balances that we reviewed in 8 States, 538 did not contain Medicaid overpayments; however, 564 patient records contained Medicaid overpayments totaling $263,582 ($170,371 Federal share). On the basis of these results, we estimated that the eight States in our review could realize an additional recovery of $24,984,165 ($16,833,392 Federal share) from our audit period and could obtain future savings if they enhanced their efforts to recover overpayments in provider accounts.

Generally, providers did not identify, report, and return Medicaid overpayments because the States did not require that providers exercise reasonable diligence in reconciling patient records that had credit balances with charges and payment records to determine whether overpayments existed. Although some States required reporting overpayments, there was no requirement that States ensure providers perform reconciliations, and some providers did not reconcile some patient records for more than 6 years.

[6] In California, Georgia, Missouri, North Carolina, and Ohio, a patient record was an individual invoice. In New York, Texas, and Virginia, a patient record was a patient account that consisted of multiple invoices.

[7] In New York and North Carolina, the sampling frame was also restricted to unresolved credit balances greater than $3. In Ohio, the sampling frame was also restricted to unresolved credit balances greater than $1.

PATIENT RECORDS WITH UNRESOLVED CREDIT BALANCES

Patient records for the 64 providers in the 8 States that we reviewed contained 24,466 unresolved credit balances totaling $7,594,589. Although Medicaid had reimbursed the providers for some portion of these patient records, the providers had not reconciled, or otherwise evaluated, the records to determine whether the unresolved credit balances contained Medicaid overpayments that should have been returned to the State agency.

Of the 24,466 patient records with unresolved credit balances, 82 percent (20,028 records[8] totaling $4,759,503) had credit balances that were at least 60 days old, and some records remained unresolved for more than 6 years, as shown in Table 1 below.

Table 1: Patient Records With Unresolved Credit Balances

Time Unresolved	Number of Patient Records	Unresolved Credit Balances
60–365 days	11,369	$3,167,371
1–2 years	4,710	1,131,530
2–3 years	2,664	380,818
3–4 years	758	72,121
4–5 years	346	5,380
5–6 years	165	1,957
More than 6 years	16	326
Total	**20,028**	**$4,759,503**

The providers did not reconcile these patient records with unresolved credit balances in a timely manner because there was no requirement for them to do so.[9]

MEDICAID OVERPAYMENTS NOT REPORTED OR RETURNED

The Federal Government has made it clear in various regulations that Medicaid overpayments, once discovered, must be refunded. A State discovers an overpayment when a provider initially acknowledges a specific overpaid amount in writing to the State (42 CFR § 433.316(c)(2)). After discovery of an overpayment, States have 1 year to refund the Federal share of an overpayment to CMS regardless of whether the provider has returned the overpayment to the State (the Act § 1903(d)(2)(C)).

[8] The number of patient records listed here (20,028) is greater than the number of patient records on which we focused our review (17,851) because New York, North Carolina, and Ohio had additional restrictions to their sampling frames. See footnote 6.

[9] Although there are no proposed or final rules implementing § 1128J(d) of the Act relating to Medicaid providers reporting and returning overpayments, Medicaid providers are still subject to the statutory requirements found in § 1128J(d) of the Act and could face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from the Federal health care programs for failure to report and return an overpayment.

Georgia, North Carolina, and Virginia required providers to acknowledge overpayments on a quarterly Medicaid credit balance report that they submit to the State. The report notifies the appropriate officials that the provider has determined that a credit is due back to the Medicaid program for an overpayment. However, this process did not require that providers reconcile patient records that had credit balances to determine whether overpayments existed. The States refund the Federal share to CMS on the quarterly CMS-64 report. California, Missouri, New York, Ohio, and Texas did not have a requirement for providers to reconcile or submit a quarterly Medicaid credit balance report.

Among the providers in our sample, the practices for reconciling credit balances and identifying, reporting, and returning overpayments varied widely, and some providers did not report or return overpayments to the State agency at all. Some providers did not have policies and procedures addressing the review of credit balances or the returning of identified overpayments; other providers did not consistently follow their policies and procedures. Providers in all eight States (with or without reporting requirements) had a high rate of patient records with credit balances that were not reconciled to identify whether an overpayment existed for at least 60 days as shown in Table 2 below.

Table 2: Quarterly Medicaid Reporting Requirement and Unreconciled Patient Records

	Patient Records	Unreconciled at Least 60 Days	Unreconciled Rate
States with reporting requirement	14,502	10,468	72%
States with no reporting requirement	9,964	9,560	96%

Of the 1,102 patient records with unresolved credit balances in our sample, 564 contained Medicaid overpayments totaling $263,582 ($170,371 Federal share).[10] On the basis of these results, we estimated that the eight States in our review could realize an additional recovery of $24,984,165 ($16,833,392 Federal share) from our audit period and could obtain future savings if they enhanced their efforts to recover overpayments in provider accounts. The providers acknowledged that the overpayments occurred, and we verified that the providers had returned $105,280 ($66,471 Federal share) of the overpayments to the State agency after our audit period.

Generally, the overpayments occurred either because the providers received duplicate and third-party payments or because they made various billing and accounting errors. Providers erroneously generating multiple billings or Medicaid paying more than once for the same services were the typical causes of duplicate payments. Third-party payments resulted from providers receiving payment from a third-party insurer, such as a commercial insurer or Medicare, for a service already paid for by Medicaid. Billing and accounting errors included overstated billings, the use of incorrect identifiers for the type of services provided, and posting errors.

[10] Patient records with unresolved credit balances that were not caused by a Medicaid overpayment were caused by an overpayment from a third party (e.g., private, Medicare, etc.) or by something else, such as a contractual adjustment.

Third-party payments and billing and accounting errors for acute care hospital services, third-party payments for nursing facilities, and duplicate and third-party payments at noninstitutional providers were the primary causes of overpayments, as shown in Table 3 below.

Table 3: Causes of Overpayments

Provider Type	Total Overpayments	Duplicate Payments	Third-Party Payments	Billing and Accounting Errors	Other
Acute care hospitals	180	31	66	65	18
Nursing facilities	158	1	96	28	33
Noninstitutional	226	109	74	43	0
Total	**564**	**141**	**236**	**136**	**51**

NO REQUIREMENT TO RECONCILE PATIENT RECORDS

The providers did not identify, report, and return Medicaid overpayments because the States did not require providers to exercise reasonable diligence in reconciling patient records that had credit balances with charges and payment records to determine whether overpayments existed. There was no requirement that States ensure that providers perform reconciliations, and some providers did not reconcile some of their patient records for up to 6 years.

RECOMMENDATIONS

We recommend that CMS issue Medicaid regulations to clarify the requirements of the Affordable Care Act that parallel its proposed Medicare rules and require that States ensure that providers exercise reasonable diligence to identify, report, and return overpayments.

CMS COMMENTS

In its written comments on our draft report, CMS concurred with our recommendation. CMS stated that it is currently using the authority provided in the Affordable Care Act to collect any identified overpayments from States and that it plans to finalize the Notice of Proposed Rulemaking applicable to the Medicare program before considering similar rulemaking relevant to Medicaid.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, are included as Appendix G.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

AUDITS OF MEDICAID CREDIT BALANCES

Report Title	Report Number	Date Issued
Acute-Care Providers in Ohio Did Not Always Reconcile Invoice Records With Credit Balances and Refund the Associated Medicaid Overpayments to the State Agency	A-05-12-00070	1/2015
Noninstitutional Providers in New York State Did Not Always Reconcile Account Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency	A-02-11-01036	6/2014
Acute Care Hospitals in Texas Did Not Always Reconcile Invoice Records With Credit Balances and Refund to the State Agency the Associated Medicaid Overpayments	A-06-11-00060	5/2014
Noninstitutional Providers in California Did Not Always Reconcile Invoice Records With Credit Balances and Refund to the State Agency the Associated Medicaid Overpayments	A-09-12-02047	7/2013
Nursing Facilities in Virginia Generally Reconciled Account Records With Credit Balances and Reported the Associated Medicaid Overpayments to the State Agency	A-03-11-00211	4/2013
Acute Care Hospitals in Georgia Did Not Always Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency	A-04-12-04021	2/2013
Nursing Facilities in Missouri Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency	A-07-11-03169	1/2013
Noninstitutional Providers in North Carolina Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency	A-04-11-04016	11/2012

APPENDIX B: PROVIDER TYPES REVIEWED

State	Provider Types
California	Physician
	Physician group
Georgia	Acute care hospitals
Ohio	Acute care hospitals
Missouri	Nursing facilities
New York	Ambulance
	Chiropractor
	Clinical psychologist
	Free-standing laboratory
	Medical appliances, equipment, and supply dealer
	Nurse practitioner
	Occupational therapist
	Optometrist
	Pharmacy medical supplies, equipment, and appliances
	Physical therapist
	Physician, physician and multispecialty group
	Podiatrist
North Carolina	Multispecialty physician and medical diagnostic clinic
	Multispecialty physician group
Texas	Acute care hospitals
Virginia	Nursing facilities

APPENDIX C: FEDERAL REQUIREMENTS

Social Security Act § 1128J(d)

> (1) IN GENERAL. If a person has received an overpayment, the person shall
>
> (A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
>
> (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
>
> (2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS. An overpayment must be reported and returned under paragraph (1) by the later of
>
> (A) the date which is 60 days after the date on which the overpayment was identified; or
>
> (B) the date any corresponding cost report is due, if applicable ….
>
> (4) DEFINITIONS. In this subsection: …
>
> (B) OVERPAYMENT. The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

Social Security Act § 1903(d)(2)

> (A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection ….
>
> (C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year 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.[11]

[11] Patient Protection and Affordable Care Act, § 6506, amended § 1903(d)(2)(C) of the Act on March 23, 2010, to permit States to have 1 year after discovery to attempt to recover an overpayment that did not result from fraud or abuse before refunding the Federal share. For any overpayment discovered prior to March 23, 2010, and not resulting from fraud or abuse, the State had 60 days to attempt to recover the overpayment before refunding the Federal share.

42 CFR § 433.304

Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

42 CFR § 433.312(a)

(1) Except as provided in paragraph (b) of this section, the State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

42 CFR § 433.316

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of—

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; ….

APPENDIX D: AUDIT SCOPE AND METHODOLOGY

SCOPE

We statistically sampled 8 providers from each of the 8 States for a total of 64 providers. These 64 providers had a total of 24,466 patient records with unresolved credit balances totaling $7,594,589, as of a quarter that ended between June 2011 and June 2012 (depending on the provider). We focused our reviews on 17,851 patient records, totaling $4,755,659, that were at least 60 days old.[12] Of the 17,851 patient records, our sample included 1,102 totaling $731,653.

We limited our internal control reviews to obtaining an understanding of the policies and procedures that the providers used to reconcile credit balances and report and return overpayments to the State agency. We accomplished our objective through substantive testing.

We conducted fieldwork at State agency and provider offices at various locations throughout California, Georgia, Missouri, New York, North Carolina, Ohio, Virginia, and Texas.

METHODOLOGY

To accomplish our objective, we:

- selected 8 States for review on the basis of the State's Medicaid credit balance reporting requirement, Medicaid reimbursement, and location;
- reviewed applicable Federal laws and regulations and State agency policy guidelines pertaining to Medicaid overpayments;
- interviewed the State agency personnel responsible for monitoring Medicaid overpayments;
- created a sampling frame for each State for the first stage of our sample design from which we randomly selected 8 providers (a total of 64 providers);
- reviewed the providers' policies and procedures for reviewing credit balances and reporting and returning overpayments to the State agencies;
- created a sampling frame for each of the 64 selected providers for the second stage of our sample design;

[12] In New York and North Carolina, the sampling frame was also restricted to unresolved credit balances greater than $3. In Ohio, the sampling frame was also restricted to unresolved credit balances greater than $1.

- selected a random sample of 30 patient records for providers with more than 30[13] patient records with credit balances or, if less than 30, reviewed all of the providers' patient records with credit balances;[14]

- reviewed provider charges, patient payment records, remittance advices, details of patient accounts receivable, and additional supporting documentation for each of the selected patient records to determine overpayments that should be reported and returned to the State agencies;

- estimated unrecovered overpayments associated with unresolved credit balances that should be reported and returned to the State agencies;

- determined whether the provider had taken action subsequent to our audit period to report and return to the State agencies the overpayments identified in our sample; and

- discussed the audit results with the State agencies and the 64 providers in our sample.

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.

[13] In California we selected a random sample of 50 patient records for providers that had more than 50 patient records with credit balances.

[14] In New York only 1 provider had more than 30 patient records with credit balances; therefore, we reviewed 100 percent of each provider's credit balances.

APPENDIX E: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of hospitals in Georgia, Ohio, and Texas; nursing facilities in Missouri and Virginia; and certain noninstitutional providers in California, New York, and North Carolina that received Medicaid reimbursement.

SAMPLING FRAME

For each State, we created a database of all payments made to the providers in the population from the State's Medicaid Management Information System. We eliminated some providers on the basis of factors unique to the individual States, such as the number of claims, amount of reimbursement, and whether the provider was previously audited. The resulting sampling frames totaled 5,924 providers.

SAMPLE UNIT

The primary sample unit was a provider. The secondary sample unit was a patient record with a Medicaid payment and in a credit balance status for at least 60 days.

SAMPLE DESIGN

We used a separate multistage sample for each State. The first stage consisted of a random selection of providers. For some States, we assigned sampling probabilities proportional to the total number of paid Medicaid claims; for other States, we used a simple random selection of providers. The second stage consisted of a simple random sample of patient records at each of the selected providers where the provider had more than 30 patient records with credit balances;[15] otherwise, we reviewed all of the providers' patient records with credit balances.

SAMPLE SIZE

We selected 8 providers in each State for a total of 64 primary units. For the secondary units, we selected a sample of patient records in a credit balance status for at least 60 days. The secondary units represented 1,102 patient records totaling $731,653.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

[15] In California we selected a random sample for providers that had more than 50 patient records with credit balances.

METHOD OF SELECTING SAMPLE ITEMS

The sample selection in some States used probability-proportional-to-size through which we considered the relative sizes of the providers when selecting the primary sampling units; for other States, we used a simple random selection. For the secondary units, we consecutively numbered the patient records with credit balances in the sampling frame for each of the providers. After generating the random numbers, we selected the corresponding frame items.

ESTIMATION

We used the OIG/OAS statistical software to estimate the amount of Medicaid overpayments for each of the 8 States included in our review. The resulting point estimates were summed to estimate the total overpayment in our frame.

APPENDIX F: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample and Frame Summary

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)
17,851	$4,755,659	1,102	$731,653	564	$263,582	$170,371

Table 5: Estimated Value of Overpayments

	Point Estimate
Overall overpayment	25,247,747[16]
Federal share of overpayment	17,003,763[17]

Note: These estimates apply to the sampling frame described in Appendix E and are not inclusive of all Medicaid claims across the eight selected States.

[16] We calculated the estimated additional recovery in the report ($24,984,165) by subtracting the actual overpayments identified in the sample ($263,582) from the total estimated value of the overpayments ($25,247,747).

[17] We calculated the estimated additional recovery (Federal share) in the report ($16,833,392) by subtracting the actual Federal share of the overpayments identified in the sample ($170,371) from the total estimated value of the Federal share of the overpayments ($17,003,763).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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JUL - 9 2015

To: Daniel R. Levinson
Inspector General
Office of the Inspector General

From: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Providers Did Not Always Reconcile Patient Records With Credit Balances and Report the Associated Medicaid Overpayments to State Agencies (A-04-14-04029)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report. CMS is committed to the integrity of the Medicaid program and takes its responsibility to taxpayers seriously throughout the management of the program.

Medicaid program integrity is a shared state/Federal responsibility, and states and the Federal Government share the goal that the Medicaid program be as secure as possible to ensure beneficiaries are protected, and that the right payments are being made. CMS is coordinating a variety of efforts with Federal and State partners to better share information to combat fraud and recover overpayments both in the Medicare and Medicaid programs. CMS has implemented a number of fraud, waste and abuse controls such as increased oversight of State Medicaid provider enrollment, enrollment moratoria for certain geographic areas facing a high risk of fraud, and using modernized, data driven approaches to verify financial and non-financial information needed to determine beneficiary eligibility. CMS also continues to implement the Medicare-Medicaid Integrity Plan by providing Medicare data to states for program integrity purposes, and facilitating development of state capacity and access to cost-effective analytics technology.

Section 6506 of the Affordable Care Act (ACA) requires that a State Medicaid agency refund the Federal share of any overpayment to CMS within one year from the date of discovery regardless of whether the State recovers the overpayment, except in cases of overpayments resulting from fraud. State Medicaid Director Letter #10-014 further explains that States must make the adjustment to return the Federal share of overpayments on their quarterly CMS-64. As a result, CMS actively works to recoup overpayments from State Medicaid agencies in a timely manner. States have the opportunity to return the Federal share of overpayments on their quarterly CMS-64 report. When it has been determined that a claim, or a portion of a claim, is not allowable and the State has not returned it on its quarterly CMS-64, CMS begins the disallowance process to recoup the funds.

The ACA also requires providers under the Medicare and Medicaid programs to report and return overpayments within a certain time period. CMS issued a Notice of Proposed Rulemaking (NPRM) at 77 FR 9179 on February 16, 2012, to implement this requirement for the Medicare program. CMS stated in the preamble to the rule that "[CMS] remind[s] all stakeholders that even without a final regulation they are subject to the statutory requirements found in section 1128J(d) of the Act and could face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from Federal health care programs for failure to report and return an overpayment." CMS is currently using the authority provided in the ACA to collect any identified overpayments from States.

OIG Recommendation

The OIG recommends that CMS issue Medicaid regulations required by the Affordable Care Act that parallel its proposed Medicare rules and require that States ensure that providers exercise reasonable diligence to identify, report, and return overpayments.

CMS Response

CMS concurs with this recommendation. CMS plans to finalize the NPRM applicable to the Medicare program before considering similar rulemaking relevant to Medicaid. However, CMS is currently using the authority provided in the ACA to collect any identified overpayments from States.