

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NORTH CAROLINA MEDICAID OVERPAID
HOSPITALS FOR SOME INPATIENT
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

May 2013
A-04-11-06137

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

North Carolina Medicaid overpaid hospitals \$576,408 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 North Carolina Division of Medical Assistance (State agency) overpaid Medicaid inpatient claims from hospitals that had 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 North 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 657 overpayments (\$3,045,413 Federal share) that we reviewed for the 3-year period January 1, 2007, through December 31, 2009, the hospitals had refunded 533 prior to our audit. However, the hospitals had not refunded the remaining 124. The hospitals had not refunded half of the 124 Medicaid overpayments because of system errors, but we cannot comment on why the hospitals had not refunded the remaining 62 overpayments because the State agency could not provide documentation. As a result, the State agency made Medicaid overpayments to hospitals totaling \$576,408 (\$401,751 Federal share).

WHAT WE RECOMMEND

We recommend that the State agency:

- recover \$576,408 in Medicaid overpayments,

- refund \$401,751 to the Federal Government,
- correct the system errors that caused the overpayments, and
- implement internal controls that ensure all refunds are properly processed and documented.

STATE AGENCY COMMENTS

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

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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 North Carolina Division of Medical Assistance (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 determined by the Federal medical assistance percentage, which varies based on a State’s relative per capita income. This percentage is commonly known as Federal financial participation or the Federal share.

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.

Division of Medical Assistance

In North Carolina, the State agency administers the Medicaid program. Within the State agency, the Program Integrity Unit is responsible for identifying Medicaid overpayments. As part of the unit, the Third-Party Recovery Section is primarily responsible for recovering Medicaid payments that other insurance plans should have paid.

The State agency utilizes Medicaid integrity contractors to perform certain functions in identifying third party payments. One contractor performs integrity audits to help identify Medicaid overpayments and conducts Medicare Recovery services on behalf of the State agency. Part of its process is to identify duplicate payments from the State agency's system.

HOW WE CONDUCTED THIS REVIEW

We reviewed 657 Medicaid overpayments for inpatient services that Medicare also paid, totaling \$4,449,630 (\$3,045,413 Federal share), submitted by 73 hospitals in North Carolina for the 3-year period January 1, 2007, through December 31, 2009. Our audit population did not include claims in which Medicaid paid only for the deductible, 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 657 overpayments that we reviewed for the 3-year period January 1, 2007, through December 31, 2009, the hospitals had refunded 533 prior to our audit. However, the hospitals had not refunded the remaining 124. The hospitals had not refunded half of the 124 Medicaid overpayments because of system errors, but we cannot comment on why the hospitals had not refunded the remaining 62 overpayments because the State agency could not provide documentation. As a result, the State agency made Medicaid overpayments to hospitals totaling \$576,408 (\$401,751 Federal share).

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

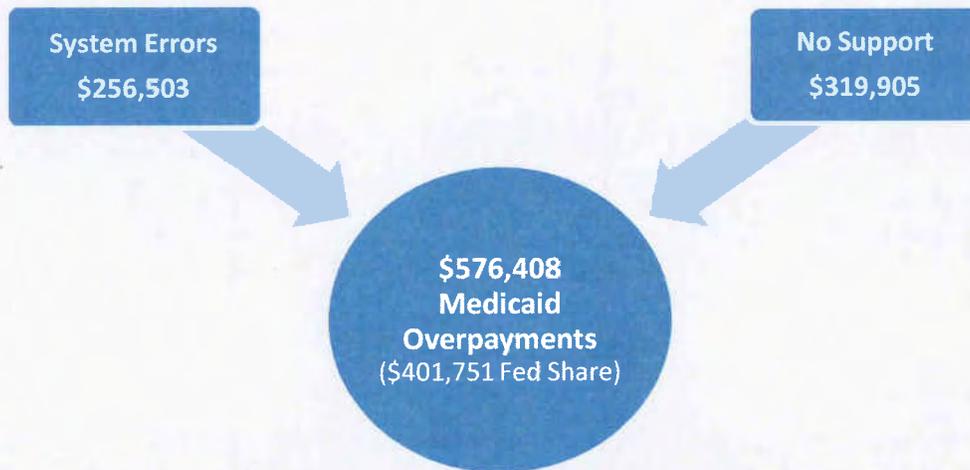
MEDICAID OVERPAYMENTS NOT RECOVERED

Section 1903(d)(2)(A) of the Act provides that the State should refund the Federal portion of any overpayment. 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 657 overpayments we reviewed, the hospitals had refunded 533 prior to the start of our audit. However, the hospitals had not refunded to CMS the remaining 124 Medicaid overpayments totaling \$576,408 (\$401,751 Federal share). Specifically:

- For 62 of the 124 overpayments, totaling \$256,503, the State agency excluded claims from additional edit cycles once the initial cycle flagged the claims for rate adjustments (EOB 9996). Thus the hospitals did not refund the overpayments because the State agency neither included these claims in the Medicare Adjustment Cycle nor reviewed them for reprocessing.
- For 62 of the 124 overpayments, totaling \$319,905, the State agency could not provide documentation to support any repayment efforts for these claims. Thus we could not determine why the hospitals had not refunded these overpayments.



WHY DID OVERPAYMENTS OCCUR?

The hospitals did not refund half of the Medicaid overpayments because of system errors. That is, the software used to check for edits, referred to as the “adjustment checker,” incorrectly excluded 62 claims from adjustment. As a result, the State agency never sent these claims to the Third Party Recovery Section¹ for review and did not adjust them in the State’s Medicaid Management Information System.

¹ For an explanation of the function of the Third Party Recovery Section, see Appendix B.

Regarding the remaining 62 Medicaid overpayments, the State agency was unable to provide documentation to support any repayment efforts. Therefore, we were unable to determine why the hospitals had not refunded these overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- recover \$576,408 in Medicaid overpayments,
- refund \$401,751 to the Federal Government,
- correct the system errors that caused the overpayments, and
- implement internal controls that ensure all refunds are properly processed and documented.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations and described corrective actions that it had taken or planned to take. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered a population of 657 Medicaid overpayments for inpatient services that Medicare also paid, totaling \$4,449,630 (\$3,045,413 Federal share), submitted by 73 hospitals in North Carolina for the period January 1, 2007, through December 31, 2009. Our audit population did not include claims in which Medicaid paid only for the deductible, 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 Raleigh, North Carolina, and at various hospitals throughout North Carolina.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements and the North Carolina State Medicaid plan,
- interviewed State agency officials to understand their policies and procedures for determining Medicare and Medicaid dual eligibility,
- 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 all of the matching 657 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 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.

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 § 433.304) define an overpayment as "... the amount paid by a Medicaid agency to a provider 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."

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 North Carolina Administrative Code (Administrative Code), 22 F .0601, states that the Medicaid agency will seek full restitution of any and all improper payments made to providers by the Medicaid program. The Administrative Code (22 G .0210) also states that for payment of Medicare Part A deductibles, the State agency must pay the Medicaid diagnosis-related group payment, less the amount paid by Medicare.

In addition, the State agency's *Hospital Provider Manual*, chapter 8, *Reimbursement and Billing*, states that Federal regulations require Medicaid to be the "payer of last resort." This means that all third parties, including Medicare, must pay before Medicaid may pay. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

Chapter 8 also states that the function of the Third Party Recovery Section is to ensure that Medicaid is the payer of last resort. If a recipient is identified as having Medicare coverage, the Third Party Recovery Section forwards a refund letter to the provider.

APPENDIX C: STATE AGENCY COMMENTS



North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

April 21, 2013

Lori S. Pilcher, Regional Inspector
General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3t41
Atlanta, GA 30303

Re: Report Number: A-04-11-06137

Dear Ms. Pilcher:

We have reviewed your draft report entitled *North Carolina Medicaid Overpaid Hospitals for Some Inpatient Services that Medicare Paid*. The following represents our response and corrective action plan to the Audit Findings and Recommendations.

Summary of Finding

The State agency overpaid some Medicaid inpatient claims from hospitals that had received Medicare payments for the same services. Of the 657 overpayments that we reviewed, the hospitals had refunded 533 prior to our audit. However, the hospitals had not refunded the remaining 124. The hospitals had not refunded half of the 124 Medicaid overpayments because of system errors, but we cannot comment on why the hospitals had not refunded the remaining 62 overpayments because the State agency could not provide documentation. As a result, the State agency made Medicaid overpayments to hospitals totaling \$576,408 (\$401,751 Federal share).

Recommendations

We recommend that the State agency:

- recover \$576,408 in Medicaid overpayments,
- refund \$401,751 to the Federal Government,
- correct the system errors that caused the overpayments, and
- implement internal controls that ensure all refunds are properly processed and documented.

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DHHS Response: The Department concurs with the finding and recommendations presented in this report, and will recover the \$576,408 in overpayments and refund the Federal share of \$401,751 within 60 days of the issuance of the final report. In addition, the Department will enhance efforts to recover additional overpayments and realize future savings by establishing procedures that will prevent operational errors that result in overpayments. In this regard, the Department will implement corrective actions to lessen the future risk of providers neglecting to properly refund Medicaid overpayments. Specifically, the Program Integrity Section of the Division of Medical Assistance (DMA) will take the following actions to address the three types of errors that allowed the overpayments to occur.

(1) As identified during the audit, one type of error resulted from the programming of the contractor's Adjustment Checker to identify claims that were previously adjusted in the Medicaid Management Information System. These claims were excluded from the Medicare Recovery Cycles to avoid double recoupment. A review of this system indicated that claims that had undergone a small adjustment, such as a rate adjustment, were taken out of the Cycles, and overpayments were not appropriately recovered. This issue was addressed with the contractor, which now thoroughly researches the outcome of the Adjustment Checker before claims are removed from the Cycle.

(2) The Medicare Enrollment Data Base (EDB) file that the contractor receives from Centers for Medicare and Medicaid Services includes Retroactive Medicare Eligibility. When the contractor matches dual eligibility with claims paid by Medicaid, it is often too late for Providers to submit the claims to Medicare. To prevent hardship to providers, the contractor excluded any claims that the providers could not file in a timely manner from its Medicare Recovery Cycles. As a result of the audit findings, the Department informed the contractor that in most of the cases the provider had already received payment from Medicare and Medicaid for the same claims. The Department is working with the contractor to establish a process whereby a revised letter will be sent to the provider for recovery of the overpayment amounts. Due to the duplicate payments made by Medicare and Medicaid, the Department and the contractor will increase utilization of the credit balance audit and credit balance self-reporting processes to determine when overpayments occur and will immediately take action to recover the funds.

(3) Based on a 2006 lawsuit brought against the Department by several hospitals, the contractor was instructed not to include these hospitals in the overpayment reviews pending the outcome of the lawsuit. The Department prevailed in the lawsuit in 2009 and the contractor was instructed to reestablish these providers as part of the Medicare Recovery Cycles. Unfortunately, the Department thought the claims not paid during the pendency of the lawsuit were beyond timely filing and did not instruct the contractor to go back to recover any overpayments. Had the Department been aware that these providers received payments from Medicare, recovery would have been pursued at that time. Since the OIG has now informed the Department that these providers received payments from Medicare and Medicaid, the necessary steps to recover these overpayments will be taken. In the future, the Department will track all claims submitted

Ms. Loris S. Pilcher
April 18, 2013
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by providers that are involved in any lawsuit and will immediately pursue recovery of all funds owed to the Department at the conclusion of the lawsuit.

The Department is committed to improving the Medicaid program and will continue its efforts to make the program more efficient and effective in meeting the needs of Medicaid recipients, providers and taxpayers. The Department will address all issues contained in this report and will continue to move forward with efforts to identify and correct problems.

We greatly appreciate the professionalism of the OIG audit staff and the analysis and recommendations provided in the draft report. If you need any additional information, please contact Mary Johnson at (919)855-3738.

Sincerely,



Aldona Wos, M.D.
Secretary

AW:mrj

cc: Sherry Bradsher, Deputy Secretary
Matthew McKillip, Senior Policy Advisor
Joseph Cooper, Jr., Chief Information Officer
Carol Steckel, Director, Division of Medical Assistance
Angeline Sligh, Director, Office of Medicaid Management Information System Services
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