



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

August 12, 2004

Report Number: A-04-04-02002

Mr. Alan Levine, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #1
Tallahassee, Florida 32308

Dear Mr. Levine:

Enclosed are two copies of the Office of Inspector General report entitled *Review of Medicaid Long-Term Nursing Care Payments for Individuals with both Medicare and Medicaid Coverage*.

Our objective was to determine whether the Agency for Health Care Administration (Agency) inappropriately made Medicaid payments for nursing facility care for dually eligible beneficiaries while the Centers for Medicare & Medicaid Services also made Medicare skilled nursing facility (SNF) payments.

We found that the Agency generally made proper Medicaid payments for dually eligible beneficiaries residing in a SNF. Out of a sample of 100 claims, we found only 4 claims totaling \$2,745 (Federal share \$1,554) that the Agency paid incorrectly. The Agency relies on the nursing facilities to provide appropriate Medicare SNF admission and discharge information on the claims submitted. The Agency recently implemented a procedure to match Medicare payment data to Medicaid nursing home payments to identify potential errors.

We recommend that the Agency refund \$1,554, which is the Federal share of the \$2,745 overpayments, and investigate these claims to determine why the payments were not adjusted.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act, (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act (see 45 CFR Part 5).

Page 2 – Mr. Alan Levine

If you have any questions or comments about this report, please contact Mr. Don Czyzewski, Audit Manager, at 305-536-5309, extension 10. To facilitate identification, please refer to report number A-04-04-02002 in all correspondence relating to this report.

Sincerely,



Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:
Rose Crum-Johnson, Regional Administrator
Centers for Medicare & Medicaid Services, Region IV
Sam Nunn Atlanta Federal Center
61 Forsyth Street SW, Room 4T20-DEMPI
Atlanta, GA 30303

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID LONG-TERM
NURSING CARE PAYMENTS FOR
INDIVIDUALS WITH BOTH MEDICARE
AND MEDICAID COVERAGE**

STATE OF FLORIDA



Inspector General

August 2004

Report No. A-04-04-02002

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

For Medicaid eligible individuals who are also eligible for Medicare coverage, a Medicaid payment should not be made for regular nursing facility care for individuals residing in a skilled nursing facility (SNF) within the 100-day limit covered by Medicare. After a 20-day stay, the Medicaid program covers the Medicare deductibles and coinsurance for SNF services provided to dually eligible beneficiaries. According to the Centers for Medicare & Medicaid Services (CMS) “SNF Manual,” section 249, the Medicaid cost sharing for SNF care applies during the 21st through the 100th day the individual is in the facility.

OBJECTIVE

The objective of the review was to determine whether the Agency for Health Care Administration (Agency) inappropriately made Medicaid payments for nursing facility care for dually eligible beneficiaries while CMS also made Medicare SNF payments.

SUMMARY OF FINDINGS

We found that the Agency generally made proper Medicaid payments for dually eligible beneficiaries residing in a SNF. Out of a sample of 100 claims, we found only 4 claims totaling \$2,745 (Federal share \$1,554) that the Agency paid incorrectly. These errors included payments for:

- regular nursing facility care for beneficiaries residing in a SNF that were made while Medicare SNF payments were also made for the same beneficiaries (three errors totaling \$1,848)
- Medicare coinsurance for SNF care that were made before the qualifying 20-day period at the facility ended (one error totaling \$897)

The Agency relies on the nursing facilities to provide appropriate Medicare SNF admission and discharge information on the claims submitted. The Agency recently implemented a procedure to match Medicare payment data to Medicaid nursing home payments to identify potential errors.

RECOMMENDATIONS

We recommend that the Agency:

- refund \$1,554, which is the Federal share of the \$2,745 overpayments
- investigate these claims to determine why the payments were not adjusted

AGENCY'S COMMENTS

In written comments to our draft report, the Agency concurred with our recommendations. The Agency is taking steps to recoup the overpayments and is conducting a project to compel providers to bill Medicare following a qualifying hospital stay. The complete text of the Agency's comments is included as an appendix.

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INTRODUCTION

BACKGROUND

For Medicaid eligible individuals who are also eligible for Medicare coverage, a Medicaid payment should not be made for regular nursing facility care for individuals residing in a SNF within the 100-day limit covered by Medicare. After a 20-day stay, the Medicaid program covers the Medicare deductibles and coinsurance for SNF services provided to dually eligible beneficiaries. According to CMS "SNF Manual," section 249, the Medicaid cost sharing for SNF care applies during the 21st through the 100th day the individual is in the facility. The daily coinsurance amount for SNF care is equal to 1/8 of the inpatient hospital deductible, or for 2001, \$99 a day.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the review was to determine whether the Agency inappropriately made Medicaid payments for nursing facility care for dually eligible beneficiaries while CMS also made Medicare SNF payments.

Scope

Our audit of Florida Medicaid SNF payments covered dates of service for the period of January 1 through August 31, 2001. Fieldwork was performed at the Agency offices in Tallahassee, FL. The fieldwork was conducted from January to April 2004.

Methodology

To accomplish our objective, we electronically matched Medicaid long-term care payments with Medicare SNF care payments for dually eligible beneficiaries with the same dates of service for our audit period. We included only net Florida Medicaid payments greater than \$100 for one or more days of long-term nursing facility care on behalf of an individual for whom Medicare made payments for SNF care covering the same day or days. We identified 35,342 Medicaid payments that fell into this category totaling \$63,799,464. From these payments, we selected a random sample of 100 Medicaid paid claims totaling \$177,256.

We reviewed the Agency's current policies and procedures and interviewed staff to gain an understanding of the Agency's management of its claim processing for nursing care services.

For the sampled 100 Medicaid payments, we reviewed:

- Medicare Common Working File documentation to determine what dates Medicare paid for inpatient and SNF services and the Medicare coinsurance amounts for which the Medicaid program would be liable
- Medicaid supporting documentation to determine the purpose of the payment and whether these payments overlapped Medicare SNF services
- the Agency’s printout of payments and adjustments for the month of each sample item

We did not review the overall internal control structure of the Agency or of the Medicaid program. We did not test the Agency’s internal controls because the objective of our review was limited to a specific type of claim and was accomplished through substantive testing. Our audit was conducted in accordance with generally accepted government auditing standards.

The Agency’s comments to our draft report are appended to this report in their entirety and summarized under “Findings and Recommendations.”

FINDINGS AND RECOMMENDATIONS

We found that the Agency generally made proper Medicaid payments for dually eligible beneficiaries residing in a SNF. Out of a sample of 100 claims, we found only 4 claims totaling \$2,745 (Federal share \$1,554) that the Agency paid incorrectly. These errors included payments for:

- regular nursing facility care for beneficiaries that were made while Medicare SNF payments were also made for the same beneficiaries (three errors totaling \$1,848)
- Medicare coinsurance for SNF care that were made before the qualifying 20-day period at the facility ended (one error totaling \$897)

Of the four payment errors we identified, the errors specifically involved Medicaid paying for:

- a month of long term nursing facility care while Medicare paid for 12 days of SNF care resulting in a Medicaid overpayment of \$1,258
- a month of long term nursing facility care while Medicare paid for a month of SNF care (less the coinsurance) resulting in a Medicaid overpayment of \$383 for 31 days of excessive reimbursement

- long term nursing facility care that had 2 overlapping days of Medicare SNF care resulting in a Medicaid overpayment of \$207
- 21 days of coinsurance while Medicare made a full payment for 11 days and paid 11 days less the daily coinsurance resulting in Medicaid overpayment of \$897 for 10 days

The Agency relies on the nursing facilities to provide appropriate Medicare SNF admission and discharge information on the claims submitted. The Agency recently implemented a procedure to match Medicare payment data to Medicaid nursing home payments to identify potential errors.

RECOMMENDATIONS

We recommend that the Agency:

- refund \$1,554, which is the Federal share of the \$2,745 overpayments
- investigate these claims to determine why the payments were not adjusted

AGENCY'S COMMENTS

The Agency responded that the Third Party Liability contractor, Health Management Systems, would attempt to recoup the payments. The recouped payments will be reported on the CMS-64 for the quarter collected.

Regarding the second recommendation, the Agency stated there was no systematic method to prevent or automatically recoup these types of overpayments. However, the Agency is undertaking a project that will compel SNF providers to bill Medicare for up to 100 days for skilled nursing services following a qualifying hospital stay for patients eligible for Medicare.

The Agency also commented that they had contacted CMS in order to express their concern on the inability for the Florida Medicaid Management Information System to match with the Medicare system on a real time basis.

OFFICE OF THE INSPECTOR GENERAL'S RESPONSE

We agree that recouped over payments listed on the CMS-64 would refund the Federal share of the overpayments.

We encourage the Agency to continue with its efforts to identify claims that could potentially be improperly billed, and its efforts to obtain the most current and accurate patient information from CMS.

APPENDIX



JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

June 25, 2004

Mr. Charles J. Curtis
Office of the Inspector General
Office of Audit Services – Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303-8909

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Office of Audit

RE: Report Number A-04-04-02002

Dear Mr. Curtis:

Thank you for the opportunity to respond to the U.S. Department of Health and Human Services Office of the Inspector General, draft report number A-04-04-02002 *Review of Medicaid Long-Term Nursing Care Payments for Individuals with Both Medicare and Medicaid Coverage – State of Florida*, dated May 27, 2004. The Agency's response to each of the report's recommendations follows:

Recommendation 1:

We recommend that the Agency refund to the Centers for Medicare and Medicaid Services (CMS) \$1,554, which is the Federal share of \$2,745 identified as overpayments.

Agency Response to Recommendation 1:

The Third Party Liability (TPL) contractor, Health Management Systems, Inc. (HMS), will attempt to recoup the overpayments. Payments recouped will be reported on the CMS-64 for the quarter collected.

Recommendation 2:

We recommend that the Agency investigate the four claims identified below to determine why the payments were not adjusted:

- Medicaid paid a month of long-term nursing facility care while Medicare paid for 12 days of Skilled Nursing Facility (SNF) care resulting in a Medicaid overpayment of \$1,258.
- Medicaid paid for a month of long-term nursing facility care while Medicare paid for a month of SNF care (less the coinsurance) resulting in a Medicaid overpayment of \$383 for 31 days of excessive reimbursement.
- Medicaid paid for long-term nursing facility care that had two overlapping days of Medicare SNF care resulting in a Medicaid overpayment of \$207.



Mr. Charles J. Curtis
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- Medicaid paid for 10 days of coinsurance (\$897) which should not have been paid. Medicare was billed for 22 days of SNF care, and made a full payment for 11 days and paid 11 days less the daily coinsurance. Medicaid paid for 21 days of coinsurance when it should have paid only 11 days.

Agency Response to Recommendation 2:

As there is no systematic method to prevent or automatically recoup these types of overpayments, HMS will attempt to recoup the overpayments. Payments recouped will be reported on the CMS-64 for the quarter collected.

HMS is in the process of conducting a project for the Agency in relation to SNFs for 2002 and 2003 dates of service. This project will be expanded further to include 2001 dates of service.

The project description is described below:

This project seeks to compel SNF providers to bill Medicare for up to 100 days of skilled nursing service following a qualifying hospitalization stay.

HMS selects claims for this project if:

1. Patient had a 3+ day qualifying hospital stay;
2. Level of care indicator on the long-term care claim was "skilled care";
3. Medicaid was billed for a hospital deductible during the qualifying hospital stay, which indicates to Medicaid that a new benefit period has started.

Data is provided to HMS through the Medicaid fiscal agent, Affiliated Computer Services, in a tape format. The data is sent to HMS on a monthly basis. The data files used for this project are the Medicaid beneficiary eligibility file, the Medicaid provider file and the Medicaid paid claims file.

The Agency contacted CMS in order to express their concern on the inability for the Florida Medicaid Management Information System (MMIS) to match with the Medicare system on a real time basis. We have not received complete support in our efforts to create an interactive communication and reconciliation between Florida MMIS and Medicare. If we are able to achieve this support, we will be better able to match data on a real-time basis, thereby assisting in the prevention of incorrect Medicaid payments.

If you have any questions regarding this response, please contact Jim Boyd, Inspector General, at (850) 921-4897 or Michael Bennett, Audit Director, at (850) 414-5419.

Sincerely,



Alan Levine
Secretary

AL/mb