Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

September 28, 2006

Report Number: A-01-06-00002

Mr. Joshua Slen, Director
Office of Vermont Health Access
State of Vermont
103 South Main Street
Waterbury, Vermont 05671-1201

Dear Mr. Slen:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Vermont's Accounts Receivable System for Medicaid Provider Overpayments." A copy of this report will be forwarded to the action official named on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the 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), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to Report Number A-01-06-00002 in all correspondence.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Review of Vermont's Accounts Receivable System For Medicaid Provider Overpayments

Daniel R. Levinson
Inspector General

September 2006
A-01-06-00002

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

The Medicaid program is a jointly funded Federal and State entitlement program that provides medical assistance for qualified people with low incomes and limited resources. The Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program at the Federal level. In Vermont, the Agency of Human Services, Office of Vermont Health Access (the State agency) administers the Medicaid program at the State level.

CMS matches the State's Medicaid spending through Federal financial participation. However, the Federal Government does not participate financially in Medicaid payments resulting from excessive or erroneous expenditures. States are generally required to return the Federal share of overpayments within 60 days of the date of discovery, whether or not the recovery was made.

OBJECTIVE

The objective of the audit was to determine if the State agency reported overpayments to Medicaid providers as credits to the Medicaid program in accordance with Federal requirements.

SUMMARY OF FINDINGS

During the period January 1, 2004, through June 30, 2005, the State agency did not report all overpayments in accordance with Federal requirements. Specifically:

- The State agency's Medicaid Fraud and Residential Abuse Unit and Surveillance and Utilization Review Unit identified overpayments to providers totaling $172,441 ($100,861 Federal share) that the State agency had not credited to the Medicaid program.

- The State agency did not credit the Medicaid program for overpayments totaling $171,484 ($100,522 Federal share) that were discovered through the cost report settlement process.

The State agency did not have adequate procedures in place to account for overpayments to providers. As a result, the State agency did not report overpayments totaling $343,925 ($201,383 Federal share) as credits to the Medicaid program on the quarterly CMS-64 reports of medical assistance payments.

RECOMMENDATIONS

We recommend that the State agency:

- report a credit of $201,383, the Federal share of provider overpayments that it owes the Medicaid program, on its next CMS-64 quarterly report of medical assistance payments;

- establish formal policies and procedures for processing all provider overpayments that the State agency recovery units and the intermediary identify, including the establishment of an accounts receivable and a system to periodically track the status of outstanding overpayments; and

- ensure that all overpayments to providers are reported as credits to the Medicaid program within 60 days of discovery, as Federal regulations require.

STATE AGENCY'S COMMENTS

In its September 19, 2006, written comments on our draft report, the State agency agreed with our finding that it had not credited the $172,441 ($100,861 Federal share) in overpayments that its Medicaid recovery units identified. The State agency said that it would make this adjustment.

In response to our finding regarding cost settlements, the State agency disagreed with the amount of cost settlements that we reported as uncollected as of May 2006. However, it stated that it had credited $34,199 ($20,223 Federal share) of these cost settlements as of June 30, 2006, and will credit the remaining $137,285 ($80,299) on the CMS-64 for the quarter ending September 30, 2006.

The State agency agreed with our procedural recommendations.

The State agency's comments are included in their entirety in the appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

As we noted in our report, the State agency did not provide us with any documentation to indicate that it had received any of the cost settlement checks for overpayments that we reported as uncollected. In further discussions with State agency officials after we received their written response, we learned that the State agency had indeed received four checks after we completed our on site fieldwork in May 2006 but had not informed us of these collections. Regardless of whether the State agency has collected the cost settlement checks, Federal regulations require the State agency to refund the Federal share of overpayments within 60 days after they have been identified.

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INTRODUCTION

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Medicaid Program

The Medicaid program, established by Title XIX of the Social Security Act (the Act), is a jointly funded Federal and State entitlement program that provides medical assistance for qualified people with low incomes and limited resources. The Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program at the Federal level. In Vermont, the Agency of Human Services, Office of Vermont Health Access (the State agency) administers the Medicaid program at the State level. If the State plan meets specific Federal requirements, CMS matches the State's Medicaid spending through Federal financial participation. However, the Federal Government does not participate financially in Medicaid payments resulting from excessive or erroneous expenditures.

Medicaid Overpayments

A Medicaid payment to a provider in excess of the allowable amount is considered a Medicaid overpayment. Section 1903(d)(2) of the Act, as amended by section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985, is the principal authority that CMS cites for requiring States to refund the Federal share of overpayments to providers. Section 1903(d)(2)(A) states:

> 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.

States are required to return the Federal share of overpayments within 60 days of the date of discovery, whether or not the recovery was made. This legislation is codified in 42 CFR § 433, subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers," which requires States to credit the Federal share of overpayments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64, for the quarter in which the 60-day period following discovery ends.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to determine if the State agency reported overpayments to Medicaid providers as credits to the Medicaid program in accordance with Federal requirements.

Scope

We examined the $4,749,645 ($2,858,080 Federal share) in provider overpayments subject to the requirements of 42 CFR § part 433, subpart F, that the State agency reported on the CMS-64 forms for the period January 1, 2004, through June 30, 2005. We did not review the overall internal control structure of the State agency's operations or its financial management. However, we gained an understanding of its controls related to determining overpayments to Medicaid providers and collecting the corresponding accounts receivables.

We performed fieldwork at the State agency in Williston, Vermont, and at the Vermont Medicaid Fraud and Residential Abuse Unit in Waterbury, Vermont, from February through May 2006.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal criteria and State agency policies and procedures for identifying and processing overpayments to providers;

- interviewed State agency officials responsible for identifying and monitoring collections of overpayments, as well as staff responsible for reporting the Federal share of overpayments;

- reviewed overpayment case files to determine dates of discovery and the status of the overpayments;

- analyzed the overpayments to determine if the State agency reported them accurately and in accordance with Federal regulations; and

- compared overpayments reported on the CMS-64 reports with the State agency's supporting documentation.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

During the period January 1, 2004, through June 30, 2005, the State agency did not report all overpayments in accordance with Federal requirements. Specifically:

- The State agency's Medicaid Fraud and Residential Abuse Unit and Surveillance and Utilization Review Unit identified overpayments to providers totaling $172,441 ($100,861 Federal share) that the State agency had not credited to the Medicaid program.

- The State agency did not credit the Medicaid program for overpayments totaling $171,484 ($100,522 Federal share) that were discovered through the cost report settlement process.

The State agency did not have adequate procedures in place to account for overpayments to providers. As a result, the State agency did not report overpayments totaling $343,925 ($201,383 Federal share) as credits to the Medicaid program on the quarterly CMS-64 reports of medical assistance payments.

FEDERAL REQUIREMENTS

Pursuant to 42 CFR § 433.312, the State must refund the Federal share of overpayments within 60 days following discovery, whether or not the State has recovered the overpayment from the provider. Federal regulations (42 CFR § 433.316) define the discovery date as the earliest date on which:

- the State first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery,

- the provider initially acknowledges a specific overpayment in writing to the Medicaid agency, or

- the State initiates a formal action to recoup a specific overpayment from a provider without having first notified the provider in writing.

42 CFR § 433.316(d) states that "An overpayment that results from fraud and abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider." Further, 42 CFR § 433.316(h) states that any appeal rights extended to a provider do not extend the date of discovery.

42 CFR § 433.310(c)(2) states that "Unallowable costs for a prior period paid to an institutional provider under a rate-setting system that the State seeks to recover in a lump sum…constitute overpayments that are subject to the requirements of [subpart F § 433]…"

UNREPORTED OVERPAYMENTS

During the period January 1, 2004, through June 30, 2005, the State agency's Medicaid Fraud and Residential Abuse Unit and Surveillance and Utilization Review Unit identified overpayments to providers totaling $253,308. As of March 31, 2006, the State agency had reimbursed Medicaid for $80,867 ($49,282 Federal share) of these overpayments. However, it had not credited the Medicaid program for the remaining overpayments totaling $172,441 ($100,861 Federal share).

The State agency did not adhere to the 60-day requirement for reporting overpayments. Instead, the State agency reported overpayments only after it had recovered them from providers. Moreover, in some instances the State agency failed to report overpayments that it had already recovered.

UNREPORTED COST SETTLEMENT REFUNDS

The State agency contracts with its Medicare intermediary, Anthem Health Plans of New Hampshire (the intermediary), to audit and finalize the Medicaid cost reports for hospitals and clinics. The results of these audits are used for determining allowable Medicaid reimbursements for each fiscal year. Once the intermediary has determined the final Medicaid settlement amount, the intermediary sends a letter to each provider that received a Medicaid overpayment or underpayment during the year. The letter instructs providers that received an overpayment to refund the overpaid amount to the State agency.

The State agency provided evidence that the intermediary had sent letters to 25 providers requesting refunds for overpayments made during our audit period. Of these 25, 20 submitted refunds to the State agency, which in turn credited the Federal share of these overpayments to Medicaid. The intermediary indicated that the remaining five providers received Medicaid overpayments totaling $171,484 ($100,522 Federal share). However, the State agency did not have any record of ever receiving checks from four of these providers. Although the State agency had received a check from the remaining provider, it returned the check to the provider because of a misunderstanding as to the check's purpose.

The State agency did not report the overpayments to these five providers as credits to the Medicaid program within 60 days of sending notification letters to the providers, as Federal regulations require.

FEDERAL SHARE OF OVERPAYMENTS

As a result of the unreported overpayments and cost settlement refunds, the State agency owes the Medicaid program a total of $201,383, the Federal share of the $343,925 in overpayments that it did not report.

INADEQUATE POLICIES AND PROCEDURES

These errors occurred because the State agency did not have adequate written policies and procedures for processing overpayments to Medicaid providers to ensure that the Federal share of overpayments was reported as required. Specifically, the State agency did not report overpayments within 60 days after discovery, as Federal regulations require. Instead, the State agency reported overpayments as it collected them from the provider. The collection of overpayments often occurred after the 60-day discovery period had ended, if at all.

In addition, the State agency did not have a formal system for tracking and processing Medicaid overpayments. The State agency did not set up an accounts receivable for each provider with an identified overpayment. As a result, the status of overpayments due the State agency was not readily available, and the State agency did not conduct periodic follow ups to recover the outstanding overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- report a credit of $201,383, the Federal share of provider overpayments that it owes the Medicaid program, on its next CMS-64 quarterly report of medical assistance payments;

- establish formal policies and procedures for processing all provider overpayments that the State agency recovery units and intermediary identify, including the establishment of an accounts receivable and a system to periodically track the status of outstanding overpayments; and

- ensure that all overpayments to providers are reported as credits to the Medicaid program within 60 days of discovery, as Federal regulations require.

STATE AGENCY'S COMMENTS

In its September 19, 2006, written comments on our draft report, the State agency agreed with our finding that it had not credited the $172,441 ($100,861 Federal share) in overpayments that its Medicaid recovery units identified. The State agency said that it would make this adjustment.

In response to our finding regarding cost settlements, the State agency disagreed with the amount of cost settlements that we reported as uncollected as of May 2006. However, it stated that it had credited $34,199 ($20,223 Federal share) of these cost settlements as of June 30, 2006, and will credit the remaining $137,285 ($80,299) on the CMS-64 for the quarter ending September 30, 2006.

The State agency agreed with our procedural recommendations.

The State agency's comments are included in their entirety in the appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

As we noted in our report, the State agency did not provide us with any documentation to indicate that it had received any of the cost settlement checks for overpayments that we reported as uncollected. In further discussions with State agency officials after we received their written response, we learned that the State agency had indeed received four checks after we completed our on site fieldwork in May 2006 but had not informed us of these collections. Regardless of whether the State agency has collected the cost settlement checks, Federal regulations require the State agency to refund the Federal share of overpayments within 60 days after they have been identified.

APPENDIX

State of Vermont
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2806
www.ovha.state.vt.us

[Phone] 802-879-5900

Agency of Human Services

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services
Region I
Office of Inspector General
Department of Health and Human Services
John F. Kennedy Federal Building
Boston, MA 02203

September 19, 2006

RE: A-01-06-00002

Dear Mr. Armstrong:

The State of Vermont has received and reviewed the draft report entitled "Review of Vermont's Accounts Receivable System for Medicaid Provider Overpayments – January 2004 through June 2005."

The Office of Vermont Health Access (OVHA) disagrees with the first finding. Of the cost settlements stated in this report as not having been received, all but one has been collected. A total of $157, 019 has been collected leaving $14,465 as uncollected. Of the $157,019 that has been collected $34,199 ($20,223 Federal share) has already been credited, and $122,820 ($71,838 Federal share) will be credited on the report for the quarter ending September 30, 2006. Vermont will also report a credit of $14,465 ($8,461 Federal share) for the uncollected balance. Of the overpayments established by the Medicaid Fraud and Residential Abuse Unit we agree that $172,441 ($100,861 Federal Share) has not been credited. Vermont shall make this adjustment.

In response to the second recommendation, a joint EDS and OVHA team was created in May 2006, to evaluate and remedy issues in the accounts receivable processes that flow through both organizations. The joint team is reviewing and modeling the current process flows to identify issues and opportunities for improvement within each flow. The assessment is expected to be completed by September 30, 2006.

In response to the third recommendation, OVHA will ensure that all overpayments to providers for programs outside of the Global Commitment to Health or for payments made prior to October 1, 2005 (the start date of the Global Commitment waiver) will be reported as credits to the program within 60 days of discovery. For programs within the Global Commitment waiver no such credit will be made as recoveries are part of the Managed Care Organization's capitation rate calculation.

Sincerely,

Joshua Slen, Director

VERMONT