DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

SEP 1 3 2005

Report Number: A-10-04-00003

Mr. Stan Marshburn
Chief Financial Officer
Financial Services Administration
Department of Social and Health Services
P.O. Box 45843
Olympia, Washington 98504-5842

Dear Mr. Marshburn:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Audit of Washington's Accounts Receivable System for Medicaid Provider Overpayments." A copy of this report will be forwarded to the HHS action official noted below 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 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.

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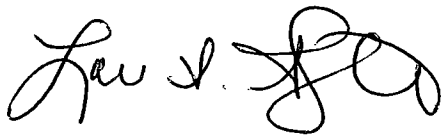
Please refer to report number A-10-04-00003 in all correspondence.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

R. J. Ruff, Jr.
Regional Administrator, Region X
Centers for Medicare & Medicaid Services
2201 Sixth Avenue, M/S-40
Seattle, Washington 98121

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

AUDIT OF WASHINGTON'S ACCOUNTS RECEIVABLE SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS

Daniel R. Levinson
Inspector General

SEPTEMBER 2005
A-10-04-00003

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

This review was part of a multistate audit focusing on States' accounts receivable systems for overpayments to Medicaid providers. An overpayment is a payment to a provider in excess of the allowable amount.

The principal authority for disallowing the Federal share of overpayments to providers is section 1903(d)(2) of the Social Security Act (the Act), as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985. Regulations addressing overpayments and credit adjustments are found at 42 CFR sections 433.312, 433.316, and 433.318.

The Act states that CMS will adjust reimbursements to a State for any overpayment or underpayment and requires the State to report overpayment adjustments within 60 days of the date of discovery, whether or not the State has recovered the overpayment from the provider. The State must credit the Federal share of those overpayments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), for the quarter in which the 60-day period ends. The Act also states that the State need not adjust the Federal payment if it is unable to recover an overpayment because the provider filed for bankruptcy or went out of business.

For the audit period October 1, 2001, through December 31, 2002, Washington (the State) reported a total of about $14.1 million in overpayments and made adjustments reclaiming about $41.2 million that it had previously classified as overpayments.

OBJECTIVE

Our objective was to determine whether the State reported Medicaid provider overpayments pursuant to Federal requirements.

SUMMARY OF FINDINGS

During our audit period, the State did not report some Medicaid provider overpayments pursuant to Federal requirements. Specifically, the State:

- did not report some overpayments[1] because of a reporting policy change and errors in the accounts receivable system and

- reported unallowable credit adjustments totaling $446,737 ($225,013 Federal share).

[1]For the period October 1, 2001, through December 31, 2002, the State did not report $6,767,939 ($3,393,661 Federal share) in Medicaid provider overpayments. In addition, the State did not report $2,381,696 ($1,197,863 Federal share) in provider overpayments for the periods April 1 through September 30, 2001, and January 1, 2003, through June 30, 2004. As a result of our audit, the State refunded $2,474,322 on its March 2004 CMS-64. In addition, after our draft report was issued, the State settled the other identified overpayments and reported them on the CMS-64. Therefore, we do not have a recommended financial adjustment.

In addition, the State did not report interest penalties collected from providers totaling $341,548 ($171,928 Federal share). This amount consisted of $256,555 ($129,029 Federal share) for our audit period and $84,993 ($42,899 Federal share) for the periods July 1 through September 30, 2001, and January 1, 2003, through March 31, 2004.

In total, the State claimed excess Federal reimbursements of $396,941. The unreported overpayments, unallowable credit adjustments, and unreported interest collections potentially resulted in approximately $84,700 in higher interest expense to the Federal Government.

The State did not report non-abuse-related overpayments 60 days following the dates of discovery (draft report dates) because its new policy was to wait for the final reports to be issued. The unallowable credit adjustments and unreported interest penalty collections resulted from the State's lack of adequate policies and procedures.

RECOMMENDATIONS

We recommend that the State:

- refund $396,941 to the Federal Government for unallowable credit adjustments and unreported interest penalty collections;
- report overpayments on the CMS-64 on the basis of draft reports unless there is evidence of abuse;
- determine whether there were any unreported overpayments, unallowable credit adjustments, or unreported interest penalty collections subsequent to our audit period or extended audit period and refund such amounts;
- ensure that all future overpayments, credit adjustments, and interest penalty collections are reported in accordance with Federal requirements, thereby mitigating the potentially higher interest expense to the Federal Government;
- establish an accounts receivable system that properly records, ages, and reports provider overpayments on the CMS-64; and
- establish and implement adequate written policies and procedures for processing and reporting overpayments, credit adjustments, and interest penalty collections.

STATE'S COMMENTS

In its written comments on the draft report, the State partially agreed that it did not report certain Medicaid provider overpayments pursuant to Federal requirements. It agreed it did not report Medicaid overpayments because of a programming error and refunded $2,474,322 on its March 2004 CMS-64. However, the State disagreed that it should report Medicaid overpayments based on the draft report date. The State asserted that all overpayments it discovered were abuse-related and therefore, the discovery date was the date of the final report.

Further, the State agreed that it reported unallowable credit adjustments totaling $42,858 (Federal share) but disagreed that its $182,155 settlement adjustment was improper. Finally, the State agreed that it did not report $171,928 in interest penalty collections.

The State did not comment on our procedural recommendations (recommendations 2 through 6) other than stating that it has revised its policies and procedures for the unallowable credit adjustments totaling $42,858.

The State's comments are included in their entirety as an appendix to this report.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We evaluated the State's comments on our draft report, obtained additional information, and revised the final report accordingly. We disagree with the State's position that all its overpayments were abuse-related and that the discovery date was the date of the final report. For non-abuse-related overpayments, the discovery date is the draft report date. In addition, we disagree that the settlement adjustment for $182,155 was proper because it did not meet the Federal requirements for reclaiming Federal funds. We continue to recommend that the State refund $182,155 to the Federal Government for the improper settlement adjustment.

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INTRODUCTION

BACKGROUND

This review was part of a multistate audit focusing on States' accounts receivable systems for overpayments to Medicaid providers. An overpayment is a payment to a provider in excess of the allowable amount.

Medicaid Program

Enacted in 1965, Medicaid is a combined Federal-State entitlement program that provides health care and long term care for certain individuals and families with low incomes and resources. Within a broad legal framework, each State designs and administers its own Medicaid program, including how much to pay for each service. Each State operates under a plan approved by CMS for compliance with Federal laws and regulations. The Federal Government established a financing formula to calculate the Federal share of the medical assistance expenditures under each State's Medicaid program.

In Washington, the Department of Social and Health Services administers the Medicaid program.

Medicaid Overpayments

The principal authority for disallowing the Federal share of overpayments to providers is section 1903(d)(2) of the Social Security Act (the Act), as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985. Regulations addressing overpayments and credit adjustments are found at 42 CFR sections 433.312, 433.316, and 433.318.

The Act states that CMS will adjust reimbursements to a State for any overpayment or underpayment and requires the State to report overpayment adjustments within 60 days of the date of discovery, whether or not the State has recovered the overpayment from the provider. The State must credit the Federal share of those overpayments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64) for the quarter in which the 60-day period ends. The Act also states that the State need not adjust the Federal payment if it is unable to recover an overpayment because the provider filed for bankruptcy or went out of business.

Washington (the State) discovered overpayments through provider reviews. Once the State discovered the overpayments, it generated draft reports notifying providers. In August 2002, the State changed its policy of reporting provider overpayments to CMS on the CMS-64. The policy change redefined all overpayments to be related to fraud and abuse. Instead of reporting routine overpayments 60 days after issuing its draft reports, as it had previously done and pursuant to Federal requirements, the State delayed reporting routine overpayments until 60 days after issuing the final reports.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State reported Medicaid provider overpayments pursuant to Federal requirements.

Scope

We examined selected overpayments to Medicaid providers, offsetting credit adjustments, and interest penalty collections during the period October 1, 2001, through December 31, 2002. Although we focused on this period, it came to our attention that the State did not report some overpayments for the periods April 1 through September 30, 2001, and January 1, 2003, through June 30, 2004. In addition, the State did not report interest penalties collected for the periods July 1 through September 30, 2001, and January 1, 2003, through March 31, 2004. Therefore, we performed a limited review of these additional overpayments and interest penalty collections.

We did not review the overall internal control structure of the State's operations or its financial management. However, we gained an understanding of its controls related to determining Medicaid overpayments and collecting the corresponding accounts receivable.

The State finalized its draft reports covered by our audit period after we completed our fieldwork. We did not review or comment on the accuracy of the overpayment amounts reported on the CMS-64s.

We conducted our fieldwork at the State's offices in Lacey and Olympia, WA.

Methodology

To accomplish our objective, we:

- reviewed section 1903 of the Act, Federal regulations at 42 CFR § 433, and applicable sections of the CMS State Medicaid Manual;

- reviewed State regulations, policies, and procedures pertaining to provider overpayments and credit adjustments;

- gained an understanding of the State's processes for recording, aging, and reporting provider overpayments;

- interviewed State agency personnel and reviewed the records of the Financial Services Administration, Medical Assistance Administration, and Aging and Disability Services Administration;

- analyzed the quarterly CMS-64s and identified overpayments and credit adjustments totaling about $14.1 million and $41.2 million, respectively;

- judgmentally selected 20 overpayments, 15 greater than $100,000 and 5 less than $100,000, totaling about $8.7 million (about 66 percent of the total);

- judgmentally selected 20 credit adjustments, 16 greater than $100,000 and 4 less than $100,000, totaling about $36.5 million (about 89 percent of the total);

- reviewed the supporting documentation for the overpayments and credit adjustments and determined whether they were reported in accordance with applicable Medicaid regulations;

- determined whether there were any additional overpayments that should have been reported on the CMS-64s for the audit period;

- determined whether the State reported interest penalty collections on the CMS-64s for the audit period;

- performed a review of other overpayments and interest penalty collections identified by the State within the extended audit period; and

- calculated the potentially higher interest expense to the Federal Government for those overpayments, credit adjustments, and interest penalty collections that were not reported within the required time frame.[2]

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

FINDINGS AND RECOMMENDATIONS

During our audit period, the State did not report some Medicaid provider overpayments pursuant to Federal requirements. Specifically, the State:

- did not report some overpayments because of a reporting policy change and errors in the accounts receivable system and

- reported unallowable credit adjustments totaling $446,737 ($225,013 Federal share).

In addition, the State did not report interest penalties collected from providers totaling $341,548 ($171,928 Federal share). This amount consisted of $256,555 ($129,029 Federal share) for our audit period and $84,993 ($42,899 Federal share) for the periods July 1 through September 30, 2001, and January 1, 2003, through March 31, 2004.

[2]We calculated the interest expense using the applicable daily interest rate pursuant to the Cash Management Improvement Act of 1990.

In total, the State claimed excess Federal reimbursements of $396,941. The unreported overpayments, unallowable credit adjustments, and unreported interest collections potentially resulted in approximately $84,700 in higher interest expense to the Federal Government.

The State did not report non-abuse-related overpayments 60 days following the dates of discovery (draft report dates) because its new policy was to wait for the final reports to be issued. The unallowable credit adjustments and unreported interest penalty collections resulted from the State's lack of adequate policies and procedures.

OVERPAYMENTS NOT REPORTED

The State did not report Medicaid provider overpayments pursuant to Federal requirements. The unreported overpayments resulted from a change in the State's policy for reporting overpayments and errors in the State's accounts receivable system.

Federal Requirements for Reporting Overpayments

The requirements for reporting Medicaid overpayments on the CMS-64 are set forth in 42 CFR § 433. 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 overpayments from the providers. Federal regulations (42 CFR § 433.316) define the discovery date as the earliest date on which (1) the State first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, (2) the provider initially acknowledges a specific overpayment in writing to the Medicaid agency, or (3) the State initiates a formal action to recoup a specific overpayment from a provider without having first notified the provider in writing.

In addition, Federal regulations (42 CFR § 455) require the State to handle overpayments involving possible abuse-related situations differently from routine overpayments. The State is required to perform additional work on abuse-related overpayments, including a preliminary investigation. If circumstances warrant, the State must refer the case to the State's Medicaid Fraud Control Unit and conduct a full investigation.

Unreported Overpayments

For the period October 1, 2001, through December 31, 2002, the State did not report $6,767,939 ($3,393,661 Federal share) in Medicaid provider overpayments. In addition, the State did not report $2,381,696 ($1,197,863 Federal share) in provider overpayments for the periods April 1 through September 30, 2001, and January 1, 2003, through June 30, 2004. As a result of our audit, the State refunded $2,474,322 on its March 2004 CMS-64 report. In addition, after our draft report was issued, the State settled the other identified overpayments and reported them on the CMS-64. Therefore, we do not have a recommended financial adjustment. However, the unreported overpayments potentially resulted in approximately $75,000 in higher interest expense to the Federal Government.

Policy Change for Reporting Overpayments and Errors in Accounts Receivable System

The overpayments resulted from a change in the State's reporting policy and errors in the State's accounts receivable system.

Policy Change for Reporting Overpayments

In August 2002, the State changed its policy for reporting routine provider overpayments. The policy change redefined all overpayments to be related to fraud and abuse. Instead of reporting routine overpayments 60 days after issuing its draft reports, as it had previously done and pursuant to Federal requirements, the State delayed reporting routine overpayments until 60 days after issuing the final reports. Pursuant to 42 CFR § 433.312, the State must refund the Federal share of routine overpayments within 60 days following discovery. The date of the draft report is the discovery date because it is the earliest written notification of a routine overpayment showing the specific dollar amount subject to recovery pursuant to 42 CFR § 433.316(c)(1).

State officials changed their reporting policy because they considered all processed overpayments to be abuse-related, thus qualifying them for a reporting delay. Although Federal regulations allow for a delay in abuse situations, we determined, after reviewing selected documents and interviewing State personnel, that not all the State's overpayments were related to abuse. In addition, we determined that the State did not perform the additional steps necessary to qualify all overpayments as abuse-related.

Errors in the State's Accounts Receivable System

Although the State's revised policy was to report routine overpayments on the CMS-64 based on the results of final reports, we identified a number of routine overpayments from final reports that had not been reported to CMS. The State informed us that programming errors had occurred when it implemented changes to its accounts receivable system. These errors prevented the system from identifying some overpayments that had not been reported within 60 days of the final report dates.

CREDIT ADJUSTMENTS NOT ALLOWABLE

The State reported $446,737 ($225,013 Federal share) in unallowable credit adjustments during the period October 1, 2001, through December 31, 2002. These credit adjustments resulted from the lack of adequate policies and procedures.

Federal Requirements for Credit Adjustments

Pursuant to 42 CFR § 433.318, "The Agency is not required to refund the Federal share of an overpayment made to a provider . . . to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section."

For providers determined to be bankrupt, the State need not refund to CMS the Federal share of an overpayment at the end of the 60-day period following discovery of the overpayment. This

regulation applies as long as the filing or petition occurs before the end of the 60-day period and the State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.

In addition, 42 CFR § 433.318 states that for providers determined to be out of business, the agency must document its efforts to locate the party and its assets and "make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law."

Section 1903(d)(2)(D) of the Act allows credit adjustments when the provider is bankrupt or the funds are "otherwise uncollectible." Whether portions of overpayments that the State gives up in a settlement agreement are creditable against the Federal Government depends on whether those funds can be deemed "otherwise uncollectible." Federal regulations identify only one circumstance apart from bankruptcy in which the State may credit uncollectible overpayments: when the provider is "out of business" as defined in 42 CFR § 433.318(d).

Finally, Departmental Appeals Board (DAB) decisions further illustrate that the inapplicability of the credit adjustments to settlements has long been a settled matter. For example, in DAB decision No. 1391 (1993), involving the California Department of Health Services, DAB upheld CMS's disallowance of credit adjustments based on settlement agreements.

Unallowable Credit Adjustments

The State reported six unallowable credit adjustments totaling $446,737 ($225,013 Federal share): one negotiated-settlement adjustment, three out-of-business adjustments, one bankruptcy adjustment, and one miscellaneous adjustment. These adjustments potentially resulted in approximately $6,300 in higher interest expense to the Federal Government.

Settlement Adjustment

The State reported one unallowable settlement adjustment of $361,633 ($182,155 Federal share). The State improperly reduced the original amount of the overpayment because it was in the State's best interest to do so. The State agreed to forgo collection of the overpayment in exchange for the provider's withdrawing its request for a hearing and abstaining from any appeals. Federal regulations identify only one circumstance apart from bankruptcy in which the State may credit uncollectible overpayments: when the provider is "out of business" as defined in 42 CFR § 433.318(d). Therefore, the settlement did not meet the criteria for reclaiming Federal funds.

Out-of-Business Adjustments

The State reported three out-of-business adjustments totaling $48,734 ($24,547 Federal share). To adjust an overpayment attributable to an out-of-business provider, Federal regulations (42 CFR § 433.318) require the State to (1) document its efforts to locate the party and its assets and (2) obtain an affidavit or certification from the appropriate State legal authority establishing

that the provider is out of business. The State did not locate the providers and their assets or obtain affidavits to document the providers' out-of-business status.

Bankruptcy Adjustment

The State reported one bankruptcy adjustment of $34,158 ($17,205 Federal share). To adjust an overpayment attributable to a bankrupt provider, Federal regulations (42 CFR § 433.318) require the State to (1) determine that the provider has filed for bankruptcy and (2) be on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment. The State did not determine that the provider filed for bankruptcy, and the State was not on record with the court as a creditor of the petitioner.

Miscellaneous Adjustment

The State reported one other unallowable adjustment of $2,212 ($1,106 Federal share). The adjustment represented an overpayment in which the provider could not be located. This type of adjustment is not allowable pursuant to 42 CFR § 433.318.

INTEREST PENALTY COLLECTIONS NOT REPORTED

The State did not report interest penalty collections on Medicaid recoveries from health care providers totaling $256,555 ($129,029 Federal share) during our audit period and totaling $84,993 ($42,899 Federal share) for the extended audit period. Section 2500.1 of the State Medicaid Manual specifies that interest received on Medicaid recoveries should be reported on the CMS-64. When the State identified an overpayment and gave sufficient notice to the provider, the State assessed a 1-percent per month interest penalty until the provider returned the overpayment. The State lacked adequate policies and procedures to ensure that the Federal Government received its share of interest penalty collections. As a result, the State claimed excess Federal reimbursement of $171,928. This claim potentially resulted in approximately $3,400 in higher interest expense to the Federal Government.

RECOMMENDATIONS

We recommend that the State:

- refund $396,941 to the Federal Government for unallowable credit adjustments and unreported interest penalty collections;
- report overpayments on the CMS-64 on the basis of draft reports unless there is evidence of abuse;
- determine whether there were any unreported overpayments, unallowable credit adjustments, or unreported interest penalty collections subsequent to our audit period or extended audit period and refund such amounts;

- ensure that all future overpayments, credit adjustments, and interest penalty collections are reported in accordance with Federal requirements, thereby mitigating the potentially higher interest expense to the Federal Government;

- establish an accounts receivable system that properly records, ages, and reports provider overpayments on the CMS-64; and

- establish and implement adequate written policies and procedures for processing and reporting overpayments, credit adjustments, and interest penalty collections.

STATE'S COMMENTS

In its written comments on the draft report, the State partially agreed that it did not report certain Medicaid provider overpayments pursuant to Federal requirements. It agreed it did not report Medicaid overpayments because of a programming error and refunded $2,474,322 on its March 2004 CMS-64. However, the State disagreed that it should report Medicaid overpayments based on draft report dates. The State asserted that all overpayments it discovered were abuse-related and therefore, the discovery date was the date of the final report.

The State cited five examples of overpayments that met the definition of "abuse." Also, the State contended that it used draft reports to inform providers of preliminary findings and to invite them to submit additional documentation. According to the State, the additional information often required the State to revise the overpayment amounts in the final reports.

The State agreed that it reported unallowable credit adjustments to the Federal share totaling $42,858 but disagreed that its $182,155 settlement adjustment was improper. The State commented that the settlement was not a credit adjustment but a correction to a reporting error.

Finally, the State agreed that it did not report $171,928 in interest penalty collections.

The State did not comment on our procedural recommendations (recommendations 2 through 6) other than stating that it has revised its policies and procedures for the credit adjustments totaling $42,858.

The State's comments are included in their entirety as an appendix to this report.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We evaluated the State's comments on our draft report, obtained additional information, and revised the final report accordingly. We disagree with the State's position that all its overpayments were abuse-related and that the discovery date was the date of the final report. In addition, we disagree that the settlement adjustment was allowable pursuant to Federal regulations.

We disagree with the State's position that all the overpayments were abuse-related. Federal regulations (42 CFR § 433.316) make a procedural distinction between abuse-related and non-

abuse-related overpayments. Non-abuse-related or routine overpayments should be reported within 60 days of discovery, when the provider is first notified of the overpayment. The overpayments identified in our report were discovered by the State through regularly scheduled reviews that identified payment errors. In some cases, the provider challenged the State's findings, but the findings were resolved pursuant to the State's audit resolution process. The State did not (1) impose sanctions, (2) refer the cases to the Medicaid Fraud Control Unit for investigation, nor (3) conduct extensive legal investigations.

Four of the five overpayments that the State cited as abuse-related were not included in our draft report. We agree that one overpayment was abuse-related and adjusted our final report accordingly.

The State's position that overpayments should be reported based on final audit reports because draft reports provide only preliminary findings has been rejected in DAB decisions.[3] The DAB determined that in cases not involving fraud or abuse, issuance of a draft audit report constituted written notice from a State official of a specified overpayment amount subject to recovery. Accordingly, the DAB concluded that overpayments are "discovered" at the draft audit report stage and must be refunded to the Federal Government within 60 days. Federal regulations (42 CFR § 433.320(c)) allow for overpayment adjustments on the CMS-64s when there are differences in the draft report and final report amounts. We continue to recommend that the State report non-abuse-related overpayments based on draft report dates.

We disagree that the credit adjustment for the $182,155 settlement was to correct an error. The State sent a letter to the provider agreeing to forgo collection of $361,633 in exchange for the provider withdrawing its request for a hearing and forgoing any appeals. This settlement did not comply with the regulation for reclaiming Federal funds. We continue to recommend that the State refund $182,155 to the Federal Government for the improper settlement adjustment.

[3]DAB decisions 1536 and 1560, dated September 21, 1995, and February 7, 1996, respectively.

APPENDIX

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, WA 98504-5843

May 11, 2005

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
50 United Nations Plaza
Room 171
San Francisco, CA 94102

Subject: Audit Report Number A-10-04-0003

Dear Ms. Ahlstrand:

We have reviewed your draft audit report entitled Audit of Washington's Accounts Receivable System for Medicaid Provider Overpayments and have provided our response on the attached document.

We strongly disagree with portions of the audit report and hope our response will provide additional information for your consideration as you finalize the audit report.

While there are points of disagreement, we would like to thank you and your audit team for identifying opportunities for improvement. Should you have any questions regarding our response or require additional information, please feel free to contact me at 360-902-8181.

Sincerely,

Stan Marshburn, Chief Financial Officer
Financial Services Administration

Attachment
c: Doug Porter
Heidi Robbins-Brown
Bob Covington
Gail Kreiger
Don Mercer

Washington Department of Social & Health Services
Response to OIG Audit of Washington's Accounts Receivable System for Medicaid Provider Overpayments

OIG FINDING AND RECOMMENDATION – "OVERPAYMENTS NOT REPORTED"

The draft report cites DSHS for not reporting Medicaid provider overpayments in accordance with federal requirements. We partially concur with this finding as described below:

Accounts Receivable System Error –

DSHS discovered a programming error within the accounts receivable system that resulted in overpayments in the amount of $2,474,322 (federal share) not being reported. We concur with this portion of the draft finding and refunded this amount on the March 2004 CMS-64 report.

Overpayments Not Reported as Required by Federal Requirements –

We do not agree with this portion of the draft finding. The auditor contends that subject overpayments are all "routine", do not fit the definition of "abuse", and that DSHS delayed reporting overpayments through the issuance of draft audit reports.

The purpose of the DSHS Medical Assistance Administration (MAA) audit program is to identify and recover overpayments that are the result of fraud and abuse. The design of the audit program and the processes MAA has implemented promote compliance with the requirements of the above citations from the CFR and support consistent recognition of abuse and fraud behavior. We believe that based on the CFR definition of "abuse" and requirements for investigation that subject audits comply with the federal definition of abuse and that date of overpayment discovery is the date of the final written notice (final audit report).

> Definition of Abuse (42 CFR Section 455.2) – "Abuse… means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."
>
> Definition of Overpayments Resulting from Fraud or Abuse (42 CFR Section 433.316) – "An overpayment that results from fraud or 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."

DSHS reviews and analyzes providers' billing practices to identify any member of a peer group who is receiving payments that appear to be excessive in comparison to other members of that peer group. This analysis is conducted looking at the total dollars paid, as well as analysis of other data relationships to identify indications of aberrant billing

practices used to maximize recovery. Providers who *appear* aberrant are referred to the audit unit for further investigation and recovery activities.

The subject audits meet the definition of abuse and include processes supporting preliminary and full investigations as defined by CFR. Provided below are examples of why we believe subject audit findings meet the definition of abuse and comply with investigation requirements:

Provider Number 5017892– The primary finding in this audit was the dentist's practice of performing root canals that were not medically necessary and failed to meet professionally recognized standards for health care. The Washington State Department of Health (DOH) confirmed MAA's finding by fining this provider $25,000 for performing root canals without clinical justification (medical necessity). DOH's sanctions also included suspending his professional license for 5 years and requiring he complete 280 Continuous Education Units, including clinical management and appropriate treatment interventions for dental diagnoses. The sanctions rendered on this dentist are one of the most severe ever issued by DOH's Dental Quality Assurance Commission and certainly would not be equitable for a routine breach of practice. This audit clearly meets the 42 CFR definition of abuse, "provider practices that are inconsistent with sound.... medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professional recognized standards for health care. " [1]

Provider Number 5034327- The MAA audit found this dentist billing for professional dental services which were rendered by unlicensed employees and failing to comply with professionally recognized standards of care for infection control. Again, DOH confirmed this finding by revoking this dentist's license for 7 years on the basis that he promoted the use of unlicensed staff to perform services that by law must be performed by a licensed dental professional; billed for services that failed to meet professionally recognized standards for health care; and failed to recognize his responsibility for complying with standard infection control practices. The deliberate decision to allow unlicensed staff to regularly perform professional services is not a decision that would be "routinely" made by any professional health care provider. This certainly is representative of a provider whose practice is inconsistent with sound medical practices and resulted in an unnecessary cost to the Medicaid program because those services failed to meet professional recognized standards for health care.

It is MAA's position that the above cases are clearly consistent with the intent and requirements of 42 CFR, Section 455.2 definition of "abuse".

In addition to determining whether or not the overpayment was a result of abuse, the auditor establishes whether or not the overpayment may have been the result of intentional behavior, or fraud. A staff member assigned to fraud investigations is key in delineating this activity from abuse, working closely with the investigator from the state's

[1] Office of Inspector General Note – This paragraph is not applicable because the overpayment referred to by the State is not included in the final report.

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Medicaid Fraud Control Unit (MFCU) to discuss the significance of the findings and the identified trends in billing patterns.

MAA process related to intentional behavior or fraud, apply to the following audits included by the OIG in their audit:

- Provider Number 74079688;
- Provider Number 5016654: and
- Provider Number 5024765

Each of these cases was referred to MFCU for criminal prosecution after the audit was completed and the purposeful intent of the provider was fairly established, per the requirements described in 42 CFR Section 455. At this time, MFCU has filed criminal charges against two of these providers, and continues to build the case against the third provider. MFCU's pursuit of these cases confirms the validity of these fraud referrals and MAA's investigational process.

Consistent with 42 CFR section 455, MAA's investigational process assures MAA handles abuse related situations differently from routine overpayments and supports accurate identification of valid fraud referrals to MFCU for further action. This is further confirmed by the fact that MFCU has only returned one referral as "not prosecutable" to MAA in the 20 plus cases referred to them in the past 3 years. The decision to return this one referral was made after 900 investigative hours and significant deliberation by MFCU staff.

In conclusion, the three audits cited above definitely revealed "abuse", and in fact elevated to the fraud level of aberrant billing behavior, resulting in unnecessary cost to the Medicaid program as required in 42 CFR Section 455.2.

In conducting audits, it is the practice of MAA to issue a "Draft" audit report to inform the providers of preliminary findings. The report includes a detailed description of the findings and invites the provider to provide additional documentation or information that may result in revising this finding and *estimated preliminary* overpayment.

This draft process almost always results in the delivery of additional information and/or documentation that is necessary to finalize the audit report and identify a sum certain which is then used to establish an overpayment. Our experience shows that the additional information and/or documentation typically results in a 52% reduction in the actual overpayment amount.

An audit conducted on Swedish Medical Center in 2003, was not selected for the OIG audit but it represents a completed MAA audit. There was an 83% change from the estimated overpayment in the draft to the sum certain overpayment in the final report. This reduction was attributed to the inability to retrieve the records correlating to the

claims in the sample at the time of the onsite visit. The patient may have been in the hospital again, the doctor may have had the record, or it may have been misfiled. Once e due process was complete, the revised **final sum certain overpayment** amount was related to primarily one finding: Non-verified services. These are billed services that can not be substantiated with the documentation in the medical record. For example: Failing to have a physician's order; billing for services that are not documented in the nurses notes, on the medication administration record, on the Emergency room flow sheet, on the respiratory treatment record; or miscalculation of time spent in specialty services units, like operating or recovery room. The extent to which these errors occurred in this one audit, totaling $56,372 in overpayment, indicates the hospital's failure to implement and follow sound business practices to assure accurate billing, including training of professional staff and a medical record quality assurance review program.

OIG FINDING AND RECOMMENDATION – "UNALLOWABLE CREDIT ADJUSTMENTS"

The draft report cites DSHS for not maintaining adequate records to support credit adjustments. We partially concur with this finding as described below:

Adjustments for Out of Business Providers –

We concur with this portion of the draft finding. The department is pursuing policy and procedure change after reviewing the files audited during the audit period to ensure that adequate documentation are obtained to support out-of-business providers upon which the State filed for reclaim of FFP. The State revised policies and procedures defining adequate documentation are being implemented to include the post audit period.

Adjustments for Policy Changes -

We do not agree with this portion of the draft finding. The auditor contends that subject adjustments are inappropriate. It is our position that credit adjustment is in fact a correction of a state reporting error and not a "credit adjustment" as defined by CFR.

Adjustments for Settlement –

MAA believes the overpayment amount cited was identified in error during the (MAA) audit. Available documentation indicates data used to assert this overpayment was captured and reported in error and that in fact the provider was paid correctly using the Fee-for-Service methodology for the services. The cancellation of the overpayment and the reclaim was appropriate. MAA is pursuing additional documentation to support this position.

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Adjustments for Bankruptcy –

We concur with this portion of the draft finding. The department is pursuing policy and procedure change after reviewing the files audited during the audit period to ensure that adequate documentation are obtained to support bankruptcy providers upon which the State filed for reclaim of FFP. The State revised policies and procedures defining adequate documentation are being implemented to include the post audit period.

Adjustments for Miscellaneous –

We concur with this portion of the draft finding.

OIG FINDING AND RECOMMENDATION – "INTEREST PENALTY COLLECTIONS NOT REPORTED"

The draft report cites DSHS for not remitting the federal share of interest and penalties. We concur with this finding and are taking action to remit the federal share of such penalties and interest.

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