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

JUL 10 2003

Report Number: A-04-03-00019

Mike Robinson, Commissioner
Department for Medicaid Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Dear Mr. Robinson:

Enclosed are two copies of a U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled, ***Audit of the Kentucky Department for Medicaid Services' On-Demand Payments, Interim Payments, and Write-Off and Adjustment Process***. A copy of this report will be forwarded to the action official noted on page 2 for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the 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 (Public Law 90-23), OIG reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 Code of Federal Regulations Part 5).

If you have any questions or comments about this report, please do not hesitate to call me or John Drake, Audit Manager, at (404) 562-7755 or through e-mail at jdrake@oig.hhs.gov. To facilitate identification, please refer to report number A-04-03-00019 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 and Medicaid Services
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30323

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

AUDIT OF THE KENTUCKY DEPARTMENT FOR MEDICAID SERVICES' ON-DEMAND PAYMENTS, INTERIM PAYMENTS, AND WRITE-OFF AND ADJUSTMENT PROCESS

JULY 2003
A-04-03-00019

Notices

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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, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

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.

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

JUL 10 2003

Report Number: A-04-03-00019

Mike Robinson, Commissioner
Department for Medicaid Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Dear Mr. Robinson:

This final report provides the results of our ***Audit of the Kentucky Department for Medicaid Services' On-Demand Payments, Interim Payments, and Write-Off and Adjustment Process.***

EXECUTIVE SUMMARY

OBJECTIVE

The objectives of this audit were to determine if the Department for Medicaid Services (DMS):

- accounted for on-demand payments to nursing facilities for the period of October 1, 1999 through September 30, 2002;
- used appropriate collection efforts to recoup interim payments; and
- accounted for the Federal share of all write-offs and overpayment adjustments made for the quarters ended September 30, 2002 and December 31, 2002.

SUMMARY OF FINDINGS

DMS did not properly account for on-demand payments to the Birchtree nursing facility for the period of October 1, 1999 through September 30, 2002, which resulted in overpayments totaling $234,466 ($165,416 Federal share). At the time our audit was initiated, DMS was already aware of the circumstances surrounding the payments to this nursing facility. Subsequent to our audit period, but prior to the initiation of our fieldwork, DMS strengthened its controls for on-demand payments.

DMS used appropriate collection efforts to recoup payments made through its interim payment process. DMS has reimbursed the Federal share of the interim payments and has implemented recommendations that the Centers for Medicare and Medicaid Services (CMS) made in a February 1997 report.

DMS did not properly account for the Federal share of all write-offs. DMS reported $204,076 ($142,962 Federal share) of write-offs on the CMS-64[1] report for the quarter ended December 31, 2002 for which it did not provide adequate support. In addition, the reporting process DMS used differs from the method CMS prescribed, and is vulnerable to reporting errors. While the method DMS followed did not result in greater charges to the Federal Government for Medicaid expenditures, the method did result in an increased difficulty in identifying specific items.

RECOMMENDATIONS

With respect to on-demand payments, we recommend that DMS continue monitoring on-demand payments to ensure proper accounting procedures are followed and that the Commissioner of DMS continues to review and approve all on-demand payments. We also recommend that DMS monitor Birchtree's bankruptcy proceedings and refund the Federal share of Birchtree's overpayment if any portion of the overpayment is recovered in the future.

With respect to proper accounting for the Federal share of all write-offs and overpayment adjustments we recommend that DMS:

- provide additional support for the write-offs questioned in this report to CMS, or repay the $142,962 Federal share;
- revise its reporting process to conform to the instructions for the CMS-64, or obtain specific approval from CMS to continue with the method currently in use; and
- perform a comprehensive review of its CMS-64 reporting process in order to identify and correct vulnerabilities in the process.

DMS generally concurred with our findings and recommendations. In addition to taking actions to strengthen its CMS-64 reporting process, DMS agreed to repay the $142,962 for the erroneous write-off. We summarized DMS' comments after the ***Recommendations*** section of this report. DMS' comments in their entirety are included as an Appendix.

INTRODUCTION

BACKGROUND

The CMS Regional Administrator, Region IV, requested the Office of Inspector General's (OIG) assistance in determining the adequacy of Kentucky's (State) controls over on-demand payments to nursing facilities. The State's on-demand payment process became an issue after CMS

[1] The CMS was formerly known as the Health Care Finance Administration (HCFA). The form used to report state Medicaid expenditures, currently referred to as the CMS-64, was formerly known as the HCFA-64.

became aware of at least two instances in which on-demand payments totaling $234,466 to the Birchtree nursing facility were not accounted for properly.

On-demand payments are payments that are unrelated to specific claims. Examples of on-demand payments would include cost settlements, supplemental payments, and lump sum payments to correct processing errors. During the audit period of October 1, 1999 through September 30, 2002, DMS made 459 on-demand payments totaling $5,203,971 to nursing facilities.

CMS asked the OIG to follow-up on any receivables that may still be outstanding from the State's interim payment process. With the approval of CMS, the State instituted in December 1995 an interim payment process for Medicaid providers. The interim payment process was necessary because the State's fiscal agent was unable to process claims through the State's new Medicaid Management Information System (MMIS).

Although the State planned the interim payments process as a short-term measure to assure continued payments and stable cash flow to Medicaid providers, the State found it necessary to continue making interim payments because of the fiscal agent's slow startup. The State stopped making interim payments in late July 1996. Up until that time, the State paid providers approximately $485 million in interim payments. Of the $485 million, approximately $109 million was paid to nursing facilities (provider type 12).

CMS also requested that the OIG provide assurance regarding the controls and procedures in place governing the reporting of write-offs and overpayment adjustments on the CMS-64. The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement that the State must submit each quarter under title XIX of the Social Security Act (the Act). It shows the disposition of Medicaid grant funds for the quarter being reported and previous fiscal years, the recoupment made or refunds received, and income earned on grant funds. It is also the vehicle for making adjustments for any identified overpayment and underpayment to the State. Write-offs and overpayment adjustments of accounts receivables, when made in accordance with CMS guidelines, allow DMS to recoup the Federal share of any payments that have previously been returned to CMS.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

The objectives of this audit were to determine if DMS:

- accounted for on-demand payments to nursing facilities for the period of October 1, 1999 through September 30, 2002;

- used appropriate collection efforts to recoup interim payments; and

- accounted for the Federal share of all write-offs and overpayment adjustments made for the quarters ended September 30, 2002 and December 31, 2002.

Scope

Our audit covered on-demand payments DMS made from October 1, 1999 through September 30, 2002; the status of interim payments as of January 24, 2003; and the write-off and adjustment of receivables for the quarters ended September 30, 2002 and December 31, 2002.

Fieldwork was performed at the DMS in Frankfort, Kentucky, CMS in Atlanta, Georgia, and at OIG offices in Tallahassee, Florida and Atlanta, Georgia.

We did not test the accounts receivables balances at DMS for completeness or adequate support as a whole. We noted that the Kentucky Auditor of Public Accounts recently completed a review of DMS' accounts receivables.[2]

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

Methodology

We met with individuals at CMS to discuss requirements for reporting of overpayment adjustments and write-offs, and to obtain an understanding of issues relevant to the current review.

We met with officials from the State's Auditor of Public Accounts to discuss audit work they performed in connection with DMS' policies and controls governing receivables and on-demand payments.

At the DMS offices, we obtained and reviewed documentation necessary to complete our audit objectives. We also followed up on recommendations made by the CMS regarding interim payments in a previous review.

We issued a draft report to DMS on May 27, 2003. DMS declined a formal exit conference. On June 27, 2003, we received DMS' written comments to the draft.

[2] See report entitled, Kentucky's Management of Its Medicaid Accounts Receivable, available at http://www.state.ky.us/agencies/apa

FINDINGS AND RECOMMENDATIONS

DMS did not properly account for on-demand payments to the Birchtree nursing facility for the period of October 1, 1999 through September 30, 2002, which resulted in overpayments totaling $234,466 ($165,416 Federal share). At the time our audit was initiated, DMS was already aware of the circumstances surrounding the payments to this nursing facility. Subsequent to our audit period, but prior to the initiation of our fieldwork, DMS strengthened its controls for on-demand payments.

DMS used appropriate collection efforts to recoup payments made through its interim payment process. DMS has reimbursed the Federal share of the interim payments and has implemented recommendations that the CMS made in a February 1997 report.

DMS did not properly account for the Federal share of all write-offs. DMS reported $204,076 ($142,962 Federal share) of write-offs on the CMS-64 for the quarter ended December 31, 2002 for which it did not provide adequate support. In addition, the reporting process DMS used differs from the method CMS prescribed, and is vulnerable to reporting errors. While the method DMS followed did not result in greater charges to the Federal Government for Medicaid expenditures, the method did result in an increased difficulty in identifying specific items.

ON-DEMAND PAYMENTS

DMS did not properly account for on-demand payments to the Birchtree nursing facility for the period of October 1, 1999 through September 30, 2002, which resulted in overpayments totaling $234,466 ($165,416 Federal share).

During the period October 1, 1999 to September 30, 2002, DMS made 459 on-demand type payments totaling $5,203,971 to nursing facilities that were not related directly to specific claims. These payments fall into five categories:

- Payout, Error on Refund – used to return a portion of a provider's refund check;
- Payout, Returned to Provider – used to return the entire amount of a provider's refund check;
- Payout, Cost Settlement – used when a Cost Settlement has resulted in an amount due to the provider;
- Payout, Other – used for payouts that do not fit the criteria for the pre-defined payout reason codes listed above; and

- Payment, Demand – used whenever a payout that would normally be a Payout – Other, is deemed to be needed immediately.

Of these 5 categories, we only reviewed the 19 payments categorized as Payout Other and Demand Payment. Only 2 of the 19 payments were not subjected to proper accounting procedures – the 2 payments to Birchtree Healthcare.

Two on-demand payments totaling $234,466 ($165,416 Federal share) were issued to Birchtree. This total reflects on-demand payments of $115,809 and $118,657 that were made in April and May of 2000 because Birchtree claimed economic hardship. According to DMS' Financial Transactions User Manual, a receivable should have been established in the claims processing system when the two on-demand checks were issued to Birchtree.

DMS did not establish the accounts receivable as required for the two on-demand payments and Birchtree was overpaid. DMS staff did not discover the overpayment until October 10, 2002. When an overpayment is identified, DMS is required to initiate recovery efforts. The 42 Code of Federal Regulation (CFR) 433.312(a) states:

> *(a) Basic rules. (1) Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to HCFA.*

By the time DMS discovered the overpayment to Birchtree, Birchtree had filed bankruptcy. On November 8, 2002, State officials filed claims totaling $242,912 in U.S. Bankruptcy Court. This amount reflects the 2 payments made in April and May 2000 and outstanding citations, and rate adjustments.

Although DMS did not properly account for on-demand payments to Birchtree, DMS is not required to refund to CMS the Federal share of the overpayment.

The 42 CFR 433.318(c) states:

> *(c) Bankruptcy. The agency is not required to refund to HCFA the Federal share of an overpayment at the end of the 60-day period following discovery, if –*
>
> *(1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 60-day period following discovery; and*
>
> *(2) The State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.*

However, if the State recovers any portion of an overpayment under a court-approved discharge of bankruptcy, the agency must refund to CMS the Federal share.

DMS implemented a series of actions to improve controls over on-demand payments subsequent to discovery of the Birchtree errors. In October 2002, DMS established new financial system procedures for tracking payouts and recoupments. Also, as of November 21, 2002, the Commissioner of DMS must initial all payment requests that are not related to claims (i.e., on-demand payments).

In the future, these controls should provide additional assurance that on-demand payments are being issued in a manner consistent with DMS guidelines and proper accounting procedures, thereby protecting State and Federal funds.

INTERIM PAYMENTS

DMS used appropriate collection efforts to recoup payments made through its interim payment process. DMS has reimbursed the Federal share of the interim payments and has implemented recommendations that CMS made in a February 1997 report.

We reviewed DMS' interim payment process in order to determine if appropriate collection efforts were taken to recoup interim payments. More specifically, we determined if DMS refunded the Federal share of the outstanding credit balance arising from interim payments.

The CMS performed a review of DMS' interim payment process and issued a report to DMS dated February 3, 1997. We followed up to determine DMS' corrective actions in response to the recommendations included in the CMS report. CMS' recommendations were as follows:

> ***Recommendation 1:*** The State should perform a reconciliation of interim payments against interim receivables as of March 31, 1997, and provide a copy to CMS.
>
> The State complied with this recommendation by performing a reconciliation of interim payment balances for the quarter ended March 31, 1997 and by providing a copy of the reconciliation to CMS.
>
> ***Recommendations 2 through 5:*** The State should report the outstanding credit balances related to all interim payments on Line 10.B. of the form CMS-64 for the quarter ended March 31, 1997.
>
> As recommended, the State reported all credit balances related to interim payments on the form CMS–64 for the quarter ended March 31, 1997.

DMS has now repaid all Federal dollars related to its interim payment process and has implemented the recommendations included in CMS' February 1997 report on this issue.

ACCOUNTING FOR WRITE-OFFS AND OVERPAYMENT ADJUSTMENTS

DMS did not properly account for the Federal share of all write-offs. DMS did not provide adequate support for $204,076 ($142,962 Federal share) of write-offs reported to CMS for the quarter ended December 31, 2002. In addition, the reporting process DMS used differs from the method CMS prescribed, and is vulnerable to reporting errors. While the method DMS followed did not result in greater charges to the Federal Government for Medicaid expenditures, the method did result in an increased difficulty in identifying specific items.

Support for Write-offs and Overpayment Adjustments

For the quarter ended September 30, 2002, we reviewed all cancellations, overpayment adjustments, and write-offs on Lines 2 and 4 of the CMS-64.9O[3]. Also, for the quarter ended December 31, 2002, we reviewed all cancellations, downward adjustments, and write-offs on Lines 2 and 4 of the CMS-64.9O totaling $5,000 or more. Five write-offs relating to Shelby Manor Health were not adequately supported. These write-offs totaled $204,076 and resulted in an increase in Federal expenditures of $142,962 (see table below).

DECEMBER 31, 2002 WRITE-OFFS

FEDERAL FYE	PROVIDER NAME	AMOUNT REPORTED	ACTIVITY DATE	CANCELLATIONS / ADJUSTMENTS	FMAP %	FEDERAL SHARE
09/18/95	SHELBY MANOR HEALTH	$ 73,366	10/02/02	$ 73,366	69.58%	$ 51,048
03/08/96	SHELBY MANOR HEALTH	$ 75,737	10/02/02	75,737	70.30%	53,243
06/23/97	SHELBY MANOR HEALTH	$ 7,019	10/02/02	7,019	70.09%	4,920
05/22/98	SHELBY MANOR HEALTH	$ 18,006	10/02/02	18,006	70.37%	12,671
10/11/01	SHELBY MANOR HEALTH	$ 29,948	10/02/02	29,948	70.39%	21,080
			Total	**$204,076**		**$142,962**

The requirements for documentation of write-offs are found in 42 CFR 433.320, and by reference in 433.318. The 42 CFR 433.320(g) states in part:

> *(1) HCFA allows the reclaim of a refund by the agency if the agency submits to HCFA documentation that it has made reasonable efforts to obtain recovery.*
>
> *(2) If the agency reclaims a refund of the federal share of an overpayment*
>
> > *(ii) In out-of-business cases, the agency must submit to HCFA a statement of its efforts to locate the provider and its assets and to*

[3] Form 64.9O is one of the supporting schedules for the Form 64-Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

> *recover the overpayment during any period before the provider is found to be out of business in accordance with 433.318.*

The 42 CFR 433.318(d) states:

> *(2) A provider is considered to be out of business on the effective date of a determination to that effect under state law. The agency must*
>
> *(i) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable state policies and procedures; and*
>
> *(ii) 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.*

We requested all documentation relating to the write-offs. The State did not provide documentation of its efforts to locate the party and its assets; and did not 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. Thus, the State did not meet the requirements of 433.318(d)(2)(i) or 433.318(d)(2)(ii) and as a result did not meet the requirements of 433.320.

We also note that for the quarter ended September 30, 2002, DMS initially reported total overpayment adjustments of $12,700,346 on Line 2 of the CMS-64.9O. These overpayment adjustments were later reduced to $11,217,416. These revisions were prompted by both an internal DMS review and a CMS review of amounts reported on Line 2 that consisted of write-offs that were not adequately supported. The revisions to the original submission occurred after the initiation of our review, but prior to the start of our fieldwork.

CMS has issued specific requirements, and DMS has recently developed implementing procedures, to properly support items appearing on Line 4.[4] We believe these new DMS procedures will improve the DMS management of its accounts receivables. We also believe the process followed in developing the accounts receivable procedures should be extended to the reporting process for the CMS-64 (see report section that follows).

[4] These DMS procedures were finalized on March 17, 2003, and were not in effect during the quarters that we reviewed.

DMS Reporting Process

The process DMS used for reporting expenditures differs from the method prescribed by CMS in at least two instances. DMS is including amounts that should be listed as write-offs on Line 4 of the CMS-64.9O as adjustments on Line 2. DMS is also erroneously reporting amounts on Lines 9A-E and 10C of the CMS-64 for which the Federal share has previously been refunded.

DMS is including write-off amounts on Line 2 of CMS-64.9O. According to CMS guidelines, write-offs should be reported on Line 4 of CMS-64.9O. There is no difference in the impact on Federal participation between items listed on Line 2 (Overpayment adjustments) and Line 4 (Write-offs) on the CMS-64.9O. However, it is crucial for those amounts to be reported on the appropriate lines because the guidelines that govern write-offs and adjustments differ. Detailed instructions for the completion of the CMS-64.9O contained in the State Medicaid Manual Part 2, Section 2500.4 state that Line 2 is for:

> *Decreasing Adjustments to Amounts Previously Reported on Line 1. -Enter any downward adjustment to overpayment previously refunded. You may only report downward adjustments made in accordance with the approved State plan, Federal Medicaid laws and regulations, and the appeals resolution process specified in State administrative policies and procedures.*

The Federal share of expenditures previously refunded can also be reclaimed on Line 4 of the CMS-64.9O. Detailed instructions for the completion of the CMS-64.9O contained in the State Medicaid Manual Part 2 Section 2500.4 states that Line 4 is for:

> *Previously Reported Overpayment to Providers Certified This Quarter as Bankrupt or Out of Business. –Enter previously reported overpayments to providers certified this quarter as bankrupt or out of business, subject to the following guidelines…*

For the quarters ended September 30, 2002 and December 31, 2002, DMS included amounts totaling $924,909, and $204,076 respectively as adjustments on Line 2 that should have been listed as write-offs on Line 4 of the CMS-64.9O.

Not only did DMS erroneously report write-offs as adjustments, but DMS also reported collections for which the Federal share had previously been refunded. The procedures followed by the State for recording collections of receivables are best illustrated with an example.

1. Assume that the State detects an overpayment to a provider of $10,000.

    - State creates a receivable for $10,000.
    - No immediate impact on Federal participation.

2. 60 days pass without collection.

- The Federal share of the overpayment is refunded on Line 1 of CMS-64.9O.

3. State subsequently collects $10,000 from provider.

- Receivable collection reported on Line 2 of CMS-64.9O.
- Receivable collection also reported on Line 9A-E of CMS-64.
- The two amounts are offsetting, so there is no effect on Federal participation.

The method prescribed by CMS for preparing the CMS-64 differs from the above example in step 3. Detailed instructions for the completion of the CMS-64 contained in the State Medicaid Manual Part 2 Section 2500.1 states:

> *Line 9 – Collections.* - *Enter all collections received during the quarter.*
>
> Do not report collections of overpayment which occurred before October 1, 1985 and have been reported on Line 10B, or overpayment which occurred on or after October 1, 1985 and have been reported on Line 10C.
>
> *Line 10C – Overpayment Adjustments.* - *Report the total computable amount and federal share of all overpayment that must be refunded because the 60-day period following discovery has expired and you have not made recovery-*
>
> If the Federal share of an overpayment, which occurred on or after October 1, 1985, has previously been returned as a Line 10C adjustment, do not report subsequent collection of that overpayment.

Because there is no Federal impact, the offsetting entries for receivables collections are not to be reported. The difference relates to the reporting of amounts collected from providers that have been previously reported to CMS and the Federal share refunded.

In explanation, DMS has indicated that its system does not allow the State to make a distinction between various types of deposits at the time the checks are cashed. DMS receives as many as 300-400 checks a day and it may take days or weeks to determine whether a particular deposit relates to a particular receivable, or should be split between different program areas, etc. As a result, DMS reports all receivable collections on Line 2 of CMS-64.9O, and on Line 9A-E of CMS-64.

While in theory, this reporting approach does not result in a difference in the Federal share of Medicaid expenditures for ordinary collections of accounts receivables. It does result in the reporting of a large number of routine transactions that may obscure the extraordinary adjustments for which Line 2 of the CMS-64.9O is designed. Also this reporting approach complicates CMS' task of reviewing and verifying reported Medicaid expenditures.

Other Reporting Issues

CMS identified errors in DMS' three quarterly CMS-64 filings immediately preceding the initiation of our fieldwork. The consistent, and repeated errors contained in the quarterly filings weaken the reliability of the report in general, and complicates CMS' oversight role.

We noted additional errors and omissions with respect to the reporting of receivables on the CMS-64 that have the potential to impact Federal participation. These discrepancies include timing errors with underlying supporting schedules and manual input errors as discussed below.

With respect to timing errors, the DMS Financial Accounting Branch receives Unisys created documents that list newly aged (over 60 days), recouped and adjusted amounts. On some occasions, data may be reported as newly aged in two different quarters. Because DMS uses the newly aged reports as the basis for repaying Federal share, such dual reporting could result in an erroneous double crediting for Federal funds. Alternatively, it is also possible for an account to age after the last Friday of the month. Since the newly aged reports are created by Unisys as of their last run date (Friday) in a month, failure to list the accounts that age over 60 days after that Friday will result in a failure to credit the Federal share for such funds. DMS has implemented a manual reconciliation process to identify these accounts, and a report modification is in process that will "flag" any accounts receivable that has been reported as newly aged.

Other points in the reporting process that require manual input are subject to errors. DMS uses a spreadsheet template to summarize transactions that are reported on the CMS-64. For the quarter ended March 31, 2002, DMS erroneously included a $4.2 million amount in the spreadsheet template that was related to a previous quarter. Similar errors occurred for the quarterly reports for December 31, 2001 and September 30, 2002. DMS has corrected this source of errors by creating a blank template that is used from quarter to quarter.

DMS is aware of these weaknesses and has taken steps to correct them as they are identified. While no system can completely eliminate the possibility of human error, the DMS' current CMS-64 reporting system as it currently operates appears to be vulnerable to errors and omissions.

RECOMMENDATIONS

With respect to on-demand payments, we recommend that DMS continue monitoring on-demand payments to ensure proper accounting procedures are followed and that the Commissioner of DMS continues to review and approve all on-demand payments. We also recommend that DMS monitor Birchtree's bankruptcy proceedings and refund the Federal share of Birchtree's overpayment if any portion of the overpayment is recovered in the future.

With respect to proper accounting for the Federal share of all write-offs and overpayment adjustments we recommend that DMS:

- provide additional support for the write-offs questioned in this report to CMS, or repay $142,962, the Federal share;

- revise its reporting process to conform to the instructions for the CMS-64, or obtain specific approval from CMS to continue with the method currently in use; and

- perform a comprehensive review of its CMS-64 reporting process in order to identify and correct vulnerabilities in the process.

DMS' Comments – On-Demand Payments and Reporting Process

DMS concurred with our recommendations relating to the monitoring and review of on-demand payments and the monitoring of Birchtree's bankruptcy proceedings. DMS also concurred with our recommendation to repay the $142,962 Federal share of erroneous write-offs. DMS said it would repay the erroneous write-off through the CMS-64 report that will be filed for the quarter ended June 30, 2003.

In regard to our recommendation that DMS revise its CMS-64 reporting process, DMS said that the only item for improvement was the report of out-of-business vendors. DMS also said that CMS had verbally approved DMS' use of a checklist prior to including write-offs on the CMS-64 report. DMS officials further stated that their CMS-64 reporting process has been reviewed and will continue to be monitored.

OIG Response – On-Demand Payments and Reporting Process

Although CMS performs a review of each CMS-64 submitted by DMS and has made suggestions for improvement, this does not serve as specific approval to report expenditures in a manner other than what is specified by instructions for preparing the CMS-64. Therefore, we reiterate our recommendation that DMS revise its reporting process to conform to the instructions for the CMS-64, or obtain specific approval (in writing) from CMS to continue with the method currently in use.

As noted previously in this report, DMS has recently completed a comprehensive review of its ***receivables*** management process and has revised its procedures as a result. We reiterate our recommendation that a similar review be undertaken to address weaknesses in the ***reporting*** process as it relates to the CMS-64. We applaud DMS' commitment to continue monitoring its reporting process.

- - - - -

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 report. 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 (Public Law 90-23), OIG, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 Code of Federal Regulations Part 5).

To facilitate identification, please refer to report number A-04-03-00019 in all correspondence relating to this report.

Sincerely,

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

Direct Reply to HHS Action Official:

Rose Crum-Johnson, Regional Administrator
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PAUL E. PATTON
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MARCIA R. MORGAN
SECRETARY

June 27, 2003

Report Number: A-04-03-00019

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Department for Health and Human Services
Office of Inspector General
Office of Audit Services
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Dear Mr. Curtis:

Attached, please find our response to the draft report entitled, ***Audit of the Kentucky Department for Medicaid Services' On-Demand Payments, Interim Payments, and Write-off and Adjustment Process***.

If you have any questions concerning this document, please contact Commissioner Robinson at 502-564-4321.

Sincerely,

Marcia R. Morgan
Secretary

c: Commissioner Robinson

Enclosure

"...promoting and safeguarding the health and wellness of all Kentuckians."

EDUCATION PAYS

Commonwealth of Kentucky
Cabinet for Health Services
Department for Medicaid Services
Response to Draft
***Audit of the Kentucky Department for Medicaid Services' On-Demand Payments, Interim Payments, and Write-off and Adjustment Process* (Report Number A-04-03-00019)**
Performed by
Department of Health and Human Services
Office of Inspector General
Office of Audit Services

Auditors Findings and Recommendations	Kentucky Cabinet for Health Services Department for Medicaid Services Response
The DMS did not properly account for on-demand payments to the Birchtree nursing facility for the period October 1, 1999 through September 30, 2002, which resulted in overpayments totaling $234,466 ($165,416) federal share). At the time our audit was initiated, DMS was already aware of the circumstances surrounding the payments to this nursing facility. Subsequent to our audit period, but prior to the initiation of our fieldwork, DMS strengthened its controls for on-demand payments.	As stated in the report, DMS became aware of the circumstances surrounding the payments to this nursing facility prior to initiation of the audit and issued corrective action prior to initiation of the audit. In addition, we engaged in a thorough process of updating and refining our processes surrounding the treatment of accounts receivable which culminated in the production and implementation of an operations/procedural manual. A key component of this process was systemic changes to significantly enhance our internal controls over the accounts receivable process.
The DMS used appropriate collection efforts to recoup payments made through its interim payment process. The DMS has reimbursed the federal share of the interim payments and has implemented recommendations that the Centers for Medicare and Medicaid Services (CMS) made in a February 1997 report.	We concur with this finding.
The DMS did not properly account for the federal share of all write-offs. The DMS reported $204,076 ($142,962 federal share) of write-offs on the CMS-64[1] report for the quarter ended December 31, 2002 for which it did not provide adequate support. In addition, the reporting process DMS used differs from the method CMS prescribed, and is vulnerable to reporting errors. While the method DMS followed did not result in greater charges to the Federal Government for state Medicaid expenditures, the method did result in an increased difficulty in identifying specific items.	We are in agreement that an error occurred in the write-off of this account. As acknowledged in the Auditor's report, DMS has recently developed modifications to its reporting processes. These modifications were tested and went into production on February 15, 2003. The process refinement was in place for the quarter ended March 31, 2003 report. We will continue to monitor the implementation of these changes.

Commonwealth of Kentucky
Cabinet for Health Services
Department for Medicaid Services
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With respect to on-demand payments, we recommend that DMS continue monitoring on-demand payments to ensure proper accounting procedures are followed and that the Commissioner of DMS continues to review and approve all on-demand payments. We also recommend that DMS monitor Birchtree's bankruptcy proceedings and refund the federal share of Birchtree's overpayment if any portion of the overpayment is recovered in the future.	We concur with this recommendation.
With respect to proper accounting for the federal share of all write-offs and overpayment adjustments we recommend that DMS: • Provide additional support to CMS for the write-offs questioned in the report, or repay the $142,962 federal share; • Revise its reporting process to conform to the instructions for the CMS-64, or obtain specific approval from CMS to continue with the method currently in use; and • Perform a comprehensive review of its CMS-64 reporting process in order to identify and correct vulnerabilities in the process.	Repayment of the erroneous write-off will occur on the quarter ended June 30, 2003 CMS-64. The CMS-64 was reviewed by Davida Kimble with CMS, Financial and Program Operations, for the most recent March '03 report. The only item for improvement was the report of out-of-business vendors. Per Ms. Kimble, a checklist was verbally approved for write-offs to be included prior to inclusion on the CMS-64 report. It has taken more than a year to get this checklist approved. The process is now in place for future quarters. This process has been reviewed and will continue to be monitored.

ACKNOWLEDGMENTS

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