DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

January 12, 2005

Report Number: A-07-04-03060

Mr. Scott Bruner
Director of Medical Policy
Department of Social and Rehabilitation Services
915 SW Harrison, Room 651 South
Topeka, Kansas 66612

Dear Mr. Bruner:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General report entitled "Review of Kansas's Accounts Receivable System for Medicaid Provider Overpayments" for the period October 1, 2002, through September 30, 2003. A copy of this report will be forwarded to the action official noted on the following page for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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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To facilitate identification, please refer to report number A-07-04-03060 in all correspondence. Any questions regarding this report are welcome. Please contact Greg Tambke, Audit Manager, of our Jefferson City Office at (573) 893-8338, extension 30.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Richard Brummel
Acting Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF KANSAS'S ACCOUNTS RECEIVABLE SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS

JANUARY 2005
A-07-04-03060

Office of Inspector General

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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 awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This report is part of a nationwide review focusing on States' accounts receivable systems for Medicaid provider overpayments that were reportable during the period October 1, 2002, through September 30, 2003. The Department of Social and Rehabilitation Services (State agency) is responsible for administering the Medicaid program in Kansas. It contracted with Electronic Data Services (fiscal agent) to act as its fiscal agent. The fiscal agent is responsible for identification and collection of most provider overpayments. State agency employees process the remaining overpayments and collections.

Provisions of the Social Security Act (the Act) provide the Centers for Medicare & Medicaid Services (CMS) with the authority to approve States' plans for administering the Medicaid program. If the State plan meets specific Federal requirements, CMS matches the State's Medicaid spending through Federal financial participation (FFP). The Act provides CMS authority to disallow the Federal share for any Medicaid provider overpayments. States are required to return the Federal share of overpayments within 60 days of the date of discovery. The State must credit the Federal share of the overpayments on the CMS 64 report for the quarter in which the 60-day period ends. Furthermore, it is not allowed to reduce the Federal share by settling overpayment receivables with a provider for less money than is supported by the provider's records.

OBJECTIVE

Our objective was to determine if the State agency reported Medicaid provider overpayments according to Federal regulations.

FINDINGS

The State agency did not report all Medicaid provider overpayments on the quarterly CMS 64 reports in accordance with Federal regulations. Its policies and procedures were not sufficient to ensure the timely reporting of all overpayments. As a result, the State agency delayed returning overpayments totaling $2,395,384 ($1,478,950 FFP). Of that amount, the State agency has not yet reported or returned to the Federal Government overpayments totaling $858,669 ($537,210 FFP).

RECOMMENDATIONS

The State agency should:

- return the Federal share of overpayments totaling $537,210 to the Federal Government as soon as possible and

- strengthen policies and procedures to ensure all overpayments are reported in accordance with Federal regulations.

Specifically, it should:

- return the Federal share of identified Medicaid provider overpayments within established timeframes and

- develop policies and procedures to report Medicaid Fraud Control Unit (MFCU) overpayments as required.

AUDITEE'S RESPONSE

The State agency agreed with our findings and recommendations. The State agency agreed to return $537,210 to the Federal Government and to strengthen its policies and procedures.

OIG COMMENTS

We reviewed additional documentation provided by the State agency in support of a reduction totaling $61,457 for overpayments we reported in our draft report as currently due. The documentation adequately supported recovery of the disputed overpayments. Therefore, we adjusted the amounts in this final report accordingly.

OTHER MATTER

By not reporting overpayments in a timely manner, the State agency effectively denied CMS the use of funds that otherwise would have been available for the Medicaid program. The Cash Management Improvement Act of 1990 (CMIA) provides a means to calculate the value of opportunity costs such as this. Applying that methodology, CMS could have realized potential interest income totaling $12,971.

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INTRODUCTION

BACKGROUND

State Responsibility for Medicaid Provider Overpayments

The Medicaid program, established by title XIX of the Act, provides grants to States for medical and health-related services for eligible low-income persons. This program is a jointly funded cooperative venture between the Federal and State Governments.

CMS administers the Medicaid program at the Federal level and is responsible for ensuring that State Medicaid programs meet all Federal requirements. States are required to submit to CMS a comprehensive State plan that describes the nature and scope of its program. If the State plan meets specific Federal requirements, CMS matches the State's Medicaid spending through Federal financial participation. The amount is determined by a formula based on the State's per capita income.

Each State establishes or designates an agency to manage the Medicaid program. The Department of Social and Rehabilitation Services is responsible for administering the Medicaid program in Kansas. It contracted with Electronic Data Services to act as its fiscal agent, which is responsible for identification and collection of most provider overpayments. State agency employees process the remaining overpayments and collections.

Criteria for Medicaid Provider Overpayments

CMS cites section 1903(d)(2) of the Act as the principal authority in disallowing the Federal share for provider overpayments. The Consolidated Omnibus Budget Reconciliation Act of 1985 amended this section and states that CMS will adjust reimbursement to a State for any overpayment. Furthermore, 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 CMS 64 report for the quarter in which the 60-day period following discovery ends.

According to 42 CFR 433.316, an overpayment resulting from a situation other than fraud or abuse is "discovered" on the earliest date that:

1) any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery,

2) a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency, or

3) any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

Additionally, the regulation specifies that overpayments resulting from fraud or abuse be considered 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.

Finally, Departmental Appeals Board decision 1391 addresses overpayment settlements between the State and a provider. States are not allowed to reduce the Federal share by settling overpayment receivables with a provider for less money than is supported by the provider's records.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if the State agency reported Medicaid provider overpayments according to Federal regulations.

Scope

We examined Medicaid provider overpayments subject to the requirements of 42 CFR 433 subpart F for the period October 1, 2002, through September 30, 2003. We also reviewed MFCU overpayments that were reportable prior to our audit period but had not yet been reported on the CMS 64 report as required. Overall, we reviewed 217 provider overpayments totaling $3,884,069.

We did not review the overall internal control structure of State agency operations or the agency's financial management. However, we gained an understanding of controls with respect to provider overpayments.

Methodology

We reviewed applicable Federal criteria, including section 1903 of the Act, 42 CFR 433, Departmental Appeals Board decision 1391, and applicable sections of the State Medicaid manual.

During fieldwork, we interviewed State agency and fiscal agent officials responsible for identifying and monitoring collections of overpayments, as well as staff responsible for reporting the Federal share of overpayments. We reviewed overpayment case files to determine the date of discovery and status of the overpayment, as well as if any adjustments or write-offs occurred during the audit period. We also reviewed information provided by the MFCU to determine outstanding balances for MFCU overpayments.

In addition, we compared the CMS 64 reports, submitted by the State agency to CMS, to supporting documentation. Furthermore, we verified the collection of some overpayments with information provided from the Medicaid Management Information System.

We calculated the number of days between the actual and required reporting dates. We analyzed this information to determine if the State agency reported overpayments accurately and in compliance with time requirements. We applied a cutoff date, September 8, 2004, for the overpayments that remained unreported during our audit.

Finally, we calculated potential lost interest using the CMIA Rate[1] applied to the Federal share of late overpayments.

We performed fieldwork at the State agency and fiscal agent offices in Topeka, KS, during September through November 2004.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency did not report all Medicaid provider overpayments on the quarterly CMS 64 reports in accordance with Federal regulations. Its policies and procedures were not sufficient to ensure the timely reporting of all overpayments. As a result, the State agency delayed returning overpayments totaling $2,395,384 ($1,478,950 FFP). Of that amount, the State agency has not yet reported or returned to the Federal Government overpayments totaling $858,669 ($537,210 FFP).

OVERPAYMENTS NOT REPORTED TIMELY

Criteria-The State Agency Must Return the Federal Share Within 60 Days of Discovery

According to 42 CFR 433 subpart F, the State agency has 60 days from the date of discovery to recover a provider overpayment. The State agency must refund the Federal share of overpayments by the end of the 60-day period, whether or not the State has recovered the overpayment from the provider. The State agency must credit the Federal share on the CMS 64 report for the quarter in which the 60-day period following discovery ends.

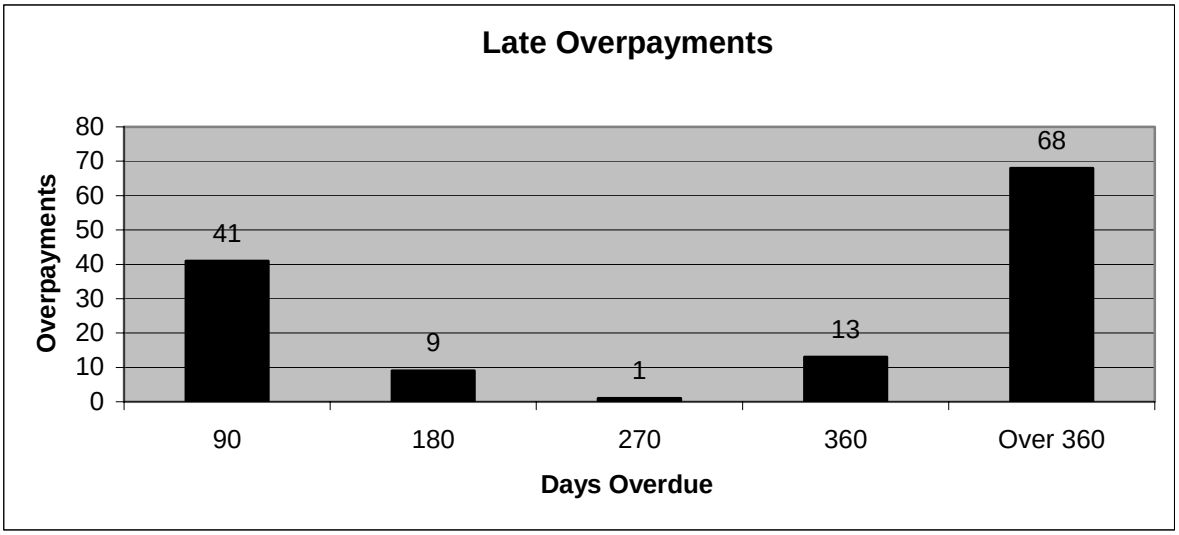
In addition, Departmental Appeals Board decision 1391 addresses overpayment settlements between the State and a provider. States are not allowed to reduce the Federal share by settling overpayment receivables with a provider for less money than is supported by the provider's records.

[1]The CMIA Rate is a 1.14 percent annualized interest rate per the CMIA. The CMIA aims to improve the transfer of Federal funds between the Federal Government and the States, Territories, and the District of Columbia and provides a means to assess an interest liability to the Federal Government and/or the States to compensate for the lost value of funds.

Condition-The State Agency Reported Overpayments Late

The State agency did not report 132 overpayments on the CMS 64 report in the proper quarter as required. Specifically, the State agency did not report all or some portion of 76 overpayments; it reported 56 others late.

The following chart provides a breakdown of the past due overpayments:



Cause-The State Agency's Policies and Procedures Were Insufficient

The State agency's policies and procedures were not sufficient to ensure timely reporting of all overpayments. Specifically, it delayed returning the Federal share of overpayments until it reached a settlement with providers. On occasion, it recovered less than the identified amount from providers, which inappropriately reduced the Federal share returned.

Furthermore, the State agency adjusted overpayments without proper supporting documentation from providers. Such action also inappropriately reduced the Federal share returned for the overpayment.

Finally, it did not have policies and procedures in place to report overpayments identified by MFCU.

Effect-The State Agency Did Not Return the Federal Share When Due

The State agency delayed reporting all or some portion of 132 overpayments. The Federal share of the overpayments totaling $1,478,950 was not returned to the Federal Government when due. The State agency has not reported or returned the Federal share of outstanding overpayments totaling $537,210.

RECOMMENDATIONS

The State agency should:

- return the Federal share of overpayments totaling $537,210 to the Federal Government as soon as possible and

- strengthen policies and procedures to ensure all overpayments are reported in accordance with Federal regulations.

Specifically, it should:

- return the Federal share of identified Medicaid provider overpayments within established timeframes and

- develop policies and procedures to report MFCU overpayments as required.

AUDITEE'S RESPONSE

The State agency agreed with our findings and recommendations. The State agency's response is included in its entirety as Appendix A.

The State agency agreed to return $537,210 to the Federal Government. That amount represents $61,457 less than we identified in our draft report as unpaid Medicaid overpayments. The State agency provided additional documentation to support the adjustment.

The State agency also agreed to strengthen its policies and procedures to ensure timely reporting of overpayments.

OIG COMMENTS

We reviewed additional documentation provided by the State agency in support of a reduction totaling $61,457 for overpayments we reported in our draft report as currently due. The documentation adequately supported recovery of the disputed overpayments. Therefore, we adjusted the amounts in this final report accordingly.

OTHER MATTER

Opportunity Cost

By not reporting overpayments in a timely manner, the State agency effectively denied CMS the use of funds that otherwise would have been available for the Medicaid program. The CMIA provides a means to calculate the value of opportunity costs such as this. Applying that methodology, CMS could have realized potential interest income totaling $12,971.

APPENDIX

GARY J. DANIELS, ACTING SECRETARY

K A N S A S

SOCIAL AND REHABILITATION SERVICES

KATHLEEN SEBELIUS, GOVERNOR

Health Care Policy / Medical Policy Division
Scott Brunner, Director

December 23, 2004

Mr. James P. Aasmundstad
Regional Inspector General for Audit Services
Office of Inspector General – Region VII
601 East 12th Street, Room 284A
Kansas City, Missouri 64106

REPORT # A-07-04-03060

Dear Mr. Aasmundstad:

This letter is in response to the U.S. Department of Health and Human Services (HHS), Office of Inspector General's draft report, dated November 29, 2004, entitled, "Review of Kansas's Accounts Receivable System for Medicaid Provider Overpayments" for the period October 1, 2002 through September 30, 2003.

We have examined the validity of the facts and the recommendations presented to us. As requested, we are providing written response to address status of implementing your recommendations as well as identification of monies actually recovered, but not originally reported to the OIG auditors as well as presentation of supporting documentation.

FINDINGS AND RECOMMENDATIONS

Overpayments Not Reported Timely

We do understand that we are required to return the Federal share of overpayments within 60 days of the date of discovery, regardless of whether the recovery of the monies from the provider has occurred. With our new interchange MMIS, as claims and adjustments are adjudicated the Federal share is automatically returned to the Government through the normal CMS reporting process.

Recommendations

Processes will be put in place to ensure timely reporting of overpayments. This will be accomplished through the system modifications described in this report response as well as implementing more stringent guidelines and procedures that will be adhered to by both the fiscal agent staff as well as Agency staff.

We are currently outlining our procedures to better monitor and track provider repayment activity resulting from SURS reviews. We will be making modifications to the Medicaid Management Information System (MMIS) to assign tracking numbers to our SURS adjustments. This number will become part of the claim record and will follow that claim adjustment through the entire process, from entry through to adjudication. In addition to this modification, we will develop a process to examine adjustments that may have been initiated by the provider that would fall outside of the SURS process, but have an impact on recoupment and reporting of the provider's overpayment.

We are setting up procedures to no longer allow settlements unless additional documentation supports the requirements for the services billed. Additionally, our processes will include specific instructions for reporting on the payment of the Federal share of the identified provider overpayment, not the reduced amount.

We are also developing policies and procedures that will be used by the State Agency to report overpayment activity to the Medicaid Fraud Control Unit (MFCU).

REBUTTAL ON SURS LOW RECOVERY AMOUNT

OIG auditors originally identified $151,493.00 as the amount that was not recovered from the providers as overpayments. After further review, we have determined that $98,019.14 of the SURS Low Recovery Amount has been recovered, however, was not originally reported to the auditors. We are requesting consideration of this additional information and asking that the Federal share of the overpayments totaling $598,667 be reduced by the appropriate amount. Attached is documentation that supports these recoveries. It is provider-specific and details the Internal Control Number (ICN) of the overpayments that have been recovered.

We appreciate the review that the auditors conducted and are continuing to work to improve our policies and procedures. If you have questions, please contact Cynthia Ludwig at 785-296-7286.

Sincerely,

Christiane Swartz for

Scott Brunner
Medicaid Director

Enclosure

SB:mcm

cc: Mary Hoover
Cynthia Ludwig
Maria Montgomery
Chris Swartz