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 26, 2005

Report Number: A-07-04-03061

Ms. Mary Steiner
Interim Medical Services Administrator
Department of Health & Human Services
P.O. Box 95026
301 Centennial Mall South, 5th Floor
Lincoln, Nebraska 68509

Dear Ms. Steiner:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General report entitled "Review of Nebraska'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 HHS 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 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-07-04-03061 in all correspondence. Any questions regarding this report are welcome. Please contact Greg Tambke, Audit Manager, 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:

Mr. Richard Brummel
Acting Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
601 E. 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

JANUARY 2005
A-07-04-03061

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 Health and Human Services Finance and Support (State agency) is responsible for the administration of the Medicaid program in Nebraska.

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 to the Federal Government within 60 days of the date of discovery. States must credit the Federal share of the overpayments on the CMS 64 expenditure report for the quarter in which the 60-day period ends.

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 448 overpayments totaling $1,474,801 ($897,261 FFP). Of that amount, the State agency had not yet reported or returned to the Federal Government 353 overpayments totaling $767,304 ($467,599 FFP) as of September 7, 2004.

RECOMMENDATIONS

The State agency should:

- return the Federal share of overpayments totaling $467,599 to the Federal Government as soon as possible and

- establish 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 Nebraska Family Online User System[1] (N-FOCUS) overpayments as required.

AUDITEE'S COMMENTS

The State agency generally agreed with our findings and recommendations. It agreed to return $313,056, representing 345 overpayments, to the Federal Government and has initiated a repayment schedule for that amount. The State agency's complete comments are included as Appendix A.

The State agency took issue with the date of discovery for the remaining eight overpayments totaling $154,543. According to the State agency, these overpayments "resulted from fraud and/or abuse reviews that are under appeal, have not had a hearing decision and have not had a final notice to the provider."

OIG'S RESPONSE

The State agency did not contend that the contested overpayments represented fraud and/or abuse, only that they were a result of fraud and/or abuse reviews. However, it did contend that the date of discovery had not been established because the cases are in appeal and, pending the outcome of a hearing, it cannot send final notices to the providers.

Federal regulations very clearly state: "Any appeal rights extended to a provider do not extend the date of discovery." Two of the cases in disagreement are not in appeal as contended by the State agency and are simply unpaid to date. Regardless, for all eight cases, the State agency initiated recovery by entering the overpayment amounts into the Medicaid Management Information System (MMIS) and notifying the provider that an adjustment was requested. That action established the date of discovery and initiated the 60-day recovery period.

The fact that the overpayments are under appeal and final amounts have not been determined by hearing have no bearing on when the Federal share is due to the Federal Government.

OTHER MATTER

By not reporting overpayments in a timely manner, the State agency effectively denied CMS the use of funds that would have otherwise 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 $11,180.

[1]The N-FOCUS processes Medicaid provider overpayments for six disability waivers which are: Aged and Disabled, Adult Developmental Disabilities, Child Developmental Disabilities, Developmental Disabilities Adult Comp, Developmental Disabilities Adult Day, and Developmental Disabilities Adult Resident.

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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 to 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. A formula based on the State's per capita income determines this amount.

Each State establishes or designates an agency to manage the Medicaid program. The Department of Health and Human Services Finance and Support is responsible for administering the Medicaid program in Nebraska.

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.

States are required to return the Federal share of overpayments within 60 days of the date of discovery, whether or not the State has recovered the amount from providers. 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 of the date:

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 reviewed overpayments that were reportable prior to our audit period but had not yet been reported on the CMS 64 report as required.

We expanded the scope of our audit to July 31, 2004, for the N-FOCUS overpayments for disability waivers[2], because we determined the State had not reported these overpayments since the system began processing the overpayments for the disability waivers in 1998.

We also expanded the scope of our audit for write-offs to cover the past 5 Federal fiscal years (1999-2004) because of discrepancies between how the State wrote-off overpayments and what is required by Federal regulations.

Therefore, we reviewed 866 provider overpayments totaling $2,977,743.

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 and 42 CFR 433. We also reviewed applicable sections of the State Medicaid manual and the State agency's policies and procedures.

[2]The N-FOCUS processes Medicaid provider overpayments for six disability waivers which are: Aged and Disabled, Adult Developmental Disabilities, Child Developmental Disabilities, Developmental Disabilities Adult Comp, Developmental Disabilities Adult Day, and Developmental Disabilities Adult Resident.

During fieldwork, we interviewed State agency officials responsible for identifying and monitoring collections of overpayments, as well as staff responsible for reporting the Federal share of overpayments. We reviewed documentation contained in provider case files, provided by State agency officials, 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. In addition, we compared the CMS 64 reports, submitted by the State agency to CMS, to supporting documentation.

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 7, 2004, for those overpayments that remained unreported.

Finally, we calculated potential lost interest using the CMIA Rate[3] applied to the Federal share of late overpayments.

We performed fieldwork at the State agency in Lincoln, NE, between September and 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 448 overpayments totaling $1,474,801 ($897,261 FFP). Of that amount, the State agency had not yet reported or returned to the Federal Government 353 overpayments totaling $767,304 ($467,599 FFP) as of September 7, 2004.

OVERPAYMENTS NOT REPORTED TIMELY

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

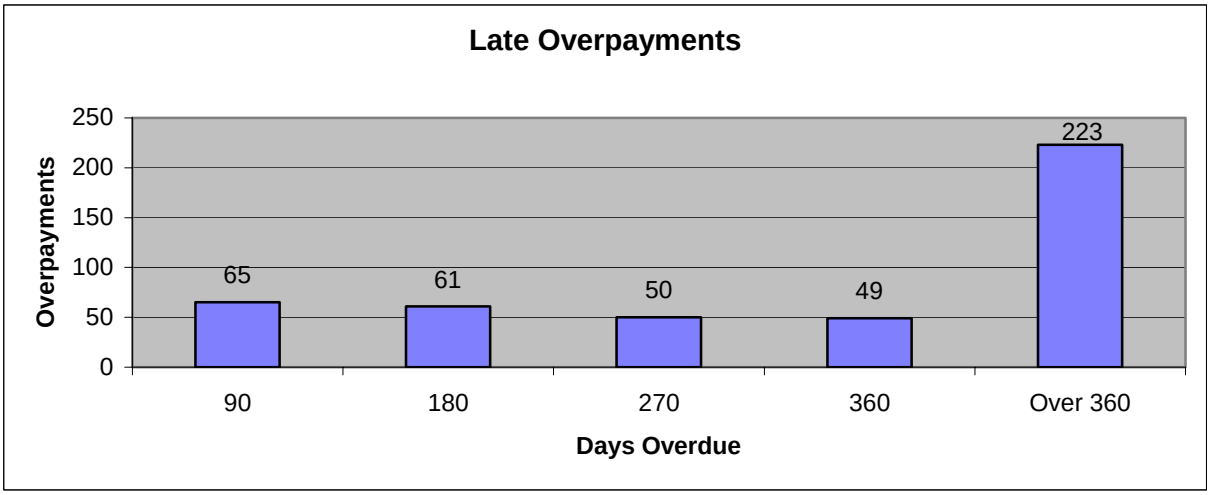
According to 42 CFR 433 subpart F, the State agency has 60 days from the date of discovery to recover a provider overpayment. The State agency must refund the Federal share of overpayments at the end of the 60-day period, whether or not the State has recovered the overpayment from the provider. The State agency must credit the Federal share on the CMS 64 report for the quarter in which the 60-day period following discovery ends. There are exceptions to this rule if a provider declares bankruptcy or goes out of business within the 60-day period providing certain requirements are met.

[3]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 448 overpayments on the proper quarterly CMS 64 report as required. Specifically, the State agency did not report all or some portion of 353 overpayments; it reported 95 others late.

The following chart provides a breakdown of the 448 past due overpayments:



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

The State agency did not have sufficient policies and procedures in place to ensure timely reporting of all overpayments on the CMS 64 reports.

Specifically, it did not have policies and procedures in place to properly report the Federal share of appealed overpayments. The State delayed reporting the Federal share of appealed overpayments until it reached final settlement with the provider. Furthermore, it did not have policies and procedures in place to properly determine and document when an overpayment may be written-off as uncollectible.

In addition, the State agency did not develop sufficient policies and procedures to monitor N-FOCUS disability waiver overpayments to ensure that these were reported to the Federal Government. A monthly delinquent account report that identifies overpayments that have no activity for 90 days was not reviewed to identify past due overpayments.

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

The State agency did not report the Federal share of 448 Medicaid provider overpayments totaling $897,261 on the CMS 64 report in accordance with Federal regulations. As of September 7, 2004, the State agency had not yet reported the Federal share for 353 of those overpayments totaling $467,599.

RECOMMENDATIONS

The State agency should:

- return the Federal share of overpayments totaling $467,599 to the Federal Government as soon as possible and

- establish 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 N-FOCUS overpayments as required.

AUDITEE'S RESPONSE AND OIG COMMENTS

The State agency generally agreed with our findings and recommendations. The State agency's complete comments are included as Appendix A.

1) The State agency should ensure that the Federal share of overpayments totaling $467,599 is returned to the Federal Government as soon as possible.

Auditee Response:

The State agency agreed to return $313,056, representing 345 overpayments, to the Federal Government and has initiated a repayment schedule for that amount. It took issue with the date of discovery for the remaining eight overpayments totaling $154,543. According to the State agency, these overpayments "resulted from fraud and/or abuse reviews that are under appeal, have not had a hearing decision, and have not had a final notice to the provider."

OIG Comments:

According to 42 CFR 433.316, an overpayment is discovered on the earliest of ". . . (1) The date on which 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; . . . (3) The date on which 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."

The State agency sent a letter to each provider as notification that a review was performed and a refund was requested. The letter explained to the provider that it is allowed 30 days to refund the amount requested, to show that the refund has already been made, or to document why the refund request is in error or appeal. The revised claim information then was entered into the

MMIS, which calculated the overpayment amount, notified the provider of the amount owed, and initiated recovery.

The State agency did not contend that the contested overpayments represented fraud and/or abuse, only that they were a result of fraud and/or abuse reviews. However, it did contend that the date of discovery had not been established because the cases were in appeal and, pending the outcome of a hearing, it cannot send final notices to the providers.

Federal regulations at 42 CFR 433.316 very clearly state: "Any appeal rights extended to a provider do not extend the date of discovery." Two of the cases in disagreement are not in appeal as contended by the State agency and are simply unpaid to date. Regardless, for all eight cases, the State agency initiated recovery by entering revised claim information into the MMIS and notifying the provider that an adjustment was requested. That action established the date of discovery and initiated the 60-day recovery period.

The fact that the overpayments were under appeal and final amounts had not been determined by hearing have no bearing on when the Federal share is due to the Government. Therefore, the State agency should return the Federal share for the remaining eight overpayments totaling $154,543 as soon as possible.

2) The State agency should strengthen policies and procedures to ensure all overpayments are reported in accordance with Federal regulations.

Auditee Response:

The State agency concurred with our findings. The State is taking steps to develop a process to ensure timely and accurate reporting of all Medicaid provider overpayments on the CMS 64.

OTHER MATTER

Opportunity Cost

By not reporting overpayments in a timely manner, the State agency effectively denied CMS the use of funds that would have otherwise 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 $11,180.

APPENDIX A

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

January 11, 2005

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

RE: Report No. A-07-04-03061

Dear Mr. Aasmundstad:

The Nebraska Medicaid Program's response to the above–referenced draft audit reported entitled "Review of Nebraska's Accounts Receivable System for Medicaid Provider Overpayments" for the period of October 1, 2002, through September 30, 2003, is attached.

If you have any questions about the State's response, please contact me at 402-471-9567 or at mary.steiner@hhss.ne.gov.

Thank you for the opportunity to review and respond to this report.

Sincerely,

Mary Steiner

Mary Steiner
Interim Medicaid Director
Medicaid Division

Attachment

Nebraska Health and Human Services Finance and Support
Medicaid Division

Response to OIG Audit Report A-07-04-03061
Accounts Receivable System for Medicaid
Provider Overpayments

Recommendation #1:

That the State agency should return the Federal share of overpayments totaling $467,599 to the Federal Government as soon as possible.

Response:

The State agrees to pay back the appropriate amount to the Federal government on the January – March 2005 CMS 64. This amount will include all those collections that have not been previously credited and are final.

The Audit report breaks down the $467,599 requested federal share into five categories. The State agrees with the federal share amounts associated with the following categories:

- SURS Overpayments Outstanding $ 39,318
- NFOCUS Overpayments Outstanding $159,008
- Write-Offs $ 51,582

The State also agrees with the federal share amount of $63,149 for the Critical Access Hospital (CAH) Overpayments Outstanding category; however, $14,019 has already been reported on the July – September 2004 CMS 64 and $20,078 is being reported on the October – December 2004 CMS 64 report. The remaining CAH overpayments of $29,052 will be reported on the January – March 2005 CMS 64.

However, the State is not in agreement with the recommendation to repay the federal share of overpayments that resulted from fraud and/or abuse reviews that are under appeal, have not had a hearing decision and have not had a final notice to the provider. This overpayment amount, categorized as MMIS Overpayments Outstanding, is currently $154,543 federal share. After final appeal hearing notices are issued, the appropriate federal share will be immediately credited to the Federal government on the next CMS 64.

Recommendation #2:

That the State agency should establish policies and procedures to ensure all overpayments are reported in accordance with Federal regulations. Specifically, that the State should return the Federal share of identified Medicaid provider overpayments within established timeframes and develop policies and procedures to report Nebraska Family Online User System (N-FOCUS) overpayments as required.

Response:

The Nebraska Medicaid Program concurs with this finding. For future balances which may exceed the 60-day requirement, the State is making a priority of developing a process to ensure timely and accurate crediting of Federal funds on the CMS 64.