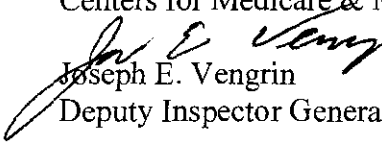




AUG 30 2005

TO: Dennis G. Smith
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of District of Columbia's Accounts Receivable System for
Medicaid Provider Overpayments (A-03-03-00222)

Attached is an advance copy of our final report on the District of Columbia's (the District's) accounts receivable system for Medicaid provider overpayments. We will issue this report to the District within 5 business days. This review was part of a multistate audit.

Our objective was to determine whether the District reported Medicaid provider overpayments in accordance with Federal requirements.

The District did not report all overpayments in accordance with Federal requirements during our October 1, 2001, through September 30, 2002, audit period. Specifically, the District (1) did not report overpayments totaling \$3,999,211 (\$2,195,049 Federal share) to the Centers for Medicare & Medicaid Services (CMS) because the overpayments had not been collected due to appeals from the providers and (2) did not report overpayments totaling \$16,172,361 (\$9,168,584 Federal share) within the required timeframe because the District reimbursed CMS only after collecting overpayments from providers. This nonreporting and untimely reporting potentially resulted in approximately \$135,000 in higher interest expense to the Federal Government.

We recommend that the District:

- include unreported overpayments totaling \$3,999,211 on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), and refund the \$2,195,049 Federal share;
- determine the value of overpayments identified after our audit period that have not been reported and include them on the CMS-64;
- establish a policy consistent with Federal reporting requirements that accurately reports overpayments on the CMS-64; and

- ensure that all future overpayments are reported within 60 days in accordance with Federal regulations, thereby mitigating the potentially higher interest expense to the Federal Government.

In response to our draft report, the District concurred with the results of our audit and said that it was in the process of reporting the identified overpayments. The District did not address our recommendation to determine the value of overpayments identified after our audit period that have not been reported. However, the District stated that, based on our recommendations, it now reported all overpayments and any changes in overpayments on the CMS-64 in the quarter when the identification or change occurred.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470. Please refer to report number A-03-03-00222 in all correspondence.

Attachment



Office of Audit Services – Region III
Public Ledger Building, Room 316
150 South Independence Mall West
Philadelphia, PA 19106-3499

AUG 31 2005

Report Number: A-03-03-00222

Mr. Robert T. Maruca
Senior Deputy Director
Department of Health
Medical Assistance Administration
825 North Capital Street, NE., Suite 5135
Washington, D.C. 20002

Dear Mr. Maruca:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General final report entitled “Review of District of Columbia’s Accounts Receivable System for Medicaid Provider Overpayments.” A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

The HHS action official named below 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 522, as amended by Public Law 104-231), Office of Inspector General reports issued to the Department’s grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to contact me at (215) 861-4470 or through e-mail at stephen.virbitsky@oig.hhs.gov, or your staff may contact Mr. James Maiorano, Audit Manager, at (215) 861-4476 or through e-mail at james.maiorano@oig.hhs.gov. Please refer to report number A-03-03-00222 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", written over a horizontal line.

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Nancy B. O'Connor
Regional Administrator
Centers for Medicare & Medicaid Services, Region III
U.S. Department of Health and Human Services
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, Pennsylvania 19106-3499

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF DISTRICT OF
COLUMBIA'S ACCOUNTS
RECEIVABLE SYSTEM FOR MEDICAID
PROVIDER OVERPAYMENTS**



**Daniel R. Levinson
Inspector General**

**AUGUST 2005
A-03-03-00222**

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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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 report is part of a multistate audit focusing on States' accounts receivable systems for Medicaid provider overpayments that were reportable during the period of October 1, 2001, through September 30, 2002. An overpayment is a payment to a provider in excess of the allowable amount.

Section 1903(d)(2) of the Social Security Act (the Act) is the principal authority that the Centers for Medicare & Medicaid Services (CMS) cites in disallowing the Federal share of overpayments to providers. Section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 amended this section of the Act. Regulations addressing overpayments and credit adjustments are found at 42 CFR part 433.

The Act states that CMS will adjust reimbursements to a State for any overpayment or underpayment and requires States to report overpayment adjustments within 60 days from 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, provided that the State followed proper due diligence during the 60-day period.

In the District of Columbia (the District), the Agency for Medical Assistance Administration administers the Medicaid program.

OBJECTIVE

Our objective was to determine whether the District reported Medicaid provider overpayments in accordance with Federal requirements.

SUMMARY OF FINDINGS

The District did not report all overpayments in accordance with Federal requirements:

- The District did not report 25 overpayments totaling \$3,999,211 (\$2,195,049 Federal share) because the overpayments were under appeal and had not been collected.
- The District did not report 78 overpayments totaling \$16,172,361 (\$9,168,584 Federal share) within the required timeframe because its practice was to report overpayments only after collecting them from providers.

As a result, the District did not return the \$2,195,049 Federal share of unreported overpayments and delayed returning the \$9,168,584 Federal share of overpayments not reported timely. The

District's nonreporting and untimely reporting also potentially resulted in approximately \$135,000 in higher interest expense to the Federal Government.

RECOMMENDATIONS

We recommend that the District:

- include unreported overpayments totaling \$3,999,211 on the CMS-64 and refund the \$2,195,049 Federal share;
- determine the value of overpayments identified after our audit period that have not been reported and include them on the CMS-64;
- establish a policy consistent with Federal reporting requirements that accurately reports overpayments on the CMS-64; and
- ensure that all future overpayments are reported within 60 days in accordance with Federal regulations, thereby mitigating the potentially higher interest expense to the Federal Government.

DISTRICT'S COMMENTS

In response to our draft report, the District concurred with the results of our audit and said that it was in the process of reporting the identified overpayments. The District did not address our recommendation to determine the value of overpayments identified after our audit period that have not been reported. However, the District stated that, based on our recommendations, it now reported all overpayments and any changes in overpayments on the CMS-64 in the quarter when the identification or change occurred.

The District's comments are included as an appendix to this report.

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INTRODUCTION

BACKGROUND

This report is 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 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 its own plan, which the Centers for Medicare & Medicaid Services (CMS) approves for compliance with Federal laws and regulations. Section 1905(b) of the Social Security Act (the Act) established a financing formula to calculate the Federal share of the medical assistance expenditures under each State's Medicaid program.

In the District of Columbia (the District), the Agency for Medical Assistance Administration (the State agency) administers the Medicaid program. The Federal share of expenditures in the District was 70 percent beginning in fiscal year 1998 and 50 percent for fiscal years before 1998.

Medicaid Overpayments

Section 1903(d)(2) of the Act is the principal authority that CMS cites in disallowing the Federal share of overpayments to providers. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 amended this section of the Act. Regulations addressing overpayments and credit adjustments are found at 42 CFR part 433.

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Therefore, when a State recognizes that it has made a Medicaid overpayment, the amount of the overpayment must be reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), as an offset to expenditures. Under certain circumstances, such as the provider's bankruptcy, the State may reclaim the overpayment on the CMS-64. For example, assume the State pays a provider \$100,000 for Medicaid services rendered and claims the expenditures on the CMS-64. Through a later review, the State learns that the provider was overpaid by \$25,000. The State must show the \$25,000 overpayment on the CMS-64, reducing expenditures eligible for Federal participation by this amount. If the provider is then determined to be bankrupt, the State may make a decreasing adjustment to the overpayments on the CMS-64, thus reclaiming the \$25,000 overpayment.

Within the District's State agency, the Office of Audit & Finance and the Office of Program Integrity identify Medicaid overpayments. These units perform reviews of Medicaid claims and settlements to determine whether payments to providers are accurate. The State agency

maintains a database of all identified overpayments to ensure collection. Each quarter, overpayments collected are summarized and reported on the CMS-64. At the end of the fiscal year, the remaining uncollected overpayments are scheduled and reported on line 10C of the CMS-64.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the District reported Medicaid provider overpayments in accordance with Federal requirements.

Scope

We examined overpayments and credit adjustments that were reported or should have been reported on the four quarterly CMS-64s for the period October 1, 2001, through September 30, 2002. The total amount reported during the audit period was \$25,422,608.

The objective of our audit did not require an understanding or assessment of the State agency's overall internal control structure. However, we gained an understanding of controls with respect to overpayments and the aging of accounts receivable. Our review was limited to controls over overpayments and was not intended to be a full-scale internal control assessment of the State agency's Medicaid operations or financial management system. We performed our audit at the State agency in Washington, DC.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal criteria, including section 1903 of the Act, Federal regulations at 42 CFR part 433, and applicable sections of the State Medicaid Manual;
- gained an understanding of the State agency's policies and procedures for managing provider overpayments;
- interviewed key State agency staff and reviewed documentation provided by the State agency's Office of Audit & Finance, Office of Program Integrity, and Office of the Chief Financial Officer;
- analyzed the four quarterly CMS-64s for fiscal year 2002, along with supporting documentation, to verify the reported overpayments and credit adjustments;
- obtained Medicaid provider overpayment listings and supporting documents to verify accurate reporting; and

- calculated, using the number of days between the actual and required reporting date, the potentially higher interest expense to the Federal Government for those overpayments that were not reported within the required timeframe.¹

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

FINDINGS AND RECOMMENDATIONS

The District did not report all overpayments in accordance with Federal requirements:

- The District did not report 25 overpayments totaling \$3,999,211 (\$2,195,049 Federal share) because the overpayments were under appeal and had not been collected.
- The District did not report 78 overpayments totaling \$16,172,361 (\$9,168,584 Federal share) within the required timeframe because its practice was to report overpayments only after collecting them from providers.

As a result, the District did not return the \$2,195,049 Federal share of unreported overpayments and delayed returning the \$9,168,584 Federal share of overpayments not reported timely. The District's nonreporting and untimely reporting also potentially resulted in approximately \$135,000 in higher interest expense to the Federal Government.

OVERPAYMENTS NOT REPORTED

The District did not report 25 identified overpayments totaling \$3,999,211 (\$2,195,049 Federal share) on the CMS-64 because they were under appeal and had not been collected. These overpayments were outstanding for an average of 684 days as of December 31, 2003.

Section 1903(d)(2) of the Act, as amended by section 9512 of COBRA, states that when an overpayment is discovered, the State has 60 days in which to recover or attempt to recover the overpayment before making an adjustment in the Federal payment to the State. Unless the provider is out of business or bankrupt, the State must make the adjustment at the end of the 60 days, whether or not the State has made the recovery. This legislation is codified in 42 CFR §§ 433.300–433.322.

In general, the District did not report overpayments until it collected them from providers or until the end of the fiscal year. However, when providers appealed disputed overpayments, the District did not report the overpayments until the appeals were complete and the overpayments were collected. As a result, the District did not return the \$2,195,049 Federal share for 25 overpayments that were under appeal during our audit period. This also potentially resulted in approximately \$43,000 in higher interest expense to the Federal Government.

¹We calculated the interest expense using the applicable annualized interest rate per the Cash Management Improvement Act of 1990.

OVERPAYMENTS NOT REPORTED TIMELY

The District did not report 78 overpayments totaling \$16,172,361 (\$9,168,584 Federal share) within the required timeframes because it reported overpayments to CMS only when it received the overpayments from the providers or at the end of the fiscal year.

Section 1903(d)(2) of the Act requires a State to report all identified overpayments within 60 days, whether or not the State recovered the funds. The Departmental Appeals Board (DAB) ruled that overpayment notification occurred when the State agency identified an overpayment in a draft report to the provider. For example, New York State Department of Social Services, DAB No. 1536 (1995), concluded that in cases not involving fraud or abuse, issuance of a draft audit report constituted written notice of a specified overpayment amount subject to recovery. Thus, under Federal criteria, overpayments are “discovered” at the draft audit stage.

The District did not have a policy for reporting overpayments when they were identified. After identifying an overpayment, the District gave the provider a year or more to repay without charging interest. When the District collected the overpayment, it reported the Federal share to CMS within 60 days. Also, at the end of the fiscal year, the District reported outstanding uncollected overpayments on the CMS-64.

As a result, the District delayed returning the \$9,168,584 Federal share of overpayments. This delay also potentially resulted in approximately \$92,000 in higher interest expense to the Federal Government.

RECOMMENDATIONS

We recommend that the District:

- include unreported overpayments totaling \$3,999,211 on the CMS-64 and refund the \$2,195,049 Federal share;
- determine the value of overpayments identified after our audit period that have not been reported and include them on the CMS-64;
- establish a policy consistent with Federal reporting requirements that accurately reports overpayments on the CMS-64; and
- ensure that all future overpayments are reported within 60 days in accordance with Federal regulations, thereby mitigating the potentially higher interest expense to the Federal Government.

DISTRICT’S COMMENTS

In response to our draft report, the District concurred with the results of our audit. The District said that it had revised several provider overpayments, which increased the Federal share owed from \$2,195,049 to \$2,262,014, an upward adjustment of \$66,965. According to the District, it

reported \$1,331,693 of the \$2,262,014 Federal share owed on the CMS-64 in fiscal year 2004 and planned to report the remaining \$930,321 on the CMS-64 for the quarter ended June 30, 2005.

The District did not address our recommendation to determine the value of overpayments identified after our audit period that have not been reported. However, the District stated that, in accordance with our recommendations, it had changed its reporting practice and now reported all overpayments and any changes in overpayments on the CMS-64 in the quarter when the identification or change occurred.

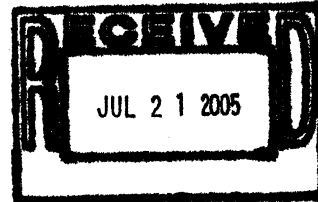
The District's comments are included as an appendix to this report.

APPENDIX

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Chief Financial Officer
Department of Health



Mr. Stephen Virbitsky
Regional Inspector General - Audit Services
Department of Health & Human Services
Office of the Inspector General
Office of Audit Services
150 South Independence Mall – West
Suite 316
Pennsylvania, PA 19106



Re: Report # A-03-03-00222

Dear Mr. Virbitsky:

The following is in response to your audit findings dated April 2005:

Finding:

The District did not report 25 overpayments totaling \$3,999,211 (\$2,195,049 Federal share) because these overpayments were under appeal and had not been collected.

Response:

It was the practice of the District to report overpayments when collected from providers or at the end of the fiscal year. If a provider appealed disputed overpayments, the District did not report the overpayments until the appeals were complete and the overpayments collected.

The District agrees that there were 25 overpayments not reported to the Centers for Medicare and Medicaid Services (CMS). However, since this audit was completed, the Medical Assistance Administration (MAA) has issued several revised final NPRs that adjust the amount owed. Revised NPRs (1996-1999) for Psychiatric Institute of Washington (provider number 0101620) were issued in 2004 and reported on the CMS-64 report for the quarter ending September 30, 2004. Revised NPRs (1994-1996) for DC ARC (provider number 0201260) were issued in 2004. The amounts owed were offset against current year expenditures, thus reducing the amount claimed on the CMS-64 for the period. Under CMS guidelines, overpayments reported for providers who subsequently go out of business or are adjudicated bankrupt may be recovered from CMS. It was the District's practice to report overpayments from providers when collected; no reporting was made for the uncollected balances for D.C. Community Services (provider numbers 0200020 and 0200350) when it went out of business in 2003. The amount for J.B. Johnson (provider number 0278950) was reported on the CMS-64 for the quarter ending December 31, 2003. Revised NPR (1993) for Capital Hill Medlink (provider number 0201400) was issued in 2004. The amounts owed were offset against current year expenditures, thus reducing the amount claimed on the CMS-64 for the period. See attached schedule.

Office of the Inspector General
Office of Audit Services
Page 2

The revised amount due to CMS is now \$1,556,068 (\$930,321 Federal share) and will be reported on the CMS-64 for the quarter ending June 30, 2005.

Base on the findings of this audit, the District has changed its practice of reporting overpayments. We are currently reporting all overpayments and any changes in overpayments on the CMS-64 in the quarter when the identification or change occurs.

Finding:

The District did not report 78 overpayments totaling \$16,172,361 (\$9,168,584 Federal share) within the required timeframe because its practice was to report overpayments only after collecting them from providers.

Response:

Based on the findings of this audit, the District has changed its practice of reporting overpayments. We are currently reporting all overpayments and any changes in overpayments on the CMS-64 in the quarter when the identification or change occurs.

If you have any questions please call Morris Thorpe, Controller, Department of Health on (202) 442-9085 or Tom Kennedy, Supervisory Accountant, Department of Health, on (202) 442-9232. Thank you.

Sincerely,



Deloras Shepherd
Associate Chief Financial Officer, Human Services Cluster

Enclosure

cc: Robert T. Maruca, Senior Deputy Director, MAA
Ed Pocaro, Chief of Staff, MAA
Morris Thorpe, OCFO
Tom Kennedy, OCFO
Isaac Woode, OCFO

MEDICAL ASSISTANCE ADMINISTRATION
MEDICAID ACCRUAL FY 2004
OIG Determination of Provider Overpayments due to CMS
9/30/2004

	Provider Number	Year	Original Unreported Amount	Revised FNPR Issued	Less: Recoupments in FY 2004	Amount Owed To CMS
Total amount owed per OIG audit						
			2,195,049.00			
Hospital for Sick Children	0101600	1998	466,943.00			
PIW	0101620	1996	106,224.00	68,631.00	(68,631.00)	466,943.00
PIW	0101620	1997	146,666.00	123,386.00	(123,386.00)	-
PIW	0101620	1998	62,104.00	79,624.00	(79,624.00)	-
PIW	0101620	1999	88,555.00	123,946.00	(123,946.00)	-
Sibley - Hospital	0190050	1996	126,212.00			126,212.00
Sibley - Hospital	0190050	1997	30,939.00			30,939.00
Sibley - Hospital	0190050	1998	6,149.00			6,149.00
Georgetown	0288866		86.00			86.00
NPRH	0157290	1996	5,062.00			5,062.00
NPRH	0157290	1999	59,912.00			59,912.00
Total for Hospitals						
			1,098,852.00	395,587.00	(395,587.00)	695,303.00
DC ARC	0201260	1994	61,447.00	9,058.00	(9,058.00)	-
DC ARC	0201260	1995	118,342.00	191,830.00	(191,830.00)	-
DC ARC	0201260	1996	91,807.00	239,827.00	(239,827.00)	-
DC Community Svcs	0200020	1996	27,172.00			-
DC Community Svcs	0200350	1996	26,539.00			-
MTS - 0200970	0200970	1996	29,038.00			-
MTS - 0201190	0201190	1995	110,721.00			29,038.00
MTS - 0201190	0201190	1996	85,714.00			110,721.00
St. John's - 0200400	0200400	1995	5,708.00			85,714.00
St. John's - 0200600	0200600	1995	976.00			5,708.00
St. John's - 0246540	0246540	1995	2,558.00			976.00
Total for ICFs/MR						
			560,022.00	440,715.00	(440,715.00)	234,715.00
Capital Hill Medlink	0201400	1993	326,855.00	286,374.00	(286,374.00)	-
J.B. Johnson	0278950	1996	209,017.00		(209,017.00)	-
Sibley - Nursing	0288841		303.00			303.00
Total for Nursing						
			536,175.00	286,374.00	(495,391.00)	303.00
Grand Total						
			2,195,049.00	1,122,876.00	(1,331,693.00)	930,321.00

Note: Interest accrued was waived by OIG auditors, see attached document.

A Recouped amounts have been reflected on CMS-64 reports.

B Provider went out of business in FY 2003.