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

August 19, 2004

Report Number: A-07-04-03051

Dr. Scott D. Williams
Executive Director
Utah Department of Health
PO Box 141000
Salt Lake City, Utah 84114-3103

Dear Dr. Williams:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Utah'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 below for his/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.

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To facilitate identification, please refer to report number A-07-04-03051 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:

Mr. Alex Trujillo
Regional Administrator, Region VIII
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

AUGUST 2004
A-07-04-03051

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This report is part of a nationwide audit focusing on States' accounts receivable systems for Medicaid provider overpayments that were reportable during the period October 1, 2002 through September 30, 2003. The Utah State Department of Health (State agency) is the single State agency responsible for the administration of the State's Medicaid program.

Provisions of the Social Security Act (the Act) provide the Centers for Medicare & Medicaid Services (CMS) the authority to approve States' plans for administering the Medicaid program. That legislation also 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. It must credit the Federal share of those overpayments on the CMS 64 report for the quarter in which the 60-day period ends.

OBJECTIVE

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

FINDINGS

The State agency did not report 93 Medicaid provider overpayments totaling $420,415 (Federal share) on the quarterly CMS 64 reports in accordance with Federal regulations. As of March 31, 2004, seven of those overpayments, totaling $22,492 (Federal share), remained unreported. It did not always follow established policies and procedures. Furthermore, its policies and procedures were not sufficient to ensure the timely reporting of all overpayments.

The State agency did not report additional overpayments totaling $110,257 (Federal share) on the September 2003 CMS 64 report. That amount represented credit balances maintained in the Medicaid Management Information System (MMIS) for 68 provider accounts that were outstanding for more than 60 days.

Therefore, the State agency did not report a total of $132,749 (Federal share) for Medicaid provider overpayments for the period October 1, 2002 through September 30, 2003 as required by Federal regulations.

RECOMMENDATIONS

The State Agency should:

- ensure that the Federal share of overpayments totaling $132,749 is returned to the Federal government as soon as possible;
- strengthen policies and procedures to ensure all overpayments are reported in accordance with Federal regulations. Specifically, it should:

- enforce its own policies and procedures;
- maintain a record or log of all claims considered for possible overpayments; and
- return the Federal share of Medicaid provider overpayments when required.

AUDITEE'S COMMENTS

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

The State agency agreed to return $132,749 to the Federal government, and to strengthen its policies and procedures. However, it took issue with the date discovery is established. According to the State agency, its "30 day letter" requests additional information and identifies an amount to be investigated. Until it receives the additional information, the amount is not "subject to recovery."

OIG'S RESPONSE

According to 42 CFR 433.316, the date on which an overpayment is discovered is when "…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…." Therefore, a letter specifying an amount "to be paid" determined the date of discovery. Granting additional time to provide further documentation or phrasing the notification letter to indicate this was a "preliminary finding" does not postpone or extend the date of discovery.

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 $2,071.

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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 written State Plan that describes the nature and scope of its program. If the State Plan meets specific Federal requirements, then CMS matches the State's Medicaid spending through Federal Financial Participation. This 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 Utah State Department of Health is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Act.

Criteria for Medicaid Provider Overpayments

The principal authority cited by CMS in disallowing the Federal share for provider overpayments is section 1903(d)(2) of the Act. 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 recovery was made. This legislation is codified in 42 CFR 433 subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers". The regulation 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, the date on which an overpayment is considered discovered is when:

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.

In cases of suspected fraud, according to 42 CFR 455.15, "(a) If a provider is suspected of fraud or abuse, the agency must--(1) In States with a State Medicaid fraud control unit[…], refer the case to the unit under the terms of its agreement[…] (b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency."

Utah's Bureau of Medicaid Operations' (BMO) policies and procedures require a weekly review of the credit balance report in order to identify credit balances older than 30 days. Such claims are subject to additional collection efforts.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

Our objective was to determine whether 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 overpayments that were reportable prior to our audit period but had not yet been reported on the CMS 64 report as required. Therefore, we reviewed 504 provider overpayments totaling $1,471,478.

We did not review the overall internal control structure of State agency operations or its 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.

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 manually pulled 629 case files to determine the date of discovery, status of the overpayment, and whether any adjustments or write-offs occurred during the audit period.

We also reviewed the credit balance report to determine if any providers had negative balances that were outstanding longer than 60 days. In addition, we compared the CMS 64 reports submitted to CMS by the State agency to supporting documentation. Furthermore, we utilized the MMIS to verify the collection of some overpayments.

We calculated the number of days between the actual and required reporting dates. We analyzed this information to determine whether the State agency reported overpayments accurately and in compliance with time requirements. We applied a cutoff date, March 31, 2004, for those 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 site work at the State agency in Salt Lake City, Utah during February through June of 2004.

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

FINDINGS AND RECOMMENDATIONS

The State agency did not report 93 Medicaid provider overpayments totaling $420,415 (Federal share) on the quarterly CMS 64 reports in accordance with Federal regulations. It reported all but seven of those overpayments totaling $22,492 (Federal share) on or before March 31, 2004. It did not always follow established policies and procedures. Furthermore, its policies and procedures were not sufficient to ensure the timely reporting of all overpayments.

The State agency did not report additional overpayments totaling $110,257 (Federal share) on the September 2003 CMS 64 report. That amount represented credit balances maintained in the MMIS for 68 provider accounts that were outstanding for more than 60 days.

Therefore, the State agency did not report a total of $132,749 for Medicaid provider overpayments for the period October 1, 2002 through September 30, 2003 as required by Federal regulations.

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.

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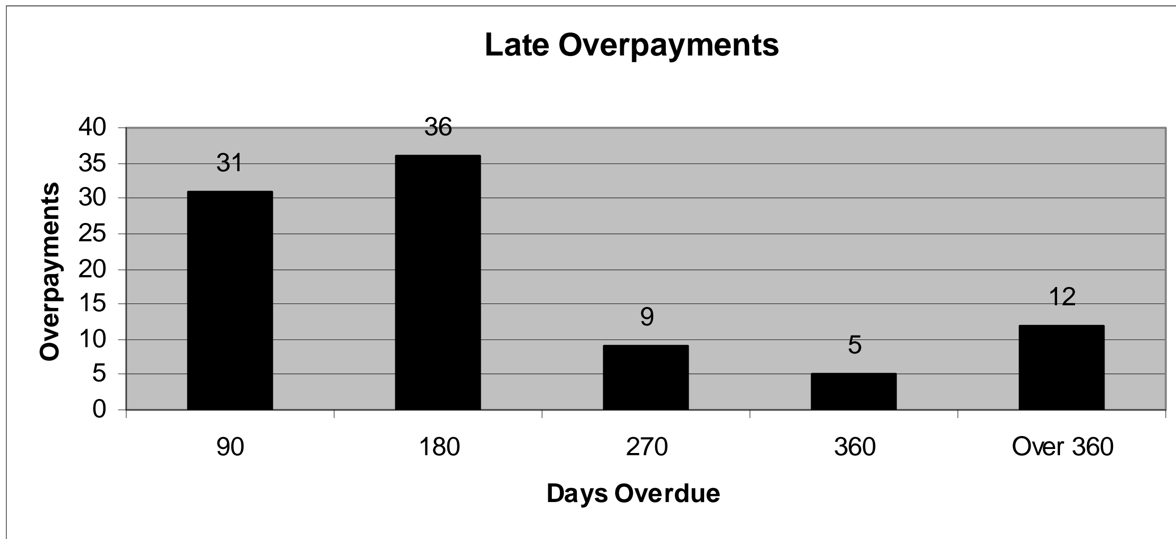
[1] 1.14 percent annualized interest rate per the CMIA of 1990. The CMIA of 1990 was passed to improve the transfer of Federal funds between the Federal government and the States, Territories, and the District of Columbia and provides a means to assess an interest liability to the Federal government 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 93 overpayments on the proper quarterly CMS 64 report as required. The State agency subsequently reported 86 overpayments, leaving 7 overpayments unreported. In addition, the BMO entered credit adjustments for providers in the MMIS in an effort to collect other overpayments. The MMIS credit balance report for September 2003 indicated that 68 providers had credit balances older than 60 days. The State agency did not report those balances on the CMS 64 report.

The following chart provides a breakdown of the 93 past due overpayments.



Cause-The State Agency Did Not Follow Its Own Policies and Procedures.

The State agency did not follow established procedures to ensure accurate processing of all accounting transactions and to ensure coordination among program units responsible for handling provider overpayments. Finance department staff did not report overpayments specified by the Program Integrity Unit (PIU) when the CMS 64 report was prepared. Those amounts were provided by the PIU to the Finance department as part of a monthly report that was to be used by them in the process of preparing the CMS 64 report. However, Finance department staff were not aware that the numbers contained in that part of the report were to be included on the CMS 64 report.

The BMO did not follow its own policies and procedures regarding credit balances. It was required to identify any credit balances that remained after 30 days by reviewing the credit balance report weekly. Further steps to collect those balances were then required. However, BMO did not perform the weekly reviews during our audit period.

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 the Federal share of overpayments. There was no central listing or control account to monitor the progress of potential overpayments. Thus, we had no assurance that, after examining more than 600 hard copy files, we had identified all overpayments applicable to our audit period.

The BMO policies and procedures regarding credit balances does not specify that when a negative credit balance extends past 60 days, it should be reported to the Finance department to be included on the quarterly CMS 64 Report.

Cause-The State Agency Misinterpreted the 60-day Requirement.

The State agency considers all overpayment cases as "potential" fraud and abuse. Therefore, it contends that the 60-day rule does not apply until a final settlement is reached with the provider. According to Federal regulations, suspected fraud or abuse cases must be referred to the Medicaid Fraud Control Unit (MFCU). Since July 1, 2002, only 18 cases have been referred to the MFCU by the State agency.

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

The State agency did not report 93 overpayments totaling $420,415 (Federal share) as required by Federal regulations. The State agency subsequently reported 86 overpayments ($397,923), leaving 7 overpayments unreported. Thus, the State agency has not reported the Federal share of those overpayments totaling $22,492.

In addition, the BMO entered credit adjustments for providers in the MMIS in an effort to collect other overpayments. The MMIS credit balance report for September 2003 indicated that 68 providers had credit balances older than 60 days. Ten of those providers had closed and were no longer submitting claims to offset the credit balances. As a result, the State agency did not return an additional $110,257 to the Federal government as required.

Overall, the State agency did not report Medicaid provider overpayments totaling $132,749 as of September 30, 2003 as required by Federal regulations.

RECOMMENDATIONS

The State Agency should:

- ensure that the Federal share of overpayments totaling $132,749 is returned to the Federal government as soon as possible;
- strengthen policies and procedures to ensure all overpayments are reported in accordance with Federal regulations. Specifically, it should:

- enforce its own policies and procedures;
- maintain a record or log of all claims considered for possible overpayments; and
- return the Federal share of Medicaid provider overpayments when required.

AUDITEE'S RESPONSE AND OIG COMMENTS

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

1) The State agency should ensure that the Federal share of overpayments totaling $132,749 is returned to the Federal government as soon as possible.

Auditee Response:

The State agency agreed to return $132,749 to the Federal government. That amount represents $2,366 less than we identified in our draft report as unpaid Medicaid overpayments. It cited additional review of documentation for the reason why the overpayment amount was reduced.

OIG Comments:

We reviewed additional documentation provided by the State agency in support of a reduction totaling $2,366 for overpayments we reported in our draft report as currently due. The documentation adequately explained eight overpayments. Those amounts were determined to have been a result of posting/billing errors or were appropriately recovered. Therefore, we adjusted the amounts in this final report accordingly.

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 and initiated corrective action. Changes will be made to the Credit Balance Report that will more efficiently identify when a provider is closed or when an overpayment is nearing the 60-day limit. Furthermore, it agreed to maintain an accurate log of all claims.

However, the State agency took issue with the date discovery is established. It stated that Federal regulations required it to conduct a preliminary investigation determining whether fraud or abuse occurred. The Program Integrity Unit (PIU) accomplishes the preliminary investigation. In this respect, all overpayments handled by the PIU are considered by them to be potential fraud and abuse cases. The PIU performs the following steps as their process of investigation:

- Identify the claim(s) to be investigated.
- Either send out a letter requesting records supporting the services billed, or do an on-site visit to evaluate the records.
- Allow designated time for the provider to submit records verifying charges.
- Evaluate records submitted, and determine what services are supported.
- Issue a letter identifying preliminary findings, and the dollar amount related to those findings. This letter would also advise the provider of the need to either remit the amount identified, submit additional information, or file a request for an administrative hearing within 30 days.

The State agency goes on to say that even if a case is determined to be a simple overpayment instead of fraud or abuse, Federal regulations require that the notice must specify "...a dollar amount that is subject to recovery." According to the State agency, its "30 day letter" requests additional information and identifies an amount to be investigated. Until the State agency receives the additional information, the amount is not "subject to recovery." According to the State agency, "Any action taken prior to the determination of a final amount of overpayment is considered part of the investigation process."

OIG Comments:

According to 42 CFR 433.316, the date on which an overpayment is discovered is when "…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…."

The first four steps of their overpayment collection process clearly represent what we would expect for a preliminary investigation. The fourth step results in the determination of supported services. At that point, they should have made a determination of the merits of the claim(s).

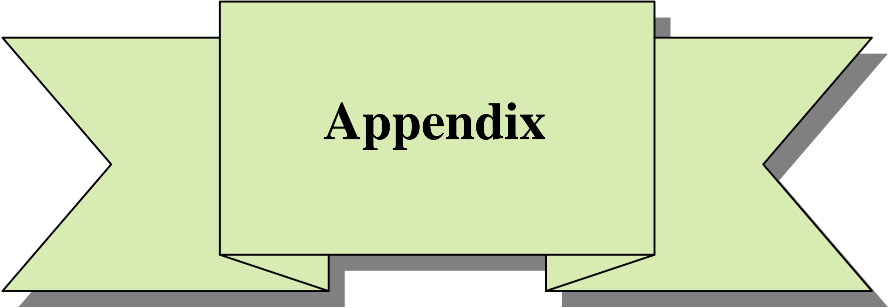
To illustrate, a letter was sent to a provider requesting information and explained that a review was being performed. That letter gave them 30 days to send in any information that would help the review process. Another letter was sent to the provider following review of the requested information, notifying the provider of an apparent total overpayment of a certain amount designated by the phrase, "This is the amount to be paid."

Therefore, a letter specifying an amount "to be paid" determined the date of discovery. Granting additional time to provide further documentation or phrasing the notification letter to indicate this was a "preliminary finding" does not postpone or extend the date of discovery.

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 $2,071.


Appendix

State of Utah

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Utah Department of Health
Executive Director's Office

Scott D. Williams, M.D., M.P.H.
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Deputy Director

August 6, 2004

James P. Aasmundstad
Regional Inspector General for Audit Services
Department of Health and Human Services
Region VII
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Aasmundstad:

Subject: Response to Draft Audit Report
No. A-07-04-03051

In accordance with your request of July 7, 2004, we are providing our response to your draft report entitled "Review of Utah's Accounts Receivable System for Medicaid Provider Overpayments." We appreciate the effort and professionalism of your audit staff, as well as the opportunity to provide our comments on the draft report. Our response by functional area follows and details our concern with the interpretation of some of the regulations cited in your report. We would prefer to resolve our differences in interpretation, if possible, prior to the final report being issued.

1. Program Integrity - Overpayments as Fraud and Abuse

There is a significant difference in interpretation of Federal regulations governing recovery of inappropriate payments in Medicaid. One of the areas of difference centers around the concept of "discovery" and differences between overpayment "discovery" and fraud and abuse "discovery". In this respect, states are required to return the Federal share of any overpayments to the Federal government within 60 days of "discovery". This is commonly referred to as the "60 day rule". Except for cases of overpayments resulting from fraud or abuse, "discovery" is determined by 42 CFR 433.316 (c) to be at the time the overpayment is identified as 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;

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"(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

"(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."

Paragraph 433.316 (d) states " An overpayment that results from fraud or abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider."

The difference in these two time frames is whether the case is being handled as a fraud or abuse issue, or a simple overpayment issue.

The Utah Medicaid Program is divided into multiple bureaus, all are involved in different aspects of the program. One of these organizations is the Bureau of Medicaid Operations. This Bureau is involved in operation of the primary components of the Medicaid Management Information System, payment of clean claims, and resolution of problems with claims that were not paid correctly. This includes both underpayments and overpayments.

The Bureau of Coverage and Reimbursement Policy includes a Program Integrity Unit which has the primary responsibility to operate the Surveillance and Utilization Review Subsystem (SURS), and investigate potential fraud and abuse issues. Functions of the Program Integrity Unit are defined in 42 CFR Part 455. Paragraph 455.1 states "This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control."

The draft audit report considers "fraud and abuse" as a single item even though Paragraph 455.2 specifically defines those terms as relating to separate and distinct practices. Page 5 of the draft report cites the referral of 18 cases to the Medicaid Fraud Control Unit (MFCU) as evidence that these were the only situations which qualify under the fraud and abuse "discovery" provision. We do not consider this a valid position. Paragraph 455.14 is part of the Program Integrity Section which, as defined above, is part of the fraud and abuse regulations. It specifically requires a state to conduct a preliminary investigation to determine whether fraud or abuse occurred. This preliminary investigation is accomplished by the Program Integrity Unit.

The report indicates that all suspected cases of fraud or abuse must be reported to the MFCU as required by Paragraph 455.15 (a) (1) which states "In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit ***under the terms of its agreement with the unit entered into under §1002.309 of this title***" (emphasis added). What the report needs to disclose is that in Utah the agreement between the two agencies states that the MFCU has the authority to process cases related to fraud or patient abuse and that billing abuse cases are processed by the Medicaid agency. In addition, although there may have only been 18 formal referrals to the MFCU, **all** Program Integrity investigations are discussed with the MFCU in monthly coordination meetings. MFCU also decides if there are additional cases they would like to review for fraud.

Issues handled by the Bureau of Medicaid Operations are considered to be simple overpayment issues, and the 60 day rule start date is the date the overpayment is first identified. Recovery of these overpayments are typically handled by offsetting amounts due against future payments and generally results in recovery of funds within a 2 week period from time of discovery. The exception to this response time has been the Credit Balance Report, which the audit correctly identified as an area requiring corrective action. We implemented procedural changes in the Credit Balance Report and believe that the changes will alleviate the type of problems previously encountered.

Issues handled by the Program Integrity Unit are considered to be potential fraud and abuse issues until completion of the "preliminary investigation" referred to in Paragraph 455.14 which states: "If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation." In this respect, the entire section of 42 CFR 455 is entitled "PROGRAM INTEGRITY: MEDICAID" and refers to situations related to fraud and/or abuse. Therefore, by Federal regulation, the actions of the Program Integrity Unit are "fraud and abuse" related activities.

If it can be agreed that activities of the Program Integrity Unit are, by definition, fraud and/or abuse activities, then the question remains, when does "discovery" take place. **Our position is that discovery cannot occur until completion of the "preliminary investigation"**. Since the purpose of the preliminary investigation is to determine whether fraud or abuse has occurred, anything prior to completion of the investigation is preliminary to discovery. You cannot have discovery until all facts have been evaluated in order to determine whether fraud or abuse has occurred, or whether there is actually an overpayment.

In the Program Integrity Unit, the process of investigation is to:

- Identify the situation to be investigated. This can be done through a SURS run, a referral, data mining, or any of a number of other investigative techniques.

- Either send out a letter requesting records supporting the services billed, or do an on-site visit to evaluate the records.

- Allow designated time for the provider to submit records verifying charges.

- Evaluate records submitted, and determine what services are supported.

- Issue a letter identifying preliminary findings, and the dollar amount related to those findings. This letter would also advise the provider of the need to either remit the amount identified, submit additional information, or file a request for an administrative hearing within 30 days.

The end of the 30 day period plus any time necessary to evaluate additional information submitted results in a determination of any actual overpayment amount, or whether there is evidence that fraud or abuse occurred. This would generally start the 60 day reporting period. However, items discovered during this period may in fact extend the initial investigation period, and would therefore affect the date discovery was determined to have occurred. Any action taken prior to the determination of a final amount of overpayment is considered part of the investigation process. Even if these cases were determined to be simple overpayments instead of fraud or abuse investigations, the Federal regulation (42 CFR 433.316 (c)(1)) indicates that the notice must specify "...a dollar amount that is subject to recovery". The 30 day letter identifies an amount that we are investigating, requests additional information, and until that information is received, the amount is not "subject to recovery". This process is similar to what the OIG has issued in this draft report. The figures are not considered "subject to recovery" until the state has had an opportunity to review the facts, agree with the facts as presented, or produce additional information to show that the draft findings are not valid.

The 30 day letter may contain a dollar amount identifying the scope of the investigation, and a potential overpayment amount. This is not an actual overpayment determination amount, but is simply identifying a potential overpayment. These figures may change based on the results of the investigation. They could increase if the scope of the investigation is expanded based on the initial findings. It is difficult to understand how the audit position could conclude that an overpayment resulted when the letter asks for documentation justifying the amount claimed, and it is evident from the documentation presented that the figure usually changes as documentation is received. The amount in the initial letter is not a "discovery" amount, but simply identifies the scope of the audit.

2. Medicaid Repayment

The audit report disclosed that we did not have sufficient policies and procedures in place to ensure timely reporting of the Federal share of overpayments. The auditors reported there was no central listing or control account to monitor the process of potential overpayments. Therefore, the auditors had little assurance that all overpayments applicable to the audit period had been identified. In this respect, we did not report 101 overpayments totaling $422,781 (Federal share) as required by Federal regulations. Subsequently, we reported 86 overpayments ($397,923), leaving 15 overpayments ($24,858 - Federal share) unreported. Our subsequent review of the 15 overpayments (providers) disclosed that 7 providers totaling $22,491.64 should have been reported. The remaining 8 providers totaling $2,366.62 did not result in overpayment as disclosed by an indepth review of supporting documentation. We also agree that additional overpayments totaling $110,257 (Federal share) were not reported on the CMS 64 Report as required.

3. Medicaid Operations-Credit Balance Report

Management recognizes that we did not always follow our established policies and procedures regarding credit balances, identifying credit balances that remained after 30 days by

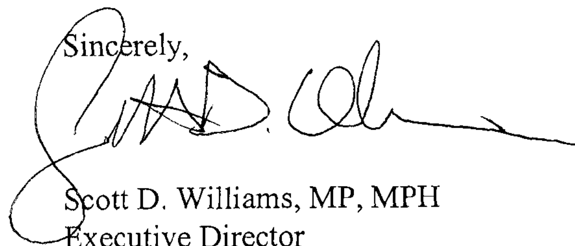
reviewing the credit balance report on a weekly basis. We also realize that an alternate or backup person should be available when designated personnel are unable to perform assigned duties. To initiate corrective action we requested changes to the Credit Balance Report (CP319) that will more efficiently identify when a provider is closed or reaching the 60 day rule. We are committed to strengthening our policies and procedures to ensure overpayments are properly reported in accordance with Federal regulations. A log of all credit balances cleared and referred to the Office of Recovery Services (ORS) has been maintained. This log has been revised to include the date of discovery, date referred to ORS, and date submitted to Finance for reporting on the CMS 64 Report. We will also take further corrective actions in accordance with your audit recommendations. Specific corrective measures will include:

- Ensuring that the Federal share of overpayments totaling $132,749 is returned to the Federal government.

- Strengthening policies and procedures to ensure that all payments are accurately reported in accordance with Federal regulations.

- Maintaining an accurate record/log of all claims considered for possible overpayment and return the Federal share of medicaid provider overpayments when required.

In summary, if you have any questions or comments concerning our comments, please contact Mr. Kent Roñer, at 801-538-6433.



Sincerely,

Scott D. Williams, MP, MPH
Executive Director