



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V  
233 North Michigan Avenue  
Suite 1360  
Chicago, IL 60601

May 25, 2011

Report Number: A-05-10-00043

Ms. Lucinda E. Jesson  
Commissioner  
Minnesota Department of Human Services  
540 Cedar St.  
St. Paul, MN 55101

Dear Ms. Jesson:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of State of Minnesota Reporting Medicaid Fraud Control Unit Recoveries on the CMS-64 for the Period October 1, 2005, Through December 31, 2008*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Lynn Barker, Audit Manager, at (317) 226-7833 ext. 21 or through email at [Lynn.Barker@oig.hhs.gov](mailto:Lynn.Barker@oig.hhs.gov). Please refer to report number A-05-10-00043 in all correspondence.

Sincerely,

/James C. Cox/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Jackie Garner  
Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, IL 60601

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF STATE OF MINNESOTA  
REPORTING MEDICAID FRAUD  
CONTROL UNIT RECOVERIES  
ON THE CMS-64 FOR THE PERIOD  
OCTOBER 1, 2005, THROUGH  
DECEMBER 31, 2008**



Daniel R. Levinson  
Inspector General

May 2011  
A-05-10-00043

# *Office of Inspector General*

<http://oig.hhs.gov>

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## EXECUTIVE SUMMARY

### BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In Minnesota, the Minnesota Department of Human Services (State agency) provides oversight for Minnesota's Medicaid program, known as Medical Assistance, for compliance with Federal requirements and the State's counties administer the program. The State's Medicaid Fraud Control Unit (MFCU) investigates potential fraud and abuse cases that are referred to MFCU by other parties such as the Surveillance and Integrity Review (SIRs) unit, local governments, and a hotline. Investigations can be either civil or criminal in nature and are settled either by a settlement agreement signed by all parties (civil) or sentencing by a judge (criminal).

Section 1903(d)(2) of the Act, requires the State to refund the Federal share of a Medicaid overpayment. Implementing regulations (42 CFR § 433.312) require the State agency to refund the Federal share of an overpayment to a provider at the end of the 60-day period following the date of discovery, whether or not the State agency has recovered the overpayment. The date of discovery for situations resulting from fraud or abuse is the date that a provider was first notified in writing of the State's final overpayment determination (42 CFR § 433.316(d)). Federal regulations (42 CFR § 433.304) define an overpayment as "... the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for the services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." Because the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), is due on a quarterly basis, the CMS *State Medicaid Manual* requires the Federal share of the overpayments be reported no later than the quarter in which the 60-day period ends.

### OBJECTIVE

Our objective was to determine whether Medicaid overpayments identified by the State's MFCU were reported on the CMS-64 in accordance with Federal requirements.

### SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments on the CMS-64 in accordance with Federal requirements. For the period October 1, 2005, through March 31, 2009, the State agency did not report Medicaid overpayments totaling \$31,133 (\$15,350 Federal share) in accordance with Federal requirements.

Of the 11 overpayments reviewed, 8 were partially reported and 3 were reported correctly on the CMS-64. The State agency did not report 2 of the 11 Medicaid overpayments to providers within the 60-day time requirement.

The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that it correctly reported overpayments on the CMS-64.

## **RECOMMENDATIONS**

We recommend that the State agency:

- include unreported Medicaid overpayments of \$31,133 on the CMS-64 and refund \$15,350 to the Federal Government,
- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments on the CMS-64.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments to our draft report, the State agency disagreed with our assertions that \$31,133 (\$15,350 Federal share) in Medicaid overpayments was partially reported and an incorrect FMAP applied. However, the State agreed to refund the \$15,350 because the amount does not warrant a challenge or appeal. The State said it will review internal controls surrounding Medicare overpayments reported on the CMS-64. The State agency's comments are included in their entirety as the appendix.

We maintain that our assertions and recommendations are valid.

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# INTRODUCTION

## BACKGROUND

### Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Federal Government pays its share (Federal share) of State Medicaid expenditures according to a defined formula. To receive Federal reimbursement, State Medicaid agencies are required to report expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64).

In Minnesota, the Minnesota Department of Human Services (State agency) provides oversight for Minnesota's Medicaid program, known as Medical Assistance, for compliance with Federal requirements. The State agency's county human services offices administer the program. The State's Medicaid Fraud Control Unit investigates potential fraud and abuse cases that are referred by other parties such as the Surveillance and Integrity Review (SIRs) unit, local governments, and a hotline. Investigations can be either civil or criminal in nature and are settled by either a settlement agreement signed by all parties (civil) or sentencing by a judge (criminal).

### Federal Requirements for Medicaid Overpayments

The Federal government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Section 1903(d)(2)(A) of the Act requires the Secretary to recover the amount of a Medicaid overpayment. Federal regulations (42 CFR § 433.304) define an overpayment as "... the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." A State has 60 days from the discovery of a Medicaid overpayment to a provider to recover or attempt to recover the overpayment before the Federal share of the overpayment must be refunded to CMS. Section 1903(d)(2) of the Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, and Federal regulations at 42 CFR part 433, subpart F, require a State to refund the Federal share of overpayments at the end of the 60-day period following discovery whether or not the State has recovered the overpayment from the provider.<sup>1</sup> Pursuant to 42 CFR § 433.316(d), an overpayment resulting 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.

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<sup>1</sup> Section 1903(d)(2)(C) and (D) of the Act and Federal regulations (42 CFR § 433.312) do not require the State to refund the Federal share of uncollectable amounts paid to bankrupt or out-of-business providers.

In addition, Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its quarterly Form CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether Medicaid overpayments identified by the State's MFCU were reported on the CMS-64 in accordance with Federal requirements.

### **Scope**

Our review covered Medicaid overpayments to providers that were identified by MFCU through civil or criminal proceedings. MFCU notified the providers between October 1, 2005, and September 30, 2008 and the overpayments should have been reported on the CMS-64 during the period from October 1, 2005, through December 31, 2008. The 11 overpayments reviewed totaled \$996,342 and represented overpayments of \$10,000 or more for Medicaid services that were subject to the 60-day rule.

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the identification, collection, and reporting policies and procedures for Medicaid overpayments.

We performed fieldwork at the State agency offices in St. Paul, Minnesota.

### **Methodology**

To accomplish our audit objective, we:

- reviewed Federal laws, regulations, and other requirements governing Medicaid overpayments;
- interviewed State agency officials regarding policies and procedures relating to Medicaid overpayments subject to the 60-day rule and reporting overpayments on the CMS-64;
- identified 60 overpayments for Medicaid services identified by MFCU subject to the 60-day rule, which totaled \$14,921,845;
- selected a judgmental sample of 11 overpayments that were identified by MFCU between October 1, 2005 and September 30, 2008 in which the original overpayment identified was greater than or equal to \$10,000;
- established the dates of discovery using the date that the Medicaid provider was either sentenced (in criminal cases) or signed a settlement agreement (in civil cases);

- determined the quarter in which the 60-day period following discovery of the overpayment ended;
- reviewed the CMS-64 to determine whether the Medicaid overpayments were reported for the quarter in which the 60-day period following discovery ended;
- reviewed the CMS-64 to determine whether Medicaid overpayments were reported during any subsequent quarter through June 30, 2009;
- determined whether cash or credit overpayment collections/recoveries were adequately supported and reported on the CMS-64;<sup>2</sup>
- determined if providers selected as part of our sample were bankrupt or out-of-business;
- computed the potentially higher interest expense to the Federal Government resulting from overpayments and income not reported within the required timeframe using the number of days between required reporting dates and the State fiscal year ending June 30, 2010.<sup>3</sup>

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

The State agency did not report all Medicaid overpayments on the CMS-64 in accordance with Federal requirements. For the period October 1, 2005, through March 31, 2009, the State agency did not report Medicaid overpayments totaling \$31,133 (\$15,350 Federal share) in accordance with Federal requirements. Of the 11 overpayments reviewed, 8 were partially reported and 3 were reported correctly on the CMS-64. The State agency did not report 2 of the 11 Medicaid overpayments to providers within the 60-day time requirement.

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<sup>2</sup> The State agency reporting process tracks overpayment recoveries/collections either through the Minnesota Accounting & Procurement System (MAPS) reports for collections by check or the Medicaid Management Information System (MMIS) for credit adjustments. Check collections are reported on Line 9c of the CMS-64 and credit adjustments on Line 29 – Other Care of the CMS-64 Base and included as part of the total expenditures claimed on Line 6 of the CMS-64 Summary.

<sup>3</sup> We calculated the interest expense using the applicable interest rates pursuant to the Cash Management Improvement Act of 1990, P.L. No. 101-453.

Because the overpayments were not properly reported on the CMS-64, the Federal Government may have incurred increased interest expense of \$1,425.

### **OVERPAYMENTS NOT REPORTED**

Pursuant to 42 CFR § 433.312(a)(2), the State agency “... must refund the Federal share of overpayments at the end of the 60-day period following discovery ... whether or not the State has recovered the overpayment from the provider.” The regulation provides an exception only when the State is unable to recover the overpayment amount because the provider is bankrupt or out of business (42 CFR § 433.318).

Pursuant to the *State Medicaid Manual* Section 2500.6(B), the State agency “Include refunds from overpaid Medicaid providers or recipients ... Upon receipt of such funds, determine the date or period of the expenditure for which the refund is made to establish the FMAP (Federal Medical Assistance Percentages) at which the original expenditure was matched by the Federal government. Make refunds of the Federal share at the FMAP for which you were reimbursed.”

For the period October 1, 2005, through March 31, 2009, the State agency did not report Medicaid overpayments totaling \$31,133 (\$15,350 Federal share) in accordance with Federal requirements. This \$31,133 (\$15,350 Federal share) represents unsupported collections that the State did not provide support to determine if the collections were either cash deposits or credit adjustments and reported correctly. In addition, the State applied the current FMAP rate instead of the rate in effect at the time the overpayment was made.

### **OVERPAYMENTS NOT REPORTED TIMELY**

Pursuant to 42 CFR § 433.312(a)(2), the State agency “... must refund the Federal share of overpayments at the end of the 60-day period following discovery ... whether or not the State has recovered the overpayment from the provider.” In addition, Federal regulation (42 CFR § 433.316(d)) defines the date of discovery for overpayments resulting from fraud or abuse as the date of the final written notice of the State’s overpayment determination. These regulations do not allow for extending the date.

The State agency did not report all Medicaid provider overpayments in accordance with the 60-day requirement. The State agency reported the 11 sampled overpayments on the CMS-64; however, 8 overpayments were considered only partially reported due to unsupported collections and applying incorrect FMAP rates. In addition, two overpayments, totaling \$269,816 (\$141,584 Federal share), were not reported on the CMS-64 at the end of the 60-day period. The untimely reporting resulted from clerical errors that occurred within the State’s overpayment reporting process. The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that it correctly reported overpayments on the CMS-64.

## **POTENTIALLY HIGHER INTEREST EXPENSE**

Because the State agency did not report some overpayments completely and was not timely in reporting others, the Federal Government did not have the use of these funds. As a result, the Federal Government potentially incurred an increased interest expense of \$1,425. However, we did not include this Federal interest expense in the amount of overpayments we recommend that the State agency refund.

## **INTERNAL CONTROLS NOT IMPLEMENTED**

The State agency did not develop and implement internal controls to ensure that it correctly reported on the CMS-64, the Medicaid overpayments identified from the State's MFCU.

## **RECOMMENDATIONS**

We recommend that the State agency:

- include unreported Medicaid overpayments of \$31,133 on the CMS-64 and refund \$15,350 to the Federal Government,
- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments on the CMS-64.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments to our draft report, the State agency disagreed with our assertions that \$31,133 (\$15,350 Federal share) in Medicaid overpayments was partially reported and an incorrect FMAP applied. However, the State agreed to refund the \$15,350 because the amount does not warrant a challenge or appeal. The State said it will review internal controls surrounding Medicare overpayments reported on the CMS-64. The State agency's comments are included in their entirety as the appendix.

We maintain that our assertions and recommendations are valid.

# **APPENDIX**



## APPENDIX: STATE AGENCY COMMENTS

### Minnesota Department of Human Services

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May 11, 2011

James Cox  
 Regional Inspector General for Audit Services  
 Office of Audit Services, Region V  
 233 North Michigan Avenue, Suite 1360  
 Chicago, IL 60601

RE: Review of State of MN Reporting MFCU Funds Recoveries on the CMS-64 for the Period October 1, 2005, Through December 31, 2008

Audit Report Number A-05-10-00043

Dear Mr. Cox,

Thank you for giving us an opportunity to respond to the OIG audit report titled "*Review of State of MN Reporting MFCU Funds Recoveries on the CMS-64 for the Period October 1, 2005, Through December 31, 2008 (A-05-10-00043)*." It is our understanding that our response will be published in the Office of the Inspector General's final audit report. The report contained the following recommendations:

**Recommendation #1**

Include unreported Medicaid overpayments of \$31,133 on the CMS-64 and refund \$15,350 to the Federal Government.

**Department Comments:**

The Department agrees two overpayments from the audit sample were not reported within the 60-day time requirement. The Department agrees some overpayments may have been reported at a different Federal Medical Assistance Percentage (FMAP) than the applicable FMAP at the time the expenditure occurred. The Department's practice has been to report the overpayment amounts at the applicable FMAP for the quarter in which they are identified. Provider overpayments often span several months or years, and may not be capable of being directly tied to individual claims (random sampling or extrapolation to a universe of claims, for example). This is done regardless of whether our FMAP is higher or lower than the applicable FMAP at the time the expenditure occurred. This is also consistent with the cash-basis reporting used on the expenditure side of the CMS-64. Lastly, the investment in time and effort required to attempt to track the original payment date of each claim to the applicable FMAP is not cost-effective given the small differences that would result from such efforts.

We also note that the draft report cites section 2500.6, subsection B of the State Medicaid Manual, but ellipses an important sentence. The entire subsection provides:

"B. Return of the Federal Share of Recoveries and Collections—Form HCFA-64 also shows the Federal share of recoveries from any source of expenditures claimed in prior quarters.

Include refunds from overpaid Medicaid providers or recipients, cancelled, uncashed or voided checks and vouchers (see 42 CFR 433.40), or settlements from liable third parties such as private insurance and casualty related court settlements.

Upon receipt of such funds, determine the date or period of the expenditure from which the refund is made to establish the FMAP at which the original expenditure was matched by the Federal government. Make refunds of the Federal share at the FMAP for which you were reimbursed. *When recoveries cannot be related to a specific period, compute the Federal share at the FMAP rate in effect at the time the refund was received* (Emphasis added). Make adjustments to prior periods in subsequent HCFA-64 forms to reflect the correct FMAP rate."

This paragraph requires that recoveries that can be related to a specific payment should be adjusted on subsequent CMS-64s, and allows for the circumstance in which a recovery cannot be related back to a specific payment. In that case, the correct FMAP rate is the rate in effect at the time the refund is received.

Lastly, the Department does not agree with the assertion it partially reported eight overpayments. Documentation was provided supporting differences between discovered overpayment amounts and amounts reported on the CMS-64. The Department provided documentation indicating the differences were caused by collections made within the same quarter the overpayment was identified.

While the Department disagrees with the OIG on the correct FMAP used to calculate unreported Medicaid overpayments, we believe the amount due does not warrant a challenge or appeal. Accordingly, the Department agrees to pay the full amount sought, \$15,350.

#### **Recommendation #2**

Develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments on the CMS-64.

#### **Department Comments:**

The Department agrees to review the internal controls surrounding Medicaid overpayments reported on the CMS-64. The Department will conduct a review of our operations procedures and update and/or modify them so that the case file documentation is adequate to support changes in recovered amounts.

The Department of Human Services will continue to evaluate the progress being made to resolve all audit findings until full resolution has occurred. If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at (651) 431-3623.

Sincerely,



Lucinda E. Jesson  
Commissioner