DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT - 9 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of Ohio Medicaid Long-Term-Care Payments to Two Providers for the Same Beneficiaries for the Same Dates of Services From October 1, 1998, Through September 30, 2005 (A-05-07-00074)

Attached is an advance copy of our final report on Ohio Medicaid long-term-care payments to two providers for the same beneficiaries for the same dates of services during October 1, 1998, through September 30, 2005. We will issue this report to the Ohio Department of Jobs and Family Services (the State agency) within 5 business days.

Pursuant to sections 1903(a)(1) and 1905(a) of the Social Security Act, Federal reimbursement at the Federal medical assistance percentage rate is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the approved State plan.

The State agency used an automated payment system that calculated claims and made monthly payments to long-term-care providers based on the providers' beneficiary enrollment data, the number of days in the month, and the providers' daily rates. During the audit period October 1, 1998, through September 30, 2005, the State agency paid $70,644,566 ($41,157,524 Federal share) to 3,100 long-term-care providers (1,550 provider pairs) for services provided to the same beneficiaries for the same dates of service. The State agency should not have paid two different providers for services provided to the same beneficiaries for the same dates of service unless one of the providers furnished services that were not reimbursed through the long-term-care daily rate.

Our objective was to determine whether the State agency's claims for payments to long-term-care providers for services provided to the same beneficiaries for the same dates of service resulted in unallowable payments.

Of a judgmental sample of 100 providers (50 pairs claiming services for the same beneficiaries for the same dates of service) that were paid $38,783,184 ($22,595,083 Federal share), the State agency appropriately claimed $20,699,649 ($12,059,616 Federal share) and paid 52 providers for long-term-care services. However, the State agency inappropriately claimed $18,083,535

($10,535,467 Federal share) and paid 48 providers that did not provide medical assistance to Medicaid beneficiaries.

Of the unallowable payments totaling $18,083,535 ($10,535,467 Federal share), the State agency, as of the start of our audit in July 2007, reported and refunded $8,446,697 ($4,921,045 Federal share) through adjustments decreasing its Medicaid claims for prior quarters on the CMS-64 for the quarter ended June 30, 2005, and had not reported and refunded $9,636,838 ($5,614,422 Federal share).

The State agency made the unallowable payments because it did not implement controls within its automated payment system to identify payments to two providers for services claimed for the same beneficiaries for the same dates of service. In addition, the State agency's policies and procedures for reporting and refunding previous overpayments on the CMS-64 did not ensure the identification of all the unallowable payments.

On August 1, 2005, the State agency implemented a new payment system that required long-term-care providers to submit claims for services before receiving medical assistance payments. Our audit period included payments made through September 30, 2005, and we did not identify any payments made to two providers for the same beneficiaries for the same dates of service after July 31, 2005.

We recommend that the State agency refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements and review payments totaling $31,861,382 ($18,562,441 Federal share) made to the providers that we did not review and refund to the Federal Government any unallowable Medicaid reimbursements.

In its written comments, the State agency said that further analysis needed to be completed before it agreed to a final dollar figure to be refunded to the Federal Government. Regarding the second recommendation, the State agency said that it has initiated a review similar to the analysis performed for this report and will refund overpayments to the Federal Government once the review is completed.

We maintain that our finding and recommendation are valid and that the State agency should refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements.

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 through e-mail at George.Reeb@oig.hhs.gov or Marc Gustafson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-07-00074.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region V
233 North Michigan Ave. Suite 1360
Chicago, IL 60601-5519
(312) 353-2618

OCT 15 2008

Report Number: A-05-07-00074

Ms. Helen E. Jones-Kelley
Director
Ohio Department of Job and Family Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215-3414

Dear Ms. Jones-Kelley:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Ohio Medicaid Long-Term-Care Payments to Two Providers for the Same Beneficiaries for the Same Dates of Services From October 1, 1998, Through September 30, 2005." 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Steve Slamar, Audit Manager, at (312) 353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-07-00074 in all correspondence.

Sincerely,

Marc L. Gustafson
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, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OHIO MEDICAID LONG-TERM-CARE PAYMENTS TO TWO PROVIDERS FOR THE SAME BENEFICIARIES FOR THE SAME DATES OF SERVICES FROM OCTOBER 1, 1998, THROUGH SEPTEMBER 30, 2005

Daniel R. Levinson
Inspector General

October 2008
A-05-07-00074

Office of Inspector General

http://oig.hhs.gov

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 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.

Pursuant to 42 CFR § 430.30(c), States report the cost of long-term care furnished to Medicaid beneficiaries on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64 (CMS-64). Pursuant to sections 1903(a)(1) and 1905(a) of the Act, Federal reimbursement at the Federal medical assistance percentage rate is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the approved State plan. If the State determines that in prior periods it claimed expenditures where no medical assistance was furnished, section 2500.4 of CMS's "State Medicaid Manual" provides that a refund of the Federal share of the overpayments can be made as an adjustment decreasing claims for prior quarters on the current CMS-64.

The Department of Job and Family Services (the State agency) is responsible for the administration of the Medicaid program in Ohio. The State agency used an automated payment system that calculated claims and made monthly payments to long-term-care providers based on the providers' beneficiary enrollment data, the number of the days in the month, and the providers' daily rates. During the audit period October 1, 1998, through September 30, 2005, the State agency paid $70,644,566 ($41,157,524 Federal share) to 3,100 long-term-care providers (1,550 provider pairs) for services provided to the same beneficiaries for the same dates of service.

OBJECTIVE

The audit objective was to determine whether the State agency's claims for payments to long-term-care providers for services provided to the same beneficiaries for the same dates of service resulted in unallowable payments.

SUMMARY OF FINDINGS

Of a judgmental sample of 100 providers (50 pairs claiming services for the same beneficiaries for the same dates of service) that were paid $38,783,184 ($22,595,083 Federal share), the State agency appropriately claimed $20,699,649 ($12,059,616 Federal share) and paid 52 providers for long-term-care services. However, the State agency inappropriately claimed $18,083,535 ($10,535,467 Federal share) and paid 48 providers that did not provide medical assistance to Medicaid beneficiaries.

Of the unallowable payments totaling $18,083,535 ($10,535,467 Federal share), the State agency, as of the start of our audit in July 2007:

- reported and refunded $8,446,697 ($4,921,045 Federal share) through adjustments decreasing its Medicaid claims for prior quarters on the CMS-64 for the quarter ended June 30, 2005, and

- had not reported and refunded $9,636,838 ($5,614,422 Federal share).

The State agency made the unallowable payments because it did not implement controls within its automated payment system to identify payments to two providers for services claimed for the same beneficiaries for the same dates of service. In addition, the State agency's policies and procedures for reporting and refunding previous overpayments on the CMS-64 did not ensure the identification of all the unallowable payments.

On August 1, 2005, the State agency implemented a new payment system that required long-term-care providers to submit claims for services before receiving medical assistance payments. Our audit period included payments made through September 30, 2005, and we did not identify any payments made to two providers for the same beneficiaries for the same dates of service after July 31, 2005.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements and

- review payments totaling $31,861,382 ($18,562,441 Federal share) made to the providers that we did not review and refund to the Federal Government any unallowable Medicaid reimbursements.

STATE AGENCY COMMENTS

In its written comments, the State agency said that further analysis needed to be completed before it would agree to refund any final dollar amount to the Federal Government. Regarding the second recommendation, the State agency said that it has initiated a review similar to the analysis performed for this report and will refund any overpayments to the Federal Government once the review is completed.

The State agency comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our finding and recommendation are valid and that the State agency should refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements.

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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.

Pursuant to 42 CFR § 430.30(c), States report the cost of long-term care furnished to Medicaid beneficiaries on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64 (CMS-64). Pursuant to sections 1903(a)(1) and 1905(a) of the Act, Federal reimbursement at the Federal medical assistance percentage (FMAP) rate[1] is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the approved State plan. If the State determines that in prior periods it claimed expenditures where no medical assistance was furnished, section 2500.4 of CMS's "State Medicaid Manual" (Pub. 45) provides that a refund of the Federal share of the overpayment can be made as an adjustment decreasing claims for prior quarters on the current CMS-64. Pursuant to 42 CFR § 433.318, a State is obligated to refund the Federal share unless the overpayment constitutes a debt that has been discharged in bankruptcy or a debt that cannot be collected under State law because the provider is out of business.

Ohio's Medicaid Reimbursement for Long-Term Care

The Department of Job and Family Services (the State agency) is responsible for the administration of the Medicaid program in Ohio. For the majority of our audit period, the State agency used an automated payment system to reimburse long-term-care providers for their costs of furnishing medical assistance to Medicaid beneficiaries. Each month, the State agency's automated payment system calculated claims and paid providers for services provided to Medicaid beneficiaries based on the providers' enrollment data, the number of days in the month, and the providers' daily rates.

During the audit period October 1, 1998, through September 30, 2005, the State agency paid $70,644,566 ($41,157,524 Federal share[2]) to 3,100 long-term-care providers (1,550 provider pairs) for services claimed by two different providers for the same beneficiaries for the same

[1]The Medicaid statute and regulations at 42 CFR § 433.10 provide for payments to States for part of their medical assistance expenditures on the basis of an FMAP determined annually by the formula described in section 1905(b) of the Act.

[2]We calculated the Federal share by using 58.26 percent, which was the lowest FMAP in effect in Ohio during the audit period.

dates of service. The State agency should not have paid two different providers for services provided to the same beneficiaries for the same dates of service unless one of the providers furnished services that were not reimbursed through the long-term-care daily rate.[3]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The audit objective was to determine whether the State agency's claims for payments to long-term-care providers for services provided to the same beneficiaries for the same dates of service resulted in unallowable payments.

Scope

Of the $70,644,566 in payments made to 3,100 long-term-care providers (1,550 provider pairs), we selected payments totaling $38,783,184 (55 percent) made to 100 providers[4] for the audit period October 1, 1998, through September 30, 2005.

Our internal control review was limited to obtaining an understanding of the policies and procedures that the State agency used to make long-term-care provider payments, identify unallowable payments, and report long-term-care expenditures and decreasing adjustments on the CMS-64 through September 30, 2005.

We relied on the State agency's determination of allowable and unallowable payments. We did not review beneficiary admission and discharge records maintained by the long-term-care providers.

We conducted our field work at the State agency's office in Columbus, Ohio, from July through November 2007.

Methodology

To accomplish our audit objective we:

- reviewed applicable Federal laws and regulations;
- interviewed the State agency official responsible for monitoring long-term-care payments and reporting expenditures on the CMS-64;
- gained an understanding of the State agency's payments and adjustments for long-term care for October 1, 1998, through September 30, 2005;

[3]The State's long-term-care daily rate did not include reimbursement for certain therapy services or items of durable medical equipment, so payments for those services and equipment to other providers on the same dates of service could be appropriate.

[4]The 100 providers represented the 50 provider pairs with the highest combined reimbursement for services provided to the same beneficiaries for the same dates of services.

- quantified the Medicaid payments to long-term-care providers for services claimed for the same beneficiaries for the same dates of service by:

    - extracting payment information from the Medicaid Statistical Information System for the period October 1, 1998, through September 30, 2005, and

    - creating a database that (1) contained 3,100 providers that were paid $70,644,566 ($41,157,524 Federal share) for 19,738 claims for the same beneficiaries for the same dates of service, (2) excluded Medicaid payments for Medicare coinsurances and deductibles, and (3) included net claim payments per beneficiary for each provider by offsetting paid claim amounts with related claim adjustment amounts;

- judgmentally selected and reviewed 10,802 claims totaling $38,783,184 ($22,595,083 Federal share) made to 100 providers from the database and requested the State agency to identify:

    - the providers that actually furnished allowable services relative to the reimbursements,

    - the providers that received inappropriate reimbursements because no medical assistance was furnished, and

    - any adjustments decreasing claims for prior quarters that the State agency made on the CMS-64; and

- determined that the unallowable payments did not constitute debts that had been discharged in bankruptcy or debts that could not be collected under State law because the provider was out of business.

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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of a judgmental sample of 100 providers (50 pairs claiming services for the same beneficiaries for the same dates of service) that were paid $38,783,184 ($22,595,083 Federal share), the State agency appropriately claimed $20,699,649 ($12,059,616 Federal share) and paid 52 providers for services to Medicaid beneficiaries receiving long-term care. Of these 52 providers, 2 claimed payment only for items or services not covered under the long-term-care rate. However, the State agency inappropriately claimed $18,083,535 ($10,535,467 Federal share) and paid the long-term-care daily rate amount to 48 providers that did not provide medical assistance to Medicaid beneficiaries.

Of the unallowable payments totaling $18,083,535 ($10,535,467 Federal share), the State agency, as of the start of our audit in July 2007:

- reported and refunded $8,446,697 ($4,921,045 Federal share) through adjustments decreasing its Medicaid claims for prior quarters on the CMS-64 for the quarter ended June 30, 2005, and

- had not reported and refunded $9,636,838 ($5,614,422 Federal share).

The State agency made the unallowable payments because it did not implement controls within its automated payment system to identify payments to two providers for services provided to the same beneficiaries for the same dates of service. In addition, the State agency's policies and procedures for reporting and refunding previous overpayments on the CMS-64 did not ensure the identification of all the unallowable payments.

On August 1, 2005, the State agency implemented a new payment system that required long-term-care providers to submit claims for services before receiving medical assistance payments.

FEDERAL REQUIREMENTS

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement at the FMAP rate is available only for amounts expended as medical assistance under an approved Medicaid State plan. Section 1905(a) of the Act defines medical assistance, in general, as payment of part or all of the cost of the listed care and services when furnished to eligible individuals. Medicaid regulations at 42 CFR § 400.203 define the term "services" to refer to the types of medical assistance specified in section 1905(a) and defined in subpart A of the regulations at 42 CFR part 440, including nursing facility services. The Departmental Appeals Board (DAB) has held that if the State agency has claimed and received the Federal share based on provider payments that do not constitute medical assistance under the State plan, the State agency has received an overpayment of Federal funds. (See, for example, Washington Dep't. of Soc. and Health Serv., DAB No. 645 (1985).)

Section 1903(d)(2)(A) of the Act and implementing regulations at 42 CFR § 433.320 provide that quarterly Federal Medicaid payments to the State must be reduced to reflect prior overpayments. Pursuant to these regulations and section 2500.4 of the CMS "State Medicaid Manual," the State agency must report the overpayment amounts on the CMS-64. Pursuant to 42 CFR § 433.318, a State is obligated to refund the Federal share of an overpayment unless the overpayment constitutes a debt that has been discharged in bankruptcy or a debt that cannot be collected under State law because the provider is out of business.

UNALLOWABLE PAYMENTS

The State agency inappropriately claimed $18,083,535 ($10,535,467 Federal share) and paid 48 providers for 4,896 claims for services that were not provided to Medicaid beneficiaries. The payments were made due to the following:

- 40 providers received $15,740,998 ($9,170,705 Federal share) because provider ownership changes were not updated in a timely manner within the State agency's automated payment system and

- 8 providers received $2,342,537 ($1,364,762 Federal share) because beneficiaries relocated to a different long-term-care provider but the changes were not reflected in the previous providers' enrollment data within the State agency's automated payment system.

As of the start of our audit in July 2007, the State agency had reported and refunded $8,446,697 ($4,921,045 Federal share) through adjustments decreasing its Medicaid claims for prior quarters on the CMS-64 for the quarter that ended June 30, 2005. The remaining $9,636,838 ($5,614,422 Federal share) had not been reported and refunded.

Change in Provider Ownership

The providers did not notify the State agency in a timely manner when long-term-care provider ownership changed. As a result, the State agency's automated payment system continued to calculate claims and made payments to the previous owners even though they no longer operated the facilities and did not provide medical assistance to Medicaid beneficiaries. The unallowable payments continued until the enrollment data from the previous owners were removed from the system and the new owners' data were entered. Once the new owners' data were entered, the State agency made retroactive payments to the new owners but did not always collect the payments made to the previous owners. As a result, the State agency reimbursed the previous and new providers for the same beneficiaries for the same dates of service.

Beneficiary Relocation

The providers did not notify the State agency in a timely manner when Medicaid beneficiaries relocated to different providers. The State agency continued to pay providers until it received notification that beneficiaries should be removed from the providers' enrollment data in the payment system. Meanwhile, the new providers updated their enrollment data to begin receiving payments for the beneficiaries' long-term-care services. Until the previous providers notified the State agency to remove the relocated beneficiaries from the providers' enrollment data, monthly payments continued to be made automatically to the previous and new providers on behalf of the same beneficiaries for the same dates of service.

INADEQUATE CONTROLS AND POLICIES AND PROCEDURES

Payments to Two Providers

The State agency did not implement controls within the automated payment system to identify payments to two different providers for the same services claimed for the same beneficiaries for the same dates of service. The State agency's system automatically issued monthly payments to providers based on their enrollment data and relied on the providers to maintain and update their enrollment data in a timely and accurate manner.

Reporting and Refunding Federal Overpayments

The State agency's policies and procedures for reporting and refunding previous overpayments on the CMS-64 did not ensure the identification of all the unallowable payments. Of the 4,896 unallowable payments we identified, the State agency did not identify 2,495 payments and report the overpayments totaling $5,614,422 (Federal share) on the CMS-64. Since the State agency's policies and procedures did not identify all unallowable payments, there may be other overpayments that have not been refunded within the $31,861,382 ($18,562,441 Federal share) that we did not review.

STATE AGENCY'S NEW PAYMENT SYSTEM

On August 1, 2005, the State agency implemented a new payment system that required long-term-care providers to submit claims for services before receiving medical assistance payments. Our audit period included payments made through September 30, 2005, and we did not identify any payments made to two providers for the same beneficiaries for the same dates of service after July 31, 2005.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements and

- review payments totaling $31,861,382 ($18,562,441 Federal share) made to the providers that we did not review and refund to the Federal Government any unallowable Medicaid reimbursements.

STATE AGENCY COMMENTS

In its written comments, the State agency said that further analysis needed to be completed before it would agree to refund any final dollar amount to the Federal Government. The State agency indicated that it needed to determine if collection of the overpayments is legally possible. The State would first determine if the provider is bankrupt or out of business. If the provider is not, the State would then determine whether a State court decision bars the State's ability to

collect the overpayments. Regarding the second recommendation, the State agency said that it has initiated a review similar to the analysis performed for this report and will refund any overpayments to the Federal Government once the review is completed.

The State agency comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our finding and recommendation are valid and that the State agency should refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements.

We relied on the State agency's determination of allowable and unallowable payments made to provider pairs. The State did not provide any indication that the unallowable payments it identified were uncollectable because the provider was bankrupt or out of business in accordance with 42 CFR § 433.318. Therefore, we have no basis to conclude that these overpayments are debts that the State need not refund. The State court decision that may bar the State agency from attempting to collect a Medicaid overpayment from a provider would not bar the State agency from refunding the Federal share of an overpayment as required by Medicaid regulations. Pursuant to 42 CFR § 433.312, the State 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. If a provider is determined to be bankrupt or out of business after the 60-day period ends, 42 CFR § 433.320(g) provides that the State may reclaim the amount of the Federal share of any unrecovered overpayment if the Medicaid agency submits the necessary documentation to CMS.

APPENDIX

Ohio | Department of Job and Family Services

Ted Strickland, Governor
Helen E. Jones-Kelley, Director

August 1, 2008

Marc Gustafson
Regional Inspector General for Audit Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

RE: OIG Report Number A-05-07-00074

Dear Mr. Gustafson:

This letter is in response to your July 2, 2008 cover letter and U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services, draft Report Number A-05-07-00074, entitled "Review of Ohio Medicaid Long-Term Care Payments to Two Providers for the Same Beneficiaries for the Same Dates of Services During October 1, 1998 through September 30, 2005". The review determined that the State agency made unallowable payments because it did not implement controls within its automated payment system to identify payments to two providers for services claimed for the same beneficiaries for the same dates of service. In addition, the state agency's policies and procedures for reporting and refunding previous overpayments on the CMS-64 did not ensure the identification of all unallowable payments. Your report did note that on August 1, 2005, the state agency implemented a new payment system that required long-term-care providers to submit claims for services before receiving medical assistance payments and you did not identify any payments made to two providers for the same beneficiaries for the same dates of service after July 31, 2005.

In response to the OIG recommendation that Ohio refund to the Federal Government $5,614,422 for unallowable Medicaid reimbursements, we feel that further analysis would need to be completed before agreeing to a final dollar figure to be refunded to the Federal Government. When an overpayment is identified for the time periods included in your current review, ODJFS analyzes the facts to determine if collection is legally possible. The first step in this process is to determine if the provider is bankrupt or out-of-business. If so, ODJFS proceeds in accordance with 42 CFR 433.318. The documentation for matters where the provider is bankrupt or out-of-business are kept in various individual provider files and would be difficult to gather.

If the provider is not bankrupt or out-of-business, ODJFS analyzes the matter to determine if the Ohio Academy of Nursing Homes v. ODJFS Case No. 99CVH-06-5249 bars our ability to collect. The Ohio Academy case held that for certain Medicaid provider types, notice of the overpayment had to be given by a certain deadline.

Marc Gustafson
August 1, 2008
Page Two

If ODJFS missed the deadline, the matter was/is not referred to the Ohio Attorney General's Office because the provider would assert the Ohio Academy decision as a defense to having to pay back the overpayment.

If the provider is not out-of-business and the time limits of the Ohio Academy case do not bar recovery, ODJFS would analyze the facts to see if Ohio Revised Code Section 5111.061 applies. In reaction to the Ohio Academy decision, ODJFS requested that the Ohio General Assembly enact a statute lengthening the amount of time ODJFS has to collect overpayments from Medicaid providers. The statute was effective June 30, 2005, and was subsequently amended March 30, 2006. It permits ODJFS to recover an overpayment "if the department notifies the provider of the overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made." This fact pattern would be handled case-by-case and the documentation would be in the case file.

In response to the OIG recommendation that Ohio review payments made to providers totaling $31,861,382 ($18,563,441 Federal Share) made to the providers that you did not review and refund the Federal Government any unallowable Medicaid reimbursements, we have already initiated an effort to conduct a review similar to what was performed for this report and will refund the Federal Government once our review has been completed.

We look forward to your final report. Please do not hesitate to contact Kevin M. Jones at 614-752-3755 to discuss Ohio's response to your findings.

Sincerely,

Helen E. Jones-Kelley, Director
Ohio Department of Job and Family Services

CC: John Corlett
Bob Ferguson
Kevin Jones

HJK: KMJ