JAN 18 2006

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

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

SUBJECT: Review of New Jersey's System for Medicaid Provider Overpayments (A-02-04-01009)

Attached is an advance copy of our final report on New Jersey's system for Medicaid provider overpayments. We will issue this report to the New Jersey Department of Human Services (the State agency) within 5 business days. This review was part of a multistate audit to determine whether States reported selected types of Medicaid provider overpayments in accordance with Federal requirements.

The State agency did not report all overpayments in accordance with Federal requirements. The amount reported was significantly understated because State agency policies and procedures did not ensure that all gross overpayments were reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), for the quarter in which the 60-day period following discovery ended. Contrary to Federal requirements, the State agency:

- delayed reporting overpayments until the date of its final decision or the date when it collected the overpayment in full,
- reported negotiated overpayment amounts rather than gross amounts, and
- recognized overpayments as of the date of the final audit report instead of the date of the draft report.

In addition, the State agency did not return the Federal share of the overpayment interest collected from providers, which it considered State revenue. The State agency practices resulted in underreporting and untimely reporting of overpayments. The reporting delays ranged from 90 days to more than 5 years.

As a result, the State agency did not properly and timely report $19,121,128 ($9,560,564 Federal share) in accordance with Federal requirements. The underreporting and untimely reporting potentially resulted in higher interest expense to the Federal Government of

approximately $1.4 million and incorrect Medicaid expenditure and overpayment data in Centers for Medicare & Medicaid Services (CMS) records.

We recommend that the State agency:

- include unreported overpayments totaling $13,242,420 ($12,279,902 not reported and $962,518 understated) on the CMS-64 and refund the $6,621,210 Federal share;

- determine the value of unreported overpayments identified after our audit period and report them on the current CMS-64; and

- ensure that all overpayments are reported in accordance with Federal requirements by:

    - implementing controls to identify overpayments when due and report them timely to CMS, thereby mitigating any potentially higher interest expense to the Federal Government;

    - reporting on the CMS-64 the full overpayment regardless of negotiated settlements (with the exception of out-of-business and bankrupt providers); and

    - refunding the Federal share of interest collected from overpayments on the CMS-64.

In its comments on our draft report, the State agency presented different interpretations of Federal requirements regarding when an overpayment is discovered and against whom a recovery applies. In addition, the State agency questioned whether a draft audit report should be considered the first notification of an overpayment. Accordingly, the State agency generally disagreed with our findings. However, the State agency agreed that in some cases, it may have reported Federal financial participation late, incorrectly, or only after the entire overpayment was recouped. According to the State agency, these inaccuracies resulted from human error and deficiencies in the reporting system that are being corrected.

The State agency did not directly address most of our recommendations. However, the State agency did not agree that the "full overpayment" must be reported regardless of prehearing reductions or negotiated settlements. The State agency did agree that interest on overpayments should be refunded.

Based on applicable Federal regulations, Departmental Appeals Board opinions, the State's policies and procedures, and the State's response to our draft report, we continue to believe that our findings and recommendations are valid.

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 James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-04-01009.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

JAN 23 2006

Report Number: A-02-04-01009

Mr. James M. Davy
Commissioner, Department of Human Services
State of New Jersey
P.O. Box 700
Trenton, New Jersey 08625

Dear Mr. Davy:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of New Jersey's System for Medicaid Provider Overpayments." A copy of this report will be forwarded to the HHS action official noted on the next 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 the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-02-04-01009 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James T. Kerr
Regional Administrator
Centers for Medicare & Medicaid Services–Region II
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW JERSEY'S SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS

Daniel R. Levinson
Inspector General

JANUARY 2006
A-02-04-01009

Office of Inspector General

http://oig.hhs.gov

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

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

This report is part of a multistate audit focusing on States' accounts receivable systems for overpayments to Medicaid providers that were reportable as of September 30, 2003. An overpayment is a payment to a provider in excess of the allowable amount.

Section 1903(d)(2) of the Social Security Act (the Act) is the principal authority that the Centers for Medicare & Medicaid Services (CMS) cites in disallowing the Federal share of overpayments to providers. The Consolidated Omnibus Budget Reconciliation Act of 1985 amended this section of the Act.

Regulations addressing overpayments (42 CFR §§ 433.312, 433.316, and 433.320) require that the State Medicaid agency 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. Because the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), is due on a quarterly basis, the "State Medicaid Manual" requires the Federal share of overpayments to be refunded no later than the quarter in which the 60-day period ends. The regulations also say that the State need not adjust the Federal share of an overpayment if it is unable to recover the overpayment because the provider filed for bankruptcy or went out of business, provided that the State followed proper due diligence during the 60-day period.

In New Jersey, the Department of Human Services (the State agency) administers the Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency reported selected types of Medicaid provider overpayments in accordance with Federal requirements.

SUMMARY OF FINDINGS

The State agency did not report all overpayments in accordance with Federal requirements. The amount reported was significantly understated because State agency policies and procedures did not ensure that all gross overpayments were reported on the CMS-64 for the quarter in which the 60-day period following discovery ended. Contrary to Federal requirements, the State agency:

- delayed reporting overpayments until the date of its final decision or the date when it collected the overpayment in full,

- reported negotiated overpayment amounts rather than gross amounts, and

- recognized overpayments as of the date of the final audit report instead of the date of the draft report.

In addition, the State agency did not return the Federal share of the overpayment interest collected from providers, which it considered State revenue. The State agency practices resulted in underreporting and untimely reporting of overpayments. The reporting delays ranged from 90 days to more than 5 years. Specifically:

- The State agency never reported 50 overpayments totaling $12,279,902 ($6,139,951 Federal share). Contrary to Federal requirements, the State agency did not report these overpayments as of September 30, 2003. These overpayments were still not reported as of March 31, 2004, the date of the last CMS-64 issued during our fieldwork.

- The State agency understated 40 reported overpayments by a total of $962,518 ($481,259 Federal share).[1] The State agency reported $2,889,183 in fraud and abuse overpayments during our audit period; the amount should have been $3,851,701.

- The State agency did not report 28 overpayments totaling $5,878,708 ($2,939,354 Federal share) within 60 days of discovery as required by 42 CFR § 433.

As a result, the State agency did not properly and timely report $19,121,128 ($9,560,564 Federal share) in accordance with Federal requirements. The underreporting and untimely reporting potentially resulted in higher interest expense to the Federal Government of approximately $1.4 million and incorrect Medicaid expenditure and overpayment data in CMS records.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported overpayments totaling $13,242,420 ($12,279,902 not reported and $962,518 understated) on the CMS-64 and refund the $6,621,210 Federal share;

- determine the value of unreported overpayments identified after our audit period and report them on the current CMS-64; and

- ensure that all overpayments are reported in accordance with Federal requirements by:

    - implementing controls to identify overpayments when due and report them timely to CMS, thereby mitigating any potentially higher interest expense to the Federal Government;

    - reporting on the CMS-64 the full overpayment regardless of negotiated settlements (with the exception of out-of-business and bankrupt providers); and

    - refunding the Federal share of interest collected from overpayments on the CMS-64.

[1]The State agency also did not report 22 of these overpayments on time; the related amounts are part of the 28 untimely overpayments totaling $5,878,708.

STATE AGENCY'S COMMENTS

In its comments on our draft report, the State agency presented different interpretations of Federal requirements regarding when an overpayment is discovered and against whom a recovery applies. In addition, the State agency questioned whether a draft audit report should be considered the first notification of an overpayment. Accordingly, the State agency generally disagreed with our findings. However, the State agency agreed that in some cases, it may have reported Federal financial participation late, incorrectly, or only after the entire overpayment was recouped. According to the State agency, these inaccuracies resulted from human error and deficiencies in the reporting system that are being corrected.

The State agency did not directly address most of our recommendations. However, the State agency did not agree that the "full overpayment" must be reported regardless of prehearing reductions or negotiated settlements. The State agency did agree that interest on overpayments should be refunded.

The complete text of the State agency's comments is included as an appendix to this report.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Based on applicable Federal regulations, Departmental Appeals Board opinions, the State's policies and procedures, and the State's response to our draft report, we continue to believe that our findings and recommendations are valid.

TABLE OF CONTENTS

Page

INTRODUCTION

BACKGROUND

This report is part of a multistate audit focusing on States' accounts receivable systems for overpayments to Medicaid providers that were reportable as of September 30, 2003. An overpayment is a payment to a provider in excess of the allowable amount.

Medicaid Program

Medicaid is a combined Federal-State entitlement program that provides health care and long term care for certain individuals and families with low incomes and resources. Within a broad legal framework, each State designs and administers its own Medicaid program, including how much to pay for each service. Each State operates under its own plan, which the Centers for Medicare & Medicaid Services (CMS) approves for compliance with Federal laws and regulations. The Federal Government has established a financing formula to calculate the Federal share of each State's Medicaid medical assistance expenditures.

In New Jersey, the Department of Human Services (the State agency) administers the Medicaid program.

Medicaid Overpayments

Section 1903(d)(2) of the Social Security Act (the Act) is the principal authority that CMS cites in disallowing the Federal share of overpayments to providers. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 amended this section of the Act.

Regulations addressing overpayments are found in 42 CFR § 433 Subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers." An overpayment is defined as an amount that a Medicaid agency pays to a provider in excess of the amount that is allowable for services furnished under the Act. Overpayments due to recipient eligibility errors, third-party payments, probate collections, and unallowable costs recovered through per diem rate adjustments are not subject to Subpart F. These regulations state that the 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.

Because the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), is due on a quarterly basis, the "State Medicaid Manual" requires the Federal share of overpayments to be refunded no later than the quarter in which the 60-day period following discovery ends. The regulations also say that the State need not adjust the Federal share of an overpayment if it is unable to recover the overpayment because the provider filed for bankruptcy or went out of business, provided that the State followed proper due diligence during the 60-day period.

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Therefore, when a State recognizes that it made a Medicaid overpayment, the overpayment amount must be reported on the CMS-64 as an offset to expenditures. Under certain circumstances, such as the provider's bankruptcy, the State may reclaim overpayments on

the CMS-64. For example, assume that the State pays a provider $100,000 for Medicaid services rendered and claims the expenditures on the CMS-64. Through subsequent review, the State learns that it overpaid the provider by $25,000. The State must show the $25,000 overpayment on the CMS-64, reducing expenditures eligible for Federal participation by this amount. If the State later receives additional documentation and determines that it did not overpay the provider, the State may make a decreasing adjustment to the overpayments on the CMS-64 to reclaim the $25,000.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency reported selected types of Medicaid provider overpayments in accordance with Federal requirements.

Scope

We limited our examination of Medicaid provider overpayments and credit adjustments to the costs subject to the requirements of 42 CFR § 433 that were reported on the four quarterly CMS-64 reports for the period October 1, 2002, through September 30, 2003. We expanded our audit to include overpayments reportable before and during our audit period but still not reported on the CMS-64 as of March 31, 2004. Overall, we reviewed 130 overpayments totaling $19,428,570 ($2,889,183 reported on the CMS-64 during our audit period, $12,300,391 in open overpayments not yet reported, and $4,238,996 in overpayments identified in Office of Inspector General (OIG) draft audit reports issued during our audit period that were not reported timely on the CMS-64).

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

We performed our audit at the State agency's offices in Mercerville, NJ.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal requirements (including section 1903 of the Act, 42 CFR § 433, Office of Management and Budget Circular A-87, and the CMS-64 instructions) and applicable sections of the "State Medicaid Manual" and the State agency policies and procedures;

- gained an understanding of the State agency procedures for managing overpayments;

- interviewed State agency officials responsible for identifying and monitoring collections of overpayments, as well as staff responsible for reporting the Federal share of overpayments;

- analyzed the four quarterly CMS-64 reports for fiscal year 2003, along with supporting documentation, and determined that the majority of the provider overpayments included on line 9c as "Collections: Identified through Fraud and Abuse" and the amounts reported on line 10a as "Adjustment Decreasing Claims for Prior Quarters-Federal Audit" were subject to 42 CFR § 433 and had to be reported within 60 days of discovery;

- reviewed $2,889,183 in overpayments reported during our audit period that were subject to the requirements of 42 CFR § 433;

- expanded our review to include $12,300,391 in open overpayment cases subject to the 60-day requirement of 42 CFR § 433 that the State agency had not yet reported on the CMS-64;

- reviewed the status of OIG draft audit reports issued during our audit period, which identified $4,238,996 in overpayments that, although reported, were not reported timely on the CMS-64;[1]

- compared the universe of overpayments obtained from the State agency with the overpayments reported on the CMS-64 reports as of March 31, 2004 (the latest CMS-64 available during our fieldwork), to determine whether all identified overpayments were reported;

- analyzed overpayment files to determine the dates of discovery, the status of overpayments, and whether any adjustments occurred during the audit period;

- calculated the number of days between actual and required reporting dates for all identified overpayments to determine whether the State agency reported overpayments accurately and within 60 days of discovery; and

- calculated, using the number of days between actual and required reporting dates, the potentially higher interest expense to the Federal Government resulting from overpayments not reported within the required timeframe.[2]

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

FINDINGS AND RECOMMENDATIONS

The State agency did not report all overpayments in accordance with Federal requirements. The amount reported was significantly understated because State agency policies and procedures did

[1]"Review of Payments for Transportation Services Made to Special Service School Districts Under New Jersey's Medicaid Program" (A-02-02-01022) and "Review of Inpatient Psychiatric Crossover Claims to Medicaid for Patients Between the Ages of 21 to 64 in New Jersey's Private and County Operated Institutions for Mental Diseases" (A-02-02-01017).

[2]We calculated the interest expense using the applicable daily interest rates per the Cash Management Improvement Act of 1990.

not ensure that all gross overpayments were reported on the CMS-64 for the quarter in which the 60-day period following discovery ended. Contrary to Federal requirements, the State agency:

- delayed reporting overpayments until the date of its final decision or the date when it collected the overpayment in full,

- reported negotiated overpayment amounts rather than gross amounts, and

- recognized overpayments as of the date of the final audit report instead of the date of the draft report.

In addition, the State agency did not return the Federal share of the overpayment interest collected from providers, which it considered State revenue. The State agency practices resulted in underreporting and untimely reporting of overpayments. The reporting delays ranged from 90 days to more than 5 years. Specifically:

- The State agency never reported 50 overpayments totaling $12,279,902 ($6,139,951 Federal share). Contrary to Federal requirements, the State agency did not report these overpayments as of September 30, 2003. These overpayments were still not reported as of March 31, 2004, the date of the last CMS-64 issued during our fieldwork.

- The State agency understated 40 reported overpayments by a total of $962,518 ($481,259 Federal share).[3] The State agency reported $2,889,183 in fraud and abuse overpayments during our audit period; the actual amount should have been $3,851,701.

- The State agency did not report 28 overpayments totaling $5,878,708 ($2,939,354 Federal share) within 60 days of discovery as required by 42 CFR § 433.

As a result, the State agency did not properly and timely report $19,121,128 ($9,560,564 Federal share) in accordance with Federal regulations. The underreporting and untimely reporting potentially resulted in higher interest expense to the Federal Government of approximately $1.4 million and incorrect Medicaid expenditure and overpayment data in CMS records.

OVERPAYMENTS NOT REPORTED

The State agency did not report all Medicaid provider overpayments in accordance with Federal requirements. The State must credit the Federal share of the gross overpayments on the CMS-64 for the quarter in which the 60-day period following discovery ends. Contrary to Federal requirements, the State agency reported the Federal share of overpayments by the date of its final decision or the date an overpayment was collected in full. The State agency did not have proper controls to ensure timely reporting of overpayments. As a result, the State did not report overpayments totaling $12,279,902 ($6,139,951 Federal share).

[3]The State agency also did not report 22 of these overpayments on time; the related amounts are part of the 28 untimely overpayments totaling $5,878,708.

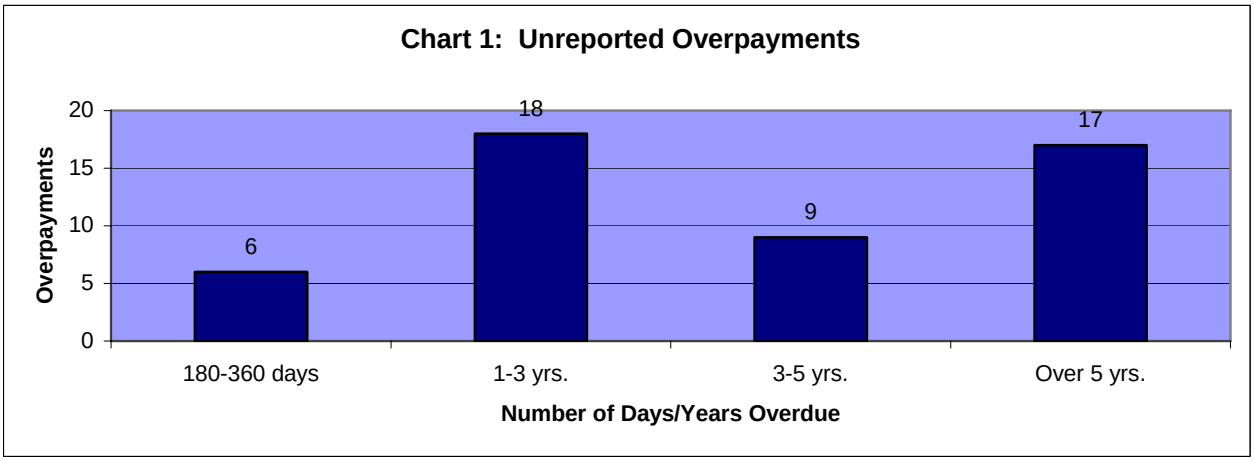
Federal Requirements

Pursuant to 42 CFR § 433.312, the State must refund the Federal share of overpayments within 60 days following discovery, whether or not the State has recovered the overpayment from the provider. Regulations (42 CFR § 433.316) define the discovery date as the earliest date on which (1) the State first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, (2) the provider initially acknowledges a specific overpayment in writing to the Medicaid agency, or (3) the State initiates a formal action to recoup a specific overpayment from a provider without having first notified the provider in writing. As stated in 42 CFR § 433.316(d), "An overpayment that results from fraud and 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." Further, 42 CFR § 433.316(h) states that any appeal rights extended to a provider do not extend the date of discovery. However, pursuant to 42 CFR § 433.320, the State may reclaim the Federal share of an overpayment refunded to CMS based on legitimate downward adjustments to the overpayment amount.

Past Due Overpayments

The State agency did not report 50 provider overpayments, totaling $12,279,902 ($6,139,951 Federal share), reportable prior to and during our audit period ended September 30, 2003. These overpayments were still not reported as of March 31, 2004, the date of the last CMS-64 issued during our fieldwork.

Chart 1 illustrates the reporting delays of the 50 past due overpayments.



Causes of Nonreporting

The State agency's practice was to report overpayments on the CMS-64 by the date of its final decision or the date when the overpayment was collected in full. However, pursuant to Federal regulations, the discovery date for overpayments resulting from fraud and abuse is the date of final written notice of overpayment to the provider. We considered the final written notice to be the last claim notice sent to the provider, which allows 20 days for a response before the State agency withholds a percentage of future Medicaid payments. However, the State did not consider an

overpayment discovered until the exhaustion of administrative and judicial proceedings, final resolution, or collection in full.

Further, the State agency did not have controls to ensure timely reporting of all overpayments. The State agency Notice of Claim allowed the provider 20 days to respond. According to this notice, the State agency was to immediately withhold a percentage of future Medicaid payments, and State agency procedures required that, absent a response, the State agency identify the overpayment and include it on the next CMS-64. However, the State agency did not follow its own policy. Had it done so, it would have discovered these unreported overpayments within 60 days and included them on the proper CMS-64.

Understated Data and Potentially Higher Interest Expense

Because the State agency did not report all overpayments as required, CMS's Medicaid expenditure and overpayment data were understated by $12,279,902 ($6,139,951 Federal share). This noncompliance also potentially resulted in higher interest expense to the Federal Government of approximately $1.2 million.

UNDERSTATED OVERPAYMENTS

The State agency understated reported Medicaid provider overpayments; it reported $2,889,183 but should have reported $3,851,701. The understated overpayments resulted from inadequate State agency policies and procedures applicable to overpayments that were reduced by negotiation agreements, interest collected from overpayments considered as State revenue, and nonreporting of funds withheld from providers before collecting the total overpayments. As a result, the State agency reported $962,518 ($481,259 Federal share) less than the actual overpayments.

Federal Requirements

California Department of Health Services, Departmental Appeals Board (DAB) No. 1391, addressed overpayment settlements between the States and providers. The decision affirmed that States may not reduce the Federal share by settling overpayment receivables for less than the actual amount of the overpayment. Settlements based on anticipated success in litigation or made simply to avoid administrative costs or litigation expenses do not justify reduction in the Federal share of overpayments.

Section 2500 of the "State Medicaid Manual" specifies that section A of the CMS-64 should include interest received on Medicaid recoveries and interest assessed on disallowances. The State is accountable for the Federal share of any interest collected on recoupments or refunds collected. According to section 2500.1 of the "State Medicaid Manual," line 3.A, this would include the Federal share of any interest received on Medicaid recoveries during the quarter. New Jersey Department of Human Services, DAB No. 480, concluded that the State agency must refund to the Federal Government interest collected applicable to provider overpayments.

Pursuant to 42 CFR § 433.312, the State agency must report overpayments within 60 days from the date of discovery. 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 refund the Federal share on the CMS-64 for the quarter in which the 60-day period following discovery ends.

Overpayments Understated on CMS-64

The State agency understated 40 overpayments reported on the CMS-64 by $962,518 ($481,259 Federal share). These understatements resulted from reporting negotiated amounts rather than actual overpayments ($852,916), from not reporting interest received from providers ($83,424), and from not reporting funds withheld from providers pending settlement of overpayment amounts ($26,178).

Causes of Understatements

The State agency policies and procedures did not ensure reporting of all overpayments within 60 days of discovery. The State agency practice was to report overpayments reduced by negotiation agreements between the State and the provider. In addition, the State agency practice was to classify interest collected from overpayments as State revenue and not to report it on the CMS-64. Further, because of clerical errors, the State agency did not report all funds withheld from providers before collecting the total overpayments.

Understated Data and Potentially Higher Interest Expense

Because the State agency understated overpayments, CMS's Medicaid expenditure and overpayment data were understated by $962,518 ($481,259 Federal share). This understatement also potentially resulted in higher interest expense to the Federal Government of approximately $91,000.

OVERPAYMENTS NOT REPORTED TIMELY

The State agency did not report Medicaid provider overpayments in a timely manner. The untimely reporting resulted from using the date of the final decision, the date that an overpayment was collected in full, or the date of the final Federal audit report, contrary to Federal requirements. In addition, the State agency had insufficient controls to ensure the integrity of its overpayment discovery process. As a result, the Federal Government incurred potentially higher interest expense of approximately $115,000.

Federal Requirements

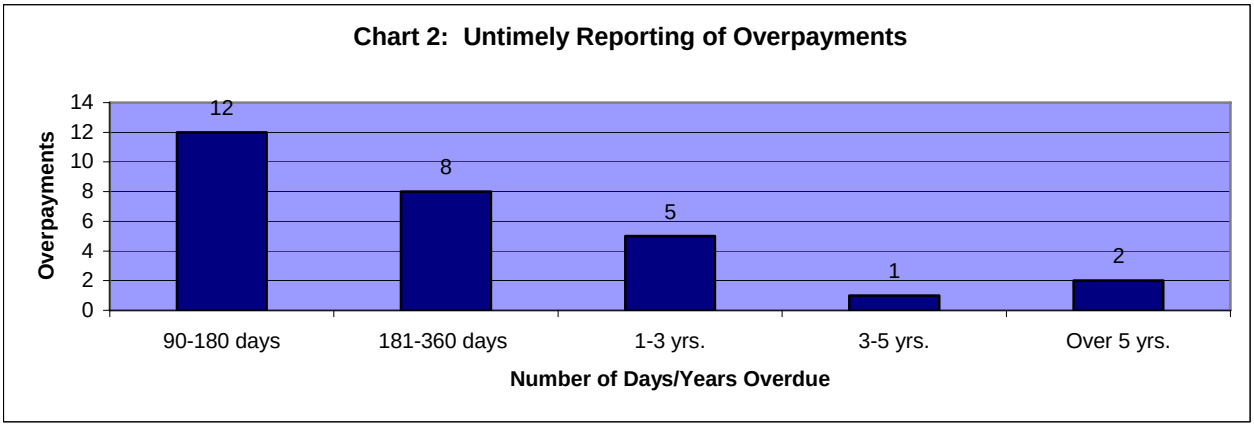
As indicated above, pursuant to 42 CFR § 433.316(d), "An overpayment that results from fraud and abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider." Section 9512 of COBRA does not extend this date pending exhaustion of appeals.

In addition, as stated in 42 CFR § 433.316(e), for overpayments identified through Federal reviews, "CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery." To the extent that a draft audit report or other interim notification is in writing and reflects a specific dollar amount of an overpayment, the plain language of the regulation suggests

that it would constitute the "first notification." Therefore, the date of the Federal draft report would be considered the discovery date.

Untimely Reporting

The State agency did not report 28 overpayments totaling $5,878,708 ($1,639,712 in fraud and abuse overpayments and $4,238,996 identified in OIG draft audit reports) timely on the quarterly CMS-64 reports. Chart 2 illustrates the reporting delays.



As Chart 2 shows, the State agency reported these overpayments from 90 days to more than 5 years late. For example, the State agency issued an overpayment notice on February 26, 1997, for $1,597,671, immediately withholding 20 percent of future Medicaid payments. Despite the withholding, the State agency did not report this overpayment on the CMS-64 until December 31, 2002, when it recovered the overpayment in full.

Causes of Untimely Reporting

The State agency's practice was to report overpayments by the date of its final decision, by the date that an overpayment was collected in full, or by the date of the final Federal audit report. This practice was contrary to the Federal requirement to "discover" fraud and abuse overpayments on the date of the final written notice to the provider. We considered the final written notice to be the last claim notice sent to the provider allowing 20 days for a response. However, the State did not consider an overpayment discovered until exhaustion of administrative and judicial proceedings, final resolution, or collection in full. In addition, the State agency practice was to report overpayments relating to Federal audits as of the date of the final report instead of the date of the draft report.

Furthermore, the State agency did not have controls to ensure timely reporting of all overpayments. The State agency Notice of Claim allowed the provider 20 days to respond. According to this notice, the State agency was to immediately withhold a percentage of future Medicaid payments, and State agency procedures required that absent a response, the State agency identify the overpayment and include it on the next CMS-64. However, the State agency did not follow its own policy. Had it done so, it would have discovered these unreported overpayments within 60 days and included them on the proper CMS-64.

Potentially Higher Interest Expense

The State agency's untimely reporting of overpayments totaling $5,878,708 potentially resulted in higher interest expense to the Federal Government of approximately $115,000.

SUMMARY

The State agency did not properly and timely report $19,121,128 ($9,560,564 Federal share), contrary to Federal requirements. Of this amount, $13,242,420 had not been reported as of March 31, 2004, the date of the latest CMS-64 available during our fieldwork, and $5,878,708 was untimely. This noncompliance resulted in potentially higher interest expense to the Federal Government of approximately $1.4 million and incorrect Medicaid expenditure and overpayment data in CMS records.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported overpayments totaling $13,242,420 ($12,279,902 not reported and $962,518 understated) on the CMS-64 and refund the $6,621,210 Federal share;

- determine the value of unreported overpayments identified after our audit period and report them on the current CMS-64; and

- ensure that all overpayments are reported in accordance with Federal requirements by:

    - implementing controls to identify overpayments when due and report them timely to CMS, thereby mitigating any potentially higher interest expense to the Federal Government;

    - reporting on the CMS-64 the full overpayment regardless of negotiated settlements (with the exception of out-of-business and bankrupt providers); and

    - refunding the Federal share of interest collected from overpayments on the CMS-64.

STATE AGENCY'S COMMENTS

In its comments on our draft report, the State agency presented different interpretations of Federal requirements regarding when an overpayment is discovered and against whom a recovery applies. In addition, the State agency questioned whether a draft audit report should be considered the first notification of an overpayment. Accordingly, the State agency generally disagreed with our findings. However, the State agency agreed that in some cases, it may have reported Federal financial participation late, incorrectly, or only after the entire overpayment was recouped. According to the State agency, these inaccuracies resulted from human error and deficiencies in the reporting system that are being corrected.

The State agency did not directly address most of our recommendations. However, the State agency did not agree that the "full overpayment" must be reported regardless of prehearing reductions or negotiated settlements. The State agency did agree that interest on overpayments should be refunded.

The complete text of the State agency's comments is included as an appendix to this report.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Based on applicable Federal regulations, DAB opinions, the State's policies and procedures, and the State's response to our draft report, we continue to believe that our findings and recommendations are valid.

APPENDIX

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712
TELEPHONE 1-800-356-1561

RICHARD J. CODEY
Acting Governor

JAMES M. DAVY
Commissioner

ANN CLEMENCY KOHLER
Director

October 14, 2005

Timothy J. Horgan
Regional Inspector General
For Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Re: Response to Draft Audit Report #A-02-04-01009 entitled "Review of New Jersey's System for Medicaid Provider Overpayments"

Dear Mr. Horgan:

This letter is the response of the Division of Medical Assistance and Health Services (DMAHS) to the draft report listed above. We will be addressing the various specific audit findings based upon the principles and interpretations listed below:

1. DMAHS disagrees with the draft audit report's description of when an overpayment is discovered. According to 42 CFR 433.316(d), 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" (emphasis added). DMAHS interprets this regulation to mean that discovery in fraud and abuse-related cases, which are the only types of cases mentioned in the audit, occurs when, as Director, I sign a final agency decision or a settlement agreement, or if the provider fails to respond to an initial recovery notice and defaults.

2. DMAHS believes that the federal regulations on sharing federal financial participation (FFP) within 60 days of discovery apply only to recovery actions against providers. DMAHS does not believe that they apply to recovery actions against provider-related parties, e.g., officers, employees, directors or shareholders of a provider, or to recovery actions against clients or client-related parties. In these types of recoveries, DMAHS will return FFP in the quarter in which the recovery is actually received rather than within 60 days of the date the overpayment is discovered.

3. Given DMAHS's position described in paragraphs #1 and 2 above, DMAHS did not delay in reporting the discovery of overpayments, but reported appropriately based on our understanding of federal regulations. In many cases, FFP was identified when the provider or beneficiary defaulted by failing to respond within the time limits given in our initial recovery notice.

4. DMAHS agrees that there may have been isolated cases when FFP was reported late, incorrectly or only after the entire overpayment was recouped, but this was due to human error and deficiencies in the system designed to report the recovery rather than any intentional delay. Measures have and will continue to be taken by my staff to assure that such errors and deficiencies do not occur again. As one example, in order to more accurately share FFP with CMS, we have been working to correct some system errors. Our system is posting adjustments incorrectly, and this alters the reports generated by the system. We rely on these figures in order to generate other reports to help us determine the amount that we need to share with CMS. My staff is actively working on this, and we hope to have this problem corrected by the end of this month, thereby making our reporting more accurate.

5. DMAHS does now agree with your office that interest on overpayments in all cases should be shared to the extent required by the Grant Appeals Board decisions that the auditors shared with my staff during the review. However, we will continue our past practice of not sharing treble damages or false claim penalties.

6. The specific dollar amounts listed in the draft audit report may not still be accurate since they represent the point in time when the audit was completed. Some of the FFP was shared in a subsequent quarter. Also, the amounts listed may change because our actions and assertions may be upheld after further review.

7. In the "Recommendations" section of the audit report, DMAHS does not agree that the "full overpayment" must be reported regardless of reductions in overpayment amounts that occur as a result of pre-hearing conferences or negotiated settlements. In addition to what was said in paragraph 1 above, many reductions in overpayments are based upon evidence or information presented by the provider that clarifies what the actual overpayment was.

8. To our knowledge, concerns regarding draft audit reports A-02-02-01022 and A-02-02-01017 were not shared with DMAHS staff. Furthermore, although the language of the federal regulation may "suggest" to the auditors that these draft audit reports should be a considered the first notification, the use of the term "draft" implies that unambiguous notification will occur at some point in the future. Rather, the final audit report more correctly represents a formal notification in writing of any alleged overpayment.

Thank you for this opportunity to review and respond to the draft report, and for the cooperation and assistance of your onsite audit staff.

Sincerely,

Ann Clemency Kohler
Director

REP:Ff
c: John Guhl
Kaye S. Morrow
Robert E. Popkin
David Lowenthal
Bruce Fritzges