DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

JAN 3 1 2005

Report Number: A-03-04-00206

Mr. Patrick Finnerty
Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Dear Mr. Finnerty:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General report entitled "Review of Virginia's Accounts Receivable System for Medicaid Provider Overpayments." This review was part of a nationwide audit requested by the Centers for Medicare & Medicaid Services. The objective of our review was to determine whether Virginia reported all identified Medicaid provider overpayments in a timely and accurate manner.

Should you have any questions or comments concerning the matters commented on in this report, please direct them to the Department official identified below.

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 reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5).

To facilitate identification, please refer to report number A-03-04-00206 in all correspondence relating to this report.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF VIRGINIA'S SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS

JANUARY 2005
A-03-04-00206

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

This report is part of a nationwide audit focusing on States' accounts receivable systems for Medicaid provider overpayments.

The principal authority cited by Centers for Medicare & Medicaid Services (CMS) in disallowing Federal financial participation in overpayments to providers is section 1903(d)(2) of the Social Security Act (the Act). This section was amended by section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The Act states that CMS will adjust reimbursements to a State for any overpayment or underpayment and requires States to report overpayment adjustments within 60 days from the date of discovery, whether or not the overpayment has been recovered. The State must credit the Federal share of those overpayments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64) for the quarter in which the 60-day period ends. The Act also states that no adjustment will be made in the Federal payment if the State is unable to recover an overpayment due to the provider filing for bankruptcy or going out of business.

In Virginia, the Department of Medical Assistance Services (the Department) administers the Medicaid program.

OBJECTIVE

Our objective was to determine if the Department reported provider overpayments (overpayments) in accordance with Federal regulations.

FINDINGS

During the period of October 1, 2002, through September 30, 2003, the Department:

- did not report 10 overpayments totaling $169,068 ($85,430 Federal share) because provider appeals had not been finalized. When we brought these overpayments to the Department's attention, it reported them on the CMS-64 for the quarter ended March 31, 2004,

- did not report 95 overpayments totaling $3,226,166 ($1,630,182 Federal share) within the required timeframe because it did not use the correct discovery date, and

- incorrectly reported a bankruptcy credit adjustment of $1,260,760 on Line 2 rather than Line 4 of supplemental schedule CMS-64.90.

By not reporting overpayments in a timely manner, the Department effectively denied CMS the use of funds that would have otherwise been available for the Medicaid program. This also potentially resulted in higher interest expense to the Federal government of approximately $9,500.

RECOMMENDATIONS

We recommend that the Department:

- provide CMS with documentation supporting the $85,430 adjustment reported on the March 31, 2004 CMS-64,

- ensure overpayments are reported to CMS within 60 days in accordance with Federal regulations,

- change the date in the Oracle Government Accounting system 60-day report to reflect the date of discovery and not the date the overpayment is input into the system, and

- establish procedures to ensure all adjustments to the CMS-64 are placed on the correct lines of the CMS-64.

AUDITEE COMMENTS

The Department responded to our draft report in a letter dated November 5, 2004. The Department generally agreed with the content of the report, however it believed that some of the conditions discussed in the findings were over simplified and did not provide a complete picture of either the circumstances or the timing of the events.

The Department stated that:

- prior to its identification by the Office of Inspector General (OIG), one of the 10 overpayments was scheduled to be reported on the March 31, 2004 CMS-64 report. All 10 accounts were reported on the March 31, 2004 CMS-64 report,

- it implemented corrective action to ensure overpayments are reported to CMS within 60 days in accordance with Federal Regulations. As a result of internal agency meetings, the Department revised its internal policies and procedures. The various agencies reported and forwarded the Provider Overpayment Notices to the Fiscal Division within 2 days after mailing the original Overpayment Notices to the Providers. All accounts are recorded within 2 days in the Oracle accounts Receivable system,

- it modified the Oracle Accounts Receivable system July 1, 2004 to include the "Notice of Program Reimbursement (NPR) Date" at the time the account is invoiced. The Oracle system requires an NPR Date in order to update the system with a new account. Finally, the Oracle 60 Day Report program was revised to use the NPR Date field to identify accounts 60 days old to be included on the CMS-64 Report, and

- it recorded a credit adjustment on Line 2 rather than Line 4 of supplemental schedule CMS-64.90, however the Department believed the reported cause of the error was over simplified. Department personnel understand the CMS-64.90 reporting requirements. The error occurred because the internal report provided to the Fiscal Division's Financial Reporting Section indicated that it was an adjustment. The bankruptcy was reported in the subsequent quarter.

OIG RESPONSE

We believe the actions taken by the Department will address our recommendations. We have revised our report, where necessary, to take into account the Department's comments. Based on the additional information provided by the Department, we deleted comments included in Other Matters.

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INTRODUCTION

BACKGROUND

The Medicaid Program

Enacted in 1965, Medicaid is a combined Federal-State entitlement program that provides health and long term care for certain individuals and families with low-incomes and resources. Within a broad legal framework, each State designs and administers its own Medicaid program, including how much to pay for each service. Each State operates under a plan approved by CMS for compliance with Federal laws and regulations. The Federal Government established a financing formula to calculate the Federal share of the medical assistance expenditures under each State's Medicaid program. In Virginia, the Department administers the Medicaid program. The Federal share of expenditures in Virginia for the period of October 1, 2002, through September 30, 2003 (fiscal year 2003) was 50.53 percent.

Medicaid Overpayments

Section 1903(d)(2) of the Act is the principal authority cited by CMS in disallowing Federal financial participation in overpayments to providers. COBRA amended this section of the Act.

The Act states that CMS will adjust reimbursements to a State for any overpayment or underpayment and requires States to report overpayment adjustments within 60 days from the date of discovery, whether or not the overpayment has been recovered. The State must credit the Federal share of those overpayments on the CMS-64 report for the quarter in which the 60-day period ends. The Act also states that no adjustment will be made in the Federal payment if the State is unable to recover an overpayment due to the provider filing for bankruptcy or going out of business.

The legislation is codified in 42 CFR, Subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers." These regulations reference additional procedures such as State Plans and State Statutes, for reporting requirements. The State Medicaid manual outlines the overpayment reporting requirements for the CMS-64.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if the Department reported overpayments in accordance with Federal regulations.

Scope

We examined overpayments and credit adjustments that were reported or should have been reported on the four quarterly CMS-64's for fiscal year 2003.

The objectives of our audit did not require an understanding or assessment of the overall internal control structure of the Department. However, we gained an understanding of controls with respect to overpayments and the aging of accounts receivables. Our review was limited in scope to controls over overpayments, and was not intended to be a full-scale internal control assessment of the Department's Medicaid operations or financial management system. We performed our audit at the Department's office in Richmond, Virginia.

Methodology

To accomplish our objectives we:

- reviewed Federal criteria; including section 1903 of the Act, Federal regulations at 42 CFR § 433, and applicable sections of the State Medicaid manual,

- gained an understanding of the Department's procedures for managing provider overpayments,

- interviewed key Department staff and an outside contractor responsible for identifying and reporting overpayments in the Provider Review, Quality Review Unit (QRU), Patient Fund Account and Cost Settlement Units,

- analyzed the four quarterly CMS-64 reports for fiscal year 2003 along with supporting documentation pertaining to the reporting of the overpayments,

- analyzed the Department's supporting documentation for credit adjustments reported on the CMS-64, including collection efforts,

- sampled 430 overpayments totaling $25,059,075 from 599 overpayments totaling $34,810,879 reported by the Department during fiscal year 2003, and

- calculated the number of days between the actual and required reporting dates for all identified overpayments; and calculated the potentially higher interest expense to the Federal government for those overpayments not reported within the required time period.[1]

Our review was conducted in accordance with generally accepted government auditing standards.

[1] Calculated using the 1.32 percent annualized interest rate per the Cash Management Improvement Act of 1990.

FINDINGS AND RECOMMENDATIONS

During the period of October 1, 2002, through September 30, 2003, the Department:

- did not report 10 overpayments totaling $169,068 ($85,430 Federal share) because provider appeals had not been finalized. When we brought these overpayments to the Department's attention, it reported them on the CMS-64 for the quarter ended March 31, 2004,

- did not report 95 overpayments totaling $3,226,166 ($1,630,182 Federal share) within the required timeframe because it did not use the correct discovery date, and

- incorrectly reported a bankruptcy credit adjustment of $1,260,760 on Line 2 rather than Line 4 of supplemental schedule CMS-64.90.

The Department (1) reported the Federal share of 10 overpayments totaling $85,430 once we brought the overpayments to the Department's attention, and (2) delayed returning the Federal share totaling $1,630,182 for the untimely overpayments. The inaccurate reporting resulted in CMS having incorrect Medicaid expenditure and overpayment data. This also potentially resulted in higher interest expense to the Federal government of approximately $9,500.

Overpayments Were Not Reported

The Department did not report 10 overpayments totaling $169,068 ($85,430 Federal share) because provider appeal of the overpayments were not finalized. One of the 10 overpayments was scheduled to be reported on the March 31, 2004 CMS-64 report. Once we brought the overpayments to the Department's attention, it included all 10 overpayments on the March 31, 2004 CMS-64. These overpayments were outstanding an average of 216 days and ranged from 183 to 456 days before being reported on the CMS-64 report.

Section 1903(d)(2) of the Act, as amended by section 9512 of the COBRA, states that when an overpayment is discovered, the State has 60 days in which to recover or attempt to recover such overpayment before an adjustment is made in the Federal payment to the State. Except for providers that are out of business or bankrupt, the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

Only the Department's fiscal unit can apply adjustments, write offs, and offset future payments to recover overpayments. The Department's QRU policy was to notify the fiscal unit when the provider appeal process was complete. The Department agreed this was a problem and stated that it would change its procedures to reflect that receivables must be established on the same date as the date of initial determination.

Because of our actions, the Department reported overpayments totaling $169,068 ($85,430 Federal share) on the March 31, 2004 CMS-64. The Department's delay in reporting

overpayments potentially resulted in higher interest expense to the Federal government of approximately $700.

Overpayments Were Reported Untimely

The Department did not report 95 overpayments totaling $3,226,166 ($1,630,182 Federal share) within the required timeframes. These overpayments consisted of 80 overpayments totaling $2,877,577 ($1,454,040 Federal share) that were reported untimely during fiscal year 2003 and 15 overpayments totaling $348,589 ($176,142 Federal share) that should have been reported as of September 30, 2003 but were reported on the December 31, 2003 CMS-64. We compared the date the overpayments were identified to the date they were reported on the CMS-64. Our comparison found that the Department took an average of 139 days to report the overpayments with some taking as long as 639 days.

Section 1903(d)(2) of the Act, as amended by section 9512 of the COBRA, states that when an overpayment is discovered, the State has 60 days in which to recover or attempt to recover such overpayment before an adjustment is made in the Federal payment to the State. 42 CFR Part 433, subpart F, defines discovery date to be the date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery.

When the Department performs an audit or review of a provider, recipient, and/or patient fund account; it sends a letter to the applicable party outlining the proposed audit findings. The Department did not consider this letter the initial letter of determination because findings can be changed if the recipient or provider submits additional information related to the review. We disagree with this approach. As stated in 42 CFR § 433.316(c) the discovery date is considered to be the date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery.

Also, the Department's accounting system did not capture the initial discovery date. When the Oracle Governmental Accounting Systems 60-Day Report was programmed, the element used to determine if an accounts receivable fell within the 60 days category was the date the receivable was entered into the Oracle system, not the date the provider was notified of an overpayment. The Department is implementing a new version of the Oracle system, which will allow it to change the programming so that the 60-Day Report will be based on the discovery date instead of the date the account receivable was entered into the system.

The Department delayed returning to CMS the Federal share of $1,630,182. This potentially resulted in higher interest expense to the Federal Government of approximately $8,800.

Claimed Credit Adjustment

The Department reported a credit adjustment of $1,260,760 on Line 2 rather than Line 4 of supplemental schedule CMS-64.90, as mandated by the CMS-64 instructions.

CMS instructions for preparing the CMS-64 mandate that downward adjustments to

overpayments previously refunded be reported on Line 2 of supplemental schedule CMS-64.90, and there is no amplification of the term downward adjustment. These same instructional guidelines mandate that adjustments for previously reported overpayments for bankrupt or out of business providers be reported on Line 4 of supplemental schedule CMS-64.90.

The Department reported that the $1,260,760 was originally reported as a CMS-64.90 adjustment because the internal report provided to the Fiscal Division's Financial Reporting Section indicated that it was an adjustment. The adjusting entry to claim the item as a bankruptcy was reported on the CMS-64 in the subsequent quarter.

By entering the bankruptcy adjustment to the wrong line, CMS was not aware of the $1,260,760 bankruptcy credit adjustment.

RECOMMENDATIONS

We recommend that the Department:

- provide CMS with documentation supporting the $85,430 adjustment reported on the March 31, 2004 CMS-64,

- ensure overpayments are reported to CMS within 60 days in accordance with Federal regulations,

- change the date in the Oracle Government Accounting system 60 day report to reflect the date of discovery and not the date the overpayment is input into the system, and

- establish procedures to ensure all adjustments to the CMS-64 are placed on the correct lines of the CMS-64.

AUDITEE COMMENTS

The Department responded to our draft report in a letter dated November 5, 2004. We summarized the Department's comments along with our response. The Department's comments are included as an appendix to this report. The Department generally agreed with the content of the report, however it believed that some of the conditions discussed in the findings were over simplified and did not provide a complete picture of either the circumstances or the timing of the events.

The Department stated that:

- prior to its identification by the OIG, one of the 10 overpayments was scheduled to be reported on the March 31, 2004 CMS-64 report. All 10 accounts were reported on the March 31, 2004 CMS-64 report,

- it implemented corrective action to ensure overpayments are reported to CMS within 60 days in accordance with Federal Regulations. As a result of internal agency

meetings, the Department revised its internal policies and procedures. The various agencies reported and forwarded the Provider Overpayment Notices to the Fiscal Division within 2 days after mailing the original Overpayment Notices to the Providers. All accounts are recorded within 2 days in the Oracle accounts Receivable system,

- effective July 1, 2004, the Oracle Accounts Receivable system was modified to include the NPR Date at the time the account is invoiced. The Oracle system requires an NPR Date in order to update the system with a new account. Finally, the Oracle 60 Day Report program was revised to use the NPR Date field to identify accounts 60 days old to be included on the CMS-64 Report, and

- it recorded a credit adjustment on Line 2 rather than Line 4 of supplemental schedule CMS-64.90, however the Department believed the reported cause of the error was over simplified. Department personnel understand the CMS-64.90 reporting requirements. The error occurred because the internal report provided to the Fiscal Division's Financial Reporting Section indicated that it was an adjustment. The bankruptcy was reported in the subsequent quarter.

Also, Department policies and procedures require preparing a separate list for any previously reported overpayments from a provider who filed for bankruptcy. In addition, all bankruptcy adjustment changes must be accompanied by (1) a write-off form signed by the appropriate supervisor or manager and (2) an official document, i.e. Final Bankruptcy Notice from the Court, supporting the claim.

OIG RESPONSE

We believe the actions taken by the Department will address our recommendations. We have revised our report, where necessary, to take into account the Department's comments. Based on the additional information provided by the Department, we deleted comments included in Other Matters.

APPENDIX

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)

November 5, 2004

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health and Human Services
Suite 316, The Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-3499

RE: Draft Audit Report Number A-03-04-00206

Dear Mr. Virbitsky:

Thank you for providing DMAS the opportunity to review and comment on your draft report number A-03-04-00206 entitled, "Review of Virginia's Accounts Receivable System for Medicaid Provider Overpayments" covering the period October 1, 2002 through September 30, 2003. We have provided a response to each of the findings presented in the draft audit report. While we generally agree with the content of the report, we believe that some of the conditions discussed in the findings were over-simplified and do not provide a complete picture of either the circumstances or the timing of events. Our responses will elaborate on those situations.

At the time of the review, the auditors indicated to us that our performance with respect to Medicaid provider overpayments was excellent when compared to other states; however, your report does not provide any mention of our performance when compared to other states. We ask that you consider including such a comment in your final audit report, as this will provide external parties with a valuable assessment of our performance.

OIG Finding 1 – Overpayments Were Not Reported

The Department did not report 10 overpayments totaling $169,068 ($85,430 Federal share) because provider appeals had not been finalized. When we brought these overpayments to the Department's attention, it reported them on the CMS-64 for the quarter ended March 31, 2004.

OIG Recommendations:

- Provide CMS with documentation supporting the $85,430 adjustment reported on the March 31, 2004 CMS-64.

DMAS Response:

We agree with the finding as stated with one qualification. Prior to its identification by OIG during the audit, one of the 10 overpayment accounts in the amount of $66,560.76 was already scheduled to be reported on the March 31, 2004, CMS-64 report. In this instance, the overpayment account was not discovered as a result of OIG auditors bringing it to Agency's attention. All 10 accounts, totaling $169,068 ($85,430 federal share), were reported on the March 31, 2004, CMS-64 report. A copy of the Schedule of New QCA Accounts from the March 31, 2004, CMS-64 report is attached to our response (See Exhibit #1). On Exhibit #1, the accounts listed in bold represent the 10 accounts that were adjusted on the CMS-64.

All 10 accounts were generated from the Quality Review Unit (i.e. the Facility and Home Based Services Unit and Waiver Services Unit of the Long Term Care and Quality Assurance Division) whose previous policy was to notify the Fiscal Division when the provider appeal process was complete. The DMAS Response to OIG Finding 2 explains the corrective actions taken to ensure overpayments are reported to CMS within 60 days in accordance with Federal regulations.

OIG Finding 2 – Overpayments Were Reported Untimely

The Department did not report 95 overpayments totaling $3,226,166 ($1,630,182 Federal share) within the required timeframe because it did not use the correct discovery date.

OIG Recommendations:

- Ensure overpayments are reported to CMS within 60 days in accordance with Federal regulations.

- Change the date in the Oracle Government Accounting system 60 day report to reflect that date of discovery and not the date the overpayment is input into the system.

DMAS Response:

We concur with the audit finding. The Department has implemented corrective action to ensure overpayments are reported to CMS within 60 days in accordance with Federal regulations.

As a result of internal agency meetings, which included management from the Long Term Care Division and the Fiscal Division, internal policies and procedures have been revised. The Quality Review Unit, the Provider Review Unit (i.e. the Program Integrity Section of the Cost Settlement and Audit Division), and provider audit contractor (Clifton Gunderson, LLP) forward copies of all Provider Overpayment Notices to the Fiscal Division within 2 days after mailing the original Overpayment Notices to the Providers. All accounts are recorded within 2 days in the Oracle Accounts Receivable system, which requires the following to be entered:

- Account Amount,
- Federal Financial Participation (percentage),
- Provider Name & Number, and
- Notice of Program Reimbursement (NPR) Date (a.k.a. Discovery date).

The Agency's policy requires Fiscal staff to return the provider overpayment Federal share within 60 days from the discovery date in accordance with federal regulations.

Effective July 1, 2004, the current Oracle Accounts Receivable system was changed to allow entry of the "Notice of Program Reimbursement (NPR) Date" to be recorded at the time the account is invoiced. The Oracle Accounts Receivable Invoice Entry screen has been modified to include the NPR Date (See Exhibit #2). In addition, the Oracle system was changed to require the NPR Date in order to update the system with a new account. The Oracle Quarterly 60 Day Report program was revised to use the NPR Date field to determine accounts 60 days old for inclusion on the Quarterly CMS-64 Report.

OIG Finding 3 – Claimed Credit Adjustment

The Department reported a bankruptcy credit adjustment of $1,260,760 on Line 2 rather than Line 4 of supplemental schedule CMS-64.90, as mandated by the CMS-64 instructions.

OIG Recommendation:

Establish procedures to ensure all adjustments to the CMS-64 are placed on the lines of the CMS-64.

DMAS Response:

We agree that the Department recorded a credit adjustment on Line 2 rather than Line 4 of supplemental schedule CMS-64.90; however, we believe that the reported cause of the finding has been over-simplified. In this instance, the draft report is misleading and does not take into account all of the circumstances and the sequence of events. The Department's CMS-64 reporting staff understands the CMS-64.90 reporting requirement. Evidence of this understanding exists on previous CMS-64 reports where bankruptcy adjustments had been reported using Line 4 of the CMS-64.90. The $1,260,760 item in question was originally reported as a CMS-64.90 adjustment because the internal report provided to the Fiscal Division's Financial Reporting Section indicated that it was an adjustment. Bankruptcy status was entered in the Oracle Accounting System the next quarter after the Final Notice was received from the Bankruptcy Court. The adjusting entry to claim the item as a bankruptcy was reported on the CMS-64 in the subsequent quarter.

Agency policies and procedures require the preparation of a separate list for any previously reported overpayment belonging to a provider who has filed for bankruptcy or is out of business. All provider bankruptcy or out of business adjustments or status of adjustment changes must be accompanied by (1.) a Write-off form signed by the appropriate supervisor or manager and (2.) an official document supporting the claim (e.g. Final Bankruptcy Notice from Court, etc.). (See Exhibit #3, section 8.6.7).

Response not shown - pertains to information not included in Report.

Response not shown - pertains to information not included in Report.

If you have any questions, please direct them to Paul Kirtz. He can be reached at (804) 225-4162.

Sincerely,

Patrick W. Finnerty
DMAS Director

cc. Manju Ganeriwala
Paul Kirtz
Sharon Long
Diana Thorpe
Jim Branham
Rudy Brown
Brenda Cooper

EXHIBIT
tabbies #1

Department of Medical Assistance Services
Quarter Ending 3/31/04
New Accounts: QCA

	FFP Date	Cust. No.	Cust. Name	Inv. Date	Invoice Numb	Curr. Amt.	Obj Code	Account Total
	1-Oct-00			3-Nov-03	000050065A	6,687.48	123308	6,687.48
	1-Oct-02			3-Nov-03	000050065A	241,185.42	123308	241,185.42
(1)	**1-Oct-02**			**5-Nov-03**	**000050128A**	**66,560.76**	**123402**	**66,560.76**
	1-Oct-02			5-Nov-03	000050123A	23,780.26	123505	23,780.26
	1-Oct-01			19-Nov-03	000050380A	152.98	123402	152.98
	1-Oct-02			19-Nov-03	000050380A	655.12	123402	655.12
	1-Oct-02			21-Nov-03	000050414A	43,380.16	123412	43,380.16
	1-Oct-02			21-Nov-03	000050413A	20,681.75	123505	20,681.75
	1-Oct-01			4-Dec-03	000050596A	206,400.83	123505	206,400.83
	1-Oct-02			4-Dec-03	000050586A	24,480.87	123402	24,480.87
	1-Oct-02			18-Dec-03	000050870A	6,502.67	123505	6,502.67
	1-Oct-02			23-Jan-04	000051365A	1,438.90	123402	1,438.90
(2)	**1-Oct-02**			**22-Mar-04**	**000052769A**	**27,627.35**	**123412**	**27,627.35**
(3)	**1-Oct-02**			**22-Mar-04**	**000053007A**	**4,060.77**	**123505**	**4,060.77**
(4)	**1-Oct-02**			**3-Feb-04**	**000051697A**	**2,633.38**	**123505**	**2,633.38**
(5)	**1-Oct-02**			**18-Mar-04**	**000052592A**	**12,877.18**	**123505**	**12,877.18**
(6)	**1-Oct-02**			**18-Mar-04**	**000052590A**	**14,827.50**	**123505**	**14,827.50**
(7)	**1-Oct-02**			**10-Feb-04**	**000051699A**	**7,626.24**	**123505**	**7,626.24**
(8)	**1-Oct-02**			**18-Mar-04**	**000052597A**	**18,162.95**	**123513**	**18,162.95**
(9)	**1-Oct-02**			**18-Mar-04**	**000052588A**	**3,119.75**	**123505**	**3,119.75**
(10)	**1-Oct-02**			**31-Mar-04**	**000054000A**	**11,572.66**	**123505**	**11,572.66**
	1-Oct-98			6-Dec-99	000021528A	7,316.50	123409	7,316.50
				TOTAL		751,731.48		751,731.48

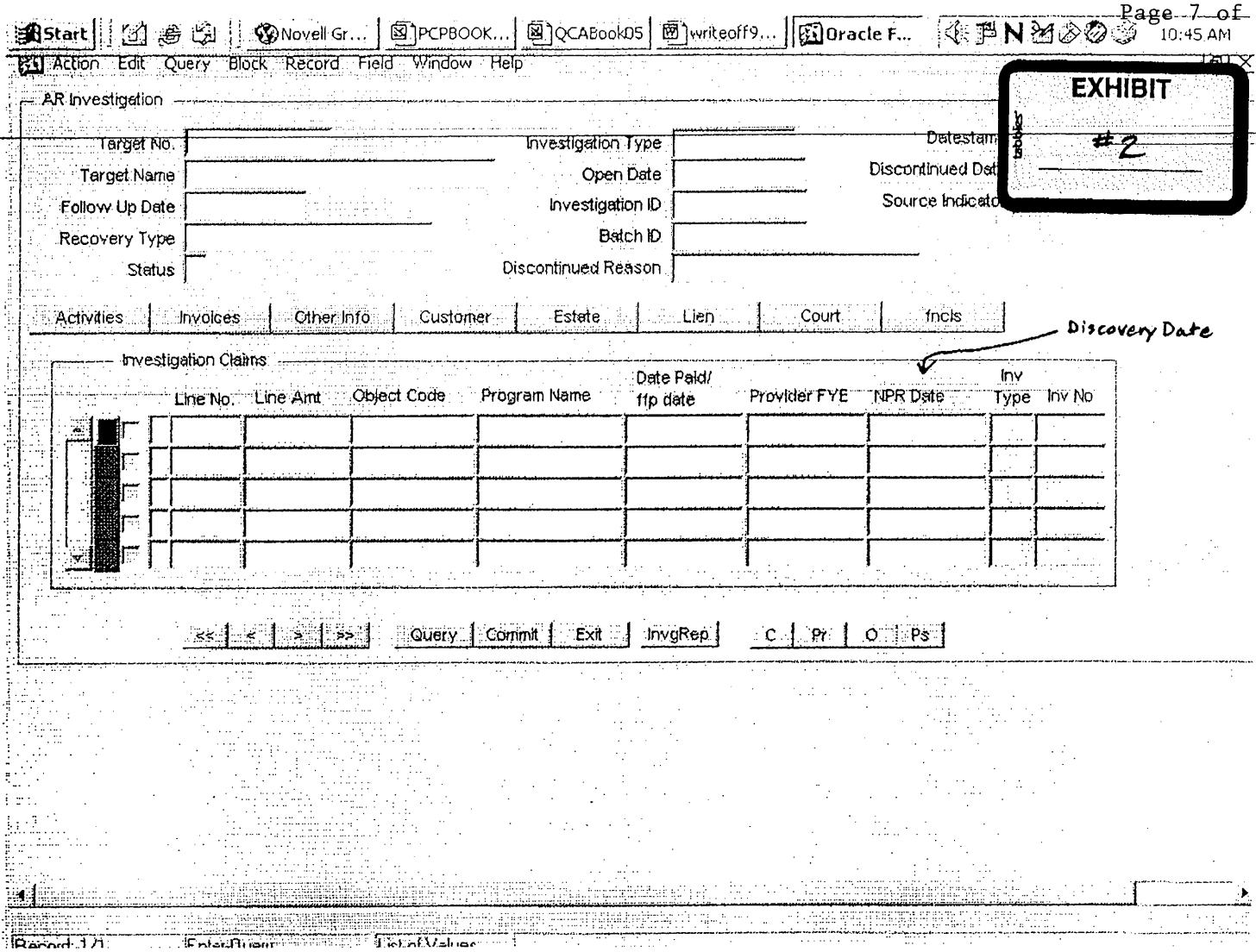
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EXHIBIT
#2
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Target Name
Follow Up Date
Recovery Type
Status
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Investigation ID
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Source Indicato
Activities
Invoices
Other Info
Customer
Estate
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Discovery Date
Investigation Claims
Line No.
Line Amt
Object Code
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EXHIBIT
#3

8.6.7 - Sixty-Day Overpayment Reporting

The Sixty (60)-Day Overpayment Report is completed Quarterly to insure that DMAS is in compliance with CFR Section 433 (Subpart F), which governs the "Refunding of Federal Share of Medicaid Overpayments to Providers". CFR Section 433.312 "Basic Requirements for Refund" describes the states general responsibility. **(See Exhibit 8.6.7 A)**
Report is prepared at the end of each quarter and includes (1) New Provider Overpayment at least 60 days old, (2) Adjustments to previously reported Overpayments and (3) Collections against previously reported Overpayments. A separate list is prepared of any previously reported overpayment belonging to a Provider who has filed for Bankruptcy or is Out of Business. All Provider Bankruptcy or Out of Business Adjustments or Status of Adjustment Changes must be accompanied by (1) Write-off Form signed by Appropriate Supervisor or Manager and (2) Officail document supporting claim (Ex. Final Bankruptcy Notice from Court, etc.)Completed report is submitted to the Federal Reporting Section to be included on the CMS-64 Quarterly Report. Federal Reporting Section submits corresponding entries into Oracle Financials, General Ledger that reclassify (offset) Medicaid expenditures from federal to State charge. This entry reduces the amount of next federal (Medicaid) weekly drawdown. **(See Exhibit 8.6.7 B)**

Desk procedures

1. Receive four major or other types of provider referrals and create invoices in Oracle Financials. (**See Section 8.4.1**)

    a. Cost Settlement Account (CSA) from Clifton Gunderson.
    b. Patient Fund Account (PFA) from Clifton Gunderson.
    c. Provider Compliance Account (PCP) from the Provider Review Unit at DMAS.
    d. Quality Care Account (QCA) from the "Waiver Services" and "Facility and Home Based Services" Units at DMAS.
    e. Other Accounts. (Ex. Medicare Crossover Project, Claim Process Error Payment, etc.)

Complete the following 60 Day Quarterly Report procedures:

2. Run and Print "Daily 60 Day Report" from Oracle for each Provider type (Provider Compliance [PCP], Cost Settlement [CSA], Patient Fund Account [PFA], Quality Care [QCA]) and Other) at end of the quarter. Report list accounts that meet the following requirements: (1) Outstanding A/R Balance, (2) 60 or more days beyond Initial Letter Date (Discovery Date) and (3) Not previously reported to CMS. (**See Exhibit 8.6.7 C**)

3. Run and Print "Adjustment to 60 Day Overpayments Report" from Oracle for each Provider