Thomas A. Schweich

Missouri State Auditor

SOCIAL SERVICES

MO HealthNet Division Payment and Cost Recovery

December 2014

Report No. 2014-140

http://auditor.mo.gov

Thomas A. Schweich
Missouri State Auditor

CITIZENS SUMMARY

Findings in the audit of the Department of Social Services (DSS), MO HealthNet Division, Payment and Cost Recovery

Contractor Oversight	The MO HealthNet Division (MHD) does not sufficiently monitor the collection activities of the Third Party Liability unit contractor used to identify claims paid by the MHD for which a third party may be partially or completely liable. The contractor provides MHD with a monthly report of activities; however, the report does not include sufficient information to allow the MHD to properly monitor the contractor's performance. Additionally, these reports were not accurate, and neither the contractor nor the MHD identified the errors. As a result of errors identified by our audit, the MHD asked the contractor to revise the reports prepared from April 2013 to April 2014 and the contractor identified additional errors. The MHD could use the contractor's case management system to monitor recoupments the contractor bills and collects; however, MHD staff indicated this system has not been utilized. MHD instead relies on monthly meetings with the contractor to identify and resolve any issues.
Timely Update of Medicare Eligibility	The MHD has not fully implemented measures to ensure it identifies and updates Medicare eligibility in the Medicaid Management Information System (MMIS) timely. The MHD has an informal agreement with a contractor to periodically generate a report of all MO HealthNet participants whose Medicare eligibility is not reflected in the MMIS. However, the MHD received this report only once during each of the years ended June 30, 2014, and June 30, 2013.
Deposit Procedures	The MHD did not deposit all funds timely. Our review of monies on hand July 8, 2014, noted the department had held 104 checks from 9 to 350 days since receipt. Additionally, the MHD has not posted some funds received to the associated account receivable timely. In instances where a single check pays multiple invoices or multiple monthly premiums, the checks are deposited into a holding account while division staff and the contractor determine to which accounts receivable the payment should be posted. As of October 3, 2014, the holding account held 6,080 outstanding items, with approximately 2,400 items older than January 1, 2014.

Provider Disclosure of Overpayment	The MHD and the Department of Social Services, Missouri Medicaid Audit and Compliance unit need to continue taking actions to ensure certain overpayments made to providers are identified and reported by the providers and recovered timely. The United States Department of Health and Human Services, Office of Inspector General, performed an audit in 2012 of the MHD's oversight of credit balances and identified $33,419 of overpayments for the quarter ended September 30, 2011. Additionally, state regulations do not require providers to reconcile their accounts, which means many payment errors may never be identified.

Because of the limited objectives of this review, no overall rating is provided.*

*****The rating(s) cover only audited areas and do not reflect an opinion on the overall operation of the entity. Within that context, the rating scale indicates the following:

Excellent: The audit results indicate this entity is very well managed. The report contains no findings. In addition, if applicable, prior recommendations have been implemented.

Good: The audit results indicate this entity is well managed. The report contains few findings, and the entity has indicated most or all recommendations have already been, or will be, implemented. In addition, if applicable, many of the prior recommendations have been implemented.

Fair: The audit results indicate this entity needs to improve operations in several areas. The report contains several findings, or one or more findings that require management's immediate attention, and/or the entity has indicated several recommendations will not be implemented. In addition, if applicable, several prior recommendations have not been implemented.

Poor: The audit results indicate this entity needs to significantly improve operations. The report contains numerous findings that require management's immediate attention, and/or the entity has indicated most recommendations will not be implemented. In addition, if applicable, most prior recommendations have not been implemented.

Department of Social Services
MO HealthNet Division Payment and Cost Recovery
Table of Contents

THOMAS A. SCHWEICH
Missouri State Auditor

Honorable Jeremiah W. (Jay) Nixon, Governor
and
Brian Kinkade, Director
Department of Social Services
and
Dr. Joseph Parks, Director
MO HealthNet Division
Jefferson City, Missouri

We have audited certain operations of the MO HealthNet Program (also known as the Medical Assistance Program, or Medicaid) and the Children's Health Insurance Program (CHIP), administered by the Department of Social Services, MO HealthNet Division, in fulfillment of our duties under Chapter 29, RSMo. The audit was conducted to review the payment and cost recovery measures performed by the division. These activities include the identification and recovery of costs paid by the division for which other responsible parties may be liable or for which the division could otherwise recover a payment. The objectives of our audit were to:

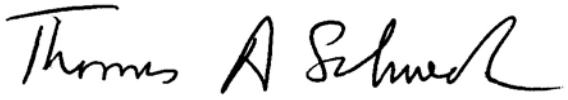
1. Evaluate the division's internal controls over significant management and financial functions related to the recovery of payments made by the division.

2. Evaluate the division's compliance with certain legal provisions related to the recovery of payments made by the division.

3. Evaluate the economy and efficiency of certain management practices and operations related to the recovery of payments made by the division, including certain financial transactions.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our 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 such a basis.

For the areas audited, we identified (1) deficiencies in internal controls, (2) no significant noncompliance with legal provisions, and (3) the need for improvement in management practices and procedures. The accompanying Management Advisory Report presents our findings arising from our audit of the Department of Social Services, MO HealthNet Division, Payment and Cost Recovery.



Thomas A. Schweich
State Auditor

The following auditors participated in the preparation of this report:

Deputy State Auditor:	Harry J. Otto, CPA
Director of Audits:	Douglas J. Porting, CPA, CFE
Audit Manager:	Lori Melton, M.Acct., CPA
In-Charge Auditor:	Patrick M. Pullins, M.Acct., CISA
Audit Staff:	Jennifer Anderson
	Nancy McDowell

Background

The federal Medical Assistance Program (also known as Medicaid and operated in Missouri as MO HealthNet) was authorized by federal legislation in 1965. The program is administered by the state and is jointly financed by the federal and state governments. The Department of Social Services (DSS), MO HealthNet Division (MHD), is responsible for administration of the program. The program provides health care access to low-income persons age 65 or over, blind, disabled, or members of families with dependent children. Additionally, the MHD provides health coverage to children meeting eligibility requirements under the federal Children's Health Insurance Program (CHIP), known in Missouri as the MO HealthNet for Kids program. Legislative changes have expanded the categories of eligibility to include MO HealthNet coverage for children and pregnant women in poverty, refugees, and children in state care.

The MHD utilizes various payment and cost recovery measures to ensure the program is paying only valid claims for which it is responsible and to ensure any other responsible parties bear their share of program costs. Responsibility for implementing these measures falls to various units within the DSS and the contractors hired in support of those units.

The Third Party Liability (TPL) unit identifies other parties that may be responsible for the payment of claims billed to the MO HealthNet program. For example, when a MO HealthNet participant is injured in an automobile accident, the TPL unit will attempt to recoup the participant's medical expenses from the insurance company of the at-fault driver. The TPL unit is also responsible for the Health Insurance Premium Payment (HIPP) program, in which the state pays the premiums for certain individuals to enroll in other insurance plans (such as one sponsored by an employer) rather than insure the participant through the MO HealthNet program.

The Medicare Buy-In unit identifies MO HealthNet participants who are also eligible for the Federal Medicare program. By ensuring Medicare eligibility is identified and paying Medicare premiums on behalf of these participants, the state is able to shift costs away from the state and federally financed MO HealthNet program to the federally financed Medicare program, saving the state money.

The Missouri Medicaid Audit and Compliance (MMAC) unit performs post-payment reviews of MHD payments to medical providers and participants to ensure that claims billed to the MHD are reasonable, appropriate, and made in compliance with state and federal regulations. The MMAC is also responsible for investigating allegations of fraud or waste in the MO HealthNet program received by the agency.

The Medicaid Management Information System (MMIS) is the MO HealthNet benefit claims processing and information retrieval system used by the state to meet the requirements of the United States Department of

Health and Human Services. The system was established in the 1980s and replaced by an enhanced system in 2009. The MMIS has also been subject to regular updates to account for changes in program rules and regulations. Various MMIS reports are available to MHD staff to identify transactions in need of additional review or potential recoupment actions, such as reports identifying transactions for which the participant might have other insurance available to pay the claims and reports identifying participants who may be eligible for insurance under the Medicare program. The Medicare Statement Control Report (MSCR) identifies claims paid on behalf of MO HealthNet participants with recent changes to Medicare eligibility. Because the MO HealthNet program is the payer of last resort, these claims are reviewed to determine if the MO HealthNet payment should be recouped and the provider instructed to rebill the claim to the Medicare program. Claims identified remain on subsequent reports until processed in the MMIS.

Federal and state regulations limit the amount of time the state has to identify potential overpayments and begin recoupment efforts. Generally, the period of time is 1 to 3 years from the date services were provided; however, there is no limit in certain circumstances, such as fraud. In most instances, if the state has not notified a provider within the allowable time limits about an incorrect payment, the state loses the ability to recoup the funds.

Scope and Methodology

The scope of our audit included, but was not limited to, management controls and other related internal controls established and managed by the MHD; policies and procedures; and other management functions and compliance issues during the year ended June 30, 2014, related to payment and cost recovery measures implemented for Missouri's MO HealthNet program.

Our methodology included conducting interviews with appropriate officials and staff of the Department and contractors; obtaining and reviewing available policies and procedures, federal and state laws and regulations, and other applicable information; and performing testing.

We obtained various system-generated management reports from the MMIS, including reports of participants who had recently become Medicare eligible (the Medicare Statement Control Report) for the period May 2013 through May 2014. This report is prepared twice monthly. Due to MMIS system updates, four reports prepared during the period October through December 2013 were not reliable and contained numerous false positive results. Accordingly, these four reports were not included in our review and potential errors from these reports are not included in our report results.

1. Contractor Oversight

The MO HealthNet Division (MHD) does not thoroughly oversee the actions of a division contractor. Additionally, the MHD failed to detect errors in the monthly reports filed by this contractor. As a result, the MHD cannot ensure that the contractor is appropriately fulfilling required duties and performing to expectations.

1.1 Documentation

The MHD does not sufficiently monitor the collection activities of the Third Party Liability (TPL) unit contractor. While the contractor provides MHD with a monthly report of activities, including recovery transactions opened, processed, and recovered, the report is summary-level only and does not include sufficient information to allow the MHD to properly monitor the contractor's performance.

The MHD TPL unit uses a contractor to identify claims paid by the MHD for which a third party may be partially or completely liable. The potentially liable third parties are identified through data matches with other insurers and employers, referrals from providers or others, information from incident reports, and other methods. Once the potential third party is identified, the contractor determines the medical expenses paid by the MHD. The contractor creates and sends an invoice to the third party requesting reimbursement for expenses incurred in the treatment of the participant, and at that time records the correspondence in a case management system.

Because the invoices are created before liability is determined, a significant portion of the invoices are denied by the third party when the eligibility is found to be incorrect. For example, the contractor may identify a MO HealthNet participant also has insurance through an insurance company. The TPL contractor will attempt to recoup the participant's medical expenses from the insurance company. If the insurance policy was not in effect on the date of service, the company may not be liable for the charges and would deny the invoice. When the invoice is paid or denied, the contractor is responsible for updating the record in the case management system and, if the invoice is paid, creating and satisfying a receivable in the Medicaid Management Information System (MMIS). The contractor is paid on a commission basis, receiving a set percentage of the funds recouped for the state.

According to the contract, the contractor's case management system could be used by the MHD to monitor recoupments the contractor bills and collects. However, MHD staff indicated this system has not been utilized to review the contractor's actions. Additionally, MHD staff indicated no data is provided by the contractor to support the amounts that the contractor includes in its monthly reports to the division. No detailed information as to the value or status of claims being pursued by the contractor (including if the claim is still active or the decision has been made to suspend collection efforts) is provided to the MHD. Instead MHD relies on monthly meetings with the contractor to identify and resolve any issues.

Without reviewing the contractor's case management system or otherwise obtaining detailed case information, the MHD cannot ensure the contractor is making a good faith effort to collect recoupment on all claims, nor can the MHD ensure that all claims billed for which payment is received by the contractor are processed and reported correctly.

1.2 Reporting Errors

Reports prepared by the TPL contractor were not accurate, and the errors were not detected by the contractor or by the MHD.

The TPL contractor prepares monthly reports for the MHD to document activities, including the count and dollar amounts of recovery activities at the beginning of the month, summarized activity during the month, and the end-of-the-month balance.

We reviewed a selection of these monthly reports for the period February 2013 through June 2014. On the report showing April 2013 activity, the contractor incorrectly reported the March beginning recovery activity balance as the March ending balance. As a result, the balance of activity for April and all subsequent months was overstated by the net amount of activity in March, or $644,350.

After we notified the MHD of this error in April 2014, MHD staff requested the contractor revise the reports prepared from April 2013 to April 2014. During the contractor's review, contractor staff identified additional errors, including a $56.7 million error where the contractor used the February 2014 beginning balance as the March 2014 beginning balance. These revisions resulted in a total net decrease of $58.3 million in the reported balance of the potentially recoverable claims to correct this error and others that had not been detected by either the contractor or the MHD, despite MHD officials' claim staff reviewed these reports monthly. A contractor representative indicated the inaccurate reports resulted from a change in the subcontractor responsible for report preparation during the year.

Recommendations

The MHD:

1.1 Require the contractor for third party liability to provide detailed reports and information in order to ensure all potential recoupments are pursued to an ultimate disposition. The MHD should review this data for reasonableness and to ensure the contractor is appropriately fulfilling duties and complying with the expectations of the MHD.

1.2 Ensure MHD staff review submitted reports for accuracy and reasonableness and work with the contractor to resolve errors.

Auditee's Response

The Department of Social Services provided the following written responses:

1.1 The MHD does receive monthly and annual summary reports including a status of recovery projects report, a posting report based on recoveries, aging reports (pending open checks), an accounts receivable report, the yield management and claims recovery report, refund reports, and cost avoidance reports. The MHD will request the detailed supporting documentation for the current reports received from the contractor when the data in the summary reports needs more explanation or further review. Additionally, the MHD will continue to meet with the contractor to review all available reports and tools to determine if other additional reports will be useful to MHD. Different reports or additional resources will be requested, if needed. Utilizing the reports received, the MHD will review the data for reasonableness and to ensure the contractor is in compliance with contract requirements.

1.2 The error noted in the audit resulted in a reported $58.3 million decrease in the total accounts receivable (A/R) balance, but does not reflect any change in recoveries. The A/R balance at the time of the audit was the raw computer match list prior to any human review for actual recoverability; thus it was more of an accounting of the total billings. Because of this, MHD staff focused more on the actual recoveries. The MHD and the contractor have now changed the process of setting up an A/R. Now, an A/R is not set up until the check is received. This change will likely result in a lower risk of errors being made. The contractor will start performing a quality control review prior to submitting reports to MHD staff and will work with MHD staff to validate the reports for accuracy and reasonableness.

2. Timely Update of Medicare Eligibility

The MHD has not fully implemented measures to ensure Medicare eligibility is identified and updated in the MMIS timely. As a result, the MMIS is not timely identifying some MO HealthNet claims paid on behalf of participants who are eligible for Medicare, and the state has lost the opportunity to challenge payment of some claims for these participants and to potentially recoup erroneous payments.

The MHD reviews various reports to identify MO HealthNet participants with Medicare eligibility. One of these reports is the result of an informal agreement with a contractor to periodically perform an eligibility data match between state MO HealthNet participant records and federal Medicare eligibility records. The data match generates a report of all MO HealthNet participants whose Medicare eligibility is not reflected in the MMIS. The contractor prepared this report quarterly during the year ended June 30,

2012, but the MHD only received it once during each of the years ended June 30, 2014, and June 30, 2013, due to delays in production.

According to MHD personnel, regular preparation and review of this report would likely reduce the number of claims paid by MHD that should have been paid by Medicare, which would also reduce the number of claims on the Medicare Statement Control Report (MSCR). The MSCR identifies claims paid for MO HealthNet participants who have recently begun receiving Medicare. The reduction in claims would be the result of Medicare eligibility being updated before a claim is submitted, resulting in cost avoidance at the time of the claim submission instead of requiring cost recovery following a claim payment.

We reviewed claims on the MSCR where staff did not take steps to recoup the claim because the one-year timely filing deadline had passed. Out of 66,514 claims included on the MSCR during the 13-month period reviewed, the identification of the participant as being Medicare eligible was not completed until over one year after the date of service for 947 claims, totaling $798,303 related to 354 participants. As a result, the state never had a chance to recoup the claims because the timely filing requirement had passed before the claims were identified.

The identification in the MSCR of claims paid on behalf of Medicare eligible participants hinges on timely updating of a participant's Medicare eligibility in the MMIS. When eligibility updates are not completed timely, the inclusion of related claims in the MSCR is delayed and the state may lose the opportunity to recoup claims that should have been paid by Medicare.

Recommendation

The MHD should ensure the timely identification of MO HealthNet participants also receiving Medicare. Once identified, the MHD should ensure the Medicare eligibility is posted to the MMIS timely to maximize opportunities to recover program expenditures.

Auditee's Response

The Department of Social Services provided the following written response:

While the MHD agrees that $798,303 in claims that were identified on the MSCR were not reviewed timely to determine recoverability, it is not correct to assume that the same amount of $798,303 was available to be recovered. There are many reasons that prohibit the MHD from recovering Medicaid dollars including:

- *Claim was received outside timely filing;*
- *Provider already did an online adjustment in the system for the dates of service identified in case management;*
- *Provider submitted a fee-for-service claim for a service provided to a participant who has a Part C plan and is not a Qualified Medicare*

Beneficiary. In these instances, they must submit a regular fee-for-service claim instead of crossover claim, and account for the Part C payment (Medicare Advantage Plan) on the TPL attachment; and
- *Procedure is not covered by Medicare.*

While this particular data match report is not currently a required report to be submitted under the contract, the MHD agrees it does have value. Thus, the MHD will include this as a required report submission in the next contract renewal/rebid.

In addition to this data match, there are seven other reports that are used to update Medicare eligibility in the MMIS. These reports have been and continue to be worked timely. These reports are as follows:

- *Monthly Prospective Report*
- *Health Insurance Claim Numbers without Effective Dates*
- *Crossover Report*
- *Participants with Medicare Part C, without Parts A or B (on file)*
- *Medicare Participants Active on Managed Care*
- *MO Rx Report*
- *Pharmacy and Clinical Services Update Reports*

Auditor's Comment

While there may have been valid reasons some of the claims identified may not have been recoverable, the total amount is unknown. Without identifying Medicare eligibility timely and reviewing the claims above, the MHD lost the opportunity to recoup any portion of the claims that may have been determined recoverable if actions had been taken timely.

3. Deposit Procedures

The MHD has not ensured receipts are deposited and processed timely.

The MHD and a contractor receive monies from various sources, including program participants, providers, and insurance companies. These payments include various forms of premiums required from program participants, refunds due to the department from providers, and various reimbursements. Most of these payments are received through a lockbox in which the payee submits payment along with a payment coupon to a vendor. The vendor is responsible for processing the payment and depositing the payment into a designated account. If there are problems with the payment (such as the amount paid does not match the coupon), the payment is forwarded to the department for further processing.

3.1 Timely depositing

The MHD did not deposit all funds timely.

We performed a cash count of funds forwarded to the division and in the division's custody on July 8, 2014. We noted 104 checks totaling $110,000 had been held in a safe by the division from 9 to 350 days since receipt.

Three of these checks, totaling $1,122, were within 2 weeks of having been held long enough to become stale dated and no longer negotiable. The division considers a check to be stale dated either one year after the date of issuance or after the date of restriction on the check, if any (such as "void after 180 days"). None of the three checks were deposited before they became stale dated, and two of these checks totaling $55 were subsequently destroyed because they could no longer be negotiated. As of August 4, 2014, the third check for $1,067 was still being held by the division, even though it became stale dated on July 12, 2014. MHD officials could not explain why these checks were held rather than deposited to a holding account until the proper disposition could be identified.

3.2 Timely posting

The MHD has not posted some funds received to the associated account receivable timely.

Most checks received by the MHD (or its contractors) include information, such as remittance advices or correspondence from the payer, to allow the MHD to determine to which account receivable the payment should be posted. These checks are deposited into a state bank account and the funds are immediately available for use. In more complex cases, for example when an insurance company pays multiple invoices or a participant pays multiple monthly premiums with a single check, MHD or contractor staff deposit the checks into a holding account. The funds remain in the holding account while MHD staff and the contractor (depending on the specific type of payment received) investigate and determine how the payment should be posted. Because the checks have not been processed and posted to an account, the funds are not available to the MHD for use supporting the MO HealthNet program.

According to a MHD report, as of July 4, 2014, the holding account held 13,261 payments totaling $59.8 million dated from October 20, 2010, through July 3, 2014. These payments included over 7,500 items older than January 1, 2014. MHD staff indicated efforts to clear the backlog of deposited but unposted items are ongoing; however the process has been slower than desired, and goals for the time to complete the process have not been met. As of October 3, 2014, the report had been reduced to 6,080 items outstanding, with approximately 2,400 items older than January 1, 2014.

Failure to deposit checks timely increases the risk that the funds could be lost, misplaced, misappropriated or become stale dated. Failure to timely post deposited funds to the appropriate account(s) receivable delays the funds being available to the MHD for program uses.

Recommendations

The MHD:

3.1 Ensure that all receipts are deposited and processed timely to prevent the stale dating of checks and the loss or misappropriation of funds.

3.2 Ensure funds are posted to accounts receivable and made available for program uses as soon as possible.

Auditee's Response

The Department of Social Services provided the following written responses:

3.1 The MHD has now implemented depositing checks within 3 business days. With this new process MHD will be depositing checks more timely, but it will increase the number of checks that are not posted timely to the A/R. Since the checks were previously being held prior to depositing the check until the additional information needed was received, it will increase the number of checks that are not posted timely.

3.2 The majority of the checks (82%) are the responsibility of a contractor to post to the A/R. The MHD has been meeting with the contractor on a monthly basis to review existing policies and processes for opportunities for improvement. While there have been improvements, the MHD will continue to work with its contractor to bring postings to the accounts receivable up to date.

Since MHD is implementing a new process to deposit checks more timely, it will increase the number of checks that are not posted timely. In particular, deposited funds from partial payment of spend down checks will need to be held up to 13 months since providers have up to 12 months to bill service claims that could potentially complete the spend down obligation.

4. Provider Disclosure of Overpayment

The MHD and the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC) unit need to continue taking actions to ensure certain overpayments made to providers are identified and reported by the providers and recovered timely.

MHD providers maintain accounting records for each participant showing the services provided, costs billed, and payments received. Each participant's account at a provider may have multiple charges, payments, and adjustments made as claims work their way through the adjudication process. For instance, a claim may be sent to multiple insurers, have deductibles or copayments from the participant posted, and have deductions posted for items not billable under insurance agreements. As a result, it is not uncommon for an account to have a credit balance, meaning the amount

received by the provider exceeds the costs billed. Because the MO HealthNet program is the payer of last resort, all overpayments are to be refunded to the MHD first. State regulation 13 CSR 70-3.030 requires providers to refund an overpayment within 45 days of receiving notice that the state has identified an overpayment, or penalties may apply. Additionally, section 1320a-7k(d) of title 42 United States Code requires providers to report and return any overpayment they have received.

Health and Human Services audit

The United States Department of Health and Human Services (HHS), Office of Inspector General, performed an audit in 2012 of the MHD's oversight of credit balances[1] to determine whether nursing facilities reconciled invoice records with credit balances and reported the associated MO HealthNet overpayments to the MHD. While the audit specifically addressed nursing homes, the same type of issues could occur at any type of provider.

The federal audit identified $33,419 of overpayments for the quarter ended September 30, 2011, and estimated the state could potentially collect an additional $572,000 of overpayments for this period. The DSS collected approximately $286,000 from nursing home and hospital providers for credit balances in the year ended June 30, 2014. Additionally, the audit noted while the state requires providers to refund overpayments within 45 days of receiving notice of overpayment, there is no actual requirement for providers to reconcile their accounts, which means many payment errors may never be identified.

In the response to the audit, the DSS officials indicated the specific overpayments identified in the federal audit sample had already been collected or were in the process of being collected. These officials also stated they would assign responsibility for performing reviews of provider accounts to a contractor. According to DSS staff, the department is now considering changes to state regulations and in July 2014 began drafting a requirement for providers to reconcile accounts. However, a draft was not available for review.

Without requiring providers to reconcile accounts, the state cannot recoup from providers who have reported no overpayments because the providers indicated they were unaware of accounts with credit balances.

Recommendation

The MHD require providers to perform periodic reconciliations of participant accounts to identify overpayments that need to be refunded in accordance with state law.

[1] United States Department of Health and Human Services, Office of Inspector General, report number A-07-11-03169, *Nursing Facilities in Missouri Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency*, January 2013.

Auditee's Response

The Department of Social Services provided the following written response:

This HHS audit was conducted while the DSS utilized a different contractor than it is currently using. Currently, the state contracts with this new contractor to conduct credit balance transfer audits. In state fiscal year 2014, the state recovered $286,479 via the contractor's credit balance transfer audits.

The HHS audit report did not describe the methodology utilized to arrive at the extrapolated amount of $572,000. Additionally, the time period for which the amount applies is unclear, as both the quarter ended September 30, 2011, and the quarter ended March 31, 2011, were referred to as the applicable scope for the extrapolated amount.

MMAC staff has a draft of a self-disclosure regulation in the review and approval process. This process started at the beginning of state fiscal year 2015. Currently, providers may make adjustments when they are paid incorrectly for claims. This includes overpayment due to receipt of third party resources. If the time limits for adjusting the claims have been exceeded, providers may self-disclose overpayments to MMAC. In state fiscal year 2014, MMAC processed $1,044,449 in self-disclosures.