DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT 17 2005

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 Florida's Accounts Receivable System for Medicaid Provider Overpayments (A-04-03-06003)

Attached is an advance copy of our final report on Florida's accounts receivable system for Medicaid provider overpayments. We will issue this report to Florida within 5 business days. This review was part of a multistate audit.

Our objective was to determine whether the State reported Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements.

The State did not report all Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements during our October 1, 2001, through December 31, 2002, audit period. Forty-one of the 42 reclaiming adjustments that we reviewed, totaling $57 million ($31.9 million Federal share), were improper.[1] Additionally, the State did not report 43 overpayment adjustments totaling $25.7 million ($14.5 million Federal share) within 60 days from the date of discovery. This untimeliness resulted in a potentially higher interest expense of approximately $1 million to the Federal Government. The improper and untimely adjustments occurred because of the State's lack of written procedures for reporting and writing off overpayments, its misinterpretation of Medicaid regulations, and its lack of an adequate system for recording overpayments in a timely manner.

We recommend that the State:

- refund to the Federal Government $14.5 million, representing the outstanding balance of the $57 million ($31.9 million Federal share) in improper reclaiming adjustments;

- establish and implement written reporting and write-off procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;

[1]The State has already corrected the Form CMS-64 report (CMS-64) for improperly adjusted amounts for two providers in the amounts of $29 million ($16.4 million Federal share) and $1.8 million ($1 million Federal share), making the net amount improperly claimed $26.2 million ($14.5 million Federal share).

- provide training regarding the interpretation of Medicaid regulations on the reclaiming of previously reported receivables;

- centralize its collection activity departmentally and add staff dedicated to the collection of overpayments;

- ensure that all future overpayments are reported within 60 days, in accordance with Federal criteria, thereby mitigating the potentially higher interest expense to the Federal Government; and

- identify overpayments that were handled incorrectly following our audit period and refund any money due the Federal Government.

In written comments on the draft report, the State generally disagreed with our findings and recommendations. Despite the State's comments, we continue to believe that our findings and recommendations are valid.

If you have any questions or comments about this report, please 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 Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750. Please refer to report number A-04-04-06003.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

OCT 18 2005

Report Number: A-04-03-06003

Mr. Alan Levine
Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Dear Mr. Levine:

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 Florida's Accounts Receivable System for Medicaid Provider Overpayments." A copy of this report will be forwarded to the action official noted below 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 members of the press and general 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-04-03-06003 in all correspondence.

Sincerely,

Lori S. Pilcher
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official

Roger Perez
Acting Atlanta Regional Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FLORIDA'S ACCOUNTS RECEIVABLE SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS

Daniel R. Levinson
Inspector General

OCTOBER 2005
A-04-03-06003

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/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 of accounts receivable systems for Medicaid provider overpayments.

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. Section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 amended this section of the Act.

States are required to return the Federal share of overpayments within 60 days from the date of discovery. Thus, States must refund the Federal share of overpayments on the Form CMS-64 report (CMS-64) as an offset to expenditures for the quarter in which the 60-day period ends, whether or not recovery was made from the provider. We defined this offset as an overpayment adjustment. The Act also states that the Federal share of a Medicaid overpayment does not have to be repaid to the Federal Government if the State is unable to recover the overpayment because the provider filed for bankruptcy or went out of business, assuming that the State followed proper due diligence during the 60-day period. If the State has reported an overpayment and subsequently determines that the provider is bankrupt or out of business, the State may reclaim the overpayment on the CMS-64. We defined these types of transactions as reclaiming adjustments. Furthermore, States are not allowed to reduce the Federal share of overpayment adjustments by entering into settlement agreements unless the funds are otherwise uncollectible.

For the audit period October 1, 2001, through December 31, 2002, Florida (the State) reported a total of $69.1 million in overpayment adjustments and made reclaiming adjustments of $73.9 million.

OBJECTIVE

Our objective was to determine whether the State reported Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements.

SUMMARY OF FINDINGS

The State did not report all Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements. Forty-one of the 42 reclaiming adjustments that we reviewed, totaling $57 million ($31.9 million Federal share),[1] were improper:

- For 31 adjustments, totaling $23.8 million ($13.4 million Federal share), the State did not exercise due diligence in pursuing collection. Federal regulations require States to be on

[1]The State has already corrected the CMS-64 for improperly adjusted amounts for two providers in the amounts of $29 million ($16.4 million Federal share) and $1.8 million ($1 million Federal share), making the net amount improperly claimed $26.2 million ($14.5 million Federal share).

record as a creditor in cases of provider bankruptcy and to document due diligence if providers are out of business.

- For seven adjustments, totaling $2.2 million ($1.2 million Federal share), the State improperly reclaimed the Federal share based on settlements in which the original amount of the overpayment was reduced solely to avoid further administrative proceedings or litigation. Federal regulations do not provide for States to use settlement agreements as a basis to reclaim provider overpayments unless the funds are otherwise uncollectible.

- The State erroneously made three adjustments, totaling $31 million ($17.3 million Federal share), to reclaim the funds. The State had never paid these amounts to providers, had never claimed the expenditures on the CMS-64, and had never reported the amounts as overpayments on the CMS-64. The State simply misclassified and reported these amounts as reclaiming adjustments on the CMS-64.

The State did not report 43 overpayment adjustments totaling $25.7 million ($14.5 million Federal share) within 60 days from the date of discovery. Pursuant to Federal requirements, the State has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS. This resulted in a potentially higher interest expense of approximately $1 million to the Federal Government.[2]

The improper reclaiming adjustments and untimely overpayment adjustments occurred because of the State's lack of written procedures for reporting and writing off overpayments, its misinterpretation of Medicaid regulations, and its lack of an adequate system for recording overpayments timely.

RECOMMENDATIONS

We recommend that the State:

- refund to the Federal Government $14.5 million, representing the outstanding balance of the $57 million ($31.9 million Federal share) in improper reclaiming adjustments;
- establish and implement written reporting and write-off procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;
- provide training regarding the interpretation of Medicaid regulations on the reclaiming of previously reported receivables;
- centralize its collection activity departmentally and add staff dedicated to the collection of overpayments;
- ensure that all future overpayments are reported within 60 days, in accordance with Federal criteria, thereby mitigating the potentially higher interest expense to the Federal Government; and

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

- identify overpayments that were handled incorrectly following our audit period and refund any money due the Federal Government.

STATE'S COMMENTS

In written comments on the draft report, the State generally disagreed with our findings and recommendations. The complete text of the State's comments is included as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Despite the State's comments, we continue to believe that our findings and recommendations are valid.

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INTRODUCTION

BACKGROUND

This report is part of a multistate audit of accounts receivable systems for Medicaid provider overpayments.

Medicaid Program

Enacted in 1965, 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. 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 the medical assistance expenditures under each State's Medicaid program. Appendix A contains the Federal medical assistance percentages (Federal shares) for Florida. In Florida (the State), the Agency for Health Care Administration (the State agency) administers the Medicaid program.

Medicaid Overpayments

Section 1903(d)(2)(A) of the Social Security Act (the Act), which is the principal authority that CMS cites in disallowing the Federal share of overpayments to providers, states:

> The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

Regulations addressing credit adjustments are found in 42 CFR § 433.318 as well as section 1903(d)(2)(D) of the Act, which states:

> In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectible, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures (42 CFR §§ 433.312, 433.316, and 433.320). Therefore, when a State recognizes that it made a Medicaid overpayment, the State must report the amount of the overpayment to CMS on the Form CMS-64 report (CMS-64) as an offset to expenditures. For the purpose of this review, we defined the offset as an overpayment adjustment. A State has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment. The Federal share must be refunded to CMS regardless of whether the State Medicaid agency collects the overpayment from the provider. Discovery is defined as

notification to the provider that an overpayment exists and is due to the State. Under certain circumstances, such as the provider's bankruptcy, the State may reclaim the overpayment on the CMS-64. For the purpose of this review, we defined these types of transactions as reclaiming adjustments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State reported Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements.

Scope

We examined reclaiming adjustments and overpayment adjustments subject to the requirements of 42 CFR § 433 Subpart F reported on the quarterly CMS-64s for the audit period October 1, 2001, through December 31, 2002. We did not review overpayments due to third-party payments, probate collections, unallowable costs recovered through per diem rate adjustments, or administrative costs because these overpayments are not subject to 42 CFR § 433 Subpart F.

We did not review the overall internal control structure of the State agency's operations or its financial management. However, we gained an understanding of controls with respect to overpayments and reclaiming adjustments and the recording of accounts receivable. We performed our fieldwork at State agency offices in Tallahassee, FL.

Methodology

To accomplish our objective, we:

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

- gained an understanding of the State's procedures for processing reclaiming and overpayment adjustments;

- identified $73.9 million in reclaiming adjustments;

- selected the 42 largest reclaiming adjustments, totaling $58.1 million (78.6 percent), and obtained and reviewed the supporting documentation;

- analyzed CMS-64s along with supporting documentation pertaining to the reporting of Medicaid provider overpayment adjustments and identified 876 overpayment adjustments in our audit period totaling $69.1 million;

- compared the date that the overpayment adjustments were reported on the CMS-64s with the date that the provider was notified;

- identified 187 overpayment adjustments (from the 876 overpayments above) representing $29.2 million that did not appear to meet the 60-day criteria;

- selected the 43 largest overpayment adjustments, totaling $25.7 million (88 percent), and reviewed documentation to verify that they did not meet the 60-day criteria; and

- calculated, using the number of days between the actual and required reporting date, the potentially higher interest expense to the Federal Government for those overpayments that were not reported within the required period.[1]

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

FINDINGS AND RECOMMENDATIONS

The State did not report all Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements. Forty-one of the 42 reclaiming adjustments that we reviewed, totaling $57 million ($31.9 million Federal share), were improper:

- For 31 adjustments, totaling $23.8 million ($13.4 million Federal share), the State did not exercise due diligence in pursuing collection. Federal regulations require States to be on record as a creditor in cases of provider bankruptcy and to document due diligence if providers are out of business.

- For seven adjustments, totaling $2.2 million ($1.2 million Federal share), the State improperly reclaimed the Federal share based on settlements in which the original amount of the overpayment was reduced solely to avoid further administrative proceedings or litigation. Federal regulations do not provide for States to use settlement agreements as a basis to reclaim provider overpayments unless the funds are otherwise uncollectible.

- The State erroneously made three adjustments, totaling $31 million ($17.3 million Federal share), to reclaim the funds. The State had never paid these amounts to providers, had never claimed the expenditures on the CMS-64, and had never reported the amounts as overpayments on the CMS-64. The State simply misclassified and reported these amounts as reclaiming adjustments on the CMS-64.

The State did not report 43 overpayment adjustments totaling $25.7 million ($14.5 million Federal share) within 60 days from the date of discovery. Pursuant to Federal requirements, the State has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS. This resulted in a potentially higher interest expense of approximately $1 million to the Federal Government.

The improper reclaiming adjustments and untimely overpayment adjustments occurred because of the State's lack of written procedures for reporting and writing off overpayments, its

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

misinterpretation of Medicaid regulations, and its lack of an adequate system for recording overpayments timely.

IMPROPER RECLAIMING ADJUSTMENTS

The State made improper reclaiming adjustments to previously reported overpayments on the CMS-64s for the audit period. Of the 42 reclaiming adjustments we reviewed, 41 did not comply with Federal requirements for due diligence, settlement agreements, or the classification of transactions.

Due Diligence

Federal Requirements

For providers determined to be bankrupt, the State is not required to refund to CMS the Federal share of an overpayment at the end of the 60-day period following discovery of the overpayment. This regulation applies as long as the filing or petition occurs before the end of the 60-day period following discovery and the State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment (42 CFR § 433.318):

> (a) Basic rules. (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by Sec. 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section.
>
> The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 60-day period following discovery, if—
>
> (1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 60-day period following discovery; and
>
> (2) The State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.

The above regulation further states that for providers determined to be out of business, the agency must document its efforts to locate the party and its assets and "make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law."

Unallowable Adjustments

In 31 cases, totaling $23.8 million ($13.4 million Federal share), the State did not determine whether the providers had filed for bankruptcy in Federal court, did not file with the court as a creditor, and did not determine whether the providers were out of business. For example, the

State failed to take these steps for one reclaiming adjustment of $755,000. The State merely sent overpayment letters to the provider in 1996 concerning improper claims for 1991 and 1992. A November 2000 internal State memo noted that no collection action had occurred in the past 5 years and that the accounts receivable still were uncollected. Further, the memo stated:

> However, in light of the time lapse since the FAL [Final Audit Letter] was issued, the lack of action on the case, and the fact that it involves nine year old medical records, this claim will be virtually impossible to pursue. We are thus recommending that the amount be written off.

Even though the State did not establish whether the provider was bankrupt or out of business as required, the State claimed the written-off account on the CMS-64 in March 2002 as a reclaiming adjustment.

Settlement Agreements

Federal Requirements

Section 1903(d)(2)(D) of the Act allows credit adjustments when the provider is bankrupt or the funds are "otherwise uncollectible." Whether portions of overpayments that the State gives up in a settlement agreement are creditable against the Federal Government depends on whether those funds can be deemed "otherwise uncollectible." Federal regulations (42 CFR § 433.318) clearly identify only one circumstance apart from bankruptcy in which the State may credit uncollectible overpayments: when the provider is "out of business" as defined in 42 CFR § 433.318(d).

Departmental Appeals Board (DAB) decisions further illustrate the inapplicability of credit adjustments to settlements. For example, California Dept. of Health Services, DAB No. 1391 (1993), upheld CMS's disallowance of credit adjustments based on settlement agreements. In ruling that California must return the Federal share of overpayments that were reduced in settlements with providers, DAB stated:

> In determining that California had made overpayments to providers, California's auditors in effect determined that California had paid the providers for services, which did qualify as medical assistance. Accordingly, unless the audit findings were incorrect because there is a factual or legal basis for determining that the overpayment amounts represented allowable expenditures, there is simply no basis for California's claim for the federal share of the overpayment amounts, regardless of any hardship California suffers as a result of the denial of this claim.

Unallowable Adjustments

In seven cases, totaling $2.2 million ($1.2 million Federal share), the State improperly reclaimed the Federal share based on settlements in which the original amount of the overpayment was reduced solely to avoid "further administrative proceedings" or "the burden, uncertainty and expense of litigation." The State did not deem the overpayments as otherwise uncollectible. Therefore, the State did not meet the requirements for reclaiming adjustments.

Classification of Transactions

Federal Requirements

Pursuant to Medicaid State operations letter 91-51, dated June 11, 1991, Medicaid pays for medically necessary services that are specified in Medicaid law when included in the State plan and when provided to eligible individuals.

Misclassified Transactions

The State erroneously made three adjustments, totaling $31 million ($17.3 million Federal share), to reclaim the funds. The State had never paid these amounts to providers, had never claimed the expenditures on the CMS-64, and had never reported the amounts as overpayments on the CMS-64. The State simply misclassified and reported these amounts as reclaiming adjustments on the CMS-64. Since the amounts are not associated with allowable Medicaid services, they are not eligible for Federal payment as reclaiming adjustments.

Unallowable Federal Share Claimed

Of the $58.1 million in reclaiming adjustments reviewed, $57 million ($31.9 million Federal share) was improper. After we brought our findings to the State's attention, it corrected the CMS-64s for two of the misclassified transactions in the amount of $29 million ($16.4 million Federal share) and $1.8 million ($1 million Federal share), making the net amount improperly claimed $26.2 million ($14.5 million Federal share).

Lack of Written Policies and Procedures

The State improperly claimed the $57 million in reclaiming adjustments because it did not have written policies and procedures for reporting and writing off overpayments. Moreover, the State misinterpreted Medicaid regulations regarding the reclaiming of previously reported receivables and accordingly wrote off uncollectible overpayments without filing as a creditor, identifying assets, documenting bankruptcy, or vigorously pursuing collection efforts. The State also reduced overpayments based on negotiated settlement agreements for solvent providers.

OVERPAYMENTS NOT REPORTED TIMELY

Federal Requirements

Pursuant to 42 CFR §§ 433.312, 433.316, and 433.320, a State has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before refunding the Federal share to CMS. Discovery is defined as notification to the provider that an overpayment exists and is due the State.

The discovery date is the beginning date of the 60-calendar-day period. The State 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 must credit the Federal share of

overpayments subject to recovery on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

Overpayments Reported After 60 Days

The State did not always report overpayments timely. The State reported overpayment adjustments on the CMS-64 beyond 60 days after discovery. All 43 of the largest overpayments, totaling $25.7 million ($14.5 million Federal share), that our computer match identified as untimely did not meet the 60-day reporting requirement based on hard-copy documentation. The time that the 43 overpayments were posted beyond the 60-day criterion averaged 317 days and ranged from 60 days to 1,860 days.

Potentially Higher Interest Expense

The State did not report overpayments of $25.7 million ($14.5 million Federal share) timely on the CMS-64 in accordance with the regulations. This untimeliness potentially resulted in approximately $1 million in higher interest expense to the Federal Government.

Accounting System Limitations

The untimely reporting of overpayments resulted from limitations in the State's accounting system, which could not accurately account for overpayments because it did not have the capability to age accounts receivable for the CMS-64 and could not reliably monitor overpayments. According to a State official, additional monitoring problems occurred because the State collection activity was not departmentally centralized and there was a lack of staff dedicated to the collection of overpayments.

RECOMMENDATIONS

We recommend that the State:

- refund to the Federal Government $14.5 million, representing the outstanding balance of the $57 million ($31.9 million Federal share) in improper reclaiming adjustments;
- establish and implement written reporting and write-off procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;
- provide training regarding the interpretation of Medicaid regulations on the reclaiming of previously reported receivables;
- centralize its collection activity departmentally and add staff dedicated to the collection of overpayments;
- ensure that all future overpayments are reported within 60 days in accordance with Federal criteria, thereby mitigating the potentially higher interest expense to the Federal Government; and
- identify overpayments that were handled incorrectly following our audit period and refund any money due the Federal Government.

STATE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In written comments on the draft report, State officials generally disagreed with our findings and recommendations. The complete text of the State's comments is included as Appendix B. A summary follows, along with our response.

Due Diligence

State's Comments

The State asserted that it had exercised "reasonable efforts" in pursuing collection of the questioned amounts, including obtaining permission from the State's Department of Financial Services to write off the uncollectible accounts receivable.

Office of Inspector General's Response

Contrary to the State's position that it documented collection efforts and made adjustments related to providers that were bankrupt or out of business, we did not find the required documentation. For example, the State could not demonstrate that the provider had filed for bankruptcy in Federal court and that the State was on record with the court as a creditor for the amount of the Medicare payment as required by 42 CFR §§ 433.318(c)(1) and (2). In addition, the State did not document its efforts to locate out-of-business providers or provide an affidavit from the appropriate State legal authority establishing that the provider was out of business and that the overpayment was uncollectible as required by 43 CFR § 433.318(d)(2).

Settlement Agreements

State's Comments

The State said that it had appropriately entered into negotiated settlements with providers and was of the opinion that it could make downward adjustments of overpayments through settlements when doing so was cost effective.

Office of Inspector General's Response

We disagree. The State may discharge overpayments only through recognition of bankruptcy or out-of-business status (42 CFR § 433.318).

Classification of Transactions

State's Comments

In regard to the three transactions that we reported as having been misclassified as reclaiming adjustments, the State believed that one transaction was actually an amount erroneously booked and corrected on the same quarterly report. The State also believed that a second transaction was an account receivable deemed uncollectible and properly reclaimed. The State acknowledged

that the third transaction was an error and said that the State corrected the error when we identified it.

Office of Inspector General's Response

We agree that the State properly refunded $29 million ($16.4 million Federal share) for the third transaction, and our draft report recognized that refund. However, we disagree with the State's position on the remaining two transactions. Available records showed that the State had never posted either transaction as an overpayment. Therefore, neither transaction was eligible for Federal payment as a reclaiming adjustment.

Lack of Written Policies and Procedures

State's Comments

The State commented that the Medicaid Accounts Receivable unit within the Bureau of Finance and Accounting followed written procedures when considering reclaiming adjustments. The State also said that during the audit period, existing policies and procedures were being updated.

Office of Inspector General's Response

While the State may have developed written procedures for overpayment recovery activities, written procedures were not in effect during our audit period. Our interviews with accounting officials indicated that the procedures followed during our audit period were essentially ad hoc.

Overpayments Reported After 60 Days

State's Comments

The State said that it reported the uncollected overpayments within the 60-day requirement based on the date of discovery. The State considered the discovery date to be the date it sent the final order to the provider as notification of an overpayment.

Office of Inspector General's Response

We disagree with the State's position on the discovery date of an overpayment. In New York State Dept. of Social Services, DAB No. 1536 (1995), DAB ruled that discovery occurs when the State first notifies the provider of an overpayment and that the notification need not be the final overpayment amount. Based on this ruling, the 43 overpayments in question exceeded the 60-day reporting requirement.

Accounting System Limitations

State's Comments

The State noted that during our fieldwork, it was implementing a new Medicaid accounts receivable system, and the Florida Legislature authorized three new positions to collect overpayments. The State explained that it had fully implemented the new accounts receivable system, which ensures that overpayments are reported in a timely manner and that no reclaiming adjustment will be made for an overpayment not previously reported. Also, according to the State, the increased staffing is expected to improve collections and tracking of accounts receivable.

Office of Inspector General's Response

The successful implementation of the State's new Medicaid accounts receivable system and the authorization of additional staff may address some of our procedural recommendations.

APPENDIXES

APPENDIX A

OVERPAYMENT RECLAIMING ADJUSTMENTS TO THE CMS-64s October 1, 2001, Through December 31, 2002

SAMPLE NUMBER	TOTAL RECLAIMING ADJUSTMENT	ALLOWABLE	UNALLOWABLE	FEDERAL MEDICAL ASSISTANCE PERCENTAGE	FEDERAL SHARE
1	$260,327.76		$260,327.76	0.5565	$144,872.40
2	535,706.69		535,706.69	0.5579	298,870.76
3	791,093.28	$784,565.44	6,527.84	0.5652	3,689.54
4	254,488.90		254,488.90	0.5503	140,045.24
5	659,649.90		659,649.90	0.5652	372,834.12
6	513,271.17		513,271.17	0.5662	290,614.14
7	219,347.00		219,347.00	0.5662	124,194.27
8	490,825.00		490,825.00	0.5582	273,978.52
9	194,977.28		194,977.28	0.5565	108,504.86
10	967,534.38		967,534.38	0.5582	540,077.69
11	203,432.31	35,902.20	167,530.11	0.5579	93,465.05
12	223,092.76		223,092.76	0.5652	126,092.03
13	508,877.07		508,877.07	0.5579	283,902.52
14	487,090.13		487,090.13	0.5579	271,747.58
15	241,026.59		241,026.59	0.5662	136,469.26
16	374,542.54		374,542.54	0.5662	212,065.99
17	201,743.05		201,743.05	0.5652	114,025.17
18	229,131.77		229,131.77	0.5565	127,511.83
19	596,824.20		596,824.20	0.5582	333,147.27
20	497,576.77		497,576.77	0.5628	280,036.21
21	1,034,357.00		1,034,357.00	0.5579	577,067.77
22	630,452.60		630,452.60	0.5565	350,846.87
23	377,000.00		377,000.00	0.5579	210,328.30
24	248,870.70		248,870.70	0.5565	138,496.54
25	215,624.80		215,624.80	0.5579	120,297.08
26	770,504.08		770,504.08	0.5652	435,488.91
27	211,389.97		211,389.97	0.5652	119,477.61
28	425,981.96		425,981.96	0.5662	241,190.99
29	301,938.44	301,938.44	-	0.5582	-
30	233,178.11		233,178.11	0.5478	127,734.97
31	328,072.56		328,072.56	0.5576	182,933.26
32	984,788.69		984,788.69	0.5579	549,413.61
33	218,585.01		218,585.01	0.5628	123,019.64
34	1,089,452.52		1,089,452.52	0.5582	608,132.40
35	254,425.78		254,425.78	0.5582	142,020.47
36	858,319.14		858,319.14	0.5446	467,440.60
37	203,197.56		203,197.56	0.5652	114,847.26
38	755,133.27		755,133.27	0.5478	413,662.01
39	29,425,754.00		29,425,754.00	0.5579	16,416,628.16
40	7,785,034.32		7,785,034.32	0.5662	4,407,886.43
41	1,399,691.00		1,399,691.00	0.5643	789,845.63
42	1,881,737.71		1,881,737.71	0.5582	1,050,385.99
	$58,084,047.77	**$1,122,406.08**	**$56,961,641.69**		**$31,863,288.92**

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

July 22, 2005

Ms. Lori S. Pilcher
Office of the Inspector General
Office of Audit Services – Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

RE: Report Number A-04-03-06003

Dear Ms. Pilcher:

We have received your letter and copies of the Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Review of Florida's Accounts Receivable System for Medicaid Provider Overpayments for the period of October 1, 2001 through December 31, 2002.*

We appreciate the opportunity to review and respond to the draft report. The following are the Agency's responses to the audit findings and recommendations. For each we have offered an explanation of the Agency's position or interpretation of the federal regulations regarding the claiming and refunding of fraud and abuse overpayments.

AUDIT FINDINGS

Finding:

"The State did not report all Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements."

- "For 31 adjustments,...the State did not exercise due diligence in pursuing collection."

Response:

The state contends it has indeed exercised "reasonable efforts" in pursuing collection of the accounts selected for review, as required by federal regulations. The amounts reclaimed during the audit period, and disallowed by the audit, represent accounts

receivable that were properly deemed uncollectible in accordance with all applicable state policies and procedures.

The Agency has 60 days after the date of discovery to determine if the receivable is collectible. The Agency is not required to refund the federal share of an overpayment made to a provider when the state is unable to recover the overpayment amount because the provider has been determined bankrupt or out-of-business. In accordance with federal requirements, Agency policies provide that reasonable collection efforts begin after the Agency Final Order (FO) is issued. Provider contact is initiated through collection letters and/or telephone calls and liens placed where possible. It is during this period the ability to collect is determined. All accounts recommended for write-off by the Agency are referred to the Florida Department of Financial Services (DFS) for approval. DFS reviews the collection efforts expended by the Agency for the referred accounts. DFS then issues a letter to the Agency approving the write-off of those accounts its review finds to be otherwise uncollectible.

The Agency contends the DFS approval letter serves as the certification in accordance with the practical application of the provisions of 42 C.F.R. 433.318.

The accounts included in the audit were related to providers that were out-of-business subsequent to the refunding of the federal portion of the Medicaid overpayment on the CMS-64 report. For some of the accounts, it was discovered the out-of-business provider had previously filed bankruptcy and had not notified the state of their filing. Some of the audited accounts involved out-of-business providers that were incarcerated, and because of the individual circumstances, were deemed to be otherwise uncollectible. As stated above, all of the amounts reclaimed were from accounts approved as uncollectible by DFS, in accordance with state laws, policies, and procedures.

Finding:

- "For seven adjustments...the State improperly reclaimed the Federal share based on settlements in which the original amount of the overpayment was reduced solely to avoid further administrative proceedings or litigation."

Response:

The Agency contends it has the ability to reduce overpayments through settlement.

Pursuant to 42 C.F.R. 433.316(f)(1), downward adjustments of Medicaid overpayments are permissible. There is nothing in subsection (f) that qualifies how such changes in the overpayment amount may be achieved or prohibits the state from adjusting an overpayment amount downward through settlement if the state determines said amount is otherwise uncollectible or recovery efforts will not be cost-effective.

The Agency is of the opinion the HHS Inspector General's draft report misstates the Agency's requirements for reclaiming overpayment adjustments through settlement. The draft report focuses on selective wording used in the Agency's standard settlement agreement. In fact, the language the report focuses on is language common to settlements regardless of the parties to the agreement. Contrary to the HHS Inspector General's findings, the Agency does not settle overpayment cases solely for purposes of avoiding administrative burdens. In fact, the Agency conducts a re-review of claims and/or relevant law prior to all settlement discussions. The Agency routinely recovers 100 percent of the adjusted overpayment amount as a result of such settlement efforts.

Each settlement offer is subject to the scrutiny and judgment of the Agency, who determines whether it is in the Medicaid program's best financial interest to settle the case. It is the Agency's standard policy to not continue with costly recoupment actions where an overpayment amount appears to be uncollectible. This policy is consistent with 42 U.S.C. 1396b(d)(2)(D), which provides "[i]n any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt...being uncollectible, no adjustment shall be made in the Federal payment to such State on account of such overpayment or portion thereof." However, in order to avoid further confusion, the Agency has removed the language referenced by the HHS Inspector General from its settlement agreements.

Although the Agency routinely recovers 100 percent of the adjusted overpayment amount as a result of such settlement efforts, the Agency does have the authority to settle otherwise uncollectible overpayments. The federal regulations, specifically 42 C.F.R. 433.316(b), require the state to "take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures." The Agency's attempts to recover Medicaid overpayments are governed within the Florida's Administrative Procedure Act (Section 120.57(4), Florida Statutes (2004)), which provides "...informal disposition may be made of any proceeding by stipulation, **agreed settlement**, or consent order" (emphasis added). Furthermore, as established by Feldman v. Kritch (824 So.2d 274 (Fla. 4th DCA 2002)), the public policy of the State of Florida encourages settlement agreements among parties and will seek to enforce them whenever possible. Accordingly, Florida's laws and procedures support the Agency's settlement of overpayment actions, even where such actions result in changes to the overpayment amount. As part of the settlement process, the Agency may consider whether the overpayment amount it reasonably expects to recover will be less than the cost of recovery or recovery efforts will otherwise not be cost-effective.

By denying the Agency the ability to adjust overpayments through settlement practices, the federal government is potentially jeopardizing the financial integrity of the Medicaid program. In Harris v. McRae, 448 U.S. 297, 308 (1980), the Supreme Court noted "Title XIX is a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons." The Court added the "cornerstone of Medicaid is financial contribution by both the Federal government and the participating State." Thus, the Supreme Court has taken the position Medicaid was designed by Congress as a cooperative program of

shared financial responsibility. Based on this joint financial responsibility for the Medicaid program, the Agency is of the opinion HHS may permit the downward adjustment of overpayments through settlement where cost-effective.

Finding:

- "The State erroneously made three adjustments...to reclaim the funds."

Response:

Although three items were identified as "simply misclassified," in reality, one item was actually an amount erroneously booked and corrected within the same quarterly CMS-64 report (12/31/2002) and therefore was not an error. A second item identified as an erroneous adjustment was not an error but was an accounts receivable deemed otherwise uncollectible and was properly reclaimed on a CMS-64 report. The remaining item was a clerical error corrected immediately upon being identified by the auditors and verified by Agency staff.

Finding:

"The State did not report 43 overpayment adjustments...within 60 days from the date of discovery."

Response:

A thorough review of the applicable federal regulations, as summarized below, has prompted the state to re-evaluate its practice of using the notice known as a Final Agency Audit Report, commonly referred to as the Final Audit Letter (FAL) to determine the date of discovery.

42 C.F.R. 433.300(b) provides, in part, "...a State has 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 60 days...." 42 C.F.R. 433.320(a)(2) provides "The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period following discovery, established in accordance with Section 433.316, ends." 42 C.F.R. 433.316(d) provides "*Overpayments resulting from fraud or abuse.* 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).

The Agency must adhere to Chapter 120, Florida Statutes, [the State Administrative Procedures Act, or APA] before it can collect an overpayment. The APA thus constitutes part of the Agency's policies and procedures. In accordance with the Agency's policies and procedures, "final written notice" of an overpayment is provided upon issuance of a FO. Section 120.52(7), Florida Statutes (2004), defines a FO as a written final decision, which includes final agency actions.

In accordance with existing Agency policy and procedures, overpayments are reported on the CMS-64 that corresponds with the 60-day period from the date of the FAL, not the date of the FO. However, upon a thorough review of the applicable federal regulations, the Agency has determined issuance of the FO is the actual final written notice of an overpayment amount. Therefore, the Agency has been reporting overpayments on a CMS-64 before it is required by 42 C.F.R. 433.320.

The Agency is of the opinion issuance of a preliminary audit report, commonly referred to as preliminary audit letter (PAL) or FAL is not final notice of the overpayment amount the Agency seeks to recoup. The PAL identifies the Agency's preliminary findings as to fraud and abuse. The PAL does not provide a provider with due process rights, but rather is an invitation for the provider to respond to the Agency's allegations of unacceptable practices or overpayments. Pursuant to the Agency's issuance of a PAL, a provider is allowed time to respond and to submit additional materials to the Agency for review and determination as to whether an impropriety occurred. The Agency issues a FAL upon completion of the review of the appropriateness of Medicaid payments made. The FAL provides notice of available administrative and/or judicial hearings by which a provider may dispute the Agency's findings as to fraud and abuse. Pursuant to the APA, a provider has 21 days to challenge the findings contained in the FAL. If it is not challenged, a FO is entered. If it is challenged, a FO is entered at the conclusion of the proceedings. Depending on the evidence presented at the administrative hearing, the amount of the overpayment may be reduced, or conceivably increased, by the Administrative Law Judge during the administrative proceeding. Therefore, the overpayment amount is not final until the FO is issued. Consequently, neither the PAL nor the FAL can validly constitute "final written notice."

All 43 of the accounts selected in the audit have been refunded on a CMS-64 report. Twenty-six of the 43 accounts reviewed in the audit were actually reported on a CMS-64 report prior to, or within 60 days of, the date of discovery, or otherwise in accordance with 42 C.F.R. 433.320(a)(2). There have been no FOs issued for the remaining 17 accounts refunded to the federal government on a CMS-64 report. Of those 17 previously reported, nine remain open, three were closed during the investigation, two were declared bankrupt prior to issuance of a FO, and three were reported on a CMS-64 upon the receipt of provider payments from a preliminary notice. This early reporting actually results in a loss of interest income for the State of Florida.

Thus, it is the Agency's position the beginning date for the 60-day reporting period commences upon the date of the issuance of the FO, and not the PAL or FAL.

Finding:

"The improper reclaiming adjustments and untimely overpayment adjustments occurred because of the State's lack of written procedures for reporting and writing off overpayments, its misinterpretation of Medicaid regulations, and its lack of an adequate system for recording overpayments timely."

Response:

The Medicaid Accounts Receivable (MAR) unit within the Bureau of Finance and Accounting (F&A) follows written procedures when considering reclaiming adjustments that are included on the CMS-64 report. These procedures were approved and implemented prior to audit. After a FO is sent to the provider, if no response is received by F&A within 45 days, a notice is sent to the provider explaining collection actions that will be taken. If the provider is currently billing Medicaid/Medicare, a lien is filed against the provider to recover overpayment. If the provider is no longer a Medicaid/Medicare provider, research is performed to determine the provider's business status. If the provider is out-of-business and no response has been received within 30 days, the account is sent to DFS for further collections or write-off approval. When DFS certifies the account should be written off, the accounts receivable records are updated accordingly and adjustments made to a CMS-64 report. These written reporting and write-off procedures were, and are, available for review and evaluation.

MAR personnel are continually trained in all aspects of their job duties, including requirements for reclaiming of previously-reported receivables. The MAR unit meets on a regular basis to review procedures, identify issues and resolve questions pertaining to collection activities. Included in the training are discussions of Medicaid regulations in regards to the recovery of overpayments.

The state does not believe it has or is misinterpreting Medicaid regulations regarding reclaiming adjustments. As detailed above, the state believes it has properly reclaimed amounts resulting from overpayments to providers that have gone out-of-business. The state also believes it has properly reclaimed amounts resulting from downward adjustments reflected in Agency FOs as a result of adjustments to FAL determination notices. It is noted the state's procedures for reclaiming amounts have been used for numerous years and previous federal reviews of CMS-64 submissions have not indicated a problem with the state's interpretation and application of federal reclaiming regulations.

A thorough review of the applicable federal regulations, however, has prompted the state to re-evaluate its interpretation of these regulations to determine if the practice of using the notice known as a FAL to determine the date of discovery is appropriate. The Agency FO may more appropriately reflect the requirements of 42 C.F.R. 433.316(d).

Regarding its "recording system" during the audit period (October 2001-December 2002), a new MAR system was being developed, tested, and implemented. Conversion of accounts receivable records from the old system to the new system began in September 2002 and was completed in December 2002. The new CMS-64 report generated by the MAR system shows the MAR number, provider number, case number, name, transaction date, transaction amount, FFP rate, and state and federal distribution of the transaction amount. It produces three different summary reports with totals for CMS-64 reporting. This provides staff a more detailed list from which to verify and confirm entries on the report. The program that generates the report also includes logic to verify no case will be adjusted or reclaimed for an amount greater than its original reporting amount. During the audit period, existing policies and procedures were being updated to reflect changes brought about by the new MAR system.

Additionally, during the audit period, the Florida Legislature authorized F&A to fill three new positions to improve collections and tracking of Medicaid accounts receivables. This increased the staffing in the MAR unit from four to seven employees.

AUDIT RECOMMENDATIONS

Recommendation:

"We recommend that the State:

- refund to the Federal Government…improper reclaiming adjustments;"

Response:

The reclaiming adjustments identified in the audit were properly made based on the state's interpretation and practical application of federal regulations.

The state contends it has indeed exercised "reasonable efforts" in pursuing collection of the accounts selected for review, as required by federal regulations. The amounts reclaimed during the audit period, and disallowed by the audit, represent accounts receivable that were properly deemed uncollectible in accordance with all applicable state policies and procedures.

In accordance with federal requirements, Agency policies provide reasonable collection efforts begin when the Agency FO is issued. It is during this period provider contact is initiated through collection letters and/or telephone calls, liens placed where possible, and account collectability is determined. All accounts recommended for write-off by the Agency are referred to the State DFS for approval. DFS reviews the collection efforts expended by the Agency for the referred accounts. DFS then issues a letter to the Agency approving the write-off of those accounts deemed uncollectible.

The Agency contends the DFS approval letter serves as the certification in accordance with the practical application of the provisions of 42 C.F.R. 433.318.

The accounts included in the audit were related to providers that were out-of-business subsequent to the refunding of the federal portion of the Medicaid overpayment on the CMS-64 report. For some of the accounts, it was found the out-of-business provider had previously filed bankruptcy and had not notified the state of their filing. Some of the audited accounts involved out-of-business providers that were incarcerated, and because of the individual circumstances, were deemed to be otherwise uncollectible. As stated above, all of the amounts reclaimed were from accounts approved as uncollectible by DFS, in accordance with state laws, policies, and procedures.

Recommendation:

- "establish and implement written reporting and write-off procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;"

Response:

F&A follows written procedures when considering reclaiming adjustments included on the CMS-64 report. These procedures were approved and implemented prior to the audit. After the FO is sent to the provider, if no response is received by F&A within 45 days, a notice is sent to the provider explaining collection actions that will be taken. If the provider is currently billing Medicaid/Medicare, a lien is filed against the provider to recover overpayment. If the provider is no longer a Medicaid/ Medicare provider, research is performed to determine the provider's business status. If no response has been received within 30 days, the account is sent to DFS for further collections or write-off approval. When DFS certifies the account should be written off, the accounts receivable records are updated accordingly and adjustments made to a CMS-64 report. These written reporting and write-off procedures were, and are, available for review and evaluation.

Recommendation:

- "provide training regarding the interpretation of Medicaid regulations on the reclaiming of previously reported receivables;"

Response:

MAR personnel are continually trained in all aspects of their job duties, including requirements for reclaiming of previously-reported receivables. The MAR unit meets on a regular basis to review procedures, identify issues and resolve questions pertaining to collection activities. Included in the training are discussions of Medicaid regulations in regards to the recovery of overpayments.

Recommendation:

- "centralize its collection activity departmentally and add staff dedicated to the collection of overpayments;"

Response:

Although the Agency has area offices throughout the State of Florida, its finance and accounting activities are centralized at its headquarters in Tallahassee. Specifically, Medicaid accounts receivable collection activity is centralized in the MAR unit within F&A. The only exceptions to this are the collections made by the State Attorney General's Medicaid Fraud Control Unit during the course of their investigations. These collections are then transferred to the MAR unit for appropriate handling on the CMS-64 report.

Additionally, during the audit period, the Florida Legislature authorized F&A to fill three new positions to improve collections and tracking of Medicaid accounts receivables. This increased the staffing in the MAR unit from four to seven employees.

Recommendation:

- "ensure that all future overpayments are reported within 60 days in accordance with Federal criteria, thereby mitigating the potentially higher interest expense to the Federal Government;"

Response:

As explained previously, 42 C.F.R. 433.316(a) and (d) require fraud and abuse overpayments are to be reported to the federal government at the end of the 60-calendar day period following the issuance of the **final** written notice, which for the State of Florida is the Agency FO. The audit asserts an earlier document, the Preliminary Agency Audit Report, initiates the 60-calendar day period. This preliminary notice does not constitute the "final written notice" prescribed by 42 C.F.R. 433.316(d).

Recommendation:

- "identify overpayments that were handled incorrectly following our audit period and refund any money due the Federal Government."

Response:

The MAR system developed during state fiscal year 2002-2003 has been fully implemented. This enhanced system greatly assures overpayments are reported timely and no reclaiming adjustment will be made for an overpayment not previously reported.

In conclusion, the Agency believes the reclaiming adjustments made by the state are in accordance with all applicable policies and procedures. Thus, the Agency requests HHS reexamine its findings the Agency improperly reclaimed federal funds.

AHCA continuously looks for opportunities to improve operations and is committed to providing cost effective and efficient health care services to the citizens of Florida. If you have any questions or comments about the response, you may contact James Boyd, Inspector General, at (850) 921-4897.

Sincerely,

for Alan Levine
Secretary

AL/mb