



UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

TRANSPORTATION AND
CLAIMS DIVISION

B-117604(17)

The Honorable
The Secretary of Health,
Education, and Welfare

Dear Mr. Secretary:

We have been interested in the Medicare program since its beginning and have issued several reports, including one on lengthy delays in settling the costs of health services. Because many of these services were furnished in 1966, 1967, and 1968, we became concerned with the possibility that, if overpayments occurred, the statute of limitations (28 U.S.C. 2415) would bar litigation if repayments were not made. We therefore began a review in October 1972 of the overpayment cases which were with the Bureau of Health Insurance.

We want to invite your attention to the fact that this report contains recommendations to you which are set forth on pages 5, 10, and 13. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions he has taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report, and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We shall appreciate receiving copies of your statements to the committees.

Copies of this report are being sent to the Director, Office of Management and Budget.

Sincerely yours,

A handwritten signature in black ink, appearing to read "T. E. Sullivan".

T. E. Sullivan
Director

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ABBREVIATIONS

BHI	Bureau of Health Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SNFs	skilled nursing facilities
SSA	Social Security Administration

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY OF
HEALTH, EDUCATION, AND
WELFARE

LENGTHY DELAYS IN PROCESSING OF
OVERPAYMENTS UNDER PART A OF THE
MEDICARE PROGRAM MAY RESULT IN
LOSSES OF MILLIONS OF DOLLARS
Social Security Administration

D I G E S T

WHY THE REVIEW WAS MADE

GAO, in its continuing effort to improve the effectiveness of the Government's collection operations reviews agency operations periodically.

One such review involved part A of the Medicare program which covers inpatient hospital services, post-hospital care in skilled nursing facilities, and care in the patient's home. The Bureau of Health Insurance administers this program. The law authorizes the Secretary of HEW to contract with intermediaries to pay hospitals and institutions for beneficiaries' care.

FINDINGS AND CONCLUSIONS

The Medicare program became effective July 1, 1966. Under Medicare reimbursement principles, intermediaries pay interim payments, not less than once a month, to providers of services for the reasonable cost of such services to beneficiaries. Providers submit cost reports to account for all costs incurred. (See p. 2.)

Overpayments arise because interim payments are too high, providers fail to file cost reports, or providers bill for excessive or noncovered services to beneficiaries. (See p. 2.)

Uncollectible overpayments are referred to GAO for possible referral to the Department of Justice for enforced collection proceedings. (See p. 2.)

GAO was concerned that overpayments made during the early years of the program would be barred under the 6-year statute of limitations, resulting in possible losses of millions of dollars to the Government. (See pp. 4 and 13.)

GAO told the Bureau of Health Insurance that under the statute of limitations the earliest possible date should be used in determining when the right of action first accrues. (See p. 13.)

GAO found that, in their referrals of overpayment cases, intermediaries often

--failed to furnish credit information on providers (see p. 7.),

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--failed to identify all parties liable for the overpayments (see p. 6.), and

--continued negotiation with providers after claims were referred to GAO or to the Department of Justice (see p. 10.).

From October 17, 1969, to November 1971, 82 cases were referred to GAO. The Department of Justice was unable to litigate some of the claims from the evidence the Bureau furnished. (See p. 3.) After GAO met with the Bureau of Health Insurance and the Department of Justice, agreements were reached on the evidence required to bring suit on the overpayment claims. (See p. 4.) Through December 4, 1974, the Bureau had forwarded a total of 848 cases to GAO.

To establish accounting controls on overpayments under part A of the Medicare program, the Bureau established a Provider Overpayment Reporting System. As of March 31, 1973, the system identified a total of \$188 million

outstanding on overpayment cases in the intermediaries' inventories or with the Bureau. Of the \$188 million, \$32.7 million involved overpayments made in cost-reporting periods ending 1966, 1967, or 1968.

RECOMMENDATIONS

The Secretary of HEW should:

--Insure that claims are forwarded to GAO in enough time for processing before the expiration of the 6-year period. (See p. 13.)

--Require full compliance with the Federal Claims Collection Act and the Joint Standards. (See p. 10.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

The Bureau sent questionnaires to the intermediaries concerning the cases held in their inventories and requested that top priority be given those cases which had potential statute-of-limitation problems.

In an effort to protect the Government's interests, uniform procedures for developing and documenting overpayment cases for litigation have been formulated by the Bureau and its legal counsel, the Department of Justice, and GAO.

CHAPTER 1

INTRODUCTION

The Federal Claims Collection Act of 1966 (31 U.S.C. 951-953) imposes primary responsibility for collecting debts due the United States on the respective agencies whose operations give rise to such indebtednesses. To implement the act, the Comptroller General and the Attorney General jointly issued statutory regulations (4 CFR 101-105). These regulations designated as Joint Standards, set forth in detail collection actions which agencies must take.

As part of the continuing effort of our Office to improve the effectiveness of the Government's collection operations, we make periodic reviews of agency operations under the act and the Joint Standards. In October 1972 we began a review of debts arising under part A of the Medicare program (Hospital Insurance Benefits for the Aged (42 U.S.C. 1395 et seq.)). This part of the program provides for payment of health care cost for eligible persons and covers inpatient hospital services and post-hospital care in skilled nursing facilities (SNFs) and care in the patient's home.

The Medicare program, administered by the Bureau of Health Insurance (BHI), Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), became effective July 1, 1966. The law authorizes the Secretary of HEW to contract with public agencies or private organizations, referred to as fiscal intermediaries, to pay hospitals and other institutions, known as providers, for services rendered to beneficiaries.

DUTIES OF INTERMEDIARIES

Intermediaries are nominated by providers and under contracts with HEW are responsible for:

- Making interim payments to providers, not less than once a month, on an estimated-cost basis for covered services furnished Medicare beneficiaries. These payments are from funds advanced to the intermediaries by HEW.
- Consulting with providers to develop accounting procedures which will insure that they receive equitable payment under the Medicare program.
- Communicating to providers information or instructions furnished by the Secretary of HEW and serving as a

channel of communication from the provider to the Secretary.

- Auditing the records of the provider to insure proper payment.
- Making final annual determinations of any additional amounts due or to be collected from the provider.

SSA reimburses intermediaries for administrative costs incurred in performing these various functions.

PROVIDERS PAID REASONABLE COSTS

A participating provider of services is a hospital; skilled nursing facility; home health agency; or, for out-patient physical therapy services, a clinic; rehabilitation agency; or public-health agency which has entered into an agreement with the Secretary of HEW to participate in the Medicare program.

Under Medicare reimbursement principles, providers of services are paid by fiscal intermediaries for the reasonable cost of services provided to beneficiaries. Intermediaries make reasonable-cost determinations by reviewing cost reports which are submitted by providers on an annual basis to account for all costs resulting from providing services to beneficiaries.

Overpayments arise because interim payments are too high, providers fail to file cost reports, or providers bill for excessive or noncovered services. Intermediaries are primarily responsible for collecting overpayments. If an intermediary is unsuccessful in collecting an overpayment, the case is forwarded through the SSA regional office to BHI, which acts as the focal point for processing all overpayment cases to us for further collection action. If appropriate, we refer the case to the Department of Justice for enforced collection proceedings.

CHAPTER 2

DELAYS ENCOUNTERED FROM THE BEGINNING

On June 23, 1971, we issued a report to the Congress (B-164031(4)) stating that, because of lengthy delays by intermediaries in completing the settlement process, billions of Medicare dollars paid out on the basis of estimated costs had not been afforded an appropriate final accounting or a timely review by the intermediaries and the Federal Government.

Hospitals entered the Medicare program on July 1, 1966, and cost reports were due 90 days after their reporting year ended. Skilled nursing facilities (formerly extended-care facilities) did not begin participating in the program until January 1967 and were not furnished cost report forms until April 1968.

There have been delays in every step of the settlement process, (1) from hospitals and SNFs preparing cost reports, (2) through intermediaries auditing cost reports, and (3) to the final settlement or agreement concerning actual and reasonable Medicare costs to be reimbursed under the program.

On August 4, 1972, we reported to the Congress (B-164031(4)) that many institutions had terminated from the Medicare program owing millions of dollars. Improvements were needed at both the intermediary and Federal levels to minimize and recoup overpayments. Under procedures in effect in November 1971, SSA did not establish accounting controls over the overpayments or unaccounted-for payments made to terminated institutions until it was ready to refer the claims to us for further collection action.

With this need to establish accounting controls on part A, Medicare overpayments, BHI set up a Provider Overpayment Reporting System which requires that intermediaries report quarterly to BHI all outstanding overpayments and actions taken to recover them. The information generated under the reporting system also contains a record of overpayment cases located in SSA regional offices, BHI, our Office, and the Department of Justice.

MEDICARE CASES REFERRED TO GAO

From October 17, 1969, to November 1971, 82 claims were referred to us for further collection action. Several of the claims which we later forwarded to the Department of Justice for enforced collection proceedings were returned

for such reasons as the U.S. Attorney could not verify from the evidence furnished the amount certified in our certificate of settlement, or he needed additional evidence to establish liability.

Another 60 claims were referred to us by August 1972, but we continued to have trouble preparing them for the Department of Justice. We held several meetings with BHI personnel trying to solve some of the problems. There were long delays in getting additional information from the BHI staff. We also met with Department of Justice officials to resolve the issues. In January 1973 the Department of Justice outlined the minimum evidence which would be acceptable for instituting suit, including the necessity for an authorized BHI official to prepare a certification for a definite amount.

The enactment on October 30, 1972, of the Social Security Amendments of 1972, 86 Stat. 1329, authorizing SSA to withhold Federal participation in State Medicaid payments to institutions caused additional delays while BHI determined whether any of the previously reported claims would be affected.

From September 1972 through July 1973, only one case was referred to our Office. From August 1973 through June 1974, 468 cases were forwarded, making a total of 611. The 611 claims represented overpayments exceeding \$32 million. The average overpayment was about \$54,000, and one claim exceeded \$800,000. Through December 4, 1974, BHI had forwarded a total of 848 cases. Virtually all of the claims forwarded to us involve 1966, 1967, or 1968 overpayments.

DELAYS CAUSE CONCERN

These delays caused concern because, in the absence of court decisions, there are numerous questions concerning the application of the 6-year statute of limitations, 28 U.S.C. 2415. (This statute is discussed in ch. 4.) These delays are also important because our collection experience has shown that the collection effectiveness depends on the prompt processing of debt claims.

As of March 31, 1973, approximately \$188 million in overpayments resulting from part A of the Medicare program was outstanding, either in the intermediaries' inventories or in BHI's. Of the \$188 million, \$32.7 involved overpayments made in cost-reporting periods ending 1966, 1967, or 1968, with \$18.5 million in the intermediaries' inventories. (It should be pointed out, however, that the

\$32.7 million in overpayments does represent a relatively small portion of the almost \$11 billion in part A benefit payments made from July 1, 1966, through June 30, 1969.) Since then, BHI has given top priority to the processing of the older cases. Although we do not have data on the current status of these cases, even if all of them had been immediately sent to our Office, there was still a potential problem with the expiration of the statute of limitations. In addition, many of the claims forwarded to our Office had serious deficiencies, making it difficult for us to refer expeditiously the cases to the Department of Justice for enforced collection proceedings. These deficiencies are discussed in chapter 3.

The Federal Claims Collection Act of 1966 and the implementing Joint Standards require agencies to take aggressive collection action on a timely basis. Our review revealed that in early years of the Medicare program, intermediaries often took as long as 4 years to establish overpayments, to issue demands, and to forward appropriate cases to the regional offices of SSA. Under current SSA instructions, criteria are outlined for the prompt issuance of three demand letters on identified overpayments and for the immediate forwarding of cases to SSA regional offices. With the present reporting system, BHI should monitor intermediary collection activity and, on an ongoing basis, insure that all cases in which the 6-year statute is expiring are given prompt attention.

Our review also revealed that BHI often took as long as 2 years to forward cases to our Office. Since BHI does not issue any demands for repayment, there is no apparent reason to hold these cases until the bar date is imminent. BHI must forward cases to us as soon as it can verify and certify the debts.

RECOMMENDATIONS

We recommend that BHI

- monitor intermediary collection activity on an ongoing basis, through examination of the printouts of the reporting system and
- forward cases to our Office as promptly as possible.

CHAPTER 3

NEED TO MEET REQUIREMENTS OF JOINT STANDARDS AND GAO MANUAL

LIABLE PARTIES

Section 102.2 of title 4, Code of Federal Regulations, provides, in part, that appropriate written demands be made upon a debtor of the United States in terms which inform him of the consequences of his failure to cooperate. Additionally, 4 CFR 103.6 requires that, when two or more debtors are jointly and severally liable, collection action will not be withheld against one such debtor until the other (or others) pays his proportionate share. The agency should not attempt to allocate the burden of paying such claims among the debtors but should proceed to liquidate the indebtedness as quickly as possible.

An integral part of enforcing the provisions of the above sections is the need to properly identify all liable parties so that appropriate demand action may be taken. In the following examples taken from a sample of overpayment cases at BHI, demands for payment were usually addressed to the institution or its administrator.

- In sole proprietorship cases, claim was usually made against the institution, and the file did not show that the intermediary's written demands either identified or explained the personal liability of the proprietor.
- In partnerships cases, claim was usually made against the institution, but, if claim was made against one partner, no attempt was made by the intermediary to inform all other partners that they too were liable.
- In cases involving corporations, claim was made against the corporation, and, if payment was not made, the claim was referred to BHI for further action. No attempt was made by the intermediaries to ascertain if corporate officials were liable.

In our discussions with BHI officials, they acknowledged that the failure to identify legally liable parties and to make demand for repayment against them are definite problem areas. In cases of sole proprietorships and partnerships, it can be readily ascertained who is legally liable, if there

is adequate disclosure of the parties in interest, but identifying liable parties in cases involving corporations is more difficult.

In limiting collection action to the corporation without exploring the legal personal liability that might be asserted, an important potential source for recovery of the overpayments is being overlooked. We discussed this problem with BHI officials and suggested that the law be researched on a State-by-State basis to determine whether corporate officials can be held liable for corporate debts.

In view of the urgency attached to the 1966, 1967, and 1968 overpayments, however, we suggested that BHI merely obtain the names and addresses of corporate officials without making legal determinations of their liability and forward these cases to us. As to those cases not having this urgency, we suggested that the liable parties be determined and demand for repayment be made against them.

We further suggested that on an ongoing basis, upon entrance of a provider in the Medicare program (as well as those presently in the program), the file show the names and social security numbers of each officer and director of a corporation and similarly the names of all partners be shown. BHI officials stated that they would consider these suggestions.

CREDIT DATA NECESSARY

Current financial information is necessary for

- evaluating any plan of repayment proposed by a debtor (4 CFR 102.8),
- inviting a compromise (4 CFR 102.9),
- accepting a compromise offered by a debtor (4 CFR part 103), and
- determining whether collection action should be suspended or terminated (4 CFR part 104) or whether the claim should be forwarded to us (4 CFR part 105).

Many case files contain no financial information upon which BHI, GAO, or the Department of Justice can base various courses of action.

If adequate financial information had been obtained and analyzed by BHI, it is probable that administrative final

action could have been taken in some of the cases under \$20,000. Such action would give BHI more time to concentrate on the cases which should be referred to our Office.

BHI instructions to intermediaries required that they furnish financial information on a provider at the time of referral of a case to the regional office, but this was not always done. Some intermediaries stated that they had not furnished such information because they did not have a contract with a commercial credit agency. We suggested that BHI officials consider obtaining a Government master contract which intermediaries may use in requesting reports. BHI officials said that generally commercial credit reports on providers are inadequate and would not serve their intended purpose; however, under the Joint Standards, credit data is essential in determining the appropriate action. Therefore, in view of the requirements of the Joint Standards, intermediaries should obtain financial information on all liable parties before referring the cases.

When a debtor is financially unable to pay the indebtedness in one lump sum, 4 CFR 102.8 provides that payments may be accepted in regular installments. If possible, the installment payments should be sufficient in size and frequency to liquidate the debt in not more than 3 years. If the balance of the debt exceeds \$750, an attempt should be made to have the debtor execute a confess-judgment note.

BHI has not issued instructions concerning confess-judgment notes, and during our review we saw no evidence of any attempt being made to obtain confess-judgment notes. This matter was called to the attention of BHI officials, and it is currently being considered.

The following examples illustrate other problems we found in specific overpayment cases.

Timelag from termination date
to date of first demand

The provider terminated participation in the Medicare program on December 31, 1967, and furnished a cost report on January 27, 1969, indicating there was money due from the intermediary. On November 30, 1970, the intermediary notified the provider of an overpayment. Not until March 7, 1972, was the first demand for payment made--over 4 years from the termination date.

No locator action

The provider terminated participation in the Medicare program in early 1968, and the facility was sold shortly thereafter. No demands for repayment were ever made because the former owners were unlocated. There is no record that any of the locator actions suggested by the Joint Standards were taken. The case points out the need for determining the addresses and social security numbers of all those connected with the institution at the time of entrance into the program.

Expeditious action not taken although funds available in trust fund

Funds for repayment of a debt were available in a county trust fund under the court's jurisdiction. The attorney general of the county suggested in early 1971 that the case be referred to our Office for appropriate action. As of January 1975, the case was still in BHI's inventory.

Failure to consider compromise offer

A provider offered to pay 50 percent of his debt as a compromise. The intermediary replied that SSA instructions would not allow such a settlement. The provider then offered an immediate cash payment and repayment of the balance through monthly installments. The intermediary also rejected this offer due to existing SSA instructions. With the provider's apparent willingness to make a settlement, it appears the intermediary could have been more flexible in trying to settle the debt, either by forwarding the compromise offer to us for advice on acceptability or by accepting an extended repayment schedule on condition that the provider execute a confess-judgment note.

Failure to reduce or suspend interim payments

A provider did not submit satisfactory cost reports for the years ending 1967, 1968, and 1969. It was not until May 1971, however, that a letter was issued to the provider, stating that because of the nonreceipt of acceptable cost reports, interim payments would be reduced. SSA instructions, effective September 1969, required that interim payments be reduced approximately 30 days after a cost report was due, unless an extension was granted.

Failure to issue demands against all liable parties

Three doctors, each having high net worth, formed a partnership to operate a provider of services. The provider became indebted to the Medicare program; however, no demands were made against the partners advising them of their personal liability for the indebtedness.

Failure to file claim against estate

The facility changed ownership in late 1968 and the former owner-administrator died in late 1969. Cost reports for 1967 and 1968 were finalized in 1971, showing a large amount due the intermediary. Although evidence in the file indicated that the intermediary was aware of both the change of ownership and the former owner-administrator's death, the intermediary issued demands for repayment in 1973 as if neither event had occurred. In 1974 the intermediary finally issued a demand to the attorneys representing the executor of the estate. The attorneys replied that a decree of distribution had been entered in 1972 and that the intermediary never filed a creditor claim. They also said that there were no further funds available from the estate.

Continued agency action

Pursuant to 4 CFR 105.7, referrals to our Office should be in accordance with instructions contained in the General Accounting Office Policy and Procedures Manual for the Guidance of Federal Agencies. Subsection 56.7 of title 4 of the manual states that administrative agencies should write off receivables which are determined to be uncollectible through means available to them and that no further control and collection effort by the administrative agency would be required. Negotiations with providers still continue after BHI referred claims to us and after we referred claims to the Department of Justice.

RECOMMENDATIONS

We recommend that the Secretary of HEW require intermediaries to comply fully with the Federal Claims Collection Act and the Joint Standards. The only exceptions should be those claims which will be barred in less than 1 year. There should be specific consideration given to the following areas.

1. Identifying and locating all liable parties.

2. Taking prompt action on all liable parties.
3. Requiring credit data on all liable parties.
4. Considering, at the administrative level, termination, suspension, and compromise as viable alternatives to referral to our Office on cases of less than \$20,000.

We recommend also that the Secretary of HEW be certain that, once a claim is reported to us, no further collection action be taken by the intermediaries or BHI. All communications and information should be referred to us (or to the Department of Justice, if the claim has been forwarded for litigation) except for setoff of amounts which may become available. These requirements are set out in 4 GAO 56.7 and 56.8.

CHAPTER 4

STATUTE OF LIMITATIONS

The statute of limitations, 28 U.S.C. 2415, 2416, was approved July 18, 1966, and provided a time limit for bringing suit against debtors. Debts arising before the effective date were deemed to have accrued on the enactment date.

The act provides that every action for money damages brought by the United States which is founded upon any contract, express or implied in law or fact, shall be barred unless the complaint is filed within 6 years after the right of action accrues or within 1 year after final decisions have been rendered in applicable administrative proceedings required by contract or by law, whichever is later. The act further provides that, in the event of later partial payment or written acknowledgment of the debt is made, the right of action shall be deemed to accrue again at the time of each such payment or acknowledgment.

Section 2416 provides that

"For the purposes of computing the limitation periods established in section 2415, there shall be excluded all periods during which * * *."

* * * * *

"(c) facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances * * *."

ABSENCE OF COURT DECISIONS

We considered the possibility that debts arising under part A of the Medicare program might be statutory in nature and not within the purview of 28 U.S.C. 2415, 2416. In the absence of court decisions to that effect, however, Medicare debts must be processed on the basis that the 6-year period does apply. A court ruling to the effect that the 6-year limitation does apply could have serious implications with regard to the Government's ability to collect overpayments to providers of service under part A of the Medicare program.

Most of the debts forwarded to us involved cost-reporting periods ending 1966, 1967, and 1968, which could mean that many claims are already barred if the debtor pleads the statute

of limitations as a defense. Additionally, there may be overpayments made during cost-reporting periods ending 1966, 1967, and 1968, which overpayments are still with BHI or the intermediary.

On March 22 and July 30, 1971, we issued letters to heads of departments, independent establishments, and others concerned which pointed out that debt claims that are proper for referral to our Office should be referred not later than 1 year before the expiration of the period within which suit can be filed. In our report of August 4, 1972 (B-164031(4)), we stated that SSA should have the necessary controls to insure that uncollected overpayment claims are submitted to us at least 1 year before the expiration of the statutory period of limitation within which any suit usually must be brought. These matters were called to the attention of BHI personnel in a meeting on April 23, 1973, and we were assured that all 1966 and 1967 cases still in BHI's inventory would be forwarded to us as soon as possible after development to ascertain the names and addresses of all corporate officials.

OUR STATEMENT ON THE STATUTE OF LIMITATIONS

On August 14, 1974, at the request of BHI, we sent a detailed statement of our position concerning the application of the statute of limitations to debt cases arising out of the Medicare program. We suggested that this information be incorporated in SSA field instructions.

In determining when the right of action first accrues, and thus the expiration date of the 6-year period, we recognize that there are few precedents in this area and that there are many different overpayment situations under the Medicare program. Generally, the earliest possible date should be used to protect the Government's interests. Our statement on this statute is included in this report as appendix I.

RECOMMENDATIONS

The requirement to forward claims to us a year before the bar date has not been met in the past. We strongly urge that, in the future, the 6-year statute of limitations play a major role in determining the disposition of individual claims. We therefore recommend that the Secretary of HEW take appropriate steps to have BHI:

1. Insure that intermediaries forward claims to BHI in enough time for BHI to process the claims and forward them to our Office 1 year before the expiration of the 6-year period.

2. Instruct intermediaries to attempt to obtain a waiver of the statute of limitations from the provider of service in cases in which hearings are being held or in which fruitful negotiations are still in process.
3. Instruct intermediaries to show the expiration date of the 6-year period on claim files sent to BHI.

CHAPTER 5

SCOPE OF REVIEW

We made an indepth review of the information generated under the Provider Overpayment Reporting System for the periods ending June 30, 1972, and March 31, 1973. This information consisted of a history of all identified overpayments under part A of the Medicare program as of these dates. Our main purpose was to compare these two printouts to determine the changes that had occurred during the 9-month period ending March 31, 1973, with respect to overpayments involving cost-reporting periods ending in calendar years 1966 and 1967. Collection by suit for the overpayments involving these years are in danger of being barred by reason of the 6-year statute of limitations running against the United States.

We reviewed 87 overpayment cases in the BHI's inventory to identify specific problems in collection operations and to report on the current status of these overpayments.

We also reviewed selected cases in our inventory of Medicare cases and discussed with GAO officials the problems they were encountering in their collection efforts.

Our review was made at SSA headquarters in Baltimore, Maryland, and at the Transportation and Claims Division of the General Accounting Office, Washington, D.C.



UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

TRANSPORTATION AND
CLAIMS DIVISION

AUG 14 1974

Mr. Ray Sillup
Director, Recovery Staff
BHI, SSA Room E-2
Glen Oak Building
Baltimore, Maryland 21235

Dear Mr. Sillup:

This letter is in response to your request for a statement of the General Accounting Office's position concerning the application of the statute of limitations, 28 U.S.C. 2415, 2416, to debt cases arising out of the Medicare program, 42 U.S.C. 1395 et seq. Generally, in these cases, the Government seeks to recover from providers of medicare services amounts which were paid as interim payments pursuant to 42 U.S.C. 1395g or 1395h(a), 20 CFR 405.454, and which the Department of Health, Education, and Welfare, or a designated fiscal intermediary, determined exceeded proper program reimbursement. If the provider withdraws from participation in the program, "current financing" paid under 20 CFR 405.454(g) and (h) also becomes due.

The views expressed below represent the position of this Office on a number of questions arising in this area. You may wish to consider incorporating these answers in your field instructions concerning the statute of limitations.

There appears to be considerable merit to the contention that an action for recovery of debts to providers of services is not an "action for money damages...founded upon... contract" within the meaning of 28 U.S.C. 2415, but is statutory in nature and hence not within the purview of 28 U.S.C. 2415. In the absence, however, of court decisions to that effect, such cases must be handled and processed on the basis that the 6-year period provided by the statute for action for money damages, founded upon contract does apply. Cases must be forwarded to GAO for referral to the Department of Justice within sufficient time before the expiration of such period to enable suit to be filed within that period. Nevertheless, in the absence of court decisions holding that the 6-year period does apply, debts in which that period has expired will still be sent to the Department of Justice for its consideration as to whether suit should be filed.

The debts here involved are of such nature that determination of the date of accrual of the right of action is dependent upon the terms of 28 U.S.C. 2416, which provides as follows:

"For the purpose of computing the limitations periods established in section 2415, there shall be excluded all periods during which--

* * * *

"(c) facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances * * *."

For the purposes of processing such debts, where a cost report has been filed, the statute must be deemed to start running from the date an "official of the United States charged with the responsibility to act in the circumstances" first discovers, or is in such position that he reasonably should have discovered, the overpayment, regardless of whether such first discovery is made in the cost report as filed by the provider or in the subsequent desk review or audit. We must consider the first discovery as the start of the period, regardless of whether changes are made in the amount of the debt during subsequent review or audit.

The designated fiscal intermediary operates under delegated authority as an agent of the Secretary of Health, Education, and Welfare to determine the amount of any overpayment (42 U.S.C. 1395h; Schroeder Nursing Care Inc., v. Mutual of Omaha Insurance Co., 311 F. Supp. 405 (DC Wisc. 1970)). Therefore, if an intermediary exists, an appropriate official of such intermediary would constitute the "official of the United States charged with the responsibility to act in the circumstances." If no intermediary exists, an appropriate official of the Social Security Administration would be such official. It is incumbent upon such official to process expeditiously any such debt immediately upon its first discovery to avoid expiration of the statutory period.

Providers of service are required to file cost reports by 42 U.S.C. 1395g or 1395h, 20 CFR 405.406(b). Since the Provider Reimbursement Manual (HIM-15), Sections 2330, 2409.1 and Part A Intermediary Manual (HIM-13), Part 2, Sections 2228.1, 2228.2, and 2232 allow the provider to submit a cost report subsequent to its due date and thus "cure" the failure to report, we believe that the starting date for the running of the statute on a claim based upon failure to file a cost report is the date on which the regulations require that a demand for repayment be sent.

To protect the Government's interest adequately, such debts should be handled and processed, and forwarded to the Department of Justice if necessary, on the basis that the period starts to run on the date the cost report is due. Should an acceptable cost report be filed subsequent to the issuance of the demand for repayment, which is permitted by the regulations, the starting date for any claim for an overpayment based upon such cost report would be as indicated hereinabove where a cost report has been filed.

For providers who file required cost reports within the time specified in the regulations, section 243 of the Social Security Amendments of 1972, Public Law 92-603, 86 Stat. 1420; added a new section, 1878, to title XVIII of the Social Security Act which authorizes, under specified circumstances, a hearing by a Provider Reimbursement Review Board.

The review provided by new section 1878 and the hearing provided by the regulations promulgated at 37 F.R. 10724-5 on May 27, 1972, added new sections 405.490-405.499i to title 20 of the Code of Federal Regulations. These sections would appear to constitute "applicable administrative proceedings required by contract or by law," as that term is used in 28 U.S.C. 2415(a), so that in any cases properly falling thereunder, suit filed within 1 year from the date of final decisions in such administrative proceedings will be timely if such period exceeds the 6-year period computed as previously indicated.

Section 405.499g, as promulgated at 37 F.R. 10725, supra, provides for the reopening, under stipulated circumstances, of the intermediary's determination of the amount of program reimbursement or the decision of a hearing officer, within 3 years from the date of such determination or decision, except in cases of fraud which may be reopened at any time. While there may be some basis for argument that the corrected debt determined to exist as a result of the reopening is a new debt and that the statute begins to run from the date of that determination, we believe that in the absence of court decisions to that effect, the interests of the United States would be better served by handling and processing such cases on the basis that the period begins to run on the date of the first discovery that a debt exists, regardless of subsequent changes in the amount of such debt.

If an indebtedness is first discovered as a result of the reopening (as might be the case in a reopening in a case of fraud) the date of first discovery after the reopening would be the beginning of the period. Also, such a reopening would appear to constitute "applicable administrative proceedings required by contract or by law," as that term is used in 28 U.S.C. 2415(a), so that in any cases properly reopened under 405.499(g) suit filed within 1 year from the date of final determination or decision in such administrative proceedings will be timely if such period exceeds the 6-year period computed as previously indicated.

The proviso to 28 U.S.C. 2415(a) reads:

"That in the event of later partial payment or written acknowledgment of debt, the right of action shall be deemed to accrue again at the time of each such payment or acknowledgment."

We believe that the proviso contemplates a voluntary payment by the debtor which in effect would constitute a recognition of the existence and validity of the debt. Hence, we do not believe that setoff action can be considered as a partial payment within the meaning of the proviso cited so as to cause the right of action to accrue again, unless the debtor, in writing, agrees and consents to the setoff action, thus, in effect, recognizing the existence and validity of the debt. Of course, if the debt has been collected in full by setoff, the debt is extinguished and there is no further limitation problem.

If any suit is filed, it would be filed by the former debtor against the Government and 28 U.S.C. 2415 is not applicable. Where the debt is only partially collected by setoff, the question of the limitation is still applicable.

The next matter for consideration is the problem of the effect, if any, of a suspension of Federal payments pursuant to the amendment of section 1903 of the Social Security Act enacted by section 290 of the Social Security Amendments of 1972, 42 U.S.C. 1396b(1), on the 6-year period of limitation. The payments suspended pursuant to the cited amendment are payments due to the State, whereas the debt involved is that of a provider in such State. There is nothing in the language of the amendment to indicate that any of the suspended payments is actually to be set off against the indebtedness. It is our view, therefore, that the safest course to pursue is to assume that the suspension of payments due the State does not constitute a partial payment by the provider which would cause the right of action to accrue again, as provided by 28 U.S.C. 2415(a). It is also our view that notwithstanding a suspension of payments, the claim against the provider should be handled and processed so that suit may be filed against the provider prior to the expiration of the applicable limitations periods, unless an agreement is entered into with the provider having the effect of extending or waiving such period.

We believe that claims for refund of "current financing" advanced to providers under 20 CFR 405.454g and h, must be handled and processed on the basis that the 6-year period provided by 28 U.S.C. 2415(a) for actions for money damages founded upon contract does apply. In general, the 6-year period begins to run from the date that the appropriate officials discovered or should have discovered an overpayment, as provided by 28 U.S.C. 2416(c).

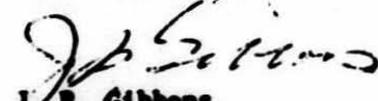
Nonprovider overpayment cases which arise under 42 U.S.C. 1395j-w, IM, Part B secs. 6408-6417.10 include those in which an overpayment is made by a carrier to an enrollee (patient) entitled to medical insurance benefits or to a physician who rendered medical service to such an enrollee. Again, we believe that, in order to protect the interests of the United States, such cases must be handled and processed on the basis that the 6-year period provided by 28 U.S.C. 2415(a) for cases founded upon contract does apply. Also, the period would appear to begin to run from the date that the appropriate officials of the carrier discovered or should have discovered the overpayment, as provided by 28 U.S.C. 2416(c). Should the debtor take advantage of the administrative proceeding provided by section 6415 of the regulations the limitation would be 1 year after the final decision therein or the original 6 years, whichever is later, as provided in 28 U.S.C. 2415(a).

On March 22 and July 30, 1971, the Director of the Claims Division (now the Transportation and Claims Division) wrote to Heads of Departments, Independent Establishments, and Others Concerned pointing out that debt claims properly for referral to GAO should be transmitted to our Office not later than 1 year prior to the expiration of the period within which suit is authorized to be filed. In those instances where a case is in controversy and the expiration date for filing suit is less than 1 year, the matter should be promptly referred to the General Accounting Office.

We understand that the Department of Justice has urged BHI to obtain extension agreements from providers of service in those cases where the running of the statute appears imminent. Where possible, any attempt by the intermediary, carrier, or BHI to seek an extension agreement from the debtor should be made before the expiration date becomes less than 1 year away.

If we can be of further assistance, please call us on 202-129-5256.

Sincerely yours,



J. P. Gibbons
Deputy Director