BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Health And Human Services

States Should Intensify Efforts To Promptly Identify And Recover Medicaid Overpayments And Return The Federal Share

The Health Care Financing Administration had not established consistent policies and guidelines for States to use in identifying and recovering Medicaid overpayments. Also, States had not developed systems and procedures for effectively controlling, pursuing, and recovering identified overpayments and for promptly returning the Federal share of recovered overpayments.

In the five States--California, Georgia, Florida, New York, and South Carolina--in our review, at least $222.6 million in substantiated and potential overpayments had been identified but not recovered, even though much of this amount had been outstanding for many years. Also, millions of additional dollars in potential overpayments had not been recovered because some States were far behind in making institutional settlement audits and these audits generally identify large amounts of overpayments.

Furthermore, the five States had recovered about $18.7 million in Medicaid funds for which they had not returned the Federal share. In some instances these funds had been on deposit in State accounts for several years.

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GAO

United States General Accounting Office
Washington, DC 20548

Human Resources
Division

B-198129

The Honorable Patricia Roberts Harris
The Secretary of Health and Human Services 4662

Dear Mrs. Harris:

We have reviewed State systems for recovering Medicaid overpayments to providers and for returning the Federal share of these overpayments to the Department of Health, Education, and Welfare (HEW). 1/ 22

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We made our review between May 1978 and August 1979 at Health Care Financing Administration (HCFA) headquarters in Washington, D.C.; HCFA regional offices in Atlanta, New York, and San Francisco; and State Medicaid agencies in California, Georgia, Florida, New York, and South Carolina. New York and California were selected because they have the two largest programs. Georgia, Florida, and South Carolina were selected because they were within the regional office area of our office directing the review. We also did limited work at the U.S. attorney's office in Columbia, South Carolina, and at the Office of the Special State Prosecutor for nursing homes, health, and social services in New York, New York.

In fiscal year 1979, expenditures for the Medicaid program nationwide totaled $19.7 billion, and expenditures in the five States reviewed totaled $7.9 billion, or 40 percent of the national total. In the five States, we found that:

--At least $222.6 million in substantiated or potential overpayments had been identified but not collected, even though much of this amount has been outstanding for several years. Because some of the States are far behind in making settlement audits of hospitals, nursing homes, and other institutional providers, additional millions of dollars in potential, but

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1/On May 4, 1980, a separate Department of Education was created. The part of HEW responsible for the activities discussed in this report became the Department of Health and Human Services. This Department is referred to as HEW throughout this report.

unidentified overpayments have also remained outstanding for years and are becoming uncollectable due to time limitations.

--The five States had recovered about $18.7 million in Medicaid funds for which they either had not returned or did not promptly return the Federal share. In some instances, States had held the funds for several years without crediting the Federal Government, and in other instances, the States were periodically crediting the Federal Government with its share of recovered funds, but the processing procedures were so slow and cumbersome that large balances continually remained in the States' accounts. Moreover, many funds recovered by the States are deposited in interest-bearing accounts, but the States have not consistently shared this interest with the Federal Government.

We believe that these conditions resulted because:

--HCFA had not established consistent policies and guidelines for States to use in administering overpayment recovery activities. Also, HCFA did not have a clear policy explaining when and under what circumstances Federal financial participation in outstanding overpayments would be denied.

--State systems for recovering overpayments and for returning the Federal share of such funds were fragmented, cumbersome, uncoordinated, and slow.

We communicated our findings concerning State cash holding accounts to the Administrator of HCFA in two letter reports, 1/ and reported these same findings, as well as others, to HCFA headquarters and regional officials during several oral briefings. These officials agreed with our findings and have begun to recover millions of dollars from the five States we reviewed and to initiate similar reviews and make recoveries from other States. In addition, they have stated that they are developing clear, consistent policies and guidelines to protect the Federal Government's interest in this area in the future.

1/Our reports dated October 27, 1978, and May 4, 1979.

BACKGROUND

Medicaid, or title XIX of the Social Security Act, established by the Social Security Amendments of 1965, is a Federal-State program in which the Federal Government pays 50 to 78 percent of a State's cost for medical care provided to the poor. At the Federal level, the Administrator, HCFA has responsibility for administering Medicaid.

Administration of Medicaid

Each State initiates and administers its own Medicaid program. The nature and the scope of a State program are contained in its State plan, which, after receiving approval from the HCFA regional administrator, provides the basis for Federal grants to the State. The regional administrator is also responsible for determining whether a State program is being administered in accordance with Federal requirements and the State's approved plan. Ten HCFA regional offices handle field activities for the Medicaid program.

The Federal Government pays its share of Medicaid program costs through quarterly grants to the States to cover estimated program expenditures. Cash is made available to the States through the letter-of-credit method whereby HEW specifies the amount and time frames so that States can withdraw funds as needed from a Federal Reserve Bank. Cash withdrawals by the States should be on the basis of meeting only immediate disbursement needs. The quarterly awards are reduced by amounts that prior quarterly grants exceeded allowable expenditures as reported on the Quarterly Statement of Expenditures (HCFA-64 Report, formerly the OA-41 Report). Overpayments reported by the States are shown as adjustments to expenses on the quarterly expenditure report and, in effect, reduce the amount of future grant awards--through this mechanism the Federal Government receives credit for its share of recovered overpayments. If a State does not voluntarily report overpayments on its quarterly expenditure report, HCFA, if it is aware of the overpayments, may at its option, issue the State a letter disallowing Federal financial participation in such overpayments and deduct the disallowed amount from subsequent grant awards.

Increased emphasis on improving agency financial systems

In October 1979 the Office of Management and Budget, in Bulletin No. 80-1, directed the heads of executive departments and establishments to report information on improvements in agency financial systems. Included in the areas to be covered are improvements in cash management, debt collection, and grant financing. For the purpose of reporting and quantifying such improvements, the bulletin stated that

> "Estimate both one time savings and annual interest savings to the Government as a whole. Any improvement in the flow of cash which causes a one time outlay saving or a continuing reduction in the need for Federal borrowing is to be counted. Methods commonly used to achieve this include speeding up collections and deposits, controlling disbursements more closely and eliminating excessive cash balances. An interest rate of 9 percent should be used in calculating interest savings * * *."

To the extent that the States identify or recover outstanding overpayments and promptly return the Federal share, the cash demands on the Federal Government would be reduced accordingly.

NEEDED: CONSISTENT POLICY REGARDING FEDERAL FINANCIAL PARTICIPATION IN OVERPAYMENTS

Existing program guidance and customary State practices support three different views concerning when the Federal Government should receive credit for its share of identified overpayments. One view is that the Medicaid program is a grant program and that overpayments represent expenditures outside the scope of the grant; therefore, the Federal share of overpayments is due immediately upon identification. A second view, which applies only to overpayments contested by providers, is that the Federal share is not refundable until overpayment findings are sustained by applicable State administrative hearings or appeals procedures. The States,

however, normally adhere to the third view, which gives the Federal Government credit only for overpayments actually recovered, regardless of how diligently the States attempt to recover them. Each view has precedent and advantages and disadvantages, as explained below.

Immediate reduction in Federal financial participation

In 1973, we reported to HCFA's predecessor, the Social and Rehabilitation Service (SRS), that Medicaid program fiscal agents in California had identified but not collected about $18 million in overpayments to skilled nursing facilities. SRS responded by issuing the following policy statement in March 1974.

> "* * * the Federal Government will not allow the Federal share of the overpayment to remain outstanding while a State agency and a provider engage in a lengthy appeal process. The State agency should, upon completion of the audit, make an adjustment on their next Quarterly Statement of Expenditures (SRS-OA-41) for the Federal share of the overpayment. If at the conclusion of an appeal process it is found that a lesser amount should have been returned to the Federal Government, an appropriate adjustment will be made." (Underscoring added.)

In April 1979 your Office of General Counsel rendered a legal opinion regarding section 1903(d)(2) of the Social Security Act which supports the March 1974 policy statement; the opinion states in part that:

> "* * * as a basic statutory principle (and obligation) requiring no regulations to become effective, the Secretary must reduce a grant award when he has determined to his satisfaction (and pursuant to any procedures he may have adopted) that an overpayment exists.
>
> "* * * there will be questions in individual cases whether an overpayment has been demonstrated to the Secretary's satisfaction. Thus, if a State audit uncovers a purported overpayment but the

> matter is still being disputed by the provider, the Secretary can await the outcome of the State appeal before making a final determination as [to] the fact and amount of the overpayment. But the Secretary is not obligated to * * *. If he believes that the evidence uncovered by the State is sufficiently strong to establish that an overpayment exists, the Secretary can (and, indeed, should) take the disallowance immediately."

Similarly, a Federal regulation (45 CFR 201.66) indicates that States should immediately repay the Federal Government for unallowed expenses claimed under various family assistance programs, including Medicaid, except when the amount due exceeds 2-1/2 percent of the estimated annual State share of allowable program expenses. Repayment in installments is allowed when the amount due exceeds this percentage and when certain other conditions are met; however, normally the amount due does not exceed the 2-1/2 percent limit.

Even though most guidance available on recovery of overpayments supports the immediate refund approach, HCFA has not implemented such an approach except in occasional highly visible cases, such as the California case mentioned earlier.

A strong argument can be made for crediting the Federal share of identified overpayments upon identification. In the States we reviewed, the appeals process was generally slow and cumbersome. 1/ Crediting the Federal share before appeal resolution would give the States added incentive to expedite the appeals process and recover funds from providers pending appeal.

Recovery of funds before appeal resolution would also discourage frivolous appeals. Current State practices give providers an incentive to appeal overpayment findings regardless of merit. Because State appeal resolution procedures are so slow and cumbersome, some providers change ownership,

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1/As discussed later (see pp. 12 and 14), about $90 million of the $222.6 million in outstanding overpayments discussed in this report were tied up in appeals processes.

go out of business, or declare bankruptcy before the appeals are resolved. In such cases, the States may eventually win the appeal but not recover the money.

Providers who retain overpayments during an appeal, but eventually lose the appeal essentially receive a loan during the appeal period. In all but one of the States reviewed, these loans are interest free (California charged proprietary providers 7-percent interest on overpayments they appealed). Moreover, many providers--i.e., those reimbursed on a cost-related basis--can charge at least a part of their appeal costs to the Medicaid program through future rate computations.

However, one argument against immediate crediting is that it gives States a strong disincentive to identify and/or disclose overpayments because they would bear full financial risk and burden for overpayments which prove to be uncollectable.

Reduction of Federal participation after contested overpayments are sustained

Providers contest many overpayment findings, especially large overpayments identified by cost settlement audits. Most States do not attempt to recover such overpayments until State administrative hearings or appeals procedures sustain the findings. 1/ The States contend that by definition an identified overpayment does not exist until the providers' appeal rights are exhausted and the overpayment sustained. Support for this position is found in the interpretation by SRS of a Federal regulation concerning overpayments identified by long-term care facility audits. This regulation (42 CFR 447.296) states that:

> "The agency must account for overpayments found in audits on the quarterly statement of expenditures no later than the second quarter following the quarter in which the overpayment was found."

1/According to South Carolina officials, recently established guidelines allow them to recover audit disallowances before appeal resolution.

Concerning when an overpayment is "found," the SRS Medical Assistance Manual (Part 6-175-10) states that:

> "'The quarter in which found' means the quarter during which the administrative hearing procedures of the State have been exhausted and a determination of overpayment has been sustained * * *."

Thus, under this interpretation, reduction of Federal participation would take place no later than the second quarter following completion of the provider appeal process whether or not the State had recovered overpayment from the provider. However, this statement contradicts the 1974 policy statement and the 1979 opinion of the HEW General Counsel.

Although the States have historically discontinued efforts to recover appealed overpayments from providers pending resolution of the appeal on the theory that the overpayment is not identified until the appeal is denied, legal precedent in both the Medicare and Medicaid programs sanctions recovery of such overpayments. For example, Medicare program regulations (42 CFR 405.1803) require recovery of overpayments, by suspension of further payments, if necessary, even though the provider has appealed the overpayment determination.

These regulations have been upheld in Federal court. In one case (Barth v. Blue Cross and Blue Shield of South Carolina, 434 F. Supp., 755 (1977), a U.S. district court ruled that withholding amounts due a provider under the Medicare program pending appeal resolution is a proper method for recouping alleged Medicare overpayments.

Several Medicaid program court cases similarly support overpayment collection before appeal resolution. However, the courts have mandated that providers be given a timely postrecoupment appeal opportunity. 1/

1/See e.g., Abraham Grossman d/b/a Bruchuer Nursing Home v. Axelrod (Civil No. 79-388 (S. D.N.Y., Feb. 26, 1979)).

Reduction of Federal participation after recovery

The common practice among the States reviewed was to withhold credit of the Federal share until after the overpayments were recovered. 1/ Only in occasional highly visible cases, has HCFA attempted to require States to refund the Federal share of uncollected overpayments.

The States apparently view the Medicaid program as a "partnership" between the States and Federal Government and, accordingly, believe the Federal Government should share in any overpayment losses. Crediting the Federal share of overpayments later determined to be uncollectible would cause the States to bear the full amount of uncollected overpayments. It could be argued that the States should bear the full amount of uncollected overpayments because such overpayments were unauthorized under the approved State plan. However, HCFA has implicitly accepted the "partnership" interpretation by not requiring the States to regularly return the Federal share of outstanding overpayments.

California has asserted that subsection 1903(d)(3) of the act, which deals with Federal Medicaid payments to the States, supports the view that the Federal share should be returned only after the overpayments are recovered by the States. That section states:

> "The pro rata share * * * of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

However, HEW maintains that the preceding section (section 1903(d)(2)), which authorizes you to determine when

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1/As discussed later, the States have been slow to refund the Federal share of overpayments even after recovered, and we found some instances of significant delinquencies, in terms of the time and amounts.

overpayments have been made to States and reduce succeeding payments acccrdingly, is the governing provision. California stated its position in response to a proposed disallowance of Federal reimbursement for about $18 million which represented the Government's share of uncollected overpayments made to hospitals and skilled nursing facilities from March 1966 through May 1978.

The States' argument for the partnership approach would have more merit if they more intensively managed overpayment recovery activities to minimize losses to both the Federal Government and themselves.

STATE RECOVERY EFFORTS: LESS THAN VIGOROUS

States have been neither timely nor vigorous in collecting documented overpayments, resolving potential overpayment situations, or returning the Federal share of overpayments recovered. For example, as summarized in the table on the following page, in the five States we reviewed, about $222.6 million in outstanding substantiated and potential overpayments had not been collected and the Federal share had not been returned--the Federal portion of another $18.7 million in recovered Medicaid funds had not been returned.

Inadequate State efforts to recover overpayments

In all five States, the systems for controlling and collecting identified overpayments and for resolving potential overpayment situations were fragmented, cumbersome, uncoordinated, and slow. 1/ Responsibility for overpayment recovery activities was often divided among many organizational units (departments, divisions, sections, individuals, etc.), and the States had not designated any specific unit as a focal point for coordinating and controlling overall recovery efforts. Furthermore, the roles and responsibilities of individual units were not clearly defined, and working relationships and communication channels among the units were

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1/South Carolina, during 1978 and 1979, made significant improvements to its overpayment recovery system (see p. 15 of this letter and p. 47 of app. for a discussion of these improvements.)

State	Uncollected overpayments: Dates of our fieldwork	Uncollected overpayments: Amount (note a)	Recovered Medicaid funds in State cash accounts: Date	Recovered Medicaid funds in State cash accounts: Amount
		(millions)		(millions)
New York	9/78-6/79	$ 84.0	(b)	$ 9.5
California	2/79-8/79	126.1	12/31/78	3.4
Florida	1/79-5/79	10.3	3/31/79	3.5
South Carolina	4/79-6/79	2.1	2/28/79	1.5
Georgia (note c)	8/78-3/79	.1	3/31/79	.8
Total		$222.6		$18.7

a/Since many identified overpayments had not been recorded in the accounts receivable records or summarized in any control records, we could not determine as of a specific date the total uncollected balance. The amounts shown are a total of the identified overpayments found in the various organizational units during our fieldwork in each State.

b/As of September 30, 1978, $4.1 million was in a State account, and as of December 31, 1978, $5.4 million was in two New York City accounts.

c/All identified but uncollected Medicaid overpayments could not be determined because Georgia had not established an accounting system nor maintained summary records for this information.

not well established. Additionally, many of the units did not maintain accounts receivable or other summary records for control, followup, and resolution of confirmed and potential overpayments.

A brief discussion of our findings in each of the five States reviewed follows. Appendixes I through V provide more detailed discussion of each State's overpayment recovery system and its recovery efforts.

New York

New York, its local districts and their fiscal agents, and Federal agencies had identified at least $84 million in firm and potential overpayments that had not been collected during the period of our review. Furthermore, additional unknown millions of dollars in overpayments probably have not been identified because the State was far behind in performing hospital and nursing home settlement audits.

Many of the overpayments, confirmed and potential, have been outstanding for several years and have not been collected or resolved because of provider appeals, especially by nursing homes and hospitals, and because the State's recovery system is cumbersome, slow moving, and fragmented. New York lacks adequate procedures and controls and fails to pinpoint responsibility for managing and coordinating the recovery effort. For example, responsibility for auditing hospital and nursing home settlements and later establishing and implementing the final rates was divided among four, and sometimes five, organizational units at the State level. In addition there was one or more units at the local level.

Also, since no one unit centrally managed, coordinated, and controlled the total recovery effort, individual units were experiencing a number of problems that impeded the recovery process. For example, two organizational units were arguing about which one had responsibility for calculating final rates and determining overpayments for 300 nursing home rate years, and another unit was far behind in computing final hospital rates because of an uneven flow of audit reports from the auditors. Some local districts were far behind in, or just not implementing final nursing home and hospital rates, and others were behind or not resolving audit report findings, reportedly because their workload was too great or because they were not receiving the necessary information.

Of New York's $84 million in outstanding overpayments, about $39.9 million--which had been identified through yearend cost settlement audits of nursing homes and hospitals--was tied up in the State's administrative appeals process. Since the State's practice is to recover overpayments after resolution of appeals, collection efforts had been suspended pending outcome of the appeals. However, even providers who lose an appeal are not charged interest on their overpayments. Therefore, the overpayments which they may retain for several years amounts to an interest-free loan. An additional $2.1 million in nursing home and hospital settlement audit overpayments not in the appeals process had not been recovered by the local paying districts because the districts were far behind in implementing final rates for these institutions.

Through computer analyses of New York City paid claims, New York State identified about $58 million in potential or suspected overpayments for the period January 1973 through August 1977; however, $34.6 million of the suspected overpayments had not been fully investigated to determine if they could be substantiated. Duplicate payments to physicians, clinics, and hospitals and excessive charges by physicians accounted for the outstanding overpayments.

The remaining $7.4 million in the State's outstanding overpayments relate to several different items identified through various State and Federal audits made since June 1975. Investigation of the $34.6 million in suspected overpayments and recovery of the $7.4 million in identified overpayments were at various stages when we completed our review in New York in June 1979. A lack of definite collection procedures and the various systems problems discussed above were hampering the State's recovery efforts. (See app. I for details of New York's efforts to recover overpayments.)

California

California had identified firm and potential Medicaid overpayments totaling about $126.1 million which were uncollected during our review. California had designated an organizational unit as the focal point for pursuing and collecting substantiated overpayments listed among accounts receivable, but only $14.8 million of the outstanding overpayments had been recorded in the State's official accounts receivable records. Memorandum records of receivables were maintained on an additional $10 million.

The receivables were not aged, and neither the length of time required for collection nor the collection success rate was shown in the collection unit's records. Also, the accounts receivable balance was understated by an undetermined amount because many overpayment cases referred from other units had not been recorded. These unrecorded backlogged cases were becoming an increasingly serious problem; during the 12-month period ended May 1979, the backlog inventory had increased from about 2,300 to 3,900 cases.

At the time of our review, about $48.2 million in overpayments were under appeal by hospitals; the State defers collection efforts on any such overpayment until the appeal is resolved. Also, not fully resolved was about $20 million received by Los Angeles County medical facilities between July 1, 1976, and June 30, 1978. Eligibility requirement and utilization control reviews have been waived for these facilities, and for several years payments to them have exceeded allowable amounts by at least $10 million annually, which is repaid after completion of semiannual State audits to determine the amount due. The most recent semiannual State audit covered the 6-month period ended June 30, 1976; thus, allowing 1 year for audit and settlement, the audits are at least 2 years behind schedule.

Four HEW Audit Agency reports 1/ identified another $33.1 million in overpayments applicable to periods as far back as 1971; but as of August 1979, no recoveries had been made because the State disagreed with HEW's findings. (See app. II for details of California's efforts to recover overpayments.)

Florida

When we completed our fieldwork in May 1979, Florida had identified about $10.3 million in outstanding overpayments. The State had recorded about $4.9 million of this amount as accounts receivable due from hospitals and nursing homes. Our analysis of about $3.7 million of the receivables identified between July 1, 1976, and December 31, 1978, showed that on the average they had been outstanding about 16 months since

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1/HEW audit reports were issued December 28, 1976, for $15.6 million; March 31, 1977, for $8.9 million; December 16, 1977, for $0.9 million; and March 9, 1979, for $7.7 million.

identified. Of the $3.7 million analyzed, about $1.9 million (51 percent) were under provider appeal and $1.8 million (49 percent) were not. Although the State reportedly suspends collection activity on appealed cases, the lengths of time that overpayments were outstanding and the level of recovery action were about the same for appealed and nonappealed cases.

Of the State's remaining $5.4 million in outstanding overpayments, $4.5 million resulted from claims processing errors made by the State's fiscal agent during calendar year 1978. Actually, the fiscal agent made over $7.2 million in overpayments during the year, but had recovered about $2.7 million as of May 23, 1979.

The remaining $845,000 in Florida's outstanding overpayments were made to nursing homes from October 1977 through October 1978. They occurred following retroactive implementation of a cost-related reimbursement system mandated by court order. Many nursing homes were also underpaid as a result of implementing this new system, and the State had settled all underpaid accounts as of May 1979. It had not recovered any of the overpayments apparently because the State's nursing home association was seeking outright relief for these debts. (See app. III for details of Florida's efforts to recover overpayments.)

South Carolina

Even though South Carolina and HEW were involved in efforts to identify and confirm significant overpayments as early as 1973, the State's Medicaid agency allowed more than $4.5 million in overpayments to accumulate before beginning serious recovery actions in October 1977. The delay occurred because the State Medicaid agency had not established effective procedures for coordination among its organizations responsible for identifying and collecting overpayments.

In October 1977 the State began to aggressively pursue collection of overpayments to nursing homes, but made no significant recoveries until late 1978. Also in 1978, the State clarified responsibilities for overpayment recovery activities, and in February 1979 it established collection procedures, including development and implementation of overpayment recovery timetables for providers and a system to record most overpayments in the accounts receivable records.

As of May 1979, about $2.1 million in substantiated overpayments were outstanding. (See app. IV for details of South Carolina's efforts to recover overpayments.)

Georgia

Georgia had no central control system for recording identified overpayments. The State made only minimal efforts to identify overpayments; it has preferred to rely on providers to identify and voluntarily refund any overpayments received. Thus, the first knowledge State officials have had of most overpayments has been the refund check itself.

By way of settling with hospitals for over- and underpayments, Georgia adjusts rates for succeeding periods. Georgia deducts overpayments from (and adds underpayments to) allowable costs in computing an interim reimbursement rate for the next period. The intent of this type of recovery system is to liquidate over- and underpayments in equal installments over the next rate period. However, timely cost settlements are not being made. For example, one of the two intermediaries conducting hospital settlement reviews and audits had a backlog of 195 unsettled hospital cost reports available, 104 of which were for cost years ended in 1977 or before. Therefore, potential over- and underpayments have remained unliquidated for extended periods. Because of this recovery system and because the State maintains no receivable or summary records for overpayments, we could not readily determine the number, amount, or current status of outstanding overpayments to Medicaid hospitals in Georgia.

With respect to overpayments to noninstitutional providers, we established from various individual case records that Georgia had not recovered about $123,000 in overpayments identified by or reported to the State Medicaid agency between July 1, 1976, and September 30, 1978. (See app. V for details of Georgia's efforts to recover overpayments.)

MEDICARE CRITERIA FOR RESOLVING DISPUTES AND RECOVERING OVERPAYMENTS ON A TIMELY BASIS

In contrast to the Medicaid program, the Federal Medicare program, administered by HCFA through its contract intermediaries and carriers, has time-phased requirements or standards

for identifying and recovering overpayments and resolving appeals--particularly with respect to institutional providers. For example:

--Providers are required to submit their annual Medicare cost reports within 3 months of the end of their accounting period.

--Upon receipt of the cost report, intermediaries have 12 months to analyze the report, undertake any audit activity, and furnish the provider with a written notice of program reimbursement which would indicate any overpayment for the period involved.

--If the amount of overpayment is not in dispute, the intermediary should adjust or suspend current payments if repayment or a satisfactory repayment plan is not received from the provider within 1 month. A repayment plan for full recovery should not exceed 12 months.

--If the amount of overpayment is in dispute, the provider has 6 months from the date the notice of program reimbursement was mailed to file an appeal either with the intermediary or the Provider Reimbursement Review Board 1/--although recovery action continues during the interim.

--For appeals to the Board, the Board has 1 month to decide whether to accept or reject the request for appeal.

--Under the Board's procedures, there is a discovery or discussion period of 2 months from the acceptance of the request.

1/The Provider Reimbursement Review Board, established by section 243(a) of the Social Security Amendments of 1972 (Public Law 92-603), hears appeals by institutional providers on adverse determinations by intermediaries as to the amount of Medicare reimbursement due the provider. The Board's authority applies to cost reporting periods ended on or after June 30, 1973, and is generally limited to controversies involving reasonable cost determinations.

--The Board should attempt to have a formal hearing within 1 month after the discussion period.

--A decision should be rendered within 3 months of the hearing.

--The Administrator of HCFA has 2 months to review the Board's decision if he elects to do so.

Thus, unless the provider elects to appeal to the Federal courts, assuming that the Medicare time-phased administrative structure is adhered to, overpayments should be recovered--or any related dispute resolved within about a 2-1/2-year period after the end of the accounting period where the overpayment occurred and identified overpayments not in dispute should not be outstanding more than 1 year.

RETURN OF THE FEDERAL SHARE IS NOT TIMELY

The States included in our review do not routinely return the Federal share of unrecovered overpayments, and even after recovery, the States often take several months or even years to return the Federal share. As shown in the table on page 11, about $18.7 million in recovered funds, a portion of which belonged to the Federal Government, were on deposit in various State and local Medicaid cash accounts or invested in interest-bearing securities.

For example, neither the State nor the city of New York had been timely in crediting the Federal Government for its share of about $9.5 million in Medicaid funds on deposit in three accounts. Between February 1976 and September 1973, the New York Office of Special Prosecutor recovered $3.8 million from nursing homes and deposited the funds in an interest-bearing, State-controlled cash account, and interest earned on the funds had increased the account balance to $4.1 million as of September 30, 1978.

According to State Medicaid officials, the delay in returning the Federal share of these funds occurred because State and local officials could not agree on a formula for distributing to each local government its proportionate share of the overpayments; this disagreement, of course, should not

have precluded the State from returning the Federal share. The details of this situation were included in our October 27, 1978, letter to the HCFA Administrator; then New York returned the Federal share--about $1.9 million.

New York City had also established and was operating two cash holding accounts which, as of December 31, 1978, contained about $5.4 million. In addition to recoveries from providers, the funds included recoveries from recipients, payments withheld from providers pending investigation, and other moneys. Some of the funds in these accounts had been on deposit for several years, and even under the most timely processing procedures, the Federal Government was not receiving credit for its share until from 6 to 9 months after recovery by the city. These two accounts and cash holding accounts in Florida, South Carolina, and Georgia were the subject of our May 4, 1979, letter to the HCFA Administrator.

Like New York, the States of Florida, South Carolina, and Georgia were (1) depositing recovered Medicaid funds in State cash accounts and (2) not promptly crediting the Federal Government with its share. Also, the three States were not sharing interest earned on the cash accounts with the Federal Government. As of March 1979, the combined recovered Medicaid fund balances in the three accounts were about $5.8 million. State Medicaid agency officials in the three States said that the primary cause of the delay in returning the Federal share was that many of the recovered (or voluntarily returned) funds could not be identified by specific Medicaid recipient, service, or payment period. This information, they say, is needed to insure that the appropriate share of each recovered amount is returned to the Federal Government. However, the States have not been timely in conducting the necessary research causing a large balance of refunds to be continually tied up in the refund processing system.

Also, California, which we visited after our May 4, 1979, letter to the HCFA Administrator, was processing recovered Medicaid funds through three cash holding accounts (one maintained by the State and two by the fiscal agent). The combined balance in the three accounts was $3.4 million, as of December 31, 1978, and the combined average quarterly balance during calendar year 1978 was about $2.8 million. However, these large balances apparently were due to the

large volume of activity in the accounts because the average processing time was less than 2 months. Also, we found no evidence that funds remained in the accounts for long periods before they were returned.

CORRECTIVE ACTION TAKEN BY HCFA

HCFA has taken timely corrective action to resolve the problems identified during our review. HCFA officials immediately began to follow up on the outstanding overpayments and cash balances identified in the five States we reviewed, and expanded the effort into other States. Although many State reviews were not started or completed, responses received through January 1980 showed that since completion of our fieldwork, the States had voluntarily returned, or HCFA representatives had succeeded in obtaining the return of, $41.9 million as the Federal share of excess cash being held by 14 States and old overpayments recovered by one State. In addition, HCFA had actions underway for the return of an additional $39.2 million in funds from eight States, which principally represented the Federal share of old unrecovered overpayments.

HCFA officials also advised us that they were developing clearly defined, consistent criteria for States to follow in crediting the Federal Government with its share of Medicaid overpayments.

We reported our findings concerning the lack of timely return of the Federal share of recovered Medicaid funds to the HCFA Administrator in two letter reports dated October 27, 1978, and May 4, 1979. We recommended that HCFA require New York, Georgia, South Carolina, Florida, and all other States which maintain Medicaid cash holding accounts to immediately credit the Federal Government (to the extent it had not already received credit) with its share of recovered funds, including interest earned on these accounts.

Also, at a meeting with HCFA headquarters officials on April 30, 1979, we discussed many of the other outstanding overpayments and related problems addressed in this report. At their request, we gave these officials a copy of the audit guidelines we were using to review States' overpayment recovery systems. On May 7, 1979, HCFA forwarded copies of the

guidelines to its regional offices for their use in reviewing States' administration of and accounting for Medicaid overpayments. At several meetings during and following completion of our fieldwork in Regions II, IV, and IX, we apprised HCFA regional officials of our findings and shared with them information on the specific findings for States reviewed in their respective regions.

For the five States included in our review, HCFA financial management personnel had either completed comprehensive assessments of overpayment recovery and cash management activities or had followed up on selected matters on which we had reported. Information contained in their reports showed that,

--the States had voluntarily returned, or HCFA officials had succeeded in obtaining the return of, $7.8 million (Federal funds) from New York, Florida, South Carolina, and Georgia which was held in various State and city cash accounts;

--HCFA had requested South Carolina to return $166,000 by March 31, 1980, and was processing a disallowance letter aimed at recovering $1.5 million in Federal funds held by New York;

--South Carolina had returned $1 million as the Federal share of outstanding overpayments at the time of our visit, but which had been since recovered; and

--HCFA had requested South Carolina and Florida to return $1.8 million, representing old uncollected overpayments, and had or was processing disallowance letters for $34.8 million applicable to California, New York, and South Carolina as the Federal share of overpayments outstanding during our review, and which remained outstanding at the time of HCFA's followup review. About $34.5 million of the amount was applicable to California.

Although HCFA's followup review efforts in other States had not been completed, information provided by HCFA representatives through early February 1980 showed that HCFA had recovered $33.1 million as the Federal share of funds on deposit in 10 State and fiscal agent accounts. Additional

cash balances had been identified, but HCFA and the States had not yet determined what portion of these funds were Federal Medicaid funds.

HCFA was also taking actions to recover $1 million as the Federal share of overdue outstanding overpayments identified in four States.

CONCLUSIONS AND RECOMMENDATIONS

Even though most of HEW's regulations and guidance concerning the recovery of the Federal share of Medicaid overpayments support the view that overpayments should be refunded immediately after being identified, HEW's regulations and instructions are not entirely consistent in this respect. Also, as a matter of practice, HEW is not usually requiring the States to refund the Federal share of overpayment recoveries until after collection is made--and often a long time elapses between the identification and recovery of overpayments.

The States have been slow in recovering old overpayments, resolving potential overpayments, and returning the Federal share of overpayment recoveries. In the States reviewed, at least $222.6 million in substantiated or potential overpayments had been identified, but had not been recovered even though much of this amount had been outstanding for several years. Additional millions of dollars in potential but unidentified overpayments have remained outstanding for years and are becoming uncollectable due to age because the States are far behind in performing settlement audits of hospitals, nursing homes, and other health-related institutions.

Except for South Carolina, which recently made significant improvements to the management of its overpayment recovery system, the States did not have well-organized systems for identifying, accounting for, recovering, and offsetting the Federal share of Medicaid overpayments against requests for Federal grant funds. Responsibility for overpayment recovery activities was divided among many of the States' organizational units, and most States had not designated a specific unit to coordinate the total recovery effort. HCFA

officials took quick action to resolve some of these problems after we brought them to their attention, and action is being taken to recover the Federal share of many overpayments. However, to minimize the problems we identified, we believe HEW should require all States to implement Medicaid overpayment recovery systems which meet minimum standards. South Carolina's recent improvements in its overpayment recovery system indicate that States can implement needed improvements.

We recommend that you prescribe standards for States' Medicaid overpayment recovery systems. Such standards should cover such areas as defining responsibilities of organizational units involved in overpayment recovery; performance standards similar to Medicare for the States' overpayment recovery systems, including timely audits, resolution of appeals, recovery actions, return of the Federal share of recoveries; and accounting controls, including the recording and aging of accounts receivable.

We also recommend that HEW take credit for overpayments on the first quarterly request for Federal Medicaid grant funds submitted after the overpayments are substantiated, unless the States demonstrate that their overpayment recovery systems are effective and in substantial conformance with HEW's standards.

If a State's system is effective and meets HEW standards, we believe that the State should be allowed a reasonable period for resolving disputes and recovering overpayments before returning the Federal share. Such an approach should be a strong inducement for States to develop effective systems meeting HEW's standards. Finally, we recommend that HEW require the States to return to the Federal Government a proportionate share of any interest earned on overpayment recoveries.

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 taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than

60 days after the date of this 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 are also sending copies of this report to the Chairmen of the four above-mentioned Committees and the cognizant legislative committees. A copy is also being sent to the Director, Office of Management and Budget, and other interested parties.

We appreciate the cooperation given our representatives during this review and welcome the opportunity to discuss these matters with you or your staff.

Sincerely yours,

Gregory J. Ahart
Director

Contents

NEW YORK'S EFFORTS TO IDENTIFY AND RECOVER OVERPAYMENTS AND RETURN THE FEDERAL SHARE

New York, its local Medicaid agencies and their agents, and Federal agencies have identified millions of dollars in overpayments to New York Medicaid providers since the program began in 1965. However, the State has not recovered at least $84 million of these overpayments and has not identified millions more because its system for recovering substantiated overpayments and identifying and resolving potential overpayments is fragmented, slow moving, and cumbersome. The system lacks adequate procedures and controls and fails to pinpoint responsibility for managing and coordinating the recovery efforts. The table on the following page summarizes substantiated and potential overpayments which had been identified, but not recovered when we conducted our fieldwork (September 1978 to June 1979) in New York.

Additionally, New York had not returned the Federal share of about $9.5 million in recovered Medicaid funds and interest on deposit in one State and two New York City cash holding accounts. Although the city was periodically processing funds through its two accounts which totaled $5.4 million as of December 31, 1978, return of the Federal share was untimely, requiring several months under the most favorable conditions. Also the State had not credited the Federal Government for the Federal share of about $4.1 million in recoveries and interest on deposit in a State account established in February 1976. The Federal share was returned on about $6.5 million of these funds after we reported this item to the HCFA Administrator in October 1978 and May 1979. Also, we were advised by the Administrator in November 1979 that HCFA was processing a letter disallowing Federal participation in the remaining $3 million; however, as of January 1980 the disallowance letter had not been issued.

OVERPAYMENTS TO INSTITUTIONAL PROVIDERS ARE NOT TIMELY IDENTIFIED AND RECOVERED

New York's efforts to recover overpayments identified through yearend settlement audits of nursing homes and hospitals have been inadequate. About $39.9 million in identified overpayments was tied up in the State's appeal system, and review of selected overpayments either not appealed or that had already cleared the appeal process

APPENDIX I

Type of overpayment	Outstanding balance (millions)	
Overpayments identified through settlement audits of institutional providers:		
Nursing home cost settlements under appeal	$37.9	
Nursing home cost settlements not under appeal	2.1	
Hospital cost settlements under appeal	2.0	$42.0
Overpayments identified through analysis of claims paid by New York City:		
Duplicate payments to physicians (note a)	5.8	
Excessive charges by physicians	15.4	
Duplicate payments to public hospitals	6.1	
Duplicate payments to hospital clinics (note a)	7.3	34.6
Overpayments identified during audits of selected Medicaid activities and providers:		
State Comptroller audit findings	3.8	
New York City audit findings	2.6	
Our audit findings	.4	
State Medicaid agency audit findings	.6	7.4
Total outstanding balance		a/$84.0

a/A report prepared by the Accounts Receivable Unit, Department of Social Services, the State Medicaid agency, showed that as of April 18, 1979, about $3.6 million of these amounts had been set up as official accounts receivable. The remaining $80.4 million in overpayments have not been recorded as official accounts receivable.

revealed that at least $2.1 million had not been recovered and many more overpayments were recovered only after being outstanding for long periods. Furthermore, the State was years behind in conducting settlement audits and in processing settlement audit reports; therefore, additional millions of dollars in overpayments probably are not being identified for recovery in a timely manner. Although the State Department of Health maintains records to show the number and amounts of overpayments under appeal, the overpayments identified through settlement audits are not recorded in the official accounts receivable records maintained by the Department of Social Services, the State Medicaid agency.

Nursing home cost settlements under appeal

The New York State Department of Health, Bureau of Audit and Investigation, has responsibility for conducting cost settlement audits for the more than 700 nursing homes in the State. 1/ The Bureau reported that as of May 31, 1979, it had audited 1968 and subsequent years' cost reports representing a total of 1,386 Medicaid rates years 2/ and had identified $55.7 million in overpayments. However, $37.9 million (about 68 percent) in overpayments for cost year 1969 and later had not been recovered because they were tied up in the State's lengthy appeals process.

Before January 1977, the Bureau of Audits and Investigations first reviewed appeals of audit findings internally; then a Rate Review Board consisting of a Deputy Commissioner from the Department of Health and two outside consultants rendered final decision on the appeal. The appeals process did not include a formal hearing at which the provider, or his representative, could appear to present evidence and plead his case. Claiming denial of due process, some providers challenged this procedure in the State courts, which ruled that providers were entitled to a formal hearing. However, the court rulings did not preclude the State Medicaid agency from recovering or starting to recover overpayments before

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1/New York pays these facilities at a prospective cost-related rate computed on the basis of costs for a prior period adjusted for inflation. The time lag between the end of the cost period and the beginning of the rate period is 1 year.

2/The rate year is the second year following the cost year.

a formal hearing began. In fact, some rulings specifically stated that prehearing recoveries were proper provided the hearing was held within 90 days from the date the recovery action began.

Apparently in an effort to eliminate provider complaints and to comply with court decisions, the State, effective January 1977, created a separate Bureau of Appeals within the Department of Health and revised the appeals process to include a formal hearing. However, the State is still far behind in processsing appeals and holding formal hearings; before December 1978, it did not even attempt to recover appealed overpayments until after the formal hearings were over. In December 1978 according to a Department of Health official, the State implemented procedures to initiate overpayment recovery 90 days before formal hearings begin. Although this procedure can result in overpayments being recovered 90 days sooner, it may have limited effect on the backlog of appealed cases, which are often under appeal for several years before formal hearings are scheduled.

Nursing home cost settlements not under appeal

Most of the overpayments that were not appealed or that had completed the appeals process have not been recovered or not recovered promptly. After completing an audit, the Bureau of Audits and Investigation sends its reports to the Bureau of Residential Health Care Facility Reimbursement, Department of Health, for final rate computation. Following final rate computation and resolution of any appeals, the Department of Health issues the final rates to each of the 58 local paying districts (57 counties and New York City), which are responsible for implementing them and recovering overpayments from Medicaid providers. Review of 139 selected final rates issued between July 1, 1976, and June 30, 1978, to 27 nursing homes in New York City and Albany County 1/ showed that 129 resulted in estimated overpayments totaling $3,240,749 and that $2,086,839 of this amount had not been recovered. Furthermore, the $1,153,910 in overpayments that were recovered required 5 years on the average to recover.

1/In Albany County, we limited our review to facilities that received more than $10,000 in Medicaid payments during the rate period(s).

For 23 New York City facilities, 129 final rates had been issued within our 2-year sample period, and 10 final rates had also been issued for 4 Albany County facilities. Of the final rates for 20 city facilities, 119 revealed overpayments totaling $3,120,290; the other 10, involving 3 city facilities, revealed underpayments. However, as of May 7, 1979, New York City had recovered only $1,152,294 (37 percent) of the total overpayments identified. The other $1,967,996 (63 percent) remained with the providers, where it has been from about 4 to 8 years. All final rates for the four Albany County facilities revealed overpayments totaling about $120,459. Records in Albany County showed recovery of only $1,616, leaving a balance of $118,843.

Information provided by State and local district officials and obtained from city and county records indicate a variety of reasons for not recovering the overpayments:

--Local districts apparently had not received or had not implemented some final rates.

--Facilities had closed and owner(s) could not be located.

--Facilities had declared bankruptcy.

--Providers opposed the appeals process claiming they did not receive due process.

However, providers act as a catalyst to insure that adjustments benefiting them (underpayments) are made.

For adjustments that were made, the cumulative time lag for the entire rate settlement process (audit appeals, rate computation, rate dissemination, and recovery) was too long. For example, an average of about 9 months elapsed between the date of final rate issuance and the date of first recoupment, in nine city cases in our sample for which recovery had begun or was complete. This time lag was in addition to an average of over 4 years from the end of the rate period to the date that the final rates were issued. Thus, on the average, providers were able to keep the overpaid funds interest free for nearly 5 years.

Nursing home cost settlement audits not current

The State is also far behind in conducting and processing nursing home cost settlement audits. In fact, the opportunity to conduct some audits and identify overpayments has been lost to the State's statute of limitations, which requires providers to make their cost records available for audit for 6 years after their cost reports are submitted. The number of audits completed (1,386) through May 31, 1979, for example, is far below the number that should have been completed through this date. For rate years 1973-78, Bureau of Audit and Investigation records show a universe of 3,617 rate years requiring audit and settlement, and since the records did not readily show the number of rate years before 1973 that required audit, the total universe is greater than 3,617. The records further show that, of the universe (3,617), only 1,190 rate years (33 percent) had been audited and final rates issued as of May 1979. An additional 1,376 audits (38 percent) were in varying stages of completion, and 1,051 audits (29 percent) had not been started.

Bureau of Audit and Investigation officials told us that one major factor contributing to the backlog of audit settlements was that at least 300 rate year audits in process were bouncing back and forth between the Department of Health and the Office of Special Prosecutor for Nursing Homes, Health and Social Services. 1/ These two agencies apparently cannot agree on which of them is responsible for calculating the final rates and determining the overpayments. All of the disputed audits pertain to rate years before 1977.

Because hundreds of audits have not been started, or started but not completed for rate years as far back as 1970, millions of dollars in probable overpayments have not been substantiated and remain with the providers. Additionally, opportunity for recovery of many such overpayments has been lost due to the State's 6-year statute of limitations.

1/The Office of Special Prosecutor is an independent agency established in the Office of the State Attorney General in 1975 to investigate fraud in the health area and designated in 1976 to conduct audits of certain proprietary nursing homes.

Hospital cost settlements under appeal

As of April 1979, $2,034,283 in overpayments to 84 hospitals and involving 119 rate years had not been recovered because they were tied up in the State's lengthy appeals process. The overpayments were made between July 1, 1971, and December 31, 1975, and identified during the hospitals' yearend cost settlement audits performed by Medicare fiscal intermediaries under a shared Medicare/Medicaid common audit agreement.

The 340 Medicaid hospitals in the State, similar to the nursing homes, are paid for Medicaid services at a prospective cost-related reimbursement rate based on an audit of the facilities' actual costs. The Medicare fiscal intermediaries usually perform the audits during the second year following the end of the hospitals' cost period and send copies of the settlement reports to the Bureau of Audit and Investigation, which reviews them for disallowed costs and formats the information for use by the Bureau of Hospital Reimbursement, Department of Health, in computing the final Medicaid rates.

The State does not attempt recovery of overpayments, but this responsibility is delegated to the 58 local paying districts. Upon receipt of a final rate, the district is supposed to recover any overpayment or pay any underpayment by adjusting the amount that the hospital was actually paid during the period covered by the rate to the amount that it should have received as determined by the final rate. However, rates are not disseminated to the local districts for implementation until after providers have an opportunity to appeal overpayment findings and appealed findings are resolved.

Hospital cost settlements not under appeal

To determine the extent final rates were being implemented and overpayments recovered, we tested final rates issued between July 1, 1976, and June 30, 1978, for hospitals located in New York City and Albany County. Results of our tests showed that only 136 (28 percent) of the 483 final rates issued for city hospitals were implemented and that final

rates for only 8 (33 percent) of the 24 rate years 1/ for Albany County hospitals were implemented. The city and county had not computed the monetary impact of not implementing these final rates.

New York City hospital rates not implemented

Of the 135 hospitals in New York City, 85 are voluntary, 31 proprietary, and 19 public. 2/ However, no final rates had been established for the public hospitals (see p. 10 of app.). Responsibility for adjusting voluntary and proprietary hospital rates is fragmented among three different city groups. The field audit group under the city's Division of Medical Payments, Human Resources Administration, has responsibility for adjusting the voluntary and proprietary hospitals' emergency and outpatient clinic final rates. This group had adjusted only 9 (6 percent) of the 149 emergency room final rates issued during the test period and implementation of these 9 rates resulted in $57,000 in underpayments and $3,200 in overpayments. Also, the group had adjusted only 7 (7 percent) of the 104 outpatient clinic final rates, which resulted in about $1,550,000 in underpayments and $68,000 in overpayments. According to Division officials so few rates had been adjusted and the amount of underpayments exceeded overpayments for those that were adjusted, because the group that adjusts them is

--adjusting primarily those rates that produce overpayments due to pressure from the hospitals,

--not increasing Medicaid payments as interim rates are increased, and

--not receiving all the final rate schedules.

The Accounts Payable section of the Office of Budgets and Fiscal Affairs, Division of Social Services, has

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1/A final rate may cover all or part of a rate year depending on whether the hospital experienced unexpected cost increases during the rate year.

2/Voluntary hospitals are operated by nonprofit charitable organizations, proprietary hospitals are operated by for-profit organizations and individuals, and public hospitals are operated by State or local governments.

responsibility for adjusting final inpatient rates for proprietary hospitals. Although 63 final rates were issued during our test period, the section had not adjusted any rates because, according to the section's deputy director, adjustments would require extensive research through a manual records system and she did not have enough staff to do the research. If the adjustments were made, she thought they probably would disclose overpayments rather than underpayments. She theorized that if hospitals had been underpaid, they already would have inquired about and collected the underpayments.

The New York City Comptroller's Office, Division of Charitable Institutions, is responsible for adjusting the final inpatient rates issued for voluntary hospitals. Records showed that the Comptroller had adjusted 120 (72 percent) of 167 final rates issued during the test period but it took an average of 19 to 22 months to make the adjustments and begin recovering overpayments. Detailed analysis of 23 adjusted rates showed that 9 resulted in overpayments of about $787,000 and 14 in underpayments of about $736,000.

Albany County hospital rates not implemented

The Internal Auditing section of Albany County's Department of Social Services is responsible for adjusting hospital rates. Of the cases we reviewed, the county should have adjusted final rates covering 24 rate years and 13 hospitals; however, only 8 rate years involving 5 hospitals had been adjusted. Of these, 4 rate years resulted in $267,588 in overpayments and the other 4 resulted in $3,576 in underpayments.

The county apparently had not made the adjustments for 16 rate years because it had either misplaced or not received final rates issued by the State Department of Health. The Director of Internal Auditing stated that his section did not receive final rates issued in 1976 for three hospitals covering 3 rate years. The estimated overpayments resulting from these final rates totaled nearly $82,000.

Also, the county had not established an effective system for following up with providers to recover overpayments. In December 1977 for example, the section notified one hospital that it was overpaid $9,231 based on final rates issued in 1977 for rate year 1973 and asked the hospital to contact the section to arrange repayment. However, the overpayment was still outstanding in May 1979, and the files contained no record of further recovery efforts.

Hospital cost settlements not current

Medicaid paid hospitals in New York $5.7 billion for 2,031 rate years from January 1973 through September 1978; however, the State had not established final rates for 1,147 (56 percent) of these rate years. 1/ In addition, the State was several years behind in auditing Medicaid costs and establishing final rates for New York City's Health and Hospital Corporation's public hospitals.

A Department of Health official attributed the large backlog of hospital audits in process (1,147) to Medicare's fiscal intermediaries' slowness in forwarding completed audits to the Bureau of Audit and Investigation for processing. In 1977, in response to pressure, the fiscal intermediaries began to forward the Bureau large quantities of audits, including 350 at one time. According to Department of Health officials, the increase backlogged the Department's processing system. However, the officials were optimistic that the Department would soon become current in its processing of hospital audits.

Because final rates had not been established based on these 1,147 audits, the State could not develop information to show the number and amount of over- and underpayments. However, it did have limited historical data indicating that most settlement audits showed overpayments to providers. For example, based on audited 1973 and 1974 final rates for 354 hospitals, 261 were overpaid an estimated $5.2 million, 91 were underpaid an estimated $1 million, and the rates for two hospitals did not change. If this trend continues, net overpayments for the 1,147 hospital audits still in process could total millions of dollars.

Before rate year 1976, rates for New York City's Health and Hospital Corporation's public hospitals were not set according to the standard rate methodology used for other hospitals. Instead, the Corporation and the State Department

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1/Of these rate years, the establishment of final rates for 538 were in process at the Bureau of Audit and Investigations, and 609 were in process at the Bureau of Hospital Reimbursement. Both Bureaus are in the State Department of Health.

of Health negotiated a composite rate for all 17 hospitals 1/ based on the hospitals' budgets, operating deficits, number of Medicaid patients, and other factors. Department of Health officials said that they do not consider the composite rates negotiated for rate years 1971-75 final, but had not decided how to establish final rates. They also said that the Medicare fiscal intermediary refused to audit Corporation hospitals under the shared audit arrangement because in the opinion of fiscal intermediary officials, the hospitals' records are a "shambles."

A public accounting firm audited the Corporation's hospital Medicare cost reports for rate years 1971-75, and these audits identified $37 million in net overpayments. Although some Department of Health officials believe that the results of these audits could be used to establish final Medicaid rates, other Department officials are reluctant to use them, apparently because Corporation officials contend that the negotiated rates were intended to be final.

For rate years 1976-78, the Department based interim rates for each Corporation hospital on the hospital's uncertified cost report. Department officials have not decided how to establish final rates for these years because of the Medicare fiscal intermediary's refusal to include these hospitals under the shared audit arrangement. The Medicare audits for 1976 and 1977 conducted by a public accounting firm revealed that Medicare had underpaid the hospitals by about $10 million.

Because of the State's 6-year statute of limitations, the continued delay in resolving the rate issue for these public hospitals may be decreasing the State's opportunity to collect any overpayments which are identified when final rates are established.

OVERPAYMENTS TO NEW YORK CITY PROVIDERS ARE NOT TIMELY IDENTIFIED, RESOLVED, OR RECOVERED

The State Medicaid Agency's Office of Audit and Quality Control is responsible through its Bureau of Fraud and Abuse for identifying potential fraud and abuse activities and for

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1/The number of Health and Hospital Corporation hospitals had increased to 19 at the time of our audit in 1979.

investigating and resolving abuse cases. 1/ One of the Bureau's primary identification and recovery efforts involved analyzing New York City's Medicaid payment computer tapes and, thus, continuing and expanding a city initiative which was begun before the Bureau was established in April 1977. The computer analysis effort which was ongoing at the time of our audit had already identified about $58 million in substantiated and potential overpayments made since 1972; however, as of April 1979, about $34.6 million had not been resolved or recovered. Of the unrecovered amount, official accounts receivable records had been established for about $3.6 million.

The Bureau's recovery activities for the overpayments identified were not effective because

--collection of some substantiated overpayments had not been diligently and timely pursued, and some may never be recovered;

--certain potential overpayments were never pursued or resolved; and

--documentation supporting decisions to compromise or not pursue certain substantiated and potential overpayments was inadequate.

Duplicate payments and excessive charges by physicians

The Bureau did its initial computer analysis to identify duplicate payments to and excessive followup visit charges by physicians between January 1973 and July 1975. 2/ However, it had no summary records showing the number or total value of overpayments identified or the value of the accounts receivable established as a result of its analysis. Officials

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1/Suspected fraud cases are referred to the State's Office of Special Prosecutor, and we did not review the status of overpayments referred to the special prosecutor.

2/A physician is allowed to claim a larger fee for a patient's first visit for a specific illness than he is allowed to charge for subsequent visits for the same illness; but some physicians apparently were erroneously charging first visit fees for followup visits.

said that actual recovery of the identified overpayments began in January 1977 and recovery efforts from most providers consisted of mailing a bill for the overpaid amount and asking the physicians to contact the Bureau and arrange to repay the billed amount. The program was analyzed in January 1978, and the results showed that $181,000 had been recovered and $1,864,500 written off as uncollectable. The records did not show the reasons for writing off cases as uncollectable.

Records also showed that 808 overpayment cases, totaling $7,069,600, were established as accounts receivable and scheduled for further investigation. However, only 258 cases totaling $1,780,330 were investigated, eventually yielding recoveries totaling $707,932. The balance, $1,062,598, was written off as uncollectable, but case files documented neither the reasons for determining cases uncollectable nor the efforts made to recover the overpayments. The Bureau subsequently removed the other 550 cases, valued at $5,289,270, from receivables without action but included them on two revised and expanded listings, one for duplicate payment cases and one for excessive followup visit cases.

Revised duplicate payments list

The revised and expanded duplicate payments list included 7,701 physicians who received an estimated $6,752,800 in overpayments from January 1, 1973, to March 31, 1977. However, as shown in the following table, only $826,064 of this amount had been recovered as of April 1979. Another $155,652 had been settled in favor of the providers leaving an outstanding balance of about $5.8 million.

Amount of individual overpayments	Number of physicians	Total overpayment	Amount recovered as of April 1979
Less than $100	2,967	$ 104,875	-
$100 to $3,000	4,195	2,861,050	$698,688
Over $3,000	539	3,786,875	127,376
Total	7,701	$6,752,800	$826,064

Recovery action was neither attempted nor planned on the cases valued at less than $100 because Bureau officials believe that recovery costs would probably outweigh any benefits derived from recovery efforts. The Bureau sent collection

letters to physicians whose overpayments were from $100 to $3,000 and at the time of our fieldwork in New York, it was conducting followup recovery activities by telephone. Although the Bureau had ceased collection activities for many of these cases, we could not readily determine the number or dollar value of such cases because it had not summarized this information. Also, documentation in selected case files reviewed did not, in our opinion, justify suspending collection on these cases. For example, collection activity was suspended on a case valued at $2,887 on the basis of a physician's signed affidavit stating that he had not received duplicate payments for the service in question.

In January 1978, Bureau officials began investigating the 539 cases, valued at $3,000 or more, but as of April 1979 had settled only 79 cases, totaling $313,011. The Bureau settled these 79 cases for $157,359, but as the table shows, actually recovered only $127,376 of the settled amount. Investigative efforts were ongoing on another 50 cases, but work had not begun on 410 others. Bureau officials said that they were not pleased with either the progress or the results of the investigations and probably would not investigate the remaining 410 cases but would handle them through their mail-out program instead. Officials believe that the return may be greater under the mail-out program because it is faster and requires only 5 employees to administer, whereas about 20 employees are involved in conducting the investigations.

Revised excessive followup visits list

Cases on the revised excessive followup visits list totaled $15,367,000 and involved 6,117 physicians, but 828 of these cases accounted for about $14.5 million of the total. As of May 1979, Bureau officials had not tried to resolve any of these cases and did not plan any recovery efforts because they thought the criteria used to produce the list may have been invalid, and even if valid, had not been properly communicated to physicians before being applied. The criteria allowed a generalist to charge only one first visit fee per patient every 60 days and a specialist to charge only one first visit fee per patient every 90 days.

Even though Bureau officials plan no additional followup visit recovery efforts, we believe that many of these cases could be substantiated and recovered because the recovery rate

from the initial list which covered both duplicate payment and excessive followup visit cases was just as successful for the followup visit cases as for duplicate payment cases.

Duplicate payments to the Health and Hospital Corporation

In December 1977, the Bureau developed a list of duplicate payments to the city's Health and Hospital Corporation from January 1974 through August 1977, but as of March 1979 had recovered none of the overpayments. Supposedly due to inaccuracies in the initial list, the Bureau reduced its estimate of total overpayments from $21 million to $6.1 million. The initial list for example, included as a duplicate payment multiple clinic charges at one hospital for the same patient; however, some hospitals have multiple clinics (e.g., psychiatric and orthopedic) and multiple clinic charges for a patient could be proper. According to Bureau officials, edits to eliminate these and other similar problems resulted in the revised amount ($6.1 million) which was firm and would be billed to the Corporation. However, the Corporation had not been billed as of March 1979.

Duplicate payments to clinics

In September 1977, the Bureau developed a duplicate payments list that showed $14.5 million in potential overpayments to 163 voluntary hospital clinics, and as of April 10, 1979, $7.3 million of this amount was still outstanding. The Bureau had audited and settled with 40 clinics with potential overpayments of $9,132,996. Of this amount, $7,875,941 (86 percent) was substantiated and $5,960,054 of the substantiated amount had been recovered. The unrecovered amount, $1,915,887, was recorded in the State's accounts receivable records and was being paid in installments by 15 clinics, 4 of which were more than $75,000 behind in their payments, and State records did not contain any evidence of actions to bring these delinquent cases current.

Bureau officials said that of the other 123 clinics with outstanding potential overpayments totaling about $5,367,004 ($14,500,000 less $9,132,966), duplicate payment audits were either in process or planned for 10 clinics and that comprehensive audits, which include review for duplicate payments, were planned for the other 113 clinics.

APPENDIX I

Duplicate payments to other providers

In addition to the lists discussed above, the Bureau had developed or was in the process of developing duplicate payment lists for 15 additional provider groups and services: osteopaths, podiatrists, optometrists, transportation, clinical laboratories, X-ray tests, EKG tests, chiropractors, appliance vendors, optometric dispensers, physical therapists, speech therapists, occupational therapists, visiting nurse services, and home health services. Bureau officials responsible for recovering these overpayments would not provide us with copies of or information about these lists because, according to the officials, the lists had not been reviewed nor criteria used to develop them tested.

OVERPAYMENTS REPORTED BY VARIOUS AUDIT AGENCIES NOT RECOVERED

The State had not recovered about $7.4 million in overpayments reported between June 1975 and December 1978 by various Federal, State, and local audit agencies. State and local Medicaid officials responsible for recovering these overpayments cited disagreement with the responsible auditing agency over the criteria used to develop the findings or the findings amounts as the reason for not recovering most of the overpayments outstanding in June 1979. Also, those officials said that some Medicaid overpayments resulted from providers' failure to first collect amounts payable by Medicare and other third-party payers, and they intended to wait until the providers collected these amounts before recovering the Medicaid overpayments. In our opinion, the State has had sufficient time to resolve these issues and recover the overpayments.

Status of overpayments reported by audit agencies

The Bureau of Policies, Plans, and Programs, Office of Audit and Quality Control, is responsible for controlling and monitoring recovery of Medicaid overpayments identified and reported by Federal, State, and local agencies (except the State Medicaid agency). Bureau records showed that, between June 1975 and December 1978, four agencies had issued 15 reports that identified $15.8 million in Medicaid overpayments. However, as shown in the following table and discussed in the following sections, about $6.8 million of this amount was still outstanding as of June 1979.

Identifying agency	Number of reports issued	Amount of overpayments Identified	Amount of overpayments Outstanding June 1979
		(thousands)	
New York State Comptroller	8	$ 8,369	$3,781
New York State Welfare Inspector General	1	50	0
New York City Comptroller	2	2,624	2,624
GAO	3	4,731	365
Total	14	$15,774	$6,770

New York State Comptroller findings

The Bureau had made no recoveries on about $2.9 million in Medicaid overpayments identified in four of the eight reports issued by the Office of the Comptroller. According to Bureau officials, two of the four reports issued in December 1978 accounted for $2.5 million of this amount and were under review within the Medicaid agency to determine the exact amount of the overpayment and to decide the action to be taken. The Medicaid agency began its review in March 1979, but as of March 21, 1980, no recoveries had been made. The Bureau had not acted on the other two reports because one involving $322,000 in overpayments reportedly could not be resolved until a policy matter was settled; the fourth involving $120,000 in overpayments supposedly required followup review because it was based on a survey. However, this "survey" report was issued in June 1976 and 3 years later the Bureau still had not made its followup review.

The Bureau had made partial recoveries on overpayment findings in two of the four other reports. The Bureau was still litigating $651,000 of a $1 million overpayment identified in a September 1976 report, and $188,000 of a $377,000 overpayment reported in June 1978. Additional Bureau review was required to determine the exact amount of the overpayment before recovery could begin. Recoveries had been made of the overpayments identified in the remaining two reports.

New York City
Comptroller findings

In January 1978, the city Comptroller's office issued a report which identified $424,413 in overpayments to a hospital supposedly because the hospital did not notify the city of patients who were medically discharged, but were remaining in the hospital awaiting alternate care placement. However, the city had recovered none of the overpayments because State Medicaid agency officials disagreed with the Comptroller's interpretation of a State regulation on which the finding was based. A second report, issued by the Comptroller's office in November 1978, identified about $2.2 million in overpayments to hospitals that failed to act on decisions made by the New York County Health Service Review Organization. Although State Medicaid agency officials are not disputing the findings, the city had made no recovery because the State agency had not validated the amount of the reported overpayment.

OUR FINDINGS

We issued three reports to the SRS Regional Commissioner (predecessor to the HCFA Regional Administrator) during the period covered by our review; one issued in June 1975, identified $365,000 in overpayments to two health clinics that had not been recovered. According to Bureau officials, the State Medicaid Audit Office was still in the process of determining the exact amount of overpayments to be recovered. The Bureau had already recovered $4 million reported by us in May 1976 1/ and the State credited the Federal share on the quarterly expenditure report for the period ended December 31, 1979. The officials also stated in February 1979 that the State Department of Health had adjusted final reimbursement rates to recover $366,000 in overpayments to three nursing homes.

1/We reported that Medicaid paid for a certain amount of medical expenses--the spend-down amount--that the medically needy whose income and resources were above a State prescribed level should have incurred. The HEW Audit Agency in a followup and expanded review determined that total overbillings to the Federal Government for spend-down amounts was $11,097,727, which has been recovered.

Status of overpayments reported by the State Medicaid agency Audit Bureau

The Bureau of Audit Operations, Office of Audit and Quality Control, is responsible for ensuring the adequacy of local districts' procedures and controls for administering the Medicaid program. It carries out this responsibility by periodically auditing the Medicaid operations of local districts and of selected Medicaid providers. We reviewed the Bureau's Metropolitan Regional Office efforts to recover Medicaid overpayments identified during such audits and found that it emphasizes identifying and reporting overpayments, but it does not routinely follow up to ensure recovery of overpayments and crediting State and Federal Governments with their fair share of recovered overpayments.

In reviewing the regional office audit reports issued between January 1, 1976, and November 30, 1978, we found 22 that had identified a total of $6,172,548 in Medicaid overpayments to providers in the New York City metropolitan area. The local districts (city or county) were responsible for recovering the overpayments, but the regional office did not know the status of these reported findings. It had not established a focal point for summarizing audit results or maintaining records of Medicaid findings, nor had it implemented a system or established procedures for following up on overpayments reported.

Our review showed that the local districts had recovered $5,508,685 in overpayments identified in 13 reports and had credited the Federal Government with its share of all but $10,986 of these overpayments. The $663,863 in overpayments identified in the other nine reports remained outstanding. Of this amount, $577,260 had gone to providers who erroneously billed Medicare charges to Medicaid. New York City's policy in these cases, according to city officials, is to recover the Medicaid funds only after the provider collects from Medicare; however, the officials did not know whether the providers in question had received payment or even submitted claims for payment from Medicare. The other $86,603 had not been recovered because

--two nursing homes that were overpaid $37,807 went out of business shortly after the reports were issued,

--city officials said that they did not receive one report which identified overpayments totaling $31,000, and

--the city and providers were still negotiating reported overpayments totaling $17,796.

DELAYS IN REFUNDING THE FEDERAL SHARE OF RECOVERED OVERPAYMENTS

New York State and New York City had not given the Federal Government timely credit for its share of about $9.5 million in Medicaid funds on deposit in three cash holding accounts. Between February 1976 and September 1978, the State's Office of Special Prosecutor recovered $3.8 million from nursing homes and deposited the funds in an interest-bearing, State-controlled cash account; interest earned on the funds had increased the account balance to $4.1 million as of September 30, 1978. According to State Medicaid officials, return of the Federal share was delayed because State and local officials could not agree on a formula for distributing to each local government its proportionate share of the recovered funds. In our view, this should not have prohibited the State from returning the Federal share. Details of this situation were included in our October 27, 1978, letter to the HCFA Administrator, and the Federal share, about $1.9 million, was returned.

New York City had established and was operating two cash holding accounts that had about $5.4 million in Medicaid funds from various sources on deposit as of December 31, 1978. In addition to recoveries from providers, the funds included recoveries from recipients and payments withheld from providers scheduled for investigation. Some of the funds in these accounts had been on deposit for several years, and even under the most timely processing situations, the Federal Government was not receiving credit for its share of funds until 6 to 9 months after recovery by the city.

The details of these two cash accounts were reported to the HCFA Administrator in our May 4, 1979 letter. In his November 19, 1979, response the Administrator advised us that HCFA had received credit for the Federal share of about $2.4 million and that it was processing disallowance letters on the Federal share of the other $3 million on deposit in these accounts.

APPENDIX II

CALIFORNIA'S EFFORTS TO IDENTIFY AND RECOVER OVERPAYMENTS AND RETURN THE FEDERAL SHARE

California, its fiscal agents, and Federal agencies have identified millions of dollars in overpayments to California Medicaid providers since the program began. However, California has not recovered all such documented overpayments nor documented other probable overpayments in a timely and efficient manner.

Provider appeals of cost settlement audits have delayed the recovery of many overpayments. California's disagreement with HEW Audit Agency findings has delayed the recovery and refund of the Federal share of others. Also, California has not been timely in conducting reviews and investigations to validate possible overpayments for recovery. The table on the following page summarizes documented and potential overpayments which were outstanding when we conducted our fieldwork in California (Mar.-Aug. 1979).

Even after overpayments are recovered by the State, between $2 and $3 million in recovered funds are continually tied up in the refund processing cycle. The processing cycle requires an average of 1 to 2 months for refunds to be processed preparatory to returning the Federal share which compares favorably with the other States we visited. The significant volume of refunds received, combined with this processing time lag, causes significant Federal funds to be continually tied up and unavailable to meet current Federal program costs.

PROVIDER APPEALS DELAY RECOVERY OF HOSPITAL COST SETTLEMENT IDENTIFIED OVERPAYMENTS

California defers collection of Medicaid overpayments which are appealed by providers pending appeal resolution. As of May 31, 1979, accounts receivable records maintained by the State's fiscal agent showed that $19.6 million in community (private) hospital cost settlement audit identified overpayments were deferred from collection because of provider appeals. Similarly, available State records showed

APPENDIX II

Type of overpayment	Outstanding balance (millions)
Hospital cost settlement audit identified overpayments tied up in appeals:	
Community hospitals (statewide balance from fiscal agent accounts receivable records)	$ 19.6
County hospitals (balance from available State records for Los Angeles County)	28.6
Estimated overpayments to Los Angeles County medical facilities resulting from a waiver of eligibility and utilization control reviews	20.0
Estimated overpayments resulting from private insurance coverage for Medicaid paid claims	10.0
Miscellaneous overpayments managed by the State's central overpayment recovery unit and recorded in the State's accounts receivable records	14.8
HEW Audit Agency identified overpayments	33.1
Total	$126.1

more than $28.6 million due from Los Angeles County hospitals was not being recovered because of pending appeals. 1/

Community hospitals

California's fiscal agent is responsible for recovering from community hospitals, overpayments which are identified by periodic cost settlement audits. For overpayments which are not appealed, the fiscal agent normally makes the recovery by offset against subsequent provider payments. Recovery actions are deferred, however, if a provider appeals. As of May 31, 1979, there were 173 community hospital rate settlement audits under appeal. As shown in the following table, the recovery of overpayments identified by these audits has been delayed long beyond the date the audits were completed and the fiscal agent recorded the overpayments in its accounts receivable records.

Age of receivables as of May 31, 1979	Amount
Less than 6 months	$ 2,164,000
6 - 12 months	2,401,000
1 - 2 years	9,903,000
More than 2 years	5,171,000
Total	$19,639,000

Even though the State charges providers interest on overpayments held during appeal (current annual rate of 7 percent), the longer appealed overpayments remain outstanding, the greater the probability they will become uncollectable even if the State's findings are sustained. In our review of selected hospital cost settlements, in one case the State had been unable to recover $10,837 ($9,808 principal + $1,029 interest) on a 1974 rate period for which the appeal decision was not rendered until September 30, 1977. This same provider has not yet repaid his 1975 cost settlement and has not even submitted cost reports to the State for fiscal years 1976, 1977, and 1978.

Public hospitals

California's Medicaid agency is responsible for recovering overpayments to county (public) hospitals which are

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1/We did not obtain public hospital appeal statistics for other counties.

identified by periodic cost settlement audits. For overpayments which are not appealed, the State normally makes the recovery by offset against payments to the counties for local Medicaid program administrative expenses. As with community hospitals, however, recovery is deferred if providers appeal. Summary information was not readily available showing the total statewide deferred collections because of pending appeals at the time of our review. However, we did assimilate this data for Los Angeles County for fiscal years 1973 through 1976. As is shown in the following table, $28.6 million in overpayments applicable to this period was still deferred from collection as of August 28, 1979.

Fiscal year	Amount deferred from collection
1973	$ 3,478,000
1974	5,142,000
1975	7,229,000
1976	12,715,000
Total	$28,564,000

Unlike community hospitals, the State does not charge the counties interest on overpayments held during appeal.

IDENTIFICATION AND RECOVERY OF OVERPAYMENTS TO LOS ANGELES COUNTY FACILITIES DELAYED BY UNTIMELY ELIGIBILITY AND UTILIZATION CONTROL REVIEWS

Because the State is delinquent in making billing reviews of Los Angeles County medical facilities, it is highly probable that more than $20 million in overpayments to these facilities remain outstanding long after adjustments should have been made.

The State's Department of Health Service has waived Los Angeles County medical facility Medicaid claims from the prepayment eligibility and utilization control reviews that are required of other providers. In lieu of such prepayment claim reviews, the State is supposed to conduct semiannual postpayment audits of statistically valid samples of Los Angeles County claims to determine the recipient eligibility, benefits coverage, and medical necessity error rates. Based on the sample audit findings, the State projects the total overpayments for the entire universe of claims paid during

the period. As shown in the following table, historically overpayments recovered by the State have averaged more than $5 million for each 6-month period.

Audit period	Number of months in audit period	Overpayment amount	Audit report date
		(millions)	
July 1972 - Dec. 1974	30	$25.6	Mar. 1976
Jan. 1975 - Dec. 1975	12	14.0	Sept. 1977--revised Jan. 1978
Jan. 1976 - June 1976	6	5.7	Dec. 1978
Total	48	$45.3	
Average overpayments per 6-month period		$5.7	

The State had not completed any audits for any period after June 1976. Considering the amounts of overpayments involved, it is in the State and Federal governments' interest to complete the audits as soon after the end of the period as feasible. Even allowing 1 year for audit and settlement, the State should have completed the audits for periods through June 1978 at the time we were conducting our review in June 1979. Assuming an overpayment rate of $5 million for each 6-month period--which is conservative based on past experience--a total of $20 million in overpayments for the period July 1976 through June 1978 has remained outstanding long after such amounts should have been identified and recovered.

UNCOLLECTED HEALTH INSURANCE COMPANY BILLINGS

California Medicaid agency officials estimated that health insurance companies owed the State about $10 million for Medicaid claims paid on behalf of recipients who had other health insurance coverage. The $10 million is State officials' estimate of the amounts due and collectable from $143 million in outstanding billings to health insurance companies.

The Social Security Act, section 1902(a)(25), requires that the State or local agency administering the Medicaid program take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under Medicaid. The law also requires that such legal liability be treated as a resource of the individual receiving medical benefits. In addition, when third-party liability is found to exist after Medicaid benefits have been provided, the law requires that the State or local agency seek reimbursement to the extent of such legal liability.

In October 1972, California implemented a system of paying Medicaid claims even though it has evidence that the recipient has health insurance coverage. Therefore, when California pays such claims, it is obligated to seek recovery from the insurance company(ies). California does this by periodically billing the insurance companies for claims the State paid on behalf of recipients who, according to State records, have health insurance coverage.

California relies primarily on the insurance companies to remit the proper amounts due, notify the State if they have already paid the provider or recipient, and notify the State if the insurer has no obligation to pay for the services billed. The State conducts only limited intermittent reviews to verify insurance company compliance with State requirements; however, based on these reviews, State officials believe compliance to be generally satisfactory.

California maintains records of receivables (not official accounts receivable) of insurance billings. California removes these receivables upon receipt of payments, notification that no payment obligation exists, or notification that payment has been made to a provider or recipient. In this latter instance, the State pursues recovery from the provider or recipient.

Of the total amount billed to insurance companies since June 1975, $143 million remained outstanding as of December 31, 1978. This amount represents the accumulated balance of amounts billed for which no response has been received from the billed companies. State officials believe, however, that most of this amount does not represent a valid debt to the State. They estimate that only about 7 percent or about $10 million represents valid receivables. They further believe that most of the $10 million is included in more recent

billings for which insurance company responses have not yet been received.

State officials cited as reasons for the vast differences between the outstanding billings and the collectable amount: billings where no valid health insurance coverage ever existed, billings to insurance companies for services provided after coverage had lapsed, and billings for services not covered by the referenced policy. Nevertheless, the State's estimate represents a large outstanding overpayment that should be pursued.

BACKLOG IN BOOKING AND RECOVERING MEDICAID AGENCY COMPLIANCE UNIT RECEIVABLES

The State Medicaid Agency Compliance Unit had nearly 8,700 overpayment cases totaling about $14.8 million recorded as accounts receivables as of April 30, 1979. In addition, it had received from other units for recovery action about 3,900 cases which had not been recorded in the receivables.

The Compliance Unit is one of the primary recovery units in the State Medicaid agency and accepts various types of overpayments identified by different groups in and outside of the State Medicaid agency. The unit also accepts overpayment cases from other collection units which are unsuccessful in their collection efforts. For example, the fiscal intermediary refers overpayments identified through settlement audits, which it is unable to collect, to this unit for further recovery efforts.

Although the receivables are not aged, agency officials acknowledge that some are old and of questionable collectability. For example, they include at least $4.8 million due from overpayments we reported to HEW in 1973. Also, the receivable records did not indicate the length of time required for collection or the collection success rate. Responsibility for recovering these receivables was transferred from the fiscal agent to the Compliance Unit in 1975.

Compliance Unit officials told us that staff limitations prevent them from the timely followup on all cases. As evidence of this, they cited the increase in cases backlogged--i.e., not investigated or recorded as receivable because of staff limitations. They said that during the 12-month period ended May 1979, the backlog inventory had increased from about 2,300 to 3,900 cases.

OVERPAYMENTS IDENTIFIED BY HEW AUDITS NOT TIMELY RESOLVED AND RECOVERED

As of August 1979 about $33.1 million 1/ in overpayments (about 50 percent of which is the Federal share) reported in four HEW Audit Agency reports also remained outstanding long after the overpayments were made, and long after much of the overpayments had been identified. The four audit reports recommended that California refund the Federal share of the identified overpayments, but the State did not do so. As shown in the table on the following page, at the time we completed our fieldwork, HEW had issued letters disallowing Federal financial participation in $25,330,034 identified in three of the four audits, but the State appealed these disallowances, further delaying the refund.

State hospital overbillings for long-term care services (Report Number 70217-09)

One of HEW's audits consisted of an evaluation of State hospital billings for long-term care patients between October 1, 1971, and September 30, 1972. HEW's report on this audit, issued on December 28, 1976, identified $15,593,800 in overbillings. State Department of Mental Hygiene officials were aware that their billing procedures for the above period resulted in overbillings as early as 1972, and they took steps to revise their billing system. In 1976 when the HEW audit report was issued, State Medicaid agency officials conducted their own review and acknowledged that the State hospitals overbilled by $13,792,633 during the audit period in question, but they made no refund. In March 1978, HEW auditors reviewed available workpapers supporting the State's claim for the reduced overpayment amount. The auditors did not consider the State's support for the reduced amount adequate, and on October 10, 1978, HCFA issued a disallowance letter for the entire $15,593,800. However, on November 3, 1978, the State appealed the disallowance, and the Federal

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1/Of this total, $2.35 million may not be due or recoverable from the providers, but it does represent an overpayment from the standpoint of Federal financial participation in the payments to those providers. (See p. 29.)

HEW audit report Number	Date	Date of Disallowance letter	Date of State appeal	Audit findings/issues	Outstanding balance
70217-09	Dec. 1976	Oct. 1978	Nov. 1978	State hospital overbillings for long-term care patients between October 1971 and September 1972	$15,593,800
70213-09	Mar. 1977	May 1979	June 1979	Payments for long-term care were made to hospitals who had no agreement to provide such services and for which they were not certified. (Audit period, Jan. 1973-Dec. 1975.)	8,876,288
80215-09	Dec. 1977	Jan. 1979	Feb. 1979	Payments were made to fee-for-service providers for recipients covered under prepaid health plans. (Audit period, July 1975-Mar. 1977.)	a/859,946
90220-09	Mar. 1979	-	-	Dental service payments for recipients not eligible for Federal financial participation. (Audit period, Jan. 1974-Feb. 1977.)	a/1,489,748
----------same report as above---------				The Federal share of overpayments to community mental health providers, identified by State audits, were not refunded. (Audit period, July 1971-Mar. 1978.)	6,252,257
Total					$33,072,039

a/These overpayments may not be due or refundable from the providers of the services.

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share of the overpayment had not been refunded when we completed our fieldwork in August 1979, over 2-1/2 years after the audit was completed and the State agreed that they owed the $13,792,633.

Ineligible long-term care providers
(Report Number 70213-09)

In the second of the four audits, HEW reviewed payments to selected hospitals for long-term care services provided between January 1, 1973, and December 31, 1975. HEW's report, issued in March 1977, cited overpayments of $8,876,288 because the hospitals were not certified to provide long-term care, and they had no agreement with the State to provide such services. As such, they were ineligible providers. The State did not refund the overpayment although it was requested to do so in the report recommendations. On May 18, 1979, HCFA issued a disallowance letter for the Federal share of the overpayments, but the State appealed the disallowance on June 14, 1979, and had made no refund as of August 1979. The basis for the State's appeal was that, unless HEW could demonstrate that long-term care facilities were available in the area, the hospitals could bill for the services provided as acute care providers.

Prepaid health plan overpayments
(Report Number 80215-09)

In the third audit, HEW reviewed payments made during July 1, 1975, through March 25, 1977, and found that $859,946 in duplicate payments occurred because payments were made to fee-for-service providers for Medicaid patients who were also enrolled in, and eligible for, services under a Medicaid financed prepaid health plan. Although HEW's report was issued in December 1977, the State made no refund of the Federal share, and in January 1979, HCFA issued a disallowance letter for the Federal share of these overpayments. In February 1979, the State appealed the disallowance, and no refund had been made as of August 1979. Although the State acknowledged that the overpayments were made, it based its appeal on the premise that the error rate was reasonable, and HEW should participate with the State in the overpayments.

Ineligible dental service payments and community mental health service overpayments (Report Number 90220-09)

In the fourth audit report, issued on March 9, 1979, HEW evaluated the State's basis for classifying dental service costs as eligible for Federal financial participation. HEW also reviewed State audits of the Community Mental Health program. Because of deficiencies in the State's procedure for classifying individuals as eligible for Federal financial participation, HEW found that Federal financial participation was incorrectly claimed for $1,489,748 in dental service costs during January 1974 through February 1977. In its response to the audit report, the State agreed that Federal financial participation was incorrectly claimed for dental services, but the State was unwilling to refund the Federal share until it completed its own audit to determine the exact amount due.

HEW auditors also found that the State had not refunded the Federal share of $8,123,040 in overpayments to Community Mental Health providers identified by State audits. These overpayments occurred during July 1971 through March 1978. Of the $8,123,040, the State had collected $1,870,783 but had recorded the collection in a memorandum account and had not refunded the Federal share. The other $6,252,257 was being appealed by the counties. In its response to the audit report, the State agreed to, and subsequently did, refund the Federal share of the amount collected, but refused to refund the Federal share of the amounts under appeal claiming that it was not yet a documented overpayment. In August 1979, HCFA Region IX sent a proposed disallowance letter to HCFA headquarters for the overpayments found in this report, but a disallowance letter had not been sent to the State as of January 31, 1980.

Hospital and skilled nursing home cost settlements

In addition to the previously discussed audits, HEW completed an audit of hospital and skilled nursing facility cost settlements in May 1979. This audit identified about $36 million in overpayments--$18 million Federal share--however, we have not included it in our summary of HEW audit identified overpayments because a part of the $36 million is currently reflected in the State's records of outstanding overpayments discussed previously.

APPENDIX II

Of the $36 million reported by HEW, about $9 million represents overpayments to skilled nursing facilities which were originally reported by us in January 1973. At that time, we reported that $18.8 million in overpayments to skilled nursing facilities were outstanding and that minimal efforts had been made by the State's fiscal agent to collect them. We could not readily determine the current status of the other $9.8 million in overpayments we reported in 1973. In May 1979 HCFA Region IX sent a proposed disallowance letter to HCFA headquarters for the overpayments found in this report, but a disallowance letter had not been sent to the State as of January 31, 1980.

SIGNIFICANT FEDERAL FUNDS TIED UP IN STATE OVERPAYMENT REFUND PROCESSING CYCLE

The State in effect retains the Federal share of between $2 and $3 million in recovered overpayments indefinitely because its system for processing the recovered funds before returning the Federal share requires about 1 to 2 months. During this interim period, refunds are held in one of three interest-bearing suspense accounts--two maintained by the fiscal intermediary and one by the State. The combined balance in the three accounts was $3.4 million as of December 31, 1978, and the combined average quarterly balance during calendar year 1978 was about $2.8 million. The Federal Government receives some benefit from the interest earned from funds on deposit in the fiscal agent's suspense accounts because it is used to offset Medicaid program bank service charges. 1/ The Federal Government does not, however, share in the interest earned on funds deposited in the State suspense account.

After the refund processing cycle is completed, the State transfers the recovered funds to the Health Care Deposit Fund, which is used to pay Medicaid claims. Recovered funds are reported to HCFA on the next quarterly expenditure report submitted by the State after the funds are transferred.

1/Our review and analysis of the funds in the fiscal agent's suspense accounts disclosed that certain interest expenses were, in our opinion, inappropriately charged to the Medicaid program. This issue was discussed in our October 10, 1979, letter report to the Region IX Medicaid Director.

APPENDIX III

FLORIDA'S EFFORTS TO IDENTIFY AND RECOVER OVERPAYMENTS AND RETURN THE FEDERAL SHARE

Florida Medicaid program officials have not taken timely and aggressive actions to identify overpayments even though they were aware of probable overpayment situations, nor have they taken adequate steps to timely recover overpayments that have been identified.

As shown in the following table, accounts receivable and other records available at the State and fiscal agent showed about $10.3 million in substantiated overpayments outstanding at the time of our review in Florida (Jan. to May 1979). Much of this amount was long overdue, before efforts were begun to identify the specific amounts outstanding or to recover amounts which had been substantiated.

Type of overpayment	Outstanding balance (thousands)	
Overpayments recorded in State's accounts receivable records as of March 31, 1979:		
Institutional providers' cost settlement overpayments	$4,685	
Nursing home billing error overpayments	185	$4,870
Overpayments recorded in fiscal agent accounts receivable records as of May 23, 1979:		
Overpayments due to fiscal agent claims processing errors	4,547	
Overpayments due to nursing home reimbursement system revisions	845	5,392
Total		$10,262

Florida has not historically refunded the Federal share of overpayments unless and until they have been collected. Therefore, significant amounts of Federal funds have been tied up for long periods.

APPENDIX III

In addition to not recovering overpayments on a timely basis, the State has not timely returned the Federal share of refunds that have been made. This delay is due to a slow, cumbersome, and at times inoperative, State system for processing refunds. Because of these refund processing problems, the State had a balance of $2.4 million in available refunds as of December 31, 1978, for which the Federal share had not been returned. The balance of unprocessed refunds increased to $3.5 million by March 31, 1979; however, the State estimated and returned the Federal share of a portion of these unprocessed refunds on its December 1978 quarterly expenditure report. This report was submitted to HEW on February 19, 1979, after we began our review in Florida. Most of these unprocessed refunds were deposited into the State Treasury where they are managed by the State Treasurer. The Treasurer invests idle funds in interest-bearing securities, but HEW has not received any interest earned on invested Medicaid program funds.

MINIMAL EFFORTS TO RECOVER OVERPAYMENTS IN THE STATE'S ACCOUNTS RECEIVABLE RECORDS

The State has made only minimal efforts to recover nearly $4.9 million in overpayments recorded as receivables in the State Medicaid agency's records and still outstanding as of March 31, 1979. Attempts to collect overpayments consist mostly of written refund requests to the overpaid providers. However, such requests are discontinued for providers who appeal overpayment findings and the number of refund requests for nonappealed overpayments generally is two or less. Moreover, when overpaid providers appeal the overpayment findings or do not respond positively to the State's collection efforts, the State does not routinely exercise its authority to recover the overpaid amounts from current payments to these providers.

Institutional provider cost settlement overpayments not recovered

The State's accounts receivable records showed $4.7 million in yearend cost settlements due from hospitals and nursing homes as of March 1979. Of this total, $3.9 million was identified by desk reviews and field audits completed between July 1, 1976, and December 31, 1978.

Our analysis of the State's recovery activities for the overpayments identified by settlement audits and reviews completed during the 2-1/2-year period showed that Florida has not acted timely and diligently to recover the overpayments. For example, as of March 31, 1979, Florida had recovered only $1.1 million (22 percent) of the $5 million overpayments identified during the period.

Of the $3.9 million outstanding as of March 31, 1979, which was identified during the 2-1/2-year period, $3.7 million represented overpayment cases on which no recoveries had been made--the $0.2 million difference represented overpayment cases on which a partial recovery had been made by March 31, 1979 (i.e., installment repayment cases, etc.). For the $3.7 million for which no recoveries had been made, the overpayments had been outstanding an average of 16 months since identified--that is, since the audit or review report was issued causing the overpayments to be established as an accounts receivable.

State officials cited provider appeals of cost settlement overpayment findings as a major factor delaying recovery ($1.9 million or 51 percent of the $3.7 million had been appealed by providers). Our review showed, however, that as of March 31, 1979, the appealed cases had been outstanding no longer than the nonappealed cases, and that Florida's recovery efforts for nonappealed cases were no more extensive than for appealed cases. Moreover, Florida had not acted to recoup from current payments to overpaid providers any of the $1.7 million not under appeal even though these overpayments had been outstanding an average of 16 months and the providers had made no refunds in response to State collection requests. Also, Florida's efforts to collect 24 nonappealed cases, valued at $585,000, were limited to one refund request, even though these overpayments had been outstanding 14 months since identified. Similarly, efforts were limited to two refund requests for another 23 cases, valued at $508,000, that had been outstanding 17 months since identified.

In addition to the average 16 months that the $3.7 million overpayments had been outstanding since they were identified, an average of 18 months lapsed between the end of the providers' cost year and the time the overpayments were identified or substantiated by field audit or desk review.

Hospital settlement audits and desk reviews are made by the Medicare program fiscal intermediaries in Florida. However, the State makes the nursing home desk reviews and either conducts nursing home field audits with internal staff or contracts with certified public accounting firms. For the 49 nursing home field audit overpayments included in our analyses, an average of 28 months lapsed between the end of the providers' cost year and the date the audit report was issued identifying the overpayment. For some nursing home audits, considerable time lapsed between the completion of audit fieldwork and the issuance of a final audit report. State officials attributed this delay to time spent reviewing certified public accounting firm audits to assure compliance with State and Federal requirements.

Nursing home billing error overpayments not recovered

The State's accounts receivable records also showed $185,000 in billing error receivables due from nursing homes as of March 31, 1979. These overpayments were identified by State District Office employees through reviews of nursing home billing and payment records. The overpayments resulted from errors, such as billings for ineligible recipients and incorrect computations of recipients' incomes to be applied to the cost of care.

Much of this amount was identified and recorded as receivables during 1974-77 and essentially all the $185,000 in outstanding overpayments was identified and recorded as receivables before January 1, 1978. This is the date that Florida contracted with a fiscal agent for processing and paying Medicaid claims.

DELAYS BY THE FISCAL AGENT IN IDENTIFYING AND RECOVERING OVERPAYMENTS

During calendar year 1978, providers (hospitals, nursing homes, physicians, dentists, and pharmacies) were overpaid about $7.2 million because of fiscal agent claims processing errors. Also, the fiscal agent, in November 1978, identified an additional $845,000 in overpayments to nursing homes after a new cost reimbursement system for nursing homes was

retroactively implemented to October 1977 by order of a U.S. district court. 1/

As of May 1979, about $4.5 million of the claims processing overpayments and the $845,000 in nursing home cost reimbursement system overpayments were still outstanding. None of these overpayments had been recorded in the State's official accounts receivable records, but they were recorded as receivables in the fiscal agent's records.

Delay in identifying and recovering claims processing error overpayments

Florida, effective January 1, 1978, contracted with a fiscal agent to develop a Medicaid management information system (MMIS) for processing and paying provider claims. Although MMIS operations began on schedule, problems with the system soon caused a backlog in claims processing and produced many errors (overpayments and underpayments) in provider claims that were processed. Both the State and the fiscal agent were aware as early as May 1978 of the claims processing problems and that substantial overpayments had been and were continuing to be made. These problems were the subject of three reports issued May 31, August 23, and November 28, 1978, by the Office of Audit Services, State Department of Health and Rehabilitative Services. 2/ These reports recommended immediate recovery of all the processing claims overpayments; however, $4.5 million was still outstanding when we completed our fieldwork in Florida in May 1979.

Initially, the fiscal agent attempted to correct system problems that were causing the backlog of unprocessed claims, and it was December 1978 before any efforts to identify and recover the overpayments were begun. Underpayments that were identified by the fiscal agent were immediately repaid to providers or, when applicable, offset against provider overpayments. However, recovery of $7.2 million in net overpayments identified and recorded in the fiscal agent's receivable records has not been as timely.

1/Florida Nursing Home Association v. Page (Civil No. 77-559 (S.D. Fla., Sept. 16, 1978).

2/The Department of Health and Rehabilitative Services is an umbrella agency in which the State Medicaid Office is organizationally located.

Of the $7.2 million, $3.2 million was identified and recorded in the receivable records in December 1978. As of May 23, 1979, at least $1.3 million (about 41 percent) of the $3.2 million remained outstanding. In addition, except for about $5,500, the fiscal agent did not identify and document the remaining $4 million in overpayments until May 1979.

The following table summarizes the fiscal agent's identification and recovery activities through May 23, 1979, for the $7.2 million in claims processing error overpayments.

Period	Identified	Recoveries (note a)
December 1978	b/$3,214,791	$ 745,973
January to May 1979	5,495	501,828
May 1979	4,014,883	1,440,068
Total	$7,235,169	$2,687,869
Outstanding balance May 23, 1979		$4,547,300

a/Recoveries made during each period were for funds identified both during the same period and during the previous periods.

b/About $1.3 million of this amount was included in the May 23, 1979, outstanding balance of overpayments.

Delays in recovering overpayments caused by new nursing home reimbursement system

Timeliness also has been a problem in recovering $845,000 in overpayments to nursing home providers, who received the funds before implementation of a cost-related reimbursement system. In September 1978, a U.S. district court (in the Florida Nursing Home Association case referred to on pp. 36 and 37 of app.) ruled that a new system, based on "reasonable cost," was to be retroactively implemented to October 1977.

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In November 1978 the fiscal agent recomputed the payments nursing homes would have received had the system been in effect beginning in October 1977. Homes found to have been underpaid received the net amount due promptly. However, neither the State nor the fiscal agent attempted to recover the $845,000 in overpayments. As of May 1979 when we completed our review, the fiscal agent had not even requested repayments. Instead, at the urging of the State nursing home's association, the State Medicaid agency had requested HEW to agree that the homes could be grandfathered into the new rate system and thus not required to repay the $845,000. In March 1980, a HCFA regional official informed us that HEW had agreed to the State agency's request with certain limits on the amount of overpayments to be forgiven. However, the portion of the $845,000 in overpayments to be forgiven has not been determined.

DELAYS IN RETURNING THE FEDERAL SHARE OF RECOVERED OVERPAYMENTS

Florida deposits Medicaid program refunds in a holding account of the State Treasury until it can determine the providers and recipients to whom the refunds pertain and the applicable Medicaid service accounts to be credited. Following these determinations, the State processes refunds out of the holding account and subsequently reports the Federal share to HCFA as an adjustment to expenses claimed on the quarterly expenditure report.

Because researching and processing refunds require considerable time, large fund balances remain in the holding account and lengthy delays occur before the Federal Government receives credit for its share of refunds. Historically, this delay has been significant, but it became even more acute during 1978 because the fiscal agent employed by the State in January 1978 had no computer program for processing refunds. The only refunds processed and reported during the first three quarters of 1978 were those that could be processed by the State, independent of the fiscal agent's input.

Normal processing delays incurred before employing the fiscal agent had resulted in an average holding account balance of about $790,000 for the seven quarters ended December 31, 1977. For the four quarters of 1978, however, the average holding account balance was about $1.5 million and the account balance totaled $2.4 million as of December 31, 1978. Applying the Federal sharing rate of 56 percent for Florida, the

average amount of Federal funds tied up in the holding account in 1978 was about $840,000. Using the Office of Management and Budget's 9-percent 1/ interest rate for calculating savings for improved cash management, the balance in the holding account represents an annual interest cost to the Federal Government of about $75,000.

Although the fiscal agent was still unable to process refunds by December 31, 1978, the State credited the Federal Government for $1.7 million on the December 31, 1978, quarterly expenditure report submitted to HEW on February 19, 1979. About $1.5 million of this amount was based on the State's estimate of the Federal share of refunds pending processing. However, after submitting the December quarterly report, Florida officials found that they had overestimated the amount of credit due the Federal Government and adjusted the March 1979 expenditure report by $177,000 to compensate for the excessive credit.

As of March 31, 1979, the holding account balance had increased to $3.5 million, of which about $1.1 million represents refunds for which the Federal Government had received no credit. This $1.1 million included $832,000 in refunds deposited in the holding accounts pending processing and $253,000 in returned provider payment checks. Rather than give the Federal Government immediate credit for returned checks, Florida chose to process them as they would other refunds and thus delay the credit to the Federal Government.

Florida had also failed to credit the Federal Government for its share of $483,000 in refunds processed through the holding account after July 1, 1976, but before the fiscal agent assumed refund processing responsibilities in January 1978. State officials informed us that they would, and subsequently did, credit the Federal Government for its share (about $280,000) of these refunds on the March 31, 1979, expenditure report.

1/As discussed on p. 4, the Office of Management and Budget in October 1979 stated that Federal agencies should use an interest rate of 9 percent in calculating interest savings.

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SOUTH CAROLINA'S EFFORTS TO IDENTIFY AND RECOVER OVERPAYMENTS AND RETURN THE FEDERAL SHARE

Even though HEW, South Carolina, and State contract agents identified many overpayments to South Carolina Medicaid providers as early as 1973, the State's Medicaid agency allowed more than $4.5 million in such overpayments to accumulate before beginning serious recovery efforts in October 1977. The State made no significant recoveries, however, until late 1978, and as shown in the table on the following page, about $2.1 million was still outstanding as of May 1979.

In February 1979, the State completed revisions to its procedures for audit settlement and overpayments recovery. The revised procedures call for timely provider notification of overpayments, timely recovery following notification, legal collection actions, charging interest on installment repayments, and overpayment recovery before appeal resolution. These procedures have not, however, been consistently applied to all outstanding overpayments.

In addition, the State has not been timely in returning the Federal share of refunds which providers have submitted. As a result, South Carolina has held large balances of unprocessed refunds in the State's Treasury. As of February 28, 1979, this balance was about $1.5 million--more than $1 million of this amount represented Federal funds. Although the State earns interest on idle funds in the State Treasury, it does not share this income with the Federal Government.

DELAYS IN RECOVERING OVERPAYMENTS FROM INSTITUTIONAL PROVIDERS

South Carolina's Department of Social Services, the State agency that administers the Medicaid program, has been auditing nursing homes and hospitals, at least on a limited basis, since 1973. However, for several years the agency, while experiencing a number of organizational changes, became delinquent in finalizing audit findings, computing overpayments, and collecting identified overpayments. In late 1977, the agency increased its efforts to settle nursing home and hospital audits, eventually substantiating and recording as receivables about $3.5 million in overpayments. Significant recoveries of the overpayments began in late 1978, but $1.4 million of the substantiated amount was still outstanding in May 1979.

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Types of overpayments	Total overpayments identified	Outstanding balance
	(thousands)	
Overpayments identified through cost settlement audits of institutional providers:		
Nursing home cost settlements, 1972-76	$2,282	a/$ 758
Hospital cost settlements, 1973-77 (excluding 1974 cost year previously settled)	1,250	658
Total - institutional providers	3,532	1,416
Overpayments to noninstitutional providers:		
Overpayments identified through cost settlement audits of transportation providers (1973-78)	664	b/611
Overpayments identified through fiscal agent post-payment claims review	315	37
Overpayments identified through HEW Project Integrity (note c)	18	4
Total - noninstitutional providers	997	652
Total - institutional and noninstitutional providers	$4,529	$2,068

a/The State recognizes only $535,000 of this amount as due from providers (see p. 46 of app.).

b/The State recognizes only $267,000 of this amount as valid accounts receivables (see p. 48 of app.).

c/Project Integrity is a national initiative by HEW's Office of Inspector General aimed at detecting and preventing fraud and abuse in the Medicare and Medicaid programs.

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Organizational changes affecting responsibility for settlement audits

In February 1973, the Department established an Audit and Control Unit and assigned it responsibility for auditing Medicaid and various social service programs. In July 1975, the Department contracted with the Medicare program intermediary for hospital and nursing home audits. Under terms of the common audit agreement, the intermediary was to audit provider cost reports for periods ending after June 30, 1974.

Between February 1973 and July 1975, the Audit and Control Unit audited several Medicaid providers; however, coverage was far from complete because, according to Department officials, the Unit's staff was also involved in auditing other programs, establishing interim hospital rates, and developing information for nursing home contract negotiations. In addition to audits by the Audit and Control Unit and the Medicare intermediary, certified public accounting firms under contract with HEW conducted two Medicaid program nursing home audits which included an evaluation of nursing home cost reports.

When first established in February 1973, the Audit and Control Unit was responsible for overpayment collection as well as audit and overpayment identification. Initial collection attempts, however, met with provider resistance, and the Audit and Control Unit was instructed to arrange for collections without adversely affecting provider operations. In October 1973, collection responsibility passed from the Audit and Control Unit to the Medicaid program office, but procedures for referring audit results to the program office for collection were not established until July 1976.

In February 1974, the Audit and Control Unit was placed within the Department's Bureau of Finance instead of reporting directly to the Commissioner of the Department as it had done previously. The Audit and Control Unit remained under supervision of the Bureau of Finance until October 1975. At that time, control passed to the Department's Chief of Staff and the Unit's name was changed to the Office of Audits. In early 1978, the Office of Audits again became an independent unit reporting directly to the Commissioner.

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Nursing home overpayment recovery efforts

In October 1977, the Medicaid program office began to review open audits to compute settlement amounts. In early 1978, however, the Department transferred responsibility for settlements back to the Office of Audits (previously Audit and Control), and in May 1978, the Commissioner employed outside legal counsel to assist the Department in arranging settlements of provider audits. Following these actions aimed at strengthening the settlements audit and overpayment recovery processes, about $2.3 million in nursing home overpayments were substantiated and as of May 1979 about $1.5 million of this amount had been recovered. The other $757,546 was still outstanding. Of the $2.3 million in overpayments identified, about $1.5 million was applicable to cost years 1972-75 and about $0.8 million was applicable to cost year 1976. 1/

When the Office of Audits began reviewing prior audits to make final settlements, it concentrated on open audits for cost years 1972-75 because the State's statute of limitations prohibited recoveries for prior periods. The Office of Audits also gathered data from providers to compare the Medicaid rate for cost years 1974 and 1975 with fees charged to private paying patients during the same period. The Office undertook this additional review step to comply with provisions in the State Medical Plan and provider contracts limiting Medicaid payments to the amount charged to private paying patients.

The Office of Audits identified the following total net overpayments.

1/The cost year is a 12-month period for which the provider must report its program costs, and these costs are used as the basis for paying the provider during a subsequent contract period.

Cost year	Contract service period	Net overpayment identified	Private pay adjustment	Net total overpayments
1972	Feb. 73-Jan. 74	$ 64,877	$ -	$ 64,877
1973	Feb. 74-Feb. 75	79,284	-	79,284
1974	Mar. 75-Feb. 76	437,150	235,895	673,045
1975	Mar. 76-Jan. 77	273,751	399,569	673,320
Total		$855,062	$635,464	$1,490,526

When the Department tried to collect the overpayments, many providers threatened to appeal the audit findings. To avoid such appeals, Department officials agreed to accept 85 percent of the overpayments as final settlement for overpayments identified for cost years 1972-75. According to Department officials, they based their decision on the following factors:

--They might not win all appeals.

--They would incur significant costs in defending the appeals.

--Appeals would delay receipt of refunds even further.

--The Medicaid program would eventually absorb much of the providers' appeal costs in future rate periods.

The negotiated settlement agreement reduced the net total refund due from providers from $1,490,526 to $1,268,305. 1/ However, HEW did not agree to participate in the 15-percent writeoff. Actual recoveries have been as follows:

1/This amount does not equal 85 percent of $1,490,526 because of rounding and other minor adjustments the State made in its computations.

Total amount identified		$1,490,526
Amount recovered:		
October - December 1978	$860,770	
January - March 1979	130,510	
April - May 21, 1979	46,955	
Total recovered through May 21, 1979		1,038,235
Outstanding balance at May 21, 1979		$ 452,291

For the cost year 1976 (contract period Feb. 1977 - Dec. 1977), the Department identified $791,848 as due the State and is attempting to recover 100 percent of these overpayments. Collections thus far have been as follows:

Total amount identified		$791,848
Amount recovered:		
January - March 1979	$427,438	
April - May 21, 1979	59,155	
Total recovered through May 21, 1979		486,593
Outstanding balance at May 21, 1979		$305,255

The total outstanding balance for cost years 1972-76 was $757,546 1/ as of May 21, 1979. The Department had not completed the settlement computations for cost year 1977 (contract period Jan. - Oct. 1978) at the time we completed our review.

Hospital overpayment recovery efforts

Even though the hospital provider audits were conducted for cost years 1973-77, the Department did not try to settle the audits, except for cost year 1974, until January 1979.

1/Because of the negotiated settlement of the 1972-75 cost years, the State recognizes receivables from providers of only $535,325.

Department officials could not clearly explain why they settled this particular cost year, but not previous and succeeding years. Hospital overpayments for 1973-77 (excluding the 1974 audits already settled) totaled $1,250,023 as of May 21, 1979. Of this amount, $591,558 had been recovered leaving an outstanding receivable balance of $658,465.

Recent actions to improve overpayment recoveries

The Department completed revision of its Medicaid audit settlement procedures and accounts receivable procedures in August 1978 and February 1979, respectively. Under the revised system, the Office of Audits certifies audit settlements as accounts receivable and notifies the affected providers. Providers can appeal the overpayment, but appeals supposedly do not delay recovery efforts. Upon notification, the providers have 30 days to either make full repayment or to arrange for an installment repayment at 8-percent interest. If they do not do so, the Department is required to initiate legal collection actions. The new procedures also enable the Department to offset certified receivables against subsequent provider payments.

DELAYS IN RECOVERING OVERPAYMENTS FROM NONINSTITUTIONAL PROVIDERS

The State agency has been slow in recovering nearly $1 million in overpayments identified during audits of selected noninstitutional providers. The outstanding balance in May 1979 was about $652,000, and most of this amount had been outstanding for several years. The State agency, however, does not recognize $344,000 of the outstanding balance as a valid receivable because special legal counsel for the agency advised that the Medicaid payments which generated the overpayments were made under fixed-price contracts. However, Federal regulations require that, to be eligible for Federal financial participation, such payments must be on a cost-related basis.

Transportation provider overpayment recovery efforts

The State Medicaid agency contracts with various Community Action Agencies to provide certain Medicaid clients with transportation to and from providers of health services. Between January and November 1976, the Office of Audit completed 17 audits of such providers covering contract service periods

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December 1, 1973, through September 30, 1975, and identified $605,000 in overpayments. The auditors assumed the provider contracts were cost reimbursable. Although four providers voluntarily submitted partial refunds totaling $53,000, the providers refused to make further refunds, citing their non-profit status as the reason, and filed a Federal court suit against HEW and the State to prohibit recovery. However, the court dismissed the case because the providers had not exhausted their administrative appeal rights.

The providers subsequently appealed the audit findings, but the appeal ended after the special counsel for the Department advised that in his opinion the transportation contracts were fixed price, not cost reimbursable. Evaluated on a fixed-price basis, the overpayments totaled $249,000. Of the $53,000 voluntarily refunded, $41,000 related to this $249,000.

Based on counsel's opinion, the State reduced the transportation audit receivables to $208,000 ($249,000 minus $41,000). But for purposes of Federal financial participation, the overpayment may be $605,000, of which $552,000 is still outstanding ($605,000 minus $53,000) because the transportation contracts were made subject to Federal laws and regulations, and HEW advised the State that Federal regulations require that reimbursement of such providers be on a cost-related basis.

From November 1977 to December 1978, the Office of Audit completed seven additional transportation audits covering contract service periods October 1, 1975, through June 30, 1977, and identified another $59,000 in overpayments. None of these have been recovered; therefore, the total outstanding overpayments for purposes of Federal financial participation may be $611,000 ($552,000 plus $59,000) although the State currently recognizes only $267,000 ($208,000 plus $59,000) as valid receivables.

Although the Department has recorded the $267,000 as accounts receivables, it was not collecting them. A "gentlemen's agreement" supposedly exists whereby the Department will not attempt to recover these overpayments because the providers supposedly do not have money to repay them. Department officials said that the State legislature may appropriate money to refund the Federal share of these overpayments, but no such appropriation had been made as of May 1979, and the amount of overpayments to be refunded to HEW had not been resolved.

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Other noninstitutional provider overpayment recovery efforts

The State Medicaid agency's fiscal agent processes claims for professional services provided by physicians, dentists, opthalmologists, optometrists, chiropractors, podiatrists, ambulances, and laboratories. In July 1973, the fiscal agent initiated postpayment reviews of selected providers and identified $315,000 in overpayments--only $57,000 of which had been collected--before terminating the project in June 1977. At that time, the fiscal agent turned all its case files over to the State agency which recovered or was recovering through installment payments or offset against current claims another $220,800. As of May 1979, eight cases, involving $37,200, were still not resolved. Three of the eight were in litigation and the other five were under appeal.

In 1977, HEW's Office of Inspector General instituted the Project Integrity review, a national initiative aimed at detecting and preventing fraud and abuse in the Medicare and Medicaid programs and in which HEW and State agencies jointly participated. By August 1978, the review had resulted in the referral of 29 providers to the State for possible fraud prosecution. The State could not support fraud charges but took administrative action against 20 providers and identified $18,000 in overpayments. About $4,000 of this amount had not been collected as of May 1979.

DELAYS IN REFUNDING THE FEDERAL SHARE OF RECOVERED OVERPAYMENTS

Medicaid funds recovered by the Department are deposited directly into the State Treasury, along with State funds from many other sources. Such recovered funds are initially accounted for in a refund holding account. The State Treasurer, who is responsible for paying State bills, controls and manages all funds in the Treasury. According to Department officials, excess funds in the Treasury are invested in short-term, interest-bearing securities, but the Medicaid program receives none of the interest earned. Thus, the Federal Government receives no financial benefits from idle Medicaid funds in the Treasury.

The Department notifies the Treasurer's office when holding account funds are to be transferred into the Medicaid claims payment account. But the Department does not have funds transferred until it has acquired all information

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necessary to match recovered amounts against appropriate provider, recipient, service, and payment period. This information is used to determine, among other things, the Federal share of the recovered funds. However, research and processing activities have not been timely, causing a large balance to be continually tied up in the holding account. As of February 28, 1979, the holding account balance totaled $1,460,000, of which more than $1,000,000 represented Federal funds. Of the $1,460,000, 24 percent ($349,000) was deposited in the holding account before June 30, 1978. Another $102,000 of the remaining funds had been in the account more than 3 months.

As of July 1978, the Department began keeping records on the age of Medicaid funds in the State Treasurer's account. Officials believe this information will improve the State's timeliness in returning the Federal share of recovered Medicaid overpayments.

APPENDIX V

GEORGIA'S EFFORTS TO IDENTIFY AND RECOVER OVERPAYMENTS AND RETURN THE FEDERAL SHARE

Georgia's system for recovering overpayments is highly fragmented and does not insure that all identified and potential overpayments are investigated, and recovered on a timely basis.

The recovery system for overpayments other than those identified through hospital settlement audits depends largely on voluntary refunds by providers. Georgia received about $11 million in cash refunds between July 1, 1976, and September 30, 1978. According to State Medicaid agency officials and based on our tests of selected refund cases, the receipt of the cash was the first knowledge that the State Medicaid agency had that most of the overpayment situations even existed. Furthermore, as of December 1978, the State Medicaid agency had not recovered about $123,000 of $207,000 in overpayments that were identified by or reported to its personnel between July 1, 1976, and September 30, 1978. Moreover, at least $22,000 of the identified amount had not been referred to the agency's collection unit.

Hospital overpayments are recovered through a unique system of adjusting subsequent years' reimbursement rates. However, the State Medicaid agency does not maintain accounts receivable or other summary records showing the balance of outstanding overpayments due to hospital rate settlements. The State is also late in completing hospital settlements, allowing potential overpayments to remain unidentified and unrecovered for extended periods.

Even after receiving overpayment refunds, Georgia has been slow in crediting the Federal Government with its share. Georgia deposits and holds cash refunds in a bank holding account pending processing back into the Medicaid program and refund of the Federal share. Between July 1977 and March 1979, an average of almost $1 million was continually tied up in the refund processing system. The State earned interest on some of these funds, but had not shared interest income with the Federal Government before our review.

SYSTEM FOR RECOVERING IDENTIFIED OVERPAYMENTS LACKS ADEQUATE PROCEDURES AND CONTROLS

Various Medicaid agency organizational units and employees have had at least limited involvement in identifying and recovering overpayments other than those disclosed by yearend cost settlement audits of hospitals. 1/ However, the Medicaid agency had not developed and implemented adequate Medicaid overpayment recovery procedures and controls. Procedures for documenting information received about actual and potential overpayment situations and for following up on such situations to insure recovery or appropriate resolution did not exist. Also, formal records to account for identified overpayments and for recovering and tracking recovery progress did not exist.

The Medicaid agency's Benefits Recovery Unit receives and processes cash refunds, solicits refunds where third-party payment liabilities 2/ are believed to exist, and serves as the agency's collection unit. The Investigation and Compliance Division investigates suspected fraudulent or abusive practices, sometimes identifying overpayments during these activities. 3/ Inquiry Unit employees provide telephone assistance to providers, recipients, and other individuals and, through these contacts, sometimes learn about actual or potential overpayment situations. Also, management personnel for the various program services (i.e., dental, hospital, and physician) become aware of actual or potential overpayments through their contacts with providers, recipients, and other individuals. However, the Medicaid agency had not provided these units and employees with any written guidance concerning (1) their roles and responsibilities for identifying and

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1/The system for managing and controlling hospital settlement audit overpayments is discussed on page 54 of the appendix.

2/This refers to situations where a recipient has other health insurance which should have paid for the services provided, or where the recipient was the victim of an accident and a third party or their insurers were liable for the medical cost incurred.

3/Cases for investigation are referred to this unit from various sources, such as other agency units and providers and through responses by recipients to Explanation of Medicaid Benefit questionnaires.

recovering overpayments or (2) what to do when they learn about actual or potential overpayment situations.

In the absence of written guidance, procedures, and summary control records, we attempted to assess the adequacy of Georgia's overpayment recovery system by

--analyzing a sample of overpayment refunds received by the Medicaid agency,

--reviewing available agency records to determine the disposition of overpayments identified by the various units and employees, and

--discussing agency practices with officials and employees in the various organizational units involved in identifying and collecting overpayments.

The State Medicaid agency, between July 1, 1976, and September 30, 1978, received almost $11 million in cash refunds from Medicaid providers. We sampled and analyzed $5.5 million of this amount received between July 1, 1977, and June 30, 1978, and found no evidence that the State had identified 94 percent of the overpayments before receiving the cash refund. The possibility exists, however, that Medicaid agency personnel had learned about some of the overpayments before receiving the voluntary refunds, but because of the absence of procedures, they did not record the information in the Medicaid records for followup and control purposes.

The records showed that agency personnel knew about the other 6 percent and requested the refunds from providers. Based on the sample results, about 68 percent of the cash refunds were from providers who had also received payment for the services from a third-party insurer (insurance company or Medicare). The other 32 percent of the cash refunds involved such things as duplicate payments, payments to the incorrect providers, improper charges for services provided, and routine billing and claims processing errors. The analysis also showed that Georgia was not timely in returning the Federal share of these cash refunds (see p. 57 of app.).

In addition to analyzing a sample of the cash refunds, we attempted to determine the number and dollar value of overpayments identified and documented from July 1, 1976, to September 30, 1978, the same period the cash refunds were received, and the disposition of these overpayments. Due to

the absence of formal records and written procedures and changes in personnel, we do not know whether we identified every known overpayment situation; however, we found evidence that at least 416 overpayments involving $207,000 were identified by the several units and agency personnel involved in activities which may have permitted them to identify such overpayments. The overpayments were essentially the same types as those for which the agency was receiving voluntary cash refunds.

By tracing these overpayments through the agency's recovery system, we learned that as of December 31, 1978, only $84,000 of the $207,000 had been recovered, and based on $48,000 of this amount for which sufficient information was available, we estimate that the recovered overpayments were outstanding an average of 17 months after they had been identified. The status of the $123,000 that had not been recovered as of December 31, 1978, was as follows:

Status	Amount
Involved in legal proceedings	$ 42,000
Balance of amounts being recouped from providers' current billings	42,000
No evidence of any collection action	35,000
Written off as uncollectable	4,000
Total	$123,000

Analysis of the $35,000 for which no action had been taken showed that the overpayments had been identified for 11 months and that $22,000 of this amount had not even been referred to the Benefits Recovery Unit for collection.

HOSPITAL COST SETTLEMENT OVERPAYMENTS ARE NOT TIMELY IDENTIFIED AND RECOVERED

Georgia reimburses hospital providers using an interim estimated reimbursement rate, but adjusts for over- or underpayments after the providers' operating period is completed and actual costs are known. However, Georgia does not maintain summary records of the outstanding over- and underpayments. Also, Georgia is not current in completing settlement reviews and audits, causing a backlog in potential over- or underpayments.

System for liquidating over- and underpayments

The difference between the reimbursement hospitals receive through the interim reimbursement rate and their actual allowable costs of providing such services constitutes an over- or underpayment. Hospital providers submit cost reports at the end of their fiscal year itemizing their costs of providing Medicaid services. Georgia examines these reported costs through desk reviews or field audits of the providers' cost reports.

The Georgia Medicaid agency contracts for desk reviews and field audits with the two Medicare program fiscal intermediaries. Rather than immediately settling with providers, Georgia liquidates any identified over- or underpayments by adjusting the interim reimbursement rate for the next period--a process referred to as carry-forward. For example, assume a provider billed Medicaid total allowable charges of $500,000 and received payments totaling $475,000 based on an interim reimbursement rate of 95 percent (.95 x $500,000 = $475,000). Also, assume the provider's yearend cost report shows actual allowable costs of only $450,000; the provider was overpaid by $25,000 ($475,000 - $450,000). Were it not for the overpayment (or if the overpayment was immediately repaid), the interim rate for the ensuing period would be set at 90 percent of billed charges ($450,000 ÷ $500,000 = .90), but in actuality it would be set at 85 percent ($425,000 ÷ $500,000 = .85) in an attempt to recover the prior period overpayment.

Georgia does not charge providers interest on overpayments recovered by the carry-forward process, nor does it pay interest on underpayments carried forward.

Georgia does not maintain accounts receivable and payable or other summary control records summarizing the amounts due from and to providers as a result of rate settlements and subsequent collections or payments. The amount due from or to a particular hospital as of the last settlement completed can be determined only by reviewing the individual hospital cost settlement files.

Hospital cost settlement reviews and audits are not current

Timely hospital cost settlements are not being made because the State has not been timely in completing the prerequisite settlement reviews and audits. Therefore, potential over- and underpayments have remained unliquidated for extended periods.

The State Medicaid agency has contracted with two Medicare fiscal intermediaries for conducting most hospital settlement reviews and audits. However, 10 hospitals are not covered by these common audit agreements.

HCFA Region IV financial management analysts, after the beginning of our work in Georgia, reviewed the status of hospital settlements as of March 30, 1979, and found that:

--One of the intermediaries had a backlog of 195 unsettled hospital cost reports available, 104 of which were for cost years ended in 1977 or before.

--The other intermediary was basically current with its cost settlements. It had only two unsettled cost reports for years before 1978.

--Seven of the 10 hospitals which were not covered by a common audit agreement were being reimbursed at 100 percent or more of their allowable billed charges even though most of these had not had a rate review and cost settlement since 1972.

According to officials of the intermediary with a backlog of 195 unsettled cost reports, the large number of unsettled rate years is because the State Medicaid agency did not timely provide them with carry-forward cost data for the initial year they had audit and settlement responsibility. The officials, in July 1979, said that they had finally received the carry-forward data, but would be further delayed in settling these rate years because of limited staff.

HCFA found that one of the hospitals not covered by the common audit agreement, which had been receiving interim reimbursements based on 100 percent of allowable charges since 1972, should have been receiving only 12 percent of charges considering the cumulative prior year overpayments. Another of the 10 hospitals was being reimbursed at 104 percent of allowable charges according to State Medicaid agency records

even though reimbursement guidelines prohibit interim payments in excess of 100 percent of allowable charges. As of July 15, 1979, none of the 10 hospitals had been scheduled for desk review or field audit in 1979.

DELAYS IN REFUNDING THE FEDERAL SHARE OF RECOVERED OVERPAYMENTS

Georgia deposits Medicaid program refunds in a special bank holding account until ready to research and process the Federal share. Researching and processing procedures take a considerable amount of time and, thus, Federal Medicaid funds are tied up unnecessarily resulting in an annual interest cost of about $56,000. Analysis of a random sample of 215 refunds received by the State between July 1, 1977, and June 30, 1978, showed that the State had refunded the Federal share in 201 cases in the sample as of December 31, 1978--about half of these refunds were reported on the expenditure report for the quarter in which they were received. But the remaining refunds involved a reporting delay of at least one quarter, and the Federal share had not been refunded at all in 14 sample cases which had been in the holding account an average of more than 16 months.

Because of normal refund processing timelags, and because some refunds remained in the holding account for extended periods, the average monthend account balance since July 1, 1977, has been about $945,000. Assuming a Federal cost-sharing rate of 65.82 percent (the lowest Federal rate since July 1, 1965), an average of $622,000 in Federal funds has been continually tied up in the account. Although the State periodically invested some holding account funds in interest-bearing certificates, it had not shared the earned interest with the Federal Government. However, after our review, State Medicaid and HCFA regional officials agreed that Georgia would share interest earned on existing and future interest-bearing investments.

Using the Office of Management and Budget's 9-percent interest rate for calculating savings for improved cash management, the balance in the holding account represents an annual interest cost to the Federal Government of about $56,000.

In some instances, the State lost track of refunds and failed to transfer them from the holding account, where they remained for extended periods of time. We notified State Medicaid program officials that the holding account bank balance did not agree with State records of individual refunds received and deposited in the account and, as a result, program officials improved controls over the deposited funds. They began a special review to reconcile the bank balance with State records and initially identified $311,284 in the holding account which could not be reconciled with individual refund receipts. By researching State records and contacting providers, they have accounted for $131,606 of this amount--$6,460 were not Medicaid program refunds, and the other $125,146 represented 1976 and 1977 Medicaid recoveries.

As of April 19, 1979, $179,678 of the $311,284 still remained unreconciled. While program officials were hopeful that additional refunds could be reconciled with individual refund receipt records, they were not optimistic that the total remaining balance could ever be reconciled.

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