DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

July 3, 2006

Report Number: A-06-06-00036

Mr. Jerry Phillips
Acting Medicaid Director
Bureau of Health Services Financing (Medicaid)
1201 Capitol Access Road, P.O. Box 91030
Baton Rouge, Louisiana 70821

Dear Mr. Phillips:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Louisiana's Accounts Receivable System for Medicaid Provider Overpayments." A copy of this report will be forwarded to the action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-06-06-00036 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, M.D.
Regional Administrator
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1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

July 2006
A-06-06-00036

Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

This review is part of a multistate audit of accounts receivable systems for Medicaid provider overpayments. An overpayment is a payment to a provider in excess of the allowable amount.

Section 1903(d)(2) of the Social Security Act (the Act), as amended by section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985, is the principal authority that the Centers for Medicare & Medicaid Services (CMS) cites in requiring States to refund the Federal share of overpayments to providers.

The Act allows a State 60 days from the date of discovery of an overpayment to recover or attempt to recover the overpayment from a provider before the State must refund the Federal share of the overpayment, whether or not it recovers the overpayment from the provider. The implementing Federal regulations require States to refund the Federal share of overpayments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 report (CMS-64) as an offset to expenditures for the quarter in which the 60-day period ends. We defined this offset as an overpayment adjustment.

The Act also states that the Federal share of a Medicaid overpayment does not have to be repaid to the Federal Government if the State is unable to recover the overpayment because the debt has been discharged in bankruptcy or is otherwise uncollectable. Federal regulations provide that if the State has reported an overpayment and subsequently determines that the provider is bankrupt or out of business, the State may reclaim the overpayment on the CMS-64. We defined these types of transactions as reclaiming adjustments.

For the audit period October 1, 2002, through September 30, 2003, Louisiana (the State) reported a total of approximately $85.1 million ($60.8 million Federal share) in overpayment adjustments. We expanded the scope of our audit for reclaiming adjustments to include the 3 previous Federal fiscal years (FYs), 2000 through 2002, because the State agency initially could identify only one writeoff made during FY 2003. The State reclaimed approximately $12.53 million during the 4 FYs.

OBJECTIVE

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

SUMMARY OF FINDINGS

The State did not report all Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements. Fourteen of the 18 reclaiming adjustments that we reviewed, totaling $1,137,456 ($836,391 Federal share), were improper.

- For five adjustments, totaling $53,950 ($40,001 Federal share), the State did not determine whether the providers receiving overpayments had filed for bankruptcy in Federal court or were out of business. In addition, for two adjustments totaling $993,900, ($730,417 Federal share), a Federal court denied the provider's petition for bankruptcy. Nonetheless, the State reclaimed the Federal share of the overpayments.

- For one adjustment, totaling $81,458 ($60,026 Federal share), the State improperly reclaimed the Federal share based on a settlement the Medicaid Fraud Control Unit (MFCU) asserted was in the "best interest of the State."

- For six adjustments, totaling $8,148[1] ($5,947 Federal share), the State improperly reclaimed the Federal share because program officials wrote off the overpayments believing that either (1) the collection efforts would not have been cost effective, or (2) the probability of collection was less than 50 percent.

The State did not report seven overpayment adjustments totaling approximately $4.03 million ($2.87 million Federal share) on the CMS-64s for the quarters in which the 60-day discovery periods ended. This resulted in a potentially higher interest expense to the Federal Government of approximately $12,419.[2]

The improper reclaiming adjustments and untimely overpayment adjustments occurred because the State lacked adequate written policies and procedures for reporting and writing off overpayments and for recording and reporting overpayments timely.

RECOMMENDATIONS

We recommend that the State:

- refund to the Federal Government $836,391 in improper reclaiming adjustments;

- revise reporting and writeoff procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;

[1]We rounded this amount up to the nearest dollar amount for the overall unallowable overpayment to balance with the unallowable overpayment reclaiming adjustments reported in Appendix A.

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

- revise written policies and procedures to ensure that future overpayments are reported timely on the CMS-64s in accordance with Federal criteria, thereby mitigating the potentially higher interest expense to the Federal Government; and

- establish and implement written policies and procedures, and monitor new policies and procedures already implemented by the MFCU, to ensure coordination among all responsible State offices so that future reclaiming adjustments and overpayment adjustments are reported in accordance with Federal requirements.

STATE'S COMMENTS

In its written comments on our draft report, the State disagreed with our findings that it did not report 14 of the 18 overpayment reclaiming adjustments we reviewed in accordance with Federal requirements. The State also disagreed with the recommended refund amount of $836,391; it agreed with the remaining recommendations. The complete text of the State's comments is included as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Based on our review of State's comments and the additional information it provided in response to the draft report, we continue to believe that all of our findings and recommendations are valid.

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INTRODUCTION

BACKGROUND

This review is part of a multistate audit of accounts receivable systems for Medicaid provider overpayments. An overpayment is a payment to a provider in excess of the allowable amount.

Medicaid Program

Enacted in 1965, Medicaid is a combined Federal and State entitlement program that provides health care and long-term care for certain individuals and families with low incomes and limited resources. Within a broad legal framework, each State designs and administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS), which is responsible for the program at the Federal level. The Federal Government has established a financing formula to calculate the Federal share of the medical assistance expenditures paid under each State's Medicaid program. In Louisiana (the State), the Bureau of Health Services Financing (State agency) administers the Medicaid program.

Medicaid Overpayments

Section 1903(d)(2) of the Social Security Act (the Act), as amended by section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is the principal authority that CMS cites in requiring States to refund the Federal share of overpayments to providers. Section 1903(d)(2)(A) states:

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

The Act allows a State 60 days from the date of discovery of an overpayment to recover or attempt to recover the overpayment from a provider before the State must refund the Federal share of the overpayment, whether or not it recovers the overpayment from the provider. The implementing Federal regulations require States to refund the Federal share of overpayments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 report (CMS-64) as an offset to expenditures for the quarter in which the 60-day period following discovery ends. We defined this offset as an overpayment adjustment.

For overpayments resulting from situations other than fraud and abuse, and other than those that are identified through Federal reviews, Federal regulations (42 CFR § 433.316)

define the discovery date as the earliest of the following: (1) the date any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; (2) the date a provider initially acknowledges a specific overpayment amount in writing to the Medicaid agency; or (3) the date any State official initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing. An overpayment that results from fraud or abuse is discovered on the date a Medicaid agency official or other State official sends the final written notice of the State's overpayment determination to the provider. Finally, for overpayments identified through Federal reviews, CMS considers the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

Under certain circumstances, States are not required to refund the Federal share of overpayments made to providers. Regulations regarding these exceptions are found in 42 CFR §§ 433.318 and 433.320 and in section 1903(d)(2)(D) of the Act, which states:

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

Furthermore, the State may reclaim the Federal share of unrecovered overpayment amounts previously refunded to CMS if the State submits documentation showing that it has made reasonable efforts to recover the overpayments. For the purpose of this review, we are calling these types of transactions reclaiming adjustments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We originally examined reclaiming adjustments and overpayment adjustments that were subject to the requirements of 42 CFR part 433 subpart F reported on the quarterly CMS-64s for the period October 1, 2002, through September 30, 2003. We expanded the scope of our audit for reclaiming adjustments to include the 3 previous Federal fiscal years (FYs), 2000 through 2002, because the State agency initially could identify only one writeoff made during FY 2003. The State reclaimed approximately $12.53 million during the 4 FYs.

We did not review overpayments related to third-party payments, probate collections, unallowable costs recovered through per diem rate adjustments, or administrative costs because these overpayments are not subject to 42 CFR part 433 subpart F.

We also did not review the overall internal control structure of the State agency's operations or its financial management. However, we gained an understanding of its controls for processing reclaiming and overpayment adjustments and for recording accounts receivable.

We performed our fieldwork at the State agency and the State's Medicaid Fraud Control Unit (MFCU) in Baton Rouge, Louisiana.

Methodology

To accomplish our objective, we:

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

- interviewed State agency and program officials and staff;

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

- obtained a list from the State that included 18 reclaiming adjustments totaling approximately $12.53 million;

- selected the 18 reclaiming adjustments totaling $12.53 million and obtained and reviewed the supporting documentation;

- obtained a list from the State that included 603 overpayments, totaling $61.7 million, that we could determine had dates of discovery that would require reporting the overpayments during our audit period;

- analyzed CMS-64s and supporting documentation pertaining to reported Medicaid provider overpayment adjustments;

- calculated the 28 largest original overpayment amounts, totaling $19.73 million, that we could determine had (1) dates of discovery that would require reporting overpayments during our audit period and (2) net balances (original overpayment amounts less recoupments during or prior to the reporting period) as of the reporting period;

- compared the date that the State reported the 28 largest original overpayment adjustments on the CMS-64s, based on State accounts receivable records, with the

date that the provider was notified, reviewed the documentation, and calculated whether they were reported timely;

- reviewed two additional original overpayment amounts, totaling approximately $423,000, with dates of discovery that required reporting the overpayments prior to our audit period but that were not reported by the State until our audit period, and calculated the number of days late the overpayments were reported; and

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

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

FINDINGS AND RECOMMENDATIONS

The State did not report all Medicaid provider reclaiming adjustments and overpayment adjustments in accordance with Federal requirements. Fourteen of the 18 reclaiming adjustments that we reviewed, totaling $1,137,456 ($836,391 Federal share), were improper.

- For five adjustments, totaling $53,950 ($40,001 Federal share), the State did not determine whether the providers receiving overpayments had filed for bankruptcy in Federal court or were out of business. In addition, for two adjustments totaling $993,900 ($730,417 Federal share), a Federal court denied the provider's petition for bankruptcy. Nonetheless, the State reclaimed the Federal share of the overpayments. Federal regulations do not allow the Federal share of an overpayment to be reclaimed when a provider's petition for bankruptcy is denied.

- For one adjustment, totaling $81,458 ($60,026 Federal share), the State improperly reclaimed the Federal share based on a settlement the MFCU asserted was in the "best interest of the State." Federal regulations do not allow States to reclaim provider overpayments based on settlement agreements.

- For six adjustments, totaling $8,148[2] ($5,947 Federal share), the State improperly reclaimed the Federal share because program officials wrote off the overpayments believing that either (1) overpayment collection efforts would not have been cost effective, or (2) the probability of collection was less than 50 percent. Federal

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

[2]We rounded this amount up to the nearest dollar amount for the overall unallowable overpayment to balance with the unallowable overpayment reclaiming adjustments reported in Appendix A.

requirements do not provide for reclaiming adjustments based on decisions about cost effectiveness or probability of collection.

The State did not report seven overpayment adjustments totaling approximately $4.03 million ($2.87 million Federal share) on the CMS-64s for the quarters in which the 60-day discovery periods ended.

The improper reclaiming adjustments and untimely overpayment adjustments occurred because the State lacked adequate policies and procedures for reporting and writing off overpayments and for recording and reporting overpayments timely. As a result, the State agency improperly reclaimed 14 adjustments totaling $1,137,456 ($836,391 Federal share) and did not report 7 overpayment adjustments totaling approximately $4.03 million ($2.87 million Federal share) within the required timeframe, resulting in potentially higher interest expense to the Federal Government of approximately $12,419. See Appendix A for details related to overpayment reclaiming adjustments.

IMPROPERLY RECLAIMED ADJUSTMENTS

The State improperly reclaimed adjustments to previously reported overpayments on the CMS-64s. Of the 18 reclaiming adjustments we reviewed, 14 did not comply with Federal requirements regarding the determination of bankruptcy and out of business, settlement agreements, and issues of cost effectiveness and probability of collection.

Determination of Bankruptcy and Out of Business

Federal Requirements

For providers determined to be bankrupt or out of business, the State is not required to refund to CMS the Federal share of an overpayment at the end of the 60-day period following discovery of the overpayment. Pursuant to 42 CFR § 433.318:

> (a) Basic rules. (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by § 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section.
>
> (c) Bankruptcy. The agency is not required to refund to HCFA [CMS][3] the Federal share of an overpayment at the end of the 60-day period following discovery, if—

[3]CMS was formerly known as the Health Care Financing Administration (HCFA). For purposes of this report, we have substituted the acronym CMS for HCFA where appropriate.

(1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 60-day period following discovery; and

(2) The State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.

A provider is considered to be out of business on the effective date of a determination to that effect under State law. The State agency must document its efforts to locate the party and its assets, and these efforts must be consistent with applicable State policies and procedures. The agency also must provide an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures, and cite the effective date of that determination under State law.

Further, 42 CFR § 433.320(g) states that if a provider is determined to be bankrupt or out of business and the State has been unable to make complete recovery of an overpayment, the State may reclaim the Federal share of any unrecovered overpayment amount previously refunded to CMS if the State submits documentation that it has made reasonable efforts to recover such overpayments.

Federal regulations do not exempt States from refunding the Federal share of overpayments simply because the State may lack a legal basis to collect from providers.

Unallowable Adjustments

For five fraud-related reclaiming adjustments, totaling $53,950 ($40,001 Federal share), the State did not determine whether the providers receiving overpayments had filed for bankruptcy in Federal court or were out of business in accordance with Federal regulations. Instead, it approved these reclaiming adjustments because the State's MFCU asserted that there was no legal basis for the State to collect the unpaid portions of overpayments owed by providers who had been convicted of Medicaid fraud and whose probation had ended prior to 2001. However, the MFCU did not provide evidence that there was no legal basis to collect the remaining overpayment balances. Further, Federal regulations do not exempt States from refunding the Federal share of overpayments simply because the State may lack a legal basis to collect from providers.

The State reclaimed two additional fraud-related overpayments, totaling $993,900 ($730,417 Federal share) made to a provider that it determined to be bankrupt. The provider filed for bankruptcy, which was subsequently denied by a Federal court. Following the denial, the State credited CMS with the Federal share of the overpayments related to this provider as required by Federal regulations. The State later reclaimed the overpayment. Federal regulations do not allow the Federal share of an overpayment to be reclaimed when a provider's petition for bankruptcy is denied.

Effective 2001, the MFCU implemented a policy requiring defendants convicted of Medicaid fraud to enter into civil consent judgments that require defendants to reimburse the State for any remaining unpaid Medicaid overpayments. The defendants enter into these judgments with the State's justice department at the same time they accept their plea agreements.

Settlement Agreement

Federal Requirements

Section 1903(d)(2)(D) of the Act states that the Federal share of a Medicaid overpayment does not have to be repaid to the Federal Government if the State is unable to recover the overpayment because the debt has been discharged in bankruptcy or is otherwise uncollectable. Federal regulations clearly identify only one circumstance, apart from bankruptcy, in which the State may reclaim overpayments: when the provider is out of business, as defined in 42 CFR § 433.318(d). Further**,** these Federal regulations do not allow States to reclaim provider overpayments based on settlement agreements.

Unallowable Adjustments

For one reclaiming adjustment, totaling $81,458 ($60,026 Federal share), the State improperly reclaimed the Federal share of a provider overpayment based on a settlement an MFCU official asserted was in the "best interest of the State."

The official believed that once a defendant completed probation, the State had no legal basis for collecting any remaining overpayment balances. However, the MFCU official did not provide evidence that there was no legal basis to collect the overpayment balance. Federal regulations do not exempt States from refunding the Federal share simply because the State may lack a legal basis to collect from providers. Federal regulations also do not allow States to reclaim provider overpayments based on settlement agreements.

Cost Effectiveness/Probability of Collection

Federal Requirements

Pursuant to section 1903(d)(2)(D) of the Act, as amended by section 9512 of the COBRA, a State is not required to refund the Federal share of overpayments that constitute debts that have been discharged in bankruptcy or that are otherwise uncollectible. Additionally, in 42 CFR part 433, Supplementary Information, CMS stated that, "…we have defined debts as 'otherwise being uncollectible' for purposes of these regulations strictly as debts of providers who are 'out of business.'"

Further, pursuant to 42 CFR § 433.316(b), a State Medicaid agency official or other State official must make reasonable attempts to recover an overpayment in accordance with State law and procedures.

Finally, 42 CFR part 433, Supplementary Information, states that, "Section 9512 of COBRA does not provide for exempting States from refunding the Federal share of discovered overpayments based on the cost effectiveness of pursuing recovery."

Unallowable Adjustments

Six reclaiming adjustments totaling $8,148 ($5,947 Federal share) were improper because program officials wrote off the overpayments believing that either (1) the collection efforts would not have been cost effective, or (2) the probability of collection was less than 50 percent.

However, the Federal regulations noted above allow for reclaiming adjustments only for debts that have been discharged in bankruptcy or for providers that are out of business, as defined in the regulations. The regulations do not provide for reclaiming adjustments based on decisions about cost effectiveness or the probability of collection. Therefore, the State did not meet the requirements for these reclaiming adjustments.

Unallowable Federal Share Claimed

Of the approximately $12.53 million in reclaiming adjustments reviewed, $1,137,456 ($836,391 Federal share) was unallowable.

Lack of Adequate Written Policies and Procedures

The State improperly reclaimed the $1,137,456 ($836,391 Federal share) in provider overpayments because the State lacked adequate written policies and procedures for reporting and writing off overpayments.

OVERPAYMENTS NOT REPORTED TIMELY

Federal Requirements

Pursuant to 42 CFR §§ 433.312, 433.316, and 433.320, a State has 60 calendar days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before refunding the Federal share to CMS.

The State must refund the Federal share of overpayments, whether or not the State has recovered the overpayment from the provider. The State must credit the Federal share of overpayments subject to recovery on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

Overpayments Reported After 60 Days

The State did not report seven overpayment adjustments totaling approximately $4.03 million ($2.87 million Federal share) on the CMS-64s for the quarters in which the 60-

day discovery periods ended. The State reported six of the seven overpayments 90 days late and the remaining overpayment 630 days late.

Overpayments Reported 90 Days Late

The State reported the six overpayments 90 days late because it:

- inadvertently omitted overpayments, listed as 60-day receivables on its Accounts Receivable Accounts Payable Control System (ARPCS) ageing reports, that should have been recorded on the CMS-64s; and

- did not have adequate policies and procedures in place to ensure that all receivables reported on the ARPCS ageing reports, including 60-day receivables, were included on the CMS-64s.

According to a State agency official, the State agency subsequently automated its CMS-64 reporting process during our fieldwork. The official further noted that this automated process will ensure that 60-day receivables listed in the ARPCS are automatically included in the total ARPCS accounts receivable amount used to derive the accounts receivable balance reported on the CMS-64s.

Overpayment Reported 630 Days Late

The State reported one overpayment 630 days late primarily because it did not have adequate policies and procedures in place to address which State office associated with the overpayment had responsibility for reporting it to the State agency.

The State's MFCU submitted a letter dated August 22, 2001, to the State agency's Program Integrity Unit (the Unit) advising it of an overpayment totaling $252,385 that had resulted from fraud and that had been discovered by the MFCU on July 27, 2001. However, the Unit did not notify the State agency office responsible for processing the overpayment. According to an official from the Unit, there were no written procedures describing which office had responsibility to report the overpayment to the appropriate State agency office when the State agency wrote off the overpayment. We calculated that 450 days out of the 630 days for which the State reported the overpayment late were attributable to the State's lack of adequate reporting policies and procedures.

Further, in correspondence dated October 28, 2002, the Louisiana State Legislative Auditor's office notified the State agency that this fraud-related overpayment had not been reported to CMS. However, the State agency did not report the overpayment to CMS until it submitted the CMS-64 for the quarter ended June 30, 2003. A State agency official assumed the delayed reporting occurred because the responsible accountant did not enter the overpayment into the receivables system. We calculated that this delay accounted for the remaining 180 days for which the State reported the overpayment late.

In December 2002, the MFCU revised its policies and procedures to require its Medicaid investigators to immediately notify the State agency upon obtaining a judgment or court order (establishes date of discovery) for restitution to the Medicaid program. In addition, the MFCU executed a memorandum of understanding with the State Department of Health and Hospitals in late 2004 in which the MFCU agreed to notify the State agency when it attempts to collect overpayments.

Potentially Higher Interest Expense

The State did not report overpayments totaling approximately $4.03 million ($2.87 million Federal share) on the CMS-64s in the timeframe specified by Federal regulations. This late reporting resulted in potentially higher interest expense to the Federal Government of approximately $12,419.

Lack of Adequate Written Policies and Procedures

The untimely overpayment adjustments occurred because the State lacked adequate written policies and procedures for recording and reporting overpayments timely.

RECOMMENDATIONS

We recommend that the State:

- refund to the Federal Government $836,391 in improper reclaiming adjustments;
- revise reporting and writeoff procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;
- revise written policies and procedures to ensure that future overpayments are reported timely on the CMS-64s in accordance with Federal criteria, thereby mitigating the potentially higher interest expense to the Federal Government; and
- establish and implement written policies and procedures, and monitor new policies and procedures already implemented by the MFCU, to ensure coordination among all responsible State offices so that future reclaiming adjustments and overpayment adjustments are reported in accordance with Federal requirements.

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

The State's comments on our draft report are summarized below, along with our response. In addition to its written comments, the State also provided supporting documentation consisting of nine attachments. Due to the sensitive nature of the supporting documentation, it has not been included in the final audit report. However, the complete text of the State's comments is included as Appendix B.

Based on our review of the State's comments and the additional supporting documentation, we have concluded that the $1,137,456 overpayment and the $836,391 refund amount owed to the Federal Government (the Federal share) are correct.

Improperly Reclaimed Adjustments

Determination of Bankruptcy

State's Comments

The State contended that for the seven reclaiming adjustments for which we found that the State had not determined whether the providers receiving overpayments had filed for bankruptcy or were out of business, four (overpayments one, three, four, and five) met the requirements of 42 CFR § 433.318(c), i.e., the debts were discharged in bankruptcy, and the adjustments should have been allowed.

Office of Inspector General's Response

The four reclaiming adjustments (overpayments one, three, four, and five) did not meet the requirements of 42 CFR § 433.318(c). Regarding overpayments one and three, the cited regulation is not applicable for these overpayments because the provider filed for bankruptcy on August 3, 1994, over 16 months after the date of discovery (March 19, 1993). The regulations the State cited provide that States are not required to refund to CMS the Federal share of an overpayment if the provider has filed for bankruptcy before the end of the 60-day period following discovery.

Nonetheless, 42 CFR § 433.320(g) allows the State to reclaim a refund of the Federal share of an overpayment when a provider is determined to be bankrupt after the 60-day period following discovery. To claim the refund, the State must submit documentation to CMS showing that it had made reasonable efforts to recover the overpayment during the period before the petition for bankruptcy was filed. However, for overpayments one and three, the State did not provide evidence that it had submitted the documentation to CMS. Therefore, these overpayments, totaling $11,566 ($8,525 Federal share), remain unallowable.

Regarding overpayments four and five, after reviewing the additional supporting documentation the State obtained and provided to us after we issued the draft report, we agree that the State correctly determined that (1) the provider, in accordance with Federal regulations, had filed for bankruptcy before the end of the 60-day period following discovery, and (2) the State was on record with the court as a creditor of the provider in the amounts of the Medicaid overpayments. Federal regulations (42 CFR § 433.320(f)) require that if a provider's petition is denied in Federal court, the agency must credit CMS with the Federal share of the overpayment. According to the documentation provided by the State, a Federal court dismissed the provider's bankruptcy case (i.e., the petition was denied); thus, the overpayments were not discharged. Federal regulations do

not allow the Federal share of the overpayment to be reclaimed when a provider's petition for bankruptcy is denied.

Therefore, the State improperly reclaimed the overpayments totaling $993,900 ($730,417 Federal share).

Uncollectible

State's Comments

The State admitted that three of the remaining seven reclaiming adjustments (overpayments two, six, and seven) did not fall directly within any Federal "write-off and reclaim" provisions. However, it contended that it did not have any legal authority to collect these debts because the providers, who had been convicted of Medicaid fraud, had completed their criminal probation periods. Additionally, the State said that, while there was no evidence that these providers were out of business, the criminal conviction would have caused them to go out of business.

Office of Inspector General's Response

As we noted in the draft report, the MFCU did not provide evidence that it lacked a legal basis to collect the remaining overpayment balances. Further, Federal regulations do not exempt States from refunding the Federal share of overpayments simply because the State may lack a legal basis to collect from providers.

For the State to reclaim overpayments for providers that are out of business, Federal regulations require the State to provide an affidavit or certification from the appropriate State legal authority establishing that the provider is in fact out of business. It also must submit to CMS documentation of its efforts to locate the provider and its assets and to recover the overpayment during any period before the provider is found to be out of business in accordance with 42 CFR § 433.318. However, as the State noted, it did not have evidence that the providers were out of business. Further, although the State considered the providers to be out of business, it did not provide evidence of attempts to locate the providers or their assets.

Therefore, the State inappropriately reclaimed the overpayments totaling $42,384 ($31,476 Federal share).

Note: The combined total of improperly reclaimed overpayments one, two, three, six and seven equals $53,950 ($40,001 Federal share), as reported in total in the report and as listed in Appendix A.

Settlement Agreement

State's Comments

The State contended that we did not understand what occurred in this case (overpayment eight). Specifically, the State explained that, although the MFCU originally identified the total amount of the fraud (overpayment) to be $400,000, the judge at the defendant's sentencing hearing reduced the amount to $200,000. Therefore, the State contended that this was not a "settlement" that MFCU negotiated with the provider because it was in the "best interest of the State," but rather a determination by a court of law. Further, the State asserted that, in this case, the "amount identified" was not the $400,000 set out in the indictment, but the $200,000 that was imposed by the judge.

Office of Inspector General's Response

We did accept the $200,000 amount, which was actually $245,742, as the amount of the overpayment on which we calculated the unallowable reclaiming adjustment. Although the State agency initially established an accounts receivable in the amount of $485,962 for this overpayment, it adjusted the balance to the $245,742 amount noted above. The provider made payments, reducing the amount owed to $156,458. The State subsequently settled with the provider for $75,000 and wrote off the remaining overpayment amount totaling $81,458 ($60,026 Federal share), which we disallowed. Therefore, because Federal regulations do not allow States to use settlement agreements for reclaiming provider overpayments, the State improperly reclaimed $81,458 ($60,026 Federal share).

Cost Effectiveness/Probability of Collection

State's Comments

For the 6 overpayments (overpayments 9 through 14), totaling $8,148 ($5,947 Federal share), program officials wrote-off believing that either (1) the collection effort would not have been cost effective or (2) the probability of collection was less than 50 percent, the State disagreed that overpayment 11 was improper, asserting that the overpayment was "otherwise uncollectible" pursuant to 42 CFR §§ 433.318 and 433.320 and to section 1903(d)(2)(D) of the Act. The State also asserted that it had ". . . made reasonable efforts to recover the overpayment."

Regarding the other five overpayments, the State agreed with our findings but disagreed with CMS's interpretation of cost effectiveness and probability of collection.

For overpayment 11, the State provided, along with its response, additional information to support the reclaiming adjustment.

Office of Inspector General's Response

Regarding overpayment 11, we do not agree with the State's assertion that the overpayment was "otherwise uncollectible" pursuant to 42 CFR §§ 433.318 and 433.320 and section 1903(d)(2)(D) of the Act and that the State ". . . made reasonable efforts to recover the overpayment."

Pursuant to 42 CFR part 433, Supplementary Information, CMS "…defined debts as 'otherwise being uncollectible' for purposes of these regulations strictly as debts of providers who are 'out of business.'" In addition, 42 CFR § 433.318(d) requires a State to (1) document its efforts to locate the party and its assets; and (2) provide an affidavit or certification from the appropriate State legal authority establishing that the overpayment could not be collected under State law and procedures, with the effective date of such determination. Further, 42 CFR § 433.320(g) requires an agency to submit to CMS a statement of its efforts to locate the provider and its assets and to recover the overpayment during the period before the provider is found to be out of business in accordance with 42 CFR § 433.318. Finally, the Act states that the Federal share of a Medicaid overpayment does not have to be repaid to the Federal Government if the State is unable to recover the overpayment because the debt is otherwise uncollectable.

Although the State provided support documenting its efforts to locate the party, it did not provide the required affidavit or certification from the appropriate State legal authority or evidence of any efforts to locate the provider's assets. Therefore, we do not consider this overpayment as "otherwise uncollectible."

Because the State did not comply with Federal regulations regarding debts that are otherwise uncollectible, the reclaiming adjustment totaling $857 ($601 Federal share) was improper.

Regarding the remaining five reclaiming adjustments, totaling $7,291 ($5,346 Federal share), we continue to believe that these adjustments remain unallowable. The State should discuss any disagreements it has regarding CMS's interpretation of cost effectiveness and probability of collections directly with CMS.

Overpayments Not Reported Timely

State's Comments

The State agreed with our findings and recommendations.

APPENDIXES

APPENDIX A

OVERPAYMENT RECLAIMING ADJUSTMENTS TO THE CMS-64s OCTOBER 1, 1999, THROUGH SEPTEMBER 30, 2003

OVERPAYMENT NUMBER	TOTAL RECLAIMING ADJUSTMENT	ALLOWABLE	UNALLOWABLE	FEDERAL MEDICAL ASSISTANCE PERCENTAGE	FEDERAL SHARE
1	$10,591.00		$10,591.00	.7371	$7,806.63
2	8,354.00		8,354.00	.7371	6,157.73
3	975.00		975.00	.7371	718.67
6	25,200.00		25,200.00	.7448	18,768.96
7	2,649.09		2,649.09	.7544	1,998.47
	3,532.12		3,532.12	.7371	2,603.53
	2,649.10		2,649.10	.7349	1,946.82
Subtotal	**$53,950.31**		**$53,950.31**		**$40,000.81**
4	496,950.00		496,950.00	.7349	365,208.56
5	496,950.00		496,950.00	.7349	365,208.56
Subtotal	**$993,900.00**		**$993,900.00**		**$730,417.12**
8	$8,145.81		$8,145.81	.7544	6,145.20
	32,583.27		32,583.27	.7371	24,017.13
	32,583.27		32,583.27	.7349	23,945.45
	8,145.82		8,145.82	.7265	5,917.94
Subtotal	**$81,458.17**		**$81,458.17**		**$60,025.72**
9	$1,127.73		$1,127.73	.7312	$824.60
10	3,337.91		3,337.91	.7312	2,440.68
11	214.20		214.20	.7037	150.73
	642.60		642.60	.7003	450.01
12	480.00		480.00	.7189	345.07
13	181.67		181.67	.7448	135.31
	1,090.00		1,090.00	.7544	822.30
	363.33		363.33	.7371	267.81
14	710.00		710.00	.7189	510.42
Subtotal	**$8,147.44**		**$8,147.44**		**$5,946.93**
15	$477,009.00	$477,009.00			
16	1,923,350.00	1,923,350.00			
17	1,957,916.00	1,957,916.00			
18	7,034,820.00	7,034,820.00			
Subtotal	**$11,393,095.00**	**$11,393,095.00**			
Total	**$12,530,550.92**	**$11,393,095.00**	**$1,137,455.92**		**$836,390.58**

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

May 8, 2006

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Mr. Sato:

RE: Report Number: A-06-06-00036

We appreciate the opportunity to respond to your draft audit (Report A-06-06-00036). While we do not disagree with the methodology used, we do disagree with some of the findings and recommendations made.

Findings:

Your audit found that 14 of the 18 reclaiming adjustments and overpayment adjustments were improper.

- For seven adjustments, totaling $1,047,850 ($770,418 Federal share), the State did not determine whether the providers receiving overpayments had filed for bankruptcy in Federal court or were out of business.

These seven cases all involved criminal actions brought by our State MFCU.

- Bankruptcy documentation

In four of the cases we contend that there was in fact a discharge in bankruptcy.

- Overpayment 1 ($10,591.00 FFY93)

In this case, the Medicaid Provider was listed as a corporation by the Louisiana Secretary of State on June 15, 1992, and the individual in question was the owner and its Director. The individual was convicted of Medicaid Fraud on March 19, 1993, by our State's MFCU. On August 3, 1994, the individual filed for Chapter 11 in the Middle District Court of Louisiana. On November 18, 1998, he and his wife were discharged in bankruptcy with one of its creditors being the State of Louisiana, Attorney General. We would assert that this overpayment was in fact discharged in bankruptcy within the meaning of 42 CFR §433.318(c). This individual, not his company was convicted of Medicaid Fraud. Attached is the documentation to support our assertions.

- Overpayments 3 ($975.00 FFY93)

This individual was an employee of the Medicaid Provider listed above in Overpayment 1. She was convicted of falsifying the books for that corporation. We would assert that this debt was discharged through the Bankruptcy proceeding as outlined above in Overpayment 1.

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- Overpayments 4 & 5 ($496,950.00 FFY94 & $496,950.00 FFY94)

In this case, the Medicaid Provider was a corporation. Its 2 owners and directors were convicted of Medicaid Fraud. On February 8, 1994, each of the owners/directors of this Medicaid Provider was convicted of Medicaid Fraud. The amount of fraud charged against each owner/director was $496,950.00. A Chapter 7 was filed on behalf the Medicaid Provider on April 16, 1991. While the criminal case against the 2 owners/directors was still pending, the Chapter 7 on the Medicaid Provider was discharged with the Louisiana Department of Health and Hospitals being listed as a creditor for an amount over $2,000,000.00. We would assert that $496,950.00 in Overpayments 4 & 5 are discharged through the bankruptcy proceedings of the Medicaid Provider and that this satisfies the discharged in bankruptcy provision of 42 CFR §433.318(c). Attached is the documentation to support our assertion.

- Overpayment 1 ($10,591.00 FFY93), Overpayment 3 ($975.00 FFY93)
  Overpayments 4 & 5 ($496,950.00 FFY94 & $496,950.00 FFY94)

As to these four, we contend that they do meet the requirements of 42 CFR §433.318(c) in that these debts were discharged in bankruptcy. Therefore, they should not be listed as unallowable.

- Uncollectible

  - Overpayments 2 ($8,354.00 FFY93), 6 ($25,200.00 FFY91) & 7 ($2,649.09 [FFY92], $3,532.12 [FFY93] & $2,649.10 [FFY94])

    No documentation could be found that the individuals who were convicted of Medicaid Fraud or the companies they operated filed for bankruptcy in Federal court.

  - Overpayment 2 ($8,354.00 FFY93)

    This individual was convicted of Medicaid Fraud on March 29, 1995, which he committed through his company which was the enrolled Medicaid Provider. This individual and his wife filed for Chapter 7 and received discharge on August 28, 1995. The State of Louisiana through the Attorney General or the Department of Heath and Hospitals was never notified of the bankruptcy action filed by this individual and his wife. The enrolled Medicaid provider was never registered with Louisiana's Secretary of State Office as a Louisiana Corporation. At the end of this individual's 5 year probation period his criminal debt to the State of Louisiana was satisfied. While this does not fit neatly under the bankruptcy provision of 42 CFR §433.318(c), it is clear that when the overpayment was reported, neither this individual nor his "company" would have had any assets that could have been used to satisfy this debt. And as stated by our Attorney General, the State had no way of enforcing this debt after this individual had served his criminal sentence.

  - Overpayment 6 ($25,200.00 FFY91)

    This individual was convicted of Medicaid Fraud on January 15, 1991. He was given a 4 year probationary period.

- Overpayment 7 ($2,649.09 [FFY92], $3,532.12 [FFY93] & $2,649.10 [FFY94])

This individual was convicted of Medicaid Fraud on July 8, 1994. He was given 3 years probation. The Medicaid provider he owned and operated is listed on the Louisiana Secretary of State website as inactive.

- Overpayment 2 ($8,354.00 FFY93), 6 ($25,200.00 FFY91) & 7 ($2,649.09 [FFY92], $3,532.12 [FFY93] & $2,649.10 [FFY94])

We admit that none of these fall directly within any Federal "write-off and reclaim" provisions. However, as noted in our original response, the State of Louisiana, at the time did not have any legal authority to collect these debts after completion of the criminal probation periods. As to these 3, the total Federal share involved is $31,478.51.

Additionally, while there is no evidence that these businesses were out of business, the logical result from the criminal convictions of the owners and operators would have caused these Medicaid providers to "go out of business."

- Overpayment 8 ($81,458.00 [FFY92-95] ($60,026.00 Federal share))

  - In this case, you assert that our MFCU entered a "settlement" which it felt was in the "best interest of the State." Therefore, you determined that this one should not be allowed. We believe that there has been a "misunderstanding" as to what occurred in this case.

This individual pled guilty to Medicaid fraud on February 26, 1996. At the sentencing hearing the only issue in dispute was the total amount of the fraud. MFCU originally identified an amount of $400,000.00. At the sentencing hearing, counsel for this individual was successful in getting the State Criminal Judge to reduce the amount to $200,000.00. In this case, MFCU did not "settle," but rather the criminal defendant was able to get the Judge to reduce the amount identified. It was not an amount agreed to by MFCU, but rather an amount imposed by the Judge. To put it succinctly, while MFCU did have the evidence to convict this individual of Medicaid Fraud, MFCU did not have the evidence in criminal court to support the total amount she was initially charged with. Therefore, this was not a "negotiated settlement" on the part of MFCU, but rather a determination by a court of law. We would assert that in this case the "amount identified" was not the $400,000.00 setout in the indictment, but the $200,000.00 which was imposed by the State Criminal Judge.[1]

This individual owned and operated the enrolled Medicaid provider which was a Louisiana company. The Secretary of State revoked the Charter of the enrolled Medicaid provider on

[1]This case involved criminal fraud. Under 42 USC §433.316 you correctly state that when fraud or abuse are involved the "time of discovery" of the overpayment the purpose of the 60 Day Rule begins "…on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to a provider." In the case of this State's administrative hearing that occurs when the final administrative sanction is issued by the Secretary of Louisiana's Department of Health and Hospitals. We would assert that in the case of a State criminal court preceding that would occur when the criminal conviction is rendered by a State court judge and not when MFCU issues an arrest warrant or obtains an indictment. This is because the final determination in a criminal prosecution is made by our State judges and not the Attorney General of this State. Using this logic, we assert that "identified amount" in this case was not $400,000.00 but rather $200,000.00 setout in the criminal conviction.

November 17, 1996. On that date, the enrolled Medicaid provider was out of business in the State of Louisiana according to Louisiana's Secretary of State.

Your audit found that:

- For six adjustments, totaling $8,148 ($5,947 Federal share), the State improperly reclaimed the Federal share because program officials wrote-off the overpayments believing that either (1) the collection effort would not have been cost effective, or (2) the probability of collection was less than 50%.

All of these cases involved administrative sanctions for Medicaid fraud or abuse.

- Overpayments 9 ($1,127.73 FFY90), 10 ($3,337.91 FFY90), 11 ($214.20 FFY99 & $642.60 FFY98), 12 ($480.00 FFY96), 13 ($181.67 FFY91, $1,090.00 FFY92 & $363.33 FFY93) & 14 ($710.00 FFY96)

- Out-of-Business

  - Overpayment 11 ($214.20 FFY99 & $642.60 FFY98)

  This individual was a Louisiana Medicaid provider from July 1, 1991, to April 6, 2000. Via letter dated May 12, 2000, this individual was notified that based on the Medicaid Agency's Program Integrity Section (PI), Medicaid felt that she owed $856.80 as an overpayment. On July 20, 2000, PI notified this individual that it would be imposing a recoupment on the overpayment amount. A PI staff member made efforts to locate this individual but could not find her. Her Louisiana Medicaid Provider number was closed with an effective date of April 6, 2000, with a closure code "32" and a negative balance was placed on her closed Medicaid Provider number. The Medicaid Provider whom she was working for and was her "Pay To" on our Provider File was registered with the Secretary of State on May 21, 1982, and terminated as a corporation on March 2, 2000[2].

  In this case, it is clear that the Medicaid provider for whom this individual worked closed its doors prior to the administrative action brought by PI against this individual. This individual's enrollment status on our Provider File was "0"[3] and she was "linked" to an enrolled Medicaid provider. This means that all Medicaid claims caused by this individual would be paid to that enrolled Medicaid provider. PI staff determined that this individual could not be found and that the Medicaid provider she had been working for had closed.

  We would assert that in this case the overpayment was "otherwise uncollectible," within the meaning of 42 CFR §§433.318 and 4333.320 and in Section 1903(d)(2)(D). And that in this case, we submitted documentation showing that the State "… [H]as made reasonable efforts to recover the overpayment." The effect of closing this individual's Medicaid Provider Number with a code "32" means that if she ever tries to "reapply for a Louisiana Medicaid number, Medicaid Provider Enrollment, which is a section within PI, will notify PI's Administrative Sanction Unit and will not reenroll her until this individual pays the negative balance of $856.80 which was placed on the Provider File.

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[2] This enrolled Medicaid provider had a rather checkered history. On May 12, 1999, MFCU obtained a criminal conviction for Medicaid Fraud against the owner of this Medicaid provider. As a result of the conviction of the owner this Medicaid provider was closed down and stopped doing business.
[3] The "0" status means that she cannot directly bill Medicaid for any services.

- Cost Effectiveness/Probability of Collections

  - Overpayment 9 ($1,127.73 FFY90) ; Overpayment 10 ($3,337.91 FFY90); Overpayment 12 ($480.00 FFY96); Overpayment 13 ($181.67 FFY91, $1,090.00 FFY92 & $363.33 FFY93) and Overpayment 14 ($710.00 FFY98)

  We do not disagree with your findings based on CMS's interpretation of Cost Effectiveness/Probability of Collection not being a valid reason for reclaiming. We do, however, respectfully disagree with CMS's interpretation.

Your audit found:

- Overpayments not reported timely

As noted in your draft audit report, we had taken steps to automate our CMS-64 reporting process during your fieldwork. We do agree that we need to, and will revise our written reporting and policies to ensure future overpayments are reported timely on the CMS-64 in accordance with Federal criteria.

Response to the Recommendations:

We assert:

- The refund amount to the Federal Government which was set at $836,391 should be reduced;
- We will revise our reporting and write-off procedures to ensure that improper reclaiming adjustments are not included on the CMS-64;
- As noted in your draft audit report, we had taken steps to automate our CMS-64 reporting process during your field work. We do agree that we need to, and will revise our written reporting and policies to ensure future overpayments are reported timely on the CMS-64 in accordance with Federal criteria, thereby mitigating potentially higher interest expense to the Federal Government; and
- We will establish and implement written policies and procedures, and monitor new policies and procedures all ready implemented by the MFCU, to ensure coordination among all responsible State offices so that future reclaiming adjustments and overpayments are reported in accordance with Federal requirements.

If you have any additional questions or concerns please feel free to contact Joe Kopsa at 225-219-4149.

Thank you,

Jerry Phillips
Acting Medicaid Director

JLP/JK:taw

Attachments/Enclosures