REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

011

NEW STATUTES, POLICIES, AND PROCEDURES COULD INCREASE MEDI-CAL RECOVERIES BY AT LEAST $4.3 MILLION ANNUALLY

FEBRUARY 1981

California Legislature

Joint Legislative Audit Committee

GOVERNMENT CODE SECTION 10500 et al

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February 17, 1981 011

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report concerning new statutes, policies, and procedures which could increase Medi-Cal recoveries by at least $4.3 million annually.

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Respectfully submitted,

WALTER M. INGALLS
Chairman, Joint Legislative
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SUMMARY

Medi-Cal is a $4.3 billion program, which is funded jointly by the State and the Federal Government. This program, authorized by Title XIX of the Social Security Act and Section 14000 _et seq_. of the Welfare and Institutions Code, provides health services to Medi-Cal eligibles and low-income Californians. An average of approximately three million persons qualify for services each month. Medi-Cal is administered by the Department of Health Services, which has a variety of responsibilities, including identifying and recovering Medi-Cal overpayments. An overpayment identification and recovery system administers this responsibility through the activities of seven primary program units.

As detailed below, our review of the overpayment identification and recovery system focused on opportunities to increase Medi-Cal recoveries, to improve information sharing, and to strengthen workload management practices. Our review also assessed the impact of certain statutes and regulations on system operations.

Opportunities to Increase Recoveries:

We found that Medi-Cal's overpayment identification and recovery system could increase recoveries of program expenditures by an estimated $4.3 million annually. By using data available from the Workers' Compensation Appeals Board, the department's Casualty Insurance Unit could identify cases in which Medi-Cal paid for medical services for work-related injuries and thus augment recoveries by nearly $1.3 million. In addition, the Medi-Cal program could recover an additional $3 million per year if the State instituted an estate recovery program for certain beneficiaries.

Need for Improved Information Sharing:

We further noted that certain units within the Medi-Cal program need to improve their sharing of information. The department's Medicaid Management Information System has not provided certain required reports to program units; consequently, the system has impeded the identification of overpayments and the investigation of fraud and abuse in the Medi-Cal program. Also, the Licensing and Certification Division has not routinely informed system units when institutional providers change ownership or close. These problems have jeopardized the identification and collection of providers' debts.

Need for Improved Workload Management:

In reviewing the department's workload management practices, we found that the Recovery Section's Southern Region offices have not adhered to procedures for following up on collection efforts or for addressing high priority cases. Departmental units responsible for identifying and recovering Medi-Cal overpayments have not monitored the fiscal intermediary's accuracy in calculating interest charges on past due account receivables; as a result, the department has not identified errors in interest assessments. Again, these conditions have jeopardized the collection of overpayments and interest charges due the Medi-Cal program.

Impact of Statutes and Regulations:

Finally, certain statutes and regulations have prevented the Medi-Cal program from realizing maximum recoveries. Specifically, a regulation governing the provider appeals process allows providers to defer repayment of disputed amounts until the appeal has been adjudicated. Another regulation requires that debtors of the Medi-Cal program be assessed a low interest rate on any unpaid debts. Our review showed that if these statutes were revised to allow the Medi-Cal program to collect overpayments before the appeals process and to assess higher interest rates, the program could have earned additional interest revenues on selected appeals filed in fiscal year 1977-78.

Recommendations

To increase Medi-Cal recoveries, we recommend (1) that the department use Workers' Compensation Appeals Board data to identify Medi-Cal benefits paid on workers' compensation cases and (2) that the Legislature consider implementing an estate recovery program. To improve information sharing functions, we recommend that the department (1) continue to closely monitor the fiscal intermediary's operation of the Medicaid Management Information System and (2) ensure that all Licensing and Certification field offices send prompt, written notices of all changes of ownership and closures to system units needing this information.

Furthermore, to improve the workload management procedures of system units, we recommend (1) that the department require all Recovery Section regional offices to adhere to procedures for following up on collection efforts and for addressing top priority cases, and (2) that the department fix responsibility for monitoring the fiscal intermediary's accuracy in calculating interest on past due accounts. To fully maximize recoveries, we recommend that the department change regulations so that overpayments can be collected before the provider appeals process. We also recommend that the Legislature consider increasing the interest rate which the Medi-Cal program is legally allowed to charge debtors of the program.

INTRODUCTION

In reponse to a resolution of the Joint Legislative Audit Committee, we have reviewed the performance of units within, and associated with, the overpayment identification and recovery system of the California Medical Assistance Program (Medi-Cal). We have also assessed the impact of certain statutes and regulations upon the program's recovery of overpayments. This review was conducted under the authority vested in the Auditor General by Sections 10527 and 10528 of the Government Code. This is the Auditor General's second report examining the Medi-Cal overpayment identification and recovery system.*

Medi-Cal is a $4.3 billion program which is jointly funded by the State and the Federal Government. This program pays for the health services received by Medi-Cal eligibles and low-income Californians. An average of approximately three million persons qualify for services each month. Known as Medicaid in other states, the program is authorized by

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* The first report (P-914.1) entitled The Impact of Staffing Shortages on the Identification and Recovery of Medi-Cal Overpayments, focused on the impact of post-Proposition 13 staffing reductions on the overpayment identification and recovery system.

Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code. For fiscal year 1980-81, the State's share of Medi-Cal expenditures is approximately 56 percent, and the federal share, 44 percent.

Medi-Cal beneficiaries are entitled to a variety of services rendered by professional health care providers. These services include outpatient visits to physicians' offices, dental services, drugs, inpatient and outpatient hospital services, nursing home care, and other health-related services.

The Department of Health Services (DHS) administers the Medi-Cal program through an agreement with the federal Department of Health and Human Services. The primary Medi-Cal responsibilities of the DHS fall into three categories:

- Service provision--The DHS operates the Medi-Cal fee-for-service program and administers and monitors prepaid health plans (PHPs), an alternative to the fee-for-service program.* The DHS also procures and manages the contract with a fiscal intermediary (a nongovernmental agency) for reviewing provider claims.**

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* In the fee-for-service program, providers of medical services charge a fee for each service rendered. In prepaid health plans, however, providers contract with the State to provide certain Medi-Cal beneficiaries necessary medical services for a prepaid per capita fee.

** The State does not directly pay physicans, hospitals, nursing homes, and other providers for the services rendered to Medi-Cal beneficiaries. Instead, it contracts with a fiscal intermediary, currently the Computer Sciences Corporation, to process Medi-Cal claims. The intermediary previously issued warrants for payment; however, the State Controller has assumed this responsibility.

- Standard and policy setting--The department develops and issues policies on Medi-Cal benefits, implements and monitors eligibility requirements, and develops the fee structure for the fee-for-service and PHP programs.

- Program utilization controls--The DHS exercises pre-payment and post-payment controls on Medi-Cal expenditures. Pre-payment controls include an authorization system prior to rendering medical services and a review system after services are delivered but before payment is made. The overpayment identification and recovery system provides the post-payment controls, those following payment of services.

The Overpayment Identification and Recovery System

Medi-Cal post-payment controls are exercised through the overpayment identification and recovery system. These are the system's three basic functions:

- Identifying potential overpayment cases from various sources, such as the fiscal intermediary's claims processing activities, county welfare departments' eligibility reviews, and beneficiary and provider complaints;

- Auditing and investigating potential overpayment cases;

- Collecting overpayments either (1) by having the fiscal intermediary deduct them from future provider claims or (2) by demanding direct repayment to the Medi-Cal program.

The overpayment identification and recovery system is composed of seven primary program units: the Audits, Investigations, Medi-Cal Quality Control, and Surveillance and Utilization Review Branches of the department's Audits and

Investigations Division; the Recovery Section of the department's Medi-Cal Division; the Medi-Cal Fraud Unit of the Department of Justice; and the fiscal intermediary. Below we describe the function of each of these units.

Audits Branch

The Audits Branch identifies Medi-Cal overpayments to institutional providers, such as hospitals and nursing facilities. Staff perform fiscal and medical audits using provider cost reports, claims payment data from the fiscal intermediary, and medical records.

Investigations Branch

The Investigations Branch receives provider and beneficiary fraud complaints from a variety of sources. It investigates beneficiary fraud and provider civil and administrative cases from the conduct of a preliminary investigation to the final disposition of a case. For provider criminal cases, the branch conducts only the preliminary investigation. Cases in which fraud is suspected are referred to the Medi-Cal Fraud Unit.

Medi-Cal Quality Control Branch

The Medi-Cal Quality Control Branch estimates the amount of Medi-Cal dollars misspent annually. It reviews a statewide sample of claims, testing for proper eligibility determination, claims processing, and payment. It then refers cases to other system components.

Surveillance and Utilization Review Branch (SUR)

The SUR Branch identifies overutilization, abuse, and fraud by Medi-Cal beneficiaries and providers. It conducts claims and medical audits and then refers its findings and recommendations for disciplinary action to other system components.

Recovery Section

The Recovery Section identifies and collects Medi-Cal overpayments made for beneficiaries with other health insurance coverage and for those injured by liable third parties. This section also collects overpayments from providers and beneficiaries identified by other sources, such as county welfare departments, the Investigations Branch, the SUR Branch, and the Medi-Cal Fraud Unit.

Medi-Cal Fraud Unit (MCFU)

The MCFU investigates and prosecutes criminal violations by providers. It receives referrals from the Investigations Branch of the Department of Health Services.

Fiscal Intermediary

Although the fiscal intermediary's main function is to review provider Medi-Cal claims, it also identifies and recovers overpayments. It refers suspected fraudulent and abusive providers and beneficiaries to other units, like the SUR Branch and the Investigations Branch; provides them with payment history data; and, at the units' request, deducts identified overpayments from current provider claims.

Providers and beneficiaries can appeal overpayment demands. The department's Office of Legal Services administers a two-level hearing process for provider appeals. Beneficiary appeals are heard by the Department of Social Services' Office of Public Inquiry and Response.

Scope and Methodology

We conducted a preliminary survey of the overpayment identification and recovery system and other units within the Department of Health Services.* During this survey, we reviewed statutes and regulations governing system operations; objectives, methods, and resources of each component; and the interaction among components. We identified several areas of operation which could benefit from formal management review: the effects of staffing reductions, workload management practices, information sharing, and the impact of certain statutes and regulations on system operations.

In identifying opportunities to increase recoveries, we reviewed a random sample of Workers' Compensation Appeal Board cases and determined whether Medi-Cal paid for services that could have been paid for by liable third parties. We also reviewed the State of Maryland's program for recovering Medicaid payments from the estates of deceased beneficiaries and calculated potential recoveries if a similar program were to be instituted in California.

* Although the State Controller's Medi-Cal Audit Project is part of the overpayment identification and recovery system, we did not include it in our review. The project independently monitors the DHS to ensure that integrity exists in the Medi-Cal payment system.

We reviewed the lines of communication between various participants within the overpayment identification and recovery system by identifying information which units needed to permit effective and efficient system performance. We reviewed case files and other documents to identify information shared between (1) the Computer Sciences Corporation and the Surveillance and Utilization Review Branch, (2) the Licensing and Certification Division and the Audits Branch, and (3) the Licensing and Certification Division and the Recovery Section.

To analyze workload management practices, we reviewed individual cases for compliance with established procedures for the Recovery Section's Compliance Unit. We also analyzed the accounting practices of units involved in processing accounts receivable and tested the accuracy of the calculation of interest charges assessed by the Computer Sciences Corporation.

Furthermore, we analyzed the fiscal impact of certain statutes and regulations governing disputed Medi-Cal reimbursements and identified potential additional recoveries associated with past due accounts. These recoveries resulted from varying (1) the interest rate allowable under the law and (2) the point at which collection is made before the final adjudication of the dispute.

AUDIT RESULTS

OPPORTUNITIES FOR INCREASING RECOVERIES

The Medi-Cal program could increase recoveries by an estimated $4.3 million annually--$1.3 million could be recovered through the use of data from the Workers' Compensation Appeals Board (WCAB) while $3 million could be recovered from the estates of deceased beneficiaries. The Recovery Section's Casualty Insurance Unit, which is responsible for identifying insurance carriers from which recoveries can be made, could use data available from the Workers' Compensation Appeals Board to identify cases in which the Medi-Cal program covered the costs of medical services for work-related injuries. Furthermore, by legislative enactment of provisions permitted under federal law, the Medi-Cal program could institute an estate recovery program for expenditures made on the behalf of recipients 65 years of age or older who have neither a surviving spouse nor certain categories of dependent children.

Data from Workers' Compensation Appeals Board Could Aid Case Identification

The Casualty Insurance Unit within the department's Recovery Section could use data available from the Workers' Compensation Appeals Board to identify Medi-Cal beneficiaries

who have suffered work-related injuries. Through identifying these cases, the Casualty Unit could recover $1.3 million annually for the Medi-Cal program.

If the Medi-Cal program pays the costs of medical services for a beneficiary injured at work, it can recover payments made from the employer, who may be a liable third party. To identify liable third parties, the Casualty Insurance Unit uses diagnosis codes, which indicate types of injuries which may result in potential third party liability cases. These diagnosis codes, which are listed on claim forms, do not identify all potential third party liability cases. Rather, they note only those injuries most likely to result in a third party liability case. Therefore, the codes would not identify high cost, work-related illnesses such as heart and lung disease and emotional stress.

However, information maintained by the Workers' Compensation Appeals Board could be used to identify injured workers whose medical costs were paid by the Medi-Cal program. The WCAB can settle disputes between employers and injured workers. Employees who are injured at work can appeal their cases to the WCAB when there is a disagreement regarding liability. Approximately 120,000 appeals were filed in fiscal year 1979-80 with the WCAB's 23 regional offices. If the WCAB

decides in favor of applicants whose medical costs have been paid by the Medi-Cal program, then Medi-Cal could recover the amount paid for those services.

The Employment Development Department (EDD) identifies potential recoveries for disability benefits paid on workers' compensation cases through the WCAB. When injured workers file an appeal with the WCAB, they must indicate on the application whether they received disability benefits. If they have received disability benefits, a copy of the application is sent to the EDD. The EDD then files a lien with the WCAB to protect the State's interest in the case. A similar system could also be used to identify injured workers whose medical services were paid by the Medi-Cal program. A WCAB official stated that an interagency agreement between the WCAB and the department would be needed to implement such a system.

To determine whether information kept by the WCAB could assist in disclosing potential third party liability cases, we reviewed two random samples comprising 200 cases each. The applications within each of these samples were filed in fiscal year 1979-80 at two WCAB offices. The offices were located in downtown Los Angeles and in San Francisco. With the asssistance of the San Francisco County Department of Social Services and the Los Angeles County Department of Public Social Services, we identified all WCAB cases in which the applicant was a Medi-Cal beneficiary. Next, we reviewed

the Casualty Insurance Unit's accounts receivable files to determine if any of these cases had been established as accounts receivable.* Finally, we ordered claims history profiles from the fiscal intermediary for cases not established by the Casualty Insurance Unit to identify those claims associated with the injury.

In our two samples involving 400 cases, we found 86 cases in which the injured party was enrolled in the Medi-Cal program after the date of the injury. Moreover, in 13 of these 86 cases, we found that the Medi-Cal program had paid for services related to the injury. In two of these cases, the Casualty Insurance Unit had established accounts receivable. Thus, the unit did not identify 11 of the 400 (2.75 percent) applicants who received Medi-Cal coverage for their work-related injuries. The cost of the medical services for these 11 cases totaled $9,145--an average of $831 per case. Further, based upon statistical sampling techniques, we are 90 percent confident that an additional 119 to 783 cases could be established from appeals filed in these two WCAB offices during fiscal year 1979-80.**

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* This step was necessary since a case could have been established based upon the diagnostic codes and other referral sources.

** This range of estimates is based upon variables such as rate of occurrence and size of the sample examined.

Although our review was limited to 2 of 23 WCAB offices, a board official stated that there is no reason to believe the results would be any lower in the other offices.* If the 2.75 percent sample occurrence rate applies to all regions of the WCAB, the Casualty Insurance Unit could identify approximately 3,300 additional workers' compensation cases annually.

We cannot statistically project the collection value of these cases; however, the Casualty Insurance Unit's experience with previous workers' compensation cases indicates that collections could be substantial. In the past, the unit has collected 47 percent of the payments that Medi-Cal has made for work-related injuries. This collection rate, applied against the $831 average case value in our sample, would give the 3,300 cases a value of nearly $1.3 million. However, management of the Casualty Unit believes that the collection potential is substantially higher than this figure because Medi-Cal payments for services have already been identified. Casualty Insurance Unit management stated that 13 additional staff would be required to process 3,300 additional cases. The unit estimates that the cost of these staff and overhead expenses would total approximately $423,000.

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* We verified this statement by reviewing counties corresponding to regions of the WCAB for these demographic characteristics: percentage of regional population eligible for Medi-Cal, percentage of appeals filed, and percentage of work-related injuries. We found that the sample counties exhibited no significant variations.

Estate Collections Could
Increase Recoveries

By instituting an estate recovery program, which is permitted under federal law, the Medi-Cal program could increase recoveries on a cost-beneficial basis. The department has estimated that by adopting this method, it could, in the second year of operation, recoup benefits yielding $1.5 million with staff costs of $119,755. This estimate yields a benefit-cost ratio of approximately 12:1.* We estimate that, after several years of operation, the Medi-Cal program could recover $3 million annually. This program can only be implemented if the Legislature enacts a statute.

Currently, the department only attempts to recover Medi-Cal benefits from the estates of beneficiaries who were not entitled to the payments. For example, the department attempts to recover payments made to beneficiaries who misrepresented their income by falsifying filed assets statements. However, federal law allows the states to recover correctly paid Medicaid expenditures from the estates of deceased recipients who were 65 years of age or older when they received the assistance [42 United States Code Annotated Sec: 1396a Para.(a) (18)]. Federal law allows recovery only for those services received when the recipient was 65 years of

* Thus, for every $12 recovered, the department will have spent $1.

age or older and only when there is no surviving spouse, surviving children under age 21, or blind or permanently and totally disabled offspring of any age.

Under the provisions of the Senior Citizens' Property Tax Postponement Law, California does have a form of an estate recovery program in effect. This law allows eligible homeowners 62 years of age or older to defer payment of property taxes on their residences. The State pays the deferred taxes to local governments and puts a lien on the property to assure that the taxes are paid when the property is transferred. All amounts owing under this program become due when the owner ceases to occupy the residence; when the owner dies; or when the owner sells, conveys, or disposes of the property.*

In 1971, the State of Maryland instituted an estate recovery program for Medicaid expenditures. During the last three fiscal years, from 1977-78 to 1979-80, the Maryland estate program has recovered over $1.6 million; program costs were reported to have totaled $44,800. Thus, Maryland's program has a benefit-cost ratio of 36 to 1.

* However, if the owner dies and the surviving spouse inherits the residence and continues to own and occupy it as a principal residence, then the lien amount does not become due and payable, except under certain circumstances.

Using information based upon Maryland's probate collection program, the Recovery Section's Compliance Unit has estimated that the Medi-Cal program could recover $1.5 million in the second year of operation at a cost of $119,775 per year. Assuming that California would be as successful as Maryland after several years of operation and based upon recent enrollment and expenditure figures, we estimate that this recovery potential could increase to $3 million a year. Appendix A presents the assumptions and methodology we used to calculate this recovery potential.

Maryland has also added safeguards for a recipient's survivors. Maryland's enabling legislation requires that possible hardship situations be considered. For example, the Maryland program would not force a sale on a recipient's property if the property were occupied by the recipient's invalid sister.

To institute an estate recovery program, the Legislature must enact a statute. The Department of Health Services has drafted a proposal to enact legislation that would allow the department to recover expenditures from beneficiaries' estates.

CONCLUSION

The Medi-Cal program could increase recoveries by an estimated $4.3 million. By using data available from the Workers' Compensation Appeals Board, the department's Casualty Insurance Unit could identify potential third party liability cases and thus augment recoveries by nearly $1.3 million. In addition, the Medi-Cal program could recover an additional $3 million per year by implementing an estate recovery program. For California to initiate such a program, the Legislature must pass legislation to implement provisions for estate recoveries permitted under federal law. The Department of Health Services has recently drafted proposed legislation for this purpose.

RECOMMENDATION

We recommend that the Department of Health Services enter into an interagency agreement with the Workers' Compensation Appeals Board so that WCAB applications may be referred to the Casualty Insurance Unit. This agreement should contain a provision for modifying the current application form to include a section on Medi-Cal participation. The department should also explore the possibility of matching the names of Medi-Cal eligibles with WCAB cases by computer.

If the department does secure such an agreement, we recommend that it increase staffing for this function commensurate with the number of cases identified. Furthermore, we recommend that the department evaluate the actual benefits of this referral system and report this information to the Legislature by January 1, 1983.

We also recommend that the Legislature consider implementing an estate recovery program for the Medi-Cal program. The Legislature may wish to consider the safeguards specified in Maryland state law relating to the protection of survivors.

NEED FOR IMPROVED INFORMATION SHARING AMONG SYSTEM UNITS

The sharing of important information related to the identification and recovery of Medi-Cal overpayments needs improvement. Specifically, the Medicaid Management Information System (MMIS) of the Department of Health Services has not provided needed reports to the Surveillance and Utilization Review Branch. Lack of these reports has impeded the branch's detection and deterrence of fraud and abuse in the Medi-Cal program. This problem has also impeded the functions of other units involved in the identification and recovery of Medi-Cal overpayments. In addition, the Licensing and Certification Division has not routinely informed units within the overpayment identification and recovery system when hospitals and nursing facilities change ownership or close. As a result, the identification and collection of debts have been jeopardized.

Untimely and Inaccurate Management Reports Have Limited the Effectiveness of System Units

The Medicaid Management Information System has not provided certain reports to units of the overpayment identification and recovery system. Furthermore, the reports that units do receive are often untimely and inaccurate. As a result, these units have been limited in identifying

overpayments and in detecting and deterring fraud and abuse in the Medi-Cal program. This condition has occurred because the fiscal intermediary, the Computer Sciences Corporation (CSC), has not fully met its responsibility for operating the Surveillance and Utilization Review (S/UR) Subsystem of the MMIS.

Title XIX of the Social Security Act provides federal matching funds for the design and operation of a Medicaid Management Information System. The federal model of the MMIS is an integrated group of procedures and computer processing operations developed to effectively process and control claims and to supply state management with the information necessary for planning and control. The Department of Health Services incorporated the federal requirements for this system into the fiscal intermediary contract awarded to the Computer Sciences Corporation.

An important area within the MMIS is the Surveillance and Utilization Review Subsystem, which is required to produce post-payment utilization review reports in a timely and accurate fashion to identify participants who overuse or misuse the Medi-Cal program. These reports are designed to be an effective aid in policing the Medi-Cal program for the State, reflecting patterns of recipient and provider use and identifying instances of abuse.

We found that although the CSC had produced S/UR reports for drugs and long-term care claim types as of September 17, 1980, it had not produced S/UR reports for the inpatient/outpatient and medical claim types. In addition, the CSC has produced but has not promptly submitted S/UR provider profiling reports, which aid in identifying potential provider fraud and abuse in the Medi-Cal program.

The Surveillance and Utilization Review Branch, the primary users of the S/UR reports, received provider profiling reports for only 4 of the 13 months between June 1, 1979 and July 31, 1980.* Those reports that were received were often late and were not usable because of inaccuracies contained in them. Branch officials stated that they have not used any S/UR reports produced by the CSC for identifying provider fraud and abuse cases but instead have relied on older information from the Medi-Cal Intermediary Operations (MIO), the previous fiscal intermediary.

The Medi-Cal Intermediary Operations identified cases of potential fraud and abuse through an exception reporting system which targeted providers who claimed services at a rate that differed significantly from the expected or average rate. The reports generated by the MIO's exception reporting system are still being used by branch officials. Specifically, branch

* The branch received provider profiling reports for September, October, and December of 1979, and for March of 1980.

personnel have relied on exception reports for the first two quarters of 1980 and a backlog of cases primarily generated by past referrals from the exception reports.

In addition to inaccuracies in the provider profiling reports, the Department of Health Services has also identified inaccuracies in the other reports being produced. For example, the department has noted such errors as duplication of random claims and inaccurate totals on provider claims detail reports. Additionally, one report has not included providers' names and addresses. Because of the inaccuracies and untimeliness of the S/UR reports, the Surveillance Utilization and Review Branch has been hindered in its efforts to effectively detect and deter fraud and abuse in the Medi-Cal program.

Performance of Previous Fiscal Intermediary

Although department staff have identified various deficiencies and weaknesses in the MIO's exception reporting system, this MIO system did contribute to the detection and deterrence of fraud and abuse in the Medi-Cal program. During fiscal year 1978-79, for example, the Surveillance and Utilization Review Branch identified over $2.8 million as overpayments to providers. As a result, the branch demanded repayments and took other actions against the providers.

Even though one branch official cited a success rate of less than 50 percent from the MIO's case referrals, the MIO's exception reporting system was still able to identify cases involving substantial overpayments. For example, the MIO referred a physician to the Surveillance and Utilization Review Branch for exceeding norms for initial visits to his office, as well as pregnancy tests and pap smears performed in his office. The physician repeated the same tests several days later on the same patients at a medical laboratory in which he had a proprietary interest. The Surveillance and Utilization Review staff determined that the physician had been overpaid by $474,816 and requested repayment of this amount from the provider. In addition, the physician was indicted in a criminal case (billing patients for services not performed). In another instance, the MIO, in conjunction with the federal Department of Health and Human Services, conducted a review of a clinical laboratory. Representatives of both the branch and the federal agency determined that the laboratory had been overpaid $482,334 and, as a result, requested that the provider repay this amount.

Department of Health Services personnel describe the CSC's system as potentially offering more flexibility and a wider range of information than did the MIO's system. Moreover, officials believe that the CSC's system will result in improved identification of fraud and abuse while providing

for better use of staff. Approximately 50 percent of the on-site reviews conducted in response to referrals from the MIO resulted in action against a provider. However, an official in the Surveillance and Utilization Review Branch indicated that by using information from the CSC, the branch hopes to seek action against providers in 67 to 80 percent of all cases.

The State, in contracting with the CSC to act as fiscal intermediary, expected to receive a functioning system capable of producing reports that identify potential fraud and abuse cases. Since the CSC has not provided needed S/UR reports, staff of the Surveillance and Utilization Review Branch are hindered in their ability to effectively and efficiently detect and deter fraud and abuse in the Medi-Cal program.

Other State Units Affected

Because the S/UR subsystem has not produced required reports, other state units, such as the Beneficiary Utilization Review Unit, the Recovery Section, and the Medi-Cal Fraud Unit (MCFU), cannot efficiently and effectively perform their duties. The Beneficiary Utilization Review Unit, which identifies beneficiaries who abuse Medi-Cal services, indicated that it needs claims detail reports for all provider types. Because reports for inpatient/outpatient and medical services

are not available, the unit has been impeded in reviewing potential cases of beneficiary drug abuse.* Further, the Recovery Section, which acts as the collection agency for the Medi-Cal program, relies upon the fiscal intermediary for payment profiles to decide whether a demand for recovery should be made. An official of the Recovery Section stated that because of the lack of payment histories of institutional and medical providers, demands for payments are down significantly.

The Medi-Cal Fraud Unit is involved in an undercover investigation of a provider suspected of fraudulent billings. This provider annually bills significant amounts to the Medi-Cal program. According to an MCFU official, problems in obtaining needed information from the CSC are jeopardizing the investigation.** The official cites the need for a listing of services given by the provider to establish the existence of a fraudulent billing pattern. Since the MMIS is not producing claims detail reports for medical services, this information is not available. More importantly, the MCFU must establish the exact services for which the provider billed the Medi-Cal program as opposed to the services actually rendered. The MCFU

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* Recipient claims detail reports for inpatient/outpatient claims became available in October 1980.

** Following the completion of our fieldwork, the MCFU staff obtained the necessary materials from the CSC. The official stated that the CSC and the DHS are resolving problems in obtaining needed information.

has requested the original claim forms submitted by the provider, citing the need for original documents for evidence in criminal prosecutions. However, the CSC has not provided them. According to the MCFU official, for every day there is a delay in getting the needed information, the greater the probability that the provider will become aware of the investigation, and in doing so, destroy his records and cost the State substantial money in potential recoveries.

Because of the CSC's failure to perform according to contract standards, the department is now assessing liquidated damages for reports not being produced for inpatient/outpatient and medical claim types.* This assessment reduces payment by 2 percent of the processing fees for these two claim types. (A DHS official estimates that this assessment totals approximately $30,000 per month.) Additional liquidated damages for late or inaccurate reports produced for drugs and long-term care claim types are also being assessed for individual cases in which performance standards are not met.

* Liquidated damages are penalties levied against contractors for cases in which their noncompliance caused the State to sustain indeterminate damage.

Licensing and Certification Division Not Sharing Information with System Units

The Licensing and Certification Division of the Department of Health Services does not routinely share important information with units of the overpayment identification and recovery system. Division offices located statewide do not inform the Audits Branch and the Recovery Section's Compliance Unit when hospitals and nursing homes change ownership or close. As a result, collection of current and future debts of these facilities is jeopardized.

The department's Licensing and Certification Division regulates California's licensed public and private health facilities including hospitals, skilled nursing facilities, and other institutions through 11 district and subdistrict offices.* This division is required to notify the Medicare program Region IX office in San Francisco when facilities participating in Medicare change ownership or close. (Medicare is the federal health insurance program for the elderly.) This notification assists Medicare staff in their efforts to ensure that providers meet program standards and qualifications. In addition, it alerts Region IX staff that a hospital provider's

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* One office is operated under contract by Los Angeles County.

final cost report must be audited. Since new providers must apply for new facility licenses and program certification through the division's district offices, these offices are an important source of information on the sale and closure of facilities.

Although the division's district offices notify the Medicare program when facilities change ownership or close, they have not regularly notified the Audits Branch and the Recovery Section's Compliance Unit of the transactions involving Medi-Cal facilities.* The Audits Branch and the Compliance Unit need timely information on facility sales and closures so they may carry out these functions:

- Request hospital providers to submit their final Medi-Cal cost reports within 45 days of a sale or closure as required by federal regulations;

- Suspend payments to the provider if the provider fails to submit the final cost report or has outstanding debts to the program resulting from previous audits or investigations;

- Schedule an audit of the final cost report and any other unaudited reporting periods;

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* Most Medicare facilities also treat Medi-Cal patients. Over 90 percent of the State's hospitals participate in both programs.

- Notify the Office of Legal Services to expedite the settling of any appeals in process.

These responsibilities must be discharged if the Medi-Cal program is to avoid overpaying the provider. Historically, the longer a provider is out of the program, the more difficult collection becomes.

In the past, the Audits Branch and the Compliance Unit have requested that the Licensing and Cerification Division notify them of facility sales, and closures.* On September 23, 1977, division management sent a memorandum to the district offices. This memorandum specified the notification procedures district offices were to follow. However, the district offices have not consistently followed these procedures.

To review the effectiveness of this notification system, we reviewed records at the division's district offices, the Sacramento headquarters of the Audits Branch, and the Compliance Unit headquarters. At the Licensing and Certification Division's district offices, we reviewed the files associated with 54 hospital sales and closures which have

* The need for these notices is especially important because the federal 45-day reporting requirement is rarely met. Few facilities submit their final cost reports on time.

occurred since the division instituted its procedures.* We recorded the dates of the sales and closures, the dates the district offices learned of these transactions, and other pertinent information about the facilities. Next, at the Sacramento headquarters of the Audits Branch, we reviewed the chronological correspondence files on these same hospitals to determine if and when district offices or division headquarters had notified the Audits Branch of the sales and closures.

We then visited Compliance Unit headquarters and reviewed the unit's accounts receivable established as a result of reviews conducted by the Investigations Branch and the Surveillance and Utilization Branch. If accounts receivable existed on any of the hospitals in question, we verified whether the accounts receivable had been established before the sale or closure. We then reviewed the Compliance Unit's case file on the facility for any notices the Licensing and Certification Division might have sent.

Generally, we found that the Licensing and Certification Division did not routinely notify the Audits Branch or the Compliance Unit of sales or closures of facilities. For example, we found that the division sent only

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* The 54 cases represent the hospital sales and closures that we could identify by reviewing facility number logs at the district offices. The actual number of sales and closures may be higher.

29 notices of sales or closures to the Audits Branch even though 54 of these transactions took place. Thus, the division only provided notices to the Audits Branch in 54 percent of the cases. Moreover, we found that of three accounts receivable files established for hospitals by the Compliance Unit, only one file contained a notice from the Licensing and Certification Division. This single notice was dated approximately 11 months after the transaction had occurred.

Furthermore, the 29 notices that the Licensing and Certification Division sent to the Audits Branch arrived at varying intervals of time. Some arrived either before the sale or closure or shortly thereafter; others arrived considerably later. The following table illustrates the varying arrival times of the 29 notices.

TABLE 1

ARRIVAL INTERVALS OF HOSPITAL SALE AND CLOSURE NOTICES
(Measured from Sale or Closure Date)[a]

Interval	Number of Notices
Before sale or closure to 15 days following	17
16 days to 1 month following	5
More than 1 to 3 months following	2
More than 3 to 6 months following	2
More than 6 months following	3

[a] Since Audits Branch staff did not stamp some of these notices when they were received, we had to calculate timeliness in these cases from the date of the form. Therefore, in some cases, the notices may have arrived later than presented in Table 1.

Because the Licensing and Certification Division does not promptly notify the Audits Branch and the Compliance Unit of facilities' sales and closures, the successful collection of overpayments is jeopardized. As previously stated, collection of overpayments is jeopardized when a provider is no longer a Medi-Cal participant. Collection is most successful when payments are withheld on unpaid claims in the fiscal intermediary claims processing system. If all claims have been paid, the intermediary must refer the debt to the Compliance Unit for collection. Historically, the Compliance Unit's collection rate for such cases is low.

We found several cases in which the lack of timely information on hospital sales and closures has jeopardized the collection of overpayments. In one case, a district office of the division learned of the impending sale of a Southern California hospital two weeks before the sale date (December 28, 1979). This office sent no notice to the Audits Branch, which did not learn of the transaction until nearly eight months later. The branch never received a final cost report and was not able to suspend Medi-Cal payments to the facility until July 17, 1980 when it became aware of the sale. Had the branch been aware of the sale, it could have legally suspended payments 45 days after the transaction because the facility had not submitted the cost report.

Another instance concerned a Bay Area hospital that closed on December 24, 1977. The Licensing and Certification Division field office learned of this closure the day before but did not notify either the Audits Branch or the Compliance Unit. The hospital had just been reviewed by the Surveillance and Utilization Review Branch; this review found nearly $80,000 in overbillings to Medi-Cal. The Surveillance and Utilization Review Branch requested repayment and referred the case to the Compliance Unit for collection. On January 30, 1978, the fiscal intermediary made a $24,000 payment on the hospital's billings. When Compliance Unit staff learned that the facility had closed, they notified the Audits Branch and the fiscal intermediary, which informed them of the payment. If the Audits Branch had known of the closure, it could have prevented the fiscal intermediary from making the $24,000 payment.

Although our review was limited to hospitals, we encountered instances in which the Licensing and Certification Division did not notify the Compliance Unit of sales and closures of other types of institutions. During our review of workload management, we found an Investigations Branch case in which a convalescent hospital had overcharged the Medi-Cal program $22,993.29. The Compliance Unit established the case and demanded repayment on February 27, 1979. In June of the same year, the Licensing and Certification Division's district office learned of the facility's pending sale which occurred in

August. The Compliance Unit did not learn of the sale until October, nearly two months later. The Compliance Unit instructed the fiscal intermediary to withhold payments but there were no Medi-Cal billings left in the payment system against which to offset the debt. Thus, the Recovery Section had to negotiate with the former owner, who succeeded in settling the debt for approximately half the liable amount.

CONCLUSION

Our review found that certain units within the Medi-Cal program need to improve their sharing of information. The Medicaid Management Information System has not provided reports to the Surveillance and Utilization Review Branch. As a result, that branch is hindered in its efforts to detect fraud and abuse. In addition, the Licensing and Certification Division has not routinely informed the Audits branch and the Compliance Unit when hospitals and nursing homes close or change ownership. As a result, the identification and collection of debts has been jeopardized.

RECOMMENDATION

We recommend that the Department of Health Services continue to closely monitor the CSC's compliance with performance criteria and to assess liquidated damages when indicated. Further, the department should periodically monitor the district offices of the Licensing and Certification Division to ensure that they comply with established procedures for sending prompt, written notification of all Medi-Cal facility sales and closures to the Audits Branch and to the Compliance Unit.

NEED FOR IMPROVED WORKLOAD MANAGEMENT

Several units within the Medi-Cal overpayment identification and recovery system need to improve the management of their workloads. The Recovery Section's Compliance Unit has not complied with procedures for following up collection cases or for addressing high priority cases. Units responsible for identifying and recovering Medi-Cal overpayments are not monitoring the accuracy with which the fiscal intermediary calculates interest charges on past due accounts receivable. As a result of these conditions, the collection of both overpayments and full interest charges due the program is being jeopardized.

Compliance Unit Has Not Followed Collection Procedures

The Recovery Section's Compliance Unit has had significant problems managing its workload. During our first review, we found that the unit's Southern Region offices were not adequately pursuing overpayment collection cases as required by the Recovery Section's procedures manual. Additionally, one office was not adhering to the Compliance Unit's policy for addressing high priority cases. As a result of these practices, the Compliance Unit's ability to successfully collect Medi-Cal overpayments has been impaired. During this review, we found that significant progress had been made to correct these deficiencies.

The Compliance Unit is one of four units within the Department of Health Services' Recovery Section. The unit acts as a collection agency, receiving overpayment referrals, establishing them as collection cases, and implementing prescribed procedures to recover the amounts due. The unit has Coastal, Northern, and Southern collection regions. Because of its size, the Southern Region has offices in three cities: Hollywood, Santa Ana, and San Diego.

Most collection cases begin when the unit's offices receive a referral from another entity such as the Surveillance and Utilization Review Branch, the Investigations Branch, the Health Insurance Unit of the Recovery Section, or a county welfare department. The Compliance Unit office establishes the case file and a tax compliance representative initiates collection procedures. To begin collection, the representatives are first required to mail a form letter to the debtor demanding payment. After this, the representatives take additional steps until the overpayment amounts are recovered.* These steps include forwarding a second demand letter and, if the debtor is an active provider, instructing the fiscal intermediary to withhold the amount of the debt from payments

* The tax representatives pursue collection efforts by using a tickler file system. In this system, clerical staff pull certain files on dates specified by representatives. The representatives review the files, taking appropriate action. They then assign new review dates and return the files to the clerical staff.

on current billings. If the debtor is a beneficiary and the demand letters have not caused a response, the representatives attempt collection by requesting the Franchise Tax Board to offset state income tax refunds. Occasionally, the representatives initiate small claims court action against debtors.

Collection is most successful when the debtor is an active provider because the technique for withholding payments assures that the debt will be satisfied as long as unpaid billings remain in the fiscal intermediary's system. However, collection of beneficiary overpayments is less successful, since most beneficiaries receive a limited income, claim few assets, and change addresses more frequently than do providers. Moreover, Title 22 prohibits the Compliance Unit from withholding public assistance payments to offset debts. Consequently, the unit's policy has been to give the highest priority to establishing provider cases.

Our review found that the Compliance Unit's Southern Region offices were not adhering to the case follow-up procedures specified in the Recovery Section's manual. We reviewed a random sample of 50 cases established during fiscal year 1978-79 at each of the Compliance Unit's five offices. These 250 cases represented 6.3 percent of the unit's 3,938 cases established during the year.

Although we found no significant deficiencies in the Northern and Coastal Region offices, we found that the Southern Region offices have not adequately pursued collection efforts. For example, tax representatives had not followed up on 20 of 33 open cases reviewed in one office. In ten of these cases, representatives had taken no action after the cases had been established. In fact, they had not sent a single demand letter.* In another office, we noted that 13 out of 15 open cases required further collection efforts; however, no follow-up had occurred beyond the first demand letter. Finally, in the third office, we noted that representatives had not followed up on 6 out of 19 open cases, aside from sending the first demand letter. For one case, representatives had taken no action.**

A case we selected from our Southern Region sample illustrates how insufficient collection efforts can prevent the Medi-Cal program from recovering overpayments. The Investigations Branch referred to a Southern Region office a case involving a Medi-Cal participant who lived in a nursing home and who had $20,636.97 in a savings account. (This amount

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* The office received these cases between 6 and 14 months prior to our review.

** Fewer open cases does not necessarily indicate that one office is more proficient at case follow-up than another. Twenty-two closed cases in one sample were voluntary repayments and needed no follow-up. And, at another office, staff were able to produce only 42 out of the 50 files requested.

exceeds the progam's allowable asset limits.) Investigators determined that the beneficiary owed the Medi-Cal program $2,013.14. The Southern Region office mailed only one demand letter five months before our sample review, which took place on October 4, 1979. Even though we brought this case to the attention of collection staff, they did not mail a second demand letter until March 4, 1980. Two days later, the office received a letter from the patient's niece stating that the patient had died on November 24, 1978; that the estate had already been settled; and that the Medi-Cal program had no claim against her. Compliance staff verified that the Decree of Final Discharge settling the estate had been signed on December 3, 1979, two months after our sample review. The case is being written off as uncollectible. Had a second demand letter been sent any time prior to December 3, 1979, the Medi-Cal program could have had a claim against the deceased's estate.

There are two reasons for the inadequate case follow-up we found in the Southern Region. First, no Southern Region office was using the tickler filing system specified in the procedures manual. Second, supervisory personnel did not adequately review cases. The regional supervisor stated that he did not routinely check cases for follow-up procedures.

We also found that collection personnel in one office had not addressed high priority cases as required. During our prior review, we identified 144 provider health insurance referrals totaling $131,605 in the offices' backlog of cases to be established. These high priority referrals were dated as far back as July 1977, and involved up to $11,991. Two referrals, for example, involved the same hospital and totaled $10,043.52. One referral was made in November 1977 and the other, in January 1978. Meanwhile, staff had been establishing lower priority beneficiary cases amounting to as little as $19.39.

Collection becomes more difficult as a case gets older. Providers such as nursing homes, pharmacies, and hospitals may terminate operations, and beneficiaries may die or relocate. Therefore, it is imperative that cases be established expeditiously and that follow-up procedures be observed.* When established procedures are not followed, collection of Medi-Cal overpayments is jeopardized.

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* There is another reason why cases should be set up expeditiously: Medi-Cal regulations allow the program to charge interest only from the date of initial payment demand. Thus, collection delays caused by untimely payment demands cost the program foregone interest.

During the course of this review, we found that the Compliance Unit's Southern Region offices have made considerable progress in correcting problems relating to the collection of overpayments. The region has established tickler file systems at each office. In addition, the region has eliminated its backlog of provider cases to be established.

Department Management Is Not Monitoring Intermediary Interest Computations

Management in the Department of Health Services has not monitored the accuracy of the Computer Sciences Corporation in maintaining accounts receivable for providers. As a result, the department has not identified errors that the CSC has made in computing interest charges on past due accounts. We found three instances in which the Computer Sciences Corporation incorrectly calculated interest charges; in these cases, over $135,000 should also have been assessed against the providers.

When the Medi-Cal program finds that a provider has been overpaid, the Department of Health Services is to recover any overpayments found due and payable. Interest on all accounts due and owing is charged at the rate of 7 percent per year on the unpaid balance commencing 30 days following the date of the initial notice of overpayment.* If the provider

* The new regulations for provider appeals allows 60 days. In addition, the program does not charge counties interest on overpayments held during appeal.

disagrees with the findings, he has the right to appeal. When a provider appeals an audit finding or examination, the program applies interest beginning 30 days following the date of the overpayment notice. However, charges apply only to the amount subsequently determined to be due to the State.

The CSC is required to issue a Statement of Account Status which reflects any outstanding debts and interest due to date. The CSC is to carry any amount under appeal as a separate accounts receivable and to accrue interest accordingly. These interest charges are computed manually by CSC personnel. Once an appeal is adjudicated, the hearing agency, Administrative Appeals, notifies the CSC to recover the amount found due to the State (or to credit the provider if money is owed by the State). The CSC notifies the provider of the principal amount due and the resulting interest charges and sends copies of the statements to the Audits Branch, the Recovery Section, and Administrative Appeals.

To determine the accuracy of computations of interest charges on amounts found due to the State after the appeals process, we selected a sample of 22 accounts involving hospital appeals for amounts greater than $10,000. We reviewed the Statements of Account Status, available in the provider correspondence files of the Audits Branch as well as in files

kept in the Compliance Unit. Statements were available in 13 of these cases. Of the nine cases remaining, statements were not available for analysis primarily because the action was too recent.

In 3 of the 11 cases in which a provider was found to owe the Medi-Cal program some amount, we found that interest charges had not been calculated correctly.* For example, the CSC assessed no interest charges to one facility which owed $50,715. Recovery of this amount had been deferred for 26 months during the appeals process. We calculated that over $7,300 should have been assessed as interest charges. In the instance of another facility with cases for two different fiscal periods, the CSC assessed interest amounting to only $15,863 on a principal amount of $739,141. Recovery of this amount had been deferred over 33 months during the appeals process. We calculated that the correct interest charges should have totaled over $124,900.

We asked officials of the CSC to research their records to verify these apparent errors; their recalculations showed that errors had been made and that an additional $135,158 should have been assessed.** The manager of the CSC's Program Accounting Unit indicated that corrections would be

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* In the remaining two cases, money was owed to the provider.

** Of this additional amount, $127,413 is due from one bankrupt provider.

made, and that the accuracy of the computations in other past statements would be reviewed. Only one of these facilities is still in operation and it has been rebilled for the additional amount of interest charges due.

These three cases of miscalculation of interest illustrate that the department should closely monitor the CSC's computations. Officals of the three departmental units which receive copies of the Statements of Account Status indicated that it was not their responsibility to monitor the accuracy of the interest computations on the statements. Furthermore, an official of the Fiscal Intermediary Management Branch, which is responsible for monitoring the performance of the CSC in fulfilling its contract with the State, indicated that while branch staff had technical responsibility for the CSC's performance, they had not assessed the accuracy of interest computations because of staffing shortages in their unit.

CONCLUSION

Certain units within the Medi-Cal overpayment identification and recovery system have not adequately managed their workloads. The Compliance Unit's Southern Region has not complied with case follow-up procedures or with procedures for addressing high priority cases. Units responsible

for identifying and recovering Medi-Cal overpayments are not monitoring the CSC's accuracy in calculating interest charges on past due accounts receivable. As a result of these conditions, the collection of Medi-Cal overpayments and interest charges has been jeopardized.

RECOMMENDATION

To improve procedures for managing workload within certain units of the overpayment identification and recovery system, we recommend that the Department of Health Services take the following actions:

- Require that all Compliance Unit regional offices follow up collection cases and comply with procedures for addressing high priority cases;

- Require regional supervisors to periodically review sample cases.

Further, we recommend that the department conduct a study to determine whether the Compliance Unit's collection procedures could be automated through the use of mini-computers or other automated systems at each regional office. If the current follow-up system were automated, it would assist the tax

representatives in handling their increasing workloads. Mini-computers could perform such functions as mailing demand letters and instructing the fiscal intermediary to withhold payments. The feasibility study should consider whether the potential for increased recoveries would offset the costs of automating the collection system.

Additionally, the department should fix the responsibility for monitoring the accuracy of the CSC's Statements of Account Status issued as a result of adjudicated appeals. Once this responsibility has been assigned, we further recommend that the unit selected immediately review all prior CSC statements for inaccurate assessments.

NEED FOR REVISING CERTAIN STATUTES AND REGULATIONS RESTRICTING MAXIMUM RECOVERIES

Certain statutes and regulations prevent the Medi-Cal overpayment identification and recovery system from realizing maximum recoveries. One regulation allows providers to defer payment until after two levels of appeal, even though most appeals are decided in the State's favor. This regulation has prevented the Medi-Cal program from earning additional interest revenue on overpayments which could have been collected before the appeals process. Moreover, some providers avoid repaying the program by discontinuing their participation in the Medi-Cal program while their appeals are still pending. As a result of this practice, there are no billings in the payment system by which Medi-Cal can offset the debt; the only recourse then becomes civil action.

In addition, the 7 percent interest rate that the law requires be charged to debtors of the Medi-Cal program is significantly lower than comparable commercial interest rates, rates charged by other states' Medicaid programs, and the rate charged by the State Board of Equalization. Our review showed that if this statute were changed, the Medi-Cal program could have earned an additional $325,315 interest on selected appeals for overpayments filed during fiscal year 1977-78.

Untimely Collection of Overpayments Loses Revenue for State

The Medi-Cal program is prevented from earning additional interest revenues because a state regulation allows providers to defer repaying overpayments until they have appealed audits and investigations in an informal and a formal hearing. This regulation allows providers to hold repayments while involved in the hearings, most of which are decided in favor of the Medi-Cal program. Our analysis showed that by collecting overpayments on initial demand, the Medi-Cal program could have earned $243,000 in additional revenue on selected overpayment appeals filed during fiscal year 1977-78. Further, the regulation has allowed some providers to avoid repaying the Medi-Cal program by closing their operations while their appeals are in process. As a result, there are no billings in the payment system by which Medi-Cal can offset the debt, and the program's only recourse is to initiate civil action against the providers.

A state regulation allows providers to defer the repayment of overpayments until they have appealed the audits or investigations. Federal regulations differ from state regulations on this point. Title 22, California Administrative Code, Section 51047, allows providers to defer repaying the Medi-Cal program until they have appealed their cases at two administrative levels. But federal regulations are less

specific and are thus open to intepretation by participating states. South Carolina, for example, interprets the regulation as allowing for collections prior to appeal. Federal Medicare program regulations also require the program to collect overpayments prior to appeal.

The two levels of appeal provided by state law include an informal and a formal hearing. The informal hearing involves the provider, the department, and a hearing auditor. At this hearing, which takes an average of 16 months to complete, disputes involving complex factual matters or matters requiring detailed accounting expertise are to be resolved. If providers are not satisfied with the decision rendered, they can appeal for a formal hearing. This formal hearing is attended by the provider, the department, and a hearing officer. At this hearing, which takes an additional 23 months to complete, disputes involving legal issues are to be resolved.

Most of these hearings are decided in favor of the State (representing the Medi-Cal program). Approximately 80 percent of all amounts appealed at informal hearings in the last four years have been sustained in the State's favor. Additionally, 68 percent of all amounts appealed at formal hearings in fiscal year 1978-79 were sustained in the State's favor.

Providers appeal a substantial number of audits and investigations. For example, in fiscal year 1978-79, 587 out of 1,078 audits and investigations (54 percent) were appealed. According to officials of the Department of Health Services, this volume of appeals has resulted in part because a regulation allowed providers to defer payments until an informal decision had been rendered. Department officials have stated that Section 51047's allowance for collection after the formal appeal may further induce providers to appeal, thereby contributing to the number of appeals and further protracting the process through which the appeals are resolved.*

The U.S. General Accounting Office conducted an audit of the Medicaid programs of five states, including California. The report indicated that provider appeals of cost audits have delayed the recovery of many overpayments and concluded that post-appeal collection gives providers an incentive to appeal.**

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* This provision became effective for audits conducted after June 1980.

** Report No. HRD-80-77, entitled States Should Intensify Efforts To Promptly Identify And Recover Medicaid Overpayments And Return The Federal Share, by the United States General Accounting Office, June 10, 1980.

To assess the monetary effects of collecting overpayments before of the appeals process and to determine the amount of additional interest revenues the Medi-Cal program would earn through this method, we examined 67 hospital audit appeals involving amounts over $15,000. Our sample included appeals that were filed in fiscal year 1977-78. We compared the interest revenue that would have been earned by collecting overpayments before the informal appeals process with the revenue that would have been earned by collecting overpayments after the formal appeals process.* We also asked the Legislative Counsel for an opinion on the legality of collecting overpayments before the appeals process (see Appendix C). The Legislative Counsel stated that this method of collection would not violate the due process of providers. We found that if the Medi-Cal program had collected overpayments before the informal hearing rather than after the formal hearing, it would have earned an additional $243,000 in interest revenues.

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* Appendix B describes the assumptions and methodology used to calculate interest revenue earned through collecting overpayments in advance of the formal appeals process.

Similarly, the Health and Welfare Agency's Systems Review office also analyzed the effect of collecting overpayments after the appeals process.* This study focused on Health and Welfare Agency overpayments that had been appealed since fiscal year 1971-72. The study found that agency programs have lost more than $25 million in purchasing power because collection on debts has been deferred. A substantial portion of this amount is due to appeals by Medi-Cal providers.

The Recovery Section also reviewed the effect of deferring overpayment recoveries until after appeal. Their review estimated that the annual loss of interest income to the State is $2,600,000.

Foregone interest is not the only negative effect of collecting overpayment after the appeals process. The program could also lose the entire principal amount if providers discontinue their operations or sell out while their appeals are in process. Collection then becomes difficult because there may be no unpaid claims in the payment system against

* Report No. SR 79-27, entitled Health And Welfare Agency Audit Appeal Status, by Systems Review, Health and Welfare Agency, September 1980.

which to offset the debt.* Moreover, the former owner may have no tangible assets and the past officers and stockholders may refuse to be personally liable for the debts incurred by the former owner.

Our review disclosed a case in which the new owners of a hospital denied liability for the overcharges incurred by the former owners. Staff of the Investigation Branch found that the hospital overcharged the Medi-Cal program $302,009 by classifying inebriated patients as emergency cases. By misclassifying these patients, the hospital was able to circumvent the Medi-Cal prior authorization system. The Medi-Cal program demanded repayment and the hospital appealed; this action stopped all collection activity. While the appeal was being processed, the hospital was sold. Collection staff of the Medi-Cal program had to wait until the appeal was settled in the State's favor before pursuing the overpayment. By instructing the fiscal intermediary to withhold payment on unpaid claims, collection staff were able to recoup $27,171 which was applied to unpaid interest. However, the principal remained outstanding. Further, the facility's new owners denied liability for the overcharges.

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* Medi-Cal cannot withhold payments to offset debts as long as they are being appealed even though the program may learn of an ownership change.

The department has recognized the problems associated with collection of overpayments after second level appeals. It has drafted changes to the current regulations to allow for collecting overpayments within 60 days after the initial demand for repayment. However, these proposed changes have not yet gone to public hearing.

Interest Rate Charged on Debts to Medi-Cal Is Low

The Medi-Cal program is prohibited from maximizing interest revenue because the 7 percent interest rate charged debtors to the Medi-Cal program is significantly lower than comparable commercial interest rates, rates other states charge for their Medicaid programs, and the rates charged by the State Board of Equalization. Also, the 7 percent interest rate may be providing incentives for some providers to appeal. Our review showed that for informal appeals filed by selected providers during fiscal year 1977-78, the program could have increased recoveries by $325,315 if the interest rate were raised to 12 percent.

The Medi-Cal program, in accordance with Section 14172 of the California Welfare and Institutions Code, is to charge interest at the rate of 7 percent per year on unrecovered overpayments.* This rate is significantly lower than commercial interest rates; the 1980 average monthly prime rate of interest on short-term loans for the first six months of 1980 ranged from 12.2 to 19.8 percent. This rate is also lower than interest rates that some other states charge for their Medicaid programs. For example, New York charges Medicaid debtors 11-¼ percent interest while New Jersey charges its debtors 12 percent interest. Further, the 7 percent rate of interest is considerably lower than that of the State Board of Equalization, which charges debtors interest at 12 percent.

According to officials of the Department of Health Services, the 7 percent interest rate may also motivate providers to appeal overpayment demands. For example, during fiscal year 1978-79, 54.5 percent of the 1,078 Medi-Cal audits and investigations were appealed. As discussed in the preceding section, these providers can defer payment until the completion of their appeal and then pay the deferred amount to which has been added 7 percent interest penalty.

* Interest begins 30 days after service of notice of an overpayment. As previously stated, the new regulation for provider appeals allows 60 days. In addition, the Medi-Cal program does not charge counties interest on overpayments held during appeal.

To determine the impact that a higher rate of interest would have on recoveries from hospital appeals, we reviewed 1977-78 hospital appeal amounts totaling over $15,000. For the appeals in our review, we calculated interest on the payment amount that was deferred by the provider from the time of the initial payment demand to that of the final payment notice.* We then calculated the interest using the 7 percent rate, the average prime rate of interest, a 10 percent rate of interest, and a 12 percent rate of interest. As shown in Table 2 below, we found that raising the interest rate would substantially increase interest revenue.

TABLE 2

INTEREST REVENUE
AT VARYING INTEREST RATES

	Interest Rates			
	7 percent	10 percent	12 percent	Prime[a]
Interest revenue	$455,455	$650,645	$780,770	$726,770
Increase over revenue resulting from 7 percent interest	--	$195,190	$325,315	$271,315

[a] The average monthly prime rate of interest on short-term loans was 11.17 percent for the period from July 1, 1977 through June 30, 1980.

* Since some of these appeals had not been adjudicated, we used an historical rate for which decisions were upheld in favor of the State to determine the deferred payment amount. Also, since some of these appeals had not been adjudicated, we used 30 days after the audit date through June 30, 1980 for the interest period.

As shown on the previous page, the 12 percent interest rate charged by the State Board of Equalization would have yielded an additional $325,315 in interest revenue.

CONCLUSION

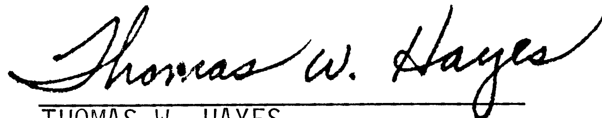
Certain statutes and regulations prevent the Medi-Cal program from realizing maximum recoveries. Our review found that if Title 22, California Administrative Code, Section 51047 were revised to allow the Medi-Cal program to collect overpayments before the appeals process, the Medi-Cal program could have earned $243,000 in additional interest on selected 1977-78 hospital appeals. Moreover, the present regulation allows some providers who discontinue participating in the Medi-Cal program while their appeals are pending to avoid repaying the program. Also, our review found that if Section 14172 of the California Welfare and Institutions Code were revised, the Medi-Cal program could have earned an additional $325,315 interest on selected appeals for overpayments filed during fiscal year 1977-78.

RECOMMENDATION

We recommend that the Department of Health Services consider the results of our review in deciding whether to change Title 22, California Administrative Code, Section 51047. This proposed change would provide for collection of overpayments before the appeals process.

We further recommend that the Legislature consider increasing the interest rate that the Medi-Cal program is legally allowed to charge debtors of the program. Additionally, if the Legislature adopts a higher interest rate, we recommend that the department increase the interest rate Medi-Cal allows creditors to an equivalent rate.

Respectfully submitted,



THOMAS W. HAYES
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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
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January 28, 1981

Thomas W. Hayes
Auditor General
952 L Street, Suite 750
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Dear Mr. Hayes:

Your draft report entitled "New Statutes, Policies and Procedures Could Increase Medi-Cal Recoveries by at Least $4.3 Million Annually" was received and reviewed. I agree with the thrust of your report.

A great deal has happened since your audit was initiated. The Governor's Budget includes several new positions to assist us in improved cost containment and recovery activities. Legislation to further improve recoveries is now being discussed with possible sponsors. The performance of the fiscal intermediary in producing surveillance and utilization reports has greatly improved. Management and procedure changes within the Department have further strengthened our program.

My comments on your four recommendations and on the text of your draft report are attached.

I appreciate the efforts that you and your staff have expended in our behalf.

Sincerely,

Beverlee A. Myers
Director

Attachment

Attachment

Recommendation 1 page 21.

"We recommend that the Department of Health Services enter into an interagency agreement with the Workers' Compensation Appeals Board so that WCAB applications may be referred to the Casualty Insurance Unit. This agreement should contain a provision for modifying the current application form to include a section on Medi-Cal participation. The department should also explore the possiblity of matching the names of Medi-Cal eligibles with WCAB cases by computer.

If the department does secure such an agreement, we recommend that it increase staffing for this function commensurate with the number of cases identified. Furthermore, we recommend that the department evaluate the actual benefits of this referral system and report this information to the Legislature by January 1, 1983.

We also recommend that the Legislature consider implementing an estate recovery program for the Medi-Cal program. The Legislature may wish to consider the safeguards specified in Maryland state law relating to the protection of survivors."

DHS RESPONSE

"Enter into an interagency agreement with the Workers' Compensation Appeals Board" (page 21).

The Department concurs with the recommendation to enter into an interagency agreement with the Worker Compensation Appeals Board. In order for such a referral system to be cost effective the WCAB must modify its application form to include a section on Medi-Cal participation and to promptly forward those related forms for our action. The Department also agrees that matching Medi-Cal eligibles with WCAB cases is desirable. A computer match with the WCAB file should be possible when their system is activated.

"Increase staffing commensurate with cases" (page 22).

The Governor's Budget for BY 1981/82 includes one new FTE staff for WCAB cases.

The Department's Recovery Branch has recognized the need to improve interface with the WCAB for several years. Since December 1975, the Section has regularly

been petitioning the WCAB to modify its application form. We have sought and received help from the Attorney General's Office. To date however, the Board has not instituted any of the Recovery Section/Attorney General suggested modifications.

"Report to the Legislature" (page 22).

A report to the Legislature by January 1, 1983 on the benefits of the WCAB referral system is reasonable.

"Consider implementing an estate recovery program".

Legislation which includes an expanded estate recovery program has been developed and is being discussed with Legislators.

Recommendation 2 page 39.
"We recommend that the Department of Health Services continue to closely monitor the CSC's compliance with performance criteria and to assess liquidated damages when indicated. Further, the department should periodically monitor the district offices of the Licensing and Certification Division to ensure that they comply with established procedures for sending prompt, written notification of all Medi-Cal facility sales and closures to the Audits Branch and to the Compliance Unit."

DHS RESPONSE

"Need for improved information sharing among system units" (page 23).
"... The Medicaid Management Information System (MMIS) ... has not provided needed reports" (page 23).

As the Auditor General points out, the new MMIS S/UR Subsystem is currently producing only a portion of the required reports. Delays in the installation of the S/URS have caused the SUR Branch and other units of the Medi-Cal overpayment identification and recovery system to utilize other available research tools or to reschedule productive output. Once the new S/URS becomes fully operational, the superior capabilities and enhanced methods offered for the identification and retreival of data will allow the DHS to recover from the difficulties it is presently experiencing and to proceed at a higher rate of effectiveness in its ability to detect and deter Medi-Cal fraud and abuse.

"Untimely and inaccurate management reports have limited the effectiveness of system units" (page 23).
In many cases, S/URS reports produced by CSC have been untimely and inaccurate; and reports for some provider types have not been produced. Reports for pharmacy and long term care have been available since May 1980. However, reports for inpatient/outpatient and medical, with the exception of recipient claim detail reports, have not been sufficiently perfected for release.

As a result of CSC's failure to produce accurate S/URS reports within the contract specified time frames, the Department of Health Services began applying liquidated damages in August 1980.

Several important improvements have occurred since the Auditor General's review. Among them are:

1. Recipient claim detail reports now include up-to-date CSC information for all claim types.

2. CSC has corrected all major errors in provider profiling for drugs and long term care. The SUR Branch is currently using the reports produced in the November 1980 cycle for actual case work.

3. Progress in testing and installation of the remainder of the S/URS is proceeding rapidly.

"Performance of previous fiscal intermediary" (page 26).
"MIO system did contribute to the detection ... of fraud and abuse"
Although S/UR reports were produced by MIO, the previous fiscal intermediary, these reports were not considered usable by the Department and were, in fact,

never used to detect fraud or abuse. MIO proprietary reports, called Peer Group Norms (PGN) reports, were used in place of the MIO produced S/UR reports. The PGN provided less comprehensive data than that now produced by CSC reports, despite current problems.

As the Auditor General's report indicated, the success rate in establishing cases from MIO referrals has been cited at less than 50 percent. By using CSC's S/URS reports, the SUR Branch expects 67 to 80 percent of the cases identified to result in action against program abuse. As an example of the anticipated rise in overall system efficiency, the S/URS Beneficiary Utilization Review Unit (BURU) has increased its ability to identify potential program abusers since the S/URS SU-0-F02 report became available (November 1979). This increase is due primarily to the fact the SU-0-F02 report allows BURU to more effectively target its reviews, therby eliminating time previously used for non-productive reviews (cases with justifiable high use). BURU reports that the number of recipients placed on drug restriction has increased approximately 40 percent with the CSC reports.

"Other state units affected" (page 28).
"The BURU needs claim detail reports for all provider types".
CSC's S/URS is now producing recipient claim detail reports for all provider types.

"Licensing and Certification Division not sharing information with system units" (page 31).
The related Licensing and Certification Division procedure is being updated and rewritten for incorporation into the Division Policy and Procedure Manual. We are studying this procedure to see if notification of change of ownership could routinely go to Audits Branch and to Recovery Branch from the computer rather than via individual District Offices. The Division will improve both the timeliness and the percentage of referrals of closure notices.

Recommendation 3 pages 59-61.
"To improve procedures for managing workload within certain units of the overpayment identification and recovery system, we recommend that the Department of Health Services take the following actions:

- Require that all Compliance Unit regional offices follow up collection cases and comply with procedures for addressing high priority cases;
- Require regional supervisors to periodically review sample cases.

Further, we recommend that the department conduct a study to determine whether the Compliance Unit's collection procedures could be automated through the use of mini-computers or other automated systems at each regional office. If the current follow-up system were automated, it would assist the tax representatives in handling their increasing workloads. Mini-computers could perform such functions as mailing demand letters and instructing the fiscal intermediary to withhold payments. The feasibility study should consider whether the potential for increased recoveries would offset the costs of automating the collection system.

Additionally, the department should fix the responsibility for monitoring the accuracy of the CSC's Statement of Account Status issued as a result of

adjudicated appeals. Once this responsibility has been assigned, we further recommend that the unit selected immediately review all prior CSC statements for inaccurate assessments."

DHS RESPONSE

"Recovery Section's Southern Regional offices follow up collection cases and comply with procedures" (page 52).
Changes insuring a uniform case follow up system have been made in Southern Region offices. This was noted in auditor comments on page 55 of the draft. Additionally, all Recovery Section Compliance Unit procedures have been reviewed and are being adhered to by staff.

"Require Recovery Section Regional supervisors to periodically review sample cases" (page 54).
Department comment: Periodic review of selected cases by Regional supervisorial personnel is essential and are now being conducted on a regular basis.

"The Department conduct a study to determine the use of mini-computers or other automated systems at Recovery's Regional offices" (page 60).
The use of computers for use as suggested by the Auditor General has previously been reviewed and discussed within the Department. The relative organizational priority for such a system has not been sufficiently high to warrant a feasibility study. We remain interested however and will continue to consider this need.

"Department management is not monitoring intermediary interest computation" (page 55).
The Department's Administrative Division is reviewing this matter and will develop recommended actions.

Recommendation 4 page 73.
"We recommend that the Department of Health Services consider the results of our review in deciding whether to change Title 22, California Administrative Code, Section 51047. This proposed change would provide for collection of overpayments before the appeals process.

We further recommend that the Legislature consider increasing the interest rate that the Medi-Cal program is legally allowed to charge debtors of the program. Additionally, if the Legislature adopts a higher interest rate, we recommend that the department increase the interest rate Medi-Cal allows creditors to an equivalent rate."

DHS RESPONSE

"Untimely collection of overpayments loses revenue for State" (page 63).
The Department has received approval to revise Title 22 CAC Section 50147 providing for immediate collection of overpayments. This regulation will now go to public hearing and could become effective in July 1981.

"Interest rate charged on debts due to Medi-Cal is low" (page 69).
The Department supported legislation during the last session (AB 282 Robinson) which, if passed, would have changed interest rates. The Department supports legislation suggested by this recommendation.

ASSUMPTIONS AND METHODOLOGY TO COMPUTE POTENTIAL ESTATE RECOVERIES

This section presents the assumptions and methodology we used in computing potential recoveries from an estate recovery program.

Assumptions

1. After three years of operation, California will be as successful as Maryland in recovering expenditures from the estate of deceased beneficiaries.

2. Recipients of aid in California are not significantly different from recipients of aid in Maryland.

Methodology

This estimate is based upon the amount recouped during a year in relation to the benefits paid to the aged during that year. We qualified our calculation according to these factors:

- The amount recouped during a particular year probably represents payments from prior periods, and may represent more than one year of aid.

- The number of aged recipients and the payments made on their behalf are based only upon the recipients categorized as receiving Public Assistance for the Aged (Old Age Assistance) and Medical Assistance to persons 65 and over.
- Calculations are based on statistics for fiscal years 1977-78 and 1978-79.

This is the calculation of the ratio of the amount recouped to the benefits paid by Maryland for the aged:

Maryland

	Amount Recouped	Benefits Paid
FY 1977-78	$474,000	$ 78,840,304
FY 1978-79	$486,000	$ 91,000,744
Total (2 years)	$960,000	$169,841,048

$$\frac{\text{Amount Recouped} \quad \$960,000}{\text{Benefits Paid} \quad \$169,841,048} = .0057$$

Average recoupment ratio (2 years) = .0057

This ratio was applied to the total California benefits paid for the aged to yield estimates of potential recoupments.

1977

Benefits Paid =	$544,682,000
	X .0057
Estimated Recoupment	$ 3,104,687

1978

Benefits Paid =	$648,620,000
	X .0057
Estimated Recoupment	$ 3,697,134

Based upon this method, we estimate that California can recover approximately $3 million by implementing an estate recovery program.

ASSUMPTIONS AND METHODOLOGY USED TO CALCULATE INTEREST REVENUE EARNED THROUGH ADVANCED COLLECTION OF OVERPAYMENTS

This section presents the assumptions and methodology we used in calculating revenue earned by collecting overpayments in advance of the informal appeals process.

ASSUMPTIONS

To calculate revenue earned, we made these assumptions:

Collection Before the Informal Appeals Process

1. The money collected from providers would be invested with the Pooled Money Investment Account (PMIA). This money would earn interest at the rate of 8.59 percent, which is the average earning rate for the PMIA over the last three years. The money would earn interest during the informal appeals process.

2. If providers are successful on all or part of their informal appeals, the State would refund the successfully appealed amount plus the standard 7 percent interest. Interest would be paid on the successfully appealed amount during the course of the informal appeals process.

3. After the informal appeal, the State would continue to earn interest on money invested with the PMIA. The amount invested would be (1) the amount originally collected (2) less the amount of any successful informal appeal (3) plus interest earned through the PMIA on funds originally collected (4) less any interest paid to the provider for a successfully appealed amount. This money would earn interest at the rate of 8.59 percent during the formal appeals process.

4. If providers are successful on all or part of their formal appeal, the State would refund the successfully appealed amount plus the standard 7 percent interest. Interest would be paid on the successful appeal amount during the informal and formal appeals process. For unadjudicated formal appeals, providers would be successful on 32 percent of the amount appealed, and the formal appeal would last 698 days.*

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* This estimate is based upon historical data.

Collection After the Formal Appeals Process

1. The State would earn the standard 7 percent interest on the amount collected after the formal appeal. Interest would be earned during the informal and formal appeals process. For unadjudicated formal appeals, the provider would be successful on 32 percent of the amount appealed and the formal appeal would last 698 days.

METHODOLOGY

Based upon these assumptions, we applied the following methodology to each of 67 appeals (totaling over $15,000) for which the informal appeal was filed in fiscal year 1977-78.

Collection Before the Informal Appeals Process

1. We calculated the interest the State would earn on monies invested with the Pooled Money Investment Account by multiplying the amount the State would have collected in advance of the informal appeal by the 8.59 percent average earning rate of the PMIA. We calculated interest over the informal appeal.

2. Next, we calculated the interest refunded to the provider for a successful informal appeal. We multiplied the successful appeal by the 7 percent interest rate over the informal appeal.

3. We then calculated the interest the State would earn on monies invested with the PMIA during the formal appeal. We multiplied (1) the amount collected in advance of the informal appeal (2) less the provider's successful appeal (3) plus the interest earned in calculation number 1 (4) less the interest paid out in calculation number 2, by 8.59 percent. We calculated interest during the formal appeal.

4. We then calculated the interest refunded to the provider by multiplying the successfully appealed amount by 7 percent over the duration of the informal and formal appeals process.

5. Next, we added the interest earned and subtracted any interest refunded in the individual appeals.

Finally, we added the interest earned for each appeal to arrive at the total interest calculation.

Collection After the Formal Appeals Process

1. We calculated the interest earned by multiplying the amount the State would have collected after the formal appeal by 7 percent. We calculated the interest over the duration of the informal and formal appeals process.

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Sacramento, California

December 2, 1980

Mr. Thomas W. Hayes
Auditor General
925 L Street, Suite 750
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Medi-Cal Overpayments - #16139

Dear Mr. Hayes:

QUESTION

You have asked whether valid regulations could be promulgated which provide that overpayments to providers of Medi-Cal services found by State Department of Health Services' audits shall be collected prior to affording a provider an administrative hearing as part of the providers' appeal process.

OPINION

Valid regulations could be promulgated which provide that Medi-Cal overpayments to providers of Medi-Cal services found by State Department of Health Services' audits shall be collected prior to affording a provider an administrative hearing as part of the providers' appeal process.

ANALYSIS

Under Section 14171 of the Welfare and Institutions Code the State Director of Health Services is mandated to establish an administrative appeals process for providers of services under the Medical Assistance Program (Medi-Cal), to

review complaints arising from findings made pursuant to audits of providers made on behalf of the director. Article 1.5 (commencing with Section 51016) of Chapter 3, Subdivision 1 of Division 3 of Title 22 of the California Administrative Code sets forth the regulations concerning this appeals process. Section 51017 of these regulations provides that providers of Medi-Cal services have a right to a hearing in order to appeal overpayment determinations made pursuant to audits performed by the State Department of Health Services. Section 51047 states, in pertinent part:

> "51047. Recovery of Overpayments.
>
> "(a) The Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment after issuance of the audit or examination report establishing such overpayment, except that where the provider has filed a valid request for hearing pursuant to Section 51022 of this article, liquidation of the disputed overpayments shall be deferred until a final administrative decision is rendered. . . .
>
> * * *"

This section provides that no overpayment will be collected until after a provider's administrative appeal has been completed.

In our opinion, however, this procedure could be altered to allow collection of overpayments upon submission of a final audit report and notice of a provider's right to a hearing. The validity of a particular rule or regulation depends upon whether the administrative agency was empowered to adopt the rule and, if so, whether the rule is reasonable (*Whitcomb Hotel* v. *California Employment Commission*, 24 Cal. 2d 753, 759). Not only has the director been given power to adopt regulations concerning the overpayment appeals system under Section 14171 of the Welfare and Institutions Code, but the director is also given general power to adopt regulations concerning the Medi-Cal program under Section 14124.5 of that code.

The provisions of the federal Social Security Act which govern the Medi-Cal program (42 U.S.C.A. 1396a) and Section 14171 of the Welfare and Institutions Code are both silent as to whether collection of overpayments may begin prior to, or after, an administrative appeal hearing has been given. Under the federally-operated Medicare program, however, regulations provide that overpayments may be collected from service providers prior to holding an administrative hearing (42 C.F.R. 405.1803). Thus, we think a court would almost certainly find that a state's attempt to collect money prior to completion of an appeals process is a reasonable method of possibly preventing unnecessary appeals and of creating better administration of the Medi-Cal program.

Finally, in our opinion, collection of overpayments prior to holding a hearing would not violate a person's constitutional right not to be deprived of property without due process of law, as guaranteed by the United States and California Constitutions. The United States Supreme Court held, in Mathews v. Eldridge, 47 L. Ed. 2d 18, at 36 and 37, that an individual receiving Social Security Disability payments was not entitled to a hearing prior to termination of the disability payments, so long as a person is afforded the right to appeal this determination. The underlying principle is that an individual must have a right to appeal adverse administrative action, but that this appeal need not be allowed prior to taking the action, except under unusual circumstances (Mathews, supra).

Also, as noted, the federal government has adopted the practice of collecting overpayments prior to actually holding a hearing in the case of overpayment disputes under the Medicare program. Section 405.1803 of Title 42 of the Code of Federal Regulations provides that although a provider under the Medicare program has a right to appeal a dispute concerning Medicare payments, collection of overpayments need not be deferred until completion of the hearing.

Courts have upheld this practice against claims by providers that the absence of a hearing prior to overpayment collection violated an individual's right to have property taken without due process of the law (Barth v. Blue Cross of South Carolina, 434 F. Supp. 755, at 756-757; Wilson Clinic and Hospital Inc. v. Bluecross of South Carolina, 494 F. 2d 50, at 52). Also, in the case of Greenspan v. Klein, 442 F. Supp. 860, at 862, it was held that a doctor who had been terminated from another state's version of

the Medi-Cal program was not constitutionally entitled to receive a hearing to appeal the termination prior to its effectiveness, although the physician did have a right to a hearing. If, therefore, a Medi-Cal provider is given a right to appeal an overpayment determination, it would not be a violation of due process to collect the overpayment prior to holding the hearing.

In summary, it is our opinion that valid regulations could be promulgated which provide that Medi-Cal overpayments to providers of Medi-Cal services found by State Department of Health Services' audits shall be collected prior to affording a provider an administrative hearing as part of the providers' appeal process.

Very truly yours,

Bion M. Gregory
Legislative Counsel

Jeff Thom

By
Jeff Thom
Deputy Legislative Counsel

JT:mcj

cc: Chairman, Joint Legislative
Audit Committee

cc: Members of the Legislature
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Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps