REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

240.3

INADEQUATE AUTHORITY TO COLLECT AMOUNTS DUE TO THE MEDI-CAL PROGRAM DEPARTMENT OF BENEFIT PAYMENTS

MAY 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

MIKE CULLEN
CHAIRMAN

May 16, 1977

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 third and final report of the Auditor General on the Department of Benefit Payments. The Department lacks the statutory authority to effectively (1) recover significant sums of monies inadvertently paid by the State to formerly eligible Medi-Cal beneficiaries, and (2) recover overpayments to Medi-Cal Program providers.

AB 377 and AB 441 by Assemblyman Rosenthal and sponsored by the Department would remedy many of the statutory deficiencies disclosed by the Auditor General. The bills are deserving of support.

By copy of this letter, the Department of Benefit Payments is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department of of Benefit Payments.

The auditors are Kurt R. Sjoberg, Audit Manager; B. L. Myers; and Daniel Perez.

Respectfully submitted,

MIKE CULLEN, Chairman
Joint Legislative Audit Committee

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SUMMARY

The Department of Benefit Payments' Health Operations Branch is responsible for auditing certain medical programs and collecting amounts owed to the Medi-Cal program.

We found that:

- The Department's authority to recover Medi-Cal payments made on behalf of ineligible Medi-Cal beneficiaries is restricted (page 6).

- The Department cannot file an administrative lien against the property of beneficiaries or providers who owe money to the Medi-Cal program (page 10).

- The Department does not have sufficient notice to collect overpayments made to hospitals which change ownership (page 13).

These problems reduce the effectiveness of the Department's collection efforts and result in substantial losses to the Medi-Cal program.

On pages 9, 12 and 15 we recommend corrective legislation.

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Section 10527 of the Government Code, we have reviewed the operations of the Health Operations Branch of the Department of Benefit Payments. This is the third report on the operations of that Department. We have previously reported on the Supplemental Security Income-State Supplemental Payments Program and the Food Stamp Program.

Title XIX of the Social Security Act as amended in 1965 provides grants to states for medical assistance programs. The Title XIX program was established to pay for necessary medical services for eligible persons whose income and resources are insufficient to pay for their health care. The Federal Government shares the cost of providing medical assistance with the states. In California the federal share of medical expenses is about 50 percent.

The U.S. Department of Health, Education and Welfare has overall responsibility for administering the Title XIX program at the federal level. The Federal Government requires that a single state agency be responsible for all state government activities involving the administration of federally financed programs. California has designated the Department of Health as the single agency responsible for the California Medical Assistance (Medi-Cal) Program.

Effective July 1, 1974, California Assembly Bill 1950 (1973 Statutes, Chapter 1212) transferred the responsibility for recovering excessive or inappropriate Medi-Cal payments from the Department of Health to the Department of Benefit Payments' Health Operations Branch. The Health Operations Branch is composed of the Health Recovery Bureau, the Health Audits Bureau and the Health Appeals Bureau. The branch expended $4.3 million during the 1975–76 fiscal year to support its activities and staff of 189.

Health Recovery Bureau

The Health Recovery Bureau administers a statewide program to recover amounts due to the Medi-Cal program from providers and beneficiaries who have received overpayments, have other legal entitlements for medical care, or who were ineligible for Medi-Cal benefits when the service was provided. This report discusses the activities of the bureau's Compliance Section. The bureau's Operations Section is responsible for recovering Medi-Cal payments from health insurance carriers and was discussed in our report number 286.2 which was released in March 1977.

The Compliance Section is comprised of field units in Los Angeles, San Francisco and Sacramento, in addition to its headquarters office in Sacramento. The section's responsibilities include:

- Collecting money due from Medi-Cal beneficiaries, providers and other legally liable entities.

- Preparing actions for Attorney General filings.

- Filing creditor claims and Notice of Filing in probate cases.

- Completing skiptracing or other collection activities necessary to obtain payments.

The section receives referrals of collection actions from such agencies as the county welfare departments, the Department of Health and the fiscal intermediary. The amount of collections, receivables and the caseload as of June 30, 1976, are shown as Appendix A. This activity was performed by 24 personnel and supported by expenditures of $272,000.

Health Audits Bureau

The Health Audits Bureau administers a statewide program of health-related audits. Appendix B provides a summary of the programs for which the bureau is responsible and the audit exceptions it made in fiscal year 1975-76. This activity was performed by 107 personnel and supported by expenditures of $2,342,000.

Health Appeals Bureau

The Health Appeals Bureau hears appeals of findings brought by those claimants who have taken issue with audit adjustments asserted by the Departments of Benefit Payments and Health. The bureau conducts informal conferences to review the facts and effect a reconciliation between the auditor and the provider of service whose charges are the subject of the auditor's adjustments. When reconciliation

is impossible, the bureau represents the State at appeal hearings before the Department's Office of Chief Referee.

During fiscal year 1975–76 the bureau held 91 informal conferences and participated in 18 appeal hearings before the chief referee. The bureau had a staff of 12 persons supported by expenditures of $302,000.

During our review of the Health Audits Bureau we learned that they do not conduct audits of individual providers such as doctors or dentists. There are about 370 doctors and dentists, practicing in groups or individually, in California who had calendar year 1975 Medi-Cal earnings in excess of $100,000. Individual doctors had earned up to $278,000, group practitioners earned up to $1 million and dentists' earnings were as high as $962,000. We believe that an audit program should be implemented to cover these providers. On March 7, 1977, the Department of Health announced its intention to conduct an 18-month review of those doctors, dentists and hospitals which have ". . . statistically unusual patterns of practice." While this audit program provides for a review of individual providers, we cannot predict its effectiveness.

AUDIT RESULTS

The Department of Benefit Payments, through its contract with the Department of Health, has the authority for recovering amounts due to the Medi-Cal program. However, gaps in this authority result in program losses.

THE DEPARTMENT OF BENEFIT PAYMENTS' AUTHORITY TO RECOVER PAYMENTS ON BEHALF OF INELIGIBLE BENEFICIARIES IS RESTRICTED

The Health Recovery Bureau is responsible for recovering payments to providers of medical services made on behalf of persons who are ineligible for Medi-Cal benefits. The ineligible recipient is liable for these payments. If these persons have become ineligible due to a change in income or resources and have failed to report these changes, the bureau's authority to effect recovery is restricted.

The Welfare and Institutions Code permits the bureau to recover overpayments which result from beneficiaries willfully failing to report changes in income or resources. The Department's Manual of Policies and Procedures specifies that a Medi-Cal beneficiary has failed in his responsibility to report if there is willful:

- Misstatement of income, resources or other circumstances which may affect the amount of grant.

- Failure to report changes in income, resources or circumstances which may affect the grant.

- Failure to report the receipt of a payment which is known to be an erroneous overpayment.

The determination of whether the failure to report is "willful" is primarily the judgment of the county eligibility worker. The only state guidelines are found in Section 11004(b) of the Welfare and Institutions Code and Section 44-333.15 of the Manual of Policies and Procedures. These sections provide that a Medi-Cal beneficiary has met his responsibility if he has made a prompt, accurate, full and complete disclosure of facts, within his competency to do so. Ignorance of the reporting responsibility and inability to speak English are examples which have been held by recent fair hearing decisions as barriers to reporting competency; hence, overpayments made to these individuals are not collectible under current law.

The recovery of beneficiary overpayments under existing law is therefore contingent upon the eligibility worker's judgment of the beneficiary's intent and upon the beneficiary's understanding of reporting requirements. If the beneficiary is considered competent, failure to report changes is "willful" and therefore the overpayment is collectible under Section 11004(d). If the beneficiary is considered incompetent, the failure to report is "unwillful" and the overpayment is not collectible in the absence of specific statutory authorization for the Department to make the collection.

The Health Recovery Bureau has demanded recovery for overpayments which resulted from "unwillful" failure to report changes in income or resources; however, the bureau does not pursue collection effort when the county eligibility worker states that the beneficiary has met his reporting responsibility.

Recoveries for beneficiary overpayments during fiscal year 1975–76 were $956,900 (see Appendix A). The Department does not maintain records to distinguish which of these collections represent "willful" or "unwillful" failure to report changes in income or resources. However, nearly 1,000 cases, totaling $62,000, were written off or otherwise reduced during the year. This is about 19 percent of the total receivables added during the year. In contrast, where greater collection authority exists, such as in provider overpayments, write-offs equaled only about nine percent of the receivables added during the year.

Failing to attempt collection of beneficiary overpayments could be considered noncompliance under the Social Security Act,* which requires states to prevent unnecessary utilization of services. Therefore, not attempting recovery could risk federal participation in the funding of those beneficiary overpayments.

* Title XIX, Section 1902(a)(30).

CONCLUSION

Due to the lack of specific statutory authority, the Department of Benefit Payments does not adequately pursue the recovery of beneficiary overpayments which result from "unwillful" failure to report changes in income or resources. If there is no attempt at recovery from "unwillful" cases, there is a risk to some federal funding.

RECOMMENDATION

We recommend that the California Legislature amend Section 11004(d) of the Welfare and Institutions Code to provide for collecting of any monies paid by the Medi-Cal program for services provided to ineligible persons.

BENEFITS

Implementing this recommendation would result in additional Medi-Cal recoveries from beneficiary overpayments and assure that the State of California is in compliance with federal law.

THE DEPARTMENT OF BENEFIT PAYMENTS LACKS THE AUTHORITY TO FILE ADMINISTRATIVE LIENS AGAINST DEBTORS OF THE MEDI-CAL PROGRAM

The Department of Benefit Payments is restricted in its ability to collect amounts due to the Medi-Cal program because it does not have the authority to file an administrative lien against the real property of providers or beneficiaries who owe money to the program.

Other state agencies such as the Franchise Tax Board and the Board of Equalization have statutory authority to file administrative liens. These agencies file a certificate with the county recorder in any county in which the debtor is suspected to have property. The certificate constitutes a lien upon all real property in the county and has the force, effect and priority of a judgment lien.* Under current law, however, the Department of Benefit Payments cannot obtain a lien without filing suit, a process which is more costly and time consuming than that available to certain other agencies.

At the close of fiscal year 1975–76 the Medi-Cal Program was owed $14.6 million by beneficiaries, insurance companies and providers of medical services (see Appendix A). The collectibility of this amount is unknown because there is no procedure available to classify these receivables by probability of collection. The degree of collectibility varies because:

* A lien issued by court decree.

- The debtor (particularly if an aid recipient) may not have the income to repay an overpayment.

- The amount of the debt may be in dispute.

- The debtor's location may be unknown.

During fiscal year 1975–76 receivables amounting to $940,000 from 12 hospitals and nursing homes were written off. Department officials have stated that they cannot determine how much of this amount was lost due to the lack of lien authority; but they do indicate that the amount is "substantial." In addition, similar circumstances could be expected from cases involving individual providers and beneficiaries.

CONCLUSION

The Department of Benefit Payments needs but does not have the statutory authority to file administrative liens against the real property of Medi-Cal providers and beneficiaries who owe money to the Medi-Cal program. Therefore, the Department is restricted in its ability to collect debts due to the Medi-Cal program.

RECOMMENDATION

We recommend that the California Legislature amend the Welfare and Institutions Code to grant the Department of Benefit Payments the authority to file administrative liens against the assets of Medi-Cal providers and beneficiaries who owe money to the program.

BENEFITS

Implementing this recommendation would provide the Department of Benefit Payments with increased ability to collect debts owed to the Medi-Cal program.

THE DEPARTMENT OF BENEFIT PAYMENTS HAS INSUFFICIENT NOTICE TO EFFECT COLLECTION OF OVERPAYMENTS MADE TO HOSPITALS WHICH CHANGE OWNERSHIP

The Department of Benefit Payments' ability to collect overpayments made to hospitals which change ownership is restricted. The Department's Health Recovery Bureau does not have sufficient notice of the negotiation and therefore cannot recover an audit settlement from the present owner prior to the sale's conclusion.

Acute care hospitals are paid for services provided to Medi-Cal beneficiaries at an interim rate for each patient day, which is determined by the Health Audits Bureau and based in part upon hospital costs. Corresponding ancillary services provided to Medi-Cal beneficiaries are added to this rate at the time Medi-Cal is billed. Each year the Department of Benefit Payments' Health Audits Bureau audits the hospital's cost report to determine the final settlement amount claimed during the hospital's preceding fiscal year. If the total amount paid during the preceding year was understated the hospital is paid the difference between the billed rate and the adjusted rate. If the interim rate was greater than the adjusted rate, the hospital is required to reimburse the Medi-Cal program. As shown in Appendix B, the Health Audits Bureau found that hospitals had underclaimed $4.8 million and had overclaimed $69.2 million.

When hospitals are sold, the transaction generally occurs before the hospital cost report is audited. Therefore, any overpayments made during the fiscal year preceding the sale of the hospital are not discovered before the sale is completed.

Currently there is no provision whereby the owner of the hospital is required to inform the Department of a pending sale. Attempts at collecting overpayments from the owner subsequent to the sale are, in many cases, ineffective because the owner cannot be located or has insufficient funds to make restitution.

During fiscal year 1974–75 about four percent of the hospitals changed ownership. The Departments of Benefit Payments and Health have estimated that during fiscal year 1975–76 the program lost $920,000 due to the Department's inability to determine an audit settlement prior to change in ownership.

CONCLUSION

Because the Department of Benefit Payments does not have sufficient notification of a pending sale to collect overpayments from the previous owner of a hospital, the Medi-Cal program lost an estimated $920,000 during fiscal year 1975–76.

RECOMMENDATIONS

We recommend that the California Legislature amend the Welfare and Institutions Code to require that:

- The proposed sale of a hospital which is providing medical services to Medi-Cal beneficiaries be reported to the Departments of Benefit Payments and Health upon commencement of negotiations.

- The owner's failure to report a pending sale would subject him to penalty.

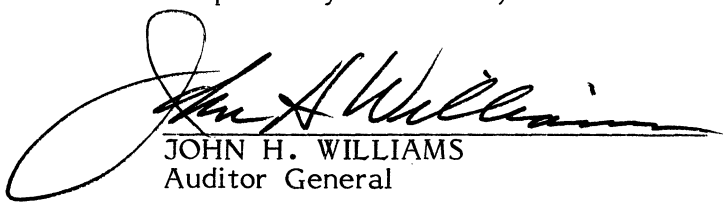
- Upon receipt of such notification, the Departments of Benefit Payments and Health complete a joint audit of the hospital within 30 days to verify its final Medi-Cal settlement.

- Any overpayments found as a result of the audit be refunded or secured for repayment to the Medi-Cal program prior to concluding the sale.

BENEFITS

Implementing these recommendations would result in additional Medi-Cal recoveries which may approach the $920,000 estimated to have been lost during fiscal year 1975-76.

Respectfully submitted,



JOHN H. WILLIAMS
Auditor General

Date: May 12, 1977

Staff: Kurt R. Sjoberg, Audit Manager
B. L. Myers
Daniel Perez

DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814
916/445-2077

May 12, 1977

John H. Williams
Auditor General
Joint Legislative Audit Committee
925 L Street, Suite 750
Sacramento, CA 95814

Dear Mr. Williams:

MAY 9, 1977 DRAFT REPORT: "INADEQUATE AUTHORITY TO COLLECT AMOUNTS DUE TO THE MEDI-CAL PROGRAM DEPARTMENT OF BENEFIT PAYMENTS" (Report #240.3)

We sincerely appreciate the opportunity to comment on the conclusions and recommendations contained in the draft report. Since your draft represents an interim report based on preliminary findings, final comments will be made if necessary when your final report is issued.

The following comments will be referenced to page number and/or recommendation as they appear in the report.

Page 3

The first paragraph refers to the Health Operations Branch which employed 189 staff and expended $4.3 million during the 1975-76 fiscal year.

It should be noted that during the same period total Branch net recoveries (including overclaims and underclaims) were approximately $76.7 million for a cost benefit ratio of 17.8:1. As shown in Appendix B of the report, most of the money was recovered as a result of auditing the Medi-Cal Program and is in addition to the $8.9 million in collections made by the Recovery Bureau.

Page 5

In the last paragraph the report suggests that "an audit program should be implemented to cover" the audit of individual providers such as physicians and dentists.

We believe a fiscal audit of individual providers would be a questionable use of our audit resource when viewed in light of the

potential payoff and when related to existing monitoring and control efforts already in place. These providers are on a fixed fee for service schedule - not a cost reimbursement system. In addition, their claims are carefully screened (audits and edits) by the State's fiscal intermediary to prevent improper claims from being paid. We also test claims to be paid through an on-site State Certifying Officer. As you acknowledged in your report, Department of Health is conducting a review (Surveillance and Utilization Review) of individual providers. This review traces the claims for service through to the provider's medical/service records and potentially to the beneficiaries of service. In the event that a fiscal audit need is identified during the course of these reviews, Department of Health will call for DBP fiscal audit assistance. We believe this to be the most effective and highest payoff method to use.

Page 9 - Recommendation

The Department of Benefit Payments vigorously pursues collections from beneficiaries who willfully fail to report changes in income or resources. We do not believe that it serves the best interest of the Medi-Cal Program, the Department of Benefit Payments or the State of California to pursue recoveries from beneficiaries who have met their reporting responsibilities. Beneficiaries who, because of their incompetency (age, language barriers, etc.), should not be penalized by a mandate to collect the value of a non-cash overpayment (medical services) when the overpayment is not their fault.

We support amending Welfare and Institutions Code Section 11004(c) and (d) to the extent that it would permit recovery of determined overpayments in a manner other than by grant offset. Since the Medi-Cal Program does not provide a direct cash grant to a beneficiary, the present grant offset requirement is unworkable.

Page 10

The last paragraph speaks about Medi-Cal Program Accounts Receivable in the amount of $14.6 million at the close of fiscal year 1975-76.

It should be noted that the predictability of accounts receivable collections in industry or government may never be totally possible. It is also normal to expect that some accounts may be uncollectible and must be written off. We agree that legislation to strengthen our collections is highly desirable as explained in the following comments.

Page 12 - Recommendation

The Departments concur and fully support the recommendation that the California Legislature grant authority to file administrative liens

against the assets of Medi-Cal providers and beneficiaries who, after all administrative rights and remedies have been granted, are determined to owe money to the Program. Similar legislation has been sponsored by the Department of Benefit Payments (DBP) and the Department of Health on four separate occasions. Presently, Assembly Bill 441 (Rosenthal), sponsored by DBP will, if passed, grant such authority on debts due from Medi-Cal providers. We encourage the support of Mr. Cullen and the Legislature on this bill.

Page 15 - Recommendation

The Departments essentially concur with the recommendation. Legislation requiring sellers or purchasers of hospitals or other institutional Medi-Cal Program providers to provide notice of sale to the Departments of Benefit Payments and Health has been sponsored by the Department of Benefit Payments on three occasions.

There is before this session of the Legislature a DBP sponsored bill, AB 377 (Rosenthal), which would accomplish this reporting requirement. Our Departments are highly desirous that this bill be enacted and invite Mr. Cullen and the Legislature to strongly support its passage. Perhaps Mr. Cullen could help to amend AB 377 to conform to Department objectives and to the audit report recommendations to:

- Subject the owner to a penalty for failure to report a pending sale

- Cause the Department of Benefit Payments to audit hospitals (or other Medi-Cal institutions) within 90 days of receipt of notification of sale with a provision that upon notification claims payments would be withheld at 50% to be deposited in an interest bearing account pending audit.

We want to take this opportunity to thank you for providing an independent report that confirms the Administration's wisdom in recognizing the problems you cited and seeking corrective legislation. We welcome your support in helping us gain passage of AB 441 and AB 377. We also hope that you will aggressively seek legislation amendments to accomplish the report recommendations which were addressed to the Legislature.

Sincerely,

MARION J. WOODS
Director
Department of Benefit Payments

JEROME A. LACKNER, M.D.
Director
Department of Health

DEPARTMENT OF BENEFIT PAYMENTS
HEALTH RECOVERY BUREAU
COLLECTIONS, ACCOUNTS RECEIVABLES
AND CASELOADS
FOR FISCAL YEAR ENDED JUNE 30, 1976*

Source of Collection	Amount Collected	Accounts Receivable	Case Load
Investigations	$ 359,700	$ 1,864,100	1,699
Probates	324,200	1,715,700	216
Audits	297,400	7,992,800	320
Beneficiary Overpayments	309,000**	341,700	1,506
Other Health Coverage	163,100	132,900	266
Third Party Liability	96,500	843,500	650
Provider Overpayments	88,600	298,500	299
Voluntary	45,600	64,500	27
Paternity	23,400	464,800	747
Other	622,100	896,200	26
Totals	$2,329,600	$14,614,700	5,756

* During our work at the Health Recovery Bureau we found mathematical errors in the accounts receivable records. The bureau, however, is in the process of converting the accounts receivable records to an automated system which should improve the overall accuracy of their records.

** 90% of "Investigations" and 100% of "Probates" are also "Beneficiary Overpayments"; therefore, Beneficiary Overpayments actually total $956,900 (90% x $359,700 = $323,700 + $324,200 + $309,000).

DEPARTMENT OF BENEFIT PAYMENTS
HEALTH AUDITS BUREAU
RECAP OF THE PROGRAMS, NUMBER OF AUDITS AND AUDIT CHANGES
FOR FISCAL YEAR ENDED JUNE 30, 1976

Audited Programs	Audits Issued	Costs Claimed	
		Overclaimed	Underclaimed
Medi-Cal Hospitals			
Hospital, Community	992	$25,327,000	$2,502,000
Hospital, County	90	30,570,000	2,266,000
Home Offices	30	n/a	n/a
Miscellaneous	11	9,000	--
Medicare Common, South	10	797,000	--
Medicare Common, North	9	371,000	--
Hospital Construction	9	--	--
Fiscal Intermediary	8	993,000	45,000
County Waivers	3	11,101,000	--
Total Hospitals	1,162	69,168,000	4,813,000
Special Programs			
Short-Doyle Program	69	2,999,000	302,000
Alcohol Abuse Program	31	469,000	74,000
Crippled Children Services Program	24	60,000	31,000
Developmental Disability Centers	16	335,000	11,000
Family Planning Program	5	49,000	--
Comprehensive Health Planning Program	4	--	--
Tuberculosis Subsidy Program	2	41,000	40,000
Drug Abuse Program	1	3,000	--
Total Special Programs	152	3,956,000	458,000
Total Audits	1,314	$73,124,000	$5,271,000