Reducing Federal Share of Medicaid Overpayments

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Problem Statement

South Carolina Department of Health and Human Services (SCDHHS) needs an effective method to identify, document, and report Medicaid providers who owe overpayments, but have declared bankruptcy and/or gone out of business, and the overpayment cannot be recovered but a federal share payment is still due CMS (Centers for Medicare and Medicaid Services). Correct and timely reporting of the bankruptcy/out of business status for these providers voids the need to return a federal share payment to CMS. Funding for Medicaid expenditures is jointly provided by the state and the federal government and it is the federal portion that must be repaid to CMS when claims are paid in error.

SCDHHS's current process is one that recognizes that the federal share amount is due to CMS within one year after the discovery of an overpayment. The focus is on getting the overpayment recovered from the provider within that single year and properly including the amounts on form CMS 64 that would allow our agency to receive credit for the payment. Current procedures do not describe any process by which SCDHHS can establish that a provider declared bankruptcy (and we filed a claim with bankruptcy court) or went out of business (Secretary of State indicates entity dissolved), two conditions that should trigger a documentation process that ends with the federal share amount being no longer due or a previously paid federal share amount being reclaimed.

The new process will close this gap by creating procedures that recognize the special opportunity to absolve our Agency from the necessity of a federal share payment, describe in detail what conditions will trigger the efforts to document a bankruptcy or out of business situation, and the subsequent steps necessary to use this documentation to satisfy our federal share of overpayments to providers that cannot be recovered due to the provider experiencing one or both of these two special conditions.

This issue is important to SCDHHS as the Medicaid Program generates large health care expenditures and these expenditures inevitably produce some claims that are paid in error, or overpaid in error, and these incorrect payments and overpayments can amount to very large amounts of money since the base from which they are derived is so large. My manager estimates that savings would easily reach into the millions if we could reduce the repayment of the federal share of these overpayments when the provider has declared bankruptcy and/or gone out of business.

Addressing this issue may seem pedestrian, but the provider community is much larger and complex in organization (both horizontally and vertically) than many realize. SCDHHS has enrolled about 65,000 providers. Also, Medicaid covers such a broad base of recipients that receive services in many different scenarios and result in the program paying for services that many might not realize are provided. For instance, if a recipient has decided they could do better at home instead of a nursing home, with appropriate assistance for their needs, they can

do that under a waiver program. The assistance comes from community long term care aides provided by home health care agencies provide assisted living or nursing services, companion care services, cooking or cleaning services or other services. Technically, all these aides become Medicaid providers. In addition to traditional medical providers, Medicaid pays suppliers for things like durable medical equipment, prosthetics, orthotics, all manner of bandages/wraps/etc., even diapers, as well as providers of pharmaceutical services and institutional providers such as clinics and hospitals and nursing homes. Every paid service has a federal share that must be repaid to CMS if the Medicaid covered service was paid in error.

Data Collection

Data collection for this project was rather straightforward as the new process being established involved observations that were already well defined and readily available in an easily constructed list. The challenge came when looking closer at each provider on the list to discern information about the provider's financial status as a "going concern". The data consisted of all known provider overpayments that have a remaining balance due to our Agency. This list contained 341 providers, of which 161 providers have outstanding balances ranging from $2,071,133 to $9,322 and another 180 providers have balances due less than $9,322, with most less than $1,000. A preliminary review of the top 161 providers with the higher balances indicated 42 providers have dissolved their business at the Secretary of State (good

indication that business is "out of business"), and one that has declared a Chapter 9 bankruptcy (municipality). This list is now being used to gather more information about the providers on the list to design an effective monitoring effort that will identify and document the providers that experience dissolution or bankruptcy and then trigger the appropriate steps to avoid paying federal share monies for these two situations. Monitoring our provider overpayment list sounds easy enough, but it comes with a fair number of complications. Not all of our providers are large enough to warrant registration with the Secretary of State, and those that do not register have no readily available way to verify that they are a going concern. The first criteria should be that the providers are still seeing our members and rendering health care services, however, providers of all sizes can still be seeing our patients even as they are planning their exit from Medicaid and or the state of South Carolina. However, once Program Integrity or its partners has issued a demand letter for recovery of overpayments, the collection responsibility, from a mechanical standpoint, shifts to our fiscal services department. Fiscal Services will use its own tools to produce an effective recovery and two-way communication between Program Integrity and Fiscal will remain essential during the collection process. Ultimately, after all collection efforts have failed and the provider is thought to be out of business, Program Integrity will ask the Agency's General Counsel for an opinion as to whether the provider is out of business. If the General Counsel agrees, and Program Integrity/Fiscal Services has vigorously pursued collections, Program

Integrity will follow the new procedures for documentation and communication for federal share adjustments (and reclaim the federal share).

Data Analysis

Key findings from the data analysis (about current and desired state):

The preliminary data found three hundred and forty-one (341) providers with outstanding overpayment balances. Looking at the top one-hundred and sixty-one providers (ranked by outstanding balance amounts), Forty-two of this group had dissolved or forfeited their Secretary of State entity registration representing 26% of this group, however, only one in this group was found to have formally filed bankruptcy, Chapter 9. When summing the outstanding balances for those who had dissolved or forfeited their entity status (the 42 providers), the total dollar amount for the combined dissolutions equaled $13,006,887 or 47% of the total dollars outstanding ($27,917,958 for all 340 providers). But this group represents only (42/340) or 12% of the total number of providers with overpayments to SCDHHS. The indication is that a dissolved provider had, on average, a higher outstanding overpayment balance than a non-dissolved provider. This makes sense in that a provider who had dissolved their entity had little incentive to pay back any remaining overpayments previously generated by the now dissolved entity. A provider who had previously declared bankruptcy, would of course, no longer have the same obligation to pay their debts as before the bankruptcy. If the provider was going to pay out a portion of their debts as part of their bankruptcy agreement, SCDHHS would make a

claim against the remaining assets in the amount of the outstanding provider's overpayment.

When examining this issue, the relevant data includes both providers who have an overpayment balance currently outstanding and the presence or absence of information about entity dissolution or forfeiture and/or bankruptcy. Although the focus is one of monitoring the providers with balances for changes in entity status, we also have providers for which investigations have commenced (many just desk reviews) but no overpayment balance has yet been established. Is there any value in monitoring the non-balance providers for the same entity status changes in the event an overpayment may be established? Of course entity status changes have other impacts on the investigation, and they are duly noted, but with this new process, it makes sense to include all instances of discovering a dissolution or bankruptcy and having each provider record so noted in a consistent fashion whether or not an overpayment balance is currently due. Improvement in capturing better data for this process will come with additional training for all relevant employees (really all PI or Program Integrity employees) in understanding where to look for entity status changes (Secretary of State website, SC LLR website, CLEAR background checks, other online resources) and where to look for evidence of bankruptcies. Bankruptcies can also be found in various background checks such as CLEAR as well as several online websites devoted to cataloguing bankruptcies, often by industry

centric websites. However, the biggest sites all require some type of registration and fee to use their sites.

Implementation Plan

A. Action Steps (complete development means securing buy-in from all stakeholders for the following changes):

1. I will complete development and teach new process flow chart (Exhibit II) in detail for Med/Ancillary Review Supervisors and more generally to all of PI. I will work with the above review supervisors and they will then teach their staff (teach the teacher).

2. PI Supervisors will complete development of a new form (see Exhibit I) that captures the steps and documentation needed to determine a provider has declared bankruptcy or has gone out of business and concludes with certification as to why the federal share payment need not be made or if made why it can be reclaimed. This form has been completed but changes are expected as it is introduced to the review teams and then put into use.

3. PI Supervisor team will complete development and distribute policy and procedures for the new processes in PI's Complaint/Case Management System for all provider fraud, waste and abuse referrals (Exhibit II). I will introduce a framework and the review supervisors will finalize based on their individual team needs.

4. PI Team will complete development of additional screens to OnBase Case Management system for capture of key dates in this new process (Exhibit III). This will be reviewed with the review supervisors, the PI data manager, the Managed Care Organization (MCO) liaison supervisor and the PI Director.

a) Effective date provider entity status was changed to dissolved or forfeited (or similar status, i.e., not in "Good Standing").
b) Effective date provider declared bankruptcy
c) Effective date Fiscal Services or General Counsel notified of provider bankruptcy
d) Date SCDHHS filed claim for Medicaid expenses with bankruptcy court
e) Effective date documentation to reclaim federal share was submitted (submitted to fiscal or just kept in OnBase)

5. PI Team will meet with Fiscal Services to verify what reporting is necessary to ensure adjustments to a previously recorded overpayment federal share amount are properly applied when a bankruptcy or out of business condition is established.

6. I will meet with Provider enrollment to establish what communication they would like Program Integrity to share regarding our determinations of bankruptcy or out of business status of an active Medicaid enrolled provider.

7. PI Team will establish a routing list of Medicaid departments that might want to be notified when a currently active Medicaid enrolled provider has been determined as bankrupt or out of business.

B. Timeframes and Cost

The timeframe for full implementation should be relatively quick in that no new software must be purchased nor major modifications devised and implemented for other systems. The case management system changes that have been proposed do not cost our unit anything but time to learn and train people on how to properly use them. The modifications to our OnBase Case Management system should be completed by fiscal year end and the time to train on these changes should be no more than six months. The plan would be to begin the training process and then utilize manual versions of the OnBase proposed changes so that when the software has been updated, the actual use of the new features could occur almost immediately as the switch from manual documentation to these pre-formatted electronic documents would be very straight forward. Truly, the costs will consist solely of opportunity costs. The costs of taking time away from routine fraud, waste and abuse processing and spending that time instead on implementing this new process.

C. Potential Obstacles and Methods to Overcome

The biggest obstacles will come from the usual places. The difficulties in getting most, if not all, of PI staff to agree to process changes that they may believe are either unnecessary or that can be accomplished better in a different manner. The second biggest obstacle will be getting buy-in and cooperation from fiscal services with our requested changes to their recovery processes that usually are entirely defined and designed with no outside input. The third biggest challenge will be getting employees to stay with these changes and new processes long enough that they become ingrained as the current proper way of handling these newly described situations.

Finally, I have some concern in getting everyone to agree with a single definition of a Medicaid provider's change in status from one of a "Going Concern" to one of "Out of Business". There will be times when the Secretary of State does not have a current registration for the particular provider in question and we will have to come up with a definition of circumstances that the Agency's General Counsel can agree "certifies" that the provider is indeed no longer a Going Concern, but is now considered "Out of Business".

D. Potential Resources

In addition to the Secretary of State and the Agency's General Counsel, PI employees can also check our normal resources for providers that have been excluded from government insurance programs. The lists include the federal OIG's List of Excluded Individuals and Entities (LEIE) and US General Services Administration System for Awards Management (GSA/SAM) which registers entities to do business with the US government and keeps an Excluded Parties List System (EPLS). These exclusion lists do not speak directly to bankruptcy or Out of Business status but do list providers that may have had an adverse outcome such as exclusion and certainly exclusion can lead to bankruptcy or Out of Business status. These lists would also help with locating providers and provider assets with addresses and phone numbers for these entities that were accurate at the time of the exclusion posting.

E. Communication with Key Stakeholders

Key stakeholders will include other Agency divisions that interface with Program Integrity such as Provider Services, who handle initial provider enrollment, and Fiscal Services, who handle the collection process once an overpayment notice is generated to a provider and the provider does not pay the outstanding balance in full by the required date. Fiscal Services will require formal approval of our new processes before

implementation whereas Provider Services will simply want to be aware of our new process. Of course, key SCDHHS management and the Agency Director are very important stakeholders and I will look to my supervisor to cover these individuals. Stakeholders will also include CMS, the federal Medicaid Agency and our recipients who will have been patients of these providers that are now considered bankrupt or out of business. We will be requesting formal approval of our new processes from CMS even though they will not directly be involved in the day to day operational issues. And finally, our patients will have already moved on to new providers as they are quite aware of the challenges in attaining Medicaid providers for most specialties.

F. Integration into Standard Operating Procedures.

As this new process is really just additional steps in an existing process that will not materially change, but simply have a few new steps added when it is determined that the provider has declared bankruptcy or has gone out of business, I do not expect any significant issues in integrating this new process in the standard operating procedures.

Evaluation Method – How well does solution work?

The key to making this process work is knowing, at any time, which providers with overpayments have declared bankruptcy and/or gone out of business, when

the event occurred, and then checking the case entries in OnBase for that provider to verify the event(s) have been properly documented. Therefore, the initial evaluation plan will piggyback on the initial data analysis of existing provider overpayments for which we could find evidence of provider bankruptcy or going out of business. We will take the existing list of relevant providers and review all new provider overpayments, following the same process that we did before (with modifications learned from experience of course) and record all providers that we find either declared bankruptcy or had an entity status change from "Going Concern" to "Dissolved" or "Forfeited" at the Secretary of State website. We will then check business background checks for any sign of bankruptcy declarations for providers on this list. For any new additions to the bankruptcy/out of business list, we will then examine that provider's case details to determine how successful we are at documenting our case management system for provider overpayments that have declared bankruptcy or gone out of business.

Summary Findings and Recommended Actions

This project started with a list comprised of 341 providers, of which 161 providers have outstanding overpayment balances ranging from $2,071,133 to $9,322 and another 180 providers have balances due less than $9,322 with most less than $1,000. A preliminary review of the top 161 providers with the higher balances indicated 42 providers have dissolved their business at the Secretary of State

(good indication that business is "out of business"), and one that has declared a Chapter 9 bankruptcy (municipality). The most important finding is that the Agency does not currently have a formalized process of identifying, tracking and reporting these balances in a way to maximize the return on avoiding the federal share repayment on these amounts. Bankruptcies do not appear to be frequent and are more likely to occur with larger organizations which readily communicate their bankrupt status. One significant challenge here is being sure that SCDHHS knows of all of the individual entities that might be part of the "global" bankruptcy so that each entity can get credit for its share of any overpayments that may be absolved from federal share return by the bankruptcy. As for "out of business" designations, they happen with some frequency (especially among certain medical specialties), and although the designation is often noted in the case management system, the designation does not appear to trigger any specific effort to record and document the finding and then follow through communications to all necessary areas to have the federal share amounts reclaimed (or avoided).

Recommendations include implementation and training on new procedures for timely recognition of an entity that has gone out of business. Recognition will come from the Secretary of State website when a business is no longer a "going concern" or an attestation from the Office of the Attorney General that an entity is no longer a "going concern" when the Secretary of State information is not available (such as when the entity never registered with Secretary of State).

Also, important will be a standard frequency with which reviewers must check these sources for an occurrence of the out of business designation. Regarding bankruptcies, recommendations will include a regular schedule to run background checks on these providers specifically looking for timely recognition of the bankruptcy occurrence. There are web services that can search for these bankruptcy filings as well, but more research will be necessary to see whether they are cost effective due to the low number of bankruptcies experienced. Finally, Exhibit II will be introduced as the document to be used in standardizing how Program Integrity will reach the conclusion that one or both of these designations has occurred and what the necessary steps are for both to be fully documented and then officially certified the designated condition.

EXHIBIT I

South Carolina Department of Health and Human Services
Uncollectible Provider Overpayments
Documentation to Reclaim the Federal Share

Date: _____

I. Provider Name and Number

Provider Name: Provider Number:	
Overpayment Amount:	
SCDHHS Division submitting the request	Program Integrity
Is the request due to the provider being bankrupt? *If yes, proceed to Section II*	Yes or No
Is the request due to the provider being out of business? *If yes, proceed to Section III*	Yes or No

II. Bankrupt Provider Documentation

Action	**Yes/No**
Has the provider filed for bankruptcy?	
Is the state on record with the applicable bankruptcy court as a creditor of the petitioner in the amount of the Medicaid overpayment?	

The federal share can be reclaimed only if the response to both questions above is "Yes". In addition, the federal share of whatever amounts are recovered under a court-approved discharge (e.g., a stipulation of non-discharge-ability) must be returned to CMS. The federal share of any overpayment to a provider whose bankruptcy petition is denied must also be returned.

III. Out-of-Business Provider Documentation

a. **Briefly describe all communications and contacts that occurred in attempting to recover this overpayment**.

b. **Describe all other actions that were pursued in attempting to recover this overpayment**.

Action	Yes/No	Explanation
Did PI attempt to transfer the O/P to another actively billing provider under the same tax ID?		Why or why not?
Did PI attempt to transfer the O/P to another actively billing provider under a different tax ID (same owner)?		Why or why not?
Did PI attempt to assign the debt to the individual owner? **(Pat address this)**		Why or why not?
Did PI attempt to enter the credit balance into the State tax return offset system?		Why or why not?
In identifying provider assets, did PI include real estate? **(Fiscal would do)**		Why or why not?
Did PI determine if the provider is now submitting claims to an MCO, and if so, consider a provider set-off request to the MCO?		Why or why not?
Were other actions pursued?		Why or why not?
Have all known avenues of recovery been exhausted?		Why or why not?

c. Transfer of ownership.

Transfer of ownership does not ordinarily entitle a state to reclaim the federal share unless state law and procedures deem a provider which has transferred ownership to be out of business and preclude collection of the overpayment from the provider.

Action	Yes/No	Explanation
Was there a transfer of ownership?		
If there was a transfer of ownership, did PI confirm with the OGC that the overpayment is still uncollectable?	N/A	

d. Certification Establishing the Provider is Out-of-Business

Action	Yes/No	Explanation
Did PI obtain documentation from the Secretary of State or OGC certifying the provider is out-of-business?		
If so, please provide a copy of this documentation.	N/A	Attached.

IV. PI Division Certification

The federal share of this provider overpayment can be reclaimed for the following reasons:

- The provider has been determined to be bankrupt or out-of-business in accordance with the federal regulations.
- The state vigorously pursued this overpayment recovery according to our standard policy as prescribed in administrative procedures and state law, though without complete success.
- There is adequate documentation supporting this decision and this documentation can be provided upon request.

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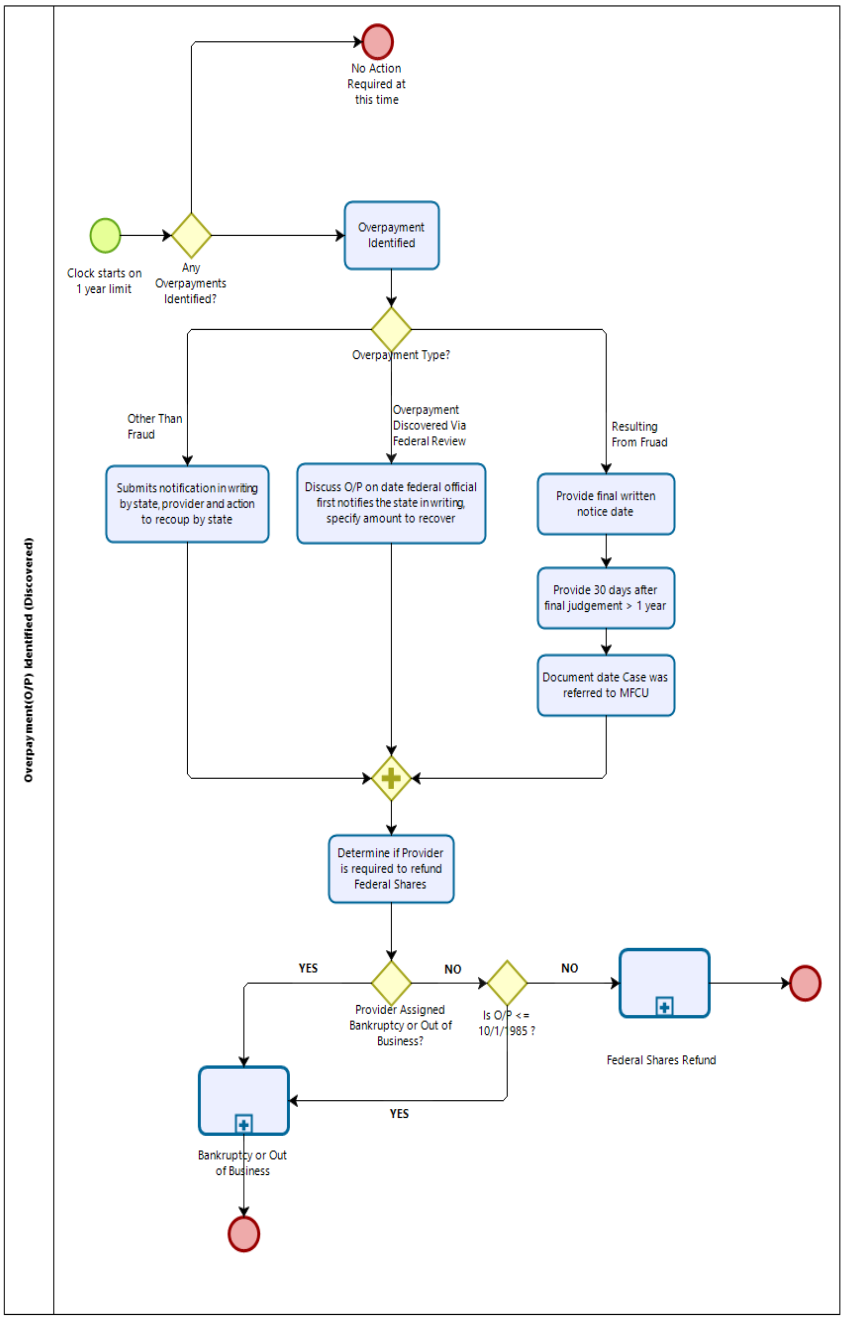
Exhibit II



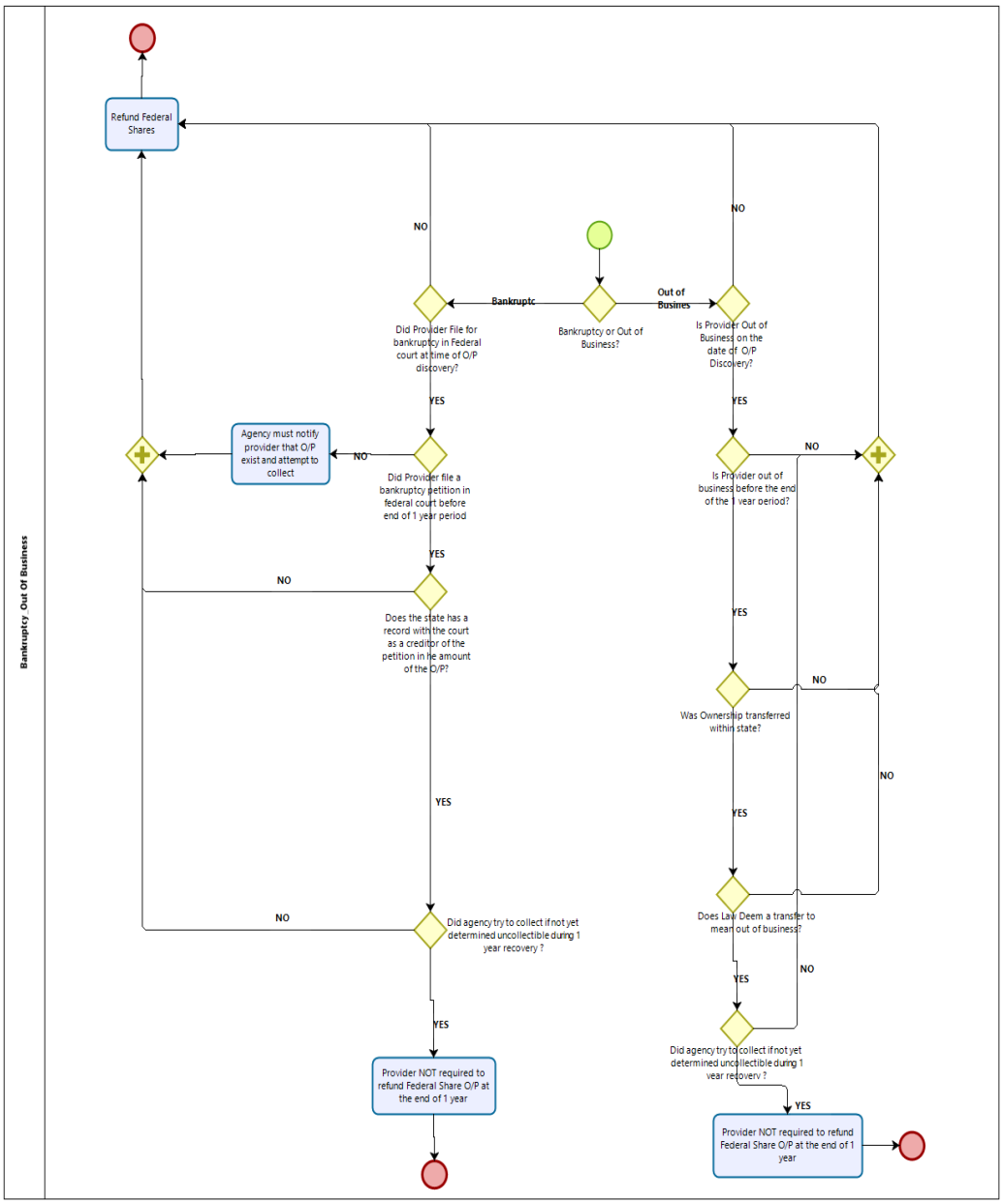
Identify Overpayments

Author: CPalmer

Version: 1.0-23OCT2019

Description: Third party payments and probate collections are not subject to these requirements

Unallowable Costs paid under a rate setting system, late recovered by state are not overpayments if received by per diem, but would be overpayment if recovered by lump sum payment plan or reduced future payments....



Bankruptcy_Out Of Business

Author:	CPalmer
Version:	1.0-23OCT2019
Description:	Determine Bankruptcy or Out of Business To the extent state is unable to recover the O/P because the Agency not required to refund

Reclaim Refunded Overpayment

Author: CPalmer

Version: 1.0- 23OCT2019

Description: Circumstances requiring refund:
1- If the 1 year recovery period has expired before O/P is found to be uncollectible under this section,
2-the state recovers an O/P under court approved discharge of bankruptcy or
3- if bankruptcy petition is denied, the agency must refund the federal share of the O/P in according to (433.32)

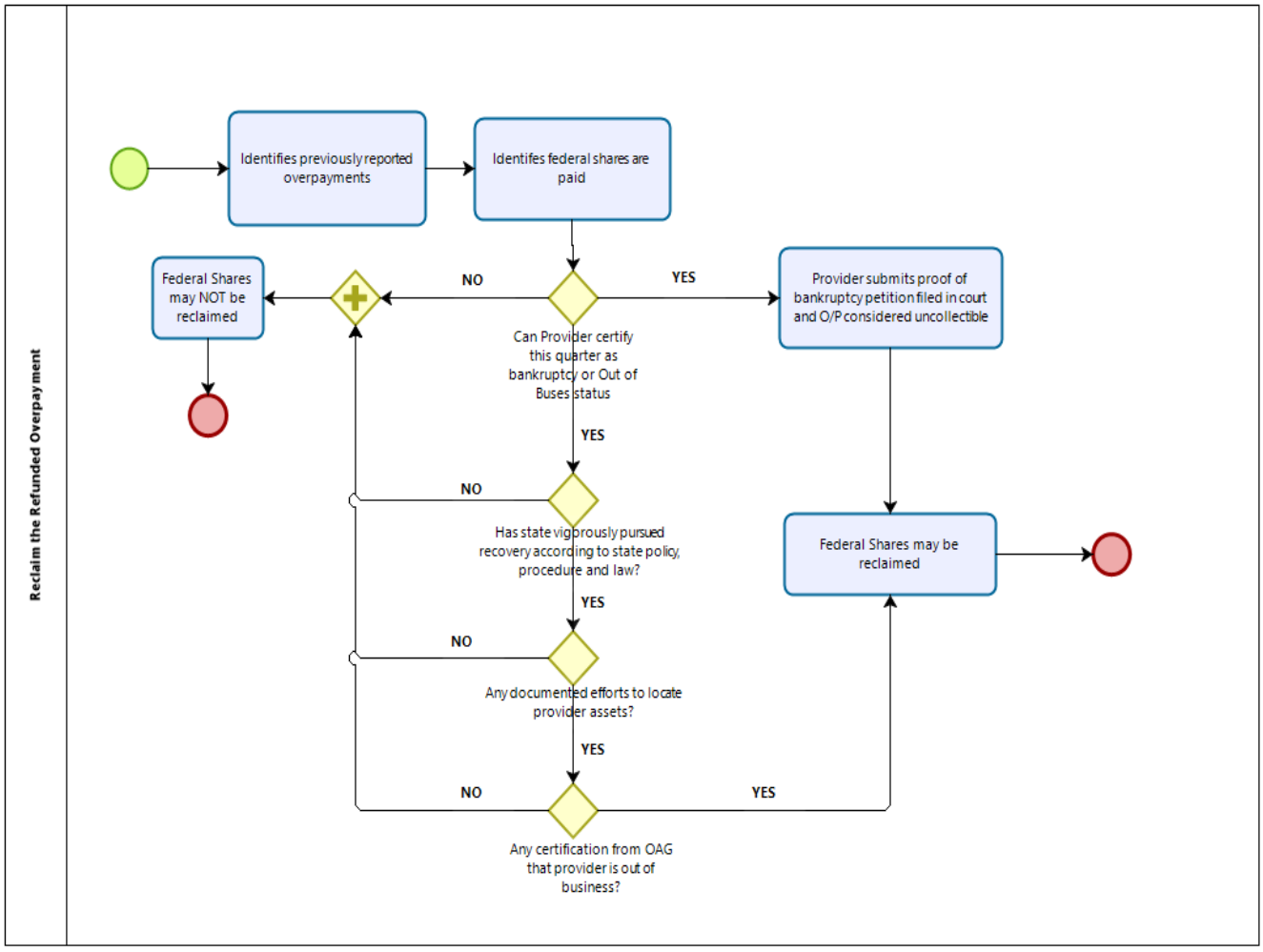


Exhibit III

Provider Out of Business

Date Out of Business (dissolved)

Date Reclaim FMAP Form Completed

Date of Communication with Fiscal

Date Provider/Assets located

Provider Has Declared Bankruptcy

Date Declared Bankruptcy

Date SCDHHS Claim filed w/court

Date Reclaim FMAP Form Completed

Date of Communication with Fiscal