Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: New Jersey Department of Human Services
Docket No. A-93-237
Audit Control No. A-02-92-01004
Decision No. 1469

DATE: March 22, 1994

DECISION

The New Jersey Department of Human Services (New Jersey) appealed the disallowance by the Health Care Financing Administration (HCFA) of $364,473 in federal financial participation (FFP) claimed under Title XIX (Medicaid) of the Social Security Act (Act). The disallowance was based on a review conducted by the Office of Inspector General (OIG) of hospital patient accounts maintained for Medicaid recipients. The review determined that eight hospitals had Medicaid patient accounts with credit balances totalling $728,946. HCFA disallowed the federal share of the credit balances as overpayments to the providers that should have been recovered by New Jersey.

New Jersey argued that the outstanding credit balances were not "overpayments" within the meaning of the Act, that HCFA should not be permitted to recover the federal share of the credit balances prior to the time that New Jersey recoups them from the hospitals, and that it was not required to reimburse HCFA for those credit balances which are uncollectible. New Jersey also disagreed with the amount of the disallowance, and reported that it had recovered some of the overpayments from the hospitals.

For the reasons stated below, we uphold the disallowance. We find that under the Act, HCFA may recoup the federal share of these overpayments regardless of whether New Jersey has recovered them from the hospitals. However, as the parties requested, we remand the appeal to HCFA to determine the amount of the disallowance.

Background -- Medicaid funding

Title XIX of the Act authorizes federal grants to states to aid in financing state programs which provide medical

assistance and related services to needy individuals. Any state that wishes to participate in the Medicaid program must develop and submit a plan that meets certain requirements set forth by the Secretary of the Department of Health and Human Services (HHS). Realizing that many states might have difficulty financing a Medicaid program even if subsequently reimbursed by the federal government, Congress also established a funding mechanism by which HHS advances funds to a state, on a quarterly basis, equal to the federal share of the estimated cost of the program. After review of the state's quarterly statement of expenditures, the Secretary may adjust future payments to reflect any overpayment or underpayment which was made to the state for any prior quarter. Section 1903(d) of the Act. Specifically, section 1903(d)(2)(A) of the Act provides that amounts paid to a state shall be reduced to the extent of any overpayment which the Secretary determines was made to the state for any prior quarter and with respect to which adjustment has not already been made.

In numerous cases involving excess or improper payments by states to Medicaid providers, this Board has held that, under section 1903(d)(2) of the Act, HCFA may require adjustment of the grant award for the federal share of firmly established overpayments, even if a state has not yet recovered these amounts from the providers. The Board reasoned that excess or improper payments are not "medical assistance" within the meaning of sections 1903(a)(1) and 1905(a) of the Act. See, e.g., California Dept. of Health Services, DAB No. 1015 (1989); California Dept. of Health Services, DAB No. 977 (1988); California Dept. of Health Services, DAB No. 619 (1985); Massachusetts Dept. of Public Welfare, DAB No. 262 (1982). The Board's prior holdings on overpayments issues have been upheld in three decisions by United States courts of appeals: Massachusetts v. Secretary, 749 F.2d 89 (1st Cir. 1984), cert. denied, 472 U.S. 1017 (1985); Perales v. Heckler, 762 F.2d 226 (2d Cir. 1985); and Missouri Dept. of Social Services v. Bowen, 804 F.2d 1035 (8th Cir. 1986).

The Board and the courts have also upheld HCFA's ability to require adjustment for the federal share of overpayments even where the state is unable to recover them due to provider bankruptcy. See, e.g., DAB No. 977; California Dept. of Health Services -- Accounts Receivable, DAB No. 334 (1982); Massachusetts v. Secretary. However, Congress subsequently created an exception to the adjustment requirements for certain types of uncollectible overpayments, including overpayments to bankrupt providers, identified for

quarters beginning on or after October 1, 1985. The Board has considered the applicability of this exception in several decisions. See, e.g., New York State Dept. of Social Services, DAB No. 1235 (1991); New York State Dept. of Social Services, DAB No. 1040 (1989).

As amended by section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85), Public Law No. 99-272, section 1903(d) of the Act reads in pertinent part as follows:

> (2)(D) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).[1]

The provisions of section 1903(d)(2) of the Act are implemented by regulations at 42 C.F.R. Part 433, Subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers." 54 Fed. Reg. 5460 (1989). In relevant portion, the regulation provides as follows:

> *Overpayment* means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

42 C.F.R. § 433.304.

The regulation further provides:

> The [State] agency is not required to refund the federal share of an overpayment made to a provider . . . to the extent that the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with the provisions of this section.

42 C.F.R. § 433.318(a)(1).

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[1]Webster's Third New International Dictionary cites "uncollectible" as the preferred spelling, which we use when not quoting from the statute.

Factual Background

The disallowance was based on OIG's review of records of patient account balances at eight acute care hospitals in New Jersey. The records provided account balance information as of December 1991 for seven of the hospitals, and as of January 1992 for the eighth hospital. OIG reviewed information on those Medicaid patient accounts which showed credit balances of at least $101. OIG identified 189 Medicaid patient credit balances totalling $728,946 that New Jersey had not recovered as of the dates of the furnished data.

OIG reported that the credit balances resulted from hospitals receiving duplicate payments, third-party payments, and excess reimbursements. Duplicate payments were typically caused by hospitals erroneously generating multiple billings or otherwise being paid twice for one service. Third-party payments resulted from hospitals receiving payment from a third-party insurer, such as Medicare, for a service paid for by Medicaid. Excess reimbursements resulted from hospitals receiving payments greater than what they were entitled to; half of these were caused by hospitals receiving higher than their "price per case" for the particular service, and half caused by hospitals receiving greater reimbursement for deductibles and coinsurance than reported. OIG reported that credit balances also resulted from overstated hospital billings, the use of incorrect identifiers for the type of services provided, and from various other types of billing or accounting errors. New Jersey Exhibit A. HCFA then disallowed the federal share of the Medicaid credit balances identified by OIG on the grounds that they represented unrecovered Medicaid program overpayments.

Analysis

1. The amounts at issue here are "overpayments" within the meaning of section 1903(d) of the Act.

New Jersey argued that the payments to the providers at issue here were not "overpayments" within the meaning of section 1903(d)(2) of the Act. In support of this argument, New Jersey cited the following language in the legislative history of COBRA '85:

> *Current law.*--State Medicaid agencies are allowed to pay nursing homes and hospitals at interim rates until final rates are established. If the final rate is less than the interim rate, the institution was overpaid

> and the State is responsible for the collection of the "overpayment".

S. Rep. No. 146, 99th Cong., 2d Sess. 314 (1985), reprinted in 1986 U.S.C.C.A.N. 281.

New Jersey asserted that since the payments here resulted from credit balances in hospital patient accounts, and not from excessive interim rates, they were not contemplated in the legislative history as "overpayments" subject to recovery by HCFA. Consequently, New Jersey argued, the regulatory definition of an overpayment at 42 C.F.R. § 433.304 goes beyond the definition in the statute and is thus invalid.

We first note that the Board does not have the authority to find that the regulatory definition of "overpayment" at 42 C.F.R. § 433.304 is invalid, since the Board is bound by all applicable laws and regulations. 45 C.F.R. § 16.14. However, even if we had the authority to entertain the argument raised by New Jersey, we would still find that the regulatory definition is fully consistent with the statute, for the reasons discussed below.

The cited legislative history does not support New Jersey's argument that "overpayments" are limited to the difference between the providers' interim and final reimbursement rates. Prior to the COBRA '85 amendments, U.S. district courts had reversed two Board decisions upholding disallowances of Medicaid funds, on the grounds that HHS had not established that payments to a provider at an interim rate that turns out to be higher than a final rate constituted overpayments for purposes of section 1903(d)(2) of the Act. Massachusetts v. Heckler, 576 F. Supp. 1565 (D. Mass. 1984), rev'd, 749 F.2d 89 (1st Cir. 1984), cert. denied, 472 U.S. 1017; Missouri Dept. of Social Services v. Heckler, Case No. 84-4106-CV-C-5 (September 27, 1984), rev'd, Missouri Dept. of Social Services v. Bowen, 804 F.2d 1035 (8th Cir. 1986). We consider it likely that Congress's intent in referring to excess payments resulting from the difference between a provider's interim and final reimbursement rates was to clarify that these, too, were overpayments for which HCFA could require adjustment, rather than to narrow the definition of "overpayment" to this one category of excess payments.

Moreover, the Board has long held that excess or improper payments are not "medical assistance" within the meaning of section 1903(a)(1) and 1905(a) of the Act, are thus not allowable costs of the Medicaid program, and

therefore constitute overpayments under section 1903(d)(2) of the Act. See, e.g., California, DAB No. 1015; California, DAB No. 977; California; DAB No. 619 (1985); Massachusetts, DAB No. 262. The Board has held that the term "overpayments" in section 1903(d)(2)(A) of the Act may include, in addition to excessive reimbursements because of invalid rate determinations, the federal share of amounts a state paid for improper provider claims, such as duplicate payments. California Dept. of Health Services, DAB No. 564, at 6 (1984). Payments to providers which the Board has found constitute overpayments have included, as well as duplicate payments, third-party reimbursements received by providers. Colorado Dept. of Social Services, DAB No. 1272 (1991); Washington Dept. of Social and Health Services, DAB No. 645 (1985). In Washington, the Board held that third-party reimbursements received by a provider are essentially duplicate payments to the provider. The Board reasoned as follows:

> Once a provider receives reimbursement from a state for services and then receives reimbursement from a third party for the same services, it would appear, unless the state can show otherwise, that the provider has received a greater amount than it was entitled to as medical assistance.

Id. at 13.

Accordingly, we conclude that the regulatory definition is consistent with HCFA's longstanding interpretation of "overpayment" as upheld in this line of Board decisions, and with the broad language of section 1903(d)(2) of the Act. New Jersey pointed to nothing in the legislative history which would indicate any intent to reverse HCFA's longstanding interpretation and the Board decisions supporting it.

Here, the various categories of overpayments identified in the OIG audit report all arose as a result of the hospitals receiving excess or duplicate payments for particular services. While New Jersey disputed OIG's determinations as to the *amounts* of the credit balances remaining outstanding, it did not challenge the factual findings underlying the determination that these balances constituted overpayments. Additionally, while New Jersey asserted on the one hand that these amounts are not overpayments subject to recovery by HCFA as described in the legislative history, New Jersey also offered to return to HCFA the federal share of the amounts it succeeds in recovering. New Jersey thus acknowledged

that the providers in these instances received more reimbursement than they were entitled to for the services they rendered.

Accordingly, we find that the hospital credit balances were overpayments within the meaning of section 1903(d)(2) of the Act and the clear definition in the regulations.

2. HCFA may recoup the federal share of the credit balances regardless of whether New Jersey has recovered them from the providers.

As discussed above, it is well settled that under section 1903(d)(2) of the Act, HCFA may require adjustment of a state's grant award to account for the federal share of overpayments, even when the overpayments have not been recovered by the state. See, e.g., California, DAB No. 1015; California, DAB No. 977; (1988); California, DAB No. 619; Massachusetts, DAB No. 262. Despite this precedent, New Jersey argued that it should not be required to refund the federal share of overpayments that have not been recovered from the hospitals. New Jersey raised arguments that have been considered and rejected by the Board in earlier appeals. As discussed below, we find these arguments unavailing here as well.

a. It is not inequitable for New Jersey to bear the burden of unrecovered overpayments.

New Jersey argued that it was inequitable and illogical for it to bear the entire loss of overpayments that it has not recovered from the hospitals, and that HCFA must also suffer the loss until the overpayments can be recovered. New Jersey noted that Medicaid is a cooperative federal-state program, and argued that forcing it to bear the entire burden of unrecovered overpayments would result in this cooperative program becoming a 100-percent state program.

However, the Board previously concluded that, in light of the fact that the states have primary responsibility for administering the program and preventing or recouping improper payments in the first instance, it is indeed consistent with the federal-state partnership concept to place the burden of unrecoverable payments on states. Michigan Dept. of Social Services, DAB No. 971 (1988); New York Dept. of Social Services, DAB No. 311 (1982). As the court observed in Massachusetts v. Heckler:

> Since only [the state] deals directly with the providers, and since the state is empowered to

> perform on-site audits of these institutions, it is clearly the party best able to minimize the risks resulting from dealing with insolvent providers. . . . Placing an additional burden on the state will increase its incentive to take care, whereas the Secretary remains powerless to reduce the risks no matter what the costs imposed on her.

749 F.2d at 96.

The Board has also found that requiring states to refund the federal share of overpayments that they may not have recouped from providers is not inconsistent with the cooperative federalism foundation of the Medicaid program. On this question the Board has previously concluded:

> [W]hile it is true that Congress devised the Medicaid program as a joint federal-state endeavor, the states have the primary responsibility for administering the program, including the duty to take steps to prevent improper payments in the first instance and to identify and recover overpayments in a timely manner when they do occur. In some instances the loss of funds might be unavoidable. However, to sort out these cases would be difficult, requiring a highly judgmental case-by-case analysis. Viewing the program as a whole, therefore, we think that the Agency is not unreasonable in requiring the states to bear the burden of unrecovered overpayments.

DAB No. 311, at 7.

Similarly, the U.S. district court in Perales v. Heckler, 611 F.Supp. 333 (N.D.N.Y. 1984), aff'd, 762 F.2d 226 (2d Cir. 1985), affirming the Board's finding that HCFA could require a state to return the federal share of overpayments that had not been recovered from providers, concluded:

> While plaintiff is entirely correct in its characterization of Medicaid as a federal/state partnership, there is no basis to believe that some of the partners' obligations are not to be borne alone. . . . The partnership upon which plaintiff relies does not in and of itself entitle the State to disclaim or abdicate its own obligations in order to make its own responsibilities easier to bear.

611 F. Supp. at 342-43.

Accordingly, based on the precedent above, we conclude that it is not inequitable or contrary to the nature of Medicaid as a cooperative federal-state program to require New Jersey to refund the federal share of those overpayments that it has not yet recovered from the providers.[2]

We note that Congress, at section 1903(d)(2)(D) of the Act, provided a specific exception to the requirement that states repay overpayments that have not been recovered from providers. As discussed below, this exception applies only to overpayments which are uncollectible due to the bankruptcy or insolvency of the provider. Creation of an exception for those limited circumstances supports our conclusion that overpayments in other situations are subject to recovery by HCFA, regardless of whether they have been recouped by a state.

b. The overpayments are not uncollectible within the meaning of section 1903(d)(2)(D) of the Act.

New Jersey asserted that it could not collect some of the overpayments at issue from the providers because records of the overpayments were not available, and because some providers had failed to resubmit corrected claims that New Jersey needed in order to adjust the payments. It argued that HCFA was barred from recovering the federal share of such overpayments by section 1903(d)(2)(D) of the Act, which excuses states from having to repay the federal share of overpayments which have been discharged in bankruptcy or are "otherwise . . . uncollectable."

New Jersey acknowledged that the regulation implementing this provision of the Act, at 42 C.F.R. § 433.318, limits uncollectible overpayments (for which a state is not liable) to those which are uncollectible because a provider is bankrupt or has gone out of business. However, New Jersey did not assert that the overpayments here were uncollectible because the providers were bankrupt or out of business. Instead, New Jersey argued that the regulation goes beyond the statutory language and is too restrictive, since section 1903(d)(2)(D) of the Act simply excuses overpayments "otherwise being uncollectable." The statute, New Jersey argued, thus

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[2]We note that New Jersey asserted that it has recovered $222,692 in FFP from the providers, or over 60 percent of the total amount of the disallowance.

mandates that any uncollectible overpayment not result in an adjustment of the federal share.[3]

The Board has previously rejected the broad construction of section 1903(d)(2)(D) of the Act advanced here by New Jersey, and has found that the language of the regulation limiting uncollectible overpayments to those involving bankrupt or out-of-business providers is fully consistent with the language and legislative history of the statute.

As discussed above, section 1903(d)(2)(D) was added to the Act by COBRA '85. In relevant portion, the Senate report that accompanied the legislation stated:

> *Explanation of provision.*--The provision would allow States up to sixty days (from the date of discovery) to recover overpayments from providers and refund the Federal share. The provision would provide that a State is not liable for the Federal share of overpayments which cannot be collected from bankrupt or out-of-business providers.

S. Rep. No. 146, 99th Cong., 2d Sess. 315 (1985), reprinted in 1986 U.S.C.C.A.N. 282.

As the Board has observed, the legislative history indicates that Congress intended to limit the application of section 1903(d)(2)(D) of the Act, and its reference to uncollectible overpayments, to situations where a provider has gone bankrupt or is out of business and the state cannot collect the funds. New York State Dept. of Social Services, DAB No. 1040, at 6-7 (1989). Reading section 1903(d)(2)(D) to cover circumstances in which a state will have difficulty collecting for reasons unrelated to provider solvency is not warranted by the legislative history. See New York Dept. of Social Services, DAB No. 1112 (1989). The Board has also noted that while the language of the statute is susceptible to multiple interpretations, the positioning of the phrase "or otherwise being uncollectable" after the reference to discharge in bankruptcy implies that Congress meant to limit the concept of uncollectible overpayments to circumstances related to the solvency of the provider. New York State Dept. of Social Services, DAB No. 1235, at

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[3]As discussed above, the Board is without authority to find that a challenged regulation is invalid. 45 C.F.R. § 16.14. However, as discussed below, we would in any event find that the regulation challenged here is consistent with the statute and congressional intent.

15-16 (1991). Further, the broad reading New Jersey gives the term uncollectible would make Congress's specific reference to bankrupt providers superfluous. Since it is appropriate to try to give effect to all parts of a statute, it is reasonable to assume that Congress intended to limit the protection for uncollectible overpayments to circumstances (such as bankruptcy) in which a state is unable to recoup the overpayment because of the financial condition of the provider. DAB No. 1235, at 15.

Applying the regulation, it is clear that New Jersey does not qualify for the exception. New Jersey did not allege nor does the record establish that the solvency or financial condition of the hospitals in question rendered them unable to repay the overpayments that New Jersey characterized as uncollectible. Rather, New Jersey asserted that they are uncollectible because records needed for precise determination of the overpayment amounts are either lost or in possession of the providers. New Jersey asserted that the providers had agreed with OIG to resubmit claims but had not done so, and that it should be incumbent upon HCFA and not New Jersey to enforce the agreement with the providers. Clearly, these circumstances are unrelated to the providers' solvency and do not render the overpayments uncollectible within the meaning of section 1903(d)(2)(D). See, e.g., New York, DAB No. 1235 (overpayments not uncollectible under section 1903(d)(2)(D) merely because of audit costs and the administrative difficulty of recovering the overpayments).

Additionally, while New Jersey attempted to characterize these overpayments as otherwise uncollectible for the purpose of section 1903(d)(2)(D) of the Act, it did not allege that it had attempted to collect them and was unable to do so. Instead, New Jersey argued that the precise amount of the overpayments could not be determined. New Jersey has not denied the underlying liability for the overpayments, and has not shown that they are in fact uncollectible within the meaning of the statute and regulation.

New Jersey also asserted that hospitals had agreed with OIG to supply additional information regarding the credit balances, and that it should be incumbent on HCFA to enforce such agreements. However, the OIG audit report does not reflect any specific agreement with the hospitals to supply records to OIG. The existence of such an agreement would not excuse New Jersey from refunding the federal share of these overpayments in any

event, since under section 1902(a)(27) of the Act, state Medicaid plans must require states to have agreements with providers in which the providers agree to keep records regarding any payments claimed for providing services under the state plan, and to furnish the Secretary with such information. See, e.g., New York, DAB No. 1235.

Finally, we note that it is not disputed here that the hospitals initially provided to OIG the credit balance information on which the OIG report is based. This information specifically lists the Medicaid recipients involved and the dates of service. New Jersey's own computerized billing system (or that of its fiscal intermediary) should at least be able to identify any duplicate payments made for such services and should also contain information on allowable reimbursement amounts and liable third parties sufficient to establish other overpayments. Thus, the mere fact that some hospitals may not now have records on some of the credit balances is insufficient even to show that New Jersey will have difficulty collecting the identified overpayments.

Accordingly, we conclude that the alleged failure of the providers to keep accurate records does not excuse New Jersey from its responsibility to account for these overpayments, and that they are not uncollectible within the meaning of section 1903(d)(2)(D) of the Act.

3. This matter should be remanded to determine the amount of the disallowance.

New Jersey requested that the disallowance, if upheld, be remanded in order to determine the actual disallowance amount, since New Jersey has recovered some of the overpayment amounts from the providers subsequent to the time of the OIG audit report. New Jersey asserted that it had recovered a total of $445,363.57 ($222,692 in FFP) from the providers as of the middle of January 1994. New Jersey also asserted that some of the amounts that OIG had reported as owing to New Jersey were different from the amounts that New Jersey had determined were due. HCFA stated that it did not object to a remand for purposes of adjusting the amount owed. Therefore, we remand the appeal to HCFA to determine the amount of the disallowance. Within 30 days of receiving this decision, or within such longer time as HCFA may permit, New Jersey should provide HCFA any information it may have regarding the amount of the credit balances. To the extent that HCFA or OIG may have information regarding the overpayment amounts that is not in the possession of New Jersey, the parties are encouraged to cooperate in

determining the amounts owed by and recovered from the various hospitals. If New Jersey disagrees with the amount of the disallowance as determined by HCFA, New Jersey may appeal on that limited issue within 30 days of receipt of a final written determination by HCFA, pursuant to the Board's procedures at 45 C.F.R. Part 16.

Conclusion

For the reasons stated above, we sustain the disallowance. However, we remand the appeal to HCFA to determine the amount of the disallowance. If New Jersey disagrees with HCFA's determination of the final disallowance amount, it may return to the Board on that issue within 30 days of receiving HCFA's determination.

/s/
Cecilia Sparks Ford

/s/
Norval D. (John) Settle

/s/
Judith A. Ballard
Presiding Board Member