

**KENTUCKY'S MANAGEMENT OF ITS  
MEDICAID ACCOUNTS RECEIVABLE**

**NOVEMBER 2002 - PERFORMANCE AUDIT**



**EDWARD B. HATCHETT, JR.  
AUDITOR OF PUBLIC ACCOUNTS**

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The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.

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EDWARD B. HATCHETT, JR.  
AUDITOR OF PUBLIC ACCOUNTS

November 19, 2002

To the People of Kentucky

The Honorable Paul E. Patton, Governor

Marcia Morgan, Secretary, Cabinet for Health Services

Michael Robinson, Commissioner, Department for Medicaid Services

Re: Kentucky's Management of its Medicaid Accounts Receivable

Ladies and Gentlemen:

We present our evaluation of Kentucky's management of its Medicaid accounts receivable. We are distributing this report in accordance with the mandates of Kentucky Revised Statute 43.090. In addition, we are distributing copies to members of the committees of the General Assembly exercising oversight authority over health and welfare issues, as well as other interested parties.

Kentucky Revised Statute 43.090 (1) requires an agency to which a report of the Auditor of Public Accounts pertains to notify the Legislative Research Commission and the Auditor of Public Accounts, within 60 days of completion of the audit report, which of the audit recommendations have been implemented and which have not. After an appropriate period of time, we will contact DMS to determine whether the report's recommendations have been implemented, and we will advise the Legislative Research Commission regarding the status of that implementation. Once we are notified that the recommendations have been implemented, they will be considered closed.

Our Division of Performance Audit evaluates the effectiveness and efficiency of government programs. The Division also performs risk assessments and benchmarks government operations. We will be happy to discuss with you at any time this audit or the services offered by our office. If you have any questions, please call Gerald W. Hoppmann, Director of our Division of Performance Audit, or me.

We appreciate the courtesies and cooperation extended to our staff during our work.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Ed Hatchett".

Edward B. Hatchett, Jr.  
Auditor of Public Accounts





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# Executive Summary

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**Audit Objective** Determine whether the Department for Medicaid Services (DMS) is effectively managing its accounts receivable consisting of provider overpayments.

**Background** Kentucky is one of dozens of states facing a Medicaid funding crisis. For FY 2002, DMS expended \$469 million more than was budgeted. DMS predicts no deficit in 2003 and a \$216 million deficit in 2004. An important issue is the Commonwealth's management of its Medicaid accounts receivable consisting of provider overpayments. A provider overpayment may result from fraud or error. Provider overpayments are discovered during periodic reviews performed by DMS.

Once DMS detects and documents an overpayment, it has 60 days to refund the federal government's share of the overpayment, which for Kentucky is approximately 70 cents of each dollar. If DMS neglects to pursue effective collection efforts, it is not only deprived of the opportunity to recoup the overpayment from the provider, but must also refund the federal share. On the other hand, if DMS proves that, despite all reasonable recoupment efforts, the receivable is uncollectible, the federal government will refund its share of the payment to Kentucky.

**Findings** DMS has allowed provider overpayments to languish indefinitely as accounts receivable. On July 20, 2001, Medicaid accounts receivable totaled \$36.5 million, including \$17.8 million outstanding for at least 2 years. Accounts receivable had increased to \$57.8 million on May 26, 2002, of which \$16.4 million was over two years old.

As of September 29, 2002, Kentucky has refunded more than \$25 million in federal reimbursements on \$35 million in accounts receivable over 60 days old. As of that date, close to \$9 million was posted to accounts receivable 60 days old or less.

DMS has neither developed or implemented effective comprehensive procedures for

- collecting accounts receivable directly from providers,
- recouping accounts receivable from subsequent Medicaid billing presented by providers for payment,
- recouping accounts receivable from the Medicare program for providers who no longer participate in Medicaid but provide services for the federal program,
- identifying uncollectible balances, and
- writing off those uncollectible balances.

Until recently, DMS did not link accounts receivable to its enrollment records and its inactive provider records, thereby preventing it from detecting providers who use different provider numbers to avoid recoupment of overpayments. DMS also until recently did not collaborate with the federal government to recoup from active Medicare providers.

In the fall of 2001, DMS underwent reorganization in which the Division of Program Integrity was established to identify accounts receivable and provider enrollment problems. DMS now has outlined policy and is developing comprehensive policies and procedures for managing accounts receivable. In 2002, DMS linked accounts receivable to records of inactive providers and new enrollees and began to collaborate with the federal government to recoup from active Medicare providers.

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# Executive Summary

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Despite these efforts, the accounts receivable balance has grown to \$44 million in a 14-month period and Kentucky's Medicaid accounts receivable are significantly higher than other states sampled during the audit.

DMS chooses not to charge interest or penalties on overdue accounts receivable. By not imposing interest or penalties, Kentucky has not encouraged repayment of receivables, has lost revenue, and has allowed receivables to depreciate by not respecting the time value of money.

## Recommendations

This report contains six agency recommendations, summarized as follows:

1. Develop and implement a strategic plan for managing accounts receivable.
2. Develop and implement a comprehensive procedures manual for identifying overpayments and writing off uncollectible debt.
3. Exhaust collection practices such as using collection agencies and legal remedies.
4. Fully document efforts to recoup and collect accounts receivable.
5. Routinely reassess the reasons for suspending collection efforts on accounts receivable to assure that each account is properly managed.
6. Establish and communicate to all providers administrative regulations and procedures for assessing interest and penalties.

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## Acronyms and Abbreviations

<b>CFR</b>	Code of Federal Regulations
<b>DMS</b>	Department for Medicaid Services
<b>Health Services</b>	Cabinet for Health Services
<b>CMS</b>	Center for Medicare and Medicaid Services
<b>HCFA</b>	Health Care Finance Administration
<b>KAR</b>	Kentucky Administrative Regulations
<b>KRS</b>	Kentucky Revised Statutes
<b>MMIS</b>	Medicaid Management Information System
<b>OIG</b>	Office of Inspector General



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# Chapter 1

## Introduction

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### **Medicaid Reimburses Providers of Health Care for Qualifying Individuals**

Medicaid is a joint federal and state health insurance program for persons of limited means. Medicaid is governed by broad federal guidelines administered by the Center for Medicare and Medicaid Services (CMS) [formerly Health Care Financing Administration (HCFA)]. Under these guidelines, each state must

1. establish eligibility standards,
2. determine the type, amount, duration, and scope of services,
3. set payment for services, and
4. administer its own program.

Kentucky's Medicaid program covers approximately 600,000 children, aged, blind, disabled, and low-income citizens. In FY 2001, the Commonwealth paid out \$3.5 billion in Medicaid expenditures. Kentucky spent approximately \$469 million more on Medicaid services than was budgeted for FY 2002. It is hoped that newly implemented cost-containment measures will result in a break-even year in FY 2003, and it is expected that during FY 2004 Medicaid will suffer a shortfall of approximately \$216 million.

Kentucky's DMS within the Cabinet for Health Services administers Kentucky's Medicaid program. DMS pays providers to deliver services to eligible participants, and, in turn, providers participating in Medicaid must accept Medicaid payment rates as payment in full. Appendix II contains the organizational chart for DMS.

The Federal Government pays a large portion of expenditures under each state's Medicaid program. By law, the federal share cannot be lower than 50 percent nor higher than 83 percent. While the federal reimbursement rate in 2001 averaged 57% nationwide, the rate reimbursed to Kentucky is approximately 70%.

DMS reorganized during the fall of 2001. As a result, the Division of Program Integrity was established to identify and correct problems related to accounts receivable and provider enrollment. Since that time, DMS has developed a policy outline and is developing policies and procedures for managing accounts receivable. In addition, DMS has (1) recently identified inactive providers and related accounts receivable balances in order to begin alternative collection procedures, (2) begun to link the enrollment process to accounts receivable, and (3) begun working with CMS to recoup Medicare payments from providers who owe money to the Medicaid program.

### **DMS Is Responsible for Identifying and Collecting Medicaid Overpayments**

The objective of this audit is to determine whether Kentucky's Medicaid program is effectively managing its accounts receivable consisting of provider overpayments. Because each state is responsible for administering its own Medicaid program, each state is responsible for identifying and collecting overpayments to providers.

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An overpayment is an amount paid by DMS to a health care provider in excess of that which is proper and allowable. Overpayments may involve fraud or could occur as the result of errors. DMS ensures that payments are proper and allowable by:

- Reviewing samples of paid provider billings. Any paid provider billing not properly supported or allowable under Medicaid regulations is deemed an overpayment.
- Reviewing information system reports of Medicaid programs in order to detect improper billing practices.
- Performing desk reviews of provider cost reports to reconcile the costs reported and the amounts paid by DMS during the reporting period. A DMS payment above that supported by the cost report is deemed an overpayment.
- Contracting with outside entities to audit provider cost reports to determine allowable costs that should be reimbursed by Medicaid.

DMS may attempt to collect overpayments directly from providers. If a provider is actively participating in Medicaid and owes DMS for overpayments, DMS can recoup the amount due by offsetting from payments for subsequent provider billings. If a provider stops participating in Medicaid but is a provider in the federal Medicare program, DMS can seek recoupment by requesting that CMS offset federal payments for Medicare provider billings.

Recovery of overpayments may be hindered if the provider has

1. gone out of business,
2. filed for bankruptcy,
3. left the state,
4. merged with another provider,
5. challenged the overpayment designation and appealed the decision, or
6. experienced financial problems and requests a repayment plan.

### **907 KAR 1:167 Defines the Accounts Receivable Collection Process**

The following steps summarize the accounts receivable process governed by 907 KAR 1:671 and outlined during interviews with DMS officials:

1. A request for a repayment demand letter to the provider is initiated when DMS determines that an overpayment occurred.
2. The Accounts Receivable Section receives a copy of the demand letter and prepares a “financial transaction” request for input by Unisys, DMS’s third-party fiscal processing agent.
3. Unisys enters the data in the DMS payment system to generate and mail the demand letter to the provider.
4. The provider has 60 days from the demand letter date to pay the amount in full, submit a written request for a payment plan, or request a dispute resolution meeting if the provider disagrees with DMS’s determination.
5. If a payment plan is requested, the provider must document that full payment would create an undue hardship. The request must also provide:
  - Financial statements
  - Notarized letters from at least two (2) financial institutions indicating the provider’s loan application for the amount owed was declined

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6. If the provider files a timely request for dispute resolution, DMS will suspend any recoupment efforts until the administrative appeals process is final.
7. If the provider fails to make payment through an established payment plan or takes no action toward repayment, Unisys begins offsetting the overpayment against future payments.
8. If the provider does not submit future Medicaid claims that total the amount of the overpayment, DMS is to continue efforts to collect and may pursue all legal remedies available to collect the debt.
9. If the overpayment has not been recouped or collected within 60 days, 90 and 240-day notice letters are subsequently sent to the provider. Overpayment accounts receivable remain in the system until paid in full or written off.
10. According to DMS officials, as of January 2002 Unisys generates a report after 270 days, which is sent to the Division of Program Integrity for action.

Each account receivable is assigned one of the following status codes:

- **Active:** A transaction ready for collection or recoupment.
- **Hold Recoupment:** A transaction placed in a hold status while a payment plan is being considered.
- **Hold-Recoupment-Other:** A transaction placed in a hold status while the provider appeals an overpayment designation.
- **Inactive:** A transaction deemed uncollectible and the refunded federal portion has been returned to the state.
- **Inactive Not Reclaimed:** A transaction deemed uncollectible, but the refunded federal portion has not been returned to the state.

### **The Federal Share Must Be Refunded If Overpayments Are Not Recovered Within 60- Days**

Once DMS detects an overpayment, it has 60 days to refund the federal government's share of the overpayment, which in Kentucky is approximately 70 cents of each dollar. States' expenditures are reduced by the federal share amount of any overdue accounts receivable on the quarterly expenditure report (CMS 64).

Using this same report, the state adds back any recoveries and/or adjustments that pertain to previously reported overdue accounts receivable. If for any valid reason the overpayment that was refunded to CMS is later reduced, written off, or recovered, the state can make the appropriate adjustments on subsequent quarterly expenditure reports to recover the federal matching funds.

States do not have to repay the federal share if the debt is discharged in bankruptcy or is otherwise uncollectible. In asserting that a provider has gone out of business, a state must document any efforts to locate the party and its assets by furnishing a legal affidavit or certification. If the state vigorously pursues recovery without success, or if there is a subsequent bankruptcy or close of business, CMS will return the 70% refunded payment to the state.

The United States Code sections addressing overpayment issues are contained in Appendix IV.

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### **Audit Objective and Focus**

Legislative committees and others have raised a number of concerns about Medicaid, including whether DMS is doing enough to pursue available revenue sources and contain costs.

This audit addresses these concerns by reviewing DMS's management of accounts receivable consisting of provider overpayments. This report identifies problems DMS has had in collecting overpayments, considers recent organizational changes at DMS, examines how well DMS is monitoring the accounts receivable as they age in the system, and recommends ways to improve these activities as well as DMS's oversight.

Our audit was designed to address the following objective:

**Determine whether the Department for Medicaid Services is effectively managing its accounts receivable consisting of provider overpayments.**

To accomplish this objective, we interviewed federal oversight officials with CMS and DMS officials. We reviewed DMS's criteria for processing overpayments. Medicaid officials from other states were surveyed, as well as other professionals knowledgeable on health care issues.

We received a July 20, 2001 report of the entire population of accounts receivable transactions. We reviewed all accounts receivable transactions with balances of \$50,000 or more that were over 90 days old. This resulted in a review of 107 transactions. At the end of the audit, we requested updated information in order to identify activity that may have occurred after we began our review.

Appendix I contains a complete description of the objective, scope, and methodology of this audit. The audit was conducted in accordance with Generally Accepted Government Auditing Standards as issued by the Comptroller General of the United States.

# Chapter 2

## Findings and Recommendations

### DMS Has Not Effectively Managed Accounts Receivable

As of July 20, 2001, the Medicaid accounts receivable balance totaled \$36,522,248, which consisted of \$17,811,803 that had been outstanding for at least 2 years. DMS has allowed provider overpayments to languish in accounts receivable indefinitely, not resorting to alternative collection procedures, designating the overpayments as bad debt, or developing write-off procedures.

An updated listing of accounts receivable as of May 26, 2002 was requested to determine progress with the older accounts receivable. At this date the accounts receivable balance had grown to \$57,800,800. Table 1 illustrates the different status codes and accounts receivable balances as of May 26, 2002.

**Table 1**  
**Status and Age of Medicaid Accounts Receivable**  
**As of May 26, 2002**

Status Code	Number of Transactions	Age in Total Days	Average Age in Days	Average Age in Years	Balance
Active	2136	4,368,939	2045	6	\$39,567,046
Hold Recoupment – (Payment Plan Under Consideration)	15	8,395	560	2	\$2,554,541
Hold-Recoupment-Other	366	647,379	1769	5	\$14,233,496
Inactive Not Reclaimed	121	525,233	4341	12	3,348
Inactive	124	330,733	2667	7	1,442,369
<b>Total</b>	<b>2762</b>	<b>5,880,379</b>	<b>2129</b>	<b>6</b>	<b>\$57,800,800*</b>

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services.

**\*According to unaudited data provided by DMS, the total accounts receivable balance as of September 29, 2002 was \$44,173,732.**

In addition, transactions over 60 days old totaled \$24,451,461, of which \$16,444,059 was over two years old. Table 2 illustrates the year that the accounts receivable were posted, the number of transactions established per year, and the total dollar amount of those transactions over 60 days old as of May 26, 2002.

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## Findings and Recommendations

**Table 2**  
**Medicaid Accounts Receivable Over 60 Days Old**  
**As of May 26, 2002**

<b>Year Established</b>	<b>Number of Transactions</b>	<b>Balance Overdue</b>
2002	110	\$1,042,208
2001	128	\$5,001,164
2000	164	\$2,469,388
1999	336	\$851,699
1998	263	\$2,077,913
1997	68	\$1,640,030
1996	241	\$3,517,235
1995	251	\$1,641,796
1994	193	\$770,648
1993	110	\$2,426,630
1992	40	\$959,840
1991	404	\$497,665
1990	43	\$447,862
1989	47	\$388,884
1988	27	\$472,220
1987	25	\$213,599
1986	34	\$8,792
1985	8	\$669
1984	12	\$23,219
<b>Totals</b>	<b>2504</b>	<b>\$24,451,461*</b>

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services.

\*According to unaudited data provided by DMS, the total balance as of September 29, 2002 was \$35,354,895.

### **Kentucky Refunded \$25 Million to the Federal Government For Accounts Receivable Not Collected Within 60 Days**

As of September 29, 2002, Kentucky has refunded more than \$25 million to CMS for \$35 million in accounts receivable over 60 days old. We asked DMS to update us on \$33 million of accounts receivable that were 60 days old or less prior to May 26, 2002. DMS responded that only \$3.1 million of that amount has been collected.

By neglecting to pursue effective collection efforts, DMS not only fails to recover overpayments from providers. It is also ineligible to recover the millions it has refunded to the federal government because, without comprehensive policies and procedures, it cannot certify exhaustive collection efforts.

# Chapter 2

## Findings and Recommendations

### Accounts Receivable Balances Are Significantly Lower In Other States

Kentucky’s large Medicaid accounts receivable balance compares unfavorably to the other states sampled during the audit. Kentucky maintains the largest Medicaid accounts receivable balance consisting of provider overpayments compared to the states in our sample. Six of the seven states in our sample have developed procedures to write off accounts receivable after a reasonable period of time, usually two years. Kentucky is in the process of developing such procedures.

Comparisons with other states provide useful benchmarks, even though different states use different reimbursement methods. The following table shows that Kentucky’s accounts receivable are significantly higher.

**Table 3**  
**State Medicaid Expenditures and A/R Balance for Provider Overpayments**

State	Medicaid Expenditures (FY2001)	A/R Balance*	Percentage of A/R Balance to Total Medicaid Expenditures	Policies or Regulations for writing off receivables
Illinois	\$ 8,421,128,340	\$ 11,500,000	0.14%	Yes
Oklahoma	\$ 2,170,592,307	\$ 3,061,605	0.14%	No
Virginia	\$ 3,201,548,208	\$ 7,144,781	0.22%	Yes
Kentucky	\$ 3,398,140,533***	\$ 57,800,800**	1.7%	In Development
New Jersey	\$ 7,361,441,113	\$ 24,000,000	.3%	Yes
Minnesota	\$ 4,076,897,096	\$ 1,262,000	0.03%	Yes
Washington	\$ 4,769,737,694	\$ 23,000,000	.5%	Yes
West Virginia	\$ 1,617,888,766	\$ 20,901,000****	1.29%	Yes

Source: Auditor of Public Accounts, from information provided by various states.

\*A/R balance dates for FY02 vary for each state.

\*\*A/R balance as of 5/26/02.

\*\*\*Expenditure data for FY02.

\*\*\*\*A/R balance is not just Medicaid, but all accounts receivable for the West Virginia Department of Health and Human Resources.

### New Collection Procedures Have Not Brought the Desired Result

Until recently, DMS had not linked accounts receivable to the identification of inactive providers and enrollment procedures to detect providers using different provider numbers to avoid recoupment. DMS has also begun collaborating with CMS to recoup overpayments from active Medicare providers.

Although DMS has recently developed various memoranda on managing accounts receivable, it has not promulgated comprehensive policies, procedures, and guidelines. Furthermore, the burgeoning accounts receivable balance belies any significant progress toward effective management.

See Appendix III for information on 907 KAR 1:671, promulgated to facilitate recoupment of overpayments through offset of subsequent billings.

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## Chapter 2

# Findings and Recommendations

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### DMS Has Not Developed or Implemented Effective Comprehensive Procedures to Identify Uncollectible Accounts

DMS does not have bad debt designation procedures for uncollectible accounts receivable. No routine reviews or applicable criteria were established to classify overdue accounts receivable transactions as uncollectible. Also, DMS did not implement any standard write-off policies to ensure that the accounts receivable balance was not overstated by uncollectible amounts. DMS officials stated that because of system limitations, Medicaid write-offs were not addressed. Uncollectible overpayments should nevertheless be written off, primarily so DMS can seek recovery of the federal refund. They should also be written off to prevent overstating the value of the accounts receivable total and the financial statements of the Commonwealth.

The following example illustrates the advantages of designating uncollectible overpayments as bad debt. If a cost settlement or DMS review concludes that a procedure billed at \$100 should have been billed at \$70 dollars, then an overpayment of \$30 has been paid to the provider. DMS attempts to collect the \$30 overpayment but is not successful. When the receivable is over 60 days old, \$21 (70%) is refunded to CMS. When DMS certifies this debt as uncollectible, it can recover the \$21 from CMS. If we look at the total accounts receivable balance of \$44 million, the Commonwealth could theoretically recover as much as \$30 million that has already been refunded to CMS.

As of May 26, 2002, there were 1,546 account transactions out of 2,762 (56%) with balances less than \$1,000 each that total \$488,369. If these receivables are uncollectible, they should be written off to prevent DMS from expending large administrative costs on maintaining these small items and to allow staff to concentrate efforts on larger overpayments.

As illustrated in Table 3, other states sampled have write-off policies that have led to lower accounts receivable balances. Illinois specifies 24 months and New Jersey's write-off criteria depend upon the age and the transaction amount of the accounts receivable. (See appendices V through VIII for samples of policies.)

### DMS Has Begun to Identify Inactive Providers

In January 2002, DMS began the process of identifying inactive providers owing accounts receivables. Because this identification was so late in coming, the accounts receivable balance probably includes provider debt that is uncollectible because providers may be deceased, out of business, or relocated out of state.

Of the 1,237 providers with accounts receivable balances, 628 have been terminated in DMS's system and can no longer submit claims under that provider number. The balances of the terminated providers totaled \$12,726,344. The following table provides additional information.



# Chapter 2

## Findings and Recommendations

**Table 4**  
**Terminated Provider Transaction Types**  
**As of May 26, 2002**

<b>Transaction Type</b>	<b>Amount</b>
Active	\$ 4,755,690
Inactive	1,200,616
Inactive Not Reclaimed	2,710
Hold Recoupment	1,315,885
Hold-Recoupment-Other	5,451,443
<b>Total</b>	<b>\$12,726,344*</b>

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services.

\*According to unaudited data provided by DMS, the total balance as of September 29, 2001 was \$10,982,844.

The Division of Program Integrity is now reviewing provider numbers that have not had billings in 24 months. Providers that have not billed within the past 24 months are sent letters notifying them that, unless they confirm an intent to continue participating in the Medicaid program, their provider numbers will be terminated. 907 KAR 1:671 defines an inactive provider number as one that has failed to present a Medicaid claim for medical care, services, or supplies for payment under that number, during the period of the previous 12 consecutive months. Program Integrity is using 24 months as the cutoff based on written guidance from CMS.

### Cross Referencing of Provider Data Began in 2002

In February 2002, DMS implemented procedures to ensure that providers with accounts receivable balances are not circumventing repayment obligations by using different provider numbers. Although 907 KAR 1:671, Section 2(14) requires that contracts for change in ownership of a Medicaid provider must detail liability for Medicaid debts, this information has not been provided or used routinely by DMS.

The Divisions of Program Integrity and Financial Management must accelerate their collaboration to ensure that outstanding debt of those who receive new provider numbers are properly converted. Providers should be required to repay existing debts before receiving new numbers.

### DMS Has Begun to Collaborate With CMS to Recoup Medicaid Overpayments From Medicare Providers

In May 2002, DMS began taking advantage of federal regulations allowing states to request that CMS offset Medicaid accounts receivable balances of providers who also participate in Medicare. 42 CFR §405.377 and §447.31 allows states to request that CMS intercept Medicare payments to providers who owe money to the Medicaid Program (see Appendix IV for the federal regulations).

According to DMS officials, DMS is working with CMS to verify whether non-participating Medicaid providers are actively participating in the Medicare program. Through September 2002, documentation from DMS shows that \$1,800 of recoupment requests for offsets from Medicare providers have been sent to CMS.

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## Chapter 2

# Findings and Recommendations

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### DMS Has Not Exhausted Collection Methods

In spite of newly-implemented recovery procedures, aged accounts receivable balances continue to grow and DMS has not exhausted steps to collect accounts receivable balances. For example, it has not contracted with collection agencies nor has it actively pursued legal remedies against providers who are not paying their debts.

In addition, accounts receivable files we reviewed were missing information. Eight accounts receivable files did not contain documentation that 60-day demand letters were sent to the providers. Additionally, of 26 transactions that required a 240-day letter, 22 could not be located. These files each represented accounts receivable balances amounting to \$50,000 or more.

Collection efforts other than recoupments or voluntary repayments have been virtually ignored by DMS. This is a function that DMS should either undertake or contract with another entity to attempt collection.

### Collection of More Than \$11 Million in Transactions Was Suspended Indefinitely

Collection efforts for more than \$11 million in accounts receivable transactions were suspended indefinitely, purportedly because of pending appeals or legal review. Overpayment designation dates for these transactions range from 1988 to 2001. Health Services officials were not able to explain why the majority of these transactions were placed in the Hold-Recoupment-Other category or why efforts have not been made to collect the money.

A “Hold-Recoupment-Other” status denotes that collection efforts have been suspended indefinitely pending appeals. While there are numerous, legitimate reasons to appeal overpayments, some providers may use this method to delay payments through lengthy appeals processes. Delaying collection allows providers to reimburse DMS at a depreciated value, due to the time value of money. For example, an overpayment of \$1,000 today (assuming a 5% inflation rate) will be worth only \$724 in five years.

The following table illustrates the number of transactions that are in the Hold-Recoupment-Other status, as well as the number of days held in that status. With the exception of \$900,000 related to five transactions, DMS was unable to provide sufficient information about the status of the remaining balances. Upon receipt of the preliminary draft of this report, they did provide unaudited data to show that \$3.4 million of the original amount has been recovered as of October 3, 2002. DMS is in the process of completing its review of these accounts.

## Chapter 2

# Findings and Recommendations

**Table 5**  
**Sample of Hold-Recoupment-Other Transactions**  
**As of November 16, 2001**

Setup Date	Number of Days Old (11/16/01)	Last Update (11/16/01)	Original Balance	Balance as of 11/16/01
7/26/1988	4859	8/8/1996	\$488,153.34	\$227,374.54
12/7/1988	4725	8/8/1996	99,803.40	99,803.40
3/6/1990	4271	8/8/1996	130,482.00	130,482.00
3/6/1990	4271	8/8/1996	86,444.00	86,444.00
7/25/1990	4130	1/25/1996	94,989.00	94,989.00
4/8/1991	3873	8/8/1996	50,049.00	50,049.00
7/17/1992	3407	2/9/1996	275,131.00	275,131.00
7/17/1992	3407	1/25/1996	136,110.00	136,037.74
7/17/1992	3407	1/14/1998	157,455.00	143,085.46
7/17/1992	3407	2/22/1996	159,267.50	159,267.50
11/11/1992	3290	1/25/1996	85,795.85	85,795.85
6/2/1993	3087	9/28/1998	263,500.86	51,493.57
6/21/1993	3068	1/25/1996	175,240.00	164,713.00
6/21/1993	3068	1/14/1998	65,458.00	65,458.00
6/21/1993	3068	1/14/1998	149,475.00	135,799.00
6/21/1993	3068	1/14/1998	176,593.00	170,534.00
6/21/1993	3068	7/5/1996	281,959.00	222,597.00
6/21/1993	3068	1/25/1996	125,670.00	123,767.00
6/21/1993	3068	1/14/1998	594,638.00	578,955.00
6/21/1993	3068	1/14/1998	238,912.00	228,682.00
7/30/1993	3029	1/25/1996	69,379.00	69,379.00
7/30/1993	3029	1/25/1996	63,447.40	63,447.40
4/14/1995	2406	1/25/1996	52,857.00	52,857.00
8/30/1995	2268	1/14/1998	658,206.00	658,206.00
9/18/1995	2249	1/14/1998	73,366.00	73,366.00
10/5/1995	2232	5/1/2000	154,118.00	150,802.30
3/8/1996	2077	1/14/1998	75,737.00	75,737.00
3/26/1996	2059	1/14/1998	280,781.00	275,817.75
6/27/1996	1966	8/23/1996	100,878.00	100,878.00
7/5/1996	1958	1/14/1998	1,282,555.22	960,467.15
2/5/1997	1743	5/21/1997	81,137.00	81,137.00

# Chapter 2

## Findings and Recommendations

**Table 5**  
**Sample of Hold-Recoupment-Other Transactions**  
**As of November 16, 2001 (Continued)**

Setup Date	Number of Days Old (11/16/01)	Last Update (11/16/01)	Original Balance	Balance as of 11/16/01
4/1/1997	1688	11/8/2001	\$86,828.00	\$17,670.00
6/17/1997	1611	1/14/1998	61,694.00	61,694.00
7/18/1997	1580	3/27/1998	132,374.00	132,374.00
12/4/1997	1441	11/1/2001	218,991.00	162,990.00
12/10/1997	1435	10/24/2001	77,696.00	74,741.00
12/31/1997	1414	1/27/1998	449,943.00	449,943.00
1/6/1998	1408	1/27/1998	142,072.00	142,072.00
1/7/1998	1407	2/11/1998	69,769.00	69,769.00
1/12/1998	1402	3/11/1998	79,471.00	79,471.00
1/22/1998	1392	10/24/2001	257,069.00	254,386.00
1/28/1998	1386	11/9/2001	53,159.00	1,862.00
4/14/1998	1310	10/29/2001	231,622.00	171,377.00
4/27/1998	1297	9/15/1998	382,350.00	382,350.00
5/12/1998	1282	6/30/1998	801,508.00	801,508.00
8/19/1998	1183	11/5/2001	126,252.00	124,319.00
9/2/1998	1169	11/5/2001	71,192.00	70,427.00
9/8/1998	1163	10/29/2001	377,995.00	254,486.00
11/24/1998	1086	12/15/1998	58,719.01	58,719.01
1/13/1999	1036	2/25/1999	134,960.00	134,960.00
2/5/1999	1013	1/5/2001	30,163.00	62,918.00
2/5/1999	1013	1/5/2001	147,460.00	72,508.00
5/11/1999	918	1/30/2001	74,617.00	64,817.00
11/18/1999	727	1/7/2000	71,966.78	71,966.78
5/31/2000	532	6/16/2000	796,368.00	796,368.00
10/25/2000	385	11/22/2000	54,568.00	54,568.00
12/11/2000	338	1/19/2001	163,423.00	163,423.00
12/22/2000	327	1/26/2001	158,980.00	158,980.00
12/22/2000	327	1/26/2001	52,322.00	52,322.00
1/31/2001	287	3/2/2001	234,788.00	234,788.00
2/6/2001	281	2/27/2001	112,267.00	112,267.00
<b>Total</b>	N/A	N/A	<b>\$12,438,174</b>	<b>\$11,082,596</b>

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services.

# Chapter 2

## Findings and Recommendations

### DMS Does Not Assess Interest or Late Penalties

DMS, at its own discretion, does not charge interest or penalties on overdue accounts receivable. Charging interest or penalties on late payments is universal inducement to pay in a timely manner. By not imposing interest or penalties, Kentucky has not incentivized repayment, lost potential revenue, and allowed receivables to depreciate by not recognizing the time value of money. Had DMS charged interest on accounts receivable 60 days or older, \$4 million to \$15 million in additional revenue for the Commonwealth could have been generated.

To offer adequate care to eligible recipients, DMS must ensure that there are a sufficient number of providers participating in the Medicaid program. DMS does not want to risk losing these providers and has determined that charging interest and penalties would be a disincentive to participation. DMS stated that it is difficult to recruit and maintain providers, especially physicians, because of the low rates Medicaid pays for medical procedures and services.

Although some physicians and other providers may refuse to pay interest and leave the program, there are providers that rely on Medicaid payments as a substantial, portion of their revenue. In a May 26, 2002 report provided by DMS, we found that hospitals and nursing facilities account for 75% of all the overpayments. Hospitals are community institutions that are typically subject to institutional charters, which require the delivery of medical services to the indigent. Therefore, it is unlikely these institutions would terminate participation in the Medicaid program. Medicaid is the primary assistance program that pays for nursing facility care and it is unlikely these facilities would be in a position to opt out of participation.

The over-60-days-late accounts receivable balance as of July 20, 2001 was \$32,038,489, and \$24,451,461 as of May 26, 2002. Assuming interest rates of 3%, 6%, and 9%, the following table illustrates the amounts of lost interest over the life of the accounts.

**Table 6**  
**Lost Interest Revenue from Overdue Accounts Receivable**

As Of:	A/R Balance Over 60 Days Late	Interest Forgone at 3% Interest Rate	Interest Forgone at 6% Interest Rate	Interest Forgone at 9% Interest Rate
07/20/01	\$32,038,489	\$3,867,884	8,502,209	\$14,080,641
05/26/02	\$24,451,462	\$4,128,765	\$9,217,736	\$15,515,021

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services.

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## Chapter 2

# Findings and Recommendations

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### **DMS Has Finally Focused on Accounts Receivable**

The Division of Program Integrity has taken the following steps recently to improve management of its Medicaid overpayment accounts receivable:

1. Developed a report entitled *Outstanding Accounts Receivable & Options for Collection: November 15, 2001* which suggests alternatives to reduce Medicaid's accounts receivable balance.

By accepting DMS's recommendation in this 2001 document, the CHS Secretary and the Special Assistant to the Governor on Medicaid agree that the best approach to managing accounts receivable is to notify CMS that debts are not collectible.

2. Issued a September 13, 2002 memorandum on setting up accounts receivable transactions.
3. Developed a list of non-participating providers that reflects all current aged accounts of providers not participating in the Medicaid program.
4. Developed a list of participating providers using an original or new provider number.
5. Changed the enrollment process to add an additional step for applications containing a change in ownership; re-enrollment after one year of previous end-date; and/or request for a number under a different provider type. The provider number will not be issued unless arrangements to pay any debt are made.
6. Worked with CMS to investigate recouping Medicaid overpayments from Medicare payments.

### **Recommendations**

DMS should

1. Develop and implement a strategic plan for managing accounts receivable.
2. Develop and implement a comprehensive procedures manual for identifying overpayments and writing off uncollectible debt.
3. Exhaust collection practices such as using collection agencies and legal remedies.
4. Fully document efforts to recoup and collect accounts receivable.
5. Routinely reassess the reasons for suspending collection efforts on accounts receivable to assure that each account is properly managed.
6. Establish and communicate to all providers administrative regulations and procedures for assessing interest and penalties.

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## Objective

Determine whether the Department for Medicaid Services is effectively managing its accounts receivable consisting of provider overpayments.

## Scope

The scope of this performance audit was to examine DMS's accounts receivable balance and determine its effectiveness in collecting the provider overpayments. The audit was limited to reviewing accounts receivable transactions related to provider overpayments that had been posted to Kentucky's Medicaid Management Information System.

This audit was conducted in accordance with *Government Auditing Standards*, as promulgated by the Comptroller General of the United States General Accounting Office and undertaken with authority granted under the Kentucky Revised Statute 43.050. Audit fieldwork began in October 2001 and was concluded during September 2002.

Because the information used to achieve our objective was generated from a computer-based system and was significant to our reported findings, compliance with Government Auditing Standard 6.62 was applicable. To obtain sufficient, competent, and relevant evidence that computer-based data was valid and reliable, a sample of A/R transactions was taken from the computer-based system's reports and direct testing was performed to compare the information with A/R files and determine compliance with applicable procedures. Additionally, we reviewed and relied on the information reported by Ernst & Young on the system's controls for the period July 1, 2000 through June 30, 2001. Ernst & Young's report presented the controls as suitably designed to provide reasonable assurance that controls were working satisfactorily.

An assessment of management controls was performed where significant to our audit objectives. Our audit findings primarily reflect the weaknesses we found in this assessment and are noted in this report.

## Methodology

To accomplish this objective, a sample of other state Medicaid officials were surveyed for feedback, as well as other professionals knowledgeable on accounts receivable issues related to Medicaid. We interviewed federal oversight officials with CMS and Kentucky's Department for Medicaid Services (DMS) officials. We reviewed DMS's criteria for processing overpayments and performed testing on a sample of accounts receivable transactions. We also performed analytical reviews of accounts receivable data requested through DMS's fiscal agent.

To obtain a general understanding of Medicaid accounts receivable at the national level, we contacted the following associations:

- Council of State Governments
- National Association of State Auditors, Comptrollers, and Treasurers
- National State Auditors' Association
- National Association of State Medicaid Directors
- National Conference of State Legislatures

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We then contacted several states recommended by the above organizations. The following states responded:

- Arkansas
- Colorado
- Georgia
- Kansas
- Louisiana
- Minnesota
- New Jersey
- New York
- North Carolina
- North Dakota
- South Carolina
- Utah
- Washington

To develop a detailed understanding of Medicaid programs in other states, five states were selected for further review. We selected Illinois and Oregon because other entities described them as exemplary programs. We selected Tennessee and Virginia because they would likely share regional similarities to Kentucky. Finally, Oklahoma was selected because it contracted with the same fiscal agent as Kentucky.

Our fieldwork consisted of interviews with various staff and other interested parties and agencies including:

- Kentucky Department for Medicaid Services, Commissioner's Office
- Kentucky Medicaid, Division of Financial Management
- Kentucky Medicaid, Division of Program Integrity
- Kentucky Medicaid, Division of System and Member Services
- Kentucky Finance and Administration Cabinet (FAC), Office of Financial Management (OFM)
- Kentucky Legislative Research Commission
- Center for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration (HCFA)), Atlanta Regional Office

To obtain an understanding of DMS's accounts receivable function related to provider overpayments, we reviewed any applicable DMS criteria and instructions to providers related to billing and collecting provider overpayments. To determine the guiding federal and state laws and regulations related to provider overpayments, we reviewed the following:

- State Medicaid Manual
- Related KY Revised Statutes and KY Administrative Regulations
- Related federal laws in the Code of Federal Regulations (CFR)
- Related federal laws in the United States Code (USC)
- Social Security Administration rules and regulations

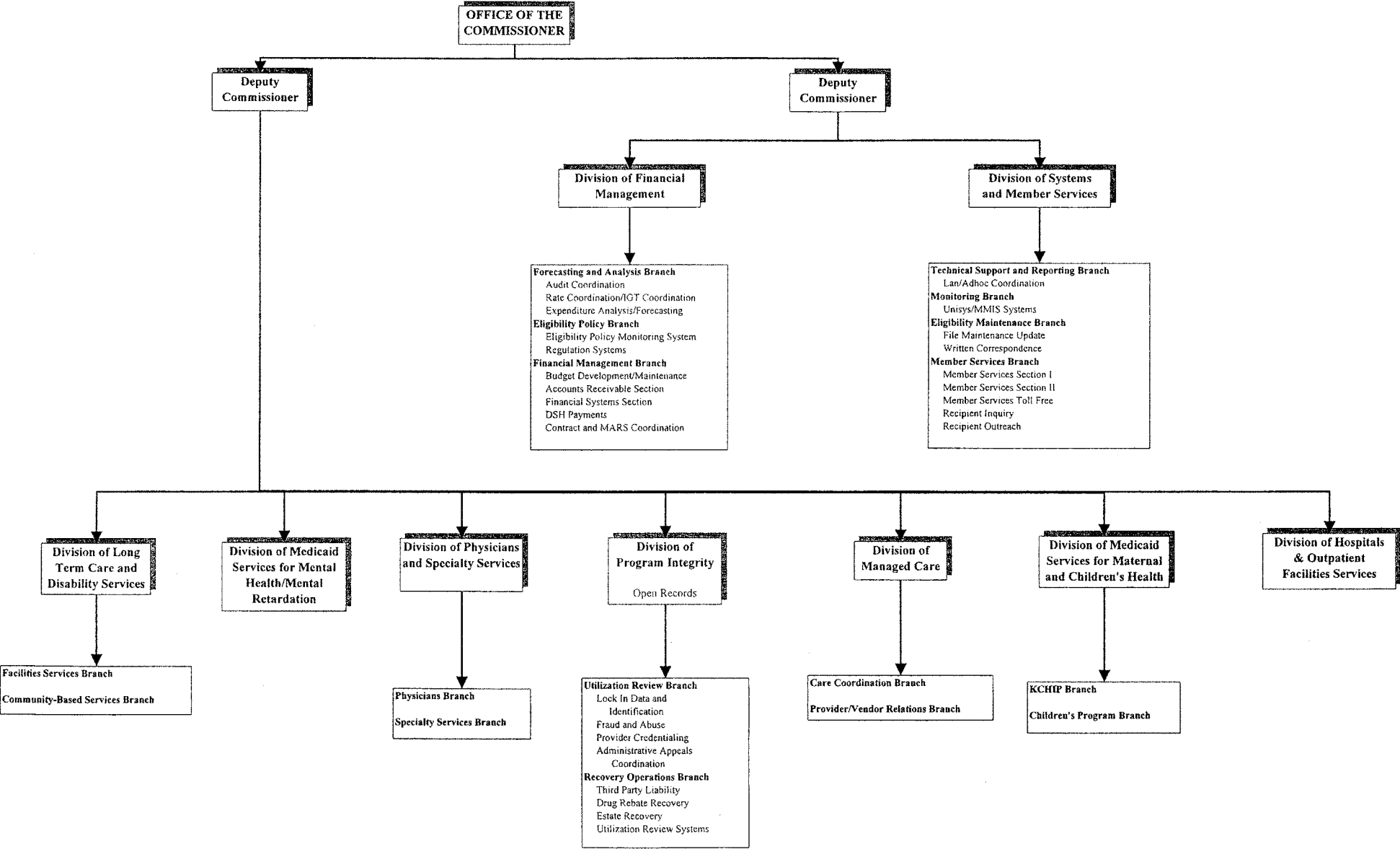


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To test accounts receivable transactions, DMS provided us with the Accounts Receivable Aging Report weekly cycle run of July 20, 2001 that listed 2349 transactions and consisted of approximately \$37 million in receivables. Because the impetus for the audit arose due to the large overall accounts receivable balance in May 2001, the auditors selected transactions that were \$50,000 or more and over 90 days old. The criteria produced a sample of 107 transactions for testing, which represented about two percent of the accounts but two-thirds (\$25 million) of the receivables' entire balance of \$37 million. These transactions were tested to determine compliance with accounts receivable and payment plan procedures and compared to the hard copy files within DMS's Accounts Receivable Section.

In November 2001, we requested another accounts receivable aging report that was dated November 16, 2001, to conduct a trend analysis of the accounts receivable population and the 107 transactions in our sample. In addition, the Accounts Receivable Aging Report as of December 7, 2001 was reviewed to determine whether the receivables that were discovered in our sample review to be paid in full had dropped from the aging report. We found that the report of December 7, 2001 accurately reflected the changes and adjustments discovered in our sample review.

When drafting our report, we had concerns that much of the accounts receivable balance remained on the books because of indefinite appeals and inactive providers and that tracking of these issues was not sufficient. To get more specific and recent information, we requested an ad hoc report that contained enrollment data for providers without accounts receivable balances; and enrollment data on providers with accounts receivable balances listing up to five other provider numbers that the provider may use for billing purposes, all accounts receivable transactions with status codes, current balances, setup dates, and date of last activity. Various analytical reviews and sorting techniques were performed to develop conclusions for our report.



### **907 KAR 1:671. Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions.**

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.8451 through 205.990, 205.624 and 194A.515 provide that the Cabinet for Health Services and the Department for Medicaid Services shall be responsible for the control of Medicaid provider fraud and abuse. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to Medicaid provider participation, withholding overpayments, appeal process and sanctions.

Section 1. Definitions. (1) "Abuse" means provider abuse or recipient abuse as defined by KRS 205.8451(8) and (10).

(2) "Active provider number" means the provider billing number issued by the department, or its fiscal agent, to a provider that has presented to the department, or its fiscal agent, a Medicaid claim for a supply or covered service for payment under that number during the period of the previous twelve (12) consecutive months.

(4) "Administrative appeal process" means an initial written request for redress setting forth the issues in dispute, dispute resolution meeting, review of documentation, prehearing, administrative hearing, recommended order, final order and all deliberations or exchange of documents or information between a provider and the department in accordance with KRS Chapter 13B.

(5) "Affiliate" means an individual agency or organization controlled by a provider or associated with a provider under common ownership or control.

(6) "Applicant" means an individual, agency, entity, or organization that submits an application to become a Medicaid provider.

(7) "Application" means the completion and submission of a Medicaid provider agreement and all required addendum and documentation specific to a provider type, which is the contract between the provider and the department for the provision of Medicaid services.

(10) "Cabinet" means the Cabinet for Health Services.

(11) "Claim" means a manually-created paper, or a computer-based electronically-created and transmitted request for payment under the Medicaid Program that relates to each individual billing submitted by a provider, or their billing agent, to the department which details services rendered to a recipient on a specific date. A claim may be either a line item of service or multiple services for one (1) recipient on a bill.

(14) "Demand letter" means correspondence to an active or inactive provider stating a dollar amount is owed the program and shall be paid by a given date.

(15) "Department" means the Department for Medicaid Services and its designated agents.

(18) "Exclusion" means the termination of the participation of a provider or the denial of the enrollment of a provider.

(24) "Inactive provider number" means the provider billing number issued by the department, or its fiscal agent, to a provider that failed to present a Medicaid claim for medical care, services, or supplies for payment under that number to the department, or its fiscal agent, during the period of the previous twelve (12) consecutive months;

(25) "Interest" means the prime interest rate that is:

(a) Charged as a simple interest by banks rounded to the nearest full percent, as quoted by commercial banks to large business, as determined by the board of governors of the Federal Reserve System; and

(b) In effect on the close of business, July 1, which is the first day of the state fiscal year.

(29) "Medicaid Fraud and Abuse Control Unit" or "MFACU" means a unit in the Office of the Attorney General of Kentucky, certified under the provisions of 42 USC 1396b(q), that conducts a statewide program for the investigation and prosecution of violations of state laws regarding fraud and abuse in connection with the Medicaid Program.

(30) "Preliminary investigation" means the activities of the Office of Inspector General (OIG), MFACU, or the department to determine whether a complaint of Medicaid fraud or abuse has sufficient basis to warrant a full investigation.

(31) "Program" means the state Medicaid Program as defined by 42 USC 1396a.

(32) "Provider" means as defined by KRS 205.8451(7).

(35) "Sanction" means an administrative action taken by the department which limits or bars an individual's, agency's, entity's, or organization's participation in the Medicaid Program or imposes a fiscal penalty against the provider, including the imposition of civil penalties, or interest imposed at the department's discretion, or the withholding of future payments.

(39) "Terminated" means a provider's participation in the Medicaid Program has been ended, and that a contractual relationship no longer exists between a provider and the department for the provision of Medicaid covered services to Medicaid eligible recipients by that individual, agency, entity, organization, fiscal agents or subcontractors of the provider.

(42) "Withholding" means not paying a provider for claims which have been processed, pending the results of an investigation of a report of fraud or willful misrepresentation based upon receipt of reliable evidence or as a result of provider bankruptcy, failure to submit timely cost reports, or closure or termination of a business.

Section 2. Methods for Recoupment of Overpayments. (1) If a determination is made by the department that a provider was overpaid, a demand letter shall be sent to the provider, at his last known mailing address. If a provider billed through an agent or entity, a copy of a demand letter may be mailed to a provider's designated payment last known mailing address. The demand letter shall contain:

- (a) The amount of the overpayment;
- (b) The period of time involved;
- (c) The basis for determining the overpayment exists;
- (d) Language granting a provider sixty (60) days advance notice that the repayment is due in full; and
- (e) Appeal rights, if any.

(2) Departmental adjustments of the reimbursements rates, and differences between estimated and actual costs a provider incurred in determining reimbursements, may create situations where a provider was overpaid. The letter of notification of adjustments and the monies due under this subsection shall include:

- (a) All required elements of subsection (1) of this section;
  - (b) Documentation to support the department's determination of adjustments; and
  - (c) Appeal rights, if any.
- (3) The provider shall within:

- (a) Sixty (60) calendar days from the date of the demand letter, pay the amount of overpayment in full; or
- b. Sixty (60) calendar days from the date of the demand letter, or during the administrative appeal process, submit a written request for a payment plan.
- (4) If the amount of overpayment resulted from rate revisions and subsequent recalculations within the Medicaid Management Information System, the department shall apply a rate adjustment against the next payment cycle for the provider prior to notifying the provider in writing of the amount of the overpayment.
- (5) A payment plan may be approved by the department, if a provider documents that payment in full would create an undue hardship. A written declaration of undue hardship shall include the following:
- (a) Copies of financial statements which indicate payment in full within sixty (60) calendar days would create an undue hardship; and
- (b) Copies of notarized letters from at least two (2) financial institutions indicating the provider's loan request was denied for the overpayment amount.
- (6) Except as provided for in subsection (7) of this section, payment plans shall not extend beyond a six (6) month period.
- (7) A payment plan approved, in writing, by the Commissioner of the Department for Medicaid Services, in accordance with subsection (5) of this section, may be approved in excess of six (6) months, if the monthly repayment exceeds twenty-five (25) percent of the provider's average monthly Medicaid payment based upon the payments made the previous twelve (12) months.
- (8) A payment plan approved in excess of six (6) months shall include provisions for payments of both principal and interest as provided in KRS Chapter 360.
- (9) If a provider fails to make a payment as specified in the payment plan or takes no action toward repayment, the department shall recoup the amount due from future payments. If a provider has insufficient funds available for recoupment through the payment system in the first payment cycle following the due date, or no longer participates in the Medicaid Program, payments shall continue to be recouped and the department may take all lawful actions to collect the debt.
- (10) Disputes.
- (a) If a provider disputes the amount of overpayment, a provider may initiate the administrative appeals process in accordance with Section 8 or 9 of this administrative regulation.
- (b) A timely-filed request of administrative appeal process shall stay the recoupment activities by the department pertaining to the issues on appeal until the administrative appeal process is final.
- (c) If the department, after reviewing all documentation submitted during the administrative appeal process, determines that no adjustments are required, the initial determination shall stand.
- (d) If the department determines that the amount of overpayment demand should be reduced, a refund due to the provider shall be refunded to him within thirty (30) calendar days from the date of the determination.
- (e) If it is determined that the amount requested should be increased, a provider shall be notified by a new demand letter pursuant to subsection (1) of this section.
- (11) Withholding Medicare payments to recover Medicaid overpayments.

(a) The department may request that the Centers for Medicare and Medicaid Services (CMS) withhold future Medicare payments to a provider in order to recover Medicaid overpayments to that provider, pursuant to 42 USC 1395vv.

(b) Amounts withheld and forwarded to the department by CMS which are ultimately determined by the department to be in excess of overpayments due to the Medicaid Program shall be returned to the provider.

(12) Statutory recovery. The department shall not issue payments otherwise due to a provider, if the department has been notified by a state or federal government agency or by a court that a court order exists requiring the department to withhold payments. The payments shall be withheld in accordance with the provisions of the order.

(13) Medicare overpayments. If ordered to recoup payment by CMS, the department shall recoup the federal share of Medicaid payments, which is the portion of the payment funded with federal funds, as a means to recover Medicare overpayments pursuant to 42 USC 1396m.

(14) A contract for the sale or change of ownership of a provider participating in the Medicaid Program shall specify whether the buyer or seller is responsible for amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of the sale. In the absence of specification in the contract for the sale or change of ownership, the recipient of the payment, who otherwise would be the provider of record at the time the department made the erroneous payment, shall have the responsibility for liabilities arising from that payment, regardless of when identified.

Section 4. Withholding of Payments During an Investigation of Fraud or Willful Misrepresentation. (1) The department may withhold Medicaid payments pursuant to 42 CFR 455.23 upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid Program.

Section 5. Sanctions. (1) The department shall comply with the requirements of 42 CFR 1002 and 42 USC 1320a-7.

(2) The department shall impose sanctions as provided in KRS 205.8467 and Sections 3, 4, 5, and 6 of this administrative regulation.

(5) The sanction process may include a termination of a provider from the Medicaid Program.

(6) The sanction process shall include liability for civil payments, restitution of overpayments and agency costs as specified in KRS 205.8467.

(7) The department shall use a lien, as specified in KRS 205.8471, to assure payment of restitution and monetary penalties imposed under the administrative determination of fraud.

(9) The provider shall be notified in writing by the department of the sanctions that are imposed pursuant to 42 CFR 1001.2002.

Section 6. Termination of Provider Participation. (1) Terminations and hearings.

(a) Before the participation of a nursing facility, as defined in 42 USC 1396r(a), or an intermediate care facility for the mentally retarded, as defined in 42 USC 1396d(d), is terminated, it shall have the right to receive an administrative hearing in accordance with Sections 8 and 9 of this administrative regulation and 42 CFR 431.151 through 431.154.

(b) Except as provided in paragraph (a) of this subsection, provider participation shall be terminated without prior hearing.

(2) A provider's participation may be terminated by either the provider or the department upon thirty (30) calendar days written notice to the other without cause or as otherwise specified in the provider agreement.

(3) A provider's participation may be terminated and a period of exclusion imposed, if an administrative determination is made, as established in Section 3 of this administrative regulation, that the provider engaged in an unacceptable practice.

(4) Except as provided for in 907 KAR 1:672, failure to maintain up-to-date information, or to submit the information within thirty-five (35) calendar days of a request by the department, shall result in termination of a provider's participation in the Medicaid Program.

(6) A provider's participation may be terminated, if the provider fails or refuses to pay or enter into an agreement to pay the amount of a penalty imposed, including interest, in accordance with Section 5 of this administrative regulation and KRS 205.8467 within sixty (60) calendar days from the date of the department's notice or the date of a hearing decision, if they occur.

(11) A provider's participation in Medicaid shall be terminated and a new application required, if the ownership or controlling interest of the provider has substantially changed since the acceptance of the current enrollment application, which may include one (1) or more of the following actions:

(a) A sole proprietor transfers title and property to another party;

(b) The addition, removal, or substitution of one (1) or more partners of a provider organized as a partnership effects the termination of the partnership, and creates a successor partnership or other entity;

(c) An incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation;

(d) Two (2) or more corporate providers consolidate and the consolidation results in the creation of a new corporate entity;

(e) Two (2) or more unincorporated providers consolidate;

(f) The sale, purchase, exchange of stock, merger or other consolidation of the business or assets directly related to the provision of health care, if the sale results in a change of ownership or control of a provider;

(g) If the ownership or controlling interest of the provider has substantially changed since the acceptance of its enrollment application regardless of reason; or

(h) A provider, or a person, or organization having direct or indirect ownership, or control interest in the disclosing entity as defined by 42 CFR 455.101 and 102, is listed, or required to be listed, on the current Medicaid enrollment application and has been convicted in a court of appropriate jurisdiction of criminal violations involving either a Medicare- or Medicaid-related offense and that conviction is final and not under appeal.

(14) Termination of inactive provider numbers. A provider shall be determined to have abandoned his provider number if twenty-four (24) consecutive months shall have expired without a claim being submitted upon that provider number to the department, or its fiscal agent for payment.

(15) The department may terminate a provider number and the provider's corresponding right to participate in the program for inactivity of billing if:

(a) A provider fails to submit the first claim upon the number initially issued to the provider within a period of twenty (24) months from the date the number was issued by the department, or its fiscal agent; or

(b) A provider number, that has had at least one (1) Medicaid claim submitted to the department, or its fiscal agent for payment, has no bill submitted for that number for twenty-four (24) consecutive months defined as:

1. When a period of twelve (12) consecutive months shall pass without a Medicaid claim being submitted for payment, the number shall be inactive; and
2. When a period of an additional twelve (12) consecutive months has passed with the number remaining inactive.

Section 8. Resolution of Provider Disputes Prior to Administrative Hearing. (1) If a provider disagrees with a Medicaid determination with regard to an appealable issue as provided for in Section 9 of this administrative regulation, the provider may request a dispute resolution meeting. The request shall be in writing and mailed to and received by the branch manager that initiated the department-written determination within thirty (30) calendar days of the date the notice was received by the provider. The department shall not accept or honor a request for administrative appeals process, or a part thereof, that is filed by a provider prior to receipt of the department-written determination that creates an administrative appeal right under this administrative regulation.

(7) The department shall, within ten (10) calendar days of receipt of the request for a dispute resolution meeting, send a written response to the provider identifying the time and place in which the meeting shall be held within thirty (30) days of receipt of the request and identifying the department's representative who is expected to attend the meeting. The meeting shall be held within forty (40) calendar days of receipt of the request, unless a postponement is requested. The dispute resolution meeting may be postponed for a maximum additional period of sixty (60) calendar days, at the request of any party.

(9) A provider may, within the same deadline specified in subsection (1) of this section, submit information that the provider wishes to be considered in relation to the department's determination without requesting a dispute resolution meeting. The submission of additional documentation shall not extend the thirty (30) day time period for requesting a resolution meeting.

(11) Information submitted for the purpose of informally resolving a provider dispute shall not be considered a request for an administrative hearing.

(12) The department may waive the dispute resolution meeting, at its sole discretion, and issue a decision in lieu of the meeting, with the decision subject to administrative hearing under Section 9 of this administrative regulation.

(13) The department may postpone the issuance of its findings of the dispute resolution meeting, or its review of the materials submitted in lieu of a dispute resolution meeting, by mailing a written notice to the provider stating the reason for the delay and the anticipated date of completion of the review. A postponement shall not extend beyond 180 days.

Section 9. Administrative Hearing. (1) The administrative hearing shall be conducted in accordance with KRS Chapter 13B by a hearing officer who is knowledgeable of Medicaid policy, as established in federal and state laws.

(2) The secretary of the cabinet, pursuant to KRS 13B.030(1), shall delegate by administrative order conferred powers to conduct administrative hearings under this administrative regulation.

(4) The administrative hearing process shall be used in the following situations:

(a) If a provider is a nursing facility as defined in 42 USC 1396r(a), or is an intermediate care facility for the mentally retarded as defined in 42 USC 1396d(d), and participation is terminated regardless of reason;

(b) A provider alleges discrimination by the department as prohibited by 42 USC 2000d;

(c) The department imposes a sanction;

(d) The department requires repayment of a noncourt-established overpayment or noncourt-ordered restitution; or

(e) A provider's payments are being withheld in accordance with Section 4 of this administrative regulation.



(5) A written request for an administrative hearing shall be received by the department within thirty (30) calendar days of the date of receipt of the department's notice of a determination or a dispute resolution decision. This request shall be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002.

(7) The notice of the administrative hearing shall comply with KRS 13B.050.

(8) If a prehearing conference is requested, it shall be held at least seven (7) calendar days in advance of the hearing date. Conduct of the prehearing conference shall comply with KRS 13B.070.

Section 10. Actions Taken at the Conclusion of the Administrative Appeal Process. (1) The stay on recoupment granted under Section 2(10)(b) of this administrative regulation shall not extend to judicial review, unless a stay is granted pursuant to KRS 13B.140(4).

(2) If during an administrative appeal process circumstances require a new or modified determination letter, new appeal rights shall be provided in accordance with this administrative regulation.

(3) Thirty (30) calendar days after the issuance of the final order pursuant to KRS 13B.120, the department:

(a) Shall initiate collection activities, and take all lawful actions to collect the debt; and

State Medicaid Manual  
Part 2 - State Organization and General Administration

10-86 STATE ORGANIZATION AND GENERAL ADMINISTRATION 2853

2853. PROCEDURES FOR REFUNDING THE FEDERAL SHARE OF MEDICAID  
OVERPAYMENTS

2853.1 Overpayment Definitions and Exclusions.--An "overpayment" is an amount which is paid by a State Medicaid agency to a provider in excess of the amount that is proper and which is required to be refunded to CMS. An excess payment to an institutional provider which you recover through an adjustment to the per diem rate for a subsequent period is not an overpayment. However, if you seek to recover such an amount in a lump sum, by an installment repayment plan, or by withholding a portion of future payments to the provider, that amount is deemed an overpayment.

2853.2 Discovery.--"Discovery" signifies the date upon which the 60/calendar-day period for recovering and refunding an overpayment commences. Discovery occurs either (1) on the date any Medicaid agency or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the State in writing, whichever date is earlier. While these alternative dates establish the point of discovery for overpayments resulting from abuse, "discovery" of an overpayment that results from fraud occurs on the date of your final notice to the provider specifying an overpayment amount to be recovered.

2853.3 Adjustment to the Federal Payment.--Credit CMS with the Federal share of the overpayment on the Medicaid expenditure report (Form CMS-64) for the quarter no later than that in which the 60-day period following discovery ends. It is irrelevant whether you are unable to recover the overpayment within the 60-day period. However, if for any valid reason, the overpayment originally credited the Federal Government is later reduced, you can make the appropriate adjustment on the Form CMS-64.

2853.4 Hold-Harmless Provisions.--Section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that you are not liable for the Federal share of overpayments which constitute debts discharged in bankruptcy or which are otherwise uncollectible. If a provider declares bankruptcy, the overpayment is considered uncollectible as of the date the bankruptcy petition is filed in court, if you are on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment. The term "otherwise being uncollectible" is strictly defined as "out-of-business," or no longer in operation. In asserting that a provider is out-of-business, document your efforts to locate the party and its assets by furnishing an affidavit or certification from your appropriate legal authority establishing that the provider is out-of-business and the effective date of that decision under State law.

Rev. 452-383

## 2853 STATE ORGANIZATION AND GENERAL ADMINISTRATION 10-86

If the 60-day limit expires before the bankruptcy petition is filed or you find the provider to be "out-of-business," you must credit CMS with its Federal share, regardless of your recovery. If the provider later files for bankruptcy, or goes "out-of-business" and the overpayment is uncollectible under State law and administrative procedures, you may reclaim the amount credited to CMS. These amounts may be reclaimed only if, until the date of bankruptcy or closing of the business, you vigorously pursue recovery according to State law, though without complete success. Naturally, you must credit CMS with the Federal share of whatever amounts you recover under a court-approved discharge of bankruptcy.

2853.5 Overpayments made on or after October 1, 1985 must be credited to CMS on the Form CMS-64 for the quarter no later than that in which the 60-day period following discovery ends. Any such overpayments for which the 60-day recovery period already has ended are due on the next Form CMS-64 submitted after publication of this instruction.

2-384Rev. 45

[Code of Federal Regulations]

[Title 42, Volume 3]

[Revised as of October 1, 2001]

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[Page 100]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE &  
MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 433--STATE FISCAL ADMINISTRATION--Table of Contents

Subpart F--Refunding of Federal Share of Medicaid Overpayments to Providers

Sec. 433.310 Applicability of requirements.

(a) General rule. Except as provided in paragraphs (b) and (c) of this section, the provisions of this subpart apply to--

(1) Overpayments made to providers that are discovered by the State; (2) Overpayments made to providers that are initially discovered by the provider and made known to the State agency; and (3) Overpayments that are discovered through Federal reviews. (c) Unallowable costs paid under rate-setting systems. (1) Unallowable costs for a prior year paid to an institutional provider under a rate-setting system that a State recovers through an adjustment. To the per diem rate for a subsequent period do not constitute overpayments that are subject to the requirements of this subpart. In such cases, the State is not required to refund the Federal share explicitly related to the original overpayment in accordance with the regulations in this subpart. Refund of the Federal share occurs when the State claims future expenditures made to the provider at a reduced rate. (2) Unallowable costs for a prior year paid to an institutional provider under a rate-setting system that a State seeks to recover in a lump sum, by an installment repayment plan, or through reduction of future payments to which the provider would otherwise be entitled constitute overpayments that are subject to the requirements of this subpart.

Sec. 433.316 When discovery of overpayment occurs and its significance.

(a) General rule. The date on which an overpayment is discovered is the beginning date of the 60-calendar day period allowed a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) Requirements for notification. Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) Overpayments resulting from situations other than fraud or abuse. An overpayment resulting from a situation other than fraud or abuse is discovered on the earliest of--(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; (2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or (3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) Overpayments resulting from fraud or abuse. An overpayment that results from fraud or abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider.

(e) Overpayments identified through Federal reviews. If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) Effect of changes in overpayment amount. Any adjustment in the amount of an overpayment during the 60-day period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 60-day recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 60-day recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 60-day period following discovery does not change the 60-day recovery period for the original overpayment amount. A new 60-day period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) Effect of partial collection by State. A partial collection of an overpayment amount by the State from a provider during the 60-day period following discovery does not change the 60-day recovery period for the original overpayment amount due to CMS.

(h) Effect of administrative or judicial appeals. Any appeal rights extended to a provider do not extend the date of discovery.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989]

### TITLE 42--PUBLIC HEALTH

#### CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

##### PART 405--FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED--Table of Contents

##### Subpart C--Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans.

##### Sec. 405.377 Withholding Medicare payments to recover Medicaid overpayments.

(a) Basis and purpose. This section implements section 1885 of the Act, which provides for withholding Medicare payments to certain Medicaid providers that have not arranged to repay Medicaid overpayments as determined by the Medicaid State agency or have failed to provide information necessary to determine the amount (if any) of overpayments.

(b) When withholding may be used. CMS may withhold Medicare payment to offset Medicaid overpayments that a Medicaid agency has been unable to collect if--(1) The Medicaid agency has followed the procedure specified in Sec. 447.31 of this chapter; and (2) The institution or person is one described in paragraph (c) of this section and either--(i) Has not made arrangements satisfactory to the Medicaid agency to repay the overpayment; or (ii) Has not provided information to the Medicaid agency necessary to enable the agency to determine the existence or amount of Medicaid overpayment.

(c) Institutions or persons affected. Withholding under paragraph

(b) of this section may be made with respect to any of the following entities that has or had in effect an agreement with a Medicaid agency to furnish services under an approved Medicaid State plan:

(1) An institutional provider that has in effect an agreement under section 1866 of the Act. (Part 489 (Provider and Supplier Agreements) implements section 1866 of the Act.)

(2) A physician or supplier that has accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act. (Section 424.55 sets forth the conditions a supplier agrees to in accepting assignment.)

(d) Amount to be withheld. (1) CMS contacts the appropriate intermediary or carrier to determine the amount of Medicare payment to which the institution or person is entitled.

(2) CMS may require the intermediary or carrier to withhold Medicare payments to the institution or person by the lesser of the following amounts:

(i) The amount of the Medicare payments to which the institution or person would otherwise be entitled.

(ii) The total Medicaid overpayment to the institution or person.

(e) Notice of withholding. If CMS intends to withhold payments under this section, it notifies by certified mail, return receipt requested, the institution or person and the appropriate intermediary or carrier of the intention to withhold Medicare payments [[Page 75]] and follows the procedure in Sec. 405.374. The notice includes--

(1) Identification of the institution or person; and

(2) The amount of Medicaid overpayment to be withheld from payments to which the institution or person would otherwise be entitled under Medicare.

(f) Termination of withholding. CMS terminates the withholding if--

(1) The Medicaid overpayment is completely recovered;

(2) The institution or person enters into an agreement satisfactory to the Medicaid agency to repay the overpayment; or

(3) The Medicaid agency determines that there is no overpayment based on newly acquired evidence or a subsequent audit.

(g) Disposition of funds withheld. CMS releases amounts withheld under this section to the Medicaid agency to be applied against the Medicaid overpayment made by the State agency.

[61 FR 63747, Dec. 2, 1996]

### TITLE 42--PUBLIC HEALTH

#### CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

#### PART 447--PAYMENTS FOR SERVICES--Table of Contents

#### Subpart A--Payments: General Provisions

#### Sec. 447.31 Withholding Medicare payments to recover Medicaid overpayments.

(a) Basis and purpose. Section 1885 of the Act provides authority for CMS to withhold Medicare payments to a Medicaid provider in order to recover Medicaid overpayments to the provider. Section 405.377 of this chapter sets forth the Medicare rules implementing section 1885, and specifies under what circumstances withholding will occur and the providers that are subject to withholding. This section establishes the procedures that the Medicaid agency must follow when requesting that CMS withhold Medicare payments.

(b) Agency notice to providers. (1) Before the agency requests recovery of a Medicaid overpayment through Medicare, the agency must send either or both of the following notices, in addition to that required under paragraph (b)(2) of this section, to the provider.

(i) Notice that--

(A) There has been an overpayment;

(B) Repayment is required; and

(C) The overpayment determination is subject to agency appeal procedures, but we may withhold Medicare payments while an appeal is in progress.

(ii) Notice that--

(A) Information is needed to determine the amount of overpayment if any; and

(B) The provider has at least 30 days in which to supply the information to the agency.

(2) Notice that, 30 days or later from the date of the notice, the agency intends to refer the case to CMS for withholding of Medicare payments.

(3) The agency must send all notices to providers by certified mail, return receipt requested.

(c) Documentation to be submitted to CMS. The agency must submit the following information or documentation to CMS (unless otherwise specified) with the request for withholding of Medicare payments.

(1) A statement of the reason that withholding is requested.

(2) The amount of overpayment, type of overpayment, date the overpayment was determined, and the closing date of the pertinent cost reporting period (if applicable).

(3) The quarter in which the overpayment was reported on the quarterly expenditure report (Form CMS 64).



(4) As needed, and upon request from CMS, the names and addresses of the provider's officers and owners for each period that there is an outstanding overpayment.

(5) A statement of assurance that the State agency has met the notice requirements under paragraph (b) of this section.

(6) As needed, and upon request for CMS, copies of notices (under paragraph (b) of this section), and reports of contact or attempted contact with the provider concerning the overpayment, including any reduction or suspension of Medicaid payments made with respect to that overpayment.

[[Page 308]]

(7) A copy of the provider's agreement with the agency under Sec. 431.107 of this chapter.

(d) Notification to terminate withholding. (1) If an agency has requested withholding under this section, it must notify CMS if any of the following occurs:

(i) The Medicaid provider makes an agreement satisfactory to the agency to repay the overpayment;

(ii) The Medicaid overpayment is completely recovered; or

(iii) The agency determines that there is no overpayment, based on newly acquired evidence or subsequent audit.

(2) Upon receipt of notification from the State agency, CMS will terminate withholding.

(e) Accounting for returned overpayment. The agency must treat as a recovered overpayment the amounts received from CMS to offset Medicaid overpayments.

(f) Procedures for restoring excess withholding. The agency must establish procedures satisfactory to CMS to assure the return to the provider of amounts withheld under this section that are ultimately determined to be in excess of overpayments. Those procedures are subject to CMS review.

[50 FR 19689, May 10, 1985, as amended at 61 FR 63749, Dec. 2, 1996]

## ACCOUNTS WRITE-OFF PROCEDURES

Accounts Receivable to be written off must meet the following criteria:

1. Accounts must be over two (2) years old.
2. Notification letters must have been sent to the provider at least three times (3).
3. Accounts must have proven not to be collectible through the Medicare or the State's (STARS) payment system.

Initial steps to determine age of cost settlement accounts:

1. Use the latest CPO-500 to determine the date the account was added to the accounts receivable file.
2. Determine if the accounts are being paid off weekly?
3. Or does a payment plan exist that will result in the account being paid off?
4. If there is no regular payment or payment plan then proceed with write-off preparations.
  - a. Determine the provider's eligibility status by the following code:

Code	Meaning
40	Cancel- provider
41	Cancel-deceased
42	Cancel- bad address
43	Cancel- number changed
44	Cancel-provider joined group
45	Cancel- legal action
46	Cancel- change of ownership
48	Cancel- per state
49	Cancel- certification revoked
50	Cancel- inactivity
51	Cancel- provider does not meet check digit criteria

- b. Research any accounts set to 999's (system notification not to collect) and determine if the reason not to collect still applies.
  - c. Determine the year the cost settlement applies to and if over two year old proceed with the write-off.
5. Write-off:
    - a. Accounts with a balance of \$10.
    - b. Accounts of businesses that the legal action or bankruptcy has been decided.
    - c. Accounts of businesses that no longer exist.
    - d. Accounts of businesses that changed ownership prior to October 1992.
  6. Prepare the letter explaining TennCare's reason for writing the account off.
  7. Provide documentation supporting write-off request and obtain the signature of Fiscal Director approving the request.
  8. Note the write-off request on Cost Settlement Log.
  9. Mail the request to the appropriate departments for approval.
  10. When the approval is returned prepare an Financial Change Request (FCR) to have the account closed. File letter, documentation, and FCR in provider file.

The State of Minnesota  
The Department of Human Services  
**Accounts Receivable Policy**

**Title:** Writing-off Uncollectible Accounts **Number:** 5.2R

**Approvals:** Accounts Receivable Committee Approval, 8/5/96 **Date:** 7/22/96

**Objective:**

1. To obtain accurate reporting of DHS' receivables by writing-off accounts that are determined to be uncollectible.
2. To provide closure to collection activities.
3. To comply with MN Department of Finance Policy 0507-01 and M.S. 16D, Debt Collection Act.

**Policy:** Statutory Authority  
Pursuant to M.S. 16D.09, Uncollectible Debts, when a debt is determined by a state agency to be uncollectible, the debt may be written-off by the state agency from the state agency's financial accounting records and no longer recognized as an account receivable for financial reporting purposes. Determining that the debt is uncollectible does not cancel the legal obligation of the debtor to pay the debt.

A debt is considered to be uncollectible when one or more of the following conditions are met:

- 1) all reasonable collection efforts have been exhausted,
- 2) the cost of further collection action will exceed the amount recovered,
- 3) the debt is legally without merit or cannot be substantiated by evidence,
- 4) the debtor cannot be located,
- 5) the available assets or income, current or anticipated, which may be available for payment of the debt are insufficient,
- 6) the debt was discharged in bankruptcy,
- 7) the applicable statute of limitations for collection of the debt has expired, or
- 8) it is not in the public interest to pursue collection of the debt.
- 9) the debt has been comprised, in the best interests of the state; M.S. 16D.15.

Program area accounts receivable staff may consult the DHS Accounts Receivable Management Services (ARMS) Accounting Officer or the Financial Management (FM) Division Collection Supervisor for assistance in determining whether the debt qualifies to be written-off pursuant to the statutory standards.

## **WRITE-OFF OF UNCOLLECTABLE ACCOUNTS RECEIVABLE**

**NO:** 94-40-OMB

**ORIGINATING AGENCY:** OFFICE OF MANAGEMENT & BUDGET

**EFFECTIVE DATE:** JULY 1, 1994

**EXPIRATION DATE:** INDEFINITE

**SUPERSEDES:** 94-27-OMB

**SUBJECT:** WRITE-OFF OF UNCOLLECTABLE ACCOUNTS RECEIVABLE

**ATTENTION:** DIRECTORS OF ADMINISTRATION AND CHIEF FISCAL OFFICERS

**FOR INFORMATION CONTACT:** ALBERTHA HYCHE

**PHONE:** 633-9056

This policy sets forth the basic responsibilities, principles, and general instructions for the removal of uncollectible accounts from an agency's records, and the subsequent write-off of such accounts which may appear in the State's general ledgers.

All requests to write off uncollectable accounts receivable for accounting purposes must be submitted to the Receivables Management Section, Division of Administration, Department of the Treasury, and must be approved by the Director of the Office of Management and Budget, Department of the Treasury. Only when such approval has been obtained may those accounts be removed from the books of the State and/or agency.

### **CRITERIA FOR WRITE-OFF**

To be eligible for write-off, a receivable must meet one of the following criteria:

1. Any debt of \$250 or less, which is delinquent at least one year with no contact with or no payment from the debtor for at least one year.
2. Any debt greater than \$250, but no more than \$500, that is delinquent at least two years with no contact with or no payment from the debtor for at least two years.
3. Any debt greater than \$500, but no more than \$1,000 that is delinquent at least three years with no contact with or no payment from the debtor for at least three years.
4. Any debt of \$1,000 or more which is delinquent at least three years with no contact with or no payment from the debtor for at least three years and, a judgment has been acquired.

5. Any debt that is owed by a debtor that is deceased and there are no assets in his or her estate from which to collect the sum owed.
6. Any debt or portion thereof that is discharged in bankruptcy.
7. Any debt that is owed by a corporation that is no longer in business or has been dissolved and there are no assets from which to collect the sum owed.
8. Any debt that is determined to be uncollectable by the Attorney General, his designee or other agency legal counsel.

## AGENCY RESPONSIBILITY

1. Each agency shall make every effort to effect collection of all of its accounts receivable. It shall develop and establish procedures and guidelines to be followed for an effective account collection function. These guidelines and procedures shall also be directed toward providing an effective appraisal and evaluation of the adequacy of the collection effort undertaken. Upon request, the guidelines and procedures must be made available to:

Department of the Treasury  
Division of Administration  
Fiscal and Resources  
Receivables Management Section  
CN 211  
Trenton, New Jersey 08625

Having pursued a conscientious but unproductive collection effort, the agency may consider the accounts receivable in question as eligible for removal from its books.

The Division of Administration, Fiscal and Resources, has been delegated the authority to perform periodic reviews of agency collection procedures to determine if the policies detailed in this Circular Letter and in the agency guidelines are being followed.

2. Agency fiscal personnel must determine whether the account in question appears on their records only or has been entered onto the State's central accounting system.

Permission to write off the account must then be formally requested through the submission of Form AR-900A for internal records or Form AR-900 (revised) for State accounting records, whichever is appropriate. These forms must be transmitted to the Receivables Management Section, Division of Administration, Fiscal and Resources.

## RECEIVABLES MANAGEMENT SECTION

The Receivables Management Section, Division of Administration, Fiscal and Resources, has been delegated the authority to review and evaluate each

write-off request, whether it concerns agency internal records only or the State's central accounting system. This review shall permit the on-site inspection of agency records. Its recommendations will be recorded in the space provided on the forms. The forms, together with documentation of the agency's collection effort and results thereof, will be transmitted to:

Director, Office of Management and Budget  
Department of the Treasury  
CN 221  
Trenton, New Jersey 08625-0221

## OFFICE OF MANAGEMENT AND BUDGET

The Director of the Office of Management and Budget, in accordance with the duties and authorities as outlined in N.J.S.A. 52:24-4 and 52:27B-33 et. seq. shall review the recommendations of the Receivables Management Section and make a formal determination as to the disposition of each account in question.

All requests for write-off, after review and determination by the Director, will be forwarded to the Financial Reporting Section of the Office of Management and Budget and will serve as the basis for recording the appropriate entries on State and agency records. The Receivables Management Section will notify the agency of the action taken by returning a copy of the completed request form. Where write-off has been approved and the account appears on the State's central accounting system, the Financial Reporting Section will remove it; if the account is solely on the agency's internal records, the copy of the approved request will serve as official authorization to remove the account from the agency's books.

Michael R. Ferrara  
Acting Director

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## West Virginia Code

### CHAPTER 14. CLAIMS DUE AND AGAINST THE STATE.

#### ARTICLE 1. CLAIMS DUE THE STATE

##### §14-1-18. Settlement or dismissal of claims.

The commissioner of finance and administration, auditor or other officer or official body having authority to collect the same may, with the advice of the attorney general, adjust and settle upon just and equitable principles without regard to strict legal rules any account or claim, in favor of the state, which may at the time have been standing upon the books of his or its office more than five years; and, with the like advice, may dismiss any proceedings instituted by him or it.

##### §14-1-18a. Consignment of claims to debt collector.

Any account, claim or debt that an agency of this state is not able to collect within three months after trying with due diligence to do so may be referred to the commissioner of finance and administration for consignment by the commissioner to a responsible licensed and bonded debt collection agency or similar other responsible agent for collection. The commissioner shall not handle or consign any such account, claim or debt unless he is satisfied that the referring agency has made a diligent effort to collect the debt on its own; that the account or claim is justly, properly and clearly due the state; and that the collection of any such debt would not impose an undue, unjust, unfair or unreasonable hardship or burden upon the health or general welfare of the party owing the debt. In any such case of undue, unjust, unfair or unreasonable hardship or burden, the commissioner may, in his discretion, and with the review and approval of the attorney general, compromise, settle or dismiss the debt or claim. If he is satisfied that the aforesaid terms of and conditions for collectibility have been met, the commissioner may consign the account, claim or debt to a responsible licensed and bonded debt collection agency or similar other responsible agent for collection. In any such case, the collection agency or other agent shall stand in the place of the state as creditor and shall have the same claims, rights and remedies against the debtor as the state has, and the debtor shall have the same rights, claims, defenses and setoffs against the collection agency or other agent as he has against the state.

##### §14-1-18b. Regulations applicable to debt collectors.

The commissioner of finance and administration shall promulgate rules and regulations for the determination and regulation of responsible licensed and bonded debt collection agencies and other responsible agents for collection. The commissioner shall determine the collection fees to be paid to any such agency or agent, which fees shall be a percentage of the amount of the debt recovered, but the commissioner shall not under any circumstances pay any agency or agent a fee of more than fifty percent of the amount of the debt recovered.

##### §14-1-18c. List of eligible debt collectors; statutory limitations applicable to debt collectors.

The state tax commissioner shall establish and maintain a list of debt collection agencies bonded and licensed with the state. When choosing collection agencies under the provisions of sections eighteen-a and eighteen-b of this article, the commissioner of finance and administration shall select and use only those collection agencies on the state tax commissioner's list. In collecting debts under sections eighteen-a and eighteen-b of this article, each debt collection agency and agent shall strictly abide by the provisions of (a) sections one hundred twenty-two through one hundred twenty-nine, inclusive, of article two, chapter forty-six-a of this code; (b) sections one through five, inclusive, of article sixteen, chapter forty-seven of this code;

and (c) the federal Fair Debt Collection Practices Act, being Public Law 95-109 of the United States Congress. If any debt collection agency or agent violates any provision of the aforesaid laws, the state tax commissioner shall remove the agency from his aforesaid list and the commissioner of finance and administration shall immediately stop his employment and use of the agency or agent.





**The Secretary for Health Services**

COMMONWEALTH OF KENTUCKY  
275 EAST MAIN STREET  
FRANKFORT 40621-0001  
(502) 564-7042

PAUL E. PATTON  
GOVERNOR

MARCIA R. MORGAN  
SECRETARY

November 15, 2002

Mr. Edward B. Hatchett, Jr.  
Auditor of Public Accounts  
Suite 144 Capitol Annex  
Frankfort, KY 40601

Dear Mr. Hatchett:

Attached is the Cabinet for Health Services' response to your audit of "Kentucky's Management of Its Medicaid Accounts Receivable" program.

I am sure you learned during the course of your audit that the Department for Medicaid Services (DMS) had previously identified problems in this area and began one year ago to focus its attention on strengthening collection efforts by developing comprehensive new policies and procedures to reduce the backlog of accounts receivable.

One of the primary objectives of the Department's reorganization in October 2001 was to place a major emphasis on developing resources to address accounts receivables and third party liability.

It was clear to the Department and the Cabinet that these efforts had, in the past, been neglected and lacked a cohesive and systematic approach for identifying and collecting money owed to the Department for Medicaid Services. We have worked the issue in the past 12 months and will continue to refine and develop appropriate tools to address the Department's accounts receivable.

Since initiation of the Department's efforts, there has been a significant reduction in aged or otherwise delinquent accounts. In May 2002, the accounts receivable balance

*"...promoting and safeguarding the health and wellness of all Kentuckians."*



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Memo to Edward B. Hatchett, Jr.  
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was \$57.8 million. By September 2002, that amount was reduced to \$44.2 million of that, the Department identified \$8.8 million in accounts receivable under 60 days old. This means that DMS is doing a better job of collecting these amounts once they are identified. The Department has also initiated procedures allowing for closer review to determine possible overpayments, making identification and collection more timely.

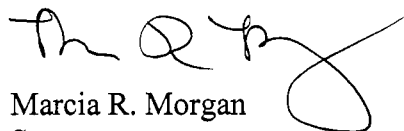
The Department takes very seriously their responsibility to make sure Medicaid dollars are spent appropriately and that when necessary, collections are made timely. The Department continues to evaluate the procedures and policies they have in place and to make changes as needed to better accomplish their objectives

The Department is confident that the procedures now in place are working and have budgeted increase collections for SFY 03 and 04 in the amount of \$36 million.

The Cabinet for Health Services will continue to review and consider recommendations made by the audit report and look forward to continuing our discussions with your office.

Thank you for the opportunity to respond to the audit of the "Kentucky's Management of Its Medicaid Accounts Receivable" program.

Sincerely,



Marcia R. Morgan  
Secretary

Attachment

Cabinet for Health Services  
 Audit Response  
 November 15, 2002

Information provided in this response is intended to either clarify information provided in the audit or to respond to specific recommendations contained in the report. Information and comments are presented in the same sequence as the audit report. Responses to specific recommendations are contained in the Executive Summary Section.

Audit Area	Cabinet Response
Executive Summary Findings	
Lack of Development or Implementation of Comprehensive Procedures Regarding Accounts Receivables	This finding is inaccurate and contradicts the remainder of the audit report which acknowledges the many steps the Department has taken, and procedures developed, since the reorganization last fall, particularly since the beginning of calendar year 2002. As the process has only been fully operational for less than a year, it is too early to conclude that effective procedures have not been developed. It is the Department's opinion that these procedures are working.
Growth of Accounts Receivable	The auditors continue to make the point of the growth in the aggregate on overall receivables, and are ignoring or are confused by the central issue, which is the growth or reduction in aged or otherwise delinquent accounts receivable. Total receivables have been reduced from \$57.8 million to \$44.2 million during the process initiated in early 2002. While the total accounts receivable over 60 days has grown from \$25 million to \$35 million, the total of aged accounts over 270 days has been reduced from \$21.1 million to \$15.8 million. This represents the Department's priority to collect or write off the oldest claims first. As resources are available, the Department will continue to work all of the remaining accounts receivable.
Failure to Charge Interest or Penalties on Overdue Accounts Receivable	This is a continuing disagreement with the Auditors as to the interpretation of the Department's Regulations. 907 KAR 1:671 does not allow for the Department to impose interest and penalties in <u>all</u> overpayment collection situations. In instances of provider misrepresentation or fraud, there is authority to add interest on the overpayment. However, in most of these situations, criminal activity is involved and the Department for Medicaid Services would refer the provider to appropriate state agencies for investigation and action. It should be noted that effective December 19, 2001, this regulation was revised and as a result the Department currently has the authority to apply interest to payment plans that exceed 6 months in repayment terms. This has been set up in the system and is already being applied. As the Department continues to develop accounts receivable policies, consideration will be given to identify other situations for which the imposition of an interest payment would be appropriate. As the auditors are aware, the majority of the Departments' receivables are from cost report settlements. Historically, many of Medicaid's

	<p>services were paid using a cost-based methodology. This approach was adopted from the Medicare program payment model. In such a reimbursement system, there is a "settlement" after the provider submits cost data.</p> <p>Once the cost data is reviewed, a determination is made whether the Medicaid program owes the provider additional payments for providing a service or if the provider was paid more than their cost and owes Medicaid.</p> <p>Under the current regulation, if the cost data indicates the provider received an overpayment for the service, no interest can be imposed.</p> <p>In recent years the Department has transitioned from cost based reimbursements to fixed payment and anticipates within one to two years, accounts receivables related to cost settlements will be reduced to less than 20% of the total accounts receivables.</p>
<p>DMS Has Begun to Identify Inactive Providers</p>	<p>In addition, the current 907 KAR 1:671 provides for the termination of providers who have not billed the program in 24 months. The regulation defines an "inactive provider number" as one that has not billed for 12 consecutive months. Inactive is a billing term, it does not mean terminated, which refers to a contractual status with the program. The 24-month period was based upon written guidance from CMS, which recommended the 24-month cut off. It was the federal guidance that empowered the Department to create this process in the regulation, over provider comments and concerns.</p>
<p>Chapter Two Findings</p>	
<p>DMS Has Not Effectively Managed Accounts Receivable</p>	<p>The Division of Program Integrity within DMS in conjunction with the Department's Division of Financial Management has effectively reviewed and identified the accounts by the following classifications:</p> <p><u>AGE</u> Individual accounts were aged based on the number of days from the set-up of the Account Receivable balance. The accounts were grouped from oldest in years to the youngest. The Division of Program Integrity focused on all accounts older than 270 days old starting with the aged accounts from as far back as 1984.</p> <p><u>STATUS</u> Accounts were also reviewed based on the status of active, inactive, or on-hold. Each status had to be worked separately from those accounts in a different status as follows:</p> <ul style="list-style-type: none"> <li>• Active accounts were first reviewed to determine the likelihood of collection under a specific provider number. In addition, a review was performed to determine if there could be an account receivable balance transfer to a second provider number with current claims liability. If the balance could not be transferred, then letters were sent to providers giving the provider the opportunity to send in funds to settle the balance. If no action was taken by the provider to settle the balance, the account was reviewed to determine if funds could be recouped from a Medicare provider number or simply written off.</li> </ul>

	<ul style="list-style-type: none"> <li>• Inactive accounts were reviewed to determine if the balance could be moved to an active vendor number preferably with current claims activity. If the balance was unable to be transferred to an active provider number, then a letter was sent to providers giving the provider the opportunity to send in funds to settle the balance. If no action was taken by the provider to settle the balance, the account was reviewed to determine if funds could be recouped from a Medicare provider number or simply written off.</li> <li>• On-Hold Pending Payment Plan accounts were reviewed to determine the reason of the hold and if a payment was necessary or already been approved. A payment plan may be for a provider deemed inactive and the balance would be moved to an active provider if available. If no active account is available, the "hold" would be moved to the inactive provider number. Letters were sent to providers giving the provider the opportunity to send in funds to settle the balance. If no action was taken by the provider to settle the balance, the account was reviewed to determine if funds could be recouped from a Medicare provider number or written off.</li> <li>• On-Hold accounts were reviewed to determine the reason for the "hold" and when it could be lifted. An account could be on hold for a number of reasons and may not need to be lifted until an appeal or legal proceeding is final. Once the determination to lift the hold is made, the account may need to be moved to a provider number with current claims activity. If the balance could not be transferred, then letters were sent to providers giving the provider the opportunity to send in funds to settle the balance. After no action was taken by the provider to settle the balance, the account was reviewed to determine if funds could be recouped from a Medicare provider number or written off.</li> </ul>
<p>Kentucky Refunded \$25 Million to the Federal Government For Accounts Receivable Not Collected Within 60 Days</p>	<p>Although DMS has refunded \$25 million to the Federal Government for accounts receivable over 60 (sixty) days old, we are aggressively taking actions to write-off and collect aged accounts evidenced by the reduction in accounts receivable greater than 270 days old from \$21.1 million to \$15.8 million. The Division for Program Integrity is currently going through the necessary steps to write-off any accounts receivable deemed uncollectable to reclaim the federal share on the CMS-64 Quarterly Report.</p>
<p>Accounts Receivable Balances Are Significantly Lower In Other States</p>	<p>The Cabinet challenges the methodology of comparing accounts receivable balances to the states listed in Table 3. Of the 10 states in the auditor's example only three (3) states reimbursed providers in a similar manner to Kentucky. All of the three (3) states are in various stages of contracting with managed care organizations to provide healthcare to the Medicaid population in heavily populated areas. For example, Illinois contracts with MCOs (Managed Care Organizations) to provide healthcare for Medicaid participants in Cook, Madison and St. Clair counties. The other six (6) states (Tennessee, Minnesota, New Jersey, Oregon, Virginia and Washington) operate under a capitated managed care arrangement for the majority of regions within their respective states. Those</p>

	<p>states contract with MCOs to administer healthcare benefits to the Medicaid population by paying the MCO a capitated rate similar to a healthcare premium. Those states' Medicaid Departments would not incur any overpayments to providers or receivables from cost settlements, since the MCOs in those states have the burden of provider cash reconciliations. Therefore comparing the accounts receivable balances for these nine (9) states to Kentucky's accounts receivable balance, is an inconsistent comparison because the detail and makeup of each states' programs are different. A more appropriate statement, if any, to compare Kentucky's accounts receivable balance would describe the system of reimbursing providers, the expected changes in that reimbursement methodology, and the potential efficiencies from a changed methodology.</p>
<p>Recommendations:</p>	
<p>Develop and Implement a Strategic Plan/Procedure Manual</p>	<p>The Department for Medicaid Services has developed and has implemented an aggressive program for identification and collection of their accounts receivable. This was done prior to the audit. The Department is committed to continuing to review and revise or add to the process now established. The ultimate goal is to minimize accounts receivable through early detection of inappropriate and abusive billing practices.</p> <p>A manual or similar comprehensive document has not yet been created as all available resources in the Cabinet are currently focused on efforts to aggressively manage accounts receivable. We agree that such a document is needed and will be created.</p>
<p>Exhaust Collection Practices Using Collection Agencies and Legal remedies</p>	<p>The Department has dedicated numerous resources this past year to address accounts receivable and is moving into a better position to aggressively manage and reduce these. Because of this, the Cabinet disagrees that the use of collections agencies would be effective and otherwise prove to be too costly and time consuming to educate a collection agent as to the complexities of the Medicaid Program. There is also a significant question whether Federal Medicaid funding would be available for a contracted collection agent. As part of our written protocol, we pursue all legal remedies when the cost/benefit appears to be favorable to the Department.</p>
<p>Fully Document Efforts to Recoup and Collect</p>	<p>DMS is fully documenting all efforts, and will continue to do so.</p>
<p>Routinely Reassess the Reasons for Suspending Collections Efforts</p>	<p>Upon the official conclusion of the current "on hold" verification project, which should occur on or before the end of this calendar year, the Division of Financial Management will generate, every 60 days, a report of all "on hold" accounts in the system. This report will be distributed through the Commissioner's Office to all Division Directors for immediate verification of existing "on hold" accounts. This will ensure that all suspended accounts are accurate in the system and avoid the creation of future backlogs.</p>
<p>Establish and Communicate to Providers</p>	<p>The Cabinet understands this to be an acknowledgement by the auditors that it would require a regulatory change to fully assess</p>

<p>Administrative regulations and Procedures for Assessing Interest and Penalties</p>	<p>interest and penalties on overpayments. We agree, of course, but, as noted above, differ as to whether such a regulatory change would be possible or ultimately productive. The Department currently has the authority to impose interest on payment plans that exceed six months repayment, and on all collections where there has been sanctioned activity, typically fraud. As we continue to evaluate our processes and our policies, this may be an area in which some regulatory changes may be made. The current regulation which supports this is adequately communicated to the provider community through the regulatory process. With the systematic changes made by the Department as to the initial set of accounts receivable, and the subsequent collection efforts, future accounts receivable will be collected timely, thus removing the issue of interest from further concern.</p>
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## Contributors To This Report

Edward B. Hatchett, Jr., Auditor of Public Accounts

Gerald W. Hoppmann, MPA, Director, Division of Performance Audit  
Jettie Sparks, CPA, Performance Audit Manager  
James Ryan, MPA, Performance Auditor  
Brooke Sinclair, Performance Auditor

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## General Questions

General questions should be directed to Matt Cantor, Intergovernmental Liaison, at (502) 564-5841 or the address above.



