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Office of the Inspector General
Miami-Dade County

COVER MEMORANDUM

To: Larry Handfield, Chairperson
Public Health Trust Board

Marvin O'Quinn, President and CEO
Public Health Trust/Jackson Memorial Hospital

Received by _____ Date _____

From: Christopher Mazzella, Inspector General

Date: September 10, 2004

Re: OIG Final Report *Review of Collection Agency Commission Fees for Collection Agency Services Rendered to Jackson Memorial Hospital*

Attached please find the Office of the Inspector General's (OIG) Final Report regarding our review of collection agency commission fees for patient accounts placed by Jackson Memorial Hospital.

In summary, the OIG found, in particular, that the placement of out-of-state Medicaid accounts for collection with the private agencies resulted in the wasteful paying of unnecessarily high commission fees. Typically, the large balance out-of-state Medicaid accounts were from patients for pre-arranged special medical services, for example organ transplants. These pre-arranged services also entail prior Medicaid authorization, and thus the OIG questioned why these accounts should be placed with an outside agency for collection. JMH concurred with this assessment and has recently shifted its billing on the out of state Medicaid accounts to an in-house process.

But furthermore, the OIG questioned the collection agencies' application of the fee rate for these out of state Medicaid accounts. While the OIG understands that each state's Medicaid program may have differences in the regulation of commission fees, it is nevertheless the contract entered into between JMH and its vendors that prevail. And therefore, the lack of any state regulation does not operate to allow collection agency vendors to collect fees restricted by the contract's fee cap for certain types of accounts. While JHM disagrees with the OIG and concurs with the vendors' interpretation, we are fairly certain that the shift to in-house collecting on these accounts will result in substantial future savings, albeit not recognizing what the OIG has identified as overpayments. The OIG reaffirms our initial recommendation to collect these overpayments, which we believe represents a substantial monetary amount.

The OIG will be requesting that JMH provide us with the documentation supporting the first year results of the newly established in-house procedures for the collection of out of state Medicaid accounts.

The OIG appreciates and thanks JMH staff and collection agency representatives for their courteousness and cooperation extended to OIG auditors during the course of this review.

cc: The Hon. Alex Penelas, Mayor, Miami-Dade County
The Hon. Chairperson Barbara Carey-Shuler, Ed. D.
and Members, Board of County Commissioners
George Burgess, County Manager
Charles Anderson, Commission Auditor
Cathy Jackson, Director, Audit & Management Services
Noel A. Felipe, Division President, Argent Healthcare Financial Services, Inc.
Ronald France, Chief Executive Officer, Broward Adjustment Services, Inc.
Carlos Novelli, Vice President, Asset Management Outsourcing, Inc.

OFFICE OF THE INSPECTOR GENERAL
FINAL REPORT
Review of Collection Agency Commission Fees for Collection Agency Services Rendered to Jackson Memorial Hospital

INTRODUCTION

The Miami-Dade Office of the Inspector General (OIG) reviewed the collection services contracts between the Public Health Trust of Miami-Dade County (PHT) and Broward Adjustment Services, Inc. (BAS), Paralign Revenue Management, Inc. (a.k.a. and hereinafter Paralign-Argent[1]) and Asset Management Outsourcing, Inc. (AMO). These three (3) vendors provided professional services to Jackson Memorial Hospital (JMH) in connection with the billing and collection of patient accounts pursuant to RFP No. 98-5070.[2]

On April 14, 2004, the OIG issued substantially this same report, in draft form, to the PHT and to the three aforementioned collection agencies. An appendix listing all the subsequent correspondence received is attached. Relevant responses to individual findings and recommendations have been inserted into the body of this final report. The complete responses are appended. Where appropriate, the OIG has inserted its rejoinder following each response received.

SUMMARY RESULTS

On March 30, 2004, the OIG met with PHT senior management to discuss its early findings. PHT management was presented with several supporting schedules summarizing key financial data reported in these findings. At that time, the OIG had analyzed only a limited number of accounts. However, the OIG deemed it appropriate and necessary to bring the results to management's immediate attention due to an excessively high error rate indicative of potentially damaging impact on the finances of the PHT.[3]

Specifically, our review of the collection services contract disclosed four (4) areas that require management's immediate attention:

1) JMH's outsourcing of out-of-state Medicaid accounts to the collection agencies results in JMH paying unnecessary commission fees. Our analysis indicated that the number of days between the patient's discharge and account placement with

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[1] Paralign has now become Argent Healthcare Financial Services, Inc., and is commonly, with regards to this contract, referred to as Paralign-Argent.

[2] New contracts were awarded for the period of January 1, 2004 through December 31, 2007. Two of the three previous vendors, Broward Adjustment Services (BAS) and Paralign-Argent, who held contracts during the previous contract cycle, are on the new contract; BCC Financial Management Services, Inc., is a new vendor and is the third collection agency on the new contract, RFP No. 03-5070.

[3] For example, 86% of the "out-of-state" Medicaid accounts reviewed had overstated commission rates.

the collection agency averaged 22 days; JMH received payment within an average of 202 days of the account being placed with the collection agency. Furthermore, these types of medical services were pre-arranged and pre-authorized, thereby substantially decreasing the risk that JMH would not be compensated. The OIG finds that the referral of these accounts is unnecessary and the PHT would save money by collecting these accounts in-house.

2) The commission rates charged for out-of-state Medicaid accounts were incorrectly applied to transferred account balances for the sample analyzed, thereby substantially increasing the fees paid to the collection agencies.

3) BAS "unbundled" out-of-state Medicaid accounts and then applied a commission fee to each portion of the total account resulting in overpayments of approximately $421,048 for the sample analyzed.[4] It must be noted that this disturbing pattern is based on the 14 accounts reviewed and it is anticipated that the overpayments resulting from this practice will be significantly greater.

4) The financial classification did not match the collection agency's rate for approximately $152,449 in commission fees charged for the sample analyzed.

SUMMATION OF THE PHT'S RESPONSES (APRIL 28,2004 AND JUNE 30, 2004)

Overall, the PHT agrees that the billing and collections services for out-of-state Medicaid accounts should be performed in house. PHT's updated response of June 30, 2004 states that "[f]or admissions after 5/31/04, all out-of-state Medicaid accounts will not be outsourced and will be billed internally."

Regarding payments made to the collection agencies during the contract period, the PHT states that there was no intentional unbundling of the accounts for billing purposes. The PHT explains that computer system limitations required accounts to be divided into multiple line items. The PHT concludes that the payment cap does not apply to states outside of Florida and therefore "the payments made to the [collection] agencies were appropriate and in compliance with the contracts." (See Appendix A-4.) In support of this conclusion, PHT relies on the assistance afforded by the law firm of Hinshaw & Culbertson (attorneys to Broward Adjustment Services, Inc. see Appendix A-5) and the legal opinion of Argent's legal counsel (see Appendix A-6) that federal regulations do not prohibit the paying of a percentage basis fee collection services when the payment is directly made to the Medicaid provider, in this case Jackson Memorial Hospital.

[4] This overpaid amount is the combination of findings nos. 2 and 3.

THE OIG'S REJOINDER AND GENERAL OBSERVATIONS:

Regardless of whether other states mandate a fee cap, this contract sets a fee cap on accounts paid by Medicaid. The contract does not distinguish between Florida Medicaid versus another state's Medicaid program. The PHT's response seems to excuse the agencies' over-billing by resting on this newly made distinction.

It makes no sense that on a $500,000 patient account, a collection agency's fee would be $7,500 if the payment is made by Florida Medicaid, and if it were paid by a non-Florida Medicaid program the collection agency's fee would be $42,500. In the case of one actual patient's account reviewed by the OIG, the collection agency received $86,196 as its fee on a $1,014,072 out-of-state Medicaid payment. This was a pre-arranged organ transplant procedure where, if paid by Florida Medicaid, the collection agency's fee would have been $7,500; a difference of $78,696.

Classification X refers to Medicaid—all Medicaid (Florida and out-of-state). When it is known upfront that payment will be made by Medicaid, the patient's account is coded X. When it is not readily apparent but there is the possibility that the patient would qualify for Medicaid, the account is coded V for "Potential Medicaid."

According to the contract, it did not appear that Medicaid accounts would be placed with the collection agencies. The following paragraph is found in Attachment I (Extended Business Office), Attachment II (Collection Services) and Attachment III (PCC Professional Fees) of the contract.

> AGENCY shall attempt to identify those patient accounts who potentially qualify for Medicaid. Patients should be assisted through the Medicaid eligibility process. Once a Medicaid approval is obtained, the account should be updated in the PHT HBOC system. The PHT Medicaid Billing/Follow-up department will bill these accounts to the Medicaid fiscal intermediary. Medicaid denials that are a result of an incorrect or unapproved number will be the responsibility of the AGENCY to rectify. (Emphasis added).

On the fee schedule itself (Attachment IV of the contract and Exhibit 1 of this report), the rate for financial class code X (Medicaid approved) is left blank. During the course of the audit, the OIG was informed by Patient Financial Services that Florida Medicaid accounts are handled internally and not placed with the collection agencies. Moreover, the OIG was told that the contract did not address out-of-state Medicaid as a distinct

category. PHT staff from the Patient Financial Services Division told the OIG that the collection agencies were instructed to use the fee rates for class V Potential Medicaid. This rate was originally 10% and later reduced to 8.5% for inpatient accounts. The class V rate has always had a cap of $7,500.

The decision to outsource out-of-state Medicaid accounts was a verbal agreement.

GOVERNING AUTHORITY

In accordance with Section 2-1076 of the Code of Miami-Dade County, the OIG has the authority to review past, present, and proposed County and Public Health Trust programs, accounts, records, contracts and transactions. The Office shall have the power to require reports from the Mayor, County Commissioners, Manager, County agencies and instrumentalities, County officers and employees and the Public Health Trust and its officers and employees regarding any matter within the jurisdiction of the Inspector General.

BACKGROUND

On May 1, 1999, the PHT entered into a collection services contract with BAS, Paralign-Argent and AMO for a period of four years with an option of early termination or extension. These three collection agencies provide extended business office (EBO) services, collection services and professional fee billing services for patient accounts transferred to them by the JMH.

The contingency commission fees received by the collection agencies are based on various contract rates applied to recovered account balances. The rates vary according to the patient's financial classification (e.g., self pay, non-resident, etc.), with the exception of Medicaid accounts. Medicaid accounts, in addition to an established rate, have a fee cap that is applied to the commission amount.

OBJECTIVE, SCOPE AND METHODOLOGY

Our objective was to determine whether the correct commission rates were applied by the collection agencies against the patient account balances recovered. We reviewed a small judgmental sample of collection/bad debt accounts placed with the collection agencies during the period June 1999 through December 2003. We prepared a

summary schedule of the fees charged by the three (3) agencies over the four and one-half year period as follows:[5]

COLLECTION FEES FOR JUNE 1999 - DECEMBER 2003

	CONTRACT PERIOD					
AGENCY	**6/99 - 5/00**	**6/00 - 5/01**	**6/01 - 5/02**	**6/02 - 5/03**	**6/03 - 12/2003**	**TOTAL**
AMO	897,329.00	2,021,142.00	1,067,245.00	921,306.00	545,180.00	5,452,202.00
BAS	991,649.00	1,670,667.00	1,729,161.00	1,822,261.00	979,375.00	7,193,113.00
PARALIGN	702,037.00	1,509,186.00	1,501,253.00	1,621,694.00	667,724.00	6,001,894.00
	$ 2,591,015.00	**$ 5,200,995.00**	**$ 4,297,659.00**	**$ 4,365,261.00**	**$ 2,192,279.00**	**$ 18,647,209.00**

After analyzing this data and based on the commission fees charged and capped rates unique to Medicaid accounts, we decided to focus our review on out-of-state "Medicaid"[6] and "Potential Medicaid" accounts. We selected a limited number of high-dollar accounts and confirmed the accuracy of the account balances using the HBOC system.[7] Additionally, we verified whether the rates applied were consistent with the contract and whether they were accurately applied to account balances. Also, in instances where they were inaccurately applied, we recalculated the commission fees charged by the collection agencies against the contract rates.

We reviewed 14 out-of-state Medicaid [8] and 26 potential Medicaid patient accounts among the three (3) agencies as follows:

[5] Source: JMH's Collection Follow-Up Unit.

[6] According to JMH's Collection Follow-Up Unit, in-state Medicaid accounts are managed by PHT's Patient Financial Services (PFS) unit.

[7] The database is actually the Patient Management Accounting System (PMAS) which is commonly referred to as the HBOC system for McKesson HBOC, Inc.

[8] There were no high-dollar out-of-state Medicaid accounts observed for the other two (2) agencies, AMO and Paralign-Argent

Out-of-State Medicaid (X)		
Agency	No. of Accounts	Collection Amounts
AMO	0	-
BAS	14	$ 5,597,940
Paralign	0	-
	14	**$ 5,597,940**

Potential Medicaid (V)		
Agency	No. of Accounts	Collection Amounts
AMO	5	$ 340,130
BAS	13	453,406
Paralign	8	145,633
	26	**$ 939,169**

FINDINGS AND RECOMMENDATIONS

Finding No. 1: JMH's outsourcing of out-of-state Medicaid accounts to the collection agencies results in JMH paying unnecessary commission fees.

Admitting and treating patients with out-of-state Medicaid coverage normally involves pre-arranged accommodations due to the nature of the procedure(s) to be performed (e.g., organ transplants and other types of procedures that cannot be performed in the patient's home state). These arrangements involve pre-authorization for payment (e.g., letters of agreement); therefore, JMH's automatic transfer of these accounts for collection services appears to be premature and unnecessary. Approximately $475,118 dollars in fees collected were collected for the accounts reviewed. OIG auditors noticed that most of these accounts are transferred to the collection agency as a "Bad Debt" within weeks of the patient's discharge. Our analysis indicates that the number of days between discharge and placement averaged 22 days for the items reviewed. Further analysis indicates that the number of days between account placement and payment remittance averaged 202 days. Thus, JMH unnecessarily pays commission for these accounts, as it is known that such Medicaid accounts involve pre-arranged and pre-authorized medical services, and are generally settled within 6-9 months (180 - 270 days) of the patient's discharge with little or no collection effort.

JMH Response of April 28, 2004 (see Appendix A-2 for the full response).

> Management is currently reviewing all Medicaid out-of-state accounts to verify that correct payments were made to the external collection agencies. Management will complete this review by June 30, 2004. This review will address finding number two as noted on you report, page 5.

BAS Response (summarized by the OIG, please refer to Appendix B-2 for BAS' full response).

BAS agrees that out-of-state Medicaid claims are generally pre-approved. BAS maintains that registration claim filing and follow-up process requires substantial collection effort and takes several months to complete.

JMH Response of June 30, 2004 (see Appendix A-4 for the full response).

> We analyzed the economic impact of outsourcing these accounts. We determined that it is in the best financial interest of the hospital to do this billing internally. We have selected one biller to perform these functions. Because of the limited volume of out-of-state Medicaid accounts, we have determined that one person can person can perform this function. For admissions after 5/31/04, all out-of-state Medicaid accounts will not be outsourced and will be billed internally.

OIG Rejoinder to both JMH and BAS responses:

The OIG maintains its position that the outsourcing of out-of-state Medicaid accounts results in the paying of unnecessary fees. We are encouraged by the move to perform these functions in-house. However, while JMH states that it has conducted an analysis of the economic impact, it has not provided the OIG with the details of its review.

During the course of this review, the OIG auditor had requested a listing of all out-of-state Medicaid accounts that were out sourced during the period June 1999 through December 2003. We eventually received this data and since the issuance of the draft report we have continued to review this information. In sum, the OIG was provided with a schedule summarizing the patients' JMH accounts. Overall, there were 555 patient account balances totaling approximately $15.7 million.

The schedule included the following patient information: (1) account number; (2) length of stay; (3) financial classification; (4) account status; (5) type of admission; (6) date of agency assignment; (7) account balance; (8) payments; and (9) last payment date. Not included in the schedule are the commission rates charged by the collection agencies.

According to the schedule, the accounts were placed with the collection agencies as follows:

- *292 accounts were placed with BAS;*
- *159 were placed with AMO;*
- *91 were placed with Paralign-Argent; and*
- *13 were placed with Miami Dade County's Finance Department.*

Of the 555 patient account balances listed on the schedule, OIG auditors noted the following:

- *94 account balances (18%) exceeded $20,000 which accounts for approximately $14.7 million or 94% of the total amount placed with the collection agencies; and*

- *10 of the 94 account balances identified above, have balances in excess of $400,000. These 10 accounts make up a mere 1.8% of the total number of accounts, and yet they represent 50% of the total account balances out sourced to the collection agencies. The below table breaks down these 10 accounts.*

ACCOUNT BALANCE	CUMULATIVE
$ 2,417,055.20	$ 2,417,055.20
$ 926,708.59	$ 3,343,763.79
$ 789,573.29	$ 4,133,337.08
$ 745,003.26	$ 4,878,340.34
$ 720,949.95	$ 5,599,290.29
$ 537,057.63	$ 6,136,347.92
$ 518,419.95	$ 6,654,767.87
$ 459,373.88	$ 7,114,141.75
$ 413,760.65	$ 7,527,902.40
$ 403,280.63	$ 7,931,183.03

While the data received by the OIG lacks the commission fees collected on these accounts, these statistics demonstrate the absurdity of placing these types of government paid accounts with private collection agencies. This is exacerbated by the collection agencies' application of a flat percentage commission fee, which the OIG disputes.

Finding No. 2: **The commission rates charged for out-of-state Medicaid accounts was incorrectly applied.**

The collection agency's commission fee for Medicaid accounts is based on a fixed rate per contract. This rate was amended throughout the contract period as follows:

5/1/99-8/9/99 **		AMENDED (AS OF 7/1/00)**		AMENDED (AS OF 9/9/02)	
INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT
6.00%	10.00%	5.00%	9.25%	$ 530	$ 30
10.00%	14.00%	8.50%	13.00%	$ 530	$ 30

****Pursuant to the contract (Attachment IV), the rate was capped at $7,500 from the contract's inception through September 9, 2002. Thereafter, Medicaid collection commission fees were capped at $530. (See OIG Exhibit A)**

OIG auditors found that the commission rate was incorrectly applied for 12 of the 14 accounts reviewed (86%). For example, a $100,000 collection item account placed with the collection agency on 4/30/02 was charged a commission rate of 8.50% (or $8,500) instead of the lower capped rate of $7,500. In another example, a $65,000 collection item placed with the collection agency on 6/7/03 was charged a commission rate of 8.50% (or $5,525) although the flat rate of $530 was in effect at the time. This condition was observed for all 12 discrepant accounts resulting in an overpayment of commission fees, which is discussed and quantified in detail in Finding No. 3 below.

JMH Response of April 28, 2004 (see Appendix A-2).

> Jackson Health System (JHS) entered into a new contract with the external collection agencies effective January 2004. The monitoring procedures were increased under the new contract. Management believes that these new procedures are sufficient to ensure accurate payments. . . . The real issue is does the payment cap apply to other States. Because Medicaid is a program administered by each individual state, the Florida statutes do not apply. We are currently researching the Medicaid rules for the states involved to determine if a payment cap applies to those states. If the applicable state's regulations do not call for a payment ceiling, then the payments made to the collection agencies would not have been affected by the dividing the account into more than one line.

BAS Response (see Appendix B-2 for the full response).

> There was never a cap on fees for Out-of-state Medicaid Financial Class 0X accounts. The contract caps fees on *Florida* Potential Medicaid accounts, Financial Class 0V and any other account converted to *Florida* Medicaid.

OIG Rejoinder to both JMH and BAS responses:

JMH's response does not adequately address the finding or recommendation. The fact that Medicaid is administered individually by each state is irrelevant to this contract. This is JMH's contract and it is JMH that sets the fees pursuant to the contract. The absence of other states mandating a fee cap does not make the fee a windfall to the collection agencies. They are still bound to the contract's fee schedule.

Patient Financial Services (PFS) representatives informed OIG auditors that there is no written policy governing out-of-state Medicaid accounts and that the parties verbally agreed to outsource this population of accounts. According to PFS representatives, the agencies were instructed to use the "fee" (Inpatient - 10% / Outpatient - 14%) for "Potential Medicaid" (Financial Class "V"). As reflected in the contract's "fee" schedule, the rate was capped at $7,500 from the contract's inception through September 9, 2002. Thereafter, Medicaid collection commission fees were capped at $530. This was the basis used by the OIG in its analysis, conclusions and recommendations.

Neither JMH nor BAS has presented authoritative written documentation prepared contemporaneous with their alleged agreement not to impose the rate cap, and therefore the OIG maintains its position.

Finding No. 3: BAS commission rates for out-of-state Medicaid accounts were misapplied, resulting in overpayments of approximately $421,048 because the patient's account was "unbundled," therefore allowing multiple collection fees against one account.

On a weekly basis, JMH shows transfers of out-of-state Medicaid accounts to the collection agency on its "Placement Reports." Within seven (7) calendar days of transfer, the collection agency is required to confirm the receipt of these accounts on its "Acknowledgment Reports."

On a monthly basis, the agency reports the collections received and commissions earned and remits the "net" collections to JMH on the "Remittance & Disbursement Report." This report indicates the patient's name, hospital account number, agency file number, total collected, amount to be applied to principal balance and payments to the agency, including the rate and commission fee earned.

Our review disclosed a troubling, consistent pattern within the BAS[9] patient accounts processing:

1. Patient's account is placed by JMH ("Placement Report") with BAS as one lump-sum balance for one patient account and/or one episode of care.
2. BAS acknowledges account referral ("Acknowledgment Report") as one lump-sum amount.
3. After patient's account placement with BAS but prior to payment remittance, BAS "unbundles" the account into multiple line items and applies its commission rate against each line item.
4. The result: the net collection remitted by BAS ("Remittance & Disbursement Report") to JMH is substantially greater than the Medicaid commission fee cap that is applied to these accounts.

For example, BAS recovered $1,014,073 on 6/12/03 for one (1) patient account, which was placed with them on 8/30/02. According to the rate table earlier shown, the account should have been charged 8.5%, or the capped commission rate of $7,500, whichever is less. OIG auditors noted that BAS split the account into 18 different line items and applied a commission rate of 8.5% to each line item. This resulted in an overpayment of $78,696, which is over 10 times what the agency should have received.

In another example, BAS recovered $350,000 on 7/3/03 for one (1) patient account, which was placed with them on 6/7/03. According to the rate table earlier shown, the rate in effect at that time was a flat fee of $530. BAS, however, split the account into six (6) different line items and again applied a commission rate of 8.50% to each line item. This resulted in an overpayment of $29,220. **(See OIG Exhibit B, Example 2)**

The OIG notes the payments for each line item in the two above-examples were all received and posted by the collection agency on the same day. Furthermore, the "unbundling" of these accounts were related to one episode of care. This pattern of "unbundling" is very disturbing to the OIG due to the frequency of its occurrence and the excessive amounts charged to the PHT.

[9] As out-of-state Medicaid accounts were not observed/sampled for the AMO and Argent-Paralign, this condition was also not observed for these two vendors.

The OIG emphasizes that the conditions described in Finding Nos. 1, 2, and 3 are not mutually exclusive. This means that they can all occur within the same account, thereby compounding the fees overcharged. OIG Exhibit A shows two examples of the Findings Nos. 1, 2, and 3.

JMH Response of April 28, 2004 (see Appendix A-2 for the full response).

> Any accounts that we divided into several amounts were done based upon the computer system limitations not an attempt to receive multiple payments on the same account. The real issues is does the payment cap apply to other States. Because Medicaid is a program administered by each individual state, the Florida statutes do not apply. We are currently researching the Medicaid rules for the states involved to determine if a payment cap applies to those states. If the applicable state's regulations do not call for a payment ceiling, then the payments made to the collection agencies would not have been affected by the dividing the account [*sic*] into more than one line.

JMH Response of June 30, 2004 (see Appendix A-4 for the full response).

> We reviewed the other states regulations and determined that the payment cap does not apply to other states and therefore the payments made to the agencies were appropriate and in compliance with the contracts.
>
> In reviewing the other state regulations, we received assistance from the law firm of Hinshaw & Culbertson, LLP. We have attached their findings letter for your review and records. [OIG Appendix A-5] To sum of their findings, federal law permits the payment based upon a percentage of collections to a collection agencies as long as the payments are made to the provider and not the collection agency. For the out-of-state Medicaid accounts, all payments are made to Jackson Memorial Hospital not a collection agency. We also had this finding confirmed by Argent's compliance officer. We have attached their letter for your review. [OIG Appendix A-6]
>
> Based upon review of Federal Law, Jackson Memorial Hospital did not overpay nor did the collection agencies over charge for the collection of out-of-state Medicaid accounts.

BAS Response (see Appendix B-2)

> We strongly disagree with this finding. Our computer system limits the number of characters available for posting payments. The largest payment we can post is $99,999.99. All payments were posted at the correct commission rate in effect at the time of the payment. The fact that some payments had to be broken down to several transactions had no adverse effect on the total commissions paid on that account. All commissions paid by JMH on these accounts were calculated correctly.

OIG Rejoinder to JMH and BAS responses:

The OIG is confused by these responses. First, with regards to the unbundling, BAS's records, not JMH, show accounts being divided into several amounts. The accounts were originally placed and acknowledged as one lump sum amount. The computer limitation, as described above, is tied to the posting of payments. However, out-of-state Medicaid pays JMH directly—not the collection agency. The collection agency's posting of the payment is for its fee collection purposes.

Secondly, according to JMH "the real issue is does the payment cap apply to other States." The OIG contends that the real issue is not what is allowable in other states but what is allowable as a collection fee under this contract. Even if this type of collection fee is permissible under Federal law, it is not the fee structure agreed to in the contract. As such, the OIG disagrees with BAS that the correct commission rate was charged.

Lastly, and most troubling is JMH's statement that it has received assistance from the law firm of Hinshaw & Culbertson, LLP. This law firm's client is Broward Adjustment Services, and the legal conclusions reached by the law firm were for its client. On behalf of its client, BAS, the law firm provided JMH with the attached letter. For JMH to endorse the legal conclusions of the collection agencies, who have a financial interest in the interpretation of the contract's fee schedule, is outrageous and contrary to good public policy.

Finding No. 4: **The financial classification did not match the collection agency's rate for approximately $152,449 in commission fees charged for accounts classified by PHT as "Potential Medicaid."**

OIG auditors observed a disparity between the patient's financial classification and the commission rate charged. Because there was incomplete information regarding the patient's ultimate financial classification and source of payment, we were unable to determine if the correct commission rate was charged. However, in many of the examples reviewed, the rate applied was inconsistent with other patient information found in the patient's file.

Frequently, JMH staff has to complete financial assessments of patients with no funding source at the time of their admissions. However, JMH cannot always immediately determine if such patients are eligible for Medicaid benefits due to a variety of reasons. Thus, PHT classifies these patients as potential Medicaid accounts because at least some of the initial Medicaid eligibility criteria were met at the time of admission. OIG auditors observed some of these notations in the patient file notes indicating the potential for Medicaid eligibility.

Potential Medicaid accounts are classified as "V" and are placed with the collection agencies through their services as an "Extended Business Office." After 90 days, uncollected accounts are referred to one of the other two collection agencies as a "Bad Debt." It appears that, in the interim, the Medicaid eligibility process was not completed and/or updated as the account is still coded as a "V Potential Medicaid" even after 90 days and one round of collection efforts.

As a "Bad Debt," Potential Medicaid accounts carry an 8% or 10% (depending on remittance date) commission rate (or cap). However, OIG auditors noted numerous examples where, upon collection, the agency applied a 17% rate to the account indicating self-pay status.

There is no information to verify the accuracy of the financial classification status and whether or not the rate charged was correct. There was no update in the HBOC system to indicate whether any third party coverage was identified, or if the individual ultimately qualified for Medicaid. Furthermore, OIG auditors observed instances where patient file notes indicated that the patient did not have any third party coverage and was, otherwise, unable to pay, unemployed, living with relatives, etc., yet on very substantial sums collected, the agency applied the 17% self-pay rate as its commission fee. In total, for the sample of 26 accounts reviewed, the OIG could not verify

$152,449 in commission fees charged for "Potential Medicaid Accounts." (Further see the OIG's rejoinder on this finding below.)

JMH Response (see Appendix A-2)

> In response to your finding number 4 as noted in your report, page 7 [of the draft report], we have completed our review of your forth [*sic*] finding, we disagree with your comment that the agency rate were [*sic*] misapplied resulting in overpayments. The rate is paid based upon final classification of the funding status of the patient. The contract rate at that time had different rate based upon the patient's insurance classification. If the funding classification changes then a different rate would be applicable. This change in payer classification data was made available to your staff but was never picked up from our office. All payments made for these patients were appropriate.

BAS Response (summarized by the OIG, see Appendix B-2 for BAS' full response)

BAS stated that the commission rated charged is applicable to the source of the payment, as directed by JMH, not the financial classification at the time of referral.

Argent Response (summarized by the OIG, see Appendix C-2 for Argent's full response)

All eight referred accounts required a financial classification change. Medicaid was not the payment source on any of these accounts. Six of the eight accounts were correctly reclassified to self-pay. One of the eight accounts was correctly reclassified to legal and the remaining account was inadvertently reclassified to self-pay when it should have been reclassified as workers compensation.

OIG Rejoinder to JMH, BAS and Argent:

The OIG's original finding states: "The financial classification did not match the collection agency's rate for approximately $152,449 in commission fees charged for accounts classified by PHT as "Potential Medicaid," not that the rates were misapplied as JMH states. The OIG recognizes that the commission rate paid is based upon final classification of the funding status of the patient. What we clearly stated is that because of incomplete information regarding the source of payment, OIG auditors could not

determine whether the fee rate was correct. OIG auditors did pick up the payer classification data referenced in PHT's response. This documentation consisted of the OIG-prepared spreadsheets originally transmitted to PHT officials, and was returned with PHT and collection agency notations for each of the OIG-listed patient accounts. A thorough reading of the agency account notes may support the final fee rate applied to the collected account, however, the patient's financial code remained the same and apparently was never updated to reflect the source of payment. For example, we found that accounts listed as "V" potential Medicaid showed a payment of "self-pay" on the PHT payment screen, and only when reviewing the agency notes does it state that payment was made through an attorney as part of a settlement, which should have been adjusted to "Q" legal account.

If the funding classification changes, it is imperative that the changes are updated in both the HBOC system and the collection agency's records to indicate the patient's ultimate financial classification and source of payment. While Argent responded specifically to each of the eight (8) patient accounts in the sample, neither Argent nor BAS have provided complete authoritative documentation showing that their final financial classifications were correct.

RECOMMENDATIONS (from the OIG's Draft Report)

In order to determine the financial impact of the conditions described above, the OIG directs PHT's management to:

1. Perform a complete analysis of the charged amounts and billing practices of the collection agencies to identify all instances when the collection agencies misapplied collection rates and/or unbundled accounts and then misapplied collection rates;

2. Review its own procedures regarding the reconciliations of collection accounts;

3. Assess the economic impact of outsourcing out-of-state Medicaid accounts; and

4. Determine the full financial impact of the overpayments immediately. This includes all commission overpayments from BAS and the other two agencies as they may relate to the same findings, and any others that are discovered by the PHT during its own analysis.

For Recommendations nos. 1 and 4, JMH concluded that there were no misapplication of rates or overcharges. This discussion runs throughout this report.

For Recommendation no. 2, JMH replied that with the new contract effective January 2004, monitoring procedures were increased. "Management believes that these new procedures are sufficient to ensure accurate payments."

For Recommendation no. 3, JMH replied that it had "analyzed the economic impact of outsourcing these accounts" and that it has "determined that it is in the best financial interest of the hospital to do this billing internally." While JMH's response did not detail the results of its analysis, the OIG is encouraged that the shifting of these accounts to be billed internally will result in substantial savings.

JMH states that one designated biller will perform these functions for all admissions after 5/31/2004. The OIG requests an update to be provided on or about June 1, 2005 to include the all out-of-state and Florida Medicaid accounts placed with the collection agencies under the new contract that became effective January 2004, and a listing of all out-of-state Medicaid accounts billed internally since May 31, 2004. An OIG auditor will contact the appropriate JMH staff for the one year review.

The OIG appreciates and thanks JMH staff and collection agency representatives for their courteousness and cooperation extended to OIG auditors during the course of this review.

OIG Exhibit A is Attachment IV of the contract entitled *Financial Class Code Grouping and Fees*.

OIG Exhibit B is a composite of three (3) examples illustrating the various conditions observed.

Appendix A

A-1 Draft notification letter to Mr. Marvin O'Quinn, President, Public Health Trust (PHT), dated April 14, 2004.
A-2 Response received from the PHT dated April 28, 2004.
A-3 OIG follow-up letter to Mr. O'Quinn dated June 16, 2004.
A-4 Follow-up response from the PHT dated, June 30, 2004, with two attachments:
- A-5 Attorney opinion letter addressed to the PHT from the law firm of Hinshaw and Culbertson, LLP on behalf of its client, Broward Adjustment Services, Inc.
- A-6 Letter from Argent Healthcare Financial Services to the PHT.

Appendix B

B-1 Draft notification letter to Mr. Ronald France, CEO, Broward Adjustment Services, Inc., dated April 14, 2004.
B-2 Response received from Broward Adjustment Services dated April 22, 2004.

Appendix C

C-1 Draft notification letter to Mr. Noel. A. Felipe, Division President, Argent Healthcare Financial Services, Inc., dated April 14, 2004.
C-2 Response received from Argent Healthcare dated April 28, 2004.

Appendix D

D-1 Draft notification letter to Mr. Carlos Novelli, Vice-President, Asset Management Outsourcing, Inc., dated April 14, 2004.
- No response received from Asset Management Outsourcing.

ATTACHMENT IV

FINANCIAL CLASS CODE GROUPINGS AND FEES

F/C GROUP	F/C CODE	INPATIENT	OUTPATIENT
EBO			
Self Pay	0N, 0P, 0R	4.25%	6.25%
Commercial/Managed Care/Auto/Workers Comp./Medicare/Other	0A, 0C, 0D, 0E, 0F, 0I, 0K, 0M, 0O, 0S, 0T, 0U, 0W, 0Y, 0Z	4.20%	6.00%
Medicaid Potential	0N, 0P, 0R, OV	6.00%	10.00%
Medicaid Approved	0X	-	-
Contract	0P & 0N with contract note	4.20%	6.00%
PRIMARY PLACEMENT Bad Debt			
Self Pay	0N, 0P, 0R	17.00%	18.00%
Commercial/Managed Care/Auto/Workers Comp./Medicare/Other	0A, 0C, 0D, 0E, 0F, 0I, 0K, 0M, 0O, 0S, 0T, 0U, 0W, 0Y, 0Z	4.75%	15.00%
Medicaid Potential	0N, 0P, 0R, OV	10.00%	14.00%
Medicaid Approved	0X	-	-
Legal	0Q	17.00%	19.00%
Contract	0P & 0N with contract note	5.00%	8.00%
SECONDARY PLACEMENT Miami-Dade Finance			
All Payor Categories		30%	30%

EXHIBIT D

Note 1: Includes professional and technical component for primary care center billings, EBO, primary and secondary placements.

Note 2: Fee cap for Medicaid Potential is $7,500 per claim.

NBR 2/11/1

1611 N.W. 12th Avenue
Miami, Florida 33136-1094

Jackson Memorial Hospital

January 24, 2001

After careful review and pursuant to our recent communications regarding the increase in the Medicaid per Diem, we are requesting a reduction in your fee rate as follows:

	Inpatient		Outpatient	
	Old	New	Old	New
EBO	6%	3%	10%	9.25%
Bad Debt	10%	8.5%	14%	13%

Please note that the new Medicaid per diem rate became effective as of 7/1/00 and we expect your agency to adjust your fees retroactively.

Thank you for your continued assistance in this matter.

Sincerely,

Gil Amara

Gil Amara
PFS Administrator

cc: Harry Rohrer
Josie B. Rippey
Ileana Cullell
EBO/Collections Follow-up Depts.

Jackson MEMORIAL HOSPITAL
Jackson Health System
PUBLIC HEALTH TRUST

1611 N.W. 12th Avenue
Miami, Florida 33136-10

NSH 9111

September 9, 2002

As you are aware, our current contract specification for payment to the agencies on accounts paid by Medicaid is based on a contingency rate. To comply with the Florida Statute that prohibits billing agents from receiving a portion of reimbursement as its fee, Jackson Memorial Hospital has been performing the billing function on accounts converted to Medicaid by the agencies. This practice has created a logistical dilemma that taxes our internal resources and ultimately delays payment.

Therefore, effective immediately the agencies will assume responsibility for billing their assigned accounts with Medicaid coverage directly to the fiscal intermediary. To ensure compliance with the Florida law mentioned previously, agencies will now be paid a flat fee upon receipt of the Medicaid payment by JMH as noted below:

Inpatient Accounts	$530
Outpatient Accounts	$ 30

Please contact ~~me if~~ you have any questions regarding this matter.

Sincerely,

Josie B. Rippey

Josie B. Rippey
Legal Liaison
(305) 585-6436

cc: Gil Amara
DaNiece Moody
Ileana Cullell
EBO/Collections Follow-up Unit

OIG EXHIBIT B

EXAMPLE 1 ILLUSTRATING FINDINGS NUMBER 1, 2 AND 3

In the example below, the patient was discharged on 7/10/01 and the account was placed for collection with BAS on 8/8/01, approximately one month later (Finding No. 1). According to the rate table earlier shown, the rate that should have been applied was the lower capped amount of $7,500, not the 8.5% that was applied (Finding No. 2). Although the recovered amount relates to one account referral, BAS split the account into three (3) different line items and applied a commission rate of 8.5% to each line item (Finding No. 3). This resulted in an overpayment of $11,872.28.

							PER BAS RECORDS				PER AUDIT		
NAME	LENGTH OF STAY		DATE		DAYS BETWEEN		**JMH RECOVERY AMOUNT	COMMISSION		AMOUNT DUE JMH	RATE	DIFFERENCE	
	ADMIT	DISCHARGED	PLACED WITH BAS	RECEIPT (PAYMENT)	DISCHARGE & PLACEMENT	PLACEMENT & RECEIPT		RATE	AMOUNT			RATE	AMOUNT
H C	5/27/01	7/10/01	8/8/01	3/20/02	29	253	99,999.99	8.50%	8,500.00	(8,500.00)	$7,500	NA	$1,000.00
H C	5/27/01	7/10/01	8/8/01	3/20/02	29	253	99,999.99	8.50%	8,500.00	(8,500.00)		NA	$8,500.00
H C	5/27/01	7/10/01	8/8/01	3/20/02	29	253	27,909.13	8.50%	2,372.28	(2,372.28)		NA	$2,372.28
H Total							$227,909.11		$19,372.28	$(19,372.28)			$11,872.28

**JMH Recovery Amount refers to the fact that payment was made directly to JMH. However, because the account was placed with the agency prior to payment, the commission fee is still exacted from the paid amount.

***Given the fact that this is an out-of-state Medicaid account for pre-arranged and pre-approved medical services, the OIG strongly questions the economic justification for out-sourcing this account, especially as a "Bad Debt." The total amount paid to BAS in collection fees is $19,373.28. The amount overpaid is $11,872.28. The amount JMH should have paid is zero.

OIG EXHIBIT B

EXAMPLE 2 ILLUSTRATING FINDING NUMBERS 1, 2 AND 3

In the example below, the patient was discharged on 5/26/03 and the account was placed for collection with BAS on 6/7/03, only 12 days later (Finding No. 1). According to the rate table earlier shown, the rate in effect at that time was a flat fee of $530, not the 8.5% that was applied (Finding No. 2). Although the recovered amount relates to one account referral, BAS split the account into six (6) different line items and applied a commission rate of 8.5% to each line item (Finding No.3). This resulted in an overpayment of $29,220.

								PER BAS RECORDS				PER AUDIT		
NAME		LENGTH OF STAY		DATE		DAYS BETWEEN		BAS RECOVERY AMOUNT	COMMISSION		AMOUNT DUE JMH	RATE	DIFFERENCE	
		ADMIT	DISCHARGE	PLACED WITH BAS	RECEIPT (PAYMENT)	DISCHARGE & PLACEMENT	PLACEMENT & RECEIPT		RATE	AMOUNT			RATE	AMOUNT
G	M	3/8/03	5/26/03	6/7/03	7/3/03	12	38	$65,000	8.50%	$5,525	$59,475	$530	NA	$4,995
G	M	3/8/03	5/26/03	6/7/03	7/3/03	12	38	$65,000	8.50%	$5,525	$59,475	$0	NA	$5,525
G	M	3/8/03	5/26/03	6/7/03	7/3/03	12	38	$65,000	8.50%	$5,525	$59,475	$0	NA	$5,525
G	M	3/8/03	5/26/03	6/7/03	7/3/03	12	38	$65,000	8.50%	$5,525	$59,475	$0	NA	$5,525
G	M	3/8/03	5/26/03	6/7/03	7/3/03	12	38	$65,000	8.50%	$5,525	$59,475	$0	NA	$5,525
G	M	3/8/03	5/26/03	6/7/03	7/3/03	12	38	$25,000	8.50%	$2,125	$22,875	$0	NA	$2,125
G Total								$350,000		$29,750	$320,250			$29,220

***Given the fact that this is an out-of-state Medicaid account for pre-arranged and pre-approved medical services, the OIG strongly questions the economic justification for out-sourcing this account, especially as a "Bad Debt." The total amount paid to BAS in collection fees is $29,750. The amount overpaid is $29,220. The amount JMH should have paid is zero.

OIG EXHIBIT B

EXAMPLE 3 ILLUSTRATING FINDINGS NUMBER 3 AND 4

In the example below, the patient was classified as a potential Medicaid account. BAS split the remittance of fees into two (2) different line items and applied a commission rate of 17.00% and 8.50% respectively, to each line item (Finding No. 3). According to the rate table earlier shown (see report page 5), the Medicaid commission rate in effect at that time was a flat fee of $530. A 17.00% commission fee, according to the contract, only applies to "self-pay accounts." The 8.5% was the old Medicaid fee that was in effect prior to September 9, 2002. Thus, there is an inconsistency between the patient's financial classification and the commission rate(s) charged. OIG auditors were unable to determine the accuracy of the financial classification status, source of payment or whether the correct rate was charged (Finding No. 4).

				PER BAS RECORDS								PER AUDIT		
NAME		LENGTH OF STAY		DATE		DAYS BETWEEN		BAS RECOVERY AMOUNT	COMMISSION		AMOUNT DUE JMH	RATE	DIFFERENCE	
		ADMIT	DISCHARGE	PLACED WITH BAS	RECEIPT (PAYMENT)	DISCHARGE & PLACEMENT	PLACEMENT & RECEIPT		RATE	AMOUNT			RATE	AMOUNT
F	E	10/15/01	11/9/01	4/9/02	10/8/02	151	333	$40,000	17.00%	$6,800	$33,200.00	$530	Could not determine	
F	E	1015/01	11/9/01	4/9/02	10/8/02	151	333	$10,000	8.50%	$850	$9,150	$0	Could not determine	
F Total								$50,000		$7,650.00	$42,350		Could not determine	

***Note that it appears inconsistent for Medicaid to make a $10,000 payment to which the collection agency applied its 8.5% commission, yet the patient seemingly has the financial resources to make a $40,000 self-payment to which BAS applied a 17% commission.

OFFICE OF THE
INSPECTOR GENERAL
MIAMI-DADE COUNTY

CHRISTOPHER R. MAZZELLA
INSPECTOR GENERAL

ALAN SOLOWITZ
DEPUTY INSPECTOR GENERAL

PATRA LIU
ASSISTANT INSPECTOR GENERAL
LEGAL COUNSEL

April 14, 2004

Mr. Marvin O'Quinn, President
Public Health Trust
West Wing Room 117
1611 NW 12th Avenue
Miami, FL 33136-1005

FILE COPY

Dear Mr. O'Quinn:

Attached please find a copy of the Office of the Inspector General's (OIG) Draft Report regarding our review of collection agency services rendered to Jackson Memorial Hospital. We are providing this draft in accordance with the Board of County Commissioners' mandate of advance notification.

The OIG requests your response to this Draft Report. In the body of our report, we outlined four (4) specific recommendations. The OIG also requested that as part of the PHT's response, it provide a plan to accomplish the recommended actions, including milestones indicating when it intends to complete individual plan elements and an end date of when it intends to accomplish its entire plan.

If you would like your response to be included in the final report, you must submit it to the OIG by close of business on April 28TH, 2004. If you wish, you may provide your response by fax to (305) 579-2656.

Please do not hesitate to call should you have any questions.

Yours truly,

Christopher Mazzella
Inspector General

APPENDIX A-1

Acknowledgment of Receipt or Proof of Service

Ivanette Cobb

4/14/04
Date

Jackson HEALTH SYSTEM

1611 N.W. 12th Avenue
Miami, Florida 33136-1094

April 28, 2004

Christopher Mazzalla
Inspector General
Miami-Dade County
19 West Flagler Street, Suite 220
Miami, FL 33130

Dear Mr. Mazzalla,

The following is our response to your four recommendations as noted in your April 14th draft report, page 8.

Recommendation 1
Perform a complete analysis of the charged amounts and billing practices of the collection agencies to identify all instances when the collection agencies misapplied collection rates and/or unbundled accounts and then misapplied collection rates.

JMH Response
Management is currently reviewing all Medicaid out-of-state accounts to verify that correct payments were made to the external collection agencies. Management will complete this review by June 30, 2004. This review will address finding number two as noted on your report, page 5.

Recommendation 2
Review its own procedures regarding the reconciliation of collection accounts.

JMH Response
Jackson Health System (JHS) entered into a new contract with the external collection agencies effective January 2004. The monitoring procedures were increased under the new contract. Management believes that these new procedures are sufficient to ensure accurate payments.

Recommendation 3
Assess the economic impact of outsourcing out-of-state Medicaid accounts.

JMH Response
Management is currently determining the economic impact of outsourcing the out-of-state Medicaid accounts. This will be completed by May 31, 2004. This review will address finding number 1 as noted in your report, page 4.

Recommendation 4
Determine the full financial impact of the overpayments immediately. This includes all commission overpayments from BAS and the other two agencies as they may relate to the same findings, and any other that are discovered by the PHT during its own analysis.

JMH Response
Management is currently conducting this review. This is the same review as recommendation #1.

As you are aware, there are several hundred accounts that we are currently reviewing to determine if the contract was applied appropriately and if an overpayment was made. Without going through this process, we are unable to make a determination if there were overpayments made to any of the outside collection agencies used by Jackson Health System. We are currently reviewing all of our internal processes to ensure that we are billing and collecting the appropriate amounts that are due from all third party payers.

In response to your finding number 3 per your report, page 5, based upon our review to this point, we have not discovered any action by the collection agencies that attempted to collect additional amounts outside of the contract in place at the time. Any accounts that we divided into several amounts were done based upon the computer system limitations not an attempt to receive multiple payments on the same account. The real issue is does the payment cap apply to other States. Because Medicaid is a program administered by each individual state, the Florida statutes do not apply. We are currently researching the Medicaid rules for the states involved to determine if a payment cap applies to those states. If the applicable state's regulations do not call for a payment ceiling, then the payments made to the collection agencies would not have been affected by the dividing the account into more than one line

In response to your finding number 4 as noted in your report, page 7, we have completed our review of your forth finding, we disagree with your comment that the agency rate were misapplied resulting in overpayments. The rate is paid based upon final classification of the funding status of the patient. The contract rate at that time had different rates based upon the patient's insurance classification. If the funding classification changes then a different rate would be applicable. This change in payer classification data was made available to your staff but was never picked up from our offices. All payments made for these patients were appropriate.

Our estimated completion for the review is June 30, 2004. If JHS overpaid the agencies for their services we will then work with the individual agencies to recoup the funds.

If you have any questions regarding our response, please call Richard Reid at 305-585-7122.

Sincerely,

Marvin O'Quinn
President

cc: David W. Cash, Acting CFO
Richard Reid, Director of Revenue Management
Juan Reyes, Chief Compliance Officer
Gus Alonso, Director of Internal Audit

OFFICE OF THE
INSPECTOR GENERAL
MIAMI-DADE COUNTY

CHRISTOPHER R. MAZZELLA
INSPECTOR GENERAL

ALAN SOLOWITZ
DEPUTY INSPECTOR GENERAL

PATRA LIU
ASSISTANT INSPECTOR GENERAL
LEGAL COUNSEL

June 16, 2004

Mr. Marvin O'Quinn, President
Public Health Trust
1611 NW 12th Avenue
Miami, FL 33136

Re: JMH's response, dated April 28, 2004, to the OIG's Draft Report of Collection Agency Commission Fees.

Dear Mr. O'Quinn,

On April 14, 2004, the Office of the Inspector General (OIG) issued its Draft Report entitled *Review of Collection Agency Commission Fees for Collection Agency Services rendered to Jackson Memorial Hospital.* Thereafter, the Public Health Trust (PHT) tendered its response on April 28, 2004 (attached), which stated that two reports are forthcoming.

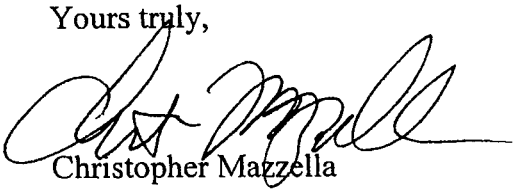
First, the PHT stated that it was performing a complete review of all out-of-state Medicaid accounts verifying that correct payments were made to the external collection agencies. According to your response, this review is to be completed by June 30, 2004. The OIG requests that we are forwarded a copy of this report by that date at the latest. Second, an economic impact review assessing the outsourcing of out-of-state Medicaid accounts was to be completed by May 31, 2004. The OIG has not received a copy of this economic assessment report and would appreciate your office forwarding us a copy as soon as possible.

In light of projected operating deficits, it is imperative for the PHT to avoid paying and overpaying for unnecessary service fees. The OIG believes that our report identifies an area where the PHT can recoup overpayments and save paying unnecessary fees, thus resulting in future savings. As you are aware, the OIG has not yet issued the final report. It is our intention to do so the first week of July. We would like to incorporate and address the results of your two reviews in the final report.

APPENDIX A-3

We look forward to receiving your two reports and finalizing this matter in the next few weeks. Should you have any questions, please feel free to contact me on this matter or any other matter of mutual concern.

Yours truly,



Christopher Mazzella

Jackson HEALTH SYSTEM
PUBLIC HEALTH TRUST

MARVIN O'QUINN
President/CEO

Executive Office

Jackson Memorial Hospital
1611 N.W. 12th Avenue
Miami, Florida 33136-1096

(305) 585-6754

June 30, 2004

Christopher Mazzella
Inspector General
Miami-Dade County
19 West Flagler Street, Suite 220
Miami, FL 33130

Dear Mr. Mazzella;

We have completed our review of the open items from your April 14 Draft Report. The following are our responses to your findings. The open items were recommendation 1 and 3.

Recommendation 1
Perform a complete analysis of the charged amounts and billing practices of the collection agencies to identify all instances when the collections agencies misapplied collection rates and/or unbundled accounts and then misapplied collection rate.

JMH Response
As we stated in our April 28 letter, we did not find any evidence that the collection agencies "unbundled" for the purpose of receiving additional payments. The accounts were divided into separate amounts due to a computer system limitation. The dividing of the account did not result in an overpayment to the agencies.

Based upon our review, as stated in our April 28 letter, the real issue is does the payment cap apply to States outside of Florida. We reviewed the other states regulations and determined that the payment cap does not apply to other states and therefore the payments made to the agencies were appropriate and in compliance with the contracts.

In reviewing the other state regulations, we received assistance from the law firm of Hinshaw & Culbertson, LLP. We have attached their findings letter for your review and records. To sum of their findings, federal law permits the payment based upon a percentage of collections to a collection agencies as long as the payments are made to the provider and not the collection agency. For the out of state Medicaid accounts, all payments are made to Jackson Memorial Hospital not a collection agency. We also had this finding confirmed by Argent's compliance officer. We have attached their letter for your review and records.

Based upon review of Federal Law, Jackson Memorial Hospital did not overpay nor did the collection agencies over charge for the collection of out of state Medicaid accounts.

Recommendation 3
Assess the economic impact of outsourcing out-of-state- Medicaid accounts

JMH Response
We analyzed the economic impact of outsourcing these accounts. We determined that it is in the best financial interest of the hospital to do this billing internally. We have selected one biller to perform these functions. Because of the limited volume of out-of-state- Medicaid accounts, we have determined that one person can perform this function. For admissions after 5/31/04, all out-of-state Medicaid accounts will not be outsourced and will be billed internally.

If you have any questions regarding our response, please call Josie Rippey at 305-585-6387.

Sincerely,

Marvin O'Quinn

Enc.

Cc: Frank Barrett, CFO
David Cash, Acting Vice President of Finance
Juan Reyes, Chief Compliance Officer
Gus Alonso, Director of Internal Audit
Josie Rippey, Associate Administrator, PFS

HINSHAW
& CULBERTSON LLP

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June 1, 2004

VIA TELECOPY 305-585-5137

Mr. Rick Reid
Director of Revenue Management
Jackson Memorial Hospital/The Public Health
Trust of Miami-Dade County
1611 N.W. 12th Avenue
Miami, Florida 33136

Re: Broward Adjustment Services, Inc.

Dear Mr. Reid:

At the request of our client Broward Adjustment Services, Inc. ("Broward") we have examined federal laws and regulations governing Broward's practices in the collection of Medicaid claims on behalf of The Public Health Trust of Miami-Dade County.

We have concluded that federal law permits a Medicaid provider to pay a collection agency such as Broward a percentage of the amount recovered for services rendered in collection of a provider's Medicaid claim. Although federal law prohibits the direct payment of a Medicaid claim to a collection agency if the collection agency is paid a percentage of the amount collected for its services, a provider may pay the collection agency a percentage of the amount collected as a fee for its services.

Pursuant to federal law, Medicaid payments may be made directly to a provider or its business agent. However, a business agent may not receive compensation related to a percentage of the amount billed or collected or compensation that is dependent on the collection of a payment. 42 C.F.R. 447.10(d) & (f). Because Broward is paid a percentage of the amount recovered by the provider contingent upon successful collection of the claim, Medicaid payments may not be paid to directly to Broward. However, there is no federal law that prohibits a Medicaid provider from paying a contingency fee to Broward based on a Medicaid payment that the provider receives as a result of Broward's collection efforts.

The federal regulations regarding who may receive direct payment of Medicaid payments have been in existence since 1978 and have never been substantively amended. Although we did not find any case law interpreting the applicable federal regulations, we did find some cases explaining the legislative intent of 42 U.S.C.A. 1396a(a)(32). *See Danvers Pathology Associates, Inc. v. Atkins*, 757 F.2d 427 (1st Cir. 1985); *Michael Reese Physicians and Surgeons, S.C. v. Quern*, 625 F.2d 764 (7th Cir. 1980). The court in *Danvers* explained that the statute "was aimed at stopping a practice under which 'some physicians and other persons providing

services . . . reassigned their Medicare and Medicaid receivables to other organizations or groups . . . [which] purchased the receivables for a percentage of their face value, submitted claims and received payments in their name.'" 757 F.2d at 430, citing H.R.Rep. No. 393, 95th Cong., 1st Sess. 48, reprinted in 1977 U.S. Code Cong & Ad.News 3039, 3051.

The court in *Danvers* stated that the purpose of the statute was to stop the "factoring" of Medicaid receivables—the selling of Medicaid obligations to collection agencies at a discount and the presentation of those obligations by the collection agencies to the state for payment. The statute stops this practice by *prohibiting* payment to those who are *not* providers. *Id.* (emphasis in original); *see also Michael Reese*, 625 F.2d at 765 (explaining that the central purpose of the statute was to "stop the common practice of factoring Medicare and Medicaid bills").

Moreover, an Assistant U.S. Inspector General for Legal Affairs pointed out that payment by a Medicaid provider of a contingent fee to a collection agency would not violate the prohibition on reassignment of claims if payment was made directly to the provider, and not the agent. *See* Statement of Lewis Morris, Asst. Inspector General For Legal Affairs (April 6, 2000).

In summary, federal law permits a Medicaid provider to pay a percentage of a Medicaid claim to a collection agency such as Broward for its services, because the applicable laws and regulations only prohibit the direct payment to collection agencies. If you have any further questions or seek additional assistance, please feel free to contact me.

Very truly yours,

HINSHAW & CULBERTSON LLP

Stephen T. Moore
Direct 815-490-4903
smoore@hinshawlaw.com

STM:hkl/sgb

cc: Mr. Ron France (via telecopy-954-565-2489)

Argent
Freedom To Focus®

April 28, 2004

RECEIVED MAY 12 2004

Josie B. Rippey
Assistant Administrator
Legal Liaison
Jackson Memorial Hospital
1611 NW 12th Avenue
Miami, FL 33136

RE: Reimbursement to Billing Agents for Medicaid payments made to providers under Federal Law

Dear Ms. Rippey,

It has been brought to my attention that there is a question regarding reimbursement to billing agents concerning payments made by Medicaid for Medicaid services under Federal law. This question is not new to me or to Argent Healthcare Financial Services, Inc. In conclusion, under Federal law, billing agents may receive payment for their services on a percentage basis where Medicaid claims are paid directly to the provider, and are not paid directly to the billing agent.

The intent of the Federal law is to prevent reassignment of Medicaid claims except in limited circumstances. Section 1902 of the Social Security Act provides that payments for services under a State Plan for Medical Assistance shall be made to the individual or to the provider of such services except under certain conditions. As applicable to billing agents, billing agents may receive such payments if the compensation for services rendered is unrelated to the amount of such payments. In no way does this Act prohibit the compensation to billing agents on a percentage basis if the Medicaid payment for services is made to the provider.

The Code of Federal Register reinforces section 1902 above. Under 42 C.F.R. § 447.10, entitled "Prohibition against Reassignment of Provider Claims", it states that it implements Section 1902 (a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or recipient, except in specified circumstances. As applied to billing agents, a billing agent may receive payment directly from Medicaid, if in addition to other factors, the billing agent's compensation is not related on a percentage basis to the amount billed or collected. Again, in no way does the Code of Federal Register prohibit the billing agent's compensation be based upon a percentage basis if the Medicaid payment is made to the provider.

I believe that this memorandum will answer your question affirmatively regarding the ability to compensate billing agents for their services on a percentage, or contingency, basis when Jackson

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APPENDIX A-6

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Memorial Hospital receives payments directly from Medicaid under Federal law. Thank you for bringing this matter to my attention. Should you have any additional questions, please do not hesitate to contact me directly at 773.250.0168.

Very kind regards,

Andrea Wenz, Esq.
Corporate Counsel and Compliance Officer

cc. Rick Reid, Director of Accounts Receivable Management

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FILE COPY

April 14, 2004

OFFICE OF THE
INSPECTOR GENERAL
MIAMI-DADE COUNTY

CHRISTOPHER R. MAZZELLA
INSPECTOR GENERAL

ALAN SOLOWITZ
DEPUTY INSPECTOR GENERAL

PATRA LIU
ASSISTANT INSPECTOR GENERAL
LEGAL COUNSEL

Mr. Ronald France
Chief Executive Officer
Broward Adjustment Services, Inc.
2876 East Oakland Blvd.
Ft. Lauderdale, FL 33306

Dear Mr. France:

Attached please find a copy of the Office of the Inspector General's (OIG) Draft Report regarding our review of services rendered by your company to Jackson Memorial Hospital.

Please be advised that you may provide a written response to these findings, which will be included with our final report. This response must be received by April 28th, 2004 should you elect to respond.

If you wish, you may provide your response by fax to (305) 579-2656.

Yours truly,

Christopher Mazzella
Inspector General

Robert D Hey
Robert D Hey
Acknowledgment of Receipt or Proof of Service Date 4/14/04

APPENDIX B-1

ACA INTERNATIONAL The Association of Credit and Collection Professionals

BROWARD ADJUSTMENT SERVICES, INC.

2876 E. Oakland Park Boulevard
P.O. Box 11879
Ft. Lauderdale, FL 33339
Phone: (954) 565-6682 • 1-800-826-8958
Fax: (954) 565-2489 • E-mail: bascoll@bellsouth.net

April 22, 2004

Mr. Christopher Mazzella
Inspector General Miami-Dade County
19 West Flagler Street
Suite 220
Miami, Florida 33130

RE: OIG DRAFT REPORT

Dear Mr. Mazzella:

We have carefully reviewed the Draft Report prepared by your staff and we strongly disagree with the findings.

Our responses are as follows:

Finding Number 1:
JMH outsourcing of Out of State Medicaid accounts results in JMH paying unnecessary commission fees. These accounts normally involve pre-arranged accommodations and are generally settled within 6-9 months of the patients' discharge with little or no collection effort.

We disagree with your conclusion that these accounts are collected with little or no collection effort.

While Out of State claims are generally pre-approved, the agencies must first go through the process of insuring that JMH is enrolled with the individual state and that the provider number is active. This process involves requesting the registration package from the state, gathering all required documents and signatures from the proper executives at JMH and submitting the registration enrollment package. Registrations are usually only active for one year and the entire process must be repeated each year to obtain the renewal.

Once JMH is properly registered with the state with an active provider number, the agency must review the filing guidelines and prepare a claim in accordance to the requirements of the state. When the claim is filed we must follow-up on the account, assist in audits, provide interim bills, etc. until the claim is paid. The entire process requires substantial collection effort and takes several months to complete.

Finding Number 2:
The commission rate charged for Out of State Medicaid accounts was incorrectly applied.

We strongly disagree with this finding.

There was never a cap on fees for Out of State Medicaid Financial Class 0X accounts.

The contract caps fees on *Florida* Potential Medicaid accounts, Financial Class 0V and any other account converted to *Florida Medicaid*.

Finding Number 3:
BAS commission rates for Out of State Medicaid accounts were misapplied, resulting in overpayments because the patient's account was "unbundled" therefore allowing multiple collection fees against one account.

We strongly disagree with this finding.

Our computer system limits the number of characters available for posting payments. The largest payment we can post is $99,999.99.

All payments were posted at the correct commission rate in effect at the time of the payment. The fact that some payments had to be broken down to several transactions had no adverse effect on the total commissions paid on that account.

All commissions paid by JMH on these accounts were calculated correctly.

Finding Number 4:
The financial classification did not match the collection agencies rate.

We strongly disagree with this finding.

As directed by JMH, we charge the commission rate applicable to the source of the payment, not the financial classification of the account at placement.

We strongly disagree with all of the OIG's findings and feel that we have complied completely with not only the word but also the intent of our contract with JMH, however, if we have misinterpreted the contract in any way we will make any necessary adjustment in our fees.

Very Truly Yours,

BROWARD ADJUSTMENT SERVICES, INC.

Ronald J France

Ronald J. France
CEO

RJF/lr

OFFICE OF THE
INSPECTOR GENERAL
MIAMI-DADE COUNTY

CHRISTOPHER R. MAZZELLA
INSPECTOR GENERAL

ALAN SOLOWITZ
DEPUTY INSPECTOR GENERAL

PATRA LIU
ASSISTANT INSPECTOR GENERAL
LEGAL COUNSEL

FILE COPY

April 14, 2004

Mr. Noel A. Felipe, Division President
Argent Healthcare Financial Services, Inc.
7715 NW 48 Street, Suite 100
Miami, Florida 33166

Dear Mr. Felipe:

Attached please find a copy of the Office of the Inspector General's (OIG) Draft Report regarding our review of services rendered by your company to Jackson Memorial Hospital.

Please be advised that you may provide a written response to these findings, which will be included with our final report. This response must be received by April 28th , 2004 should you elect to respond.

If you wish, you may provide your response by fax to (305) 579-2656.

Yours truly,

Christopher Mazzella
Inspector General

Acknowledgment of Receipt or Proof of Service

4/14/04
Date

APPENDIX C-1

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MDC-OFFICE OF THE
INSPECTOR GENERAL

2004 MAY -3 AM 10: 49

April 28, 2004

Christopher Mazzella
Inspector General
Office of the Inspector General Miami-Dade County
19 West Flagler Street
Suite 220
Miami, FL 33130

Dear Mr. Mazzella:

We have reviewed the Office of the Inspector General's Draft Report entitled "Review of Collection Agency Commission Fees for Collection Agency Services Rendered to Jackson Memorial Hospital." Following review of the Draft Report, it appears that Findings Nos. 1, 2, and 3 were not applicable to Argent Healthcare Financial Services, Inc. and therefore, will not be discussed.

We would like to address the issue raised under Finding No. 4 of the report, "The financial classification did not match the collection agency's rate for approximately $152,449 in commission fees charged for accounts classified by PHT as 'Potential Medicaid.'" The Draft Report states that "(b)ecause there was incomplete information regarding the patient's ultimate financial classification and source of payment, [OIG auditors] were unable to determine if the correct commission rate was charged." The eight accounts associated with Argent are as follows:

1. 07073xxxxxxxxxx
2. 07082xxxxxxxxxx
3. 02775xxxxxxxxxx
4. 02825xxxxxxxxxx
5. 02813xxxxxxxxxx
6. 02724xxxxxxxxxx
7. 07088xxxxxxxxxx
8. 02945xxxxxxxxxx

All eight referred accounts required a financial classification change. This financial classification may not be the same as the financial classification initially assigned by JMH at the time the account is referred to us.

Seven of the eight accounts were received from Jackson Memorial Hospital as Primary Placement, Potential Medicaid, financial classification "V." The remaining account was received as Primary Placement, Commercial Insurance, financial classification "Z." Our investigation concluded that

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Medicaid was not the payment source on any of these accounts. On the account initially received as Commercial Insurance, commercial insurance was not the payment source. In fact, six out of the eight accounts were correctly reclassified to self-pay, as a result of the ultimate payment source for those accounts. One out of the eight accounts was correctly reclassified to legal, as a result of the ultimate payment source of that account. The remaining account, Account number 02825xxxxxxxxxx, was inadvertently reclassified to self-pay when it should have been reclassified as workers compensation. This misclassification will be corrected on the next statement by reversing the account at the self-pay rate and re-posting the account at the workers compensation rate, thereby establishing a proper audit trail.

Argent's Corporate Compliance and Ethics program, *Integrity Focus*, requires that we conduct ourselves in accordance with the highest standards of conduct and ethics as well as comply with all applicable laws. In addition, it is our continued goal to provide excellent service to JMH as well as to all of our clients. We thank you for the opportunity to review and respond to your findings. Your observations have enabled us to review our processes and enhance our service delivery.

Sincerely,

Andrea Wenz
Corporate Counsel and Compliance Officer

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Argent Healthcare Financial Services

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April 14, 2004

OFFICE OF THE INSPECTOR GENERAL MIAMI-DADE COUNTY

CHRISTOPHER R. MAZZELLA
INSPECTOR GENERAL

ALAN SOLOWITZ
DEPUTY INSPECTOR GENERAL

PATRA LIU
ASSISTANT INSPECTOR GENERAL
LEGAL COUNSEL

Mr. Carlos Novelli
Vice President
Asset Management Outsourcing, Inc.
7067 W. Broward Blvd., Suite C
Plantation, FL 33317

Dear Mr. Novelli:

Attached please find a copy of the Office of the Inspector General's (OIG) Draft Report regarding our review of services rendered by your company to Jackson Memorial Hospital.

Please be advised that you may provide a written response to these findings, which will be included with our final report. This response must be received by April 28TH, 2004 should you elect to respond.

If you wish, you may provide your response by fax to (305) 579-2656.

Yours truly,

Christopher Mazzella
Inspector General

Acknowledgment of Receipt or Proof of Service

4/14/2004
Date

APPENDIX D-1