SEP 30 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Indiana's Reporting Fund Recoveries for the Medicaid Rehabilitation Option Program on the Form CMS-64 for Fiscal Years 2000 to 2005 (A-05-07-00072)

Attached is an advance copy of our final report on the State of Indiana's reporting fund recoveries for the Medicaid Rehabilitation Option (MRO) Program on the Form CMS-64 (CMS-64) for fiscal years 2000 to 2005. We will issue this report to the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, (the State Agency) within 5 business days.

Section 1903(d)(2) of the Act and Federal regulations (42 CFR § 433.312(a)(2)) require the State agency to refund the Federal share of overpayments by the Medicaid program at the end of the 60-day period following the date of discovery, whether or not the State has recovered the overpayment.

Our objective was to determine whether Medicaid overpayments made under the MRO Program and identified by surveillance and utilization review (SUR) audits and the interest earned on those overpayments were reported on the CMS-64 in accordance with Federal regulations.

The State agency did not report Medicaid overpayments totaling $23,407,983 ($14,483,814 Federal share) and interest earned on the overpayments totaling $129,605 ($82,028 Federal share) in accordance with Federal requirements. The State agency did not report these amounts because it did not develop and implement internal controls to ensure that overpayments identified from SUR audits and interest earned on recovered overpayments were reported on the CMS-64.

We recommend that the State agency:

- include unreported Medicaid overpayments totaling $23,407,983 on the CMS-64 and refund $14,483,814 to the Federal Government,

- include unreported interest earned on Medicaid recoveries totaling $129,605 on the CMS-64 and refund $82,028 to the Federal Government, and

- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments and interest earned on the overpayments on the CMS-64.

In written comments on our draft report, the State agency disagreed with our first and third recommendations and did not address our second recommendation. The State agency said it believes that CMS agreed with the State's interpretation that the 60-day period did not begin until the State had the authority under State law to recover funds after a final legal decision was rendered.

After reviewing the State agency comments, we maintain that our findings and recommendations are valid.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Marc Gustafson, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-07-00072.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

OCT - 3 2008

Report Number: A-05-07-00072

Mr. Jeffrey M. Wells
Director of Medicaid
402 W. Washington Street, Room W461
Indianapolis, Indiana 46204-2739

Dear Mr. Wells:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Indiana's Reporting Fund Recoveries for the Medicaid Rehabilitation Option Program on the CMS-64 for Fiscal Years 2000 to 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Lynn Barker, Audit Manager, at (317) 226-7833, extension 21, or through e-mail at Lynn.Barker@oig.hhs.gov. Please refer to report number A-05-07-00072 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INDIANA'S REPORTING FUND RECOVERIES FOR THE MEDICAID REHABILITATION OPTION PROGRAM ON THE FORM CMS-64 FOR FISCAL YEARS 2000 TO 2005

Daniel R. Levinson
Inspector General

October 2008
A-05-07-00072

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, (State agency) administers the Medicaid program. The State agency uses a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. The State agency contracted with Health Care Excel, Inc. (HCE), to conduct surveillance and utilization review (SUR) audits of Medicaid providers, including community mental health centers (CMHC) providing services under the Medicaid Rehabilitation Option (MRO) Program. When SUR audits identified overpayments, HCE, on behalf of the State agency, sent letters to the CMHCs identifying the overpayment amounts and applicable interest charges and directed the CMHCs to send payments to HCE.

Section 1903(d)(2) of the Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, and Federal regulations (42 CFR § 433.312) require the State agency to refund the Federal share of overpayments by the Medicaid program at the end of the 60-day period following the date of discovery, whether or not the State has recovered the overpayment. The date of discovery is the date that a provider was first notified in writing of an overpayment and the specified dollar amount subject to recovery (42 CFR § 433.316(c)). Federal regulations (42 CFR § 433.304) define an overpayment as " . . . the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for the services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." In addition, Federal regulations require the State agency to report interest earned on overpayments. Because the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64 (CMS-64), is due on a quarterly basis, the CMS "State Medicaid Manual" requires the Federal share of the overpayments be refunded no later than the quarter in which the 60-day period ends.

OBJECTIVE

Our objective was to determine whether Medicaid overpayments made under the MRO Program and identified by SUR audits and the interest earned on those overpayments were reported on the CMS-64 in accordance with Federal regulations.

SUMMARY OF FINDINGS

The State agency did not report Medicaid overpayments totaling $23,407,983 ($14,483,814 Federal share) and interest earned on the overpayments totaling $129,605 ($82,028 Federal share) in accordance with Federal requirements. The State agency did not report these amounts because it did not develop and implement internal controls to ensure that overpayments identified from SUR audits and interest earned on recovered overpayments were reported on the CMS-64.

Because the overpayments were not reported on the CMS-64, the Federal Government may have incurred increased interest expense of approximately $1.9 million.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments totaling $23,407,983 on the CMS-64 and refund $14,483,814 to the Federal Government,

- include unreported interest earned on Medicaid recoveries totaling $129,605 on the CMS-64 and refund $82,028 to the Federal Government, and

- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments and interest earned on the overpayments on the CMS-64.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first and third recommendations and did not address our second recommendation. The State agency said that, under State law and regulations, a provider may dispute any claim for overpayment and elect not to repay the amount pending a hearing and any subsequent appeal. The State agency said that it believes that CMS agreed with the State's interpretation that the 60-day period did not begin until the State had the authority under State law to recover funds after a final legal decision was rendered. In addition, the State agency said there may be an overlap in the recommended overpayment amounts with OIG audit report A-05-07-00057. The State agency also said it will review its internal control structure to determine if it can improve the timely reporting of overpayments recovered from providers and refund the Federal share.

After reviewing the State agency comments, we maintain that our findings and recommendations are valid. The State agency's policy and procedures do not conform to Federal requirements at section 1903(d)(2) of the Act and implementing regulations at 42 CFR § 433.316. We revised our finding and recommendation to exclude from our current review the overlap in overpayments from the prior OIG audit report.

The State agency comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Federal Government pays its share (Federal share) of State Medicaid expenditures according to a defined formula. To receive Federal reimbursement, State Medicaid agencies are required to report expenditures on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64 (CMS-64).

In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency) administers the Medicaid program. The State agency uses a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. The State agency contracted with HealthCare Excel, Inc. (HCE), to conduct surveillance and utilization review (SUR) audits of Medicaid providers, including community mental health centers (CMHC) providing services under the Medicaid Rehabilitation Option (MRO) Program. HCE conducted 42 SUR audits and issued 36 overpayment letters, on behalf of the State agency, to 26 CMHCs providing MRO services during our audit period. The overpayment letters identified the amount of the overpayment and applicable interest charges and directed the CMHCs to send payment to the HCE.

Federal Requirements for Medicaid Overpayments

Pursuant to the Medicaid statute and regulations, a State has 60 days from the discovery of a Medicaid overpayment to recover or attempt to recover the overpayment before the Federal share of the overpayment must be refunded to CMS. Section 1903(d)(2) of the Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, and Federal regulations at 42 CFR part 433, subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers," require a State to ". . . refund the Federal share of overpayments at the end of the 60-day period following discovery . . . whether or not the State has recovered the overpayment from the provider."[1] Pursuant to 42 CFR § 433.316(c), an overpayment that is not a result of fraud or abuse is discovered on the earliest date:

[1]Section 1903(d)(2)(C) and (D) of the Act and Federal regulations (42 CFR § 433.312) do not require the State to refund the Federal share of uncollectible amounts paid to bankrupt or out-of-business providers.

> (1). . . 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) . . . on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or (3) . . . 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.

Federal regulations (42 CFR § 433.304) define an overpayment as ". . . the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." In addition, Federal regulations at 42 CFR § 433.320 require that the State refund the Federal share of an overpayment through a credit on its CMS-64 submitted for the quarter in which the 60-day period following recovery ends.

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Therefore, when a State recognizes that an overpayment has been made, the overpayment and any associated interest earned must be reported on the CMS-64 as an adjustment to expenditures.

Federal Requirements for Interest Earned

Federal regulations at 45 CFR § 92.21(f)(2) state that ". . . grantees and subgrantees shall disburse program income, rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting additional [Federal] cash payments." Federal grant administration regulations at 45 CFR part 92 are applicable to the Medicaid program, effective September 8, 2003. For prior periods, similar provisions in 45 CFR part 74 were applicable. In addition, the Departmental Appeals Board (DAB) has determined that where Federal funds are used to produce interest payments, these payments constitute an applicable credit within the meaning of Office of Management and Budget Circular A-87 (now codified at 2 CFR part 225). CMS is entitled to a share in the amount of any interest collected (e.g., New Jersey Department of Human Services, DAB No. 480 (1983)).

Section 2500.1 of CMS's "State Medicaid Manual" instructs the State to report the Federal share of any interest received or earned on Medicaid recoveries on the CMS-64 Summary Sheet.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicaid overpayments made under the MRO Program and identified by SUR audits and the interest earned on those overpayments were reported on the CMS-64 in accordance with Federal regulations.

Scope

Our review covered the MRO overpayments identified by SUR audits that should have been reported on the CMS-64 during Federal fiscal years (FY) 2000 to 2005. During this period, SUR audits identified Medicaid overpayments related to the MRO Program[2] totaling $23,407,983 ($14,483,814 Federal share).

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the identification, collection, and reporting policies and procedures for Medicaid overpayments and related interest collected.

We performed fieldwork at the State agency and HCE offices in Indianapolis, Indiana, from August 2007 through January 2008.

Methodology

To accomplish our audit objective, we:

- reviewed Federal laws, regulations, and other requirements governing Medicaid overpayments and related interest earned;

- interviewed State agency and HCE officials regarding policies and procedures relating to SUR audits and reporting overpayments on the CMS-64;

- reviewed 36 SUR audit reports of SUR audits issued from January 1, 2000, to June 30, 2005, to identify Medicaid overpayments and related interest collected for MRO services that were subject to the 60-day rule;

- established the dates of discovery using the dates that HCE notified CMHCs in writing, on behalf of the State, of the overpayments and the dollar amount and interest subject to recovery;

- reviewed the CMHC's audited financial statements to determine whether the entity had ongoing business concerns, such as bankruptcy;

- determined the quarter in which the 60-day period following discovery of the overpayment ended;

- reviewed the CMS-64 to determine whether the Medicaid overpayments and interest earned were reported within the quarter in which the 60-day period following discovery ended;

[2]We did not include SUR-identified overpayments totaling $739,085 for MRO services provided during FY 2003 during this review. We previously audited MRO services provided by CMHCs during FY 2003 (A-05-05-00057) and recommended a financial recovery for services that did not meet Federal and State reimbursement requirements.

- reviewed the CMS-64 to determine whether Medicaid overpayments and interest collected were reported during any subsequent quarter through September 30, 2007; and

- computed the potentially higher interest expense to the Federal Government resulting from overpayments and income not reported within the required timeframe using the number of days between required reporting dates and the State FY ending June 30, 2007.[3]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not report Medicaid overpayments totaling $23,407,983 ($14,483,814 Federal share) and interest earned on the overpayments totaling $129,605 ($82,028 Federal share) in accordance with Federal requirements. The State agency did not report these amounts because it did not implement internal controls to ensure that overpayments identified from SUR audits and interest earned on recovered overpayments were reported on the CMS-64.

Because overpayments were not reported on the CMS-64, the Federal Government may have incurred increased interest expense of approximately $1.9 million.

OVERPAYMENTS NOT REPORTED

Pursuant to 42 CFR § 433.312(a)(2), the State agency ". . . must refund the Federal share of overpayments at the end of the 60-day period following discovery . . . whether or not the State has recovered the overpayment from the provider." The regulation provides an exception only when the State is unable to recover the overpayment amount because the provider is bankrupt or out of business (42 CFR §433.318).

As a result of SUR audits issued from October 1999 through September 2005, HCE issued 36 provider letters identifying Medicaid overpayments totaling $23,407,983 ($14,483,814 Federal share) to 26 CMHCs who were not bankrupt or out of business (Table 1).

[3]We calculated the interest expense using the applicable daily interest rates pursuant to the Cash Management Improvement Act of 1990, P.L. No. 101-453.

Table 1: Community Mental Health Center Overpayments Identified by HealthCare Excel, Inc.

Fiscal Year	Overpayment Amount
2000	$2,826,735
2001	2,421,492
2002	512,399
2003	3,171,729
2004	1,030,440
2005	13,445,188
Total	**$23,407,983**

At the time of our audit, HCE had identified the overpayments, notified the CMHCs, and recovered $3.3 million in overpayments. Another $20.1 million in overpayments remained outstanding. The State agency had not reported any of the $23.4 million ($14.5 million Federal share) on the CMS-64 in accordance with Federal requirements.

INTEREST NOT REPORTED

In accordance with Federal requirements, section 2500.1 of the "State Medicaid Manual" instructs State agencies to report interest earned on Medicaid recoveries on the CMS-64 Summary Sheet.

As a result of SUR audits issued from October 1999 through September 2005, the State agency earned interest totaling $129,605 ($82,028 Federal share) on the recovered overpayments (Table 2).

Table 2: Interest Collected on Overpayments

Fiscal Year	Overpayment Recovered	Interest Collected
2000	$451,599	$11,006
2001	1,065,172	15,602
2002	72,181	0
2003	1,077,376	57,218
2004	345,227	21,993
2005	289,567	23,786
Total	**$3,301,122**	**$129,605**

Although the State agency earned interest on the recovered overpayments, it did not report the $129,605 ($82,028 Federal share) on the CMS-64 in accordance with Federal requirements.

INTERNAL CONTROLS NOT IMPLEMENTED

The State agency did not develop and implement internal controls to ensure that it reported on the CMS-64 the Medicaid overpayments identified from SUR audits and interest earned from recovered overpayments.

POTENTIALLY HIGHER INTEREST EXPENSE

Because the State agency did not report the overpayments totaling $23,407,983 ($14,483,814 Federal share) on the CMS-64, the Federal Government did not have the use of these funds. As a result, the Federal Government potentially incurred an increased interest expense of approximately $1.9 million.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments totaling $23,407,983 on the CMS-64 and refund $14,483,814 to the Federal Government,

- include unreported interest earned on Medicaid recoveries totaling $129,605 on the CMS-64 and refund $82,028 to the Federal Government, and

- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments and interest earned on the overpayments on the CMS-64.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first and third recommendations and did not address the second recommendation. The State agency said that, under State law and regulations, a provider may dispute any claim for overpayment and may elect not to repay the amount pending a hearing and any subsequent appeal. The State agency said that it believes that CMS agreed with the State's interpretation that the 60-day period did not begin until the State had the authority under State law to recover funds after a final legal decision had been rendered. In addition, the State agency said there may be an overlap in the recommended overpayment amounts with OIG audit report A-05-07-00057. Although the State agency said that its current policies are consistent with CMS requirements, it said it will review its internal control structure to determine if it can improve the timely reporting of overpayments recovered from providers and refund the Federal share.

The State agency comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency comments, we maintain that our findings and recommendations are valid. We revised our finding and recommendation to exclude from our current review the overlap in overpayments from the prior OIG audit report.

Medicaid regulations at 42 CFR § 433.316(c)(1) specifically provide that an overpayment resulting from a situation other than fraud or abuse is discovered on the date on which 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. In its comments, the State agency recognized that Federal regulations at 42 CFR § 433.316(h) provide that appeal rights extended to a provider do not extend the date of discovery of an overpayment. CMS, in issuing these regulations, stated that the plain wording of sections 1903(d)(2)(C) and (D) of the Act does not permit the Federal government to delay adjustment to Federal financial participation by allowing the State a recovery period of more than 60 days while the State awaits the exhaustion of provider appeals or judicial review or the execution of repayment plans (54 Fed. Reg. 5452, 5455 (Feb. 3, 1989)). The DAB has affirmed that CMS is entitled to recover the Federal share of Medicaid overpayments before any recovery by the State (e.g., New York State Dept. of Social Services, DAB No. 810 (1986)).

The State agency said that it explained its overpayment recovery process to a CMS regional office official and that it understood that CMS approved a process under which the State would return the Federal share based on the date the State could finalize the amount and obtain recovery from the provider. The State agency has provided no documentation of those discussions. Furthermore, the DAB has established that the State is charged with being aware of the governing Federal law and regulations in operating its Medicaid program and that a Government agent cannot obligate the Government to pay funds in violation of statutory authority (e.g., Mississippi Div. of Medicaid, DAB No. 1305 (1992)).

The State agency's policy and procedures do not conform to Federal requirements at section 1903(d)(2) of the Act and implementing regulations at 42 CFR §433.316.

APPENDIX

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

People helping people

July 9, 2008

Mr. Marc Gustafson
Regional Inspector General for Audit Services
Office of Audit Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Draft Report A-05-07-00072

Dear Mr. Gustafson:

In response to your letter dated April 29, 2008 regarding audit report A-05-07-00072, "Review of Indiana Reporting of Medicaid Rehabilitation Option Program Fund Recoveries on the CMS-64," the Office of Medicaid Policy and Planning (OMPP) has reviewed the recommendations provided. The recommendations are summarized below, and the State's responses follow:

- Include unreported Medicaid overpayments totaling $24,147,068 on the CMS-64 and refund $14,943,721 to the Federal Government
- Include unreported interest earned on Medicaid recoveries totaling $129,605 on the CMS-64 and refund $81,312 to the Federal Government
- Develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments and interest earned on the overpayments on the CMS-64

State Response – Upon review, the State disagrees with most of the OIG's conclusions. The basic requirements stated in 42 CFR § 433.312 provide for refund of the federal share within 60 days of discovery of an overpayment. The rule states: (a)(1) "Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS." In 42 CFR § 433.316, titled "When discovery of overpayment occurs and its significance," the general rule states: "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." Subpart (b) states that a state official must notify the provider 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."

State statute and regulations allow a provider to dispute any claim for overpayment and to obtain an administrative hearing decision. Under these regulations, the provider may elect not to repay the amount pending the hearing and any subsequent appeal. See Ind. Code § 12-15-13-3(b); 405 Ind. Admin. Code § 1-1-5(d). Thus, the State may not recover or seek to recover an overpayment until a final legal decision has been rendered. Once a final legal decision has been rendered and repayment received from the provider, OMPP's policy is to report the overpayment to CMS and to return the federal portion within 60 days.

The State communicated and developed the conditions for this process with the CMS Region V accountant in charge to facilitate effective returns of the federal share through reporting on the CMS-64. During the CMS review, state officials explained that the State is unable to recover from the provider pending completion of the appeals process. The State understood that CMS was aware of these conditions and approved a process under which the State would return the federal share based on the date the State could finalize the amount and obtain recovery from the provider.

OMPP recognizes that subsection (h) of 42 C.F.R. 433.316 states that appeal rights extended to a provider do not extend the date of discovery. However, in view of CMS's awareness of and apparent acquiescence in the State's procedure, we believe CMS agreed with our interpretation that the sixty days did not begin running until the State had the authority under state law to recover the funds.

Separately, OMPP believes there may be significant overlap between the amount OIG has identified in this case and the amount it has recommended for refund in the final report in A-05-05-00057. In the latter audit, OIG extrapolated from a sample of Medicaid Rehabilitation Option claims, but the sample appears to have included claims that had previously been audited and disallowed by the State's fiscal agent. Such claims presumably were subject to recovery and likely are included in the figure OIG calculated for this audit. We believe the overlap should be identified before this audit is finalized. If OIG has already recommended refund of amounts that duplicate some of the overpayment amounts in this audit, OIG should not recommend refund of these amounts a second time.

OMPP further questions the OIG's calculation of "potentially higher interest expense" (at page 6 of the draft report). We are unaware of any basis for such a claim by the federal government. Since the draft report does not include a request to refund this alleged interest expense amount, we assume OIG is not taking the position that the State would owe any such amount.

OMPP believes its current policies are consistent with CMS's requirements. The State will review its current internal control structure to determine whether changes should be made to improve the timely reporting of amounts OMPP recovers from providers and refund of the federal share of such amounts. In addition, the State is prepared to discuss with CMS staff any

ways in which CMS believes the State should modify its process of recovering overpayments from providers and reporting to CMS going forward.

If you have any questions or concerns regarding the above, please contact either Terri Willits or Catherine Snider from my staff at 317-232-7053.

Sincerely,

Jeffrey M. Wells
Director of Medicaid