DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

June 22, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Delaware Did Not Comply With Federal Requirements To Report All Medicaid Overpayment Collections (A-03-11-00203)

Attached, for your information, is an advance copy of our final report on our review of Delaware's reporting of Medicaid overpayment collections. We will issue this report to Delaware's Division of Medicaid and Medical Assistance within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov, or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-11-00203.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION III
PUBLIC LEDGER BUILDING, SUITE 316
150 S. INDEPENDENCE MALL WEST
PHILADELPHIA, PA 19106

June 28, 2012

Report Number: A-03-11-00203

Ms. Rosanne Mahaney
Director
Division of Medicaid and Medical Assistance
1901 North DuPont Highway
New Castle, DE 19720

Dear Ms. Mahaney:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Delaware Did Not Comply With Federal Requirements To Report All Medicaid Overpayment Collections*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Leonard Piccari, Audit Manager, at (215) 861-4493 or through email at Leonard.Piccari@oig.hhs.gov. Please refer to report number A-03-11-00203 in all correspondence.

Sincerely,

/Stephen Virbitsky/
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, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DELAWARE DID NOT COMPLY WITH FEDERAL REQUIREMENTS TO REPORT ALL MEDICAID OVERPAYMENT COLLECTIONS

Daniel R. Levinson
Inspector General

June 2012
A-03-11-00203

Office of Inspector General

http://oig.hhs.gov

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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 Federal requirements. In Delaware, the Delaware Health and Social Services, Division of Medicaid and Medical Assistance (State agency), administers the Medicaid program.

Pursuant to section 1905(b) of the Act, States receive a Federal share for medical assistance based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, authorized the States to temporarily receive a higher FMAP (enhanced rate) during a specified recession adjustment period.

The Medicaid program is intended to be the payer of last resort. Section 1902(a)(25)(A) of the Act states that a State plan for medical assistance must provide that the State or local agency administering the plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan.

States claim medical assistance and administrative costs, and credit CMS with any refunds due, on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). CMS's Medicaid Budget and Expenditure System allows States to submit Form CMS-64 electronically.

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal requirements to report all Medicaid overpayment collections.

SUMMARY OF FINDINGS

The State agency did not comply with Federal requirements to report all Medicaid overpayment collections. Of the $16,293,609 Medicaid overpayments collected, the State agency failed to report $16,272,518 ($10,080,378 Federal share). State agency officials said that they believed the overpayments had been netted out of reported Medicaid expenditures but did not provide support for such an adjustment.

The State agency reported on Form CMS-64 collections totaling $21,091 for overpayments that it identified as recoveries resulting from fraud and abuse investigations but calculated a Federal share of $10,552 based on an incorrect FMAP. Using the correct FMAP, the State agency should have reported a Federal share of $12,943. The incorrect calculation resulted in a $2,391

understatement of the Federal share. The State agency based its calculation on the FMAP in effect before the Recovery Act increased the Federal share but did not provide support that the claims had been paid at the lower rate.

The State agency did not properly report its collections for Medicaid overpayments because it did not develop and implement effective internal controls to ensure accurate reporting on Form CMS-64.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayment collections of $16,272,518 on the next Form CMS-64 and refund $10,080,378 to the Federal Government,
- identify and report any unreported Medicaid overpayments collected before and after our audit period,
- account for the incorrectly calculated Federal share for the collections resulting from fraud and abuse investigations by refunding $2,391 to the Federal Government,
- apply the correct FMAP when reporting Medicaid overpayments on Form CMS-64, and
- develop and implement internal controls that will enable the State agency to correctly report and refund the Federal share of Medicaid overpayments on Form CMS-64.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our second, third, and fourth recommendations and described steps that it has taken to address them. The State agency partially concurred with our fifth recommendation. The State agency said that it had not completed system enhancements to correctly report Medicaid overpayments on the Form CMS-64 because of other federally mandated priorities, but that it had properly refunded the Federal share of overpayments. The State agency did not concur with our first recommendation. The State agency agreed that overpayments were not reported separately on the Form CMS-64, as instructed in the State Medicaid Manual, but stated that Delaware's Form CMS-64 reports do reflect the collections as an offset to expenditures. The State agency further stated that we acknowledged this process of netting collections against expenditures in a prior report.

The State agency's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Both our current and prior reports showed that Delaware incorrectly netted unspecified collections out of expenditures before reporting the expenditures on the Form CMS-64 and recommended that the State agency implement internal controls to properly report overpayments

and refund the Federal share on Line 9 of the Form CMS-64. The State agency has not amended its internal controls. As a result, although the State agency was able to show that the collections were entered into the Medicaid Management Information System, it did not support that the specific Medicaid overpayments we reviewed had, in fact, been carried through to the netted expenditures on the Form CMS-64. Therefore, we maintain that our findings and recommendations are valid.

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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 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 Federal requirements. In Delaware, the Delaware Health and Social Services, Division of Medicaid and Medical Assistance (State agency), administers the Medicaid program.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance costs under Medicaid (Federal share) based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. States with a lower per capita income relative to the national average are reimbursed a greater share of their costs. States with a higher per capita income are reimbursed a lesser share. By law, the FMAP cannot be lower than 50 percent. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time. In fiscal year 2009, the FMAPs initially ranged from a low of 50 percent to a high of 75.84 percent, depending on the State.

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, authorized the States to temporarily receive a higher FMAP (enhanced rate) during a specified recession adjustment period. The enhanced rates ranged from 56.20 percent to 84.86 percent. During our audit period, Delaware's FMAP ranged from 60.19 percent to 64.38 percent.

States claim medical assistance and administrative costs, and credit CMS with any refunds due, on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). CMS's Medicaid Budget and Expenditure System allows States to submit Form CMS-64 electronically.

Payer-of-Last-Resort Requirement

The Medicaid program is intended to be the payer of last resort. Pursuant to section 1902(a)(25)(A) of the Act, a State plan for medical assistance must provide that the State or local agency administering the plan take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan. Third parties include health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, and other parties that are responsible for payment of a claim for a health care item or service.

Federal Requirements for Medicaid Overpayments

Section 1903(d)(2) of the Act requires States to refund the Federal share of Medicaid overpayments. Payments for which a third party has directly reimbursed the State are treated as overpayments. Federal regulations (42 CFR § 433.140(c)) require States that receive third-party reimbursement to pay the Federal Government its portion of the reimbursement in accordance with the FMAP for that State. Medicaid payments to providers who have been reimbursed by a liable third party for the same services are also unallowable overpayments. Federal regulations (42 CFR § 433.312) require the State to refund the Federal share of those provider overpayments at the appropriate FMAP rate.[1]

The State Agency's Third-Party Liability Services Vendor

The State agency contracts with Hewlett Packard, a fiscal agent, for Medicaid claims processing. The fiscal agent contracts with a third-party liability services vendor that reviews the State agency's Medicaid claims and determines whether any claims should have been paid by a third party. The vendor identifies overpayments, some of which the third party pays directly to the State agency and some of which the State agency collects through provider disallowance of future payments. The State agency also identifies and collects various overpayments through its own efforts and through its Audit and Recovery Management Services Section (Audit and Recovery).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with Federal requirements to report all Medicaid overpayment collections.

Scope

Our review covered identified collections of Medicaid overpayments totaling $16,293,609 that the State should have reported on Form CMS-64 during the period January 1, 2009, through December 31, 2010.

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 of program income from Medicaid overpayments.

We performed fieldwork at the State agency offices in New Castle, Delaware, from January through June 2011.

[1] Pursuant to sections 1903(d)(2)(C) and (D) of the Act and Federal regulations (42 CFR § 433.312(b)), States are not required to refund the Federal share of uncollectable amounts paid to bankrupt or out-of-business providers.

Methodology

To accomplish our audit objective, we:

- reviewed Federal laws, regulations, and guidance governing the collection of Medicaid overpayments;
- interviewed State agency officials regarding policies and procedures for reporting collections of Medicaid overpayments on Form CMS-64;
- interviewed the State agency's fiscal agent regarding procedures for processing claims;
- interviewed the fiscal agent's subcontractor regarding procedures for identifying third-party liabilities and collecting overpayments;
- obtained summary and claims information for all program income from Medicaid collections for the audit period;
- reviewed collections of Medicaid overpayments to determine whether they were processed directly through the State agency's Medicaid Management Information System and included on the correct lines of Form CMS-64; and
- reviewed the State agency's Form CMS-64 and supporting documentation to determine whether the collection of Medicaid overpayments was reported properly.

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 objectives. 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 comply with Federal requirements to report all Medicaid overpayment collections. Of the $16,293,609 Medicaid overpayments collected, the State agency failed to report $16,272,518 ($10,080,378 Federal share). State agency officials said that they believed the overpayments had been netted out of reported Medicaid expenditures but did not provide support for such adjustments.

The State agency reported on Form CMS-64 collections totaling $21,091 for overpayments that it identified as recoveries resulting from fraud and abuse investigations but calculated a Federal share of $10,552 based on an incorrect FMAP. Using the correct FMAP, the State agency should have reported a Federal share of $12,943. The incorrect calculation resulted in a $2,391 understatement of the Federal share. The State agency based its calculation on the FMAP in effect before the Recovery Act increased the Federal share but did not provide support that the claims had been paid at the lower rate.

The State agency did not properly report its collections for Medicaid overpayments because it did not develop and implement effective internal controls to ensure accurate reporting on Form CMS-64.

COLLECTIONS OF MEDICAID OVERPAYMENTS

Federal Requirements and Guidance

Section 1903(d)(2)(A) of the Act requires the Secretary of Health and Human Services to recover Medicaid overpayments. Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." Section 1902(a)(25)(A) of the Act identifies third-party liability as the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. Pursuant to section 1903(d)(2)(B), the Federal share of Medicaid payments for which the State has been reimbursed directly by a third party is treated as an overpayment. In addition, Medicaid payments to providers who received third-party payments for the same services would be unallowable provider overpayments and, as such, must be refunded under section 1903(d)(2)(A). Under the same provision, estate recoveries are also treated as overpayments and must be refunded to CMS.

Section 2500.1(B) of the State Medicaid Manual (the Manual) instructs States to report collections of Medicaid overpayments on Line 9 of Form CMS-64 and return the Federal share of those overpayments. State agencies should report:

- third-party liability collections on Line 9.A,
- estate probate collections on Line 9.B, and
- collections it identified as recoveries resulting from fraud and abuse investigations on Line 9.C.

Collections Not Reported

The State agency failed to report collections for Medicaid overpayments totaling $16,272,518 ($10,080,378 Federal share). These collections included third-party liability payments and disallowances, estate probate collections, and collections it identified as recoveries resulting from fraud and abuse investigations.

Third-Party Liability Collections

The State agency did not report on Line 9.A of Form CMS-64 $10,656,981 ($6,603,157 Federal share) in third-party liability collections.

- The third-party liability vendor identified $9,110,107 ($5,644,663 Federal share) that the liable third parties had not paid. The vendor instructed the parties to deposit that amount into a State-owned bank account. The third-party liability vendor then notified the fiscal agent when the collections had been made. However, the State agency did not report the collections on Form CMS-64.

- The third-party liability vendor identified $1,546,874 ($958,494 Federal share) in disallowances of overpayments to providers who received payments for the same service from both the Medicaid program and Medicare or a private insurer. The third-party liability vendor notified the State agency of the overpayments and the State agency withheld payments for the providers' later claims to cover the identified amounts. However, the State agency did not report the withheld payments as collections on Form CMS-64.

Estate Probate and Injury Settlement Collections

The State agency did not report on Line 9.B of Form CMS-64 $5,612,050 ($3,475,023 Federal share) in overpayments collected through recoveries from estates and trauma and injury settlements. These overpayments represented amounts the State agency collected from a recipient's estate or medical settlement to recoup prior Medicaid payments made on behalf of the recipient.

Fraud and Abuse Collections

The State agency did not report on Line 9.C of Form CMS-64 $3,487 ($2,198 Federal share) in overpayments collected as a result of fraud and abuse investigations. Audit & Recovery identified the overpayments in its reviews and the State agency collected them from Medicaid recipients during the third and fourth quarters of calendar year (CY) 2010.

Inadequate Internal Controls

The State agency did not have adequate internal controls to assure that it properly reported its collections from Medicaid overpayments. The collections were combined with various other adjustments and entered as an aggregate amount into the Medicaid Management Information System (MMIS). However, the State agency did not have internal controls to verify or track the collections once they entered the MMIS or to report them correctly on Form CMS-64. State agency officials said that they believed the aggregate amount was netted with expenditures in the MMIS before the expenditures were reported on Form CMS-64 but could not provide support for this explanation.

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGE RATE

Federal Requirements and Guidance

Federal regulations (42 CFR § 433.140(c)) require any State that receives a Federal share in Medicaid payments for which it receives third-party reimbursement to pay the Federal

Government its portion of the reimbursement determined in accordance with the FMAP for that State.

According to the Manual, section 2500.6(B), the State agency must "upon receipt of such refunds, determine the date or period of the expenditure for which the refund is made to establish the FMAP at which the original expenditure was matched by the Federal government. Make refunds of the Federal share at the FMAP for which you were reimbursed." Section 2500.6 further states, "When collections cannot be related to a specific period, compute the Federal share at the FMAP in effect at the time the collection was received."

Incorrect Federal Medical Assistance Percentage Rate Used

For CY 2009 and the first two quarters of CY 2010, the State agency reported a total of $21,091 in collections resulting from fraud and abuse investigations. However, the State agency used an incorrect FMAP for calculating the Federal share for those collections. The State agency reported a Federal share of $10,552, which it calculated based on an incorrect FMAP of 50 percent. Using the correct FMAP for each reporting quarter, the State agency should have reported a Federal share of $12,943. This resulted in a $2,391 understatement of the Federal share.

State agency officials said that they believed the accounting system netted the collections out of expenditures before the expenditures were reported on Form CMS-64. Therefore, officials did not adjust the accounting system to reflect the enhanced rate for Line 9. When Audit & Recovery reported some collections on Line 9.C, the accounting system based the calculation on the lower FMAP in effect before the Recovery Act increased the Federal share. However, the State agency did not provide support that the claims had been paid at the lower rate. According to CMS guidance in the Manual, because the collections could not be related to a specific period, the State agency should have computed the Federal share at the rate in effect at the time the collection was received.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayment collections of $16,272,518 on the next Form CMS-64 and refund $10,080,378 to the Federal Government,

- identify and report any unreported Medicaid overpayments collected before and after our audit period,

- account for the incorrectly calculated Federal share for the collections resulting from fraud and abuse investigations by refunding $2,391 to the Federal Government,

- apply the correct FMAP when reporting Medicaid overpayments on Form CMS-64, and

- develop and implement internal controls that will enable the State agency to correctly report and refund the Federal share of Medicaid overpayments on Form CMS-64.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our second, third, and fourth recommendations and described steps that it has taken to address them. The State agency partially concurred with our fifth recommendation. The State agency said that it had not completed system enhancements to correctly report Medicaid overpayments on the Form CMS-64 because of other federally mandated priorities, but that it had properly refunded the Federal share of overpayments. The State agency did not concur with our first recommendation. The State agency agreed that overpayments were not reported separately on the Form CMS-64, as instructed in the Manual, but stated that Delaware's Form CMS-64 reports do reflect the collections as an offset to expenditures. The State agency further stated that we acknowledged this process of netting collections against expenditures in a prior report.

The State agency's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Our audit showed that Delaware's accounting system had not been adjusted to correctly report Medicaid overpayments. Both our current and prior reports[2] showed that Delaware incorrectly netted unspecified collections out of expenditures before reporting the expenditures on the Form CMS-64 and recommended that the State agency implement internal controls to properly report overpayments and refund the Federal share on Line 9 of the Form CMS-64. The State agency has not amended its internal controls. As a result, although the State agency was able to show that the collections were entered into the MMIS, it did not support that the specific Medicaid overpayments we reviewed had, in fact, been carried through to the netted expenditures on the Form CMS-64. Therefore, we maintain that our findings and recommendations are valid.

OTHER MATTER: REPORTING SYSTEM ERRORS

According to the Manual, section 2500.1(B), States are to use Line 9—Collections—of Form CMS-64 for "all collections received during the quarter." However, we noted that for five quarters, from October 1, 2009, through December 31, 2010, the State agency incorrectly reported adjustments to waiver claims as overpayment collections on Line 9 of Form CMS-64. Because CMS's Medicaid Budget and Expenditure System would not accept negative adjustments electronically submitted on Form CMS-64.9 waiver schedules, CMS instructed the State agency to record those adjustments on Line 9 of Form CMS-64. However, waiver adjustments do not represent collections of Medicaid overpayments as described in the Manual.

[2] *Review of Delaware's Accounts Receivable System for Medicaid Provider Overpayments*, (A-03-04-00205), issued October 13, 2004.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR

March 14, 2012

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Report Number: A-03-11-00203

Dear Mr. Virbitsky:

Thank you for the opportunity to review the DHHS, Office of Inspector General's draft report entitled *Delaware Did Not Comply with Federal Requirements to Report All Medicaid Overpayment Collections*. Please find Delaware's response to the OIG recommendations below.

Recommendation 1: We recommend that the State agency include unreported Medicaid overpayment collections of $16,272,518 on the next Form CMS-64 and refund $10,080,378 to the Federal Government.

Delaware does not concur with this recommendation. The State's MMIS does identify and report all collections at the point they are dispositioned, but it does not currently differentiate between the types of collections and recovered overpayments. Collections are used to offset the weekly paid claims to ensure that the Federal government is fully credited for collected overpayments. The net expenditure is reported on the CMS-64. Delaware concedes that overpayments were not reported separately on the CMS-64 in the prescribed format. Nevertheless, Delaware's CMS-64 reports do reflect the collections as an offset to expenditures.

The OIG report states that "State Agency officials said they believed the accounting system netted the collections out of expenditures before the expenditures were reported on the Form CMS-64 but could not provide support for this explanation." The State strongly disagrees with this description. Delaware is certain that net expenditures reported on the CMS-64 reflect overpayment collections. During the spring of 2011, staff from DHSS and the Medicaid fiscal agent, HPES, provided detailed, transaction-level reports that demonstrated to the satisfaction of the onsite OIG reviewers that Delaware's MMIS process netted out recoupments from expenditures within a reporting quarter. This documentation, which

included wire transfers, invoices, bank statements, and funding reports, was provided for a subset of the total collections. That same process, however, is applied to all collections, thereby enabling the State to be confident in stating that each quarterly federal claim is net of collections, even though the collections were not reported separately on the CMS-64.

Additionally, the process of netting collections against expenditures in Delaware has been acknowledged by the OIG in the past and was documented in OIG Report Number A-03-04-00205. In that review, the OIG reviewed Delaware's Accounts Receivable System for Medicaid Provider Overpayments. The report included the following:

> *The Department does not have an accounting system that separately identifies collected overpayments from other collections. Through its fiscal agent, the Department enters each overpayment identified after June 30, 2003 into the MMIS as an account receivable. The MMIS is not set up to separate overpayment collections from other collections, but instead consolidated all account receivables collected through recoupments, refunds and voided claims. The Department then netted the collections against expenditures reported on the CMS-64. For fiscal year 2003, the Department netted $89.2 million in collections against expenditures. The Department could not identify what portion of the $89.2 million represented overpayments that should have been reported on the CMS-64.*

That report, while pointing out that overpayments were incorrectly reported on the CMS-64, did not conclude that the State had failed to properly account for collected overpayments as it related to the State's federal claim. Consequently, there was no recommendation to refund any part of the collected overpayments to the Federal government. Delaware did concur with recommendation to modify its claims processing system and CMS-64 reporting procedures to accurately report overpayments on the CMS-64. While the State has begun work to enable the MMIS to separate overpayment collections by the reporting categories on the CMS-64, completion has been delayed as a result of higher priority projects to comply with federal mandates under the Deficit Reduction Act, Affordable Care Act, HIPAA 5010 and ICD-10, etc. MMIS changes that must be made related to the mandated RAC audits will facilitate the State's ability to report other types of collections separately.

Recommendation 2: We recommend that the State agency identify and report any unreported Medicaid overpayments collected before and after our audit period.

The State concurs with this recommendation and is working toward being able to report overpayments by the specified categories on the CMS-64. Delaware wishes to reiterate, however, that state's federal Medicaid claims have been reduced by the amount of the overpayment collections before, during and after the audit period.

Recommendation 3: We recommend that the State agency account for the incorrectly calculated Federal share for the collections resulting from fraud and abuse investigations by refunding $2,391 to the Federal Government.

The State concurs with this recommendation and will make the necessary adjustment on the next CMS-64 report.

Recommendation 4: We recommend that the State agency apply the correct FMAP when reporting Medicaid overpayments Form CMS-64

The State concurs with this recommendation and is amending collections and reporting procedures in the Audit and Recovery Management Services unit to assure the application of the correct FMAP.

Recommendation 5: We recommend that the State agency develop and implement internal controls to correctly report and refund the Federal share of Medicaid overpayments on Form CMS-64.

The State believes that this recommendation involves two separate issues: 1) correct reporting on the CMS-64 and 2) refunding the Federal share of Medicaid overpayments.

Delaware concurs with the recommendation to develop controls to correctly report overpayments on the CMS-64. As noted above, the State has initiated efforts to modify the MMIS so that overpayments could be reported separately and will continue to advance this work as resources permit. Unfortunately, these system enhancements have not been completed due to federally mandated projects which have assumed a higher priority.

The State contends that the Federal share of Medicaid overpayments have been correctly refunded to the Federal government.

I appreciate the opportunity to respond to the draft report and hope that the final report will be amended to reflect Delaware's concerns with the findings. If you have any questions, please contact Linda Murphy at 302-255-9801.

Sincerely,

Rosanne Mahaney
Director

cc: Stephen Groff
Beth Laucius
Linda Murphy
Harry Roberts