DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

September 14, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

/Joe J. Green/ for
FROM: George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2008 and 2009 (A-05-09-00103)

Attached, for your information, is an advance copy of our final report on Michigan's reporting fund recoveries for State Medicaid programs on the Form CMS-64 for Federal fiscal years 2008 and 2009. We will issue this report to the Michigan Department of Community Health 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 Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or James C. Cox, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through email at James.Cox@oig.hhs.gov. Please refer to report number A-05-09-00103.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

September 17, 2010

Report Number: A-05-09-00103

Ms. Janet Olszewski
Director
Michigan Department of Community Health
201 Townsend Street
Lansing, MI 48913

Dear Ms. Olszewski:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2008 and 2009*. 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 Lynn Barker, Audit Manager, at (317) 226-7833, extension 21, or through email at Lynn.Barker@oig.hhs.gov. Please refer to report number A-05-09-00103 in all correspondence.

Sincerely,

/James C. Cox/
Regional Inspector General
for Audit Services

Enclosure

cc:
Ms. Pam Myers
Audit Liaison
Michigan Department of Community Health

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 & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MICHIGAN'S REPORTING FUND RECOVERIES FOR STATE MEDICAID PROGRAMS ON THE FORM CMS-64 FOR FEDERAL FISCAL YEARS 2008 AND 2009

Daniel R. Levinson
Inspector General

September 2010
A-05-09-00103

Office of Inspector General

http://oig.hhs.gov

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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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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.

The State Medicaid agency uses a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. In Michigan, the Department of Community Health (State agency) administers the Medicaid program. The State agency, through the Medicaid Integrity Program section, Hospital Health Plan Reimbursement division, and Long Term Care division, conducted audits of Medicaid providers. In addition, the State agency contracted with Michigan Peer Review Organization and ACS Heritage to conduct audits of Medicaid providers. The Michigan Office of the Auditor General (OAG) and the Medicaid Fraud Control Unit (MFCU) conducted audits and investigations, respectively, of Medicaid providers. When any of these organizations identified overpayments, the State agency sent letters to the provider that (1) identified the overpayment amounts and (2) directed the providers to send payments to the State agency or notified providers of future payment offsets. The OAG sent notice to the State agency of overpayments identified through its federally required audits. Providers were notified of fraud and abuse-related overpayment amounts determined through settlements resulting from MFCU investigations.

Section 1903(d)(2) of the Act requires the State to refund the Federal share of a Medicaid overpayment. Implementing regulations (42 CFR § 433.312) require the State Medicaid agency to refund the Federal share of an overpayment to a provider at the end of the 60-day period following the date of discovery, whether or not the State Medicaid agency has recovered the overpayment. The date of discovery for situations other than fraud or abuse 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)). For provider overpayments resulting from fraud or abuse, discovery occurs on the date of the State's final written notice of the overpayment determination (42 CFR § 433.316(d)). 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." 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 reported no later than the quarter in which the 60-day period ends.

OBJECTIVE

Our objective was to determine whether Medicaid overpayments were reported on the CMS-64 in accordance with Federal regulations.

SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. Of the 134 overpayments we reviewed, 15 were partially reported or not reported on the CMS-64. The remaining 119 were reported correctly or were not required to be reported. The State agency also did not report all Medicaid provider overpayments within the 60-day time requirement. For Federal fiscal years 2008 and 2009, we estimated that the State agency did not report Medicaid overpayments totaling $2,340,182 ($1,320,131 Federal share) in accordance with Federal requirements.

The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on the CMS-64.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $2,340,182 on the CMS-64 and refund $1,320,131 to the Federal Government and

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

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and said that it had refunded part of the overpayments and would refund additional overpayments at a later time. The State agency's comments are included in their entirety as Appendix C.

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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).

The State Medicaid agency implements a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. In Michigan, the Department of Community Health (State agency) administered the Medicaid program. The State agency, through the Medicaid Integrity Program section (MIP), Hospital Health Plan Reimbursement division (HHPRD), and Long Term Care division (LTC), conducted audits of Medicaid providers. In addition, the State agency contracted with Michigan Peer Review Organization (MPRO) and ACS Heritage to conduct surveillance and utilization review audits of Medicaid providers. The Michigan Office of the Auditor General (OAG) conducted federally required audits and provided overpayment findings to the State agency. The State Medicaid Fraud Control Unit (MFCU) obtained settlements from Medicaid providers in situations related to fraud or abuse investigations. All together, the OAG, MIP, HHPRD, LTC, MFCU, and MPRO and ACS Heritage issued 2,119 audit reports, settlement agreements, and overpayment letters to the State agency or Medicaid providers on behalf of the State agency. The reports, agreements, and letters identified the amounts of the overpayments. In addition, the agreements and letters directed the providers to send payment to the State agency or notified providers of future payment offsets.

Federal Requirements for Medicaid Overpayments

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Section 1903(d)(2)(A) of the Act requires the Secretary of Health & Human Services to recover the amount of a Medicaid overpayment. 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." A State has 60 days from the discovery of a Medicaid overpayment to a provider to recover or attempt to recover the overpayment before the Federal share of the overpayment must be refunded to

CMS.[1] Section 1903(d)(2)(C) of the Act and Federal regulations at 42 CFR part 433, subpart F, 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.[2] 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) ... 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.

Pursuant to 42 CFR § 433.316(d), an overpayment resulting from fraud or abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider. For overpayments identified through Federal reviews, 42 CFR § 433.316(e) provides that an overpayment is discovered when the Federal official first notifies the State in writing of the overpayment and the dollar amount subject to recovery.

In addition, Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its quarterly Form CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicaid overpayments were reported on the CMS-64 in accordance with Federal regulations.

Scope

Our review covered Medicaid provider overpayments that were identified in audit reports, settlement agreements, and overpayment letters issued to providers that should have been reported on the CMS-64 during Federal fiscal years (FY) 2008 and 2009. We reviewed 134 of the 1,624 identified overpayments totaling $279,218,229. The identified audit reports, settlement

[1] Effective March 23, 2010, section 6506 of the Patient Protection and Affordable Care Act (P.L. No. 111-148) provides an extension period for the collection of overpayments. Except in the case of overpayments due to fraud, States have up to 1 year from the date of discovery of a Medicaid overpayment to recover, or to attempt to recover, the overpayment before making an adjustment to refund the Federal share of the overpayment. For overpayments identified before the effective date, the previous rules on discovery of overpayments remain in effect.

[2] 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 uncollectable amounts paid to bankrupt or out-of-business providers.

agreements, and overpayment letters represented overpayments of $1,000 or more for Medicaid services that were subject to the 60-day rule.

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.

We performed fieldwork at the State agency offices in Lansing, Michigan, from August 2009 through March 2010.

Methodology

To accomplish our audit objective, we:

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

- interviewed State agency officials regarding policies and procedures relating to Medicaid overpayments subject to the 60-day rule and reporting overpayments on the CMS-64;

- identified 1,624 overpayments of $1,000 or more for Medicaid services subject to the 60-day rule, which totaled $279,218,229;

- selected a stratified random sample of 134 overpayments: 100 from the 1,590 overpayments of $1,000 to $1 million and all 34 overpayments of more than $1 million (Appendix A);

- established the dates of discovery using the dates that the State agency notified Medicaid providers in writing of the overpayments and the dollar amount subject to recovery;

- established dates of discovery using the date the OAG sent a copy to the State agency of the written audit report of the overpayment amount subject to recovery;

- 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 were reported within the quarter in which the 60-day period following discovery ended;

- reviewed the CMS-64 to determine whether Medicaid overpayments were reported during any subsequent quarter through December 31, 2009;

- determined whether overpayments were processed directly through the Medicaid Management Information System and included on other lines of the CMS-64;

- determined if providers selected as part of our sample were bankrupt or out of business;

- estimated, based on the results of our stratified sample, the value of overpayments in the sample frame that were not reported during the audit period of FYs 2008 and 2009 (Appendix B); 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 FY ending September 30, 2009.[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 all Medicaid overpayments in accordance with Federal requirements. Of the 134 overpayments we reviewed, 15 were partially reported or not reported on the CMS-64. The remaining 119 were reported correctly or were not required to be reported. The State agency also did not report all Medicaid provider overpayments within the 60-day time requirement. For Federal FYs 2008 and 2009, we estimated that the State agency did not report Medicaid overpayments totaling $2,340,182 ($1,320,131 Federal share) in accordance with Federal requirements.

Because the State agency did not report all overpayments and was not always timely in reporting, the Federal Government incurred a potentially higher interest expense. Because the overpayments were not properly reported on the CMS-64, the Federal Government may have incurred increased interest expense of $8,655.

The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on the CMS-64.

OVERPAYMENTS NOT REPORTED

Pursuant to 42 CFR § 433.312(a)(2), the State Medicaid 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).

[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.

For Federal FYs 2008 and 2009, we estimated that the State agency did not report Medicaid overpayments totaling $2,340,182 ($1,320,131 Federal share) in accordance with Federal requirements. Of the 134 overpayments we reviewed, 15 overpayments were partially reported or not reported on the CMS-64. Specifically:

- Of the 100 randomly selected overpayments of $1,000 to $1 million,[4] 11 were partially reported or not reported on the CMS-64 and totaled $407,685 ($229,994 Federal share). Based on the sample results, we estimate that $696,472 ($394,424 Federal share) of the Medicaid overpayments between $1,000 and $1 million were not reported on the CMS-64.

- Of the 34 overpayments that exceeded $1 million, 4 were partially reported or not reported on the CMS-64 and totaled $1,643,710 ($925,707 Federal share).

OVERPAYMENTS NOT REPORTED TIMELY

Pursuant to 42 CFR § 433.312(a)(2), the State Medicaid 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." For situations other than fraud and abuse, Federal regulations (42 CFR § 433.316(c)) define the date of discovery as the date that a provider was first notified in writing of an overpayment and the specified dollar amount subject to recovery. For overpayments resulting from fraud or abuse, the date of discovery is defined at 42 CFR § 433.316(d) as the date of the final written notice of the overpayment determination that the State sends to the provider. For overpayments identified through Federal reviews, CMS will consider the overpayment discovered on the date the Federal official first notifies the State in writing of the overpayment amount. These regulations do not allow for extending the date.

The State agency did not report all Medicaid provider overpayments in accordance with the 60-day requirement. Of the 134 sampled overpayments, the State agency reported 108 overpayments on the CMS-64, which included 3 overpayments that were only partially reported. For the 108 overpayments that were reported, 28 overpayments totaling $6,355,037 ($3,868,327 Federal share) were not reported on the CMS-64 at the end of the 60-day period. The untimely reporting resulted from using the date of the final decision for non-fraud and abuse overpayments or the date that the State agency collected the overpayment rather than the date of discovery.

POTENTIALLY HIGHER INTEREST EXPENSE

Because the State agency did not report some overpayments and was not timely in reporting others, the Federal Government did not have the use of these funds. As a result, the Federal Government potentially incurred an increased interest expense of $8,655. However, we did not include this Federal interest expense in the amount of the overpayments we recommend that the State agency should refund.

[4] Five of the selected sample items were not required to be reported on the CMS-64. One overpayment was reduced to zero in our audit period, one was a voided transaction, and three represented overpayments due to providers.

INTERNAL CONTROLS NOT IMPLEMENTED

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

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $2,340,182 on the CMS-64 and refund $1,320,131 to the Federal Government and

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

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and said that it had refunded part of the overpayments and would refund additional overpayments at a later time. The State agency's comments are included in their entirety as Appendix C.

OTHER MATTERS

The State agency did not report Medicaid overpayments from State Medicaid audits on the correct line of the CMS-64. Of the 108 sampled overpayments that were reported on the CMS-64, 90 were reported incorrectly. In addition, the State agency did not report Medicaid overpayments from State Medicaid audits at the correct Federal medical assistance percentages (FMAP). Currently, the State agency reports Medicaid overpayments at the current quarter FMAP rate, rather than the FMAP rate current at the time the claim was submitted on the CMS-64.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid overpayments that should have been reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64) during fiscal years (FY) 2008 and 2009 (October 1, 2007 through September 30, 2009).

SAMPLING FRAME

The Michigan Department of Community Health (State agency) provided lists of Medicaid provider overpayments identified by the State agency, all its contractors, the Medicaid Fraud Control Unit, and the Office of the Auditor General for FYs 2008 and 2009. The sampling frame was limited to overpayments exceeding $1,000.

The sampling frame was an Excel file containing 1,624 Medicaid overpayments with a total projected recovery of $279,218,229. We separated the sampling frame into two strata. Stratum 1 consisted of 1,590 Medicaid provider overpayments from $1,000 to $1,000,000, with a total projected recovery of $102,418,816. Stratum 2 consisted of 34 Medicaid provider overpayments of more than $1,000,000, with a total projected recovery of $176,799,413.

SAMPLE UNIT

The sample unit was a Medicaid provider overpayment.

SAMPLE DESIGN

We used a stratified random sample, defined as follows:

Stratum 1: 1,590 Medicaid overpayments of $1,000 to $1 million.

Stratum 2: 34 Medicaid provider overpayments of more than $1 million.

SAMPLE SIZE

We selected a random sample of 100 items from the 1,590 Medicaid provider overpayments in stratum 1 and reviewed all 34 sample items in stratum 2.

SOURCE OF RANDOM NUMBERS

Random numbers were generated by the Department of Health & Human Services, Office of Inspector General (OIG), Office of Audit Service's (OAS) RAT-STATS statistical software package.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of Medicaid provider overpayments not properly reported.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Overpayments Not Reported Properly in Sample	Value of Overpayments Not Reported Properly in Sample
1	1,590	$102,418,816	100	$9,955,950	11	$407,685
2	34	$176,799,413	34	$176,799,413	4	$1,643,710
Totals	1,624	$279,218,229	134	$186,755,363	15	$2,051,395

Estimated Medicaid Overpayments Not Reported Properly on the CMS-64

(Limits Calculated for a 90-percent Confidence Interval)

Overall	Total Unallowable	Federal Share
Lower Limit	$2,340,182	$1,320,131
Point Estimate	$8,125,899	$4,582,618
Upper Limit	$13,911,617	$7,845,105

APPENDIX C: STATE AGENCY COMMENTS

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

July 28, 2010

Mr. James C. Cox
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

Re: Report Number (A-05-09-00103)

Dear Mr. Cox:

Enclosed is the Michigan Department of Community Health's response to the draft report entitled "Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2008 and 2009".

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Pam Myers at (517) 373-1508.

Sincerely,

Janet Olszewski
Director

JO:kk

Enclosure

cc: Steve Fitton
Mary Jane Russell
Pam Myers
Tim Becker

Review of Michigan's Reporting Fund Recoveries for
State Medicaid Programs on the Form CMS-64
for Fiscal Years 2008 and 2009
(A-05-09-00103)

Finding

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. Of the 134 overpayments we reviewed, 15 were partially reported or not reported on the CMS-64. The remaining 119 were reported correctly or were not required to be reported. The State agency also did not report all Medicaid provider overpayments within the 60-day time requirement. For Federal fiscal years 2008 and 2009, we estimated that the State agency did not report Medicaid overpayments totaling $2,340,182 ($1,320,131 Federal share) in accordance with Federal requirements.

The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on the CMS-64.

Recommendations

We recommend that the State agency:

- include unreported Medicaid overpayments of $2,340,182 on the CMS-64 and refund $1,320,131 to the Federal Government and

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

DCH Response

The Department:

- has reported and refunded the Medicaid overpayments on the CMS-64 for the quarter ended December 31, 2009. An additional $423,850 will be returned on the June 30, 2010 report.

- concurs with the recommendation and will develop procedures to correctly report and refund the federal share of identified Medicaid overpayments on the CMS-64. With the implementation of the new Community Health Automated Medicaid Processing System (CHAMPS) in September 2009, for any Medicaid overpayment receivables that are 60 days old, the federal share is automatically returned on the CMS-64, regardless of collection status.