



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

December 20, 2011

Report Number: A-06-10-00051

Mr. Eugene Gessow
Director
Division of Medical Services
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201

Dear Mr. Gessow:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Arkansas' Reporting Fund Recoveries for Federal and State Medicaid Programs on the CMS-64 Report for State Fiscal Year 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 at (214) 767-8414, or contact Matthew Moore, Audit Manager, at (817) 685-2450 or through email at Matthew.Moore@oig.hhs.gov. Please refer to report number A-06-10-00051 in all correspondence.

Sincerely,

Patricia Wheeler
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 (CMCHO)
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 ARKANSAS'
REPORTING FUND RECOVERIES
FOR FEDERAL AND STATE
MEDICAID PROGRAMS ON THE
CMS-64 REPORT FOR STATE
FISCAL YEAR 2009**



**Daniel R. Levinson
Inspector General**

**December 2011
A-06-10-00051**

Office of Inspector General

<http://oig.hhs.gov>

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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 Arkansas, the Department of Human Services, Division of Medical Services (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 QSource and the Arkansas Foundation for Medical Care (AFMC) to conduct State Medicaid audits of Medicaid providers. In addition, the Medicaid Program Integrity Unit (MPIU) and the Medicaid Fraud Control Unit (MFCU) conducted audits and investigations, respectively, of Medicaid providers. When QSource, AFMC, or MPIU identified overpayments, the State agency sent letters to the providers 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. 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 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 agency has recovered the overpayment. The date of discovery for situations other than fraud and abuse is the date the provider is 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 Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), 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 report in accordance with Federal regulations.

SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. Also, the State agency was unable to support that all Medicaid overpayments had been reported. For State fiscal year 2009, the State agency did not report or have supporting documentation for Medicaid overpayments totaling \$128,912 (\$94,790 Federal share). Of the 125 overpayments we reviewed, 7 were partially reported or not reported on the CMS-64 report and 13 were not supported by documentation that reconciled with the CMS-64 report. The remaining 105 were correctly reported or were not required to be reported.

Also, the State agency did not report overpayments that were refunded to it on the CMS-64 report for the quarter ended March 31, 2009. Because of this error, the Federal Government did not receive a credit of \$3,791,246 (\$2,760,406 Federal share) on the CMS-64 report. As a result of our audit, the State agency refunded the overpayments on the CMS-64 report for the quarter ended March 31, 2010.

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

RECOMMENDATIONS

We recommend that the State agency:

- include unreported and unsupported Medicaid overpayments of \$128,912 on the CMS-64 report and refund \$94,790 to the Federal Government,
- develop and implement internal controls to ensure that the Federal share of identified Medicaid overpayments is reported on the CMS-64 report in the required time period, and,
- develop and implement internal controls to ensure that items included in the CMS-64 report reconcile with supporting documentation to prevent unreported overpayments similar to the \$3,791,246 (\$2,760,406 Federal share) error that occurred on the CMS-64 report for the quarter ended March 31, 2009.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency did not fully agree with our first recommendation. The State agency agreed that it had not correctly reported overpayments totaling only \$110,737 (\$81,519 Federal share) of the \$225,494 (\$171,225 Federal share) that we questioned. The State agency provided additional documentation with its response to support that \$96,582 of the \$225,494 was all State funds and did not need to be reimbursed to the Federal Government. For our other two recommendations, the State agency said that it had implemented new procedures and additional internal controls to prevent these types of errors. The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree that the \$96,582 was all State funds and have adjusted our findings and recommendations accordingly. The State agency did not provide any details on the new procedures and additional internal controls implemented; thus, we are not able to comment on them.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security 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 applicable 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 Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report).

In Arkansas, the Department of Human Services, Division of Medical Services (State agency), administers the Medicaid program. The State agency used a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and overpayments by Medicaid to providers. The State agency contracted with QSource to review therapeutic claims and the Arkansas Foundation for Medical Care (AFMC) to review inpatient and emergency room claims. In addition, the Medicaid Program Integrity Unit (MPIU) conducted audits of Medicaid providers. The State Medicaid Fraud Control Unit (MFCU) obtained settlements from Medicaid providers in situations related to fraud or abuse investigations. All together, QSource, AFMC, MPIU, and MFCU identified 15,706 overpayments. The overpayments were included in 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 overpayment amounts and directed the providers to send payment to either the appropriate contractor or to the State agency or notified providers of future payment offsets. Hewlett Packard (HP) acted as the State agency's Medicaid fiscal agent and processed Medicaid claims.

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 to recover the amount of the 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, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, 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 CMS-64 report. Provider overpayments must be credited on the CMS-64 report 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 report 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 during State fiscal year (FY) 2009 (July 1, 2008, through June 30, 2009). Of the identified 15,706 Medicaid overpayments

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, such 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 overpayment will be in effect.

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

that were \$50 or more and totaled \$9,554,849, we reviewed 125. The identified audit reports, settlement agreements, and overpayment letters represent Medicaid overpayments 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 in Little Rock, Arkansas, and at the AFMC offices in Fort Smith, Arkansas, from January 2010 through March 2011.

Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and other requirements governing Medicaid overpayments;
- interviewed State agency, HP, QSource, AFMC, MPIU, and MFCU officials regarding policies and procedures relating to Medicaid overpayments subject to the 60-day rule and reporting overpayments on the CMS-64 report;
- identified 15,706 Medicaid overpayments that were \$50 or more and totaled \$9,554,849 for claims subject to the 60-day rule;
- selected a stratified random sample of 125 overpayments:
 - 30, which ranged from \$50 to \$522, from the 4,645 identified by QSource,
 - 30, which ranged from \$50 to \$12,214, from the 10,966 identified by AFMC,
 - 30, which were less than \$20,000, from the 60 overpayments identified by MPIU, and
 - 23 identified by MPIU that were more than \$20,000 and all 12 identified by MFCU, which ranged from \$210 to \$1,322,618;
- established the dates of discovery using the dates QSource, AFMC, MPIU, and MFCU notified Medicaid providers in writing, on behalf of the State agency, of the overpayments and the dollar amount subject to recovery;
- determined the quarter in which the 60-day period following discovery of the overpayment ended;
- reviewed supporting documentation provided by the State to determine whether Medicaid overpayments were reported;

- calculated the value of the sampled overpayments that the State agency did not report or for which it did not provide supporting documentation;
- reviewed CMS-64 reports to determine whether the Medicaid overpayments were reported for the quarter in which the 60-day period following discovery ended; and
- estimated, based on sampling, the number of overpayments that were reported by the end of the 60-day period following discovery.

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 report all Medicaid overpayments in accordance with Federal requirements. Also, the State agency was unable to support that all Medicaid overpayments had been reported. For State fiscal year 2009, the State agency did not report or have supporting documentation for Medicaid overpayments totaling \$128,912 (\$94,790 Federal share). Of the 125 overpayments we reviewed, 7 were partially reported or not reported on the CMS-64 report and 13 were not supported by documentation that reconciled with the CMS-64 report. The remaining 105 were correctly reported or were not required to be reported.

Also, the State agency did not report overpayments that were refunded to it on the CMS-64 report for the quarter ended March 31, 2009. Because of this error, the Federal Government did not receive a credit of \$3,791,246 (\$2,760,406 Federal share) on the CMS-64 report. As a result of our audit, the State agency refunded the overpayments on the CMS-64 report for the quarter ended March 31, 2010.

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

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).

For State FY 2009, the State agency did not report Medicaid overpayments in accordance with Federal requirements. Of the 125 Medicaid overpayments we reviewed, 7 totaling \$85,024 (\$62,686 Federal share) were partially reported or not reported on the CMS-64 report.

Specifically:

- Of the 30 randomly selected overpayments identified by MPIU of \$107 to \$18,740, 2 overpayments totaling \$6,438 (\$4,696 Federal share) were partially reported or not reported.
- Of the 23 overpayments identified by MPIU that were more than \$20,000 and all 12 overpayments identified by MFCU, 5 overpayments totaling \$78,586 (\$57,990 Federal share) were partially reported or not reported.

OVERPAYMENTS NOT SUPPORTED

The State agency did not provide adequate documentation supporting that Medicaid overpayments were included in the CMS-64 report. Of the 125 Medicaid overpayments reviewed, we did not receive adequate supporting documentation to verify that 13 overpayments totaling \$43,888 (\$32,104 Federal share) were reported on the CMS-64 report. Specifically:

- Of the 30 randomly selected overpayments identified by QSource of \$50 to \$522, 3 overpayments totaling \$231 (\$175 Federal share) were not supported on the CMS-64 report.
- Of the 30 randomly selected overpayments identified by AFMC of \$50 to \$12,214, 4 overpayments totaling \$2,703 (\$1,972 Federal share) were not supported on the CMS-64 report.
- Of the 30 randomly selected overpayments identified by MPIU of \$107 to \$18,740, 3 overpayments totaling \$5,031 (\$3,670 Federal share) were not supported on the CMS-64 report.
- Of the 23 overpayments identified by MPIU that were greater than \$20,000 and the 12 overpayments identified by MFCU, 3 overpayments totaling \$35,923 (\$26,287 Federal share) were not supported on the CMS-64 report.

OVERPAYMENTS NOT REPORTED TIMELY

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.” For situations other than fraud or 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.

During our review, the regulation was changed to extend the 60 days to 1 year; however, the effective date of the change was after our audit period. During our audit period, the State agency did not report all Medicaid overpayments in accordance with the 60-day requirement. Of the 125 sampled overpayments, the State agency reported 104 and partially reported 2 on the CMS-64 report. For the 104 overpayments that were reported, 47 overpayments totaling \$1,261,711 were not reported on the CMS-64 report at the end of the 60-day period.

CMS-64 REPORT DID NOT RECONCILE TO SUPPORTING SUMMARY DOCUMENTATION

Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its CMS-64 report. For the quarter ended March 31, 2009, the State agency did not include on the CMS-64 report overpayments totaling \$3,791,246 (\$2,760,406 Federal share) it received from providers. Because of this omission, the Federal Government did not receive a credit of \$2,760,406 (Federal share) for overpayments identified by the State. As a result of our audit, the State agency refunded the overpayments on the CMS-64 report for the quarter ended March 31, 2010.

INTERNAL CONTROLS NOT IMPLEMENTED

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

RECOMMENDATIONS

We recommend that the State agency:

- include unreported and unsupported Medicaid overpayments of \$128,912 on the CMS-64 report and refund \$94,790 to the Federal Government,
- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments on the CMS-64 report in the required time period, and,
- develop and implement internal controls to ensure that items included in the CMS-64 report reconcile with supporting documentation to prevent unreported overpayments similar to the \$3,791,246 (\$2,760,406 Federal share) error that occurred on the CMS-64 report for the quarter ended March 31, 2009.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency did not fully agree with our first recommendation. The State agency agreed that it had not correctly reported overpayments totaling only \$110,737 (\$81,519 Federal share) of the \$225,494 (\$171,225 Federal share) that we questioned. The State agency provided additional documentation with its response to support

that \$96,582 of the \$225,494 was all State funds and did not need to be reimbursed to the Federal Government. For our other two recommendations, the State agency said that it had implemented new procedures and additional internal controls to prevent these types of errors. The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree that the \$96,582 was all State funds and have adjusted our findings and recommendations accordingly. The State agency did not provide any details on the new procedures and additional internal controls implemented; thus, we are not able to comment on them.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid overpayments that had an initial finding date of July 1, 2008, to June 30, 2009.

SAMPLING FRAME

The Arkansas Department of Human Services' Medicaid Program Integrity Unit, Arkansas Foundation for Medical Care, QSource, and the Medicaid Fraud Control Unit provided lists of Medicaid provider overpayments they identified for the period July 1, 2008, to June 30, 2009. The sampling frame, which was limited to overpayments of \$50 or more, was an Excel file containing 15,706 Medicaid provider overpayments totaling \$9,554,849.

SAMPLE UNIT

The sample unit was a Medicaid provider overpayment.

SAMPLE DESIGN

We used a stratified random sample, defined as follows:

Stratum 1: 4,645 Medicaid provider overpayments of \$50 to \$522.

Stratum 2: 10,966 Medicaid provider overpayments of \$50 to \$12,214.

Stratum 3: 60 Medicaid provider overpayments of \$107 to \$18,740.

Stratum 4: 35 Medicaid provider overpayments greater than \$20,000.

SAMPLE SIZE

We selected a random sample of 30 overpayments from each of the first 3 stratum and reviewed all 35 sample items in stratum 4.

SOURCE OF RANDOM NUMBERS

We generated random numbers using Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the number of Medicaid overpayments properly reported.

APPENDIX B: STATE AGENCY COMMENTS



Division of Medical Services

P.O. Box 1437, Slot S-401 · Little Rock, AR 72203-1437
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August 30, 2011

Report Number: A-06-10-00051

Ms. Patricia Wheeler
Regional Inspector General
For Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Dear Ms. Wheeler:

This letter is in response to the above referenced draft audit report entitled *Review of Arkansas' Reporting Fund Recoveries for Federal and State Medicaid Programs on the CMS-64 Report for State Fiscal Year 2009*. It is our understanding that this report is subject to review and revision.

The following comments are being submitted for your consideration in preparation of the final report.

Finding: The State Agency did not report all Medicaid overpayments in accordance with Federal requirements. Also, the state agency was unable to support that all Medicaid overpayments had been reported. For State Fiscal year 2009, the State agency did not report or have supporting documentation for Medicaid overpayments totaling \$225,494 (\$171,225 Federal share). Of the 125 overpayments we reviewed, 8 were partially reported or not reported on the CMS-64 report and 13 were not supported by documentation that reconciled with the CMS-64 report. The remaining 104 were correctly reported or were not required to be reported.

Response: The state submitted documentation multiple times to support the reporting of the overpayments. We again reviewed the remaining items addressed in this finding and all documentation to support these were submitted to the OIG during their audit. With this final review, the state does not concur with the total finding, but does concur with a portion of the finding. The amount that the state concurs with is a total of \$110,737 (\$81,519 federal share). A spreadsheet is attached showing those items that the state concurs. Also attached is the Brighter Futures Court Settlement and Memorandum from the Attorney General's Office to support the position that this settlement was 100% state dollars. The state has implemented additional internal controls to ensure that those few items that were not sufficiently documented would not reoccur.

Finding: The State agency did not report overpayments that were refunded to it on the CMS-64 report for the quarter ended March 31, 2009. Because of this error, the Federal Government did not receive a credit of \$3,791,246 (\$2,760,406 Federal share) on the CMS-64 report. As a result of the audit, the State agency refunded the overpayment on the CMS-64 report for the quarter ended March 31, 2010.

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Ms. Patricia Wheeler

Report Number: A-06-10-00051

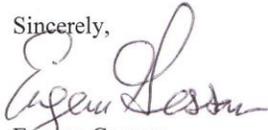
Response: The state has implemented new procedures to ensure that this error does not happen in the future.

Finding: The state did not properly report these overpayments because it had not implemented internal controls to ensure that overpayments were reported on the CMS-64 report.

Response: Although the state has several internal controls in place, the state has implemented additional internal controls to ensure the proper reporting of overpayments to prevent any instances of error. The state is constantly evaluating the controls in place and making revisions.

Thank you for your reconsideration. If you have any questions concerning this response, please do not hesitate to contact Thomas Carlisle, DMS, CFO at (501) 682-0422 or Sharon Jordan at (501) 682-8489.

Sincerely,



Eugene Gessow,

Director

Division of Medical Services

Department of Human Services

Attachments