October 21, 2010

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

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Indiana's Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008 (A-05-09-00021)

Attached, for your information, is an advance copy of our final report on the review of Indiana's reporting fund recoveries for Federal and State Medicaid programs on Form CMS-64 for Federal fiscal years 2000 through 2008. We will issue this report to the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, 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 at (312) 353-2621 or through email at James.Cox@oig.hhs.gov. Please refer to report number A-05-09-00021.

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

October 26, 2010

Report Number: A-05-09-00021

Ms. Patricia Casanova
Director of Medicaid
Office of Medicaid Policy and Planning
Indiana Family & Social Services Administration
402 W. Washington Street, Room 461, MS-25
Indianapolis, IN 46207

Dear Ms. Casanova:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Indiana's Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008*. 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-05-09-00021 in all correspondence.

Sincerely,

/James C. Cox/
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 & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INDIANA'S REPORTING FUND RECOVERIES FOR FEDERAL AND STATE MEDICAID PROGRAMS ON THE FORM CMS-64 FOR FEDERAL FISCAL YEARS 2000 THROUGH 2008

Daniel R. Levinson
Inspector General

October 2010
A-05-09-00021

Office of Inspector General

http://oig.hhs.gov

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

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

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

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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.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency), administers the Medicaid program. The State agency uses a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. The State agency contracted with Health Care Excel, Inc. (HCE), Clifton Gunderson, and PrudentRX to conduct State Medicaid audits of Medicaid providers. In addition, the Indiana State Board of Accounts (SBOA) and the Medicaid Fraud Control Unit (MFCU) conducted audits and investigations, respectively, of Medicaid providers. When they identified overpayments to providers, HCE, Clifton Gunderson, and PrudentRX sent letters to the providers on behalf of the State agency that (1) identified the overpayment amounts and applicable interest charges and (2) directed the providers to send payments either to the appropriate contractor or to the State agency or notified providers of future payment offsets. The SBOA notified 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 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 or abuse is the date that a provider is first notified in writing of an overpayment and the specified dollar amount subject to recovery (42 CFR § 433.316(c)). For overpayments to providers 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." In addition, Federal regulations (45 CFR § 92.21(f)(2)) require the State agency to refund interest earned on overpayments before requesting additional Federal funds. 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 and the interest earned on those overpayments were reported on Form CMS-64 in accordance with Federal regulations.

SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. For Federal fiscal years 2000 through 2008, we estimated that the State agency did not report Medicaid overpayments totaling $61,644,098 ($38,858,614 Federal share) in accordance with Federal requirements. Also, the State agency did not report interest it collected on 24 overpayments totaling $61,894 ($39,061 Federal share) in accordance with Federal requirements.

Of the 120 overpayments we reviewed, 63 were partially reported or not reported on the CMS-64. The remaining 57 were reported correctly or were not required to be reported. The State agency also did not report all Medicaid overpayments to providers within the 60-day requirement. Although the State agency collected interest on the overpayments collected, it did not report all interest on the CMS-64 in accordance with Federal requirements.

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

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $61,644,098 on the CMS-64 and refund $38,858,614 to the Federal Government,

- include unreported interest it collected on Medicaid recoveries totaling $61,894 on the CMS-64 and refund $39,061 to the Federal Government, and

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

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our third recommendation. Regarding the first recommendation, the State agency provided additional documentation and indicated that most of the overpayments exceeding $1 million had been repaid, reported, or resolved. The State agency stated that the remaining $18.5 million in overpayments had been properly recorded in accordance with 42 CFR § 433.320. The State agency said that its practice has been “to reduce federal draws to account for overpayments.” Regarding the second

recommendation, the State agency said it "routinely uses interest assessment as a form of settlement with providers."

The State agency comments are included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's response, we revised our findings and recommendations to exclude $26.9 million in overpayments as a result of additional documentation. We maintain that our findings and recommendations for the remaining $61,644,098 in overpayments are consistent with Federal requirements. The State agency's policies regarding interest earned on overpayment amounts are not in accordance with Federal regulations. During our review, we took into account the State agency's practice of reducing Federal draws to account for overpayments. However, the State agency did not document that such reductions were made for the overpayments we reviewed.

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INTRODUCTION

BACKGROUND

Medicaid Program

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

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

In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency), administers the Medicaid program. The State Medicaid agency implements 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 Health Care Excel, Inc. (HCE), Clifton Gunderson, and PrudentRX to conduct surveillance and utilization review audits of Medicaid providers. The Indiana State Board of Accounts (SBOA) conducted federally required audits and provided overpayment findings to the State. The State Medicaid Fraud Control Unit (MFCU) obtained settlements from Medicaid providers in situations related to fraud or abuse investigations. All together, SBOA, MFCU, HCE, Clifton Gunderson, and PrudentRX issued 3,498 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 and applicable interest charges. In addition, the agreements and letters directed the providers to send reimbursement either to the appropriate contractor or to the State agency or notified providers of future payment offsets. Electronic Data Systems (EDS) 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 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, 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 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 CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

Federal Requirements for Interest Earned

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

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[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.

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered Medicaid overpayments to providers 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) 2000 through 2008.[3] We reviewed 120 of the 3,498 identified overpayments totaling $353,006,823. The identified audit reports, settlement agreements, and overpayment letters represent 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 gaining an understanding of the identification, collection, and reporting policies and procedures for Medicaid overpayments and related interest collected.

We performed fieldwork at the State agency, HCE, Clifton Gunderson, and EDS offices in Indianapolis, Indiana, from November 2008 through July 2009.

Methodology

To accomplish our audit objective, we:

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

- interviewed State agency, HCE, Clifton Gunderson, PrudentRX, SBOA, and EDS officials regarding policies and procedures relating to Medicaid overpayments subject to the 60-day rule and reporting overpayments on the CMS-64;

- identified 3,498 overpayments of $1,000 or more for Medicaid services subject to the 60-day rule, which totaled $353,006,823;

- selected a stratified random sample of 120 overpayments: 100 from the 3,478 overpayments of $1,000 to $1 million and all 20 overpayments of more than $1 million (Appendix A);

[3] We did not include Medicaid Rehabilitation Option program overpayments for FYs 2000 to 2005 that were identified in a previous Office of Inspector General report (A-05-07-00072).

- established the dates of discovery using the dates that HCE, Clifton Gunderson, PrudentRX, and MFCU notified Medicaid providers in writing, on behalf of the State agency, of the overpayments and the dollar amount and interest subject to recovery;

- established dates of discovery using the date SBOA sent a copy to the State of the written audit report of the overpayment amount and interest 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 and interest earned were reported for the quarter in which the 60-day period following discovery ended;

- reviewed the CMS-64 to determine whether Medicaid overpayments and interest collected were reported during any subsequent quarter through June 30, 2009;

- determined whether overpayments were processed directly through the Medicaid Management Information System and included on other lines of the CMS-64;[4]

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

- based on the results of our stratified sample, estimated the value of overpayments in the sampling frame that were not reported during the audit period of FYs 2000 through 2008 (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 Indiana FY ending June 30, 2009.[5]

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.

[4] EDS researched some of the sample items to determine whether they were posted correctly through the system.

[5] 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.

FINDINGS AND RECOMMENDATIONS

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. For Federal FYs 2000 through 2008, we estimated that the State agency did not report Medicaid overpayments totaling $61,644,098 ($38,858,614 Federal share) in accordance with Federal requirements. Also, the State agency did not report interest it collected on 24 overpayments totaling $61,894 ($39,061 Federal share) in accordance with Federal requirements.

Of the 120 overpayments we reviewed, 63 were partially reported or not reported on the CMS-64. The remaining 57 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. Although the State agency collected interest on overpayments it collected, it did not report all interest on the CMS-64 in accordance with Federal requirements. Finally, 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.

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. Because the overpayments were not properly reported on the CMS-64, the Federal Government may have incurred increased interest expense of $786,500.

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 Federal FYs 2000 through 2008, we estimated that the State agency did not report Medicaid overpayments totaling $61,644,098 ($38,858,614 Federal share) and interest it collected on the overpayments totaling $61,894 ($39,061 Federal share) in accordance with Federal requirements. Of the 120 Medicaid overpayments reviewed, 63 overpayments were partially reported or not reported on the CMS-64. Specifically:

- Of the 100 randomly selected overpayments of $1,000 to $1 million,[6] 60 were partially reported or not reported on the CMS-64 and totaled $854,040 ($535,555 Federal share). Based on the sample results, we estimated that $18,528,351 ($11,615,084 Federal share) of the Medicaid overpayments between $1,000 and $1 million were not reported on the CMS-64.

[6] Four of the selected overpayments were not required to be reported on the CMS-64. Two overpayments were reduced to zero in our audit period; one overpayment was a bankruptcy; and the remaining overpayment was handled through the court system, which required separate reporting.

- Of the 20 overpayments that exceeded $1 million, 3 were partially reported or not reported on the CMS-64 totaling $43,115,747 ($27,243,530 Federal share).

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 and abuse, Federal regulation (42 CFR § 433.316(c)) defines 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 120 sampled overpayments, the State agency reported 47 overpayments on the CMS-64, which included 9 overpayments that were only partially reported. For the 47 overpayments that were reported, 22 overpayments totaling $32,951,628 ($20,410,636 Federal share) were not reported on the CMS-64 at the end of the 60-day period. The untimely reporting resulted from the State agency's unwritten policy of using the date of the final decision for overpayments not related to fraud or abuse or the date that the State agency collected the overpayment rather than the date of discovery. We discovered this in a prior audit.[7]

INTEREST NOT REPORTED

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

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

As a result of State Medicaid audits issued from FYs 2000 through 2008, the State agency collected interest on recovered overpayments. For the 120 Medicaid overpayments reviewed, the State agency collected interest totaling $78,857 for 53 overpayments. Twenty-nine of the fifty-three interest payments totaling $15,610 were fully reported on the CMS-64. The State

[7] A-05-07-00072, *Review of Indiana's Reporting Fund Recoveries for the Medicaid Rehabilitation Option Program on the Form CMS-64 for Fiscal Years 2000 to 2005.*

agency partially reported one interest payment of $1,653. The State agency reported only $1,353, leaving an unreported amount of $300 ($195 Federal share). For the remaining 23 overpayments, the State agency collected interest totaling $61,594 ($38,866 Federal share) and did not report any of those interest payments on the CMS-64.

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 $786,500. However, we did not include this Federal interest expense in the amount of overpayments that we recommend the State agency refund.

INTERNAL CONTROLS NOT IMPLEMENTED

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

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments totaling $61,644,098 on the CMS-64 and refund $38,858,614 to the Federal Government,

- include unreported interest it collected on Medicaid recoveries totaling $61,894 on the CMS-64 and refund $39,061 to the Federal Government, and

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

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our third recommendation. Regarding the first recommendation, the State agency provided additional documentation and indicated that most of the overpayments exceeding $1 million had been repaid, reported, or resolved. The State agency stated that the remaining $18.5 million in overpayments had been properly recorded pursuant to 42 CFR § 433.320. The State agency said that its practice has been "to reduce federal draws to account for overpayments." Regarding the second recommendation, the State agency said it "routinely uses interest assessment as a form of settlement with providers."

The State agency comments are included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's response, we revised our findings and recommendations to exclude $26.9 million in overpayments as a result of additional documentation. We maintain that our findings and recommendations for the remaining $61,644,098 in overpayments are consistent with Federal requirements. The State agency's policies regarding interest earned on overpayment amounts are not in accordance with Federal regulations. During our review, we took into account the State agency's practice of reducing Federal draws to account for overpayments. However, the State agency did not document that such reductions were made for the overpayments we reviewed.

OTHER MATTERS

The State agency did not report Medicaid overpayments from State Medicaid audits on the correct line of the CMS-64. Of the 47 sampled overpayments that were reported on the CMS-64, 18 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 at the FMAP rate in place when 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) 2000 through 2008 (October 1, 1999, through September 30, 2008).

SAMPLING FRAME

The Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency), provided lists of Medicaid provider overpayments identified by all its contractors, the Medicaid Fraud Control Unit, and the State Board of Accounts for FYs 2000 through 2008. The sampling frame was limited to overpayments exceeding $1,000.

The sampling frame was an Excel file containing 3,498 Medicaid provider overpayments with a total projected recovery of $353,006,823. The sampling frame was separated into two strata. Stratum 1 consisted of 3,478 Medicaid provider overpayments of $1,000 to $1 million, with a total projected recovery of $62,459,464. Stratum 2 consisted of 20 Medicaid provider overpayments of more than $1 million, with a total projected recovery of $290,547,359.

SAMPLE UNIT

The sample unit was a Medicaid provider overpayment.

SAMPLE DESIGN

We used a stratified sample, defined as follows:

Stratum 1: 3,478 Medicaid provider overpayments of $1,000 to $1 million.

Stratum 2: 20 Medicaid provider overpayments of more than $1 million.

SAMPLE SIZE

We selected a random sample of 100 items from the 3,478 Medicaid provider overpayments in stratum 1 and reviewed all 20 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	3,478	$62,459,464	100	$1,589,585	60	$854,040
2	20	$290,547,359	20	$290,547,359	3	$43,115,747
Totals	**3,498**	**$353,006,823**	**120**	**$292,136,944**	**63**	**$43,969,787**

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	$61,644,098	$38,858,614
Point Estimate	$72,819,254	$45,870,136
Upper Limit	$83,994,411	$52,881,658

APPENDIX C: STATE AGENCY COMMENTS

"People helping people help themselves"

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

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

July 19, 2010

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

Re: Draft Report Number A-05-09-00021

Dear Mr. Cox:

We are writing in response to the draft Office of Inspector General (OIG) report entitled "*Review of Indiana's Reporting Fund Recoveries for Federal and State Programs on the CMS64*". The audit period covered federal fiscal years 2000 through 2008. The OIG recommendations and our responses are noted below:

OIG Audit Recommendation: "include unreported Medicaid overpayments totaling $88,563,104 on the CMS-64 and refund $55,687,871 to the Federal Government".

The Office of Medicaid Policy and Planning (OMPP) obtained the audit workpapers of the OIG to validate the sample size and methodologies described in the draft report. Our review noted that of the 20 overpayments that exceeded $1.0 million, totaling $70.0 million, $68.6 million in overpayments included in the audit workpapers have either been repaid, reported, or resolved. Please see Attachment 1 which details our overpayment/reporting findings. We respectfully request the opportunity to continue our work with CMS on resolution of the remaining items included in this audit.

Upon review of the sample pertaining to overpayment letters issued to providers by our contractors HealthCare Excel, Clifton Gunderson and PrudentRX, it was not readily apparent from the audit workpapers that the OIG considered the reduction in federal monies drawn compared to expenditures paid by the State. It has been the practice of the State to reduce federal draws to account for overpayments.

As a part of the State's due dilgence, we performed a limited scope audit on the remaining $18.5 million in provider overpayments of listed "Unable to Trace to CMS-64". We were able to validate proper recording of overpayments in accordance with 42 CFR §433.320 (also included in Attachment 1). We would respectfully request that the documentation showing that these samples were indeed recorded on the CMS-64 be accepted as validation and the remainder of the extrapolated amounts be removed from repayment consideration.

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

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

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

OIG Recommendation: "include unreported interest collected on Medicaid recoveries totaling $61,894 on the CMS-64 and refund $39,061 to the Federal Government".

According 405 IAC 1-1-5(g), Indiana has the discretion to assess interest on identified overpayments. The State routinely uses interest assessment as a form of settlement with providers. As noted above, we request the OIG work with the State to satisfy this reporting requirement.

OIG Recommendation: "develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments and interest it collected on the overpayments on the CMS-64".

It is the State's goal to properly report overpayments in accordance with 42 CFR §433.320. We will implement internal controls to ensure accurate, timely reporting of overpayments and properly return federal monies as a credit on the CMS-64 beginning December 2010.

As noted previously, we propose to make the required reporting changes to bring Indiana into compliance with federal regulations. At this time, we would like to re-iterate our desire to work with the OIG to perform a combined adjustment on the CMS-64.

We are hopeful that you find this to be a sufficient response to the OIG audit report. Please contact Donna Rutherford at 317-234-5287 should you have any questions or require additional information.

Sincerely,

P Casanova

Patricia Casanova
Director of Medicaid

Report Number A-05-09-00021 Attachment 1

Sample #	State Agency Comments to Draft Report (A-05-09-00021)
3	Enclosed you will find screen prints from the Indiana AIM System which supports the establishment of an Accounts Receivable (A/R) for the repayment. Once the A/R is established, the amount is included on the MAR, which feeds the CMS-64 line 10 for the quarter in which the A/R is established. In this example, the overpayment was reported on line 10 of the CMS 64 for the quarter ending 9/30/2001.
42	Enclosed you will find screen prints from the Indiana AIM System which supports the establishment of an Accounts Receivable (A/R) for a claim specific recoupment. As in the previous example, the amount is included on the MAR, which feeds the CMS-64 line 10. In this example, the recoupment was on reported on line 10 of the CMS-64 for the quarter ending 3/31/2008.
118	Enclosed you will find a letter and press release from the U.S. Department of Justice regarding a restitution order for repayment and the collection of from two individuals involving Medicaid Fraud. Per Section 2500.1 of the State Medicaid Manual: "Where a Civil Monetary Penalty action is taken, and the provider returns an overpayment to the Federal government, the State share is returned by a U.S. Treasury check. Since the Federal government obtains the Federal share of the overpayment, CMS does not recognize the decreasing adjustment for Federal funding purposes
122	Enclosed you will find an email dated June 22, 2009 from the State Board of Accounts Auditor in Charge, which confirms adjusting the overpayment to $11,494,502.86, which the auditors confirmed as reported on the CMS-64.
123	Enclosed you will find the packet "SBoA Audit Finding: 2007-FSSA-3", which shows the reporting of the repayment on Line #10B of the CMS-64 for the Quarter Ended, March 31, 2009.
124	Enclosed you will find the SBoA Audit Finding: 2007-FSSA-6. The Indiana Family Social Services Administration disagrees with this finding and the need for repayment, as OMPP believes the calculation of the quarterly payments is in accordance with the Indiana Medicaid State Plan.

Note: Samples 3, 42 and 118 contain proprietary and/or personally identifiable information. As a result, these samples are not included as part of this report.

Note: The documents referred to in this attachment are not included in the report due to PII and/or proprietary information. Also, these documents do not meet the requirements of FOIA.

Sample 122 SBoA Audit Finding 2006-FSSA-5

Rutherford, Donna L

From: Nelson, David A
Sent: Thursday, April 01, 2010 8:54 AM
To: Rutherford, Donna L
Subject: FW: status of finding 2006-fssa-5 State Owned Intermediate Care Facility

---

From: Rankin, Mary E.
Sent: Monday, June 22, 2009 10:08 AM
To: Nelson, David A
Cc: Willits, Terri; Kirby, Robin; 'Schmit, Cody J (OIG/OAS)'
Subject: RE: status of finding 2006-fssa-5 State Owned Intermediate Care Facility

David:

Yes this is correct. We have a remaining variance as to the federal share rate applied upon returning the funds, as the 2008 rate of 62.69 was used, but when the overpayment was issued the rate of 62.98 applied. My calculations show an additional $33,334 owed to the federal government then.

Thank you,

Mary Rankin C P A
Auditor in Charge
State Board of Accounts

From: Nelson, David A
Sent: Wednesday, June 17, 2009 7:16 PM
To: Rankin, Mary E.
Cc: Willits, Terri; Kirby, Robin; Schmit, Cody J (OIG/OAS)
Subject: status of finding 2006-fssa-5 State Owned Intermediate Care Facility

As we discussed, please confirm that the SBoA concurs that the total overpayment amount of finding 2006-FSSA-5 State Owned Intermediate Care Facility, has been revised to be calculated as $11,494,502.85 and the only outstanding issue is an difference between the federal share computer by SBoA and the actual federal share returned.
Thanks,
David

Prior Comment:
The federal share of the overpayment at .6298 (2006 rate) was $7,239,237.81. On June 18, 2008 the federal share of current expenses was reduced by $ 7,205,903.84 in the grant ledger.

Sample 123 SBoA Audit Finding 2007-FSSA-3

SBoA Audit Finding

2007 – FSSA - 3

Department of Health and Human Servi
Centers for Medicare & Medicaid Services

OMB No. 0938-0067
Expires 8/31/2011

Medical Assistance Expenditures By Type Of Service
For The Medical Assistance Program
Prior Period Adjustments In This Quarter

State: Indiana

Quarter Ended: 03/31/2009
Fiscal Year: 2008

Line #10B

MAR 7015Q Medical Assistance Payments REDUCTION OF LAST PAY CYCLE OF SEPT 2008 AUDIT ADJ FOR QAF FROM SBOA		Total Comp.	Federal Share FMAP 62.69%	I.H.S Fac. Services 100%	Fam. Pln. Services 90%	Opt. Brst or Cerv. Cancer Services	0.00%	Federal Share	Total Federal Share	Deferral Or C.I.N. Number
		(A)	(B)	(C)	(D)	(E)	(F)		(G)	(H)
1A	Inpatient Hospital Services: Regular Payments	3,468,834	2,174,612 0	0	0	0	0.00%	0	2,174,612	
1B	Inpatient Hospital Services: DSH Adjustment Payments	0	0 0	0	0	0	0.00%	0	0	
2A	Mental Health Facility Services: Regular Payments	489,103	306,619 0	0	0	0	0.00%	0	306,619	
2B	Mental Health Facility Services: DSH Adjustment Payments	0	0 0	0	0	0	0.00%	0	0	
3	Nursing Facility Services	21,572,114	13,523,558 0	0	0	0	0.00%	0	13,523,558	
4A	Intermediate Care Facility Services - Mentally Retarded: Public Providers	0	0 0	0	0	0	0.00%	0	0	
4B	Intermediate Care Facility Services - Mentally Retarded: Private Providers	2,188,605	1,372,036 0	0	0	0	0.00%	0	1,372,036	
5	Physicians' Services	888,852	557,221 0	0	0	0	0.00%	0	557,221	
6	Outpatient Hospital Services	851,157	533,590 0	0	0	0	0.00%	0	533,590	
7	Prescribed Drugs	2,166,509	1,357,838 0	0	447	41	0.00%	0	1,358,326	
7A1	Drug Rebate Offset - National Agreement	0	0 0	0	0	0	0.00%	0	0	
7A2	Drug Rebate Offset - State Sidebar Agreement	0	0 0	0	0	0	0.00%	0	0	
8	Dental Services	381,686	239,279 0	0	0	0	0.00%	0	239,279	
9	Other Practitioners' Services	79,670	49,945 0	0	0	0	0.00%	0	49,945	
10	Clinic Services	3,100,248	1,943,515 0	0	44	0	0.00%	0	1,943,559	
11	Laboratory And Radiological Services	165,850	103,902 0	0	0	82	0.00%	0	103,984	
12	Home Health Services	1,789,193	1,121,645 0	0	0	0	0.00%	0	1,121,645	
13	Sterilizations	6,181	3,875 0	0	0	0	0.00%	0	3,875	
14	Abortions 0	0	0 0	0	0	0	0.00%	0	0	
15	EPSDT Screening Services	19,176	12,021 0	0	0	0	0.00%	0	12,021	
16	Rural Health Clinic Services	57,004	35,736 0	0	0	0	0.00%	0	35,736	
17A	Medicare Health Insurance Payments: Part A Premiums	0	0 0	0	0	0	0.00%	0	0	
17B	Medicare Health Insurance Payments: Part B Premiums	0	0 0	0	0	0	0.00%	0	0	

Department of Health and Human Serv.
Centers for Medicare & Medicaid Services

OMB No. 0938-0067
Expires 8/31/2011

Medical Assistance Expenditures By Type Of Service
For The Medical Assistance Program
Prior Period Adjustments In This Quarter

State: Indiana

Quarter Ended: 03/31/2009
Fiscal Year: 2008

Line #10B

	Medical Assistance Payments	Total Comp.	Federal Share: FMAP 62.69%	Federal Share: I.H.S Fac. Services 100%	Federal Share: Fam. Pln. Services 90%	Federal Share: Opt. Brst or Cerv. Cancer Services	Federal Share: 0.00%	Federal Share	Total Federal Share	Deferral Or C.I.N. Number
		(A)	(B)	(C)	(D)	(E)	(F)		(G)	(H)
17C1	Medicare Health Insurance Payments: Qualifying Individuals/120% - 134% of Poverty	0	0 0	0	0	0	100.00%	0	0	
17C2	Medicare Health Insurance Payments: Qualifying Individuals/135% - 175% of Poverty	0	0 0	0	0	0	0.00%	0	0	
17D	Medicare Health Insurance Payments: Coinsurance and Deductibles	0	0 0	0	0	0	0.00%	0	0	
18A	Medicaid Health Insurance Payments: Managed Care Organizations	0	0 0	0	0	0	0.00%	0	0	
18B1	Prepaid Ambulatory Health Plan	0	0 0	0	0	0	0.00%	0	0	
18B2	Prepaid Inpatient Health Plan	0	0 0	0	0	0	0.00%	0	0	
18C	Medicaid Health Insurance Payments: Group Health Plan Payments	0	0 0	0	0	0	0.00%	0	0	
18D	Medicaid Health Insurance Payments: Coinsurance and Deductibles	0	0 0	0	0	0	0.00%	0	0	
18E	Medicaid Health Insurance Program: Other	200	125 0	0	0	0	0.00%	0	125	
19	Home And Community-Based Services	0	0 0	0	0	0	0.00%	0	0	
20	Home And Community-Based Care For Functionally Disabled Elderly	0	0 0	0	0	0	0.00%	0	0	
22	Programs Of All-Inclusive Care Elderly	0	0 0	0	0	0	0.00%	0	0	
23	Personal Care Services	0	0 0	0	0	0	0.00%	0	0	
24	Targeted Case Management Services	9,963	6,246 0	0	0	0	0.00%	0	6,246	
25	Primary Care Case Management Services	0	0 0	0	0	0	0.00%	0	0	
26	Hospice Benefits	386,546	242,326 0	0	0	0	0.00%	0	242,326	
27	Emergency Services Undocumented Aliens	0	0 0	0	0	0	0.00%	0	0	
28	Federally-Qualified Health Center	29,564	18,534 0	0	0	0	0.00%	0	18,534	
29	Other Care Services	2,041,094	1,279,512 0	0	0	59	0.00%	0	1,279,571	
30	Total	39,691,549	24,882,135 0	0	491	182	0.00%	0	24,882,808	

Line 3 i
MAR-7015 2,487,366 (A)
Last Sept. Pay 10,797,344. (B)
2007-FSSA-3 8,247,404 (C)
21,532,114

MAR-7015-Q

PERIOD: 3/31/2009

7015 Medicaid FY2008

	TYPE OF SERVICE	ON-DEMAND TOTAL COMPUTABLE	FMAP 62.69%	INDIAN HEALTH SERVICES	FAMILY PLANNING SERVICES	BREAST OR CERVICAL CANCER SERVICES	CALCULATED TOTAL COMPUTABLE	TOTAL FEDERAL SHARE
1A.	INPATIENT HOSPITAL SERVICES - REGULAR PAYMENTS	$586,714.04	$586,714.04	$0.00	$0.00	$0.00	$586,714.04	$367,811.03
1B.	INPATIENT HOSPITAL SERVICES - DSH ADJUSTMENT PAYMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2A.	MENTAL HEALTH FACILITY SERVICES - REGULAR PAYMENTS	$34,980.44	$34,980.43	$0.00	$0.00	$0.00	$34,980.43	$21,929.23
2B.	MENTAL HEALTH FACILITY SERVICES - DSH ADJUSTMENT PAYMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	NURSING FACILITY SERVICES	$2,487,366.37	$2,487,366.36	$0.00	$0.00	$0.00	$2,487,366.36	$1,559,329.97
4A.	ICF MENTALLY RETARDED SERVICES - PUBLIC PROVIDERS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4B.	ICF MENTALLY RETARDED SERVICES - PRIVATE PROVIDERS	$522,151.01	$522,151.00	$0.00	$0.00	$0.00	$522,151.00	$327,336.46
5	PHYSICIANS' SERVICES.	$56,317.91	$56,235.38	$0.00	$0.00	$82.51	$56,317.89	$35,314.93
6	OUTPATIENT HOSPITAL SERVICES	$147,793.71	$146,718.81	$0.00	$0.00	$1,074.88	$147,793.69	$92,772.15
7	PRESCRIBED DRUGS	$262,797.24	$262,244.27	$0.00	$497.29	$55.67	$262,797.23	$164,889.63
7A1.	DRUG REBATE OFFSET - NATIONAL AGREEMENT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7A2.	DRUG REBATE OFFSET - STATE SIDEBAR AGREEMENT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
8	DENTAL SERVICES	$9,884.48	$9,884.48	$0.00	$0.00	$0.00	$9,884.48	$6,196.58
9	OTHER PRACTITIONERS' SERVICES	$3,286.72	$3,286.71	$0.00	$0.00	$0.00	$3,286.71	$2,060.44
10	CLINIC SERVICES	$503,056.79	$503,008.04	$0.00	$48.74	$0.00	$503,056.78	$315,379.61
11	LABORATORY & RADIOLOGICAL SERVICES	$12,973.76	$12,863.30	$0.00	$0.00	$110.45	$12,973.74	$8,145.60
12	HOME HEALTH SERVICES	$72,290.26	$72,290.25	$0.00	$0.00	$0.00	$72,290.25	$45,318.76
13	STERILIZATIONS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
14	ABORTIONS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
15	EPSDT SCREENING SERVICES	$267.08	$267.08	$0.00	$0.00	$0.00	$267.08	$167.43
16	RURAL HEALTH CLINIC SERVICES	$24,789.04	$24,789.03	$0.00	$0.00	$0.00	$24,789.03	$15,540.24
17A.	MEDICARE HEALTH INSURANCE PAYMENTS - PART A PREMIUMS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
17B.	MEDICARE HEALTH INSURANCE PAYMENTS - PART B PREMIUMS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
17C1.	MEDICARE HEALTH INSURANCE PAYMENTS - QUALIFYING INDIVIDUALS - 120%-134% OF POVERTY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

MAR-7015-Q

PERIOD: 3/31/2009

17C2.	MEDICARE HEALTH INSURANCE PAYMENTS - QUALIFYING INDIVIDUALS - 135%-175% OF POVERTY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
17D.	MEDICARE HEALTH INSURANCE PAYMENTS - COINSURANCE AND DEDUCTIBLES	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18A.	MEDICAID HEALTH INSURANCE PAYMENTS - MANAGED CARE ORGANIZATION (MCO)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18B.	MEDICAID HEALTH INSURANCE PAYMENTS - PREPAID HEALTH PLANS (PHP)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18C.	MEDICAID HEALTH INSURANCE PAYMENTS - GROUP HEALTH PLANS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18D.	MEDICAID HEALTH INSURANCE PAYMENTS - COINSURANCE AND DEDUCTIBLES	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
18E.	MEDICAID HEALTH INSURANCE PAYMENTS - OTHER	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
20	HOME AND COMMUNITY BASED SERVICES FUNCTIONALLY DISABLED ELDERLY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
21	COMMUNITY SUPPORTED LIVING ARRANGEMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
22	PROGRAMS OF ALL-INCLUSIVE CARE ELDERLY (PACE)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23	PERSONAL CARE SERVICES	$143.40	$143.39	$0.00	$0.00	$0.00	$143.39	$89.89
24	TARGETED CASE MGMT SERVICES	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
25	PRIMARY CARE CASE MANAGEMENT SERVICES	$47,630.18	$43,926.61	$0.00	$0.00	$3,703.56	$47,630.17	$30,273.78
26	HOSPICE BENEFITS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
27	EMERGENCY SERVICES - UNDOCUMENTED ALIENS	$46.00	$45.99	$0.00	$0.00	$0.00	$45.99	$28.83
28	FEDERALLY QUALIFIED HEALTH CENTER	$99,573.86	$99,494.29	$0.00	$0.00	$79.55	$99,573.84	$62,431.75
29A.	OTHER CARE SERVICES	$4,872,062.29	$4,866,409.43	$0.00	$546.03	$5,106.62	$4,872,062.08	$3,055,016.31
30A	Subtotal							
19	HOME AND COMMUNITY BASED SERVICES - TOTAL	$240,884.09	$240,884.08	$0.00	$0.00	$0.00	$240,884.08	$151,010.23
	A. AGED AND DISABLED WAIVER	$14,916.01	$14,916.00	$0.00	$0.00	$0.00	$14,916.00	$9,350.84
	B. AUTISM WAIVER	$4,944.87	$4,944.86	$0.00	$0.00	$0.00	$4,944.86	$3,099.93
	C. DEVELOPMENTALLY DISABLED WAIVER	$207,165.26	$207,165.26	$0.00	$0.00	$0.00	$207,165.26	$129,871.90
	D. MEDICALLY FRAGILE CHILDREN'S WAIVER	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	E. TRAUMATIC BRAIN INJURY WAIVER	$1,656.29	$1,656.28	$0.00	$0.00	$0.00	$1,656.28	$1,038.32
	F. ASSISTED LIVING WAIVER	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	G. SUPPORT SERVICES WAIVER	$12,201.66	$12,201.66	$0.00	$0.00	$0.00	$12,201.66	$7,649.22
	H. SERIOUS EMOTIONAL DISTURBANCE WAIVER	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	I. COMMUNITY ALTERNATIVES TO PRTF	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	J. AGED AND DISABLED MFP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	K. DEVELOPMENTALLY DISABLED MFP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	L. TRAUMATIC BRAIN INJURY MFP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
30B	TOTAL	$5,112,946.38	$5,107,293.51	$0.00	$546.03	$5,106.62	$5,112,946.16	$3,206,026.54

4,872,062
34,819,488
39,691,550 ✓

Last Pay Cycle 2008
SBOA Audit QAF

<26,532,082>
< 8,289,404>
34,819,486

Query Results for last pay cycle of September to be booked in October 2008
CMS 64
Line 7 2009 Increasing Adjustment
Line 10B 2008 Decreasing Adjustment

Medicaid Fee for Service		Line Number		Amount		
7010	2	1	1A	2,882,120.04		
7010	5	2	2A	454,122.91		
7010	7	3	3	10,797,344.24	B	
7010	10	4	4B	1,666,453.69		
7010	11	5	5	832,533.98		
7010	12	6	6	703,362.83		
7010	13	7	7	1,903,711.92		
7010	16	8	8	371,802.22		
7010	17	9	9	76,382.79		
7010	18	10	10	2,597,190.53		
7010	19	11	11	152,875.69		
7010	20	12	12	1,716,903.12		
7010	21	13	13	6,180.77		
7010	23	15	15	18,908.60		
7010	24	16	16	32,214.96		
7010	36	18	18E	199.60		
7010	51	24	24	9,819.90		
7010	53	26	26	338,916.16		
7010	55	28	28	29,517.94		
7010	56	29	29	1,941,520.23		
7010 Total				**26,532,082.12**		
HCBS Waivers						
7010	38	19	19A	**803,951.55**	**Aged Disabled**	
7010	39	19	19B	**103,647.62**	**Autism**	
7010	40	19	19C	**2,916,718.59**	**Dev Disabled**	
7010	42	19	19E	**34,551.51**	**TBI**	
7010	44	19	19G	**178,340.34**	**Support Services**	
HIP Caretakers						
7050	11	5	5	355.60		
7050	13	7	7	509.91		
7050	18	10	10	40.47		
7050	19	11	11	109.49		
7050	32	18	18A	2,178,350.24		
7050	36	18	18E	946,175.66		
7050 Total				**3,125,641.37**		

2008 Line 10B Removing Last Pay Cycle of September 2008 HHW Pregnant	(9,645,494)	(6,046,760)	
	(11,201,997)	(7,022,547)	
2009 Line 10B EDS Decreasing Adjustment HHW Caretakers Family	0	(51)	
2009 Line 10B Removing 2009 MCO Expends for HHW Caretakers	(2,165,841)	(1,586,045)	Certified on 3-30-09
2009 Line 10B EDS Decreasing Adjustment HHW Caretakers	(71,958)	(52,695)	
	(2,237,799)	(1,638,791)	
2009 Line 10B Removing 2009 MCO Expends for HHW Children	(1,058,852)	(775,397)	Certified on 3-30-09
2009 Line 10B EDS Decreasing Adjustment HHW Children	(415,524)	(304,288)	
2009 Line 10B EDS Decreasing Adjustment HHW Children Family Planning	0	(46)	
	(1,474,376)	(1,079,732)	
2009 Line 10B Removing 2009 MCO Expends for HHW Pregnant Women	(353,562)	(258,913)	Certified on 3-30-09
2009 Line 10B EDS Decreasing Adjustment HHW Pregnant Women	(65,344)	(47,851)	
	0	(8)	
Planning	(418,906)	(306,773)	
2009 Line 10B EDS Decreasing Adjustments for Medicaid	(4,419,894)	(3,236,795)	
2008 Line 10B Removing Last Pay Cycle of September 2008 Medicaid	(26,632,082)	(16,632,962)	
2008 line 10B Removing QAF Refunds per SBOA Audit Finding Medicaid	(6,287,404)	(5,195,374)	Certified on 3-30-09
2008 Line 10B EDS Decreasing Adjustment 7015Q	(4,872,062)	(3,054,296)	
2008 Line 10B EDS Decreasing Adjustment 7015Q Family Planning		(76)	
2008 Line 10B EDS Decreasing Adjustment 7015 Q BCCT		(100)	
	(39,691,548)	(24,882,808)	24882808
2008 Line 10B Removing Last Pay Cycle of Sept 2008 - HIP Caretakers	(3,125,541)	(1,959,402)	
2008 Line 10B Removing Last Pay Cycle of Sept 2008 - HIP Adults	(6,748,148)	(4,230,414)	
2008 Line 10 B EDS Decreasing Adjustments	(30)	(19)	
	(6,748,178)	(4,230,432)	
2008 Line 10B Removing Last Pay Cycle of Sept 2008 - DD Waiver	(731,077)	(458,312)	
2008 Line 10B EDS Decreasing Adjustments	(3,568)	(2,237)	
	(734,645)	(460,549)	
2008 Line 10B Removing Last Pay cycle of Sept 2008 - Careselect Other	(1,121,801)	(703,257)	
2008 Line 10B EDS Decreasing Adjustments	(85,629)	(53,681)	
	(1,207,430)	(756,938)	
2008 Line 10B Removing Last Pay Cycle of Sept 2008 - Aged/Blind/Disabled	(10,384,752)	(6,510,201)	
2008 Line 10B EDS Decreasing Adjustments w/ 546 FP	(956,857)	(600,021)	
	(11,341,609)	(7,110,222)	
2008 Line 10B Removing Last Pay cycle of Sept 2008 - All Other	(1,102,220)	(690,982)	
2008 Line 10B EDS Decreasing Adjustments - HCBS - Dev Disabled Waiver	(210,313)	(131,845)	
2008 Line 10B Removing Last Pay cycle of Sept 2008 - Dev Disabled Waiver	(2,916,719)	(1,828,491)	
	(3,127,032)	(1,960,336)	
2008 Line 10B Remvoing Last Pay Cycle of Sept 2008 - Aged/Disabled Waiver	(803,952)	(503,997)	
2008 Line 10B Removing Last Pay Cycle of Sept 2008 - Autism Waiver	(103,648)	(64,977)	
2008 Line 10B Removing Last Pay cycle of Sept 2008 - TBI Waiver	(34,552)	(21,660)	
2008 Line 10B Removing Last Pay Cycle of Sept 2008 - Support Ser Waiver	(178,340)	(111,802)	
2008 Line 10B EDS Decreasing Adjustments - Other	(55,208)	(34,619)	
2008 Line 10B EDS Decreasing Adjustments - HCBS - Aged/Disabled	(15,094)	(9,462)	
2008 Line 10B EDS Decreasing Adjustments - HCBS - Autism Waiver	(4,988)	(3,127)	
2008 Line 10B EDS Decreasing Adjustments - HCBS - TBI Waiver	(1,656)	(1,038)	
2008 Line 10B EDS Decreasing Adjustments - HCBS - Support Services	(15,961)	(10,006)	
	(1,213,398)	(760,688)	
2009 Line 10B EDS Decreasing Adjustments - HIP Adults	(453)	(332)	
2009 Line 10B EDS Decreasing Adjustments - HIP Caretakers	(7)	(5)	
2009 Line 10B EDS Decreasing Adjustments - Careselect ABD Waiver	(575,223)	(421,302)	
2009 Line 10b EDS Decreasing Adjustments - Careselect - Other	(25,571)	(18,726)	
2009 Line 10B EDS Decreasing Adjustments - All Other	(54,925)	(40,264)	
2009 Line 10B EDS Decreasing Adjustments - Dev Disabled Waiver	(5,267)	(3,869)	
2009 Line 10B EDS Decreasing Adjustments - HCBS Aged/Disabled	(31,045)	(22,734)	

Sample 124

SBoA Audit Finding

2007-FSSA-6

FINDING 2007 - FSSA-6, FACULTY PHYSICIAN ACCESS TO CARE ADJUSTMENTS

Federal Agency:	Department of Health and Human Services
Federal Program:	Medical Assistance Program
CFDA Number:	93.778
Auditee Contact Person:	Terri Willits
Title of Contact Person:	Director of Finance, OMPP
Phone Number:	317-234-5553
Compliance Requirement:	Allowable Costs/Cost Principles
Internal Control:	Significant Deficiency

Finding:

FSSA-OMPP is authorized by the approved state plan to make adjustments to payments for services provided by faculty physicians to Medicaid recipients. These payments are made in order to maintain adequate access to such care, and in recognition of additional costs incurred in providing faculty physician services to Medicaid patients. There are two physician groups that were identified as qualified to receive these payments as faculty of the School of Medicine.

The approved state plan, attachment 4.19B part V, 1.a. specifies the calculation method as follows:

> ". . . adjustments to payments for faculty physician services will be made quarterly by the office in an amount not to exceed the lesser of billed charges or an amount equal to the difference between:
>
> i. The amounts paid for services rendered to Medicaid recipients pursuant to the RBRVs fee schedule and
>
> ii. The amounts that are the usual charges as defined in c. below, for the same services."

Usual charges are defined for calendar years beginning after December 31, 2003, as "an amount equal to the amount of the immediately preceding calendar year's usual charges, increased by an amount that is equal to the applicable Medicare Sustainable Growth Factor as calculated pursuant to the formula at 42 USCS 1395w-4(f)(2)."

The plan further provides that results of an annual review will be applied to the quarterly payments for the following calendar year. Examples were given which indicate that payment reductions would occur if performance levels are not met.

Payments issued for the faculty physician access to care adjustments for calendar 2006 and 2007 were based upon estimates. The estimated payments for 2006 were the 2005 payments multiplied by the percentage change between 2004 and 2005. The estimated payments for 2007 were the 2006 estimate multiplied by the same percentage change between 2004 and 2005. The two faculty physician groups experienced rates of change between 2004 and 2005 of 17% increase and 15.5% decrease, respectively.

There also were no state contracts with the provider entities even though the payment adjustments were only based upon estimates, and as such could result in amounts owed back to the program.

During fiscal 2007, a total of $41,666,667 was paid for 2006 and 2007 estimated faculty physician access to care adjustments. The federal share of these costs was $26,087,500. By February 2008 the actual payments owed for these periods had not yet been calculated, nor had the effect of the performance measures been applied. Due to the use of the estimates only, we were unable to determine the accuracy of the payments issued. As a result, we consider the federal share of the amounts paid to be questioned costs which may be required to be repaid to the federal government.

The conditions noted above result in a significant control deficiency.

"The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program." 42 CFR 447.201 (b)

Indiana Code 4-13-2-14.2 requires that state agency contracts be in writing. Indiana Code 4-13-2-1-20 generally prohibits advance payments without the approval of the State Budget Agency.

We recommended that FSSA ensure that the faculty physician service adjustments are calculated in accordance with the approved state plan provisions. The amounts calculated for 2006 and 2007 should then be compared to the payments that were issued, with collection sought for any excess payments issued. Written state contracts should be issued to the faculty physician groups to specify the terms of the access to care adjustment payments and to document the performance attributes referred to in the plan.

Status of Finding as of September 2009:

As noted above, OMPP believes that using estimates for the quarterly payments is reasonable based on the language in the state plan, Page 1c of section 4.9 B of the Indiana Medicaid State Plan. The calendar year 2006 year-end settlement was completed in August 2008, and the calendar year 2007 year-end settlement was completed in April 2009. One provider received additional payments for both years, while the other owed money to the State for both years and has repaid the amounts due. Quarterly payments of $34.5 million were made for calendar year 2008, and the year end settlement calculation will be completed following the providers' one year claims filing period.

Since the CY 2006 and 2007 settlements have been finalized, and the money owed to the state has been returned, OMPP believes this finding should be resolved and intends to appeal this matter to CMS. As our opinions differ on this matter, the finding remains open.