Department of Health and Human Services
Office of Inspector General
Office of Audit Services

September 2025 | A-06-24-04002

Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases

REPORT HIGHLIGHTS

September 2025 | A-06-24-04002

Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases

Why OIG Did This Audit

- This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts. For this audit, we focused on Mississippi's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that Mississippi had pursued under relevant Medicaid fraud statutes. These recoveries also include court-ordered awards. We refer to these recoveries as "MFCU-determined Medicaid overpayments."
- This audit examined whether Mississippi reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during Federal fiscal years 2021, 2022, and 2023.

What OIG Found

We determined that Mississippi should have reported MFCU-determined Medicaid overpayments totaling $4.5 million ($3.7 million Federal share) for the 20 cases during the period that we reviewed.

- Mississippi did not report and return MFCU-determined Medicaid overpayments related to paid claim amounts for six cases, totaling $4.2 million ($3.5 million Federal share), on the Form CMS-64;
- Mississippi did not report and return MFCU-determined Medicaid overpayments related to court-ordered awards that MFCU collected for 4 cases totaling $7,217 ($6,077 Federal share) on the Form CMS-64; and
- Mississippi reported and returned MFCU-determined Medicaid overpayments for 12 cases, totaling $290,584 ($241,948 Federal share), on the Form CMS-64.

What OIG Recommends

We made five recommendations to Mississippi, including that it return the Federal share of $3.5 million for the unreported cases that related to paid claims and $6,077 for the unreported cases that related to court-ordered awards. The full recommendations are in the report.

Mississippi did not concur with four of our findings and recommendations and partially concurred with one recommendation. For this recommendation, it detailed steps it plans to take in response to our recommendation.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

This audit is one of a series of audits we performed to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts.[1] For this audit, we focused on Mississippi's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes.[2] These recoveries also include court-ordered awards.[3] We refer to these recoveries as "MFCU-determined Medicaid overpayments." The Mississippi Division of Medicaid (State agency) is required to report these recoveries to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) and to refund the Federal share of those recoveries to the Federal Government.

OBJECTIVE

Our objective was to determine whether the State agency reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2020, through September 30, 2023 (Federal fiscal years (FYs) 2021, 2022, and 2023).

BACKGROUND

Medicaid Program and Medicaid Fraud Control Units

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

The Federal Government pays its share of a State's medical assistance costs (Federal share) under the Medicaid program based on the Federal medical assistance percentage (FMAP), which changes each FY and varies depending on the State's relative per capita income. The State agency is responsible for computing and reporting the Federal share, which is based on

[1] See Appendix B for a list of related Office of Inspector General reports.

[2] MFCUs, which are required by Federal statue, investigate and prosecute Medicaid provider fraud and abuse or neglect of residents in health care facilities and board and care facilities and of Medicaid enrollees in noninstitutional or other settings.

[3] Court-ordered awards include fines, penalties, and investigative costs.

the total computable amount multiplied by the FMAP.[4] The total computable amount and the Federal share are both reported on the Form CMS-64.

Section 1902(a)(61) of the Act requires each State to operate a MFCU or receive a waiver. The Act, section 1903(q), specifies that the function of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The Mississippi MFCU operates thru the Mississippi Attorney General's Office.

Federal Requirements Concerning Reporting of Medicaid Overpayments

Federal regulations implementing sections 1903(d)(2) and (3) of the Act specify that State agencies have 1 year from the date of discovery to recover Medicaid overpayments before the Federal share must be refunded to CMS. These regulations generally direct State agencies to make adjustments for the overpayments after 1 year whether or not the State has recovered the overpayment from the provider (42 CFR part 433, subpart F).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment within 1 year of discovery[5] because the relevant court has not determined the overpayment amount, the State is not required to report the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, reached a final judgment, including, if applicable, a final determination on appeal), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2)).

Further, Federal regulations state that a State agency is not required to return the Federal share if the State agency is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business (42 CFR § 433.312(b)). The Form CMS-64 provides a mechanism for State agencies to reclaim the Federal share of previously reported overpayments for cases in which the providers in question are subsequently determined to be bankrupt or out of business.

The Federal Share of Recoveries Is Computed on the Entire Recovery

Section 1903(d)(2)(A) of the Act states, "The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under

[4] CMS's *2020 Payment Error Rate Measurement Manual* defines the Form CMS-64 "total computable amount" as the Federal share plus the State share of Medicaid costs.

[5] Under 42 CFR § 433.316(d)(1), an overpayment that results from fraud is discovered on the date of the final written notice, as defined under 42 CFR § 433.304, of the State's overpayment determination.

this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection."

Section (d)(3)(A) of the Act states, "The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

On October 28, 2008, CMS issued to State health officials (SHOs) a letter (SHO # 08-004) (the SHO Letter) that interprets section 1903(d) of the Act regarding overpayments. This letter states: "Any State action taken as a result of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares . . . . The Federal Government is entitled to the applicable FMAP share of a State's entire recovery." This applies irrespective of whether the State action is pursuant to a State False Claims Act or other State statutory or common law cause of action.

The SHO Letter also states that "[t]he Act's broad mandate demands that a State return not only the Federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery." This includes the Federal share of any legal expenses, such as attorneys' fees and court costs.

Reporting of Fraud-Related Medicaid Overpayments

States use the Form CMS-64 to report actual Medicaid expenditures for each quarter. In turn, CMS uses the Form CMS-64 to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the Form CMS-64 and its attachments must be actual expenditures with supporting documentation (42 CFR § 430.30).

CMS's *State Medicaid Manual*, Pub. No. 45, instructs State agencies to apply the FMAP rate at which the original expenditure was matched when reporting recoveries (chapter 2, §§ 2500 (D)(2) and 2500.6(B)). If the expenditure cannot be immediately tied to a specific period, State agencies are to compute the Federal share at the FMAP rate in effect at the time the refund was received.

State Agency Policies and Procedures for Reporting Medicaid Fraud Control Unit-Determined Overpayments

The State agency has written procedures concerning preparation and submission of the Form CMS-64, which include procedures for reporting Medicaid overpayments. The MFCU collects the provider payments and sends the payment and related court documents to the State agency. State officials record the receipt of the funds in their accounting system and report the MFCU-determined Medicaid overpayments on the Form CMS-64 once the check is received. State officials told us that they do not report any MFCU-determined Medicaid overpayment amounts until they receive the payment from the providers.

HOW WE CONDUCTED THIS AUDIT

For our audit period (October 1, 2020, through September 30, 2023) we identified and reviewed MFCU-determined Medicaid overpayments totaling $4,599,828 ($3,857,526 Federal share) for 20 cases. Specifically, the total includes $4,454,024 for Medicaid restitution and $145,804 for court-ordered awards.

We reviewed the case files provided by the State agency and the MFCU and worked with the State agency to determine whether the MFCU-determined Medicaid overpayments were reported on the Forms CMS-64.[6] We reviewed the State agency's documentation supporting its reporting of the MFCU-determined Medicaid overpayments and reconciled the overpayments with the corresponding Forms CMS-64. We reviewed State agency payment documentation to determine whether the State agency returned the correct Federal share of its recoveries.

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 objectives.

See Appendix A for details on our audit scope and methodology.

FINDINGS

The State agency did not report and return the Federal share of all MFCU-determined Medicaid overpayments identified for FYs 2021 through 2023. The State agency reported and returned MFCU-determined Medicaid overpayments for 12 cases, totaling $290,584 ($241,948 Federal share), on the Form CMS-64. However, the State agency should have reported and returned MFCU-determined Medicaid overpayments totaling $4,461,240 ($3,743,043 Federal share) for the 20 cases during the period that we reviewed.

We found that the State agency:

- did not report and return MFCU-determined Medicaid overpayments related to paid claim amounts for six cases, totaling $4,163,439 ($3,495,018 Federal share), on the Form CMS-64;

- did not report and return MFCU-determined Medicaid overpayments related to court-ordered awards that MFCU collected for four cases, totaling $7,217 ($6,077 Federal share), on the Form CMS-64; and

[6] According to information provided by MFCU officials, the 20 cases with MFCU-determined Medicaid overpayments totaling $4,599,828 did not include judgments on appeal.

- may not have correctly reported and returned MFCU-determined Medicaid overpayments related to court-ordered awards that the MFCU may have collected for nine cases, totaling $138,588 ($114,483 Federal share) on the Form CMS-64.[7]

See Appendix C for the details related to the cases listed above.

This occurred because the State agency: (1) was not aware that it had to report overpayments for cases in which it had not yet collected the payments from the providers; (2) believed that since the MFCU receives all of the court-ordered awards and those amounts do not go to the State agency, it did not have to report the awards on the Form CMS-64; (3) did not have adequate internal controls to ensure that all checks that were received were reported on the Form CMS-64; and (4) did not think it had to return the Federal share for cases in which the provider was incarcerated.

OVERALL FEDERAL REQUIREMENTS AND GUIDANCE REGARDING THE REPORTING OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

Section 1903(d)(3)(A) of the Act states: "[t]he pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

Federal regulations state that "[a]n overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination" (42 CFR § 433.316(d)(1)).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment because the relevant court has not determined the overpayment amount, the State is not required to return the Federal share of the overpayment until 30 days after the date of the final judgment (42 CFR 433.316(d)(2)). Once the court has determined the overpayment amount (that is, has reached a final judgment, including, if applicable, a final judgment that has been appealed), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment.

Federal regulations specify that a State agency is not required to return the Federal share if the State agency is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business (42 CFR § 433.312(b)). The Form CMS-64 provides a mechanism (discussed below) for State agencies to reclaim the Federal share of previously

[7] Of the 20 cases we reviewed and categorized, some individual cases had both reported amounts and unreported amounts. Additionally, some cases had both reported or unreported overpayments related to both paid claims and unreported court-ordered awards. See Appendix C for a table that lists the cases and their respective categories.

reported overpayments for cases in which the providers in question are subsequently determined to be bankrupt or out of business.

In accordance with section 1903(d) of the Act and Federal regulations at 42 CFR part 433, subpart F, the State agency must refund the Federal share of Medicaid overpayments to CMS. The SHO Letter further states: "Any State action taken as a result of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares . . .. The Federal Government is entitled to the applicable FMAP share of a State's entire recovery."

Appendix D contains details on the Federal requirements and guidance related to the reporting of MFCU-determined Medicaid overpayments.

Departmental Appeals Board Decision

The Department of Health and Human Services, Departmental Appeals Board (DAB), issued DAB No. 2546 in 2013.[8] In this decision, the DAB distinguished provider overpayments from court-ordered penalties, fines, and costs for purposes of refunding the Federal share. The DAB noted that provider overpayments should be refunded to the Federal Government, regardless of whether the State is able to collect, while court-ordered penalties, fines, and costs (i.e., court-ordered awards) should be refunded when the State has actually collected them.

THE STATE AGENCY DID NOT REPORT AND RETURN THE FEDERAL SHARE OF ALL MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

Overpayments Not Reported

The State agency did not report and return MFCU-determined Medicaid overpayments related to paid claim amounts totaling $4,163,439 ($3,495,018 Federal share) for six cases on the Form CMS-64. The reasons the State agency did not report and return overpayments for these six cases are presented below:

- Four overpayments were not reported due to inadequate internal controls. The State agency did not have a process in place to review the checks and information containing relevant court decisions provided by the MFCU to ensure that all payments from MFCU-determined Medicaid overpayments were entered into the State agency's accounting system and that the Federal share was appropriately reported for all amounts.

[8] Missouri Department of Social Services, DAB No. 2546 (2013). Although the DAB decision refers to a 60-day timeframe for the State to attempt to recover overpayments before reporting, the Patient Protection and Affordable Care Act amended section 1903(d)(2) of the Act to extend the timeframe to 1 year.

- One overpayment was not reported because the State agency was unaware that it was required to report overpayments it had not yet collected and thought that it did not have to report the Federal share until it recovered the overpayment.

- One overpayment was not reported because the State agency did not receive the payment and the provider was incarcerated. State agency officials cited the provider's incarceration as the reason they believed the State agency did not have to report the restitution. The State agency did not provide any documentation that would support a determination that the provider was bankrupt or out of business, which is required in Federal regulations (42 CFR §§ 433.318(c) and (d)(2)).

Federal regulations specify that the State agency must report overpayments related to paid claims within 1 year from the date of discovery, regardless of whether recovery has been made, unless the provider is bankrupt or out of business (42 CFR § 433.300(b)). For overpayments resulting from fraud, if a final determination of the amount of the overpayment has not been made within 1 year of discovery of the overpayment, the State agency is not required to return the Federal share of such overpayment until 30 days after the date on which a final judgment is made (42 CFR §§ 433.316(a) and (d)(2)).

The relevant Federal requirements regarding documentation for providers that have gone bankrupt or out of business appear in Federal regulations at 42 CFR §§ 433.318(c) and (d)(2). The former provision states that the State agency is not required to refund the Federal share of an overpayment to CMS at the end of the 1-year period following discovery if the provider in question has filed for bankruptcy in Federal court before the end of the 1-year period following discovery and the State is on record with the court as a creditor in the amount of the Medicaid overpayment. The latter provision states:

> A provider is considered to be out of business on the effective date of a determination to that effect under State law. The agency must—
>
> > (i) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable State policies and procedures; and
> >
> > (ii) Make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law.

Federal regulations further specify that, unless the State agency is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business, after the 1-year recovery period has expired, a State agency must report and return the Federal share of the overpayment, regardless of whether or not the State agency has recovered all or

part of that amount (42 CFR § 433.312). Therefore, if a State has not met the documentation requirements regarding bankrupt or out-of-business providers under 42 CFR sections 433.318(c) and (d), cited above, then it must refund overpayments within regulatory timeframes and any other court-ordered awards (including double and treble damages) if and when it collects those amounts.

Court-ordered Awards Not Reported

The State agency did not report and return at least $7,217 ($6,077 Federal share) for court-ordered awards that the MFCU had collected. During our audit period, we identified an additional $138,588 ($114,483 Federal share) for court-ordered awards that the State agency is required to report and return upon collection.

State agency officials stated that the MFCU collects and keeps all of the funds collected for court-ordered awards and does not inform the State agency when it collects these amounts. Therefore, the State agency did not have records of receipts of court-ordered awards collected by the MFCU, and we did not review MFCU's documentation of its collections of these payments in its entirety. However, through documentation that we did obtain, we determined that the MFCU collected at least $7,217 for court-ordered awards for the cases included in our review. We did not receive documentation related to the remaining $138,588 ($114,483 Federal share) court-ordered awards. State agency officials stated that because the MFCU receives all of the funds collected for court-ordered awards and not the State agency, the State agency was not required to report them on the Form CMS-64. Nevertheless, court-ordered awards that are collected must be reported immediately after the end of the 1-year period specified in 42 CFR § 433.312(a).[9] Contrary to Federal requirements, the State agency did not report court-ordered awards that had been collected of at least $7,217 ($6,077 Federal Share) and may not have reported additional collections up to $138,588 ($114,483 Federal share).

RECOMMENDATIONS

We recommend that the Mississippi Division of Medicaid:

- work with CMS to determine whether any Federal share is owed for the six unreported cases that related to paid claims, totaling $4,163,439 ($3,495,018 Federal share);

- work with any necessary State authorities to report and return the Federal share of the unreported MFCU-determined Medicaid overpayments that related to court-ordered awards that were collected, totaling $7,217 ($6,077 Federal share);

[9] See DAB No. 2546 (2013).

- work with any necessary State authorities to identify MFCU collections of the remaining $138,588 ($114,483 Federal share) in court-ordered awards and report and return the Federal share if and when they are collected;

- strengthen internal controls by expanding written policies and procedures to include procedures for reviewing all checks and MFCU-determined Medicaid overpayment court documents received from the MFCU, recording them in the State agency's accounting system, reporting them on the Form CMS-64 within prescribed regulatory timeframes, and adding instructions on how to report court-ordered awards; and

- work with any necessary State authorities to determine the Medicaid overpayments and court-ordered awards for cases after our audit period and include any unreported items on the Form CMS-64 according to Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with our fourth recommendation and did not concur with the other four recommendations.

For our first recommendation, the State agency commented that it had reported $67,729 on the Form CMS-64 on September 30, 2024, and $4,563 on March 31, 2025. It also stated that the $4,091,208 was uncollectable because the business had been dissolved prior to the provider being incarcerated. The State agency provided additional documentation showing the dissolution of the business.

The State agency also did not concur with our second, third, and fifth recommendations to report and return any MFCU-determined Medicaid overpayments that related to court-ordered awards that were collected by the MFCU. The State agency stated that since the MFCU is separate and distinct from the Medicaid agency, the State agency had no authority to require MFCU to remit any court-ordered awards to the State agency. It also commented that court-ordered awards in excess of the State's restitution value are not recovered by, never in possession of, do not belong to, and are not under the control of the State agency. It suggested that any amounts unreported to the State agency by the MFCU be collected by CMS directly from the MFCU.

The State agency partially concurred with our fourth recommendation to strengthen its internal controls. It stated that it is expanding its policies related to MFCU-determined Medicaid overpayments. However, it noted that this policy will only include a process to report and return the Federal share of any amounts the MFCU reports and returns to the State agency.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

With respect to the State agency's comments on our first recommendation, we were unable to verify that the State agency reported and returned the Federal share for these cases because the State agency did not provide documentation demonstrating that it had reported these amounts on the Form CMS-64. For the case the State agency said was uncollectable due to the provider's business being dissolved, the State agency did not provide any documentation of its efforts to locate the provider's assets, which is required in Federal regulations. We modified our report to recommend that the State agency work with CMS to determine whether any Federal share is owed for these cases.

Regarding the State agency's comments on our second, third, and fifth recommendations, we modified our second recommendation to clarify the State agency should work with any necessary State authorities to report and return the $7,217 ($6,077 Federal share) that the MFCU collected from court-ordered awards on the Form CMS-64. Additionally, we modified the language for the third and fifth recommendations. In *Missouri Department of Social Services,* DAB No. 2546 (2013), the court upheld that collected court-ordered awards are applicable credits that reduce the amount of Medicaid expenditures. Accordingly, the retention of the Federal share of any such funds results in an overpayment by CMS within the meaning of section 1903(d)(2)(A) of the Act, and CMS is authorized to recoup that overpayment via a disallowance. Additionally, the SHO letter makes clear that the State agency is responsible for returning and reporting the Federal share of its entire recovery, including court-ordered awards. The requirement for refunds applies to States in general, and the State Medicaid agency is responsible for reporting and returning the Federal share on the Form CMS-64. As such, we modified the third and fifth recommendations to recommend that the State agency work with any necessary State authorities to ensure appropriate refund of the Federal share.

Regarding the State agency's comments on our fourth recommendation, we disagree that it is sufficient that the State expand its policies related to MFCU-determined Medicaid overpayments to only include a process to report and return the Federal share of any amounts the MFCU reports and returns to the State agency. We want to clarify that the State's responsibility to report and return the Federal share of recoveries applies to overpayments that must be reported, regardless of whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.[10] Additionally, we want to reiterate that the State agency is the agency responsible for reporting and returning the Federal share of the State's entire recovery, including court-ordered awards. The Act's broad mandate demands that a State return not only the Federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery.[11]

[10] 42 CFR part 433, subpart F.

[11] SHO # 08-004.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

This audit covers 20 MFCU cases with associated MFCU-determined Medicaid overpayments totaling $4,599,828 ($3,857,526 Federal share). According to information provided by the Mississippi MFCU, it received final determinations for 24 cases during our audit period (October 1, 2020, through September 30, 2023). For three of these cases, Department of Justice Federal prosecutors were involved, and the Federal share was returned to CMS directly. The State agency would not have received any of these funds to return; therefore, we removed these 3 cases from our audit. Additionally, one case we reviewed did not have any Medicaid restitution.

We did not audit the State agency's overall internal control structure. Rather, we reviewed only those internal controls related to our audit objective. To evaluate these internal controls, we interviewed State agency officials to determine what policies and procedures were related to collecting, recording, and returning MFCU-determined Medicaid overpayments.

We performed our audit work from April through December 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- conducted interviews with State agency staff to determine the policies and procedures for collecting, recording, and returning MFCU-determined Medicaid overpayments;
- conducted interviews with MFCU staff to determine their policies and procedures for reporting case information to the State agency;
- evaluated policies and procedures for recording the MFCU-determined Medicaid overpayments and determined how the overpayments flowed through the State's accounting system and were reported on the Form CMS-64;
- obtained a list from the MFCU of finalized cases for our audit period;
- obtained the case files for the judgments and settlements that the MFCU finalized during our audit period;
- reviewed case files to identify the amount the State agency should have reported on the Form CMS-64;

- reconciled State agency payment records with Medicaid overpayments reported on the Form CMS-64 to determine whether all payments were reported in accordance with Federal requirements; and

- discussed the results of our audit with State agency officials.

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 objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases	A-06-23-04004	6/20/2024
Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 70 Percent of the State's Medicaid Fraud Control Unit Cases	A-07-21-02834	10/25/2022
Texas Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases	A-06-20-04004	5/25/2022
Nebraska Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 76 Percent of the State's Medicaid Fraud Control Unit Cases	A-07-18-02814	6/10/2021
Wisconsin Did Not Report and Refund the Full Federal Share of Medicaid-Related Settlements and a Judgment	A-05-17-00041	12/13/2018

APPENDIX C: DETAILS OF REPORTED AND UNREPORTED CASES (FEDERAL SHARE)

Case	Reported Restitution	Unreported Restitution	Court-Ordered Awards Collected but Not Reported*	Court-Ordered Awards To Report if Collected
1	$3,209	$0	$2,706	$6,922
2	1,411	0	0	0
3	27,102	0	0	0
4	5,012	0	0	5,011
5	0	5,936	0	0
6	126,090	0	0	1,051
7	3,079	0	1,359	8,297
8	48,511	0	0	31,849
9	1,244	0	0	3,733
10	0	0	1,379	0
11	4,643	3,832	0	17,368
12	16,370	0	0	0
13	0	45,638	0	37,222
14	0	27	0	0
15	0	4,607	0	0
16	2,821	0	0	0
17	0	0	633	0
18	0	0	0	3,030
19	0	3,434,978	0	0
20	2,456	0	0	0
Total	**$241,948**	**$3,495,018**	**$6,077**	**$114,483**

***** All of the court-ordered awards identified during our audit period were unreported.

APPENDIX D: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL LAWS

Section 1903(d)(2)(A) of the Social Security Act (the Act) provides that "[t]he Secretary [of Health and Human Services (HHS)] shall . . . pay to the State, in such installments as he may determine, the amount so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection."

Section 1903(d)(3)(A) of the Act provides that "[t]he pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

FEDERAL REGULATIONS

Federal regulations (42 CFR § 433.300(b)) state:

> Section 1903(d)(2)(C) and (D) of the Act . . . provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Federal regulations state: "The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS" (42 CFR § 433.316(a)).

Under 42 CFR § 433.316(d)(1), an overpayment that results from fraud is discovered on the date of the final written notice, as defined under 42 CFR § 433.304, of the State's overpayment determination.

Federal regulations (42 CFR § 433.316(d)(2)) state:

> When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a

judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

CMS GUIDANCE (STATE HEALTH OFFICIAL LETTER)

The SHO Letter, dated October 28, 2008 (internal footnotes omitted), states:

> The [Social Security] Act requires that the amounts recovered by a State through a State FCA [False Claims Act] action be refunded at the Federal Medical Assistance Percentage (FMAP) rate. The Act's broad mandate demands that a State return not only the Federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery.
>
> Any State action taken as a result of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares. A State may not seek to recover merely the 'State share' of computed fraud damages unless appropriate Federal and State authorities formally agree to pursue them as separate actions. If there is no formal agreement to sever, a State may not claim in a State FCA case that it is only recovering damages incurred by the State, but not the Federal Government. Nor may a State return merely the Federal portion of 'single' damages and retain all other amounts, such as double and treble damages. The Federal Government is entitled to the applicable FMAP share of a State's entire recovery.
>
> States are also required to return the FMAP percentage on State recoveries based upon actions brought against third parties, such as actions against pharmaceutical companies, alleging inappropriate Medicaid expenditures. Though these third parties are not necessarily directly reimbursed by Medicaid, they may be liable under a State FCA for having caused false or fraudulent claims to be submitted by others. A State may not avoid adhering to the requirements set forth in section 1903(d) of the Act by virtue of pursuing legal action against a person or entity that has caused false or fraudulent claims to be submitted rather than the party that directly submitted false or fraudulent claims.
>
> The FMAP proportionate share of State FCA-based fines, penalties, or assessments imposed against providers or entities are to be refunded. The HHS Departmental Appeals Board has long recognized the Federal Government's entitlement to its proportionate share of civil penalties assessed by States against providers or other entities . . . .
>
> For State FCA legal actions neither the relator's share, nor legal expenses (whether borne by the State or the relator) or other administrative costs arising

from such litigation, may be deducted from the Federal portion of the entire proceeds of the litigation. A State must return the Federal portion of such recoveries at its applicable FMAP rate for medical services in recognition of the overpayment that resulted from a payment for Medicaid services. Historically, costs that are in support of the proper and efficient administration of a State's Medicaid program are recognized as administrative costs and not service costs. To the extent attributable to Medicaid recoveries, these costs may be the basis for claims for reimbursement as an administrative cost that benefits the Medicaid program and reimbursed at the regular administrative percentage rate. Federal reimbursement is not available for administrative costs that are not directly related to Medicaid recoveries.

Appendix E: State Agency Comments

Docusign Envelope ID: 2B9DE240-AAD7-4443-925B-3C3358E72DBA

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

May 9, 2025

Report Number A-06-24-04002

Patricia Wheeler
Regional Inspector General for Audit Services
HHS – OIG – Office of Audit Services
1100 Commerce Street
Dallas, TX 75242

RE: *Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases*

Dear Ms. Wheeler,

The Mississippi Division of Medicaid (DOM) has reviewed the Office of the Inspector General draft report entitled *Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases*. As requested, DOM's response is attached.

Kind Regards,

Cindy Bradshaw

Cindy Bradshaw
Executive Director
Mississippi Division of Medicaid

Toll-free 800-421-2408 | Phone 601-359-6050 | Fax 601-359-6294 | medicaid.ms.gov

Responsibly providing access to quality health coverage for vulnerable Mississippians

Recommendation 1: Report and return the Federal share for the six unreported cases that related to paid claims, totaling $4,163,439 ($3,495,018 Federal share).

DOM Response: *DOM does not concur.* Of the $4,163,439 listed above:

- $67,729 was reported on the Form CMS-64 report for QE 9/30/2024;
- $4,563 was reported on the Form CMS-64 report for QE 3/31/2025; and
- $4,091,208 is not collectable as the business was dissolved prior to the client being incarcerated, as shown in the supporting documentation attached.

Recommendation 2: Report and return the Federal share of the unreported MFCU-determined Medicaid overpayments that related to court-ordered awards that were collected, totaling $7,217 ($6,077 Federal share).

DOM Response: *DOM does not concur.* The $7,217 identified above was reported to the OIG by MFCU and represent court-ordered awards in excess of the value required to make DOM whole (the restitution value). DOM had no knowledge of MFCU receiving these funds nor was DOM ever in possession of these funds.

The Mississippi Legislature established DOM in the Office of the Governor while MFCU is located in the Office of the Attorney General. *See* Miss. Code Ann. §§ 43-13-107, 43-13-219, and 43-13-221. Additionally, OIG's own regulations mandate that MFCU be "separate and distinct from the Medicaid agency" such that "[n]o official of the Medicaid agency will have authority to review the activities of the Unit …" 42 CFR §1007.9. Thus, per both federal regulation and state statute, DOM has no authority to require MFCU to remit any court-ordered awards to DOM.

It is DOM's understanding that MFCU has clearly indicated its position on this issue to OIG, as stated on page 35 of the OIG Mississippi MFCU 2020 Inspection. MFCU relied on *Alabama v. Centers for Medicare and Medicaid Services*, 780 F. Supp. 2d 1219 (M.D. Ala. 2011) to support its belief that MFCU had appropriately calculated the repayment of all federal funds. *See* https://oig.hhs.gov/documents/evaluation/3201/OEI-12-20-00200-Complete%20Report.pdf.

Court-awarded awards in excess of DOM's restitution value are not recovered by DOM, are never in possession of DOM, do not belong to DOM, and are not under the control of DOM. Any concerns OIG may have about these amounts should be directed to MFCU. If the OIG still believes that MFCU owes this amount, the recommendation should be updated to urge CMS to obtain any award collections directly from MFCU.

Recommendation 3: Work with the MFCU to identify collections of the remaining $138,588 ($114,483 Federal share) in court-ordered awards and report and return the Federal share if and when they are collected.

DOM Response: *DOM does not concur.* DOM has reported all amounts recovered by MFCU which were returned to DOM. MFCU does not report or provide to DOM the amounts collected from court-ordered awards in excess of DOM's restitution value. As stated above, MFCU and DOM are separate entities, and DOM has no statutory or regulatory authority to force MFCU to

provide the court ordered awards to DOM. If the OIG still believes that MFCU owes this amount, the recommendation should be updated to urge CMS to obtain any award collections directly from MFCU.

Recommendation 4: Strengthen internal controls by expanding written policies and procedures to include procedures for reviewing all checks and MFCU-determined Medicaid overpayment court documents received from the MFCU, recording them in the State agency's accounting system, reporting them on the Form CMS-64 within prescribed regulatory timeframes, and adding instructions on how to report court-ordered awards.

DOM Response: *DOM concurs.* DOM is working to strengthen internal controls by expanding its policies related to MFCU-determined Medicaid overpayments. However, as discussed above, DOM is without statutory or regulatory authority to require MFCU to report or provide any court-ordered awards to DOM. DOM's policy will only include a process to report and repay the federal share of any amounts MFCU reports and returns to DOM. Per OIG's regulations, no DOM official has authority to review the activities of MFCU. Thus, any concerns OIG may have about amounts identified and collected by MFCU which are not reported and returned to DOM should be directed to MFCU.

Recommendation 5: Work with the MFCU to determine the Medicaid overpayments and court-ordered awards for cases after our audit period and include any unreported items on the Form CMS-64 according to Federal requirements.

DOM Response: *DOM does not concur.* As previously stated, no DOM official has authority to review the activities of MFCU pursuant to 42 CFR §1007.9. Any concerns OIG may have about amounts identified and collected by MFCU which are not reported and returned to DOM should be directed to MFCU. All amounts MFCU returns to DOM will be reported on the Form CMS-64 according to Federal requirements. Any amounts recovered by MFCU which are not reported and returned to DOM should be collected by CMS directly from MFCU.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov