

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**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**

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**June 2021
A-07-18-02814**

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief

Date: June 2021

Report No. A-07-18-02814

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



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 Medicaid claims amounts and damages. For this audit, we focused on Nebraska's Medicaid Fraud Control Unit (MFCU) actions related to Medicaid overpayments from legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. Nebraska is required to report recoveries for these MFCU-determined Medicaid overpayments to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share to the Federal Government.

Our objective was to determine whether Nebraska reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018.

How OIG Did This Audit

We worked with Nebraska to identify what portion of 66 MFCU cases, which resulted in MFCU-determined Medicaid overpayments totaling \$5.6 million, it reported to CMS for the period October 1, 2011, through September 30, 2018. We obtained legal documents related to MFCU-determined Medicaid overpayments as well as Nebraska's documentation that supported its reporting of those overpayments to determine whether Nebraska reported the correct Federal share.

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

What OIG Found

Nebraska did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018. Nebraska reported \$943,162 (\$498,299 Federal share) for this period. However, we determined that Nebraska should have reported MFCU-determined Medicaid overpayments totaling \$5.6 million (\$3.1 million Federal share) for the 66 MFCU cases that we reviewed. Therefore, Nebraska did not report \$4.6 million (\$2.6 million Federal share) of MFCU-determined Medicaid overpayments for this period. In addition, Nebraska did not report \$595,723 (\$311,352 Federal share) in a timely manner. Nebraska did not have adequate policies and procedures to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

What OIG Recommends and Nebraska Comments

We recommend that Nebraska refund \$1.8 million (Federal share) of the unreported MFCU-determined Medicaid overpayments that related to paid claims and that it report and refund up to \$781,732 (Federal share) of the unreported MFCU-determined Medicaid overpayments that related to court-ordered awards if and when collected. We also recommend that Nebraska determine the value of overpayments identified after our audit period that have been collected but not reported, report them to CMS, and refund the Federal share of the collected overpayments. We make other recommendations for the improvement of relevant policies and procedures.

Nebraska disagreed with the amount (\$2.6 million) in our draft report's first recommendation and added that it would work with CMS to determine and report the amount owed. Nebraska also said that it would work with CMS regarding overpayments identified after our audit period and that it would improve policies and procedures. Nebraska said that some providers went out of business or were bankrupt and added that it was not reporting or refunding amounts that it had not collected. We revised our recommendations for this final report by narrowing the focus and revising the amount of questioned costs in our first recommendation; by adding a new second recommendation that Nebraska report and refund overpayments related to court-ordered awards; and by clarifying our recommendation that Nebraska determine and report overpayments that occurred after our audit period.

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INTRODUCTION

WHY WE 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 claims amounts as well as any damages (when assessed). For this audit, we focused on the State of Nebraska's Medicaid Fraud Control Unit (MFCU)¹ actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. We refer to these recoveries as "MFCU-determined Medicaid overpayments." The Nebraska Department of Health and Human Services (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, 2011, through September 30, 2018 (Federal fiscal years (FYs) 2012 through 2018).

BACKGROUND

The 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 on the basis of 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 the total computable amount multiplied by the FMAP.² The total computable amount and the

¹ MFCUs, which are required by Federal statute, investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities and board and care facilities.

² CMS's *2018 Payment Error Rate Measurement Manual* defines the Form CMS-64 "total computable amount" as the Federal share plus the State share of Medicaid costs.

Federal share are both reported on the Form CMS-64. During our audit period, Nebraska's FMAP ranged from 51.16 percent to 56.64 percent.

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 and neglect in facility settings. The Nebraska MFCU was established by State statute that was signed into law on April 15, 2004.

Federal Requirements Concerning Reporting of Medicaid Overpayments

Federal regulations implement sections 1903(d)(2) and (3) of the Act and specify that State agencies have 1 year from the date of discovery to recover Medicaid overpayments before the Federal share must be reported to CMS. These regulations generally direct State agencies to make adjustments for the overpayments after 1 year if recovery is not made, unless the overpayments are fraud-related and are being determined in the courts.

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 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 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 (42 CFR § 433.316(d)(2); *Medicaid Program Integrity Manual*, § 11005).

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 (discussed below) 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

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. These expenses may be claimed for reimbursement as administrative costs that benefit the Medicaid program at the regular administrative percentage rate.

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.

CMS’s Medicaid Program Integrity Manual, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1 feeder form³ (Form CMS-64.9C1), if collected, or, for overpayments identified but not yet collected within regulatory timelines, on the Form CMS-64.9O feeder form⁴ (Form CMS-64.9O) (chapter 11, §§ 11005 and 11035).⁵

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.

According to CMS officials:

- In FY 2011, CMS revised the Form CMS-64.9O so that State agencies should report only Medicaid overpayments *not* resulting from fraud, waste, and abuse on that form.
- At the same time, CMS introduced the Form CMS-64.9OFWA feeder form (Form CMS-64.9OFWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse (including MFCU-determined Medicaid overpayments).
- The Form CMS-64.9OFWA is formatted similarly to the Form CMS-64.9C1 but includes a separate line for State agencies to report amounts reclaimed for cases in which the

³ The Form CMS-64.9C1 feeder form is used to provide detailed information about fraud, waste, and abuse collection efforts. The total from this feeder form carries over to the Form CMS-64 Summary sheet, line 9c.

⁴ Before it was revised (as discussed below), the Form CMS-64.9O feeder form was used to provide detailed information about overpayments identified but not yet collected, including overpayments concerning fraud, waste, and abuse. The total from this feeder form carried over to the Form CMS-64 Summary sheet, line 10c.

⁵ *CMS’s State Medicaid Manual*, chapter 2, § 2500.1(B), sets forth detailed instructions for the Form CMS-64 and states that collections identified through fraud, waste, and abuse efforts should be reported on line 9c.

State agencies subsequently determine that the providers in question are bankrupt or out of business. The Form CMS-64.9OFWA was available in the Medicaid Budget and Expenditures System beginning with FY 2011.^{6, 7}

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

The State agency has written policies and procedures concerning preparation and submission of the Form CMS-64, which include procedures for reporting Medicaid overpayments. In response to our questions regarding reporting timelines for Medicaid overpayments, State agency officials explained to us that Medicaid overpayments are reported after the provider has paid either all or part of the overpayment, or after 1 year from the date of final determination if all or some of the overpayments have not been collected.

HOW WE CONDUCTED THIS AUDIT

According to information provided by the State agency, during our audit period (October 1, 2011, through September 30, 2018), MFCU-determined Medicaid overpayments totaled \$19,983,596 for 70 cases. We removed 4 of the 70 cases, for reasons provided in Appendix A, and reviewed the remaining 66 MFCU cases with Medicaid overpayments totaling \$5,553,537.

We worked with the State agency to identify what portion of the \$5,553,537 it reported on the Form CMS-64 for the period October 1, 2011, through September 30, 2018. We obtained legal documents related to MFCU-determined Medicaid overpayments as well as the State agency's documentation that supported its reporting of those overpayments on the Form CMS-64 to determine whether the State agency reported the correct Federal share.

For our review of the overpayments that the State agency reported, we recalculated the amounts using the FMAP rates in effect as of the paid claims dates for the improper claims for each of the reporting quarters in our audit period. We applied the FMAP rate in effect as of the reporting quarter-end to any court-awarded damages. For each MFCU case, we determined the quarter in which the 30-day collection period ended and generally identified that quarter as the quarter for which the State agency should have reported the associated overpayments on the Form CMS-64. For further details on this analysis, see Appendix A.

⁶ The Medicaid Budget and Expenditures System is a Web-based application that Medicaid and Children's Health Insurance Program (CHIP) State agencies use to report budgeted and actual expenditures for Medicaid and CHIP for each fiscal period in addition to the actual quarterly expenditures that occur. Summarized statistical data are available for download.

⁷ The *Medicaid Program Integrity Manual* in effect for most of our audit period did not include guidance for the preparation of the Form CMS-64.9OFWA. CMS updated this manual in FY 2018, the last year of our audit period; this update eliminated guidance for the preparation of the Form CMS-64.9C1. Information for the Form CMS-64 and its feeder forms and subsidiary schedules is available at <https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/index.html> (accessed Jun. 11, 2020).

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 A contains the details of our audit scope and methodology and Appendix B contains details on the Federal share of the MFCU-determined Medicaid overpayments to be refunded.

FINDINGS

The State agency did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018. The State agency reported \$943,162 (\$498,299 Federal share) for this period. However, we determined that the State agency should have reported MFCU-determined Medicaid overpayments totaling \$5,553,537 (\$3,068,149 Federal share) for the 66 MFCU cases that we reviewed. The State agency reported the entire Medicaid overpayment amount for only 16 of these MFCU cases and did not report some or all of the Medicaid overpayment amounts for the remaining 50 cases. In total, the State agency did not report \$4,610,375 (\$2,569,851 Federal share) of MFCU-determined Medicaid overpayments for 76 percent (50 of 66) of the MFCU cases for this period.

The unreported funds consisted of the following:

- \$4,535,449 (\$2,528,595 Federal share) substantially associated with double and treble damages that had been determined by the courts, which the State agency was aware of but did not report;
- \$56,019 (\$31,400 Federal share) resulting from unreported attorneys' fees; and
- \$18,907 (\$9,856 Federal share) that had previously been reported but that the State agency incorrectly reclaimed.

In addition, although the State agency reported the \$943,162 (\$498,299 Federal share) of MFCU-determined Medicaid overpayments on the Form CMS-64, it did not always apply the correct FMAP rate to compute the Federal share of the MFCU-determined Medicaid overpayments on the Form CMS-64.⁸ Moreover, of the reported overpayments, the State agency did not report \$595,723 (\$311,352 Federal share) in a timely manner.

⁸ The difference between the amounts of Medicaid overpayments that the State agency should have reported (at the correct FMAP rates) and the amounts that it did report was relatively minor. That difference is reflected in the \$4,535,449 (\$2,528,595 Federal share) that we describe above as substantially associated with double and treble damages.

Furthermore, the State agency did not report MFCU-determined Medicaid overpayments related to fraud, waste, and abuse on the correct line of the Form CMS-64.9C1 if collected or the Form CMS-64.9OFWA if not collected within regulatory timeframes.

These errors occurred because the State agency did not have adequate policies and procedures to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

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

Federal regulations implement sections 1903(d)(2)(C) and (D) of the Act and state:

[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 (42 CFR § 433.300(b)).

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. 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 (42 CFR § 433.316(d)(2); *Medicaid Program Integrity Manual*, § 11005).

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 (discussed below) 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 *Medicaid Program Integrity Manual*, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1, if collected, or,

for overpayments identified but not yet collected on the Form CMS-64.90 (chapter 11, § 11035).⁹

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

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

Federal Requirements and CMS Guidance for Reporting the Federal Share of Medicaid Fraud Control Unit-Determined Medicaid Overpayments

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 interprets section 1903(d) of the Act regarding overpayments. The 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.”

The SHO Letter also explains that legal expenses or other administrative costs (including attorneys’ fees) arising from litigation may not be deducted from the Federal portion of the entire proceeds of the litigation. The letter states:

A [S]tate 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 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.

For additional details on this CMS guidance, see Appendix C.

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Not Reported

The State agency did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018. The State agency reported \$943,162 (\$498,299 Federal share) for this period. However, we determined that the State agency should have reported MFCU-determined Medicaid overpayments totaling \$5,553,537 (\$3,068,149 Federal share) for the 66 MFCU cases that we

⁹ Beginning in FY 2010, CMS implemented the Form CMS-64.90FWA feeder form (Form CMS-64.90FWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse (including MFCU-determined Medicaid overpayments).

reviewed. The State agency reported the entire Medicaid overpayment amount for only 16 of these MFCU cases and did not report some or all of the Medicaid overpayment amounts for 50 of these cases. In total, the State agency did not report \$4,610,375 (\$2,569,851 Federal share) of MFCU-determined Medicaid overpayments for 76 percent (50 of 66) of the MFCU cases for this period.

Overpayments Not Reported or Reported but at Incorrect Federal Medical Assistance Percentage Rates

The State agency did not report MFCU-determined Medicaid overpayments totaling \$4,535,449 (\$2,528,595 Federal share) that were substantially associated with double and treble damage amounts determined by the courts that the State agency was aware of but did not report. This amount also reflects our recalculation of overpayments that the State agency did report but at incorrect FMAP rates (footnote 8).

Attorneys' Fees Not Reported

The State agency did not report attorneys' fees totaling \$56,019 (\$31,400 Federal share). However, these costs may be claimed as administrative costs (on other lines of the Form CMS-64) at the regular administrative percentage rate.

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Incorrectly Reclaimed

The State agency incorrectly reclaimed \$18,907 (\$9,856 Federal share) of MFCU-determined Medicaid overpayments that had previously been reported on the Form CMS-64. None of the \$18,907 that the State agency reclaimed was related to cases in which a provider had declared bankruptcy or gone out of business.

Inadequate Policies and Procedures

The State agency did not correctly report funds associated with MFCU-determined Medicaid overpayments because its policies and procedures did not specify how to report double and treble damage amounts determined by the courts.

THE STATE AGENCY REPORTED THE FEDERAL SHARE OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS AT INCORRECT RATE, LATE, AND ON INCORRECT LINES OF THE FORM CMS-64

Federal Requirements and Guidance Regarding the Use of Federal Medical Assistance Percentage Rates, Reporting Timeframes, and Lines of the Form CMS-64

CMS guidance addresses the FMAP rates at which Medicaid overpayments are to be reported: "When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the

time the expenditure was recorded in your accounting system” (*State Medicaid Manual*, § 2500(D)(2)).

CMS guidance also sets out the requirements for reporting the Federal share of recoveries and collections. This guidance states: “[D]etermine the date or period of the expenditure for which the refund is made to establish the FMAP at which the original expenditure was matched by the Federal government. Make refunds of the Federal share at the FMAP for which you were reimbursed” (*State Medicaid Manual*, § 2500.6(B)).

Federal regulations specify that a State agency has 1 year from the date of discovery to collect Medicaid overpayments before the Federal share must be refunded. 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(d)(2)).

The *Medicaid Program Integrity Manual*, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1, if collected, or, for overpayments identified but not yet collected, on the Form CMS-64.90 (chapter 11, §§ 11005 and 11035) (footnote 9).

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Reported at Incorrect Federal Medical Assistance Percentage and Late

The State agency reported MFCU-determined Medicaid overpayments at the incorrect FMAP rate, and it did not report the majority of these overpayments in a timely manner. Specifically, of the \$943,162 (\$498,299 Federal share) of MFCU-determined Medicaid overpayments that the State agency reported on the Form CMS-64, it did not always apply the correct FMAP rate to compute the Federal share of the MFCU-determined Medicaid overpayments on the Form CMS-64 (footnote 8). In addition, of the reported overpayments, the State agency did not report \$595,723 (\$311,352 Federal share) in a timely manner.

The State agency did not correctly report funds associated with these MFCU-determined Medicaid overpayments because its written policies and procedures included instructions on how to refund the Federal share of these overpayments, but these policies and procedures did not include accurate instructions on the application of the correct FMAP rate. In addition, these policies and procedures did not include accurate instructions on the timely reporting of MFCU-determined Medicaid overpayments (both collected and uncollected). State agency officials told us that they believed that once the court had made its final determination, the State agency had an additional 1 year to report MFCU-determined Medicaid overpayments. However, the specified timeframe is 30 days.

These officials added that the State agency also followed unwritten procedures under which it reported some MFCU-determined Medicaid overpayments only after it had collected these

overpayments from providers. These overpayments were collected and reported after the 1-year date of discovery and the 30 days after the final judgment was made. These procedures did not comply with all applicable Federal requirements.

Medicaid Fraud Control Unit-Determined Medicaid Overpayments Reported on Incorrect Lines of the Form CMS-64

For the MFCU-determined Medicaid overpayments that the State agency reported, its practice was generally to report the amounts on line 6 of the Form CMS-64.9C1.¹⁰ However, all MFCU-determined Medicaid overpayments that were collected within regulatory timelines should have been reported on line 2 of that form. By using line 6 to report MFCU-determined Medicaid overpayments as well as other recoveries from other individual sources (such as CMS Program Integrity audits and Medicare Integrity Contractor audits, among others), the State agency incorrectly combined those recovery amounts. This adversely affected CMS's ability to track recoveries by the individual sources and evaluate the effectiveness of those various sources.

Also, the State agency reported some MFCU-determined Medicaid overpayments that were not collected within regulatory timelines on line 1 of the Form CMS-64.9O. However, CMS officials informed us that beginning in FY 2011, all MFCU-determined Medicaid overpayments that were not collected within regulatory timelines should have been reported on line 2 of the Form CMS-64.9OFWA. Although the *Medicaid Program Integrity Manual* in effect for most of our audit period did not include guidance for the preparation of the Form CMS-64.9OFWA (footnote 7), CMS officials informed us during our audit of the existence of this form and gave us information concerning its purpose and use. In addition, the Form CMS-64.9OFWA was available in the Medicaid Budget and Expenditures System (footnote 6) beginning with FY 2011.

CMS developed the Form CMS-64.9OFWA to work in conjunction with the Form CMS-64.9C1 as a mechanism for CMS and State Medicaid agencies to track both collected and uncollected Medicaid overpayments related to fraud, waste, and abuse (whether or not specifically identified as such by MFCUs). Because the State agency did not correctly prepare the Form CMS-64.9C1 and did not use the Form CMS-64.9OFWA, CMS did not receive accurate information on fraud, waste, and abuse that should have been available to both CMS and the State agency.

The State agency did not correctly report funds associated with MFCU-determined Medicaid overpayments because its policies and procedures were inadequate to ensure that it reported overpayments that were collected within regulatory timelines on the correct lines of the Form CMS-64.9C1. In addition, State agency officials told us that they did not know which reporting line of the Form CMS-64.9C1 related to MFCU-determined Medicaid overpayments. They also

¹⁰ Line 6 of both the Form CMS-64.9C1 and the Form CMS-64.9OFWA is for the reporting of any recoveries from activities not specific to recoveries reported on lines 1 through 5.

said that they were unaware of the existence of the Form CMS-64.9OFWA used to report uncollected Medicaid overpayments related to fraud, waste, and abuse.

RECOMMENDATIONS

We recommend that the Nebraska Department of Health and Human Services:

- report and refund \$1,788,119 (Federal share) of the unreported MFCU-determined Medicaid overpayments that related to paid claims;
- report and refund up to \$781,732 (Federal share) of the unreported MFCU-determined Medicaid overpayments that related to court-ordered awards if and when collected;
- determine the value of overpayments, including those related to court-ordered awards, identified after our audit period that have been collected but not reported; report them on the Form CMS-64; and refund the Federal share of the collected overpayments;
- improve policies and procedures to ensure that overpayments are reported correctly and in a timely manner on the Form CMS-64 in accordance with Federal requirements, to include adding instructions on (1) how to report double and treble damage amounts awarded by the courts, (2) application of the correct FMAP rate, and (3) the timely reporting of these overpayments; and
- improve policies and procedures to ensure that MFCU-determined Medicaid overpayments are reported on line 2 of the Form CMS-64.9C1 if collected or on line 2 of the Form CMS-64.9OFWA if not collected within timelines specified by Federal requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with the amount we questioned in our draft report's first recommendation and added that after working with CMS, it would report the amount owed to CMS. The State agency also said that it would work with CMS to execute our draft report's second recommendation and, with respect to our draft report's third and fourth recommendations, stated that it would improve policies and procedures with an estimated completion date of March 31, 2021.

After reviewing the State agency's comments, we revised our recommendations for this final report by narrowing the focus and revising the amount of questioned costs in our first recommendation, by adding a new second recommendation, and by revising our third recommendation for clarity. We made no changes to our last two recommendations.

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE REGARDING RECOMMENDED REFUND

State Agency Comments

The State agency disagreed with our recommendation to refund \$2,569,851 (Federal share) of the unreported MFCU-determined Medicaid overpayments. The State agency said that it had examined the MFCU cases that we reviewed, and it arranged those cases into four categories for purposes of its written comments:¹¹

1. providers that went out of business or were bankrupt,
2. paid settlements that included only the State share, with the Federal share handled by other entities,
3. other providers that the State agency, through its program integrity activities, identified in its Nebraska Family On-Line Client User System (N-FOCUS) and reviewed,¹² and
4. other providers that the State agency, through its program integrity activities, identified in its Medicaid Management Information System (MMIS) and reviewed.¹³

Regarding providers that went out of business or were bankrupt, the State agency stated: “we agree with the nature of the finding [but] disagree with respect to the questioned cost.” The State agency added that it was in the process of collecting documentation to reclaim from CMS “dollars already reported to CMS.”

The State agency agreed with our findings on the paid settlements for which the State agency received only the State share.

Regarding providers identified in the N-FOCUS system and reviewed, the State agency disagreed with the questioned cost and stated that a majority of providers in this category had made refunds to the State agency. The State agency added, though, that it had “limited documentation to provide OIG [Office of Inspector General] the receipt of funds during the audit.”

¹¹ The State agency’s comments spoke of 69 MFCU cases that we had analyzed, of which it compiled 59 cases into these 4 categories. Our audit identified 66 MFCU cases, of which 50 cases had not been reported in part or in total on the Form CMS-64. The State agency’s four categories do not align with the headings and subheadings of our findings.

¹² N-FOCUS is a comprehensive, integrated computer system that the State agency developed and that supports all State-level Medicaid program activities from intake and case management to case closure.

¹³ An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services.

Regarding providers identified in the MMIS and reviewed, the State agency disagreed with the questioned cost. The State agency said some providers in this category are on payment plans and continue to make payments. The State agency said that it would identify the cases that occurred after our audit period and work with CMS to determine the net effect of the judgments that had not been reported.

Separately from its comments on the four categories into which it arranged the MFCU cases we reviewed, the State agency also commented on our finding on double and treble damages (which are classified as “court-ordered awards” and which comprised a significant portion of the \$4,535,449 (\$2,528,595 Federal share) in MFCU-determined Medicaid overpayments discussed earlier in this report). In this respect, the State agency stated: “it is unreasonable for the [S]tate to refund awarded double and treble damages for [F]ederal dollars that were never expended, nor ever recovered by the [S]tate.” The State agency cited 42 CFR § 433.318(b), which concerns overpayment debts that a State need not refund. The State agency added that any amount above the original claims amount “would result in a net loss to the State.” The State agency pointed out that it refunded any amounts that it received, including any damages assessed, and stated that it “is not withholding receipts, but simply not reporting funds that are not recoverable.” The State agency acknowledged the need to be consistent with Federal guidelines and said that it was drafting new policies and procedures to be used going forward.

With respect to our draft report’s first recommendation in its entirety, the State agency reiterated that it disagreed with “the amount determined as recoverable” and stated that it would work with CMS to determine and report the amount owed.

Office of Inspector General Response

After reviewing the State agency’s comments, we revised our recommendations for this final report. Specifically, we narrowed the focus of our first recommendation so that it calls for the State agency to report and refund the overpayments that related only to paid claims (that is, actual claims that the MFCU determined were paid in error). In addition, we added to this final report a new second recommendation that involves court-ordered awards (including double and treble damages), and that recommends that the State agency report and refund amounts from that category of overpayments if and when the State agency is able to collect them. We also revised our recommendation (now the third recommendation) that involves the identification and reporting of overpayments that occurred after our audit period.¹⁴

¹⁴ In revising our recommendations in this manner, we are acknowledging the relevance of the Department of Health and Human Services, Departmental Appeals Board (DAB), decision in *Missouri Department of Social Services*, DAB No. 2546 (2013). In this decision, the DAB distinguished provider overpayments from penalties, fines, and costs for purposes of refunding the Federal share. The DAB noted that provider overpayments should be refunded, regardless of whether the State is able to collect, while penalties, fines, and costs (i.e., court-ordered awards) should be refunded when the State has actually recovered them. Our first two recommendations, as they appear in this final report, make the same distinction.

Regarding the first category into which the State agency's comments arranged the MFCU cases we reviewed, the State agency did not, either during our audit or after issuance of our draft report, give us documentation demonstrating that any of the providers were bankrupt or out of business. The State agency also did not provide any documentation concerning its efforts to locate these providers and recover the overpayment amounts.

The relevant Federal requirements regarding documentation for providers that have gone bankrupt or out of business appear in Federal regulations (42 CFR §§ 433.318(c) and (d)(2)). The former provision states that the State agency is not required to refund an overpayment to CMS if the provider in question has filed for bankruptcy in Federal court before 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.

Additionally, Federal regulations 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 the entire amount of the overpayment, regardless of whether or not the State agency has recovered all or part of that amount (42 CFR § 433.312). These regulations also describe conditions under which a State agency must refund the Federal share of MFCU-determined Medicaid overpayments (42 CFR § 433.316(d)).

We note the State agency's comment that it agreed with us regarding paid settlements that included only the State share and clarify that we did not include settlements in which the State agency received only the State's share of the overpayments in our calculation of the questioned costs.

Also, although the State agency may have received some refunds from providers identified in its N-FOCUS system, the State agency did not provide any new information that it had reported those refunds to the Federal Government. We therefore did not make any changes to our findings with respect to these providers.

Regarding providers that the State agency identified in its MMIS and reviewed, Federal regulations cited earlier state that the State agency has 1 year from the date of discovery to

recover MFCU-determined Medicaid overpayments. These regulations also state that after that 1-year period, the State agency must report and refund the overpayments, regardless of whether or not the recovery is made (42 CFR §§ 433.312 and 433.316(d)). The State agency's comment that some providers had set up payment plans has no direct bearing on what these Federal regulations require the State agency to do.

In addition, Federal regulations cited earlier provide that in cases involving court determinations for the total overpayments, if the 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)).

Taken together, these regulations convey the requirements, to include specified timeframes, for the reporting and refund of MFCU-determined Medicaid overpayments. During our audit, we obtained relevant court documents from the Nebraska MFCU and used them to determine the date on which the 30-day collection period ended after the court-determined settlement or judgment. We then identified the FY quarter in which that 30-day period ended and determined that the State agency should have reported the overpayment in total on that quarter's Form CMS-64 (Appendix A and footnote 15). The State agency did not report all overpayments from these cases in or after those quarters, and the \$2,569,851 (Federal share) remained unreported as of the end of our fieldwork.

Concerning the State agency's comments on reporting double and treble damages, specifically overpayment debts that the State need not refund under 42 CFR § 433.318(b), for a State to avoid returning the full overpayment amount, the State must meet the various conditions in Federal regulations (including providing supporting documentation) related to providers that are determined bankrupt or out of business. However, if a State has not met the documentation requirements regarding bankrupt or out-of-business providers under 42 CFR §§ 433.318(c) and (d), cited above, then it must refund any court-ordered awards (including double and treble damages) if and when it collects those amounts.

Specifically, section 1903(d)(3)(A) of the Act (Appendix C) states that the Federal Government is entitled to its pro rata share of any overpayments for medical assistance provided under a State's approved State plan. The SHO Letter cited earlier and in Appendix C states that section 1903(d)'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." The recommendations that we have revised for this final report clarify that in the context of the Department of Health and Human Services, Departmental Appeals Board, decision cited in footnote 14, we recognize that with respect to "any other recovery" (that is, court-ordered awards), a State agency is required to report and refund those amounts if and when they are actually recovered.

In the context of all of our findings, a mechanism exists through Form CMS-64.90FWA in which the State agency can reclaim any overpayments reported and refunded to the Federal

Government for which the State agency later determines that the provider is bankrupt or out of business, provided that the State agency follows the requirements of 42 CFR § 433.320(g).

We therefore recommend that the State agency report and refund the \$1,788,119 (Federal share) of unreported MFCU-determined Medicaid overpayments that related to paid claims to the Federal Government. We also recommend that if and when the State agency collects unreported MFCU-determined Medicaid overpayments that relate to court-ordered awards, it reports and refunds those overpayments.

STATE AGENCY COMMENTS REGARDING PROCEDURAL RECOMMENDATIONS

For our second recommendation, the State agency stated it would begin working with CMS to determine the value of overpayments identified after our audit period that had not been reported and would report them on the Form CMS-64.

The State agency agreed with our fourth and fifth recommendations (which in the draft report on which the State agency commented were the third and fourth recommendations, respectively). Specifically, the State agency said that it was working on improving policies and procedures to ensure that overpayments are reported correctly and in a timely manner, and to ensure that the MFCU-determined overpayments are reported on line 2 of the Form CMS-64.9C1 or Form CMS-64.9OFWA as applicable and in accordance with Federal requirements. The State agency added that its estimated completion date for these corrective actions was March 31, 2021.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

According to information provided by the State agency, during our audit period (October 1, 2011, through September 30, 2018) the Nebraska MFCU received final determinations for 70 cases that resulted in MFCU-determined Medicaid overpayments totaling \$19,983,596. Of the 70 cases, we removed 4 cases from our scope for the following reasons:

- Two of the cases involved only the State share because the Federal Government pursued its share separately (through mechanisms unrelated to the current audit).¹⁵
- One case involving \$14.4 million of pharmacy expenditures had been reported on different lines of the Form CMS-64 than the lines the State agency used to report the remaining cases.
- For one other case, the State agency was not required to refund the Federal share until after the end of our audit period.

This audit covers the remaining 66 MFCU cases with associated MFCU-determined Medicaid overpayments totaling \$5,553,537.

We did not audit the State agency's overall internal control structure. Rather, we reviewed only those internal controls related to our objective.

We performed our audit work, which included (in June and July 2018) on-site fieldwork at the State agency in Lincoln, Nebraska, from June 2018 to October 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- worked with our legal counsel and CMS staff to obtain an understanding of where on the Form CMS-64 State agencies should report MFCU-determined Medicaid overpayments;
- obtained documents from the Nebraska MFCU and the State agency that summarized the MFCU-determined Medicaid overpayments for which Nebraska received final determinations during our audit period;

¹⁵ According to the SHO Letter, a State may seek to recover only the State share if appropriate Federal and State authorities agree to "sever" the Federal and State portions and pursue them as separate actions.

- obtained legal documents related to the MFCU-determined Medicaid overpayments from the Nebraska MFCU and the State agency;
- obtained the State agency’s case log that it used to track MFCU-determined Medicaid overpayments related to fraud, waste, and abuse;
- obtained the State agency’s documentation supporting its reporting of the MFCU-determined Medicaid overpayments on the Form CMS-64;
- obtained and evaluated the State agency’s policies and procedures regarding the receipt and deposit of State recoveries;
- interviewed State agency personnel to understand:
 - how information regarding MFCU-determined Medicaid overpayments was shared among staff,
 - the staff’s understanding of its policies and procedures and their relationship to applicable Federal requirements, and
 - how MFCU-determined Medicaid overpayments were reported to the Federal Government;
- obtained documentation from the State agency’s payment system that identified which of the 66 MFCU cases were reflected on each submitted Form CMS-64 and that identified the specific MFCU-determined Medicaid overpayment associated with each case;
- reviewed that documentation to determine whether the State agency returned the correct Federal share of its recoveries;
- evaluated relevant court documents to determine the date on which the 30-day collection period ended for each MFCU case and
 - for each case, determined the quarter in which the 30-day period ended and
 - identified that quarter as the quarter for which the State agency should have reported the associated overpayments on the Form CMS-64,¹⁶

¹⁶ To be conservative, if the 30-day collection period ended within or during the last week of a quarter, we identified the following quarter as the quarter for which the State agency should have reported the associated overpayments.

- applied the FMAP rates in effect as of the paid claims dates to the improper claims amounts from the MFCU-determined Medicaid overpayments;
- applied the FMAP rates in effect as of the reporting quarter-end to the court-awarded damages amounts from the MFCU-determined Medicaid overpayments;
- calculated the Federal share of the total MFCU-determined overpayments that should have been reported on the Form CMS-64;
- calculated the difference in overpayments between what the State agency reported to CMS and what it should have reported; and
- discussed the results of our audit with State agency officials on November 18, 2019.

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: FEDERAL SHARE OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS NOT REPORTED AND NOT REPORTED IN A TIMELY MANNER

Table 1: MFCU-Determined Medicaid Overpayments Not Reported (Total and Federal Share)		
Federal Fiscal Year	Total Not Reported	Federal Share of Total Not Reported
2012	\$500,304	\$293,246
2013	2,037,739	1,146,250
2014	20,822	12,854
2015	9,645	6,611
2016	853,309	473,377
2017	666,665	357,896
2018	521,890	279,616
Totals	\$4,610,374	\$2,569,850

Table 2: Federal Fiscal Year Amounts That Were and Were Not Reported in a Timely Manner				
Fiscal Year	Amounts Reported in a Timely Manner	Federal Share of Amounts Reported in a Timely Manner	Amounts Not Reported in a Timely Manner	Federal Share of Amounts Not Reported in a Timely Manner
2012	\$16,159	\$9,443	\$35,960	\$20,282
2013	26,805	15,182	66,239	34,917
2014	22,036	12,287	15,079	8,078
2015	65,093	34,979	23,550	12,193
2016	130,756	69,654	295,537	153,315
2017	506	262	155,122	80,366
2018	104,991	54,994	4,236	2,202
Totals	\$366,346	\$196,801	\$595,723	\$311,353

APPENDIX C: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL LAWS

Section 1903(d)(2)(A) of 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 law states that any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment is liable to the Federal Government “for a civil penalty of not less than \$5,000 and not more than \$10,000 . . . plus 3 times the amount of damages which the Government sustains because of the act of that person.” However, the damages can be reduced to not less than 2 times the amount of damages if the person fully cooperated with the investigation, reported the information in a timely manner, and did not have actual knowledge of the investigation at the time the information was furnished (31 U.S.C. § 3729).

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)).

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 (PROGRAM MANUALS)

The *Medicaid Program Integrity Manual*, Sept. 23, 2011, states: “The form CMS-64.9C1 feeder form is used to provide detail about the fraud, waste, and abuse collection efforts and flows into line 9c of the Form CMS-64” (chapter 11, § 11035).

This manual also provides instructions for reporting MFCU-determined Medicaid overpayments on the Form CMS-64.9C1: “Line 2—MFCU Investigations[:] Used to report overpayment amounts collected from investigations conducted by the State’s MFCU” (chapter 11, § 11035).

The *State Medicaid Manual*, section 2500(D)(2), states:

FMAP Rate Applicable to Expenditures/Recoveries. When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider. Noncash expenditures, such as depreciation, are made when they are recorded in the accounting records in accordance with generally accepted accounting principles. The term ‘State’ means any agency of the State including the State Medicaid agency, its fiscal agents, a State health agency, or any other State or local organization incurring matchable expenditures.

Section 1903(a)(1) of the Act provides that [CMS] reimburse you quarterly an amount equal to the FMAP of the total amount expended during such quarter as Medical Assistance under the approved State plan. It provides that [CMS] reimburse you at the FMAP rate for the quarter in which the expenditure was made, even if the expenditure is not claimed for Federal reimbursement until some later quarter. To establish the FMAP rate applicable to a given expenditure, determine when the expenditure was made. When the expenditure cannot be tied to a specific prior period, compute the Federal share at the current FMAP rate. Make adjustments to reflect the correct FMAP rate in subsequent [Form CMS-64] as adjustments to prior period claims. Do not delay

the refunding of the Federal share simply because you cannot immediately tie the expenditure to a specific prior period.

CMS GUIDANCE (STATE HEALTH OFFICIAL LETTER)

The SHO Letter, dated October 28, 2008, 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.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

January 29, 2021

James Korn, Assistant Regional Inspector General for Audit Services
Office of Inspector General
Department of Health & Human Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: OIG audit A-07-18-02814

Mr Korn

The Nebraska Department of Health and Human Services (NDHHS) appreciates the opportunity to respond to the U.S. Department of Health and Human Services, Office of Inspector General Draft Report Number A-07-18-02814, regarding Medicaid Fraud Control Unit Overpayments in Nebraska. NDHHS agrees with recommendations regarding the improvement of policies and procedures related to the MFCU overpayment process. NDHHS disagrees with the recommendation to refund \$2.6 million (federal share) of potential Medicaid overpayments. Additional responses to each OIG recommendation are listed below.

If you have any questions, please contact John Meals at (402) 471-1332 or via email at john.meals@nebraska.gov.

Thank you.

Sincerely,

/s/ Kevin Bagley

Kevin Bagley
Director, Division of Medicaid and Long Term Care
Nebraska Department of Health & Human Services

cc Jeremy Brunssen, Deputy Director of Finance, Division of Medicaid and Long Term Care, NDHHS
John Meals, Comptroller, NDHHS

Helping People Live Better Lives

OIG Finding:

The State agency did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018. The State agency reported \$943,162 (\$498,299 Federal share) for this period. However, we determined that the State agency should have reported MFCU-determined Medicaid overpayments totaling \$5,553,537 (\$3,068,149 Federal share) for the 66 MFCU cases that we reviewed. The State agency reported the entire Medicaid overpayment amount for only 16 of these MFCU cases and did not report some or all of the Medicaid overpayment amounts for the remaining 50 cases. In total, the State agency did not report \$4,610,375 (\$2,569,851 Federal share) of MFCU-determined Medicaid overpayments for 76 percent (50 of 66) of the MFCU cases for this period.

The unreported funds consisted of the following:

- \$4,535,449 (\$2,528,595 Federal share) primarily associated with double and treble damages that had been determined by the courts, which the State agency was aware of but did not report.
- \$56,019 (\$31,400 Federal share) resulting from unreported attorneys' fees.
- \$18,907 (\$9,856 Federal share) that had previously been reported but that the State agency incorrectly reclaimed.

In addition, although the State agency reported the \$943,162 (\$498,299 Federal share) of MFCU determined Medicaid overpayments on the Form CMS-64, it did not always apply the correct FMAP rate to compute the Federal share of the MFCU-determined Medicaid overpayments on the Form CMS-64.8. Moreover, of the reported overpayments, the State agency did not report \$595,723 (\$311,352 Federal share) in a timely manner.

Furthermore, the State agency did not report MFCU-determined Medicaid overpayments related to fraud, waste, and abuse on the correct line of the Form CMS-64.9C1 if collected or the Form CMS-64.9OFWA if not collected within regulatory timeframes.

These errors occurred because the State agency did not have adequate policies and procedures to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

OIG Recommendation:

- refund the \$2,569,851 (Federal share) of the unreported MFCU-determined Medicaid overpayments.
- determine the value of overpayments identified after our audit period that have not been reported and report them on the Form CMS-64.
- improve policies and procedures to ensure that overpayments are reported correctly and in a timely manner on the Form CMS-64 in accordance with Federal requirements, to include adding instructions on (1) how to report double and treble damage amounts determined by the courts, (2) application of the correct FMAP rate, and (3) the timely reporting of these overpayments.

- improve policies and procedures to ensure that MFCU-determined Medicaid overpayments are reported on line 2 of the Form CMS-64.9C1 if collected or on line 2 of the Form CMS-64.9OFWA if not collected within timelines specified by Federal requirements.

Nebraska DHHS Response and Corrective Action:

NDHHS does not agree with the recommendation to refund the \$2,569,851 (federal share) of MFCU-determined Medicaid overpayments.

NDHHS completed a thorough examination of the 69 cases that OIG had included in the information. We compiled the list into four main categories.

1. Providers out of business and/or bankrupt pursuant to 42 CFR § 433.318(b) (13)
2. Settlements paid only including the state share with another entity handling the federal share (2)
3. Other Providers out of NFOCUS (28)
4. Other providers out of MMIS (16)

We agree with the OIG regarding settlements paid only including the state share (item number two from above).

For the providers that are out of business (item number one above), we agree with the nature of the finding, however disagree with respect to the questioned cost. The State is in the process of collecting documentation that will be provided to CMS when NDHHS reclaims the dollars already reported to CMS.

For item number three above, the State disagrees with the questioned cost. A majority of the NFOCUS providers have refunded NDHHS, but we had limited documentation to provide OIG the receipt of funds during the audit.

Some MMIS providers (item number four above) are on a payment plan and have continued to make payments. NDHHS will identify those that occurred after the audit period and work with CMS to get a net effect of the judgements not reported back to CMS. The State disagrees with the questioned costs for this item.

Specifically regarding the refund recommendation, NDHHS disagrees with the amount determined as recoverable. NDHHS will report, after working with CMS, the amount owed to CMS.

Concerning damages, NDHHS position is that it is unreasonable for the state to refund awarded double and treble damages for federal dollars that were never expended, nor ever recovered by the state. Specifically when a refund categorically falls within 42 CFR § 433.318(b), overpayment debts that the state need not refund. Any amount above the original claims would result in a net loss to the State. NDHHS would also clarify that as the State receives any refund, including any damages assessed, it returns the federal share of any dollars received applicable to that case. The State is not withholding receipts, but simply not reporting funds that are not recoverable. The State acknowledges this process should be completed in a manner consistent with federal guidelines and is drafting new policies and procedures to be used going forward.

NDHHS is working to improve the following policies and procedures as requested above with an estimated completion date of 3/31/21:

- improve policies and procedures to ensure that overpayments are reported correctly and in a timely manner on the CMS-64 Report in accordance with Federal requirements, to include adding instructions on (1) how to report double and treble damage amounts determined by the courts, (2) application of the correct FMAP rate, and (3) the timely reporting of these overpayments; and
- improve policies and procedures to ensure that MFCU-determined Medicaid overpayments are reported on line 2 of the Form CMS-64.9C1 if collected or on line 2 of the Form CMS-64.9OFWA if not collected within timelines specified by Federal requirements.

Additionally, DHHS will begin working with CMS to execute the following report recommendation:

- determine the value of overpayments identified after our audit period that have not been reported and report them on the CMS-64 Report;