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December 2013

# MEDICAID

## CMS Should Ensure That States Clearly Report Overpayments

# GAO Highlights

Highlights of [GAO-14-25](#), a report to congressional requesters

## Why GAO Did This Study

While states and certain federal entities have had long-standing roles identifying Medicaid improper payments, the Deficit Reduction Act of 2005 expanded CMS's role in identifying improper payments. As a result, CMS created a national audit program, which uses federal contractors to audit state Medicaid claims and identify overpayments—payments that should not have been made or were higher than allowed—to providers. States are responsible for recovering any identified overpayments and reporting the return of the federal share of those overpayments to CMS.

GAO was asked to examine states' efforts to recover and report overpayments identified by federal audits, and examine CMS's review of state reporting. This report assesses the extent to which: (1) states recovered Medicaid overpayments identified by federal audits and reported the return of the federal share, and (2) CMS reviewed states' reporting of Medicaid overpayments related to these federal audits. GAO obtained overpayment and recovery data from all states with an identified overpayment and compared this with CMS data; reviewed relevant laws, regulations, and CMS guidance; and interviewed CMS and state officials.

## What GAO Recommends

GAO recommends that the CMS Administrator increase efforts to ensure that states are clearly reporting overpayments identified by federal audits in the designated location of the CMS-64 form. HHS concurred with this recommendation.

View [GAO-14-25](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

December 2013

## MEDICAID

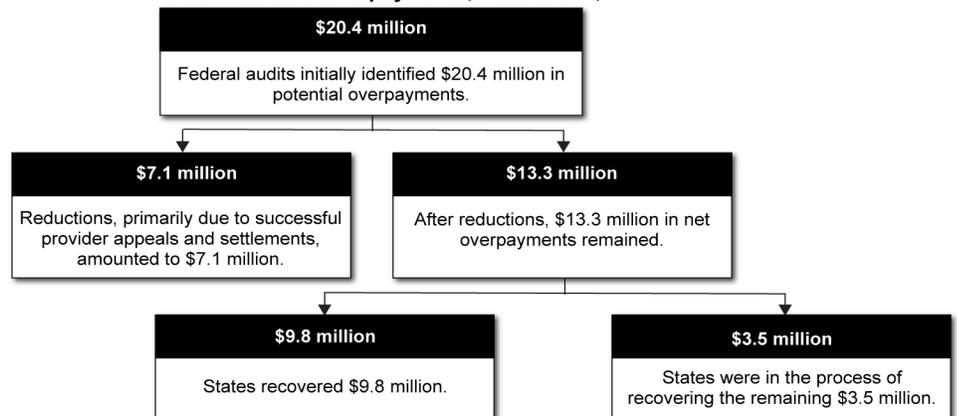
### CMS Should Ensure That States Clearly Report Overpayments

## What GAO Found

States recovered \$9.8 million in Medicaid overpayments, but they did not clearly report the overpayments and the return of the federal share to the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS). Federal audits initially identified about \$20.4 million in potential Medicaid overpayments across the 19 states with identified overpayments from June 2007 through February 2012. Of the \$13.3 million in net overpayments shown below, states recovered \$9.8 million and were in the process of recovering the remaining \$3.5 million. States should have reported the return of the federal share for \$13.3 million on the line designated for overpayments identified by national audit program contractors on the CMS-64—the form that states fill out quarterly to obtain federal reimbursement for Medicaid services. However, states made multiple reporting errors. Specifically:

- instead of reporting \$13.3 million, states reported the return of the federal share for \$12.4 million and did not report the return of the federal share for the remaining \$855,000; and
- within the \$12.4 million that was reported by states, \$6.6 million was correctly reported on the CMS-64, while the remaining \$5.8 million was reported on the CMS-64, but not on the correct line.

#### Overview of Potential Medicaid Overpayments, Reductions, and Recoveries



Source: GAO review of Centers for Medicare & Medicaid Services documents.

CMS generally reviewed states' reporting of overpayments but was not always aware of incomplete reporting. All 7 of the CMS regional offices GAO spoke with indicated that reviewing states' reporting of the return of the federal share of overpayments was a routine part of their quarterly review of the CMS-64 and helped ensure the timely return of the federal share of overpayments in 59 of the 89 audits GAO reviewed. In some cases, though, regional offices were not always aware that states' reporting was incomplete. CMS's Medicaid Integrity Group may review data from these audits on the designated line of the CMS-64, which can be an important gauge for measuring the effectiveness of CMS's efforts to reduce improper payments. However, reviewing these data would not yield a clear picture of the return of the federal share of overpayments given the errors GAO identified in state reporting.

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## **Abbreviations**

CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FAR	Final Audit Report
HHS	Department of Health and Human Services
MIG	Medicaid Integrity Group
NMAP	National Medicaid Audit Program

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December 6, 2013

The Honorable Thomas R. Carper  
Chairman  
Committee on Homeland Security and Governmental Affairs  
United States Senate

The Honorable Darrell Issa  
Chairman  
Committee on Oversight and Government Reform  
House of Representatives

The Centers for Medicare & Medicaid Services (CMS), the federal agency within the Department of Health and Human Services (HHS) that oversees Medicaid, estimated that \$19.2 billion of Medicaid's federal expenditures in fiscal year 2012 involved improper payments.<sup>1</sup> Improper payments include overpayments, which are any payments that should not have been made or were more than allowed. While states and certain federal entities have had long-standing roles in program integrity activities, such as identifying improper payments and recovering overpayments,<sup>2</sup> the Deficit Reduction Act of 2005 (DRA) expanded CMS's role.<sup>3</sup> CMS subsequently established the National Medicaid Audit Program (NMAP), which uses contractors to audit state Medicaid claims. From June 2007, when these audits began, through February 2012, NMAP contractors conducted over 1,500 audits and identified potential overpayments to health care providers of about \$20.4 million in their audit reports.

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<sup>1</sup>An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note).

<sup>2</sup>State entities include Medicaid Fraud Control Units and state program integrity units, while other federal entities engaged in Medicaid program integrity activities include HHS's Office of Inspector General and the Department of Justice.

<sup>3</sup>See, Pub. L. No. 109-171, § 6034, 120 Stat. 4, 74-78 (2006) (codified at 42 U.S.C. § 1396u-6).

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States are responsible for recovering overpayments identified by audits. Because the federal government matches states' expenditures for most Medicaid services, a portion of the overpayments are federal dollars that states must return to CMS. States return the federal share by reporting the overpayment amount on the CMS-64—a form that states fill out quarterly to obtain federal reimbursement for services provided under the Medicaid program.<sup>4</sup>

Our recent work identified limitations in the effectiveness of NMAP audits and instances where states may have under-reported the recovery of overpayments.<sup>5</sup> To follow-up on our recent work, you asked us to examine states' efforts to recover and report overpayments identified by NMAP contractors—which we refer to as federal audits—and CMS's review of state reporting. This report focuses on the extent to which:

1. states recovered Medicaid overpayments identified by federal audits and reported the return of the federal share, and
2. CMS reviewed states' reporting of Medicaid overpayments related to these federal audits.

To address both reporting objectives, we collected data on state recoveries and conducted structured interviews with all 19 states that had one or more overpayments identified by federal audits conducted from June 2007 through February 2012. We chose this end date because states should have reported the return of the federal share for their overpayments to CMS by March 2013 when we began our data collection.<sup>6</sup> We compared the data we collected from states on recoveries to the overpayments identified by the federal audits and to the overpayments reported by the states on the CMS-64. We also

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<sup>4</sup>States report actual expenditures and overpayment amounts on the CMS-64. Generally speaking, the reported overpayments are subtracted from states' Medicaid expenditures, which forms the basis for computing the federal share of program costs. Throughout this report, we refer to this process as reporting the return of the federal share.

<sup>5</sup>See GAO, *National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States*, [GAO-12-627](#) (Washington, D.C.: June 14, 2012), and *Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, [GAO-13-50](#) (Washington, D.C.: Nov. 13, 2012).

<sup>6</sup>Generally, states have one year from the date of the final audit report to return the federal share, regardless of whether or not the state was successful in recovering the overpayment amount. See 42 U.S.C. § 1396b(d)(2)(C); 42 C.F.R. § 433.312.

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interviewed CMS headquarters staff, including the Medicaid Integrity Group (MIG), the main entity responsible for establishing policies for the NMAP and, through the contractors, conducting the federal audits; the Financial Management Group, which is responsible for reviewing the CMS-64; and the 7 CMS regional offices responsible for overseeing the reporting of overpayments for the 19 states that had an identified overpayment. In addition, we reviewed relevant Medicaid Integrity Program laws and regulations. We also reviewed CMS guidance issued to states on reporting of overpayments from federal audits, including the CMS financial review guide on the CMS-64.<sup>7</sup>

We reviewed the state data we collected for reasonableness and verified whether the provider identification, overpayment amount, and audit report's issuance date was consistent with overpayment data from the federal audits. In four instances, we found differences in the overpayment amount identified by the state and by the federal audits. For these instances, we discussed the differences with the states and CMS and resolved the discrepancies. Based on these checks, we determined that these data were sufficiently reliable for our purposes. We also performed checks of the CMS-64 data, and discussed these data and their internal controls with knowledgeable CMS officials. Because state reporting of overpayments on the CMS-64 was incomplete, we discuss the CMS-64's data limitations in this report, but did not use these data to report states' return of the federal share of overpayments.<sup>8</sup>

We conducted this performance audit from January 2013 to December 2013 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.

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<sup>7</sup>See *The Centers for Medicare and Medicaid Services, Financial Review Guide for the Quarterly Medicaid Statement of Expenditures (Form CMS-64 Report)*, February 2012.

<sup>8</sup>See GAO, *Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, [GAO-13-50](#) (Washington, D.C.: Nov. 13, 2012).

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## Background

When a contractor conducts a federal audit of claims data and identifies an overpayment, the contractor drafts an audit report and obtains comments from CMS, the provider, and the state before submitting the completed report to CMS. Within CMS, the MIG reviews the audit contractor's submission and, when finalized, sends a final audit report (FAR) to the state, as well as the appropriate CMS regional office that oversees the state. The FAR identifies the total overpayment amount paid to the provider and specifies the amount of the federal share of that overpayment the state must return.<sup>9</sup>

To initiate recovery of the overpayment, the state sends a demand letter to the provider indicating the amount due as identified in the FAR. Providers may opt to appeal the findings in the FAR, thus initiating an appeals process that is determined by each state and is subject to the state's Medicaid program requirements.<sup>10</sup> When the state's appeals process is complete, that decision determines the final amount owed by the provider. This final amount may be the full overpayment, a reduced amount of the overpayment, or nothing.

The state generally has one year from the date of the FAR to recover the overpayment from the provider before reporting the return of the federal share to CMS.<sup>11</sup> Federal law requires the state to return the federal share of the overpayment regardless of whether the state was able to recover it, unless the provider has been determined to be bankrupt or out of business.<sup>12</sup> If the overpayment is reduced through an appeals process, the state is only required to return the federal share for the net overpayment amount.

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<sup>9</sup>The amount of the federal share varies by state. The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income. Under this statutory formula, the federal government's share of Medicaid expenditures—and thus, its share of reported overpayments—can range from 50 to 83 percent.

<sup>10</sup>States may also challenge the findings of a FAR by filing an appeal with the Department of Health and Human Services' Appeals Board Appellate Division.

<sup>11</sup>42 U.S.C. § 1396b(d)(2)(C); 42 C.F.R. § 433.312. States must return the federal share of the overpayment either when it is recovered or at the end of the one-year period following discovery of the overpayment, whichever is earlier. 42 C.F.R. § 433.320(a). The discovery date for overpayments typically begins on the date of the final written notice of the state's overpayment determination to the provider.

<sup>12</sup>42 U.S.C. § 1396b(d)(2)(D); 42 C.F.R. § 433.312(b).

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CMS has had a long-standing requirement that states report overpayments and the return of the federal share on the CMS-64. Beginning in fiscal year 2010, CMS initiated a more detailed reporting requirement to better track overpayments and the return of the federal share from different types of audits. As a result, CMS required states to report overpayments from federal audits, as well as other sources—such as state audit results, Medicaid Fraud Control Units, and others—on each of the six line items specified for each type of audit.<sup>13</sup> The reported overpayments are subtracted from the states' Medicaid expenditures, which forms the basis for computing the federal share of program costs.

CMS's regional offices are responsible for overseeing states' reporting of overpayments identified in the FARs and receive a copy of the FAR when it is sent to a state in its region.<sup>14</sup> The FAR alerts the regional office of its responsibility for ensuring that the state reports the overpayment identified and returns the federal share at the applicable federal match within one year from the date of the FAR. If the state does not return the federal share of an overpayment within one year, the state will be liable for interest on the federal share of overpayments not recovered and not returned.<sup>15</sup> (See fig. 1.)

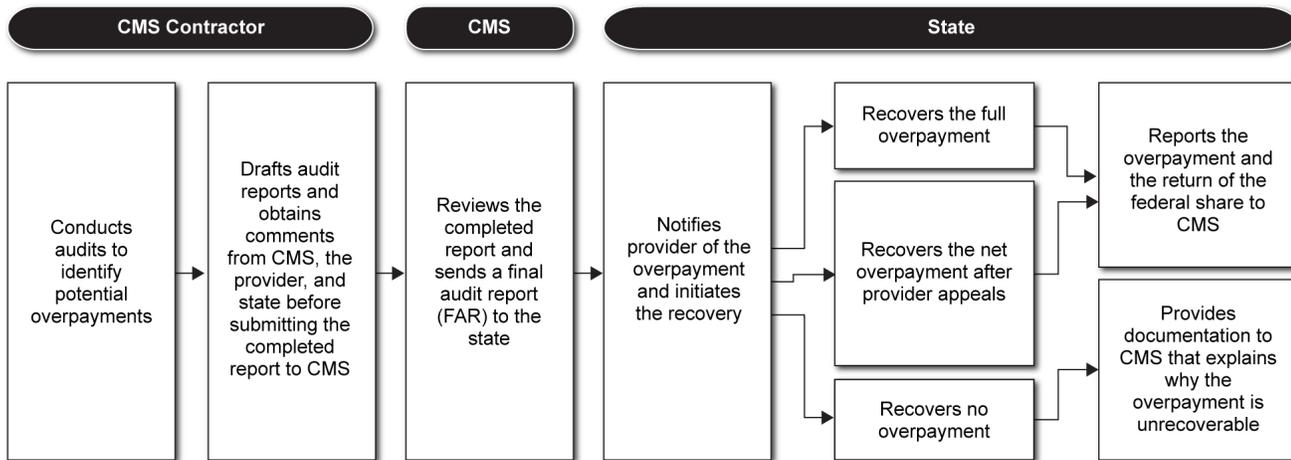
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<sup>13</sup>Specifically, CMS included 6 lines related to overpayment reporting on the CMS 64.9C1, which is a sub-form within the CMS-64. Line 5 on this form is designated for overpayments identified by federal audits conducted by NMAP contractors. For the purposes of this report, we refer to this as line 5 of the CMS-64.

<sup>14</sup>CMS must ensure that state expenditures claimed for federal matching on the CMS-64 are programmatically reasonable and allowable under federal laws, regulations, and policy guidance. To achieve this, CMS relies primarily on its regional offices' financial and funding staff to perform quarterly reviews and validate state entries on the CMS-64. The 10 regional offices, located throughout the country, validate and audit the reported expenditure data and accompanying detailed information each quarter in their respective states.

<sup>15</sup>42 C.F.R. § 433.320(a)(4). If the state does not return the federal share of an overpayment within one year, CMS issues a demand letter requesting the immediate return of the federal share. If the state still does not return the federal share, CMS then issues a disallowance—which is a letter that specifies, among other things, the amount that is not allowed and the reason for this determination—to the state for the federal share of the overpayment. The state will be liable for interest at the Current Value of Funds Rate, which will accrue beginning on the day after the end of the one year period following discovery of the overpayment until the last day of the quarter for which the state submits a CMS-64 report returning the federal share of the overpayment.

**Figure 1: CMS and State Roles in Identifying, Recovering, and Reporting Medicaid Overpayments**

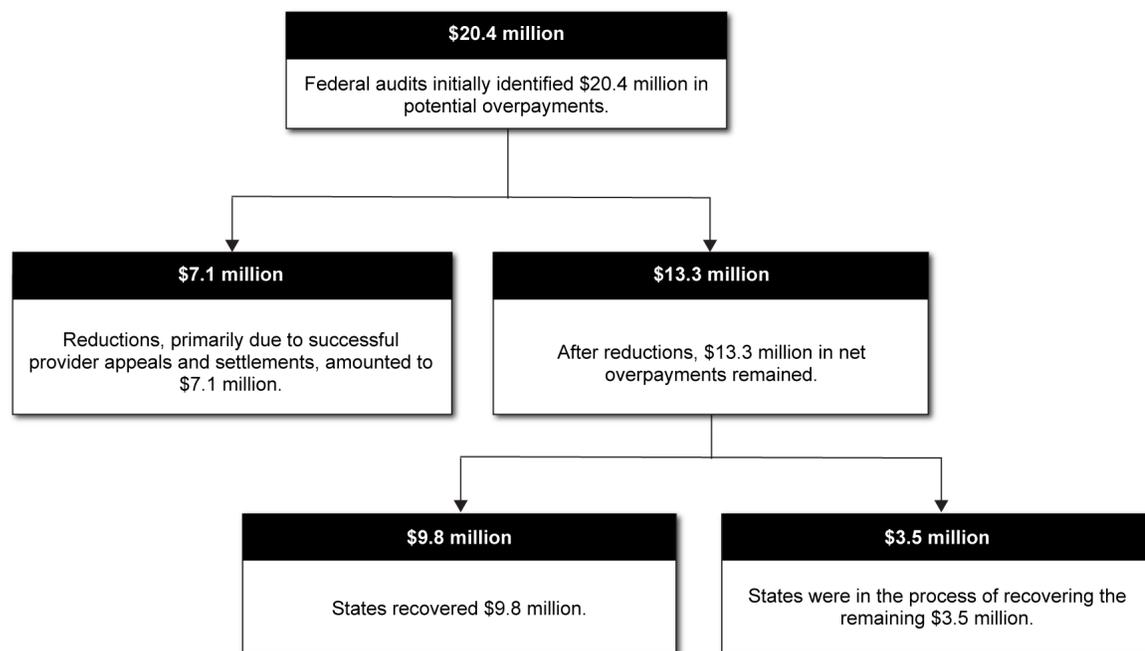


Source: GAO review of Centers for Medicare & Medicaid Services (CMS) documents.

**States Recovered \$9.8 Million in Medicaid Overpayments, but Did Not Clearly Report the Overpayments and the Return of the Federal Share to CMS**

Federal audits conducted from June 2007 through February 2012 initially identified \$20.4 million in potential Medicaid overpayments across 19 states, an amount that was reduced by \$7.1 million, primarily due to successful provider appeals and settlements. Of the remaining \$13.3 million in net overpayments, states recovered \$9.8 million in overpayments as of March 2013, and state officials told us that they are in the process of recovering the remaining \$3.5 million. (See fig. 2.) (Appendix I summarizes the potential Medicaid overpayments identified by federal audits, net overpayments, and state recoveries.)

**Figure 2: Overview of Potential Medicaid Overpayments, Reductions, and Recoveries from Federal Audits Conducted June 2007 through February 2012**



Source: GAO review of Centers for Medicare & Medicaid Services documents.

Of the \$7.1 million in overpayment reductions, state officials told us that successful provider appeals and settlements accounted for \$6.9 million of that total; the remaining overpayment reductions—approximately \$186,000—represented overpayments that states had already identified and recovered or were overpayments that could not be recovered due to the provider filing for bankruptcy. State officials told us that appeals may be successful for a number of reasons. For example, in one state, providers successfully demonstrated that state law did not preclude them from receiving payments for services provided to Medicaid patients, even though they were not approved Medicaid providers. In another state, providers successfully appealed an audit’s finding that services were not medically necessary.

The \$9.8 million in recovered overpayments represented full recoveries in 15 of the 19 states we reviewed. Officials in the remaining 4 states told us they were in the process of recovering \$3.5 million in overpayments, accounting for the remainder of the \$13.3 million in net overpayments. Medicaid overpayments may be recovered by offsetting a provider’s subsequent Medicaid reimbursements against the balance due to the

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state, and officials in 3 states told us that, as a result, certain providers had not yet paid the full amounts owed. In the fourth state, officials told us that the overpayments had not been fully recovered for several reasons, including that (1) some providers had not provided full payment, (2) there were pending appeals, and (3) in one case, state officials were unable to confirm the receipt of the FAR from CMS. As a result, the state had not initiated the recovery process.

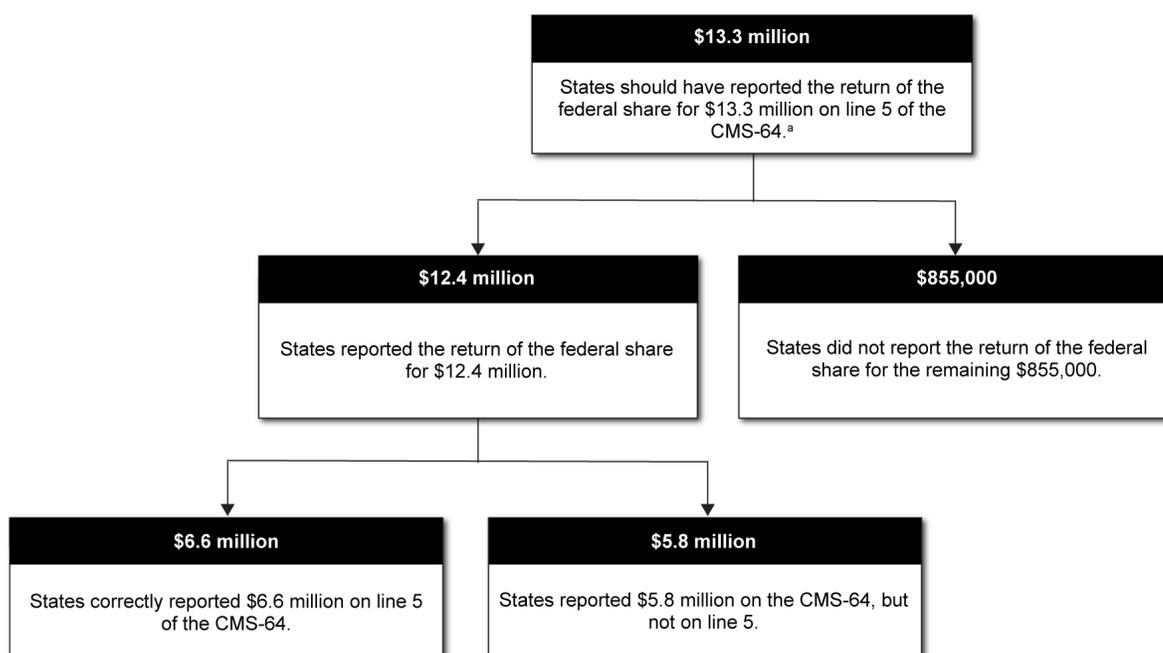
States should have reported the return of the federal share for \$13.3 million on line 5 of the CMS-64, the line designated for overpayments identified by federal audits.<sup>16</sup> Based on data we collected from the states, we found that states made multiple errors reporting the return of the federal share for overpayments identified by federal audits, as detailed below.

- Instead of reporting \$13.3 million, states reported the return of the federal share for \$12.4 million, and did not report the return of the federal share for the remaining \$855,000.
- Within the \$12.4 million that was reported by states, \$6.6 million was correctly reported on line 5 of the CMS-64, while the remaining \$5.8 million was reported in the CMS-64, but not on line 5. (See fig. 3.)

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<sup>16</sup>States generally have one year from the date of the final audit report to report the return of the federal share. Thus, the full \$13.3 million should have been reported, regardless of pending appeals or states' ability to collect the overpayments from providers.

**Figure 3: States' Reporting of the Return of the Federal Share from Audits Conducted June 2007 through February 2012**



Source: GAO review of Centers for Medicare & Medicaid Services (CMS) documents.

<sup>a</sup>CMS requires states to report overpayments from federal audits on line 5 of the CMS 64.9C1, a sub-form within the CMS-64.

In addition to incomplete and inconsistent reporting of the return of the federal share, we identified errors in states' reporting. In particular, states included \$20.2 million in overpayments on line 5 of CMS-64 that were not related to federal audits. This \$20.2 million represented errors by 4 states,<sup>17</sup> one of which was a \$20 million error made by 1 state.

Officials provided several reasons for states' errors in reporting overpayments, including not understanding CMS's reporting requirements, frequent state staff turnover, and not being able to identify and, therefore, correctly report overpayments that resulted from federal

<sup>17</sup>Two of the 4 states that made errors were not part of the 19 states in our review. These 2 states reported overpayments on line 5 of the CMS-64 even though they had not received a FAR.

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audits.<sup>18</sup> State officials told us that about \$568,000 of the unreported overpayments would be reported by June 2013.

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## CMS Generally Reviewed States' Reporting of Overpayments, but Was Not Always Aware of Incomplete Reporting

All 7 of the CMS regional offices we spoke with indicated that reviewing state reporting of the return of the federal share of overpayments was a routine part of their quarterly review of the CMS-64. Regional office officials noted that they review state documentation for the amounts entered on the form and check them against the FAR to make sure that states accurately report the return of the federal share. This review is also specifically noted as a required step in the CMS Financial Review Guide, which regional office financial analysts must follow when verifying state entries on the CMS-64.<sup>19</sup> Regional office officials also said that they work with states to improve reporting of overpayments on line 5 on the CMS-64, but there was some variability in how the regional offices required states to correct errors in their reporting. For example, some regional offices verified the overpayment reported on lines other than line 5 of the CMS-64 and encouraged states to report appropriately in the future, while other regional offices required states to make a correction for the quarter in which the error appeared.

As part of their reviews, regional office officials noted that when they receive a FAR for one of the states in their region they follow-up with the state to make sure the state is aware of the FAR and the timeframes for returning the federal share. As a result of these efforts, CMS's regional offices helped ensure the timely return of the federal share for most overpayments. For 59 of the 89 audits we reviewed, states reported the return of the federal share of the overpayment within 1 year as required by federal law. This on-time reporting of the return of the federal share represented \$9.8 million out of \$13.3 million in net overpayments related to federal audits. For the remaining 30 audits that states did not report the

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<sup>18</sup>In 2009 and 2011, CMS provided training to the states on how to correctly report overpayments from the federal audits. Additionally, CMS began including instructions in FARs issued in 2010 on correct reporting and issued additional reporting guidance to states in early 2012.

<sup>19</sup>CMS financial analysts verify that the amounts entered by the state were entered in accordance with required timeframes and correspond to the amounts specified in the FARs sent to the states. Centers for Medicare & Medicaid Services, *Financial Review Guide for the Quarterly Medicaid Statement of Expenditures (Form CMS-64 Report)*, February 2012.

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return of federal share within 1 year, \$2.7 million was reported late and \$855,000 was not reported at all.<sup>20</sup>

However, in some cases, regional offices were not always aware that states' reporting was incomplete.

- In one regional office, the CMS analyst charged with reviewing a particular state's CMS-64 was unaware that the state did not report returning the federal share from several FARs.<sup>21</sup>
- In another regional office, it was unclear if the office had received copies of the numerous FARs that a particular state in its region had received in 2011 and 2012. Thus, the regional office was not aware of the need to look for these overpayments and the return of the federal share on the CMS-64.

In these two cases, MIG officials were aware of the FARs but the regional offices were not. Additionally, the MIG does not regularly follow-up with the regional offices on the status of overpayments in light of CMS's approach to divide responsibility related to state recovery and reporting of overpayments. Rather, the MIG interacts with the offices as needed.<sup>22</sup> MIG officials acknowledged that at the beginning of the audit program, they had more contact with the regional offices on state recovery efforts. But such direct follow-up was not continued since the MIG may review data on line 5 of the CMS-64, enabling them to check the status of state overpayments directly, according to two regional office officials. However, given the errors we identified on the CMS-64, checking the status of state reporting of overpayments based on the reported CMS-64 data would not always yield a clear picture of states' reporting of the federal share of overpayments.

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<sup>20</sup>Among the seven states that were late in reporting their return of the federal share, the delay ranged from one quarter to nearly two years.

<sup>21</sup>The CMS analyst noted significant difficulties obtaining the information needed to verify entries on the state's CMS-64, as well as the recent turnover of state staff charged with reporting duties for the CMS-64. State officials indicated they were waiting for the results of appeals before initiating their recovery efforts on some of the overpayments—an approach that is inconsistent with CMS's requirements and policy requiring that returns be reported within one year of the audit findings, regardless of whether appeals are pending.

<sup>22</sup>Regional office officials told us that they had contacted the MIG when there was an issue with the state, such as an appeal, or when the state reported an overpayment amount that was less than the amount identified on the FAR.

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## Conclusions

CMS's audit approach for identifying Medicaid overpayments has shown some success in that states have returned most of the federal share of net overpayments—often within the one-year timeframe. However, state errors in reporting overpayments in the proper location of the CMS-64 prevent CMS from having a full understanding of the extent to which the federal share has been returned from the audits that they conduct. Officials in the regional offices play a critical role in reviewing and assisting states in reporting, and they are well positioned to ensure that states correctly report overpayments and the return of the federal share. Additionally, a full accounting of federal audit recoveries is an important gauge for measuring the effectiveness of CMS's efforts to reduce improper payments, but states' reporting of overpayments and the return of the federal share are not always clear or complete. Gaps such as these hamper federal efforts to quantify the results of state and federal activities, and make it difficult to determine the extent to which states are returning the federal share of these overpayments.

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## Recommendations

To ensure the timely return of the federal share of Medicaid overpayments, the CMS Administrator should increase efforts to ensure that states are clearly reporting overpayments identified by federal audits on the designated location of the CMS-64 form.

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## Agency Comment

We provided a draft of this product to HHS for comment. In its written comments, reproduced in appendix II, HHS concurred with our recommendation and noted that CMS will increase efforts to ensure that states correctly report overpayments on the CMS-64 by providing additional training to states and regional offices on accurate reporting and improve internal processes to ensure timely resolution of incorrect reporting. HHS also provided technical comments that we incorporated, as appropriate.

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We are sending copies to the Secretary of Health and Human Services, the Administrator of CMS, and the appropriate congressional committees. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff has any questions about this report, please contact me at (202) 512-7114 or at [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in Appendix III.



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Medicaid Overpayments Identified by Federal Audits Conducted June 2007 through February 2012

State (number of audits)	Potential overpayments	Net overpayments	State recoveries
AR (15)	\$489,966	\$488,996	\$130,862
CA (2)	\$1,196,634	\$1,196,634	\$186,054
CO (1)	\$2,376	\$2,376	\$2,376
DC (4)	\$1,711,520	\$1,575,476	\$1,575,476
DE (6)	\$4,614,912	\$4,614,912	\$4,614,911
FL (21)	\$1,789,559	\$597,347	\$597,348
IA (1)	\$31,875	\$31,875	\$31,875
KY (1)	\$9,445	\$9,445	\$9,445
MD (3)	\$2,944,875	\$484,601	\$484,601
MS (10)	\$5,731,435	\$3,042,697	\$1,011,869
NE (1)	\$25,165	\$25,165	\$25,165
NM (1)	\$14,821	\$14,821	\$14,819
PA (1)	\$4,856	\$4,856	\$4,856
SC (5)	\$92,535	\$77,934	\$77,934
SD (1)	\$90,465	\$90,465	\$90,465
TX (5)	\$795,484	\$650,605	\$567,743
UT (1)	\$27,521	\$27,521	\$27,521
VA (2)	\$40,005	\$40,005	\$40,005
WA (8)	\$821,529	\$324,522	\$324,522
<b>Total</b>	<b>\$20,435,009</b>	<b>\$13,301,254</b>	<b>\$9,817,848</b>

Source: GAO analysis of Centers for Medicare & Medicaid Services and state information.

# Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

NOV 2 2013

Carolyn L. Yocom  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Yocom,

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid: CMS Should Ensure That States Clearly Report Overpayments" (GAO-14-25).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID: CMS SHOULD ENSURE THAT STATES CLEARLY REPORT OVERPAYMENTS" (GAO-14-25)**

The Department appreciates the opportunity to review and comment on this draft report.

**GAO Recommendation:**

GAO recommends that to ensure the timely return of the federal share of Medicaid overpayments, the CMS Administrator should increase efforts to ensure that states are clearly reporting overpayments identified by federal audits on the designated location of the CMS-64 form.

**HHS Response:**

HHS concurs with this recommendation and will increase CMS efforts to ensure that states correctly report overpayments identified by federal audits on the CMS-64. In addition to its routine provision of technical assistance to states through the CMS-64 review process, CMS will provide additional training to states and regional office staff on the procedures required for accurate state reporting of overpayments.

As part of an initiative to provide greater transparency to overpayment reporting on the CMS-64, CMS expanded the CMS-64 to include the Fraud Waste and Abuse Collection screen 64.9C1 for quarterly expenditures beginning FY 2010. In conjunction with these new reporting requirements, CMS communicated these new requirements to its staff and to all states and conducted an on-site nationwide training for states and CMS staff at the Medicaid Integrity Institute in October 2011. CMS issued additional reporting guidance to states in April of 2012. Additionally, CMS will initiate improvements to its internal processes to ensure timely resolution of incorrect state reporting.

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# Appendix III: GAO Contact and Staff Acknowledgements

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## GAO Contact

Carolyn L. Yocom, (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff

### Acknowledgements:

In addition to the named above, key contributors to this report were: Rashmi Agarwal, Assistant Director; Walter Ochinko, Assistant Director; Sarah Harvey; Drew Long; JoAnn Martinez-Shriver; and Jennifer Whitworth.

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# Related GAO Products

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*GAO, Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, [GAO-13-50](#) (Washington, D.C.: Nov. 13, 2012).

*National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States*, [GAO-12-814T](#) (Washington, D.C.: June 14, 2012).

*National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States*, [GAO-12-627](#) (Washington, D.C.: June 14, 2012).

*Program Integrity: Further Action Needed to Address Vulnerabilities in Medicaid and Medicare Programs*, [GAO-12-803T](#) (Washington, D.C.: June 7, 2012).

*Medicaid: Federal Oversight of Payments and Program Integrity Needs Improvement*, [GAO-12-674T](#) (Washington, D.C.: April 25, 2012).

*Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States*, [GAO-12-288T](#) (Washington, D.C.: Dec. 7, 2011).

*Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services*, [GAO-11-822T](#) (Washington, D.C.: July 12, 2011).

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, [GAO-11-475](#) (Washington, D.C.: June 30, 2011).

*Improper Payments: Recent Efforts to Address Improper Payments and Remaining Challenges*, [GAO-11-575T](#) (Washington, D.C.: April 15, 2011).

*Status of Fiscal Year 2010 Federal Improper Payments Reporting*, [GAO-11-443R](#) (Washington, D.C.: March 25, 2011).

*Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, [GAO-11-409T](#) (Washington, D.C.: March 9, 2011).

*Medicare: Program Remains at High Risk Because of Continuing Management Challenges*, [GAO-11-430T](#) (Washington, D.C.: March 2, 2011).

*Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington, D.C.: March 1, 2011).

*High-Risk Series: An Update*, [GAO-11-278](#) (Washington, D.C.: February 2011).

*Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, [GAO-10-143](#). (Washington, D.C.: March 31, 2010).

*Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States*, [GAO-09-1004T](#) (Washington, D.C.: Sept. 30, 2009).

*Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States*, [GAO-09-957](#) (Washington, D.C.: Sept. 9, 2009).

*Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments*, [GAO-09-628T](#) (Washington, D.C.: April 22, 2009).

*Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System*, [GAO-08-239T](#) (Washington, D.C.: Nov. 14, 2007).

*Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System*, [GAO-08-17](#) (Washington, D.C.: Nov. 14, 2007).

*Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts*, [GAO-06-705](#) (Washington, D.C.: June 22, 2006).

*Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse*, [GAO-06-578T](#) (Washington, D.C.: March 28, 2006).

*Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited*, [GAO-05-855T](#) (Washington, D.C.: June 28, 2005).

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**Related GAO Products**

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*Major Management Challenges and Program Risks: Department of Health and Human Services, [GAO-03-101](#) (Washington, D.C.: January 2003).*

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