Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK OVERPAID CERTAIN MEDICAID MENTAL HEALTH SERVICES PROVIDERS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Deputy Inspector General
for Audit Services

June 2016
A-02-13-01021

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

New York State claimed approximately $8.1 million over 4 years in unallowable Federal Medicaid reimbursement for supplemental payments related to certain mental health services, but credited the Federal Government for overpayments related to prior periods.

WHY WE DID THIS REVIEW

During a prior review of a Medicaid-funded mental health program in New York State (the State), we observed that some providers were paid more than the Medicaid base rate for certain services. These providers participated in the State's Comprehensive Outpatient Program Services (COPS) and Community Support Program (CSP) programs and, as program participants, received supplemental (add-on) payments subject to annual payment thresholds in exchange for offering "enhanced services" to Medicaid beneficiaries. We decided to review these add-on payments and other aspects of the State's COPS and CSP programs.

The objectives of this review were to (1) determine whether the State made COPS and CSP add-on payments to providers in excess of their annual thresholds (overpayments) for the period 2009 through 2012 and (2) ensure that the Federal share of any overpayments made prior to 2009 was credited to the Federal Government.

BACKGROUND

In New York State, the Department of Health (State agency) administers the Medicaid program. Through its COPS and CSP programs—outpatient programs administered by the State's Office of Mental Health (OMH)—the State agency paid certain mental health providers add-on payments above the Medicaid base rate for certain program services. These payments were subject to annual thresholds in exchange for the providers' offering "enhanced services." The payments were not dependent on the provision of these services.

Providers who participated in the COPS and CSP programs were responsible for the accounting of program revenues received in excess of their thresholds and were required to keep this amount in a reserve account for future recovery by the State agency and OMH.

In 2010, the State agency and OMH began collecting these overpayments for the period 2003 through 2005 (a period the State refers to as "Phase I") and, in 2012, began collecting overpayments for the period 2005 through 2008 (a period the State refers to as "Phase II"). To collect these overpayments, the State agency and OMH issued preliminary reports (initial notifications) to providers. After providers had an opportunity to comment on these reports and calculations were finalized, final reports were issued. The State agency discontinued the COPS and CSP programs in October 2013, subsequent to the start of our review.

HOW WE CONDUCTED THIS REVIEW

We identified 110 providers who received add-on payments for the period 2009 through 2012 and calculated the amount, if any, of their overpayments. We also reviewed, on a test basis, overpayments that the State identified for Phases I and II to ensure that the Federal share of the overpayments was credited back to the Federal Government.

WHAT WE FOUND

We identified COPS and CSP program overpayments totaling $8,106,746 (Federal share) for the period 2009 through 2012. Although the State agency had credited to the Federal Government the Federal share of reviewed Phase I and Phase II overpayments that the State agency identified in its final reports, millions in overpayments remain uncollected. Specifically, the State agency continues to work with OMH to collect $184 million ($92 million Federal share) in final report overpayments, plus an additional $54.9 million ($27.4 million Federal share) in preliminary report overpayments for the period 2003 through 2008. Further, State agency officials indicated that $5.4 million ($2.7 million Federal share) in other overpayments made during this period were not collectable because of provider bankruptcy or business closure.

The overpayments occurred because the State agency did not have any financial management procedures in place to ensure that providers were not paid more than their annual thresholds, and the State agency did not initiate collection of overpayments until years after they occurred. We are not making any procedural recommendations in this report because the State agency discontinued the COPS and CSP programs in October 2013.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $8,106,746 to the Federal Government for COPS and CSP overpayments for the period 2009 through 2012,

- continue working with OMH to collect the additional $54.9 million ($27.4 million Federal share) in overpayments for the period 2003 through 2008 and return the applicable Federal share to CMS,

- identify any overpayments made between the end of our audit period (December 2012) and when the State ended the COPS and CSP programs (October 2013) and refund the applicable Federal share, and

- exhaust all legal efforts to collect the $5.4 million ($2.7 million Federal share) in overpayments that the State indicated were not collectable because of provider bankruptcy or business closure.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency agreed with our recommendations. The State agency reported that it had credited approximately $20 million to the Federal Government for overpayments identified in our draft report and stated that it will continue to identify and recover COPS and CSP overpayments. The State agency also stated that, owing to a data entry error on its part, the dollar amount indicated in our draft report regarding overpayments for the period 2003 through 2008 was overstated. Under separate cover, the State agency provided supporting documentation for a revised figure.

After reviewing the State agency's comments and supporting documentation, we revised our findings and recommendation related to its overpayments for the period 2003 through 2008.

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INTRODUCTION

WHY WE DID THIS REVIEW

During a prior review of a Medicaid-funded mental health program in New York State (the State), we observed that some providers were paid more than the Medicaid base rate for certain services. These providers participated in the State's Comprehensive Outpatient Program Services (COPS) and Community Support Program (CSP) programs and, as program participants, received supplemental (add-on) payments subject to annual payment thresholds in exchange for offering "enhanced services" to Medicaid beneficiaries. We decided to review these add-on payments and other aspects of the State's COPS and CSP programs.

OBJECTIVE

Our objectives were to (1) determine whether the State made COPS and CSP add-on payments to providers in excess of their annual thresholds (overpayments) for the period 2009 through 2012, and (2) ensure that the Federal share of any overpayments made prior to 2009 was credited to the Federal Government.

BACKGROUND

Medicaid Program

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

New York's Medicaid Outpatient Mental Health Services Programs

In New York State, the Department of Health (State agency) administers the Medicaid program. Through its COPS and CSP programs—outpatient programs administered by the State's Office of Mental Health (OMH)—the State agency paid certain mental health providers add-on payments above the Medicaid base rate for certain program services.[1] These payments were subject to annual thresholds in exchange for the providers' offering "enhanced services."[2] The payments were not dependent on the provision of these services.

[1] Payments applied to services in the following programs: clinic, continuing day treatment, day treatment, partial hospitalization, and intensive psychiatric rehabilitation treatment. The provider-specific add-on payments varied widely, from $2 per claim to more than $300 per claim.

[2] Although State regulations outlined what providers needed to do to be designated as a COPS or CSP provider, none of the applicable regulations defined or described "enhanced services."

Providers who participated in the COPS and CSP programs were responsible for the accounting of program revenues received in excess of their thresholds and were required to keep this amount in a reserve account for future recovery by the State agency and OMH.[3] In 2008, OMH eliminated annual COPS thresholds for all clinics. As a result, the clinics were allowed to keep all COPS add-on payments, even those that exceeded their thresholds. For all other providers, OMH phased in a reduced add-on payment, resulting in fewer providers exceeding their annual thresholds. The State agency discontinued the COPS and CSP programs in October 2013, subsequent to the start of our review.

New York's Collection of Overpayments

Since 2010, the State agency and OMH have issued final reports[4] (notifications) to providers with COPS and CSP program overpayments totaling approximately $184 million ($92 million Federal share) for the period 2003 through 2008. Specifically:

- Phase I: In 2010, the State agency and OMH began collecting overpayments for the period 2003 through 2005 (a period the State refers to as "Phase I"). According to the State, the agencies identified approximately $103 million ($51.5 million Federal share) in overpayments to 165 providers for this period.

- Phase II: In 2012, the State agency and OMH began collecting overpayments for the period 2005 through 2008 (a period the State refers to as "Phase II").[5] According to the State, the agencies identified approximately $81 million ($40.5 million Federal share) in overpayments to 145 providers for this period.

The State agency and OMH have also issued preliminary reports[6] (initial notifications) to providers with COPS and CSP program overpayments totaling approximately $54.9 million ($27.4 million Federal share) for the period 2003 through 2008.

Federal Requirements Related to Medicaid Overpayments

States have 60 days from the discovery of a Medicaid overpayment to a provider to recover (or attempt to recover) the overpayment before the Federal share of the overpayment must be

[3] On an annual basis, OMH notified providers of their annual thresholds for add-on payments.

[4] Final reports are notifications that the State agency and OMH send to providers notifying the providers of their total overpayments due back to the State.

[5] The years overlap because, under the COPS and CSP programs, New York City providers operated on a fiscal year basis, and providers throughout the rest of the State operated on a calendar year basis.

[6] Preliminary reports are notifications that the State agency and OMH send to providers notifying the providers of overpayments. Providers have the opportunity to review these reports for accuracy. Once preliminary reports are finalized, the State agency and OMH send out final reports.

refunded to CMS (42 CFR § 433.312(a)).[7] Section 1903(d)(2)(C) of the Act and Federal regulations (42 CFR part 433, subpart F) require States to refund the Federal share of overpayments at the end of the 60-day period following discovery whether or not States have recovered the overpayment from the providers. States are not required to refund the Federal share of uncollectable amounts paid to bankrupt or out-of-business providers (sections 1903(d)(2)(C) and (D) of the Act and 42 CFR § 433.312).

For details on Federal requirements related to Medicaid overpayments, see Appendix A.

HOW WE CONDUCTED THIS REVIEW

We identified 110 providers that received add-on payments for the period 2009 through 2012 and calculated the amount, if any, of their overpayments. We also reviewed, on a test basis, overpayments that the State agency and OMH identified for Phases I and II to ensure that the Federal share of the overpayments was credited back to the Federal Government.

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 contains the details of our audit scope and methodology.

FINDINGS

We identified COPS and CSP program overpayments totaling $8,106,746 (Federal share) for the period 2009 through 2012. Although the State agency had credited to the Federal Government the Federal share of reviewed Phase I and Phase II overpayments that the State agency identified in its final reports, millions in overpayments remain uncollected. Specifically, the State agency continues to work with OMH to collect the $184 million ($92 million Federal share) in overpayments identified in final reports, plus an additional $54.9 million ($27.4 million Federal share) in overpayments identified in preliminary reports for the period 2003 through 2008. Further, State agency officials indicated that $5.4 million ($2.7 million Federal share) in other overpayments made during this period are not collectable because of provider bankruptcy or business closure.

[7] Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for services … and which is required to be refunded … ." Effective March 23, 2010, section 6506 of the Patient Protection and Affordable Care Act, P.L. No. 111-148, provides an extension for the collection of overpayments. Except in the case of overpayments involving fraud, States have up to 1 year from the date of discovery of a Medicaid overpayment to recover, or to attempt to recover, the overpayment before making an adjustment to refund the Federal share of the overpayment. For overpayments identified before the effective date, the previous rules on discovery of overpayments remain in effect, which required the State to refund CMS the Federal share of an overpayment 60 days after the discovery of a Medicaid overpayment.

The overpayments that we identified occurred because the State agency did not have any financial management procedures in place to ensure that providers were not paid more than their annual thresholds, and the State agency did not initiate collection of overpayments until years after they occurred.

OVERPAYMENTS FOR THE PERIOD 2009 THROUGH 2012

We identified $8,106,746 in Federal Medicaid reimbursement (Federal share) for COPS and CSP program overpayments for the period 2009 through 2012. Of the 110 providers we reviewed, 72 providers had overpayments for at least 1 of the years covered by our review. Individual overpayments for the period ranged from $159 to $3,784,123. The table below details the overpayments made to providers by OMH program.

Table: Overpayments to Providers by Mental Health Program

Office of Mental Health Program	Providers Exceeded Their Threshold	Total Overpayments (Federal Share)
COPS		
Day treatment	19	$5,357,216
Continuing day treatment	45	1,595,407
Intensive psychiatric rehabilitation treatment	7	39,762
Partial hospitalization	3	35,386
Subtotal	*74*	*$7,027,771*
CSP		
Continuing day treatment	10	$994,956
Day treatment	2	84,019
Subtotal	*12*	*1,078,975*
Total (COPS and CSP)	**86[a]**	**$8,106,746**

[a] The total does not equal 72 because some providers participated in both the COPS and CSP programs.

FEDERAL SHARE OF OVERPAYMENTS FOR 2003 THROUGH 2008 CREDITED TO THE FEDERAL GOVERNMENT

As described above, OMH and the State agency have issued final reports totaling approximately $184 million in overpayments for Phases I and II. On the basis of our testing of Phase I and Phase II overpayments identified by the State agency and OMH, we found that the State credited the Federal share of these overpayments to the Federal Government. Specifically, we traced 134 overpayments totaling $72.6 million ($36.3 million Federal share) to the Form CMS-64, Quarterly Statement of Medical Assistance Program Expenditures.

STATE EFFORTS TO RECOVER OVERPAYMENTS FOR THE PERIOD 2003 THROUGH 2008 WERE NOT INITIATED TIMELY

The State agency and OMH did not begin collecting overpayments until up to 7 years after some overpayments were made. Although the State agency continues to work with OMH to collect the $184 million ($92 million Federal share) in final reports and $54.9 million ($27.4 million Federal share) in additional overpayments identified in preliminary reports for the period 2003 through 2008, the State's Phase I and Phase II collection activities were not initiated timely.

In addition, we found that the State agency and OMH identified a total of $1.9 million ($950,000 Federal share) in overpayments not included in the above figures to four providers to whom the State suspended collecting overpayments because the providers had initiated bankruptcy proceedings. We also found that the State agency and OMH identified additional overpayments totaling $3.5 million ($1.75 million Federal share) to four providers for which the State deemed the overpayments uncollectable because the providers were out of business.[8]

CONCLUSION

The overpayments occurred because the State agency did not have any financial management procedures in place to ensure that providers were not paid more than their annual thresholds. In addition, the State agency and OMH did not seek to collect overpayments for up to 7 years after they occurred. We are not making any procedural recommendations in this report because the State agency discontinued the COPS and CSP programs in October 2013.

RECOMMENDATIONS

We recommend that the State agency:

- refund $8,106,746 to the Federal Government for COPS and CSP overpayments for the period 2009 through 2012,
- continue working with OMH to collect the additional $54.9 million ($27.4 million Federal share) in overpayments for the period 2003 through 2008 and return the applicable Federal share to CMS,
- identify any overpayments made between the end of our audit period (December 2012) and when the State ended the COPS and CSP programs (October 2013) and refund the applicable Federal share, and
- exhaust all legal efforts to collect the $5.4 million ($2.7 million Federal share) in overpayments that the State indicated were not collectable because of provider bankruptcy or business closure.

[8] One provider accounted for $3.4 million ($1.7 million Federal share) of this total.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our recommendations. The State agency reported that it had credited approximately $20 million to the Federal Government for overpayments identified in our draft report and stated that it will continue to identify and recover COPS and CSP overpayments.[9] The State agency also stated that, owing to a data entry error on its part, the dollar amount indicated in our draft report regarding overpayments for the period 2003 through 2008 was overstated. Under separate cover, the State agency provided supporting documentation for a revised figure.

After reviewing the State agency's comments and supporting documentation, we revised our findings and recommendation related to its overpayments for the period 2003 through 2008.

The State agency's comments are included in their entirety as Appendix C.

[9] Regarding our first recommendation, the State agency reported that, thus far, it had credited nearly $2 million to the Federal Government. Regarding our second recommendation, the State agency reported that it had credited nearly $18 million to the Federal Government. Regarding our fourth recommendation, the State agency indicated that it determined that $4.5 million of the $5.4 million in overpayments to bankrupt or out-of-business providers is not collectable. The State agency reported that it had recovered $10,000 from these providers.

APPENDIX A: FEDERAL REQUIREMENTS RELATED TO MEDICAID OVERPAYMENTS

Section 1903(d)(2)(A) of the Act requires the Secretary of Health and Human Services to recover the amount of a Medicaid overpayment.

Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." A State has 60 days from the discovery of a Medicaid overpayment to the provider to recover, or attempt to recover, the overpayment before the Federal share of the overpayment must be refunded to CMS (42 CFR § 433.312(a)).[10]

Section 1903(d)(2)(C) of the Act and Federal regulations (42 CFR part 433, subpart F) require a State to refund the Federal share of overpayments at the end of the 60-day period following discovery whether or not the State has recovered the overpayment from the provider.

Pursuant to 42 CFR § 433.316(c), an overpayment that is not a result of fraud or abuse is discovered on the earliest date:

> (1) … on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; (2) … on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or (3) … on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its quarterly Form CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends (60-day rule). If the amount of an overpayment is adjusted downward (e.g., on the basis of the provider's appeal) after the State has credited CMS with the Federal share, the State may reclaim the amount of the downward adjustment on a subsequent CMS-64 (42 CFR § 433.320(c)).

[10] Effective March 23, 2010, section 6506 of the Patient Protection and Affordable Care Act, P.L. No. 111-148, provides an extension for the collection of overpayments. Except in the case of overpayments involving fraud, States have up to 1 year from the date of discovery of a Medicaid overpayment to recover, or to attempt to recover, the overpayment before making an adjustment to refund the Federal share of the overpayment. For overpayments identified before the effective date, the previous rules on discovery of overpayments remain in effect, which required the State to refund CMS the Federal share of an overpayment 60 days after the discovery of a Medicaid overpayment.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered COPS and CSP add-on payments for the period 2009 through 2012.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information file for our audit period, but we did not assess the completeness of the file.

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objectives.

We performed fieldwork at the State agency's and OMH's offices in Albany, New York, and at the State agency's fiscal agent in Rensselaer, New York.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency, OMH, and provider officials to gain an understanding of the COPS and CSP programs;
- identified the procedures used by the State agency to identify and collect overpayments for Phases I and II;
- obtained from OMH the provider-specific rate sheets and annual thresholds for each provider that received an add-on payment for the period 2009 through 2012;
- ran computer programming applications at the Medicaid Management Information System (MMIS) fiscal agent[11] that identified claims related to the providers that received add-on payments and, for each provider:
    - calculated the total add-on payments for each year and
    - compared the annual add-on payments to the provider's annual threshold;
- determined the total amount of add-on payments, if any, that exceeded providers' annual thresholds;

[11] DOH has contracted with Computer Sciences Corporation to be its MMIS fiscal agent.

- verified, on a test basis, that the State agency credited the Federal share of excess add-on payments identified during the two phases of the State agency's collection process; and[12]

- discussed our results with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12] Specifically, we traced these identified excess add-on payments to the Form CMS-64, Quarterly Statement of Medical Assistance Program Expenditures.

APPENDIX C: STATE AGENCY COMMENTS

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 19, 2016

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
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New York, New York 10278

Ref. No: A-02-13-01021

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-13-01021 entitled, "New York Overpaid Certain Medicaid Mental Health Services Providers."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

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New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-13-01021 entitled
"New York Overpaid Certain Medicaid Mental Health Services Providers"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-13-01021 entitled, "New York Overpaid Certain Medicaid Mental Health Services Providers."

Background

New York State (State) discontinued both Comprehensive Outpatient Program Services (COPS) and the Community Support Program (CSP) in October 2013. Starting in 1991, the State had provided supplemental Medicaid Level I COPS payments to mental health providers for enhanced services to seriously and persistently mentally ill adults and seriously emotionally disturbed children. Starting in 2001, the State had provided supplemental Medicaid Level II COPS payments to mental health providers for enhanced services to seriously and persistently mentally ill adults and seriously emotionally disturbed children. The supplemental payments for Level I and II COPS, made in addition to a provider's Medicaid rate, served as a deficit funding mechanism. The amount of Level I and II COPS reimbursement that a provider could retain in any fiscal year was limited to a specific COPS threshold. The Level I and II COPS threshold was a provider and program-specific amount. Level I and II COPS received in excess of that year's threshold amount was subject to recoupment by the State. CSP payments also funded community-based mental health programs that served the severely and persistently mentally ill population. CSP payments that were in excess of the Provider's CSP threshold were subject to recovery by the State. In cases where recoveries were necessary, the State adjusted the CSP supplemental rate prospectively.

General Comment

As of March 22, 2016, the Office of the Medicaid Inspector General (OMIG) has recovered a total of $134,008,150, and the Department has recovered $50,219,505. OMIG and the Department will continue with their overall recovery efforts.

Recommendation #1

Refund $8,106,746 to the Federal Government for COPS and CSP overpayments for the period 2009 through 2012.

Response #1

OMIG has issued final audit reports totaling $3,934,694, and credited $1,967,347 back to the Federal Government. OMIG will continue to work on these projects to identify and recover overpayments and credit the applicable Federal share.

Recommendation #2:

Continue working with OMH to collect the additional $63.5 million ($31.8 million Federal share) in overpayments for the period 2003 through 2008 and return the applicable Federal share to CMS.

Response #2

After OMIG review of the OIG audit data, it was discovered that there was a data entry error in the information that was originally sent to OIG during the course of the audit. This led to an overstatement of the overpayments identified for the period 2005 through 2008, by $8,606,490 ($4,303,245 Federal share). The accurate additional overpayments for the period 2003 through 2008, is $54,896,450 ($27,448,225 Federal share). OMIG will send supporting documentation to OIG under separate cover.

To date, OMIG has issued final audit reports in the amount of $23,136,909, crediting back the Federal Government $11,568,455. The Office of Mental Health (OMH) has issued final reports in the amount of $12,728,251, crediting back the Federal Government $6,364,126. OMIG will continue working with OMH to make recoveries and credit the applicable Federal share.

Recommendation #3

Identify any overpayments made between the end of our audit period (December 2012) and when the State ended the COPS and CSP programs (October 2013) and refund the applicable Federal share.

Response #3

OMIG will identify and recover any inappropriate payments, and credit the applicable Federal share.

Recommendation #4

Exhaust all legal efforts to collect the $5.4 million ($2.7 million Federal share) in overpayments that the State indicated were not collectable because of provider bankruptcy or business closure.

Response #4

After OMIG review, it has been determined that $4.5 million ($2.25 million Federal share) in overpayments is uncollectable, due to bankruptcies or providers who have gone out of business. OMIG has recovered $10,000, and will continue with recovery efforts.