



HHS Circular C-045
**HHS Guidance for Resolution of CMS Medicaid Integrity Program Audits:
Provider Appeals, Recovery of Provider Overpayments,
and Return of Federal Funds**

Purpose

This circular includes guidance to staff in health and human services (HHS) agencies for audit resolution actions to be taken when the Centers for Medicare and Medicaid Services (CMS) issues a Medicaid Integrity Program final audit report. The circular details HHS agency roles and responsibilities related to provider appeals, collection of provider overpayments, and return of federal funds related to overpayments identified through CMS Medicaid Integrity Program audits.

Background

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program under the direction of the CMS Medicaid Integrity Group (later changed to the Investigations and Audits Group). The Medicaid Integrity Program represents a CMS national strategy to combat fraud, waste, and abuse in the Medicaid program. As part of the Medicaid Integrity Program, CMS contracts with entities known as audit Medicaid integrity contractors to conduct post-payment audits of Medicaid providers. These audits examine whether Medicaid payments were for covered services that were actually provided, and properly billed and documented. These audits may identify overpayments made to Medicaid providers. All Medicaid providers in Texas are subject to and may be selected for Medicaid Integrity Program audits.

During each audit, HHS agencies and the Medicaid provider are given an opportunity to provide feedback on preliminary draft audit reports. Once the final report is issued, HHS agencies will refund the federal share of the final identified overpayment amount within one year of the date of its discovery, usually represented by the date the final audit report is issued. The overpayment must be refunded to CMS, regardless of whether the overpayment is recovered from the Medicaid provider, unless it is determined that the provider is out of business or bankrupt in accordance with Code of Federal Regulations, 42 CFR §433.318.

HHS agencies distribute the final report to the Medicaid provider along with instructions for how to reimburse any overpayments identified in the audit. HHS agencies also give the Medicaid provider an opportunity to appeal the audit findings contained in the final report. CMS does not dictate the appeals process. The appeal process for Medicaid Integrity Program



final audit reports is determined by applicable Texas Medicaid program requirements. In the case of a Medicaid Provider's appeal of a Medicaid Integrity Program final audit report, HHS agencies interpret the date of discovery to be determined by the result of the appeals process rather than the issuance of the final report. CMS decides on a case by case basis whether to accept the appeal process results and the impact of the appeal results on the final overpayment amount. Final overpayment amounts shall be refunded to CMS.

Role and Responsibilities

Once HHS agencies receive the final audit report from CMS, HHS agency staff is responsible for: (a) taking action to collect the provider overpayment; (b) returning the federal share of overpayments to CMS; and (c) retaining relevant documentation for tracking and reporting purposes.

HHS agencies are responsible for initiating the process to recover the identified overpayment from a Medicaid provider. For most Medicaid Integrity Program audits, the HHSC Inspector General (IG) is responsible for the Medicaid provider recoupment process, including provider notification, collection efforts, and appeals. The Department of Aging and Disability Services (DADS) is responsible for recoupment, collection, and appeals processes for audits involving programs under DADS oversight.

Roles and responsibilities for the resolution and disposition of Medicaid Integrity Program final audit reports are detailed below.

HHSC Federal Audit Coordination:

- Distribute the final audit report to the applicable HHS agency program, as well as the IG or DADS, as appropriate.
- Provide documentation to the applicable agency's financial reporting function detailing the federal share to be returned after collection from the provider.
- Notify the CMS Medicaid integrity contractor that an appeal has been requested.
- Provide updates, upon request, on the status of the federal share refunded to CMS as a result of the Medicaid Integrity Program audits.
- As applicable, receive and maintain documentation supporting the Medicaid providers:
 - final notice of overpayment;



- request for appeal; or
- repayment plan agreement, settlement agreement, or final notice.

Evidence of overpayment collection, return of the federal share, or determination that the Medicaid provider is out of business or bankrupt in accordance with Code of Federal Regulations, 42 CFR §433.318.

HHS Agency Financial Reporting

- Return the federal share of the final report overpayment amount, settlement agreement or final notice, as appropriate, within one year of the date of discovery.
- Provide HHSC Federal Audit Coordination with evidence of the return of the federal share of the overpayment.

IG (Refer to the DADS sections below for audits involving programs under DADS oversight.)

- Send final notice of overpayment to the Medicaid provider.
- Send documentation to Federal Financial Reporting including, as applicable:
 - final notice of overpayment sent to provider;
 - provider's request for an appeal;
 - provider payment plan agreement, settlement agreement, or final notice;
 - evidence of overpayment collection from provider; or
 - determination that the Medicaid provider is out of business or bankrupt.
- Administer an informal hearing if the Medicaid provider requests an appeal.
- Report provider collections to the applicable HHS agency financial staff.

DADS Utilization Management and Review

- Send the Medicaid provider a final notice of overpayment.
- Send documentation to HHSC Federal Audit Coordination and DADS Internal Audit including, as applicable:
 - final notice of overpayment sent to provider;
 - provider's request for appeal;
 - provider payment plan agreement, settlement agreement, or final notice;
 - evidence of overpayment collection from provider; or



- determination that the Medicaid provider is out of business or bankrupt.
- Coordinate with DADS Legal Services, as appropriate, to:
 - determine payment plan or settlement agreement; and
 - provide support throughout the appeals process.
- Instruct DADS Third-Party Recovery to recoup the overpayment from the provider.

DADS Claims Management Division – Third Party Recovery (TPR):

- Recoup the overpayment from the Medicaid provider.
- Report the collection to:
 - DADS Financial Reporting for the CMS 64 quarterly report; and
 - DADS Utilization and Management Review for tracking.

DADS Legal Services:

- Negotiate and execute final payment plan agreement, or proceed with the Medicaid provider's appeal pursuant to Chapter 357, Subchapter I of Title 1 of the Texas Administrative Code.
- Send DADS Utilization Management and Review a signed copy of the payment plan agreement, settlement agreement, or final order.

Inquiries

Questions regarding the content of this memorandum may be directed to David Griffith, Deputy Inspector General for Audit, at (512) 491-2806 or by email at David.Griffith@hhsc.state.tx.us.