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

September 2026 | OAS-25-06-061

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

REPORT HIGHLIGHTS

September 2026 | OAS-25-06-061

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

Why OIG Did This Audit

This audit, one of a series examining whether States had recovered and returned the correct Federal share of improper provider claim amounts, focused on whether California reported and returned the correct Federal share of overpayments identified by its Medicaid Fraud Control Unit (MFCU) during Federal fiscal year 2023.

What OIG Found

We determined that California should have reported MFCU-determined Medicaid overpayments totaling $231.2 million ($99.3 million Federal share) for 26 cases during the audit period.

- California did not report and return MFCU-determined Medicaid overpayments related to paid claim amounts for 14 cases, totaling $113.3 million ($47.8 million Federal share), on the Form CMS-64.
- California did not report and return $27,515 ($11,006 Federal share) in MFCU-determined Medicaid overpayments for one court-ordered award in its Form CMS-64.
- California did not report and return $74.9 million ($32.1 million Federal share) for 14 cases within the required timeframe.

What OIG Recommends

We made four recommendations to California, including that it return the Federal share of $47.8 million for the unreported overpayments related to paid claims and $11,006 for a court-ordered award. We also recommended that California improve coordination with MFCU and develop policies and procedures to facilitate timely and accurate reporting.

California concurred with three of our recommendations and did not concur with one recommendation. The full recommendations are in the report.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

This audit is one of a series of audits we performed to determine whether States had recovered and returned the correct Federal share of improper provider claim amounts.[1] For this audit, we focused on California's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes.[2] These recoveries also include court-ordered awards.[3] We refer to these recoveries as "MFCU-determined Medicaid overpayments." The California Department of Health Care 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, 2022, through September 30, 2023 (Federal fiscal year (FY) 2023).

BACKGROUND

Medicaid Program and Medicaid Fraud Control Units

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

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

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

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

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

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

Section 1902(a)(61) of the Act requires each State to operate an MFCU or receive a waiver. The Act, section 1903(q), specifies that the function of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The California Division of Medi-Cal Fraud and Elder Abuse operates as the MFCU through the California Attorney General's Office.

Federal Requirements Concerning Reporting of Medicaid Overpayments

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

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment within 1 year of discovery 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.[5] Once the court has determined the overpayment amount—including any final judgment following an appeal—the State has 30 days to collect the overpayment from the provider before reporting the amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2)).

The Federal Share of Recoveries Is Computed on the Entire Recovery

Section 1903(d)(2)(A) of the Act states, "The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection."

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

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

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

On October 28, 2008, CMS issued to State health officials a letter (SHO # 08-004) (the SHO Letter) interpreting 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 states, "For State [False Claims Act] 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."

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

Reporting of Fraud-Related Medicaid Overpayments

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

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

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

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

HOW WE CONDUCTED THIS AUDIT

For our audit period (October 1, 2022, through September 30, 2023) we identified and reviewed MFCU-determined Medicaid overpayments totaling $231,201,507 ($99,341,141 Federal share) for 26 cases. That total includes $231,173,991 ($99,330,135 Federal share) for Medicaid restitution and $27,515 ($11,006 Federal share) for a court-ordered award.

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

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

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

FINDINGS

The State agency did not report and return the Federal share of all MFCU-determined Medicaid overpayments identified for FY 2023. We determined that the State agency should have reported and returned MFCU-determined Medicaid overpayments totaling $231,201,507 ($99,341,141 Federal share) for the 26 cases during the period that we reviewed.[7]

[6] We reviewed State agency payment documentation for MFCU-determined Medicaid overpayments identified in FY 2023 that were reported and returned on the CMS-64 as of April 2025.

[7] Under Section 1909 of the Social Security Act, States with a qualifying false claims act, such as California, receive an additional 10 percentage point increase in their share for recoveries under such law, which reduces the Federal share below the standard FMAP. For the quarters reported on Form CMS-64, the Federal share was calculated using the applicable FMAP, which ranged from 50 percent to 56.2 percent.

We found that the State agency:

- Did not report and return $113,269,575 ($47,769,205 Federal share) on the Form CMS-64 for MFCU-determined Medicaid overpayments related to paid claim amounts for 14 cases[8]

- Did not report and return $27,515 ($11,006 Federal share) on the Form CMS-64 for a court-ordered award that the MFCU collected for 1 case

- Did not report and return $74,879,534 ($32,102,769 Federal share) for 14 cases within the required timeframe

- Correctly reported and returned $43,024,883 ($19,458,161 Federal share) on the Form CMS-64 for MFCU-determined overpayments related to paid claim amounts for 10 cases[9]

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

This occurred because the State agency did not have procedures in place to ensure that all MFCU-determined Medicaid overpayment case files were sent to the State agency. The State agency relied on the MFCU to provide the case files and overpayment information. In addition, the instructions that the State agency received from the MFCU were sometimes inconsistent with Federal guidelines regarding the calculation of the Federal share of overpayments, the reporting of court-ordered awards, and the timeliness of reporting overpayment amounts.[10]

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

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

[8] Of this amount, $103,388,524 ($43,950,462 Federal share) is related to one case.

[9] Of the 26 cases we reviewed and categorized, some individual cases had both reported amounts and unreported amounts. In addition, some cases had reported amounts that were reported late. See Appendix C for a table that lists the cases and their respective categories.

[10] Although the State agency is generally required to report overpayments 30 days after the date of the final court judgement, the Memorandum of Understanding between the two agencies allows the MFCU up to 60 days to notify the State agency after receiving the judgement.

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

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment within 1 year of discovery—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, including any final judgment following an appeal, the State has 30 days to collect the overpayment from the provider before reporting the amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2)).

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

The SHO Letter also states that "for State False Claims Act 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."

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

Departmental Appeals Board Decision

The Department of Health and Human Services, Departmental Appeals Board (DAB), issued DAB No. 2546 in 2013.[11] In this decision, the DAB distinguished provider overpayments from court-ordered penalties, fines, and costs for purposes of refunding the Federal share. The DAB noted that provider overpayments should be refunded to the Federal Government, regardless of whether the State is able to collect, while court-ordered penalties, fines, and costs (i.e., court-ordered awards) should be refunded when the State has collected them.

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

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

Overpayments Not Reported

For 14 of the 26 cases we reviewed, the State agency did not report and return on the Form CMS-64 MFCU-determined Medicaid overpayments related to paid claim amounts totaling $113,269,575 ($47,769,205 Federal share). This occurred because the State agency waited to report the overpayments until it received payments from the MFCU, rather than reporting the full amount owed after the final judgment. In many of these cases, the recoveries were made and reported in installments. The State agency lacked policies and procedures to facilitate timely reporting of the overpayments in accordance with Federal requirements.

In addition, the State agency lacked policies and procedures that addressed the calculation of the Federal share of overpayments. It relied on the MFCU's calculations and instructions, which were often based on State regulations rather than Federal requirements. In cases involving a State false claims act, the MFCU deducted attorney fees and the relator's share before applying the FMAP to calculate the Federal share. As a result, the Federal share was not always based on the full recovery amount and was not always calculated or reported correctly.

Court-ordered Awards Not Reported

The State agency did not report and return a court-ordered award that had been collected by the MFCU. State agency officials were instructed by the MFCU to retain this award. However, court-ordered awards that are collected must be reported immediately after the end of the 1-year period specified in 42 CFR § 433.312(a).[12] Contrary to Federal requirements, the State agency did not report the collected court-ordered award totaling $27,515 ($11,006 Federal Share).

THE STATE AGENCY DID NOT REPORT MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS WITHIN THE REQUIRED TIMEFRAME

The State agency was late in reporting and returning $74,879,534 ($32,102,769 Federal share) in MFCU-determined Medicaid overpayments for 14 of the 26 cases we reviewed. In most cases, the agency waited to report overpayments on Form CMS-64 until it received payments from the MFCU, rather than reporting the full amount owed after the final judgment. Because many payments were made in installments, the full amounts were not reported within the required timeframe. Additional delays occurred because the State agency did not receive restitution or settlement information from the MFCU in time to meet the Federal reporting requirements. Although the Memorandum of Understanding (MOU) allows the MFCU up to 60 days to notify the agency after receiving a judgment, Federal regulations generally require the agency to report overpayments 30 days after the date of a final judgment, including any

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

appeals (42 CFR § 433.316(d)(2)). As a result, the Federal Government did not receive its share in a timely manner.

RECOMMENDATIONS

- We recommend that the California Department of Health Care Services report and return the Federal share of Medicaid overpayments for the 14 unreported cases identified in this report that total $113,269,575 ($47,769,205 Federal share).

- We recommend that the California Department of Health Care Services report and return the Federal share of the collected court-ordered award for one case, totaling $27,515 ($11,006 Federal share).

- We recommend that the California Department of Health Care Services work with the MFCU to revise the current notification timeline in the MOU to facilitate the timely notification of final judgments to meet Federal requirements.

- We recommend that the California Department of Health Care Services develop written policies and procedures to facilitate (1) timely and complete reporting of all identified overpayments, regardless of payment status and (2) accurate calculation of the Federal and State shares of overpayments in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our first recommendation, but it did concur with our other three recommendations.

For our first recommendation, the State agency said that it had determined that the amount owed for the 14 unreported cases (12 criminal cases and 2 civil cases) will differ from the $113,269,575 ($47,769,205 Federal share) identified by OIG. It stated that of the 12 criminal cases totaling $5,484,316 ($2,883,267 Federal share), one criminal case's judgment (in the amount of $4,366,018 ($2,292,159 Federal share)) did not list CMS or any other Federal agency as a restitution victim. In addition, the State agency stated that it reported and returned $20,023 ($10,624 Federal share) in additional payments that OIG did not include in its calculations. It believes the amount to report and return for these cases is $1,098,275 ($580,090 Federal share).

The State agency also stated that the $107,785,258 ($44,885,939 Federal share) associated with the two civil cases remains subject to adjustment based on OIG's position on the False Claims Act bonus and potential approval from CMS for claiming administrative costs.

Regarding our second recommendation, the State agency stated that it will remit the $27,515 ($11,006 Federal share). Regarding our third recommendation, the State agency stated that it

will work collaboratively with the MFCU to revise the current notification timeline in the MOU to facilitate the timely notification of final judgments to meet Federal requirements. Regarding our fourth recommendation, the State agency stated that it will strengthen internal controls by updating and expanding written policies and procedures to ensure timely and complete reporting of all identified overpayments—regardless of payment status—and to ensure the accurate calculation of the Federal and State shares of overpayments.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

With respect to the State agency's comments on our first recommendation, we were unable to verify that the criminal case totaling $4,366,018 ($2,292,159 Federal share) should be 100 percent State share. The documentation provided for this case supports total restitution ordered of $4,366,018 for the conspiracy to commit health care fraud related to false claims. Although this restitution was ordered to be paid to the State agency, the restitution was for health care fraud within the State's Medicaid Family Planning program.[13] This program receives Federal Medicaid reimbursement; therefore, the Federal government is owed its share. We were also unable to verify that the State agency reported and returned $20,023 ($10,624 Federal share) for payments received because the State agency did not provide documentation demonstrating that it had reported these amounts on the Form CMS-64.[14]

For the two civil cases, we appropriately included the False Claims Act bonus in our calculation. With respect to the administrative costs for the two civil cases, these costs should not be deducted before applying the FMAP to calculate the Federal share.[15] The SHO Letter states that "for State [False Claims Act] 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." We maintain that our findings and recommendations are correct.

[13] The Family Planning, Access, Care, and Treatment Program provides comprehensive family planning services to eligible California residents.

[14] As part of the resolution process for this audit, a CMS official will allow the State agency to provide documentation supporting that funds have been returned before making a final determination on the monetary audit recommendations in this report.

[15] The State agency may be able to claim administrative costs in its reporting to the Federal government, but any administrative costs claimed that the State may be entitled to does not negate the amount of recoveries that should have been reported and that are the basis for our findings and recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

This audit covered 26 MFCU cases with associated MFCU-determined Medicaid overpayments totaling $231,201,507 ($99,341,141 Federal share). According to information provided by the California MFCU, it received final determinations for 81 cases during our audit period (October 1, 2022, through September 30, 2023). For 55 of these cases, Department of Justice prosecutors were involved, and either the Federal share was returned to CMS directly or the case did not involve Medicaid restitution; therefore, we removed these cases from our audit.

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

We performed our audit work from April 2025 through April 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

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

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

- Discussed the results of our audit with State agency officials

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases	A-06-24-04002	09/08/2025
North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases	A-06-23-04004	6/20/2024
Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 70 Percent of the State's Medicaid Fraud Control Unit Cases	A-07-21-02834	10/25/2022
Texas Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases	A-06-20-04004	5/25/2022
Nebraska Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 76 Percent of the State's Medicaid Fraud Control Unit Cases	A-07-18-02814	6/10/2021
Wisconsin Did Not Report and Refund the Full Federal Share of Medicaid-Related Settlements and a Judgment	A-05-17-00041	12/13/2018

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

Case	Reported Restitution	Restitution Reported Correctly	Restitution Reported Late	Unreported Restitution	Court-Ordered Awards Not Reported
1	$562	0	$562	$0	$0
2	0	0	0	35,435	0
3	0	0	0	32,493	0
4	3,372	3,372	0	0	0
5	9,284	9,284	0	0	0
6	1,995	0	1,995	3,625	0
7	12,364	2,810	9,554	38,216	0
8	56	0	56	7,819	0
9	20,813	20,813	0	0	0
10	1,007	0	1,007	35,019	0
11	1,899	0	1,899	32,097	0
12	1,540	0	1,540	0	0
13	24,750	0	24,750	10,820	0
14	5,756	5,756	0	0	0
15	5,250	0	5,250	9,757	0
16	1,242,265	0	1,242,265	0	0
17	10,819	0	10,819	0	0
18	25,750	25,750	0	0	0
19	5,199	5,199	0	0	0
20	128,750	0	128,750	375,110	0
21	562	0	562	0	0
22	0	0	0	2,292,159	0
23	5,250	5,250	0	10,716	0
24	2,070,687	2,070,687	0	935,477	0
25	47,613,000	16,939,240	30,673,760	43,950,462	0
26	370,000	370,000	0	0	11,006
Total	**$51,560,930**	**$19,458,161**	**$32,102,769**	**$47,769,205**	**$11,006**

APPENDIX D: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL LAWS

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

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

FEDERAL REGULATIONS

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

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

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

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

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

> When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no

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

CMS GUIDANCE (STATE HEALTH OFFICIAL LETTER)

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

> The [Social Security] Act requires that the amounts recovered by a State through a State FCA [False Claims Act] action be refunded at the Federal Medical Assistance Percentage (FMAP) rate. The Act's broad mandate demands that a State return not only the Federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery.
>
> Any State action taken as a result of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares. A State may not seek to recover merely the 'State share' of computed fraud damages unless appropriate Federal and State authorities formally agree to pursue them as separate actions. If there is no formal agreement to sever, a State may not claim in a State FCA case that it is only recovering damages incurred by the State, but not the Federal Government. Nor may a State return merely the Federal portion of 'single' damages and retain all other amounts, such as double and treble damages. The Federal Government is entitled to the applicable FMAP share of a State's entire recovery.
>
> States are also required to return the FMAP percentage on State recoveries based upon actions brought against third parties, such as actions against pharmaceutical companies, alleging inappropriate Medicaid expenditures. Though these third parties are not necessarily directly reimbursed by Medicaid, they may be liable under a State FCA for having caused false or fraudulent claims to be submitted by others. A State may not avoid adhering to the requirements set forth in section 1903(d) of the Act by virtue of pursuing legal action against a person or entity that has caused false or fraudulent claims to be submitted rather than the party that directly submitted false or fraudulent claims.
>
> The FMAP proportionate share of State FCA-based fines, penalties, or assessments imposed against providers or entities are to be refunded. The HHS Departmental Appeals Board has long recognized the Federal Government's entitlement to its proportionate share of civil penalties assessed by States against providers or other entities . . ..

For State FCA legal actions neither the relator's share, nor legal expenses (whether borne by the State or the relator) or other administrative costs arising from such litigation, may be deducted from the Federal portion of the entire proceeds of the litigation. A State must return the Federal portion of such recoveries at its applicable FMAP rate for medical services in recognition of the overpayment that resulted from a payment for Medicaid services. Historically, costs that are in support of the proper and efficient administration of a State's Medicaid program are recognized as administrative costs and not service costs. To the extent attributable to Medicaid recoveries, these costs may be the basis for claims for reimbursement as an administrative cost that benefits the Medicaid program and reimbursed at the regular administrative percentage rate. Federal reimbursement is not available for administrative costs that are not directly related to Medicaid recoveries.

APPENDIX E: STATE AGENCY COMMENTS

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

5/20/2026
THIS LETTER SENT VIA EMAIL

Patricia Wheeler
Regional Inspector General
Office of Audit Services, Region IX
U.S. Department of Health and Human Services
90 – 7th Street, Suite 3-650, San Francisco, CA 94103

DHCS' RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S DRAFT AUDIT REPORT OAS-25-06-061

Dear Ms. Patricia Wheeler:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the Office of the Inspector General's (OIG) draft audit report OAS-25-06-061, titled, "California Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases".

In the referenced draft audit report, OIG issued four recommendations for DHCS. DHCS has reviewed all of OIG's recommendations and has prepared a response describing the nature of the corrective actions taken or planned.

DHCS is committed to complying with federal requirements and has taken steps to strengthen internal controls and procedures. DHCS is working collaboratively with the Medicaid Fraud Control Unit (MFCU) to update processes and the Memorandum of Understanding for timely, accurate reporting of Medicaid overpayments and ensuring federal requirements are met.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any questions, please contact the DHCS Office of Compliance, Internal Audits at (916) 261-0346.

Signed by:
Sincerely,
Michelle Baass
D897AA6F96FE48F...

Michelle Baass
Director

Enclosure

cc: See Next Page

Director's Office
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413
Phone (916) 440-7400 | www.dhcs.ca.gov

State of California
Gavin Newsom, Governor
California Health and Human Services Agency

cc:

Lindy Harrington
Chief Deputy Director
Policy and Program Support
Department of Health Care Services
Lindy.Harrington@dhcs.ca.gov

Tyler Sadwith
Chief Deputy Director and
State Medicaid Director
Department of Health Care Services
Tyler.Sadwith@dhcs.ca.gov

Saralyn Ang-Olson, JD, MPP
Chief Compliance Officer
Office of Compliance
Department of Health Care Services
Saralyn.Ang-Olson@dhcs.ca.gov

Wendy Rasmussen, MPA
Chief
Internal Audits
Department of Health Care Services
Wendy.Rasmussen@dhcs.ca.gov

Bill Otterbeck
Deputy Director
Program Operations
Department of Health Care Services
Bill.Otterbeck@dhcs.ca.gov

Bruce Lim
Deputy Director
Audits and Investigations
Department of Health Care Services
Bruce.Lim@dhcs.ca.gov

Lori Walker
Chief Financial Officer
Fiscal
Department of Health Care Services
Lori.Walker@dhcs.ca.gov

Department of Health Care Services

Report: *"California Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases."*

External Entity: Office of Inspector General
Report Number: OAS-25-06-061 (25-08) (California Reporting Federal Share of Medi-Cal Overpayments)
Response Type: DHCS' Responses to OIG's Draft Audit Report

Table of Contents

Finding 1: We determined that the State agency should have reported and returned MFCU-determined Medicaid overpayments totaling $231,201,507 ($99,341,141 Federal share) for the 26 cases during the period that we reviewed. We found that the State agency:

- **Did not report and return $113,269,575 ($47,769,205 Federal share) on the Form CMS64 for MFCU-determined Medicaid overpayments related to paid claim amounts for 14 cases.**

Recommendation 1

We recommend that the California Department of Health Care Services report and return the Federal share of Medicaid overpayments for the 14 unreported cases identified in this report that total $113,269,575 ($47,769,205 Federal share).

What is DHCS' Response to the Recommendation? Nonconcurrence

DHCS' Response:

The Department of Health Care Services (DHCS) has determined that the amount owed for the 14 unreported cases will differ from the $113,269,575 ($47,769,205 federal share) identified by OIG, because $1,098,275.34 ($580,090.14 federal share) applies only to the 12 criminal cases. The amounts associated with the two civil cases remain subject to adjustment based on OIG's position on the False Claims Act bonus and potential approval from CMS for claiming administrative costs.

- For the 12 criminal Medicaid Fraud Control Unit (MFCU) cases totaling $5,484,316.46 ($2,883,266.50 federal share):
  - One of the cases for which OIG listed the federal share to be returned is 100 percent state share and was prosecuted in United States District Court (USDC). The USDC judgment did not list the Centers for Medicare & Medicaid Services (CMS) or any other federal agency as a restitution victim. USDC confirmed that the case is 100 percent state share. DHCS does not agree that $4,366,018 ($2,292,159.45 federal share) is owed for this case.
  - DHCS reported and returned an additional $20,023.12 ($10,623.52 federal share) for payments received that were not included in OIG's calculations.
  - Based on the above, DHCS calculates the amount to report and return is $1,098,275.34 ($580,090.14 federal share).

- For the two civil MFCU cases totaling $107,785,258.30 ($44,885,938.94 federal share):
  - OIG calculated a total of $107,785,258.30 ($44,885,938.94 federal share) to be reported and returned. DHCS believes OIG's calculation may not have taken into account the 10 percent False Claims Act bonus received by DHCS. In addition, OIG's calculation did not take into account the administrative costs of $107,785,258.30 ($53,892,629.15 federal share) per the State Health Official (SHO) Letter dated October 28, 2008, given

the direct connection for claiming administrative costs. DHCS will continue to work with OIG to reconcile the total amount to be repaid.

Finding 1: We determined that the State agency should have reported and returned MFCU-determined Medicaid overpayments totaling $231,201,507 ($99,341,141 Federal share) for the 26 cases during the period that we reviewed. We found that the State agency:

- **Did not report and return $27,515 ($11,006 Federal share) on the Form CMS-64 for a court-ordered award that the MFCU collected for 1 case.**

Recommendation 2

We recommend that the California Department of Health Care Services report and return the Federal share of the collected court-ordered award for one case, totaling $27,515 ($11,006 Federal share).

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:

DHCS will remit the court-ordered award that the MFCU collected for one case, totaling $27,515 ($11,006 federal share).

Finding 2: The State agency was late in reporting and returning $74,879,534 ($32,102,769 Federal share) in MFCU-determined Medicaid overpayments for 14 of the 26 cases we reviewed. In most cases, the agency waited to report overpayments on Form CMS-64 until it received payments from the MFCU, rather than reporting the full amount owed after the final judgment. Because many payments were made in installments, the full amounts were not reported within the required timeframe. Additional delays occurred because the State agency did not receive restitution or settlement information from the MFCU in time to meet the Federal reporting requirements.

Recommendation 3
We recommend that the California Department of Health Care Services work with the MFCU to revise the current notification timeline in the MOU to facilitate the timely notification of final judgments to meet Federal requirements.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS will work collaboratively with the MFCU to revise the current notification timeline in the Memorandum of Understanding (MOU) to meet Federal requirements. Specifically, DHCS will:

- Ensure the MOU language is compliant with 42 CFR § 433.316(a) and (d)(2), which require reporting the Federal share of Medicaid overpayments within 30 days of final judgment in fraud cases.
- Continue to conduct periodic reviews of the revised MOU provisions during scheduled meetings with the MFCU to monitor compliance and address emerging issues.

Finding 3: **The State agency lacked policies and procedures to facilitate timely reporting of the overpayments in accordance with Federal requirements. In addition, the State agency lacked policies and procedures that addressed the calculation of the Federal share of overpayments. It relied on the MFCU's calculations and instructions, which were often based on State regulations rather than Federal requirements.**

Recommendation 4
We recommend that the California Department of Health Care Services develop written policies and procedures to facilitate (1) timely and complete reporting of all identified overpayments, regardless of payment status and (2) accurate calculation of the Federal and State shares of overpayments in accordance with Federal requirements.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS will strengthen internal controls by updating and expanding written policies and procedures to ensure:

- Timely and complete reporting of all identified overpayments, regardless of payment status.
- Accurate calculation of the federal and state shares of overpayments in accordance with federal requirements.

Additionally, DHCS has initiated internal discussions to develop and update processes, procedures, and the Memorandum of Understanding with the MFCU. These efforts include:

- Creating a standardized form to ensure consistency, accuracy, and timeliness in reporting federal and state share information.
- Designating clear points of contact for case-related information, documentation, and inquiries.
- Implementing a case log exchange between the MFCU and DHCS to reconcile finalized case referrals.

Report Fraud, Waste, and Abuse

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

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

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

How Does It Help?

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

Who Is Protected?

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

Stay In Touch

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

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

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

Email: Public.Affairs@oig.hhs.gov