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INTRODUCTION

WHY WE DID THIS AUDIT

The Indiana Family and Social Service Administration (State agency) is responsible for reporting Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). Indiana has a 1915(c) Community Integration and Habilitation Waiver (CIH Waiver) that provides services that enable individuals with intellectual or developmental disabilities to remain in their homes or community-based settings and assists other such individuals as they transition from State-operated facilities or other institutions into community settings. Services reported on the Form CMS-64 under the CIH Waiver accounted for just over $1.1 billion in Medicaid expenditures during Federal fiscal years (FFYs) 2015 and 2016. These expenditures represented approximately 5.9 percent of the total Medicaid expenditures reported on the Form CMS-64 during this period. We decided to perform this audit of the CIH Waiver services because of the significant dollar expenditures.

OBJECTIVE

Our objective was to determine whether the State agency ensured that CIH Waiver services at 12 selected providers were provided in accordance with Federal, State, and waiver requirements.[1]

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to 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, the Centers for Medicare & Medicaid Services (CMS) administers the 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.

CMS Waivers

Section 1915(c) of the Act authorizes the Home and Community Based Services (HCBS) Waiver programs. These waiver programs permit States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. Waiver services complement or supplement

[1] In calendar year 2015, there were 268 providers that received payment for CIH Waiver services. We selected the 11 service providers and 1 case management provider that reported the highest amount of CIH Waiver service expenditures to the State agency during our audit period.

the services that are available to beneficiaries through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of the waiver's beneficiaries.

The Indiana CIH Waiver

In Indiana, one of these 1915(c) HCBS Waivers is the CIH Waiver. The CIH Waiver provides services that enable eligible individuals to remain in their homes or community-based settings and assists individuals who are transitioning from State-operated facilities or other institutions into community settings. The CIH Waiver allows flexibility in providing the supports necessary to help individuals gain and maintain optimum levels of self-determination and community integration. [2]

HOW WE CONDUCTED THIS AUDIT

In FFYs 2015 and 2016, CIH Waiver expenditures totaled approximately $1.2 billion.[3] Our audit covered 487,576 CIH Waiver service claims from 12 selected CIH service providers,[4] totaling approximately $467.4 million,[5] that had service dates during FFYs 2015 and 2016. These 12 service providers together accounted for approximately 40 percent of the CIH Waiver services expenditures reported on the Form CMS-64 for our audit period. Using a stratified random sample, we randomly selected and reviewed 300 CIH Waiver service claims totaling $864,685 to determine whether the State agency ensured that the CIH Waiver services were provided in accordance with Federal, State, and waiver requirements. On the basis of our sample results, we estimated the total value and Federal share of Medicaid overpayments.

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.

[2] Self-determination refers to individuals having the authority to make decisions over some or all of their supports and services.

[3] In FFYs 2015 and 2016, CIH Waiver expenditures totaled $1,164,665,326. This was the most recent finalized claims data available from the State at the beginning of the audit.

[4] CIH service providers are agencies, companies, and individuals that the Family and Social Service Administration Division of Disability and Rehabilitative Services has approved and are paid by Medicaid to provide direct services to Medicaid waiver program participants.

[5] The total CIH Waiver services expenditures reported by the 12 providers during FFYs 2015 and 2016 was $467,413,722.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not ensure that all CIH Waiver services were provided in accordance with Federal, State, and waiver requirements. We determined that services associated with 236 claims were provided in accordance with the requirements; however, services associated with 64 claims were not. Documentation provided by CIH Waiver service providers did not support that services associated with 39 claims were provided in accordance with the requirements. Overpayments associated with these 39 claims totaled $10,675 ($7,108 Federal share). In addition, some CIH Waiver service providers were unable to provide any documentation to support 25 claims totaling $90,802 ($60,448 Federal share). Therefore, overpayments associated with the 64 claims totaled $101,477 ($67,556 Federal share).

The unallowable claims occurred because the State agency's monitoring of the CIH Waiver services program was not adequate to ensure that services complied with Federal, State, and CIH Waiver requirements.

On the basis of our sample results, we estimated that these providers were unable to support that they provided services totaling at least $33.5 million ($22.3 million Federal share)[6] in accordance with the CIH Waiver requirements.

DOCUMENTATION DID NOT SUPPORT THAT SERVICES WERE PROVIDED IN ACCORDANCE WITH REQUIREMENTS

For 39 claims totaling $10,675 ($7,108 Federal share), CIH Waiver service providers were unable to provide complete and accurate documentation to support that services were provided in accordance with the requirements. (Table 1 contains a summary of the deficiencies we found in the sampled claims.)

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims*
Documentation did not support all units billed	35
Documentation did not support the level of service billed	5
Beneficiary was not in residence	2
Received payment for 25 hours of service in a day	1

* The total exceeds 39 because 4 claims contained more than 1 deficiency.

[6] Rounded to the nearest dollar, the amounts equaled $33,538,635 and $22,328,438, respectively.

Documentation Did Not Support All Units Billed

Providers must keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid services (the Act § 1902(a)(27)(A)). In order to be allowable, expenditures must be supported with adequate documentation (45 CFR § 74.403(g); the *State Medicaid Manual* § 2497.1). In accordance with Appendix C, C-1/C-3, of the CIH Waiver, providers must comply with the Indiana Administrative Code (IAC), 460 IAC 6, as well as the *Division of Disability and Rehabilitative Services Home and Community Based Services* (DDRS HCBS) *Waiver Provider Manual*. Documentation of all health and medical services provided to an individual must include the date of services, description of services provided, and the signature of the provider (460 IAC 6-17-4(e)). Units of service as billed must be substantiated by documentation (DDRS HCBS Waiver Provider Manual § 2.5).[7]

Services must address the needs identified in the person-centered planning process and be outlined in the "Individual Support Plan" (ISP) (42 CFR § 441.301(c); CIH Waiver, Appendix D; DDRS HCBS Waiver Provider Manual §10.24).

For 35 of the CIH Waiver services we reviewed, providers were unable to produce documentation to support all of the units they billed and the State agency reimbursed. Specifically, the State agency reimbursed claims that lacked documentation to support 13 residential habilitation support (RHS) services, 6 behavior management services, 5 transportation services, 4 community habilitation services, 4 wellness coordination services, 2 case management services, and 1 facility habilitation service.

Representative Examples of Documentation That Did Not Support All Units Billed

Example 1—The State agency paid a claim for 8 hours of community habilitation services. However, the provider was unable to support all the units claimed through the documentation we reviewed during our site visit. The provider could support only 6.75 hours of the 8 hours of community habilitation services.

Example 2—The State agency paid a claim for 650 hours of residential habilitation services. However, the documentation produced by the provider during our site visit supported only 615 hours of residential habilitation services.

Example 3—The State agency paid a claim for 41 transportation service trips. However, the documentation produced by the provider during our site visit supported only 30 of the 41 transportation service trips.

[7] The DDRS HCBS Waiver Provider Manual was updated during our audit period. We refer to version 3.0, published September 8, 2015.

Documentation Did Not Support the Level of Service Billed

Wellness coordination services extend beyond those services provided through routine doctor visits required under the Medicaid State Plan and are specifically designed for beneficiaries who require the assistance of a registered nurse (RN) or licensed practical nurse (LPN) to properly coordinate their medical needs. The level of wellness coordination increases on the basis of the number of consultations and face-to-face visits (CIH Waiver, Appendix C, C-1/C-3; DDRS HCBS Waiver Provider Manual § 10.34).

Adult day services are community-based group programs that are designed to meet the needs of the participating beneficiaries. These programs are structured, comprehensive, and nonresidential; they provide supervised services in the areas of health, social, recreational, and therapeutic activities, including certain support or personal care services. The level of service for adult day service claims is based on the activity and the ratio of staff to beneficiary (CIH Waiver, Appendix C, C-1/C-3; DDRS HCBS Waiver Provider Manual § 10.3).

Providers score the level of support that beneficiaries need. Beneficiaries with a score of three or higher qualify for "Residential Habilitation and Support – Daily" (RHS Daily) services effective July 1, 2015. Beneficiaries with scores of zero through two have at least a moderate level of independence and do not require full-time supervision or 24 hours a day, 7 days a week staff availability (CIH Waiver, Appendix C, C-1/C-3; 460 IAC 13-5-1). These individuals receive Level 1 or Level 2 services and do not qualify for RHS Daily services (CIH Waiver, Appendix C, C-1/C-3).

For five of the sampled CIH Waiver services, the documentation did not support the level of service billed and reimbursed by the State agency. Specifically, providers could not support the level of service for two wellness claims, two RHS claims, and one adult day service claim.

A Representative Example of Documentation That Did Not Support the Level of Service Billed

Example—The State agency paid a claim for "Wellness Coordination Tier 2," which indicates a beneficiary requires at least weekly consultation with an RN or LPN, including face-to-face visits at least twice monthly. The provider's documentation listed only one face-to-face visit; therefore, the provider should have billed the claim as "Wellness Coordination Tier 1," which is a lower level of reimbursement that requires only one face-to-face visit per month.

Providers Billed for Residential Habilitation Support Services When the Beneficiary Was Not in the Residence

RHS Daily services provide up to a full day (24 hours) of services and supports that are designed to ensure the health, safety, and welfare of the participant. RHS Daily services assist with the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their own homes, acquire and enhance natural supports, and become integrated

and participate in their larger community. The individual must be present and receive RHS Daily services for at least a portion of any day the provider bills as a day of RHS Daily service (CIH Waiver, Appendix C, C-1/C-3).

For two of the CIH Waiver services selected, the provider was paid for days when, according to the documentation, the beneficiary was not in the residence and there was no documentation showing that any CIH Waiver services were provided on these days.

A Provider Billed for 25 Hours of Service in a Day

For one of the CIH Waiver services selected, the provider billed and received reimbursement from the State agency for RHS totaling 25 hours of service in 1 day.

PROVIDERS DID NOT HAVE ANY REQUIRED DOCUMENTATION

States must have agreements in place that require providers to "keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan" (the Act § 1902(a)(27)(A)). "Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met" (the *State Medicaid Manual* § 2497.1).

"All providers participating in the Indiana Medicaid program shall maintain, for a period of seven (7) years from the date Medicaid services are provided, such as medical or other records, or both, including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provision of the Indiana Medicaid program" (405 Indiana Administrative Code 1-5-1).

CIH Waiver service providers were unable to provide any required documentation to support 25 of the 300 claims in our sample. Payments associated with these 25 claims totaled $90,802 ($60,448 Federal share).

THE STATE AGENCY DID NOT ADEQUATELY MONITOR WAIVER SERVICE PROVIDERS

The State agency did not adequately monitor CIH Waiver service providers for compliance with requirements for providing, documenting, and billing services. The State agency conducts audits of a limited number of CIH Waiver service providers each year. Despite these monitoring efforts, some CIH Waiver service providers did not comply with Federal, State, and CIH Waiver requirements.

ESTIMATE OF UNALLOWABLE MEDICAID PAYMENTS

On the basis of our sample results, we estimated that the State agency made overpayments totaling at least $33,538,635 ($22,328,438 Federal share) to the 12 selected providers for claims with service dates during our audit period.

RECOMMENDATIONS

We recommend that the Indiana Family and Social Service Administration:

- refund $22,328,438 to the Federal Government and
- improve its monitoring of the CIH Waiver program to ensure that service providers comply with Federal, State, and CIH Waiver requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally did not concur with our findings and recommendations. The State agency provided a variety of legal, statistical, and other reasons for not concurring with our recommendation to refund $22.3 million to the Federal Government. The State agency did not concur with our second recommendation and stated that it actively monitors its providers for compliance with Federal, State, and CIH waiver requirements and already has a robust system in place, which it is continuously improving upon. The State agency's comments are summarized below and included in their entirety as Appendix D. After considering the State agency's comments, we maintain that our findings and recommendations are valid for the reasons detailed below.

REFUND $22.3 MILLION TO THE FEDERAL GOVERNMENT

State Agency Comments

The State agency did not concur with our recommendation to refund $22.3 million to the Federal Government. The State agency stated it was not able to trace the information referenced in our draft report to the individual sampled claims based on the information provided and asked for additional information for each of the 300 claims that we sampled. Among other things, the State agency asked that we provide a description of any documentation we believe was missing and a citation to any legal provisions that we believe were violated.

In addition, the State agency objected to our recommendation to the extent that it relies on findings of alleged noncompliance with State law and guidance. Specifically, the State agency stated that the Federal Government lacks a general inherent power to enforce (as well as any valid interest in enforcing) State Government compliance with State law. The State agency cited *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 105–06 (1984) as holding that

the Eleventh Amendment prohibited a Federal court from enjoining State officials to comply with State law, in part because "[a] federal court's grant of relief against state officials on the basis of state law . . . does not vindicate the supreme authority of federal law."

The State agency also raised concerns about our use of sampling and statistics. First, the State agency stated that it opposes our use of a 300-claim sample to draw conclusions about 487,576 claims submitted by 12 providers for services provided in different areas throughout Indiana. Second, the State agency stated that we did not provide sufficient information to allow it to evaluate our sampling and extrapolation methodology. Specifically, the State agency said that our draft report did not provide information about why we sampled claims from only the 12 largest providers, why we used a stratified sample, and why we excluded claims of less than $10. The State agency also said that we did not provide information about the RAT-STATS statistical software we used to choose sampled claims and to estimate the amount we recommended for refund or about the qualifications of the individuals that conducted the sampling and extrapolation. The State agency requested that we provide this information in our final report.

Office of Inspector General Response

Separate from the draft report, we provided the State agency with additional information about the 64 sampled claims that we determined did not meet requirements. This information included claim identification numbers and additional claim fields for each of the 64 sampled claims and a brief explanation of why we determined that they did not meet requirements. We believe this additional information combined with the criteria cited in the Findings section of our report provides sufficient information for the State agency to review and verify our findings. Consistent with OIG practice, we did not provide detailed information on the 236 claims we accepted as allowable.

With regard to the State agency's objection to our recommendation to the extent that it relies on findings of alleged noncompliance with State law and guidance, we want to state clearly that our findings are based on Federal and CIH Waiver requirements. Any reference to State regulations or guidance in our findings pertains to the CIH Waiver's specific incorporation of such requirements. As stated in the report, the CIH Waiver specifically requires compliance with 460 IAC 6 and the DDRS HCBS Waiver Provider Manual. Further, longstanding Federal cost principles have established that costs must be in compliance with State and local laws and regulations in order to be allowable under Federal awards.[8] Finally, the State agency's reliance on the Supreme Court's decision in *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984), to support its position that the Federal Government lacks the power to enforce State Government compliance with State law is misplaced. *Pennhurst* pertained to whether the

[8] 2 CFR part 225, App. A, § C.1.c; 45 CFR §§ 75.403, 75.404. Office of Management and Budget Circular A-87, Cost Principles for State, Local, and Tribal Government, was relocated to 2 CFR part 225 and made applicable to HHS awards by 45 CFR § 92.22(b). Federal cost principles were consolidated under uniform requirements for Federal awards, which are now located at 2 CFR part 200 and implemented for HHS awards at 45 CFR part 75.

Eleventh Amendment, which establishes that a State cannot be sued in Federal courts by its citizens, barred Federal jurisdiction over a suit against State officials for violating a State law. Thus, *Pennhurst* does not stand for the position the State purports and does not impact our findings and recommendations.

Regarding the State agency's objection to our sample size of 300 claims, we point out that sample sizes smaller than 100 have routinely been upheld by the Departmental Appeals Board and Federal courts.[9] To account for our design choices, the precision of our estimate, and the potential differences between our sample and sampling frame, we estimated the overpayment amount using the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment in the sampling frame 95 percent of the time. Thus, the use of the lower limit generally favors the auditee.[10]

We relied on our professional judgment in deciding to limit our sampling frame to claims submitted by the largest 12 providers. These 12 providers were associated with approximately 40 percent of the amounts paid for CIH Waiver services during the audit period. We did not look at claims of $10 and less because these claims accounted for $91,840 (.02 percent of expenditures) for the audit period. Our overpayment estimate does not extend beyond the specific claims included in our sampling frame.

We also relied on our professional judgment in deciding on our sample design, a stratified random sample. This type of sample design typically yields an estimate that is more precise than a simple random sample of the same size and has been upheld in Federal courts.[11] To ensure our stratified random sample was representative of the frame, we used the HHS-OIG-OAS statistical software package, RAT-STATS, to randomly select the sample.[12] Many statistical samples that have been upheld in administrative appeals were selected and appraised using RAT-STATS.[13]

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[9] See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 10 (E.D.N.Y. 2012) (upholding a sample size of 95 claims); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *30-31 (S.D. Tex. 2012) (upholding a sample size of 30 claims).

[10] See *Puerto Rico Dep't of Health,* DAB No. 2385, at 10 (2011)*; Oklahoma Dep't of Human Servs.*, DAB No. 1436, at 8 (1993) (stating that the calculation of the disallowance using the lower limit of the confidence interval gave the State the "benefit of any doubt" raised by use of a smaller sample size).

[11] See William G. Cochran, *Sampling Techniques,* John Wiley & Sons, Inc. (3rd ed. 1977); *United States v. Rite Aid Corp.*, 2020 U.S. Dist. LEXIS 123820 (E.D. Cal. 2020); and *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012).

[12] https://oig.hhs.gov/compliance/rat-stats/index.asp.

[13] See *Sans Bois Health Servs., Inc.,* Decision of Medicare Appeals Council, Docket Number M-14-2629 (2014); and *New York State Department of Social Services,* DAB No. 1531 (1995).

Government Auditing Standards, 2018 Revision, section 9.14, state that when sampling significantly supports the auditor's findings, conclusions, or recommendations, auditors should describe in their report the sample design and state why the design was chosen, including whether the results can be projected to the intended population. We have done so. Our sampling and estimation methodology are detailed in Appendix B.

IMPROVE MONITORING OF THE CIH WAIVER PROGRAM TO ENSURE THAT SERVICE PROVIDERS COMPLY WITH STATE, FEDERAL, AND CIH WAIVER REQUIREMENTS

State Agency Comments

The State agency stated that it actively monitors its providers for compliance with Federal, State, and CIH waiver requirements, and it already has a robust system in place, which it is continuously improving upon.

The State agency provided an example of a monitoring and technical assistance process that began after we completed our fieldwork. The monitoring and technical assistance process includes onsite reviews with the goals to: (1) ensure that waiver-eligible individuals are receiving quality person-centered supports and services; (2) assess provider compliance with HCBS regulations; (3) identify areas where providers are doing well in addition to areas where providers will need further followup, guidance, and technical assistance; and (4) identify the educational needs of waiver providers to support them with meeting program requirements.

Office of Inspector General Response

Although the State has provided an example of a new monitoring program for the CIH Waiver, the program does not appear to address the documentation issues identified in our audit. We recommend that the State continue to improve its monitoring of the CIH Waiver program to ensure that service providers comply with Federal, State, and CIH Waiver requirements regarding the documentation of services provided.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

In FFYs 2015 and 2016, CIH Waiver expenditures totaled approximately $1.2 billion. Our audit covered 487,576 CIH Waiver service claims from 12 selected CIH service providers, totaling approximately $467.4 million, that had service dates during FFYs 2015 and 2016. These 12 service providers together accounted for approximately 40 percent of the CIH Waiver services expenditures reported on the Form CMS-64 for our audit period. Using a stratified random sample, we randomly selected and reviewed 300 CIH Waiver service claims totaling $864,685, to determine whether the State agency ensured that the CIH Waiver services were provided in accordance with Federal, State, and waiver requirements.

We did not review the overall internal control structure of the State agency or its Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our fieldwork from May 2019 through August 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal, State, and waiver requirements;
- interviewed State agency officials to gain an understanding of the CIH program;
- obtained and reviewed State agency policies and procedures related to the CIH Waiver;
- selected the 11 service providers and 1 case management provider that reported the highest amount of CIH Waiver service expenditures to the State agency during our research period;
- assessed CIH Waiver claims data reliability by comparing Medicaid Management Information System and Transformed Medicaid Statistical Information System claims data to the Form CMS-64s on file with CMS;
- selected a stratified random sample of 300 CIH Waiver claims for review;
- determined whether the documentation provided by the selected providers supported that the services were provided in accordance with Federal, State, and CIH Waiver requirements;

- estimated the lower limit at the 90-percent confidence level for the total and Federal share of Medicaid overpayments that could not be supported by documentation or did not meet requirements; and

- 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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 487,576 CIH Waiver service claims from the 12 selected CIH service providers totaling $467,413,722. The sampling frame did not include claims with payment amounts of $10 or less.

SAMPLE UNIT

The sample unit was a CIH Waiver service claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 2). We stratified the CIH Waiver service claims based on payment amount, as follows:

Table 2: Sample Design Summary

Stratum	Stratum Range	Number of Claims	Frame Dollar	Sample Size
1	$10 to $200	294,457	$31,237,270	75
2	>$200 to $3,400	144,682	$144,669,144	100
3	>$3,400 to $29,646	48,437	$291,507,309	125
	Total	**487,576**	**$467,413,722***	**300**

* Because of rounding, the numbers in this column do not total $467,413,722.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General/Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum. After a statistical specialist generated 300 random numbers given the stratum sample sizes in Table 2, we selected the corresponding sampling frame items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the dollar amount of any improper CIH Waiver service claims in our sampling frame at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Paid Sample Items	Value of Overpayments in Sample
1	294,457	$31,237,270	75	$7,875	11	$678
2	144,682	144,669,144	100	93,879	21	7,588
3	48,437	291,507,309	125	762,932	32	93,212
Total	**487,576**	**$467,413,722***	**300**	**$864,685†**	**64**	**$101,477‡**

* Because of rounding, the numbers in this column do not total $467,413,722.
† Because of rounding, the numbers in this column do not total $864,685.
‡ Because of rounding, the numbers in this column do not total $101,477.

Table 4: Estimates of Unallowable Payments in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Level)

	Total Amount	Federal Share
Point estimate	$49,759,702	$33,124,633
Lower limit	33,538,635	22,328,438
Upper limit	65,980,770	43,920,828

Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
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VIA US AND ELECTRONIC EMAIL

March 12, 2021
(Updated)

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audi Services, Region V
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Chicago, IL 60601

RE: A-05-19-00022

Dr. Ms. Fulcher:

This letter is in response to the January 7, 2021 U.S. Department of Health and Human Services, Office of Inspector General ("OIG") draft report No. A-05-19-00022 titled *Indiana Received Over $22 Million in Excess Federal Funds Related to Unsupported Community Integration and Habilitation Services at 12 Selected Providers* ("Draft Report"). We appreciate having the opportunity to respond and to explain why the Indiana Family and Social Services Administration ("FSSA") does not concur with the findings and where additional information is needed to assist us with responding to the Draft Report. Our responses regarding the findings and recommendations appears below.

Recommendation #1: Refund $22,328,438 to the Federal Government

FSSA is unable to concur with this recommendation because FSSA is not able to trace the information referenced in the Draft Report to the individual sampled claims based on the information provided. OIG's basis for each of its specific findings is unclear from the Report and the other information provided by OIG to the State. Accordingly, FSSA requests that OIG provide FSSA with a document that shows the following *for each of the 300 sampled claims*:

- The provider, beneficiary, and date(s) of services;
- Whether OIG accepted or rejected the claim;

- The amount of the claim paid and the amount rejected by OIG;

- For any claims rejected, OIG's basis for rejecting the claim, including a description of any documentation that OIG believes was missing and a citation to any legal provision(s) that OIG believes were violated.

OIG has provided FSSA with a spreadsheet (titled, "Outstanding items for the State") listing some of this information for rejected claims, including a brief and vague "finding explanation" for each claim, but OIG has never provided FSSA with a spreadsheet identifying which legal provisions OIG believes were not followed for each claim and specifying exactly what documents OIG believes were missing.

In addition, FSSA objects to OIG's recommendation to the extent it relies on findings of alleged noncompliance with state law and guidance. OIG's Draft Report indicates that it found that some of the sampled claims did not comply with Indiana regulations and guidance, including Article 1 of Title 405 of the Indiana Administrative Code, Article 6 of Title 460 of the Indiana Administrative Code, and provisions of the Division of Disability and Rehabilitative Services ("DDRS") Home and Community Based Services ("HCBS") Waiver Provider Manual. *See* Draft Report, at 4-6. There is no basis in law for a federal disallowance based on noncompliance with state law or guidance. The federal government lacks a general inherent power to enforce (as well as any valid interest in enforcing) state government compliance with state law. *Cf. Pennhurst State School & Hosp. v Halderman*, 465 U.S. 89, 105-06 (1984) (holding that Eleventh Amendment prohibited federal court from enjoining state officials to comply with state law, in part because "[a] federal court's grant of relief against state officials on the basis of state law . . . does not vindicate the supreme authority of federal law"). As the Supreme Court has observed, in a case involving a state recipient of federal dollars, "it is difficult to think of a greater intrusion on state sovereignty than when a federal court instructs state officials on how to conform their conduct to state law." *Id.* at 106 (emphasis added).

FSSA OIG has not shown that the state law noncompliance it alleges warrants recoupment under Indiana law. FSSA is committed to ensuring its providers comply with requirements for claims submission, and any providers identified as not complying that fail to either provide sufficient document or remedy the noncompliance will be subject to a corrective action plan and possible additional sanctions. FSSA does not believe recoupment is appropriate, for every instance of noncompliance with every state documentation requirement.

Finally, FSSA opposes the use of a 300-claim sample to draw conclusions about 487,576 claims submitted by 12 providers for services provided in different areas throughout the State. Such a sample is unlikely to capture a true picture of the large and diverse population of claims submitted by these 12 providers. Further, OIG did not provide the State with sufficient information to allow the State to evaluate OIG's sampling and extrapolation methodology. For example, the Draft Report did not provide information about, among other things: why OIG sampled claims from the 12 largest providers, rather than the claims from all 252 providers; why OIG used a stratified sample; why OIG excluded claims of less than $10; the RAT-STATs statistical software that was apparently used to choose the sample claims and conduct the extrapolation; or the qualifications

of the individuals that conducted the sampling and extrapolation. FSSA requests that OIG provide this information in its final audit report.

Recommendation #2: Improve Monitoring of the CIH Waiver program to ensure that service providers comply with federal, state and CIH waiver requirements

FSSA actively monitors its providers for compliance with federal, state and CIH waiver requirements, and it already has a robust system in place, which it is continuously improving upon. For example, in 2020, the Bureau of Quality Improvement Services ("BQIS") began a new monitoring and technical assistance process for providers that includes conducting Quality On-Site Provider Reviews, which serve as the basis for ensuring that BDDS waiver providers are providing quality person-centered supports and services for BDDS Waiver-eligible individuals and that they are compliant with the Home and Community-Based Settings rule.

These onsite provider reviews are used to evaluate the effectiveness of a provider's supports and services, organizational systems, records, staff training, qualifications, and compliance with DDRS policies and procedures. In addition, these on-site reviews serve as critical opportunities to engage provider staff as well as develop and strengthen relationships. The goals of these reviews include:

- Ensuring that BDDS waiver-eligible individuals are receiving quality person-centered supports and services.
- Assessing provider compliance with HCBS regulations.
- Identifying areas where providers are doing well in addition to areas where providers will need further follow-up, guidance, and technical assistance.
- Identifying the educational needs of BDDS waiver providers to support them with meeting program requirements.

If you require additional information, please contact Cathy Robinson, Director of the Bureau of Developmental Disabilities at cathy.robinson@fssa.in.gov.

Sincerely,

[redacted]

Medicaid Director