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

November 2026 | A-05-24-00017

Nursing Facilities Retained Only About Half of the $1.02 Billion Indiana Reported as Nursing Facility Supplemental Payments in Federal Fiscal Year 2022

REPORT HIGHLIGHTS

November 2026 | A-05-24-00017

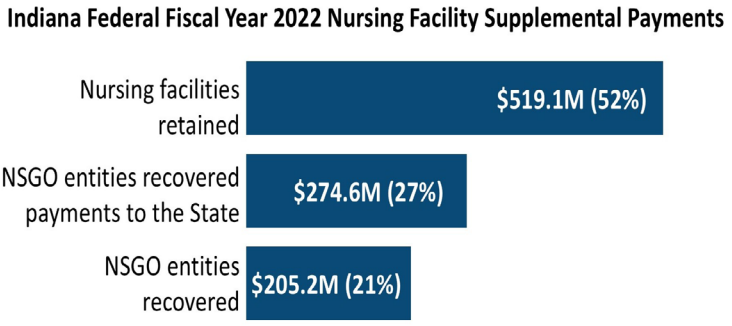
Nursing Facilities Retained Only About Half of the $1.02 Billion Indiana Reported as Nursing Facility Supplemental Payments in Federal Fiscal Year 2022

Why OIG Did This Audit

- Federal oversight of Medicaid supplemental payments has long been a concern because of their complexity, scale, and limited transparency. Indiana reported the most nursing facility supplemental payments in the Nation (approximately $1.02 billion of the $2.36 billion in total payments) during Federal fiscal year (FFY) 2022. Medicaid supplemental payments are Medicaid payments to providers that are separate from, and in addition to, the payments for services rendered to people enrolled in Medicaid.
- We conducted this audit to: (1) describe how supplemental payments were distributed among and used by the State, selected non-State government-owned (NSGO) entities, and the nursing facilities the NSGO entities own and (2) determine whether the payments that Indiana claimed for its supplemental payment program complied with Federal and State requirements.

What OIG Found

- Although Indiana distributed $1.02 billion in supplemental payments, nearly half ($479.8 million) was recovered by NSGO entities rather than benefiting nursing home residents. Of this amount, NSGO entities recovered $274.6 million that they had originally paid as the State's share of supplemental payments. Most notably, they recovered $205.2 million that was not used to increase Medicaid reimbursement for participating nursing facilities as intended.



- In addition, Indiana claimed $12.2 million in Federal payments that did not comply with Federal and State requirements.

What OIG Recommends

We made four recommendations to Indiana, including that it explore ways to increase the portion of Medicaid supplemental payments that participating nursing facilities retain and refund the $12.2 million in excess supplemental payments to the Federal Government. The full recommendations are in the report.

Indiana did not indicate concurrence or nonconcurrence with our recommendations but stated that it will take our first recommendation into consideration and detailed steps it has taken and plans to take in response to our other recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Federal oversight of Medicaid supplemental payments has long been a concern because of their complexity, scale, and limited transparency. Supplemental payments are Medicaid payments to providers that are separate from, and in addition to, the payments for services rendered to people enrolled in Medicaid.[1] A Senate Finance Committee report issued April 30, 2019, emphasized that Medicaid supplemental payments often lack provider-level detail, obscuring how taxpayer dollars are actually used and whether they achieve intended outcomes.[2]

Investigative reporting identified potential risks tied to Indiana's supplemental payment practices.[3] The reporting indicates that billions of dollars in supplemental Medicaid payments intended for nursing facilities were diverted to county-owned hospitals over several years, raising concerns about whether these funds directly benefited nursing facility residents as intended.

In Federal fiscal year (FFY) 2022, States reported to the Centers for Medicare & Medicaid Services (CMS) $2.36 billion in Medicaid nursing facility supplemental payments, with Indiana accounting for approximately $1.02 billion, or 43 percent, of the total nationwide. We selected Indiana for this audit because it accounted for the largest share of these payments. We conducted this audit because of the magnitude of these payments, combined with concerns raised by Congress and investigative reporting about transparency and whether funds benefited nursing facility residents as intended.

[1] Congressional Research Service Report (R45432), *Medicaid Supplemental Payments*, updated Dec. 17, 2018. Accessed on May 15, 2026.

[2] Senate Finance Committee, *Greater Transparency of Supplemental Payments Needed*, Apr. 30, 2019. Accessed on Feb. 5, 2026.

[3] Tony Cook, Tim Evans, and Emily Hopkins, "What you need to know about IndyStar's nursing home investigation," *Indianapolis Star* (Mar. 15, 2020). Accessed on Feb. 13, 2026.

OBJECTIVES

Our objectives were to: (1) describe how the Indiana Office of Medicaid Policy and Planning's (State agency's) supplemental payment program payments were distributed among and used by the State, selected non-State government-owned (NSGO) entities, and the nursing facilities the NSGO entities own and (2) determine whether payments that the State agency claimed for Indiana's supplemental payment program complied with Federal and State requirements.

What Are NSGO Entities?

During our audit period, Indiana NSGO entities consisted of:

- 20 county hospitals
- 1 county nursing facility
- 1 county
- 1 municipal corporation

These NSGO entities owned 498 nursing facilities.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. 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 Under Title XIX of the Social Security Act Medical Assistance Program* (Indiana State Plan). Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Indiana, the State agency administers the Medicaid program.

States report Medicaid expenditures on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the rate of Federal financial participation (FFP). The FFP is reflected in the Federal medical assistance percentage (FMAP) that is calculated annually by a defined formula that compares a State's average per capita income to the national average, with lower-income States receiving a higher percentage of Federal funding (42 CFR § 433.10). The State's share is the remaining portion of the expenditures. The Secretary of Health and Human Services calculates the FMAP (the Social Security Act § 1101(a)(8)(B)).

Supplemental Payments

Supplemental payments are Medicaid payments to providers that are separate from and in addition to the base payments for Medicaid services rendered to people enrolled in Medicaid (Medicaid enrollees). State Medicaid programs have considerable flexibility to determine payment methods and amounts for most provider types. Often, providers receive supplemental payments in a lump sum, and these supplemental payments are not tied to specific services provided to Medicaid enrollees. For example, States may provide

supplemental payments to providers to support quality initiatives, graduate medical education, and certain types of facilities. The Federal Government reimburses States for a portion of supplemental payment expenditures based on each State's FMAP.[4]

There are different types of supplemental payments, including upper payment limit (UPL) supplemental payments, each governed by different statutory and regulatory requirements.[5] These payments are provided to many different Medicaid providers, such as hospitals, nursing facilities, physicians, and mental health facilities.[6]

For most institutional providers, including nursing facilities, the UPL is defined as a reasonable estimate of what Medicare would have paid for the same services. States may make UPL supplemental payments to providers based on the difference between the base fee-for-service (FFS) payments made to a class of providers (in aggregate) and a UPL established by Federal regulation. To promote economy and efficiency, CMS set this UPL, as outlined in 42 CFR sections 447.272 and 447.321, on aggregate FFS payments using Medicare payment principles.[7]

In August 2022, CMS issued an informational bulletin encouraging States to assess their approach to payments to long-term care providers. Specifically, CMS advised States to use flexibilities in establishing Medicaid base and supplemental payments, as appropriate, to provide adequate nursing facility rates to ultimately achieve better health outcomes for Medicaid enrollees residing in nursing facilities.[8]

Indiana Medicaid UPL Supplemental Payment Formula

During our audit period, the Indiana State Plan specified that during each quarter of the State fiscal year the State agency must calculate the interim Medicaid supplemental payment (interim payment) as the difference between: (1) the amount that the State agency reasonably estimates the Medicare rate would have paid an NSGO entity's nursing facilities and (2) the estimated Medicaid payments to those nursing facilities.[9]

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[4] See footnote 1.

[5] Medicaid and CHIP Payment and Access Commission (MACPAC), *Upper Payment Limit Supplemental Payments*, November 2021. Accessed on May 8, 2026.

[6] See footnote 1.

[7] See footnote 5.

[8] CMS, Center for Medicaid & CHIP Services Informational Bulletin, *Medicaid nursing facility payment approaches to advance health equity and improve health outcomes*, Aug. 22, 2022. Accessed on Apr. 14, 2026.

[9] Indiana State Plan, attachment 4.19D, page 48(a), TN No. 12-009.

The Indiana State Plan further directed that following the completion of the State's fiscal year, the State agency must calculate the final supplemental payment amounts (final payments) for that State fiscal year and compare them to the interim payment totals. The difference, if positive (i.e., larger than the interim payment total), would be paid by the State agency to the NSGO entity. If the difference was negative (i.e., smaller than the interim payment total), the State agency would collect the difference from the NSGO entity.[10] For this audit, we considered a negative difference to be an overpayment.

Nursing Facility Financial Report

During our audit period, each nursing facility participating in the Indiana Medicaid program prepared a Nursing Facility Financial Report. Nursing facilities certified the report—including all supplemental attachments, exhibits, schedules, and explanations—as accurate, complete, and related to patient care. Each facility submitted its report annually to the State agency's rate-setting contractor (contractor) following the end of its fiscal year for use in determining the facilities' Medicaid per diem payment rate. The contractor conducted annual desk reviews of the reports to assess their accuracy.

Indiana Nursing Facility Ownership

Nursing facilities could be owned or operated by an NSGO entity, such as a county hospital, county nursing facility, county, or municipal corporation.[11, 12] For purposes of this audit, we refer to nursing facilities that were owned or operated as owned.

NSGO entities owned 97% of Indiana nursing facilities during our audit.

In Indiana when an NSGO entity acquired a nursing facility and a change of ownership was finalized, the NSGO entity could enter into contracts with the prior nursing facility owners for lease, management, and operations. The NSGO entity then became the operating manager of the nursing facility, and the previous owners could be retained to oversee the day-to-day operations. If any of the contracts were terminated, ownership of the facility returned to the original owners. There were no limits to the number or location of nursing homes an NSGO entity could own.

According to the Indiana State Plan during the audit period, any nursing facility owned by an NSGO entity that had entered into an agreement with the State agency to participate in the State's nursing facility supplemental payment program was eligible for an additional Medicaid

[10] Indiana State Plan, attachment 4.19D, page 48(b), TN No. 12-009.

[11] For the audit period, there were 25 NSGO entities; however, 2 had left the program and received only final payments. We contacted the 23 that received interim and final payments.

[12] The remaining 16 (3 percent) were proprietary for-profit or voluntary nonprofit nursing facilities.

payment adjustment that could not exceed the nursing facility's UPL (42 CFR § 447.272). In addition, the Indiana State Plan stated, "The supplemental payment is created to increase Medicaid reimbursement to participating nursing facilities that are owned or operated by [an NSGO] entity."[13]

Intergovernmental Transfers

An intergovernmental transfer (IGT), as applicable to Medicaid, is a transfer of funds between State or sub-State government entities within the same level of government or between different levels of government. For instance, IGTs may occur between local and State government groups or State-owned hospitals and the State Medicaid agency. They may be made by government entities to finance the State's share of Medicaid payments that the Federal Government matches at the applicable rate.[14]

States generally fund the State's share of supplemental payments through IGTs from local governments, provider taxes, or certified public expenditures from public providers, all of which are allowable sources of funding for the State's share of Medicaid. Some States have used these funding sources to pay for the State's share of Medicaid supplemental payments without expending much, if anything, from State general funds.[15]

Under Indiana's supplemental payment program, NSGO entities made quarterly IGTs for the State's share of the supplemental payments based on the UPL supplemental payment formula. Next, the State agency made the quarterly supplemental payments and claimed Federal matching funds for the full amount of the UPL supplemental payment formula result. The State agency reported supplemental payments on Form CMS-64, line 3B, "Nursing Facility Services—Supplemental Payments."

HOW WE CONDUCTED THIS AUDIT

Our audit covered Indiana nursing facility supplemental payments totaling $1.02 billion during FFY 2022 (the audit period). We sent questionnaires to the NSGO entities that received interim payments during the audit period to confirm the amounts received and ownership. We then inquired whether the supplemental payments were recovered by the NSGO entities and, if so, how they were used and what level of interaction the NSGO entities had with the nursing facilities. We reviewed the responses from the questionnaires returned by the NSGO entities to verify how the entities distributed and used the supplemental payment funds.[16]

[13] Indiana State Plan, attachment 4.19D, page 48(a), TN No. 12-009.

[14] See footnote 2.

[15] See footnote 1.

[16] One NSGO entity owned a nursing facility that did not respond to our requests for information.

From the highest paid NSGO entities we selected a nonstatistical sample of 24 nursing facility contacts (representing 391 nursing facilities).[17] We sent questionnaires to the selected nursing facility contacts requesting information on ways the nursing facilities used the supplemental payments, the amounts of supplemental payments the nursing facilities used, and an overview of the working relationship between the nursing facilities and the NSGO entities. We then reviewed and documented the responses from the 21 selected nursing facility contacts (representing 362 nursing facilities) that responded to our requests for information.[18]

We selected a nonstatistical sample of 62 interim nursing facility supplemental payments made to the highest paid NSGO entities by analyzing resident counts and total payment amounts. We then selected 32 final payments to verify the accuracy of the amounts used in the UPL interim and final supplemental payment calculations.[19]

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 A contains the details of our audit scope and methodology.

FINDINGS

For our audit period, the State agency distributed all $1.02 billion of the nursing facility supplemental payments to NSGO entities. Of this amount**,** nursing facilities spent $519.1 million on capital and operating expenses. However, the NSGO entities recovered the remaining $479.8 million to recover $274.6 million in IGT payments they made to cover the State's share of the supplemental payments and used the remaining $205.2 million for other purposes.

Although no Federal or State regulation requires the State agency to make all the UPL supplemental payment funds available to nursing facilities to improve patient care, during our audit period the Indiana State Plan stated, "The supplemental payment is created to increase Medicaid reimbursement to participating nursing facilities that are owned or operated by [an NSGO] entity." Opportunities exist for the State agency to explore ways to increase Medicaid

[17] The top 16 NSGO entities, which owned 483 nursing facilities, gave us a list of 90 contacts. We selected the 24 contacts who were associated with the most nursing facilities.

[18] Three selected nursing facility contacts representing 23 nursing facilities did not respond to our requests for information. Also, of the responses we received, two did not provide information for six nursing facilities.

[19] The 62 interim payments were selected from 1,993 interim payments made during the audit period. The 32 final payments were selected from the 950 final payments made during the audit period.

reimbursement to participating nursing facilities in accordance with the Indiana State Plan's intent for the supplemental payments.

In addition, the payments that the State agency claimed to CMS for Indiana's supplemental payment program did not fully comply with Federal and State requirements. The State agency demonstrated that the UPL supplemental payment formula it used complied with the Federal UPL requirement. However, the State agency: (1) did not report the overpayments collected from the final supplemental payments on Form CMS-64, (2) included an extra day in the final payment formula, and (3) reported adjustments at the wrong FMAP.

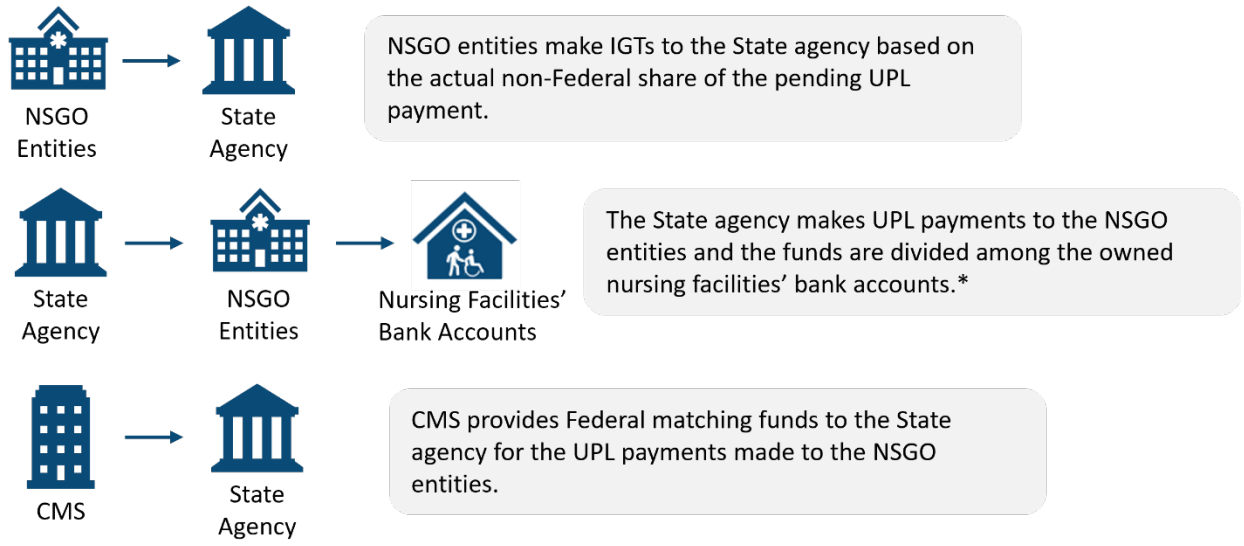
These instances of noncompliance occurred because the State agency: (1) did not follow its policies and procedures, (2) carried over an extra day from the 2020 leap year, and (3) did not use the FMAP rate in effect for 2021 when making a prior-period adjustment in 2022 as established in CMS's *State Medicaid Manual*.[20] As a result, the State agency claimed $12.2 million in Federal supplemental payments that did not comply with Federal and State requirements.

THE SUPPLEMENTAL PAYMENTS WERE DISTRIBUTED BY THE STATE AND USED BY NSGO ENTITIES AND NURSING FACILITIES

The State agency distributed quarterly supplemental payments to the NSGO entities after the NSGO entities contributed the State Medicaid share (based on the UPL supplemental payment formula) through IGTs. After receiving the supplemental payments, the NSGO entities distributed the supplemental payments to the nursing facilities they owned by depositing the funds into bank accounts that nursing facilities could access for the rest of the fiscal year. After the end of the fiscal year, the NSGO entities could collect any funds remaining in the accounts. See Figure 1, on next page, for a depiction of the supplemental payment process.

[20] The *State Medicaid Manual* provides instructions, regulatory citations, and information needed by the States to administer the Medicaid program.

Figure 1: Supplemental Payment Process



* Partnership arrangements between NSGO entities and nursing facilities are confidential. During our audit period nursing facilities had exclusive access to their bank accounts for operating expenses for the remainder of their fiscal year. NSGO entities collected any supplemental payments remaining after the end of a nursing facility's fiscal year.

For FFY 2022, we determined that the State agency reported on Form CMS-64 $1.02 billion in supplemental payments to NSGO entities for the nursing facilities they owned. State agency officials confirmed that the State agency received $274.6 million in IGTs from NSGO entities in quarterly payments that the State agency used to fund the non-Federal share of Indiana's Medicaid program expenditures.

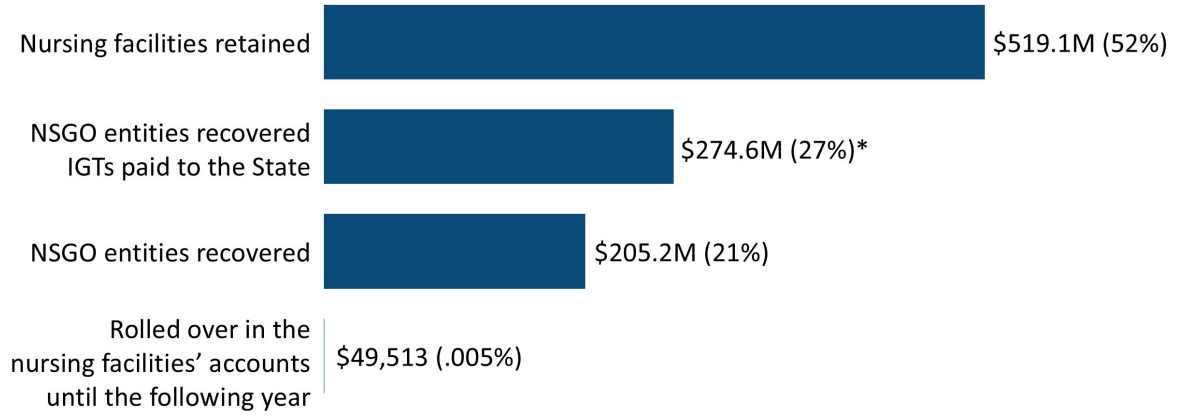
We determined that the NSGO entities received payments totaling $998.9 million in FFY 2022 from the State agency as part of the supplemental payment program.[21] The NSGO entities allocated all the payments to the nursing facilities they owned.[22] The NSGO entities confirmed that the nursing facilities used $519.1 million. The nursing facilities contacts who responded to our questionnaires stated that they used this amount for capital and operational expenses during the audit period.

[21] The difference between the $1.02 billion and $998.9 million is $13.6 million in provider overpayment collections made but not reported on Form CMS-64 (as described in this report's finding below: "The State Agency Did Not Report All Overpayments Collected on Form CMS-64"). In addition, one NSGO entity that owned one nursing facility did not respond to our questionnaire. We also did not contact two NSGO entities that were included in the final supplemental payment formula in 2022 because they were no longer in the supplemental payment program.

[22] The partnership arrangements between NSGO entities and nursing facilities are confidential. Therefore, we do not know whether the NSGO entities placed any limitations on how nursing facilities could use the supplemental payments or whether nursing facilities were required to return a certain amount to the NSGO entities.

After the end of the fiscal year, the NSGO entities recovered most of the supplemental payment amounts that remained in the nursing facilities' bank accounts. In total, the NSGO entities recovered $479.8 million that included their initial IGT payments of $274.6 million. According to responses from the NSGO entities, these funds were recovered typically in mid to late January. In addition to the IGT payments, NSGO entities recovered supplemental payments totaling $205.2 million that were not used by the nursing facilities. The NSGO entities used the remaining funds for their own capital and operational expenses.[23, 24] See Figure 2 for a breakdown of the nursing facility supplemental payments.

Figure 2: Indiana FFY 2022 Nursing Facility Supplemental Payments



* The IGT portion of the supplemental payments was based on the formula the contractor used to determine the UPL amount. The State agency collected the IGT portion from the NSGO entities before the State agency made supplemental payments. The NSGO entities recovered this amount from the nursing facilities' bank accounts at the end of the facilities' fiscal years.

Although nothing prohibited Indiana from allowing the NSGO entities to recover the $205.2 million in nursing facility supplemental payments, these funds were not used as increased Medicaid reimbursement for participating nursing facilities as described in the Indiana State Plan. Opportunities exist for the State agency to explore ways to increase Medicaid reimbursement to participating nursing facilities in accordance with the Indiana State Plan's intent for the supplemental payments. If allowed to retain more of the supplemental payments, nursing facilities may be able to provide higher quality care and achieve better health outcomes for Medicaid enrollees residing in nursing facilities.

[23] As shown on page 2, the majority of NSGOs are county hospitals.

[24] There is a remainder of $49,513 because one NSGO entity stated that it left this amount in the bank accounts of the nursing facilities instead of collecting it after the end of the fiscal year.

PAYMENTS MADE BY THE STATE AGENCY DID NOT FULLY COMPLY WITH STATE AND FEDERAL REQUIREMENTS

The State Agency Did Not Report All Overpayments Collected on Form CMS-64

Following the completion of the State's fiscal year, the State agency calculated the final payments for the nursing facilities for that State fiscal year and compared them to the interim payments. The difference, if positive, was paid by the State agency to the NSGO entity. If the difference was negative, the State agency collected the difference from the NSGO entity.[25]

Federal regulations (42 CFR § 433.304) define an overpayment as "the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for the services furnished under section 1902 of the [Social Security Act (the Act)] and which is required to be refunded under section 1903 of the Act." Section 1903(d)(2) of the Act requires the State to refund the Federal share of a Medicaid overpayment.

The *State Medicaid Manual* (§ 2500.1, line 10.B—Other) directs States to "[e]nter all decreasing adjustments for prior periods except for audit disallowances reported on Line 10.A and overpayments reported on Line 10.C."

The State agency did not report on Form CMS-64 the amounts collected from NSGO entities to recover overpayments in the final supplemental payment calculations for 2021. We identified $13,562,217 ($9,768,865 Federal share) in provider overpayment collections made but not reported on Form CMS-64. The State agency did not report these overpayments because it did not follow its policies and procedures for reporting recoveries on Form CMS-64.

The State Agency Included an Extra Day for the Final Payment Calculation

The State agency mistakenly used 366 Medicaid days instead of 365 days in the 2021 final UPL supplemental payment formula, resulting in supplemental payments to 497 nursing facilities that were calculated using 1 more day than there was in 2021.

This miscalculation was likely the result of a carryover of an extra day from the 2020 leap year in the 2021 (non-leap year) formula. This mistake resulted in the State agency overpaying the NSGO entities $3,202,739 ($2,306,933 Federal share) for the extra day.

The State Agency Reported Final Payment Adjustments at the Wrong Federal Medical Assistance Percentage

Section 2500.2(E)(4) of the *State Medicaid Manual* states that increasing adjustments related to public providers are considered adjustments to prior-period claims and are matched using the

[25] Indiana State Plan, attachment 4.19D, page 48(b), TN No. 12-009.

FMAP rate in effect at the time the expenditure was paid or recorded by the State agency, whichever was earlier.

Section 2560.4(G)(1) in the *State Medicaid Manual* defines a public provider as one that is owned or operated by a State, county, city, or other local government agency or instrumentality. The nursing facilities, which are owned by NSGO entities, receiving these supplemental payments are public providers.

Based on these provisions in the *State Medicaid Manual*, the 2021 FMAP would apply because it was in effect at the time of the initial 2021 supplemental payments.

The State agency did not use the 2021 FMAP when making an adjustment in 2022, as required by the *State Medicaid Manual* and the instructions for Form CMS-64. Because the final supplemental payment for 2021 was calculated in 2022, the State agency should have treated it as a prior-period adjustment. However, the State agency applied the 2022 FMAP of 72.50 percent rather than the applicable 2021 FMAP of 72.03 percent when reporting the adjustment. Thus, the State agency overstated the Federal share of expenditures by $145,887.

RECOMMENDATIONS

- We recommend that the Indiana Office of Medicaid Policy and Planning explore ways to increase the portion of Medicaid supplemental payments that participating nursing facilities retain.

- We recommend that the Indiana Office of Medicaid Policy and Planning refund to the Federal Government $9,768,865 in supplemental payments made to nursing facilities but not reported to CMS for the 2021 final supplemental payment calculations.

- We recommend that the Indiana Office of Medicaid Policy and Planning refund $2,306,933 to the Federal Government for supplemental payments that resulted from the inclusion of an extra day in the 2021 final payment formula.

- We recommend that the Indiana Office of Medicaid Policy and Planning submit a corrected Form CMS-64 to accurately report prior-period adjustments using the correct FMAP and reimburse the Federal Government $145,887.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations but stated that it will take our first recommendation into consideration and detailed steps it has taken and plans to take in response to our other recommendations.

With respect to our first recommendation to explore ways to increase the portion of Medicaid supplemental payments that participating nursing facilities retain, the State agency stated that it would take this recommendation into consideration; however, the State agency noted that it is not a party to the revenue-sharing agreements between the NSGOs and nursing facilities. The State agency also stated that based on informal industry feedback it believes that nursing facilities are now receiving a larger share of the supplemental payment.

In response to our second recommendation, the State agency stated that it refunded $9,768,865 on Form CMS-64 for the quarter ended September 30, 2024.

In response to our third recommendation, the State agency stated that it will revise the final payment calculation to remove the extra day and refund the Federal share.

In response to our fourth recommendation, the State agency stated that it will make a prior period adjustment to correct the FMAP of the final payment.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Indiana nursing facility supplemental payments totaling $1.02 billion during FFY 2022 (the audit period). We selected NSGO entities that received interim payments during the audit period to confirm the supplemental payment amounts received, nursing facility ownership, ways the supplemental payments recovered by the NSGO entities were used, and the NSGO entities' oversight of the management and operations of the nursing facilities.

We then selected nursing facilities to gain an understanding of their working relationships with the NSGO entities, ways the nursing facilities used supplemental payments, and the amounts used. We reviewed and documented the responses to our requests for information to verify how the facilities obtained and used the supplemental payment funds.

We reviewed the reports with the State contractor to determine the amounts owed to each nursing facility that participated in the supplemental payment program and the amounts paid to each NSGO entity. We then selected a nonstatistical sample of interim and final nursing facility supplemental payments to verify the accuracy of the amounts used in the UPL interim and final supplemental payment calculations.

We limited our review of internal controls to those that were significant to our audit objectives. In particular, we gained an understanding of the State's, the State contractor's, and the NSGO entities' policies and procedures regarding the supplemental payment program.

We performed audit work from May 2024 through July 2026.

METHODOLOGY

We took the following steps to accomplish our objectives:

- Reviewed applicable Federal and State requirements

- Interviewed State agency officials to gain an understanding of the nursing facility supplemental payment program, including amounts paid to NSGO entities during the audit period

- Sent questionnaires to the NSGO entities to confirm the information compiled from the State and other sources, asking about the supplemental payment amounts received, nursing facilities owned, and other information determined relevant

- Selected a nonstatistical sample of 24 nursing facilities owned by the highest paid NSGO entities

- Sent questionnaires to 24 selected nursing facility contacts to confirm the amounts of the supplemental payments used by the nursing facilities and information regarding the relationships among the previous owners, the nursing facilities, and the NSGO entities[26]

- Assessed the documentation supporting how the supplemental payment funds were distributed and used by the NSGO entities and selected nursing facilities

- Obtained and reviewed contractor policies and procedures regarding the supplemental payment program that were used to determine the amounts of the payments made to the NSGO entities

- Verified the amounts reported on Form CMS-64 with supporting documentation

- Interviewed the contractor's officials to gain an understanding of their role in Indiana's nursing facility supplemental payment program

- Analyzed the UPL supplemental payment formula used by the contractor to calculate the amounts owed to each nursing facility and the payments made to each NSGO entity

- Selected a nonstatistical sample of 62 interim nursing facility supplemental payments made to the highest paid NSGO entities by selecting facilities with higher payments and lower numbers of residents

- Selected an additional 32 final payments by dollar amounts[27]

- Verified the accuracy of the sampled payments by confirming the amounts used in the UPL supplemental payment formulas for each nursing facility

- 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.

[26] We selected 24 nursing facility contacts who were individually listed as contacts for the most nursing facilities from the 90 provided by the top 16 NSGO entities, which owned 483 nursing facilities.

[27] The 62 interim payments were selected from 1,993 interim payments made during the audit period. The 32 final payments were selected from the 950 final payments made during the audit period.

APPENDIX B: STATE AGENCY COMMENTS

Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration

402 W. WASHINGTON ST., P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. MITCHELL ROOB JR., SECRETARY

September 21, 2026

Tate Clark
Acting Regional Inspector General for Audit Services

Re: Report Number: A-05-24-00017

Please find below Indiana's responses to the audit finding recommendations from Report Number A-05-24-00017

Recommendation: We recommend that the State agency explore ways to increase the portion of Medicaid supplemental payments that participating nursing facilities retain.
Response: The State will take this recommendation into consideration; however, the State is not a party to the revenue-sharing agreements between the NSGOs and nursing facilities. Based on informal industry feedback, the State believes nursing facilities are now receiving a larger share of the supplemental payment than they had been receiving during the years addressed by the audit.

Recommendation: We recommend that the State agency refund to the Federal Government $9,768,865 in supplemental payments made to nursing facilities but not reported to CMS for the 2021 final supplemental payment calculations.
Response: The State reported a total computable adjustment of $13,562,217 on the QE 9/30/24 CMS-64 as a Line 10B prior-period 4/2021 decreasing adjustment to COS Line 3B to return the Federal share of $9,768,865. The State considers this item resolved.

Recommendation: We recommend that the State agency refund $2,306,933 to the Federal Government for supplemental payments that resulted from the inclusion of an extra day in the 2021 final payment formula.
Response: The calculation will be revised accordingly, and a corresponding Line 10A adjustment will be reflected on the CMS-64 submission to refund the Federal share of the Medicaid overpayment.

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Recommendation: We recommend that the State agency submit a corrected Form CMS-64 to accurately report prior-period adjustments using the correct FMAP and reimburse the Federal Government $145,887.

Response: The State will make a prior-period adjustment on the CMS-64 to correct the FMAP rates for any amount not already returned.

Sincerely,

[redacted]

Audrey Frenzel

Medicaid Director

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.

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