



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



July 18, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Maine Did Not Always Make Correct Medicaid Claim Adjustments
(A-01-12-00001)

Attached, for your information, is an advance copy of our final report on Medicaid claim adjustments made by Maine. We will issue this report to the Maine Department of Health and Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-12-00001.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION I
JFK FEDERAL BUILDING
15 NEW SUDBURY STREET, ROOM 2425
BOSTON, MA 02203

July 20, 2012

Report Number: A-01-12-00001

Ms. Mary Mayhew
Commissioner
Department of Health and Human Services
221 State Street
State House Station 11
Augusta, ME 04333

Dear Ms. Mayhew:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Maine Did Not Always Make Correct Medicaid Claim Adjustments*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through email at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-12-00001 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MAINE DID NOT ALWAYS
MAKE CORRECT MEDICAID
CLAIM ADJUSTMENTS**



Daniel R. Levinson
Inspector General

July 2012
A-01-12-00001

Office of Inspector General

<http://oig.hhs.gov>

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), 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, 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. In Maine, the Department of Health and Human Services (State agency) administers the Medicaid program.

The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement that the State agency must submit each quarter under Title XIX of the Act, in accordance with 42 CFR § 430.30(c). The form shows the disposition of Medicaid grant funds for the quarter being reported and previous fiscal years, the recoupment made or refunds received, and income earned on grant funds. It is also used to make adjustments for any identified overpayment or underpayment of the Federal Medical Assistance Percentage (FMAP). These adjustments are made on specific lines of the Form CMS-64 for prior-period increases and decreases. Adjustments are made for a variety of reasons, including correcting inaccurate provider billings and retroactive changes in provider payment rates.

The State agency was reimbursed \$251 million (\$166 million Federal share) for 1 million Medicaid claims that it originally paid and subsequently adjusted through the Form CMS-64 for calendar years 2005 through 2009. We limited our review to 637,057 claims totaling \$218 million (\$155 million Federal share) that were originally paid and subsequently adjusted, resulting in a payment difference.

OBJECTIVE

Our objective was to determine whether the State agency used the correct FMAP when it processed claim adjustments reported on the Form CMS-64.

SUMMARY OF FINDING

The State agency did not always use the correct FMAP when processing claim adjustments reported on the Form CMS-64. Of the 637,057 claims reviewed, the State agency processed 63,989 claim adjustments using the correct FMAP and 573,068 claim adjustments using an incorrect FMAP. As a result, the State agency incorrectly claimed \$9,179,777 (Federal share) for Medicaid claim adjustments. These errors occurred because the State agency processed the whole amount of adjusted private-provider claims as new expenditures rather than treating only the increases as new expenditures.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$9,179,777 to the Federal Government and
- ensure that it processes future adjustments using the correct FMAP.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed to work with CMS to refund identified overpayments and to determine the proper processing and reporting of future adjustments. The State agency noted, however, that because of the current configuration of the claims system, there will be a reduction to any amount due to CMS.

We appreciate the State agency's agreement to work with CMS. We are unable to comment on any adjustments that may occur after our audit period because these adjustments were not within the scope of our audit.

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

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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, 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. In Maine, the Department of Health and Human Services (State agency) administers the Medicaid program.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement that a State agency must submit each quarter under Title XIX of the Act, in accordance with 42 CFR § 430.30(c). The form shows the disposition of Medicaid grant funds for the quarter being reported and previous fiscal years, any recoupment made or refunds received, and income earned on grant funds.

The Form CMS-64 is also used to make adjustments for any identified overpayment or underpayment of the Federal Medical Assistance Percentage (FMAP). Adjustments are made for a variety of reasons, including correcting inaccurate provider billings and retroactive changes in provider payment rates.

Federal Medical Assistance Percentages

The Federal Government pays its share of a State's Medicaid payments based on the FMAP, also called the Federal matching rate, which varies depending on the State's relative per capita income. CMS made \$11.2 billion (\$7.47 billion Federal share) in Medicaid funding available to the State agency from January 2005 through December 2009. For that period, the FMAP ranged from 62.90 percent to 74.86 percent (see Appendix A).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency used the correct FMAP when it processed claim adjustments reported on the Form CMS-64.

Scope

We reviewed Medicaid claim adjustments that were submitted and claimed by the State agency for Federal reimbursement on the Form CMS-64. Of the \$7.47 billion that the State agency received from CMS for calendar years 2005 through 2009, \$251 million (\$166 million Federal

share) was reimbursed for approximately 1 million Medicaid claims originally paid and subsequently adjusted through the Form CMS-64. We limited our review to 637,057 subsequently adjusted claims totaling \$218 million (\$155 million Federal share) because the original and adjusted payment amounts were different.

Our objective did not require an understanding or assessment of the complete internal control structures at the State agency. Rather, we limited our review to those controls that were significant to the objective of our audit.

We performed our fieldwork at the State agency in Augusta, Maine, from December 2011 through March 2012.

Methodology

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed officials from CMS and the State agency;
- obtained from the State agency 1,009,031 claims originally paid and subsequently adjusted through the State agency's Medicaid Management Information System (MMIS);
- reviewed a judgmental sample of remittance advices and electronic fund transfer documentation to confirm that the adjustments and payments shown were consistent with those of the MMIS data;
- reconciled the adjustments to the Form CMS-64; and
- calculated the correct Federal share for 637,057 claim adjustments.

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 objective.

FINDING AND RECOMMENDATIONS

The State agency did not always use the correct FMAP when processing claim adjustments reported on the Form CMS-64. Of the 637,057 claims reviewed, the State agency processed 63,989 claim adjustments using the correct FMAP and 573,068 claim adjustments using an incorrect FMAP. As a result, the State agency incorrectly claimed \$9,179,777 (Federal share) for Medicaid claim adjustments. These errors occurred because the State agency processed the whole amount of adjusted private-provider claims as new expenditures rather than treating only the increases as new expenditures.

FEDERAL MEDICAID REQUIREMENTS

Section 1903(a)(1) of the Act requires that the Federal Government reimburse the State at the FMAP rate in effect at the time the State made the expenditure.

The *State Medicaid Manual* (section 2500(D)(2)) provides the following instruction to States: “When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider To establish the FMAP rate applicable to a given expenditure, determine when the expenditure was made.” Section 2500.1 further instructs States to claim “cost settlements” and “other increasing adjustments” involving private providers as current expenditures in the quarter in which the adjustments are made. The FMAP rate in effect when the adjustment is paid should be applied when the adjustment amount is submitted. The FMAP rate in effect for the original payment does not change.

INCORRECTLY REPORTED CLAIM ADJUSTMENTS

The State agency did not always make adjustments to Medicaid claims in accordance with Federal requirements. Of the 637,057 claims reviewed, the State agency processed 63,989 using the correct FMAP. However, a portion of the Federal share for the remaining 573,068 adjusted claims totaling \$175,376,686 (\$126,014,614 Federal share) was paid using the incorrect FMAP. State agency officials informed us that the MMIS system was unable to process claim adjustments prior to January 1, 2008.

In the example below, the State agency made an adjustment based on a new payment rate. It made the adjustment by voiding a claim that it had processed and paid using the FMAP in effect at the time the claim was originally processed. It then processed an entirely new claim, including the adjustment amount, as a current expenditure that replaced the voided claim. The State agency reported the entire amount of the new claim on Form CMS-64 at the current FMAP, rather than treating only the adjustment amount as a current expenditure; therefore, the State agency overstated the Federal share.

An Example of an Incorrect Claim Adjustment

Adjustment Made by the State Agency

<u>Transaction Type</u>	<u>Payment Date</u>	<u>Paid</u>	<u>FMAP</u>	<u>Federal Share</u>
Original claim	7/23/2008	\$1,483.93	63.31%	\$939.48
Adjusted claim	10/7/2009	(\$1,483.93)	63.31%	(\$939.48)
Revised claim	10/7/2009	\$1,880.90	74.86%	\$1,408.04

Office of Inspector General Recalculation of the Adjustment

<u>Transaction Type</u>	<u>Payment Date</u>	<u>Paid</u>	<u>FMAP</u>	<u>Federal Share</u>
Original claim	7/23/2008	\$1,483.93	63.31%	\$939.48
Adjusted claim	10/7/2009	\$396.97	74.86%	\$297.17
				\$1,236.65

Amount of the Incorrect Claim Adjustment: \$1,408.04 – \$1,236.65 = **\$171.39**

The State agency could have avoided the overstatement if it had processed and reported only the adjustment amount at the current FMAP.¹ Based on our analysis of all claim adjustments processed during the period of our audit, the State agency incorrectly claimed \$9,179,777 (Federal share) for Medicaid claim adjustments reimbursed through the Form CMS-64.

These errors occurred because the State agency processed the whole amount of adjusted private-provider claims as new expenditures rather than treating only the increases as new expenditures. State agency officials stated that they believed the entire amount of an adjusted claim should have been processed as a new expenditure.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$9,179,777 to the Federal Government and
- ensure that it processes future adjustments using the correct FMAP.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed to work with CMS to refund identified overpayments and to determine the proper processing and reporting of future adjustments. The State agency noted, however, that because of the current configuration of the claims system, there will be a reduction in any amount due to CMS.

We appreciate the State agency's agreement to work with CMS. We are unable to comment on any adjustments that may occur after our audit period because these adjustments were not within the scope of our audit.

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

¹ Increasing adjustments to private providers are expenditures that are matched at the FMAP rate for the quarter in which the adjustment amount was paid.

APPENDIXES

APPENDIX A: FEDERAL MEDICAL ASSISTANCE PERCENTAGES

Time Period	FMAP¹ Rate
January 2005 through September 2005	64.89%
October 2005 through September 2006	62.90%
October 2006 through September 2007	63.27%
October 2007 through September 2008	63.31%
October 2008 through March 2009	72.40%
April 2009 through September 2009	74.35%
October 2009 through December 2009	74.86%

¹ Federal medical assistance percentage.



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11 State House Station
Augusta, Maine 04333-0011
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June 25, 2012

Mr. Michael J. Armstrong, Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building, Room 2425
Boston, MA 02203

**Re: *Maine Did Not Always Make Correct Medicaid Claim Adjustments –
Report Number A-01-12-00001.***

Dear Mr. Armstrong:

The Department of Health and Human Services (DHHS) appreciates the opportunity to respond to the above mentioned draft audit report. We offer the following comments in relation to the recommendations on Page 4 of this report.

For your convenience, below we include the summary finding and list each recommendation followed by our response. Each response includes the State's proposed corrective action plan which we believe will bring the State into compliance with Federal requirements.

Finding:

The State agency did not always use the correct FMAP when processing claim adjustments reported on the Form CMS-64. Of the 637,057 claims reviewed, the State agency processed 63,989 claim adjustments using the correct FMAP and 573,068 claim adjustments using an incorrect FMAP. As a result, the State agency incorrectly claimed \$9,179,777 (Federal share) for Medicaid claim adjustments. These errors occurred because the State agency processed the whole amount of adjusted private provider claims as new expenditures rather than treating only the increases as new expenditures.

Recommendation:

Refund \$9,179,777 to the Federal Government.

Response:

DHHS will work with the Center for Medicare and Medicaid Services, however, please note due to the current configuration of the claims system that for the time period beyond the audit period covered there will be a reduction in any amount due to CMS.

Page Two

Recommendation:

Ensure that it processes future adjustments using the correct FMAP

Response:

DHHS will work with CMS to determine the proper processing and reporting of future adjustments.

We appreciate the time spent in Maine by OIG's staff reviewing Maine's claim adjustments reported on CMS-64. We look forward to working with CMS and Molina on possible solutions to this issue, which was exacerbated by the large swings in FMAP due to ARRA-enhanced FMAP. Now that state FMAP's are again relatively stable, this may again become an issue of minor significance.

Sincerely,

/s/

Mary C. Mayhew
Commissioner

MCM/klv