DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

March 24, 2010

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of Delaware's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-03-09-00202)

Attached, for your information, is an advance copy of our final report on Delaware's claims associated with the increased Federal medical assistance percentage under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, enacted February 17, 2009. We will issue this report to the Delaware Department of Health and Social 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 George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-09-00202.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

March 31, 2010

Report Number: A-03-09-00202

Mr. Charles Britton
Deputy Director
Division of Management Services
Delaware Department of Health and Social Services
1901 North DuPont Highway, Main Building
New Castle, DE 19720

Dear Mr. Britton:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Delaware's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009.* We will forward a copy of this report to the HHS action official noted below.

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 direct them to the HHS action official. Please refer to report number A-03-09-00202 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

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 & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF DELAWARE'S CLAIMS ASSOCIATED WITH THE INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Daniel R. Levinson
Inspector General

March 2010
A-03-09-00202

Office of Inspector General

http://oig.hhs.gov

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

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 Medicaid program provides medical assistance to 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 Delaware, the Department of Health and Social Services (State agency) administers the Medicaid program, which includes developing and maintaining internal controls.

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated $87 billion in additional Medicaid funding based on temporary increases in States' Federal medical assistance percentage (FMAP). The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on that State's relative per capita income.

The Department of Health & Human Services, Office of Assistant Secretary for Planning and Evaluation (ASPE), calculates the increased FMAP on a quarterly basis for the 50 States and the District of Columbia. ASPE provides these increased FMAPs to CMS, which uses them to determine the amount of Federal funds to award to the States through its Medicaid grant process. In a previous audit, we reviewed the ASPE FMAP calculations (*Review of the Calculations of Temporary Increases in Federal Medical Assistance Percentages Under the American Recovery and Reinvestment Act*, A-09-09-00075) and determined that ASPE calculated the increased FMAPs for the first and second quarters of Federal fiscal year (FY) 2009 for all 50 States and the District of Columbia in accordance with applicable provisions of the Recovery Act. In another audit, we reviewed CMS's calculation for the additional FMAP Medicaid funding (*Review of the Calculation of Additional Medicaid Funding Awarded Under the American Recovery and Reinvestment Act*, A-09-09-00080) and determined that, for the first two quarters of FY 2009, CMS had calculated the additional Medicaid funding awarded under the Recovery Act in accordance with Federal law.

The amount to be claimed for the temporary increase in FMAP is not based on total Medicaid expenditures. Section 5001(e) of the Recovery Act lists the Medicaid expenditures that do not qualify for the temporarily increased FMAP: disproportionate share hospital payments, Children's Health Insurance Program expenditures, expenditures subject to an enhanced FMAP described in section 2105(b) of the Social Security Act, and some Temporary Assistance to Needy Families expenditures; expenditures for individuals made eligible through income eligibility expansions after July 1, 2008; and expenditures not based on the FMAP. Furthermore, section 5001(f)(5) of the Recovery Act states that no increase in a State's FMAP may result in an

FMAP that exceeds 100 percent. For the first and second quarters of FY 2009, the State agency's regular FMAP rate was 50 percent, and the temporarily increased FMAP rate was 60.19 percent.

The State agency claimed medical assistance payments of approximately $360 million for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64) for the period of October 1, 2008, through March 31, 2009. Recovery Act funds of approximately $60 million were included in this reimbursement.

OBJECTIVES

Our objectives were to determine whether the State agency's $60 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act and whether the expenditures were supported by the State agency's accounting records.

RESULTS OF AUDIT

The State agency's $60 million in claims associated with the temporarily increased FMAP were computed using the Medicaid expenditure base specified in the Recovery Act, and the expenditures were supported by the State agency's accounting records.

In addition, the State agency had policies and procedures in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that those Medicaid expenditures that did not qualify were not being claimed for reimbursement at the temporarily increased FMAP. The State agency had documented these policies and procedures, and their dissemination to the staff responsible for submission of the CMS-64, to ensure that the State agency claimed only Medicaid expenditures that were eligible for the temporarily increased FMAP under the provisions of the Recovery Act.

Therefore, we have no recommendations.

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INTRODUCTION

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Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to 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.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

States report Medicaid expenditures to CMS on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64).

In Delaware, the Department of Health and Social Services (State agency) administers the Medicaid program, which includes developing and maintaining internal controls.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides these increases to help avert cuts in health care provider payment rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid. For the first two quarters of Federal fiscal year (FY) 2009, CMS made available to States, beginning February 25, 2009, approximately $16 billion in additional Medicaid funding based on the increased FMAP for each State. Since then, CMS has provided guidance to State Medicaid agencies (in the form of letters to State Medicaid directors) regarding implementation of the provisions of the Recovery Act, including provisions for the temporarily increased FMAP.

The Department of Health & Human Services, Office of Assistant Secretary for Planning and Evaluation (ASPE), calculates the increased FMAP on a quarterly basis for the 50 States and the District of Columbia. ASPE provides these increased FMAPs to CMS, which uses them to determine the amount of Federal funds to award to the States through its Medicaid grant

process. In a previous audit, we reviewed the ASPE FMAP calculations (*Review of the Calculations of Temporary Increases in Federal Medical Assistance Percentages Under the American Recovery and Reinvestment Act,* A-09-09-00075) and determined that ASPE calculated the increased FMAPs for the first and second quarters of FY 2009 for all 50 States and the District of Columbia in accordance with applicable provisions of the Recovery Act. In another audit, we reviewed CMS's calculation for the additional FMAP Medicaid funding (*Review of the Calculation of Additional Medicaid Funding Awarded Under the American Recovery and Reinvestment Act*, A-09-09-00080) and determined that, for the first two quarters of FY 2009, CMS had calculated the additional Medicaid funding awarded under the Recovery Act in accordance with Federal law.

The amount to be claimed for the temporary increase in FMAP is not based on total Medicaid expenditures. Section 5001(e) of the Recovery Act lists the Medicaid expenditures that do not qualify for the temporarily increased FMAP: disproportionate share hospital payments, Children's Health Insurance Program expenditures, expenditures subject to an enhanced FMAP described in § 2105(b) of the Act, and some Temporary Assistance to Needy Families expenditures; expenditures for individuals made eligible through income eligibility expansions after July 1, 2008; and expenditures not based on the FMAP.

Pursuant to section 5001(f)(5) of the Recovery Act, no increase in a State's FMAP may result in an FMAP that exceeds 100 percent. For the first and second quarters of FY 2009, the State agency's regular FMAP rate was 50 percent, and the temporarily increased FMAP rate was 60.19 percent.

The State agency claimed medical assistance payments of approximately $360 million for Federal reimbursement on its CMS-64s for the period of October 1, 2008, through March 31, 2009. Recovery Act funds of approximately $60 million were included in this reimbursement.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency's $60 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act and whether the expenditures were supported by the State agency's accounting records.

Scope

We reviewed the amount claimed on the CMS-64s for the first two quarters of FY 2009 (October 1, 2008, through March 31, 2009). We reviewed the State agency's internal controls to the extent necessary to accomplish our objective.

We did not audit expenditures made by the State agency during this period to assure that they qualified for Federal Medicaid reimbursement.

We performed fieldwork at the State agency's offices in New Castle, Delaware, in July 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- reviewed the State agency's policies and procedures for segregating the Medicaid expenditures that qualified for the temporarily increased FMAP from those that did not;
- reviewed the State agency's State Medicaid plan;
- reviewed Delaware's FY 2008 A-133 audit[1] and interviewed personnel in Delaware's Office of the Auditor of Accounts for insight on possible internal control weaknesses found during that office's review of the State agency;
- interviewed State agency personnel in charge of compiling the CMS-64s to understand the procedures used to calculate the reported Medicaid expenditures;
- identified the Medicaid expenditures that did and did not qualify for the temporarily increased FMAP, as reported on the CMS-64s for the first two quarters of FY 2009;
- traced selected Medicaid expenditure line item amounts (both those that qualified for the temporarily increased FMAP and those that did not qualify) as reported on the CMS-64s to the accounting records and supporting documentation; and
- discussed our results 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.

[1] The Office of Management and Budget issued Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, pursuant to the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act Amendments of 1996, P.L. 104-156, to set forth standards for obtaining consistency and uniformity among Federal agencies for the audit of States, local governments, and nonprofit organizations expending Federal awards. A single audit requires an audit of the State's financial statements and expenditures of Federal awards.

RESULTS OF AUDIT

The State agency's $60 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act, and the expenditures were supported by the State agency's accounting records.

In addition, the State agency had policies and procedures in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that those Medicaid expenditures that did not qualify were not being claimed for reimbursement at the temporarily increased FMAP. The State agency had documented these policies and procedures, and their dissemination to the staff responsible for submission of the CMS-64, to ensure that it claimed only Medicaid expenditures that were eligible for the temporarily increased FMAP under the provisions of the Recovery Act.

Therefore, we have no recommendations.