



January 19, 2010

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

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

**SUBJECT:** Review of Florida's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-04-09-06110)

Attached is an advance copy of our final report on Florida's claims associated with the increased Federal medical assistance percentage (FMAP) under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009. We will issue this report to Florida's Agency for Health Care Administration (State agency) within 5 business days.

The Recovery Act 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.

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 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.

The State agency claimed medical assistance payments of approximately \$4.9 billion for Federal reimbursement for the period of October 1, 2008, through March 31, 2009. Recovery Act funds of approximately \$817 million were included in this reimbursement. For this period, the State agency's regular FMAP rate was 55.40 percent, and the temporarily increased FMAP rate was 67.64 percent.

Our objectives were to determine whether the State agency's \$817 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.

The State agency's \$817 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (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 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](mailto:George.Reeb@oig.hhs.gov) or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at [Peter.Barbera@oig.hhs.gov](mailto:Peter.Barbera@oig.hhs.gov). Please refer to report number A-04-09-06110 in all correspondence.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region IV  
61 Forsyth Street, SW., Suite 3T41  
Atlanta, GA 30303

January 25, 2010

Report Number: A-04-09-06110

Mr. Dyke Snipes  
Deputy Secretary for Medicaid  
Florida Medicaid Agency  
2727 Mahan Drive, Mail Stop 8  
Tallahassee, Florida 32308

Dear Mr. Snipes:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Florida's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act." 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-04-09-06110 in all correspondence.

Sincerely,

/Peter J. Barbera/  
Regional Inspector General  
for Audit Services

Enclosure

**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, Illinois 60601

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

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



Daniel R. Levinson  
Inspector General

January 2010  
A-04-09-06110

# *Office of Inspector General*

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

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.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *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 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 Florida, the Agency for Health Care Administration (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 and 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 § 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. 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 55.40 percent, and the temporarily increased FMAP rate was 67.64 percent.

The State agency claimed medical assistance payments of approximately \$4.9 billion for Federal reimbursement on its Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" for the period of October 1, 2008, through March 31, 2009. Recovery Act funds of approximately \$817 million were included in this reimbursement.

## **OBJECTIVES**

Our objectives were to determine whether the State agency's \$817 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.

## **SUMMARY OF RESULTS**

The State agency's \$817 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.



## TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Medicaid Program.....	1
American Recovery and Reinvestment Act of 2009.....	1
<b>OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	2
Objectives .....	2
Scope.....	2
Methodology .....	3
<b>RESULTS OF AUDIT</b> .....	4

## **INTRODUCTION**

### **BACKGROUND**

#### **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 Florida, the Agency for Health Care Administration (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 will provide 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 and 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 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 55.40 percent, and the temporarily increased FMAP rate was 67.64 percent.

The State agency claimed medical assistance payments of approximately \$4.9 billion for Federal reimbursement on its CMS-64s for the period of October 1, 2008, through March 31, 2009. Recovery Act funds of approximately \$817 million were included in this reimbursement.

## **OBJECTIVES, SCOPE, AND METHODOLOGY**

### **Objectives**

Our objectives were to determine whether the State agency’s \$817 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 objectives.

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 Tallahassee, Florida, during June 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 Florida's FY 2008 A-133 audit<sup>1</sup> and interviewed personnel in the Florida State Auditor's Office 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 qualified for the temporarily increased FMAP, as well as those that 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 high-level 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 finding and conclusions based on our audit objectives.

---

<sup>1</sup>The Office of Management and Budget (OMB) 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 \$817 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, as well as 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.