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

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

December 31, 2009

Report Number: A-07-09-02754

Mr. Michael Hales
Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Hales:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of the Reconciliation and Reporting of Medicaid Non-Risk Contract Payments by the Utah Department of Health." 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.

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If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact James Korn, Audit Manager, at (303) 844-7153 or through email at James.Korn@oig.hhs.gov. Please refer to report number A-07-09-02754 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
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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 THE RECONCILIATION AND REPORTING OF MEDICAID NON-RISK CONTRACT PAYMENTS BY THE UTAH DEPARTMENT OF HEALTH

Daniel R. Levinson
Inspector General

December 2009
A-07-09-02754

Office of Inspector General

http://oig.hhs.gov

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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.

As part of the implementation of their Medicaid programs, States may submit waiver requests to CMS; these waivers, when approved, allow exceptions to certain requirements or limitations of the Act. Two Medicaid waivers used by the State of Utah are Section 1915(b) freedom of choice waivers and Section 1115 demonstration waivers.

In Utah, the Utah Department of Health, Division of Health Care Financing (State agency) administers the Medicaid program. The State agency contracts with three managed care organizations to provide Medicaid physical health services under waivers approved by CMS. Two of the three contracts are nonrisk, and managed care organizations that enter into nonrisk contracts with the State agency are federally defined as prepaid inpatient health plans. In reporting year 2007 (August 1, 2006, through July 31, 2007), the State agency paid its two nonrisk contractors approximately $177 million.

Federal requirements for nonrisk contracts allow a State agency to reimburse nonrisk contractors based on payment arrangements other than those specified in the State plan payment rates. However, the State agency must have a process in place to assure that the nonrisk contractor's total payments do not exceed what the State agency would have paid, on a fee-for-service (FFS) basis, under the State plan. This amount is known as the upper payment limit (UPL) for a nonrisk managed care contract. The UPL constitutes the maximum amount that is eligible for Federal reimbursement, and the process whereby it is calculated and compared to the nonrisk contractor's payments is known as the UPL reconciliation. To obtain the assurance mentioned above, the State agency must perform an annual UPL reconciliation and submit the results of that reconciliation to CMS.

On a quarterly basis, the State agency reports its quarterly Medicaid expenditures to CMS on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64 report). Based on the CMS-64 report, CMS matches a portion of the State's Medicaid expenditures. The expenditures made under the Sections 1915(b) and 1115 demonstration waivers are reported on separate CMS-64 reports in order for CMS to track the costs for each waiver.

We performed this audit at the request of CMS.

OBJECTIVE

Our objective was to determine whether, pursuant to Federal requirements, the State agency (a) adequately fulfilled the requirements of the UPL reconciliation for nonrisk managed care contracts and did not exceed the UPL in State fiscal year (State FY) 2007; and (b) accurately reported payments made under the nonrisk managed care contracts in State FY 2008.

SUMMARY OF FINDINGS

The State agency adequately fulfilled the requirements of the UPL reconciliation for nonrisk managed care contracts and did not appear to exceed the UPL for reporting year 2007; however, there were areas in which the State agency could improve the completeness, accuracy, and transparency of the UPL reconciliation process. Moreover, for State FY 2008 the State agency did not accurately report payments made under the nonrisk managed care contracts. Specifically:

- The State agency adequately fulfilled the requirements of the UPL reconciliation of the reporting year 2007 payments to the contractors. However, we identified areas in which the State agency could improve the completeness, accuracy, and transparency of the UPL reconciliation process:

    - The State agency's UPL reconciliation was missing a payment to a contractor and included encounter records that should have been excluded. The State agency did not have adequate policies and procedures to ensure the completeness and accuracy of the reporting year 2007 encounter records used for the UPL reconciliation. As a result, the State agency's UPL reconciliation was incomplete and inaccurate.

    - The State agency did not adequately document the manual and system procedures (to include alternative methods) it employed to calculate the UPL. The State agency did not put in place comprehensive policies and procedures to adequately document the assumptions used to determine the UPL amount and to identify how these assumptions affected the overall UPL reconciliation. As a result, CMS was unable to fully (a) assess the accuracy and completeness of the UPL amount, (b) completely understand all of the issues that prevented the State agency's automated FFS payment system from accurately pricing a claim, (c) gauge the impact of these issues on the outcome of the UPL reconciliation, and (d) assess the cost and benefit of correcting these issues.

- In addition, the State agency did not accurately report payments made under the nonrisk managed care contracts in State FY 2008. Specifically, the State agency misclassified expenditures made under the approved waivers and reported on the separate CMS-64 reports. The State agency had inadequate internal controls over the CMS-64 reporting process, which resulted in the inaccurate reporting of Medicaid expenditures. Although the State agency inaccurately reported payments, there was no monetary effect from the errors because the overall Medicaid expenditures equaled the total reported costs.

However, assessments of cost effectiveness of, and future funding determinations for, these waivers could be based on inaccurate information if these errors are not corrected.

RECOMMENDATIONS

We recommend that the State agency:

- strengthen policies and procedures to perform UPL reconciliations pursuant to Federal requirements,

- strengthen policies and procedures that will ensure proper documentation of the reconciliation process to improve transparency of the UPL, by articulating the underlying assumptions used to determine the UPL and explaining how these assumptions affected the overall UPL reconciliation, and

- strengthen internal controls, to include the implementation of the internal controls outlined by CMS's conditional extension of Utah's 1915(b) waiver agreed to by the State agency on January 7, 2009.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and pointed out that it was "aware of several of the weaknesses in the data" for the State FY 2007 UPL reconciliation that it had submitted at CMS's direction. The State agency also provided information on corrective actions that it will undertake. Specifically, the State agency said that it will perform a new reconciliation test for State FY 2007 to address the concerns found in the audit. The State agency added that the new test will include only those claims paid in the State FY, which will allow the results to be compared with information on the CMS-64 report. The State agency also stated that it will provide documentation regarding system edits that were modified, the justifications for the modifications, and all issues that prevented the Utah Medicaid Management Information System from properly pricing a claim. Furthermore, the State agency said that it is working with CMS to improve the reporting of expenditures on the CMS-64 report.

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

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INTRODUCTION

BACKGROUND

Medicaid Program and Associated Waivers

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.

As part of the implementation of their Medicaid programs, States may submit waiver requests to CMS; these waivers, when approved, allow exceptions to certain requirements or limitations of the Act. Two Medicaid waivers used by the State of Utah are Section 1915(b) freedom of choice waivers and Section 1115 demonstration waivers.[1]

Managed Care Organizations

In Utah, the Utah Department of Health, Division of Health Care Financing (State agency) administers the Medicaid program. Approximately 89 percent of Utah's 195,000 Medicaid enrollees receive health care services through managed care. The State agency contracts with three managed care organizations to provide the Medicaid physical health services provided under the Section 1915(b) and Section 1115 waivers. These managed care plans operate in the four most densely populated, urbanized counties in the State. Two of the three contracts are nonrisk, and managed care organizations that enter into nonrisk contracts with the State agency are federally defined as prepaid inpatient health plans. In reporting year 2007,[2] the State agency paid its two nonrisk contractors approximately $177 million.

Effective at the start of State FY 2003 (July 1, 2002), two of the State agency's three managed care plan contracts changed from risk-based to nonrisk. Federal requirements for nonrisk contracts allow a State agency to reimburse contractors administering nonrisk managed care plans (contractor) based on payment arrangements other than those specified in the State plan payment rates.

[1]As provided for in Titles XIX and XI of the Act, respectively.

[2]In order to explain the State agency's administration of the Medicaid program, we must refer to two different time periods used by the State agency. Each State fiscal year (State FY) ran from July 1 of one year to June 30 of the next. However, the State agency used a different period, August 1 to July 31, for the 2007 UPL reconciliation because it was trying to capture the claims that were paid to the providers by the nonrisk contractors in the State FY instead of basing the expenditures on the date that the State agency paid the nonrisk contractors. For purposes of this report, we will refer to this August 1—July 31 period as the reporting year to differentiate it from the State FY.

Upper Payment Limit Reconciliation Process

When using nonrisk contracts, the State agency must have a process in place to assure that the contractor's total payments do not exceed what the State agency would have paid, on a fee-for-service (FFS) basis, under the State plan. This amount is known as the upper payment limit (UPL) for a nonrisk managed care contract. The UPL constitutes the maximum amount that is eligible for Federal reimbursement, and the process whereby it is calculated and compared to the contractor's payments is known as the UPL reconciliation. To obtain the assurance mentioned above, the State agency must perform an annual UPL reconciliation and submit the results of that reconciliation to CMS.

The State agency used the following process to perform the UPL reconciliation. The contractors requested reimbursement for qualified payments to providers by submitting encounter data to the State agency, which processed that data through the State agency's two automated processing systems, the Medicaid Managed Care System (MMCS) and the Utah Medicaid Management Information System (MMIS). The MMCS approved the claims for payment, and MMIS's task was to determine the UPL. To complete the UPL reconciliation, the State agency compared the actual costs with the UPL, and if the payments to the contractor exceeded the UPL, then the State agency would refund the overpayment to CMS.

Cost Reporting

On a quarterly basis, the State agency reports its quarterly Medicaid expenditures to CMS on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64 report). Based on the CMS-64 report, CMS matches a portion of the State agency's Medicaid expenditures. The expenditures made under the Sections 1915(b) and 1115 demonstration waivers are reported on separate CMS-64 reports in order for CMS to track the costs for each waiver.

Prior Deficiencies Identified By Centers for Medicaid & Medicare Services

Deficiencies in Upper Payment Limit Reconciliation

In October 2004, CMS identified the State agency's lack of compliance with the nonrisk contract requirements. The State agency attempted to fulfill the requirements but experienced problems with the completeness of its encounter data that made it extremely difficult to perform the UPL reconciliation for State FYs 2003 through 2005. To address these difficulties, the State agency implemented the MMCS in March 2005 to validate the encounters. Although the data was more complete than before, it still did not contain enough detail to allow the MMIS to determine the amount the State agency would have paid for each encounter on an FFS basis.

During and after a CMS on-site review of the Utah MMIS and MMCS in July 2007, CMS worked with the State agency to make additional improvements to facilitate the UPL reconciliation. These improvements involved (a) adding data fields to the encounter records, (b) developing an automated process to link managed care cycle payment dates and warrant information stored in the accounting system to encounter data records in MMCS, and

(c) developing a centralized recordkeeping system. To test the sufficiency of these enhancements, CMS directed the State agency to perform a UPL reconciliation of the most recent State FY (that is, State FY 2007) to assess whether, going forward, the State agency could fulfill the Federal requirements.

Deficiencies in Cost Reporting

CMS also identified CMS-64 cost reporting deficiencies during the July 2007 on-site review. CMS found that the State agency could not accurately determine which waiver the nonrisk claims were paid under, because the State agency's automated processing systems did not record the beneficiary's eligibility status applicable at the date of service. CMS also found that for the period reviewed, the State agency used estimates to allocate nonrisk contract payments made under the waivers. CMS concluded that as a result of this inability to determine actual waiver costs, the State agency was misclassifying payments on the separate CMS-64 reports (used to report expenditures made under the CMS-approved waivers) and on the main (base) CMS-64 reports themselves. These discrepancies resulted in reporting estimated rather than actual expenditures on the CMS-64 reports and, along with the system issues described earlier, resulted in inaccurate cost reporting.

State Agency Improvements in Reporting Processes and Systems

In the first quarter of State FY 2008, the State agency began to address the reporting issues identified by CMS. The State agency began to append the encounter record in MMCS with eligibility and rate code fields as encounters were processed. The additional information enabled the State agency to properly identify the beneficiary's eligibility status and the applicable waiver authority for each encounter paid through the nonrisk managed care plans.

Also, the State agency implemented a process that in part allowed the State agency to reconcile nonrisk contract costs reported on the CMS-64 reports with payments to the contractors. In April 2008, the reconciliation process was further enhanced with a system change that allowed the State agency to trace each individual claim paid to a contractor to the specific disbursement as reflected in the State agency's accounting system (which is called FINET).

The State agency also implemented improved procedures to (a) group claims by eligibility groups and by categories of service codes and (b) identify more readily and accurately whether or not a particular claim was associated with a CMS-approved waiver (thereby enhancing the accuracy of the separate CMS-64 reports for expenditures associated with those waivers).

We performed this audit at the request of CMS.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether, pursuant to Federal requirements, the State agency

(a) adequately fulfilled the requirements of the UPL reconciliation for nonrisk managed care contracts and did not exceed the UPL in State FY 2007; and (b) accurately reported payments made under the nonrisk managed care contracts in State FY 2008.

Scope

The audit period for our review of the UPL reconciliation was August 1, 2006, to July 31, 2007. The audit period for our review of the reporting accuracy was July 1, 2007, to June 30, 2008. The Medicaid claims subject to review were paid to two contractors and totaled approximately $177 million in reporting year 2007 and $176.7 million in State FY 2008.

The State agency provided us with the reporting year 2007 encounter data submitted by the contractors and processed through MMCS. The State agency's UPL reconciliation included injectable claim reimbursements totaling approximately $600,000.[3] However, we excluded these claims because the State agency paid them after reporting year 2007. In addition, the State agency's UPL reconciliation also included individual claims for capitated services totaling approximately $800,000 that were paid after reporting year 2007, which we included because the State agency was unable to separate these claims from the rest of the population.

We conducted our fieldwork at the State agency in Salt Lake City, Utah, from July to September 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations;

- interviewed CMS officials to obtain an understanding of their roles in the oversight of the Medicaid program, and to obtain additional CMS documentation pertaining to these programs;

- reviewed the nonrisk managed care contracts between the State agency and the contractors, as well as prior audits and reviews of the State agency's management of the nonrisk managed care contracts;

- interviewed State agency officials to obtain an understanding of the State agency's automated systems, its UPL reconciliation process, and the process for reporting the nonrisk contract costs on the CMS-64 reports;

- analyzed encounter data from the contractors as they were processed through the State agency's automated systems;

[3]Injectable claims reimburse providers for the delivery of prescription medication. This type of claim cannot be processed through MMCS.

- traced costs from the encounter data to the State FYs 2007 and 2008 CMS-64 reports and reconciled reported costs with FINET to verify the accuracy of the reports submitted to CMS; and

- provided our preliminary results and recommendations regarding the accuracy of the State FY 2008 CMS-64 reports to CMS national and regional officials on November 17, 2008.

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.

FINDINGS AND RECOMMENDATIONS

The State agency adequately fulfilled the requirements of the UPL reconciliation for nonrisk managed care contracts and did not appear to exceed the UPL for reporting year 2007; however, there were areas in which the State agency could improve the completeness, accuracy, and transparency of the UPL reconciliation process. Moreover, for State FY 2008 the State agency did not accurately report payments made under the nonrisk managed care contracts. Specifically:

- The State agency adequately fulfilled the requirements of the UPL reconciliation of the reporting year 2007 payments to the contractors. However, we identified areas in which the State agency could improve the completeness, accuracy, and transparency of the UPL reconciliation process:

    - The State agency's UPL reconciliation was missing a payment to a contractor and included encounter records that should have been excluded. The State agency did not have adequate policies and procedures to ensure the completeness and accuracy of the reporting year 2007 encounter records used for the UPL reconciliation. As a result, the State agency's UPL reconciliation was incomplete and inaccurate.

    - The State agency did not adequately document the manual and system procedures (to include alternative methods) it employed to calculate the UPL. The State agency did not put in place comprehensive policies and procedures to adequately document the assumptions used to determine the UPL amount and to identify how these assumptions affected the overall UPL reconciliation. As a result, CMS was unable to fully (a) assess the accuracy and completeness of the UPL amount, (b) completely understand all of the issues that prevented the State agency's automated FFS payment system from accurately pricing a claim, (c) gauge the impact of these issues on the outcome of the UPL reconciliation, and (d) assess the cost and benefit of correcting these issues.

- In addition, the State agency did not accurately report payments made under the nonrisk managed care contracts in State FY 2008. Specifically, the State agency misclassified expenditures made under the approved waivers and reported on the separate CMS-64 reports. The State agency had inadequate internal controls over the CMS-64 reporting process, which resulted in the inaccurate reporting of Medicaid expenditures. Although the State agency inaccurately reported payments, there was no monetary effect from the errors because the overall Medicaid expenditures equaled the total reported costs. However, assessments of cost effectiveness of, and future funding determinations for, these waivers could be based on inaccurate information if these errors are not corrected.

NEED FOR IMPROVEMENTS IN THE UPPER PAYMENT LIMIT RECONCILIATION

The State agency adequately performed a UPL reconciliation of the reporting year 2007 payments to the contractors. However, we identified areas in which the State agency could improve the completeness, accuracy, and transparency of the UPL reconciliation process.

Federal Requirements for Nonrisk Managed Care Contracts

Pursuant to 42 CFR § 447.362, under a nonrisk contract, Medicaid payments to the contractor may not exceed what Medicaid would have paid, on an FFS basis, for the services actually furnished to recipients.

Reporting Year 2007 Reconciliation Results

The State agency processed the claims through MMIS to determine the amounts that it would have paid for the services on an FFS basis. The State agency's reconciliation of the UPL for reporting year 2007 showed that total expenditures of $177,877,868 were less than the UPL of $182,801,365. Although the expenditures were still under the UPL, we calculated total expenditures of $179,327,238 and a UPL of $182,762,097. The difference between the State agency's UPL reconciliation and our own calculations was due to claims that should have been excluded from the analysis because they were either not valid or could not be processed. The cumulative impact of these issues on the UPL reconciliation was to reduce the difference between the actual cost of the nonrisk contracts and the UPL by approximately $1.49 million, as shown in the following table.

	Per State Agency	Per OIG[4]	Net Difference
Actual Costs	$177,877,868	$179,327,238	$1,449,370
UPL	182,801,365	182,762,097	39,268
Amount Under UPL	**$4,923,497**	**$3,434,859**	**$1,488,638**

[4]Office of Inspector General.

Need for Improvement in the Completeness and Accuracy of the Upper Payment Limit Reconciliation Process

Generally, the State agency's payments to the nonrisk contractors in reporting year 2007 did not exceed the UPL.[5] However, we identified two areas in which the State agency could improve the completeness and accuracy of the UPL reconciliation process. Specifically, the State agency can (a) reconcile the total costs of the encounters in the population with the disbursement records from the State agency's accounting system (FINET) and (b) exclude encounters that were denied by the contractors or that MMIS was unable to process.

Shortcomings in the UPL reconciliation process for reporting year 2007 included the following issues:

- Originally, the State agency reported to CMS that the expenditures for the period totaled $171 million. However, we found that FINET showed total payments of approximately $177 million. The State agency determined that it missed the encounters for an approximately $6 million payment because it mistakenly used the wrong payment date in the query used to pull the encounters.

- We identified 85,450 claims that should have been excluded from the UPL reconciliation process.

    - The State agency included almost 80,000 claims that were originally denied by one of the contractors. In these cases, the contractor submitted the denied encounters to the State agency with a zero payment amount. Since the contractor did not pay these claims, they should have been excluded from the reconciliation process. Removing these claims from the UPL reconciliation would reduce the UPL by over $39,000.

    - In addition, we identified approximately 5,450 claims that MMIS could not process. State agency officials explained that MMIS could not determine the beneficiary's eligibility status for these cases. Because these claims could not be processed, they should have been excluded from the reconciliation. Further, because most of these claims were voids, removing them from the UPL reconciliation increased actual expenditures by $1.45 million.[6]

The State agency did not have policies and procedures to reconcile the expenditures with the disbursement records. State agency officials told us that they believed that all of the encounters submitted by the contractors in the period should have been included in the UPL reconciliation

[5]We could not make a UPL determination for six percent of the total payments because the State agency was unable to determine an FFS price.

[6]Based on guidance from CMS, the State agency revised MMCS, beginning with July 2007 encounters, to capture eligibility as of the initial processing date instead of the snapshot date. This change eliminated the problem of linking encounters with eligibility information that might have changed since the encounter was initially processed. All of the claims that MMIS could not process had dates of service that occurred prior to the State agency's system change.

and that they did not adequately consider the circumstances that should have resulted in the exclusion of certain encounters. As a result, the State agency's UPL reconciliation was incomplete and inaccurate.

Need for Additional Policies and Procedures

The State agency experienced limitations that prevented MMIS from properly processing claims associated with the reporting year 2007 encounter data. In an attempt to resolve these limitations in MMIS and process all of the nonrisk claims, the State agency employed a variety of alternative methods that included turning off system edits in MMIS and manually changing some claim amounts determined by MMIS. However, the State agency did not adequately document these alternative methods and thus could not specify all of the MMIS edits that had been changed. The State agency told us that MMIS did not maintain a history of edit changes but that, going forward, the State agency could start tracking future modifications used for the UPL reconciliation. Consequently, it was not possible for us to fully measure the effect of these alternative methods on the determination and accuracy of the UPL.

Moreover, the system edit changes did not resolve all of the issues that prevented MMIS from properly processing a nonrisk contract claim. For over 960,000 claims that the State agency processed in reporting year 2007 (for which it reimbursed the contractors approximately $177 million), approximately 135,600 claims (over 14 percent) had exception codes (reflecting errors in the claims data) and did not fully pass the MMIS system edits. Although the majority of these 135,600 claims had exception codes that affected individual line items in each claim (as opposed to the entire claim), MMIS reduced payments in approximately 53,300 claims and did not determine a payment amount for approximately 27,600 claims. Depending on the type of exception, the State agency made a determination to deny the claim or to manually set the price to equal the amount the State agency paid. We determined that manually changing MMIS claim amounts meant that approximately $10.8 million (6 percent) of the total $177 million paid to contractors could not be processed for the UPL reconciliation.

The State agency disclosed one of the key conditions preventing MMIS from properly processing claims, but the State agency did not put in place comprehensive policies and procedures to document the assumptions used to determine the UPL amount and to identify how these assumptions affected the overall UPL reconciliation. Consequently, CMS was unable to fully (a) assess the accuracy and completeness of the UPL amount, (b) completely understand all of the issues that prevented the State agency's automated FFS payment system from accurately pricing a claim, (c) gauge the impact of these issues on the outcome of the UPL reconciliation, and (d) assess the cost and benefit of correcting these issues.

INACCURATE REPORTING OF MEDICAID EXPENDITURES

The State agency did not accurately report payments made under the nonrisk managed care contracts in State FY 2008. Specifically, the State agency misclassified expenditures made under the approved waivers and reported on the separate CMS-64 reports. The State agency had inadequate internal controls over the CMS-64 reporting process, which resulted in the inaccurate reporting of Medicaid expenditures. Although the State agency inaccurately reported payments,

there was no monetary effect from the errors because the overall Medicaid expenditures equaled the total reported costs. However, assessments of cost effectiveness of, and future funding determinations for, these waivers could be based on inaccurate information if these errors are not corrected.

Federal Requirements for CMS-64 Reporting

42 CFR § 430.30(c)(2) describes the CMS-64 report as the State's accounting of actual recorded expenditures and specifies that the disposition of Federal funds may not be reported on the basis of estimates.

Inaccurate CMS-64 Reporting for State Fiscal Year 2008

The State agency did not accurately report payments made under the nonrisk managed care contracts in State FY 2008. In State FY 2008, the State agency paid its two contractors approximately $176.7 million. For this period, the State agency implemented changes and improvements to resolve the deficiencies identified in the CMS on-site review mentioned earlier. System enhancements facilitated the determination of the proper waiver for each paid claim. In addition, the State agency created an automated process to roll up claim level detail into a summary report that could readily be used to populate the CMS-64 reports. Furthermore, the State agency reconciled the claim level detail with the FINET disbursement records.

Although the process was much improved, it was not thoroughly tested prior to the State FY 2008 CMS-64 report submissions. A reconciliation of the actual expenditures with the costs reported on the State agency's State FY 2008 CMS-64 reports revealed the following inaccuracies[7]:

- The State agency reported all expenditures for family planning and sterilization services on the CMS-64 base report, even though the beneficiaries were eligible under either the Section 1915(b) or Section 1115 demonstration waivers. The expenditures for these beneficiaries should have been reported as applicable on the separate CMS-64 reports for the relevant waiver. Originally the State agency reported approximately $4.2 million on the base report for all family planning and sterilization services. However, the total family planning and sterilization costs should have totaled approximately $5.4 million and should have been allocated to the separate CMS-64 reports as follows: approximately $1.8 million on the base reports, approximately $2.0 million on the Section 1915(b) waiver reports, and approximately $1.6 million on the Section 1115 demonstration waiver reports.

- The State agency incorrectly reported, for State FY 2008, approximately $4.4 million in Section 1115 demonstration waiver payments that should have been reported in prior State FYs.

[7]These inaccuracies did not affect the UPL reconciliations, which are based on actual costs rather than reported costs.

- The State agency incorrectly reported approximately $113 million of rural service costs on the separate CMS-64 reports for the Section 1915(b) waiver instead of on the base CMS-64 reports. Rural service costs are not covered under the Section 1915(b) waiver and should have been reported on the base CMS-64 reports. Accordingly, the State agency should have reported total expenditures of approximately $353 million under the Section 1915(b) waiver, rather than the approximately $466 million as originally reported.

There was no monetary effect from these errors because the overall Medicaid expenditures equaled the total reported costs. However, assessments of cost effectiveness of, and future funding determinations for, these waivers could be based on inaccurate information if these errors are not corrected.

Inadequate Internal Controls and Effect on Accuracy of CMS-64 Reports

The State agency did not detect the inaccurate reporting of Medicaid expenditures in its CMS-64 reports because it had inadequate internal controls over the reporting process. Specifically, the State agency did not have a way of validating the automated process used to summarize claim level information and to independently review the costs prior to submission of the CMS-64 reports.

Consequently, assessments of cost effectiveness of, and future funding determinations for, these waivers could be based on inaccurate information.

Prior to the conclusion of our audit, we communicated our preliminary findings and recommendations to central office and regional CMS officials. CMS and the State agency agreed to address our recommendation associated with this finding (that is, our third recommendation) in the provisions of a conditional temporary extension of the Section 1915(b) waiver granted by CMS and signed by the State agency on January 7, 2009.

RECOMMENDATIONS

We recommend that the State agency:

- strengthen policies and procedures to perform UPL reconciliations pursuant to Federal requirements;

- strengthen policies and procedures that will ensure proper documentation of the reconciliation process to improve transparency of the UPL, by articulating the underlying assumptions used to determine the UPL and explaining how these assumptions affected the overall UPL reconciliation, and

- strengthen internal controls, to include the implementation of the internal controls outlined by CMS's conditional extension of Utah's 1915(b) waiver agreed to by the State agency on January 7, 2009.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and pointed out that it was "aware of several of the weaknesses in the data" for the State FY 2007 UPL reconciliation that it had submitted at CMS's direction. According to the State agency, CMS requested this reconciliation "despite warnings from the State" that performing this reconciliation "out of sequence would require the State to make several assumptions" about adjustments of prior-year claims, assumptions that would affect the accuracy of the data. The State agency added that it regarded the UPL reconciliation information that it provided to CMS as "preliminary" and that it "fully intends to release a final version once the analysis of prior years has been completed to the satisfaction of both CMS and the State."

The State agency also provided information on corrective actions that it will undertake. Specifically, the State agency said that it will perform a new reconciliation test for State FY 2007 to address the concerns found in the audit. The State agency added that the new test will include only those claims paid in the State FY, which will allow the results to be compared with information on the CMS-64 report. The State agency also stated that it will provide documentation regarding system edits that were modified, the justifications for the modifications, and all issues that prevented MMIS from properly pricing a claim. Furthermore, the State agency said that it is working with CMS to improve the reporting of expenditures on the CMS-64 report.

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

APPENDIX

APPENDIX: AUDITEE COMMENTS

State of Utah
JON M. HUNTSMAN, JR.
Governor
GARY R. HERBERT
Lieutenant Governor

Utah Department of Health
Executive Director's Office
David N. Sundwall, M.D.
Executive Director
A. Richard Melton, Dr. P.H.
Deputy Director
Allen Korhonen
Deputy Director
Health Care Financing
Michael T. Hales
Division Director

December 15, 2009

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Attention: Patrick J. Cogley
Regional Inspector General for Audit Services
601 East 12th Street, Room 0429
Kansas City, Missouri 64106

RE: Report Number: A-07-09-02754 Review of the Reconciliation and Reporting of Medicaid Non-Risk Contract Payments by the Utah Department of Health for State Fiscal Year 2007.

Dear Mr. Cogley:

We have received your draft report and agree with the report and recommendations for the most part. There are a few specific points that warrant further discussion. I will address each recommendation individually:

- strengthen policies and procedures to perform UPL reconciliations pursuant to Federal requirements;

  CMS requested that the State perform an upper limit test for State Fiscal Year 2007 (SFY 2007) despite warnings from the State that running this test out of sequence would require the State to make several assumptions regarding claims which adjusted paid claims from previous years. The State completed this analysis on a preliminary basis and fully intends to release a final version once the analysis of prior years has been completed to the satisfaction of both CMS and the State. As a result, the State submitted the report aware of several of the weaknesses in the data. That being said, the State agrees and will release an updated version of the test for SFY 2007 which addresses the concerns found in this audit.

Utah Department of Health
Promote Prevent Protect

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The State originally performed this test based on State Fiscal Year which runs approximately from July 15th through July 14th the next year because it captures expenses on an accrual basis. When the revised version is released, it will be run from July 01st through June 30th. This will allow the results to be directly comparable to information reported on the CMS 64 which is run on a cash basis and should eliminate the confusion regarding which contractor payments should and should not be included in the test.

- strengthen policies and procedures that will ensure proper documentation of the reconciliation process to improve transparency of the UPL, by articulating the underlying assumptions used to determine the UPL and explaining how these assumptions affected the overall UPL reconciliation

  The State agrees with this recommendation and will provide documentation regarding system edits that were modified and justifications as to the reasoning behind each modification and all issues that prevented MMIS from properly pricing claims.

- strengthen internal controls, to include the implementation of the internal controls outlined by CMS's conditional extension of Utah's 1915(b) waiver agreed to by the State agency on January 7, 2009.

  The State agrees with this recommendation and has been working with CMS regional office to improve the reporting of expenditures on the CMS 64 report.

If you have any questions regarding this response, please contact Eric Grant at (801) 538-6428 or via email at egrant@utah.gov

Sincerely,

/Blake Anderson/
Assistant Division Director