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

October 4, 2011

Report Number: A-07-11-06019

Ms. Vivianne Chaumont
Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68508

Dear Ms. Chaumont:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in Nebraska*. 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-07-11-06019 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 MEDICAID PROMPT PAY REQUIREMENTS IN NEBRASKA

Daniel R. Levinson
Inspector General

October 2011
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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.

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. Pursuant to sections 1903(a) and 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.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, 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 provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Pursuant to section 5001(f)(2)(A) of the Recovery Act, effective February 18, 2009, and CMS guidance, a State is not eligible for the increased FMAP for any claim received from a practitioner on days when the State did not comply with prompt pay requirements referenced at section 1902(a)(37)(A) of the Act. Pursuant to section 5001(f)(2)(B) of the Recovery Act, effective June 1, 2009, these requirements also apply to claims submitted by hospitals and nursing facilities.

Pursuant to 42 CFR § 447.45(d), a State Medicaid agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of such claims within 90 days of the date of receipt.

Nebraska State Medicaid Program

In Nebraska, the Department of Health & Human Services (State agency) administers the State's Medicaid program and oversees compliance with Federal and State requirements. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims.

For the period July 1, 2009, through September 30, 2009, the State agency received 2,095,810 clean claims from applicable providers and made payments for these claims totaling approximately $287.2 million.

OBJECTIVE

Our objective was to determine whether the State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

RESULTS OF REVIEW

The State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act. Specifically, the State agency paid 99.3 percent of the 2,095,810 clean claims it received from applicable providers within 30 days of the date of receipt and 99.7 percent of all claims received within 90 days of the date of receipt. Therefore, we have no recommendations.

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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 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 sections 1903(a) and 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.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, 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 provided 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 reimbursement rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid. For Federal fiscal year (FY) 2009, these temporary FMAP increases ranged from 6.2 to nearly 14 percentage points, depending on State unemployment rates.

Pursuant to section 5001(f)(2)(A) of the Recovery Act, effective February 18, 2009, and CMS guidance,[1] a State is not eligible for the increased FMAP for any claim received from a practitioner on days when the State did not comply with prompt pay requirements referenced at section 1902(a)(37)(A) of the Act. Pursuant to section 5001(f)(2)(B) of the Recovery Act, effective June 1, 2009, these requirements also apply to claims submitted by hospitals and nursing facilities. In this report, we refer to these three requirements as the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

[1] State Medicaid Director Letter No. 09-004 (July 30, 2009).

Prompt Pay Requirements

Section 1902(a)(37)(A) of the Act and implementing regulations (42 CFR § 447.45) specify prompt pay requirements. Pursuant to 42 CFR § 447.45(d)(2), a State Medicaid agency "must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt." Pursuant to 42 CFR § 447.45(d)(3), a State Medicaid agency must pay 99 percent of such claims within 90 days of the date of receipt.[2,3]

Federal regulations define a clean claim as a claim that can be processed without obtaining additional information from the provider or a third party. It does not include claims from a provider that is under investigation for fraud or abuse or claims under review for medical necessity (42 CFR § 447.45(b)).[4] CMS's guidance defines the date of receipt as the actual date that a State receives a claim from a provider. CMS further defines a claim's payment date as either the payment check date, the date of an electronic funds transfer payment, the date that a payment is mailed, or the date on the Explanation of Benefits or denial notice for denied claims (CMS's State Medicaid Director Letter No. 09-004, Appendix, section B).

Nebraska State Medicaid Program

In Nebraska, the Department of Health & Human Services (State agency) administers the State's Medicaid program and oversees compliance with Federal and State requirements. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims.

For the period July 1, 2009, through September 30, 2009, the State agency received 2,095,810 clean claims from applicable providers and made payments for these claims totaling approximately $287.2 million.[5]

[2] In general, a State Medicaid agency must pay all other claims within 12 months of the date of receipt.

[3] Because the Recovery Act was enacted on February 17, 2009, the first compliance date with respect to prompt pay requirements for receiving the increased FMAP under the Recovery Act for practitioner claims was February 18, 2009. Therefore, claims received 30 days before this date (on January 20, 2009) were the first claims subject to the 30-day requirement, and claims received 90 days before this date (on November 21, 2008) were the first claims subject to the 90-day requirement (CMS's State Medicaid Director letter No. 09-004).

[4] Throughout our report, "claims" refers to clean claims as defined pursuant to 42 CFR § 447.45(b).

[5] Pursuant to CMS guidance, the prompt pay requirements for receiving the increased FMAP under the Recovery Act apply to claims received from applicable providers—practitioners, nursing facilities, and those hospital costs submitted as claims—not to claims from managed care organizations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

Scope

We reviewed all Medicaid claims received by the State agency from applicable providers on each day for the 3-month period July 1 through September 30, 2009, and payments made to the providers for claims received during this period.

We did not assess the State agency's overall internal control structure. We reviewed the State agency's internal controls to the extent necessary to accomplish our objective. We reviewed the State agency's procedures for ensuring compliance with the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

We performed our work in our Kansas City, Missouri, field office from September 2010 through July 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- reviewed the prompt pay requirements contained in the State agency's State Medicaid plan;
- reviewed the State agency's policies and procedures for complying with prompt pay requirements of the Recovery Act;
- interviewed State agency personnel to gain an understanding of its Medicaid claims processing methodology;
- reviewed a Medicaid claims database to identify the claims subject to the prompt pay requirements of the Recovery Act for FY 2009;
- analyzed claims subject to the prompt pay requirements for each day from July 1, 2009, through September 30, 2009, for compliance with the prompt pay requirements of the Recovery Act; and
- determined, for each date of receipt, whether the State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act by:

- determining the number of clean claims received;
- determining, for each claim, the date of payment or denial;
- computing, for each claim, the number of days between the date of receipt and the date of payment or denial;
- determining the total number of claims paid or denied within 30 days and within 90 days; and
- calculating the percentage of claims paid or denied within 30 days and within 90 days.[6]

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS OF REVIEW

The State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act. Specifically, the State agency paid 99.3 percent of the 2,095,810 clean claims it received from applicable providers within 30 days of the date of receipt and 99.7 percent of all claims received within 90 days of the date of receipt. Therefore, we have no recommendations.

[6] For each receipt date, we calculated these percentages by dividing the number of claims paid or denied within the specified period by the total claims received on that date.