DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

May 17, 2012

Report Number: A-07-12-03174

Mr. Brian D. Kinkade
Interim Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102-1527

Dear Mr. Kinkade:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Most of Missouri's Medicaid Expenditures for the Quarter Ended March 31, 2009, Were Adequately Supported and Allowable*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Greg Tambke, Audit Manager, at (573) 893-8338, extension 30, or through email at Greg.Tambke@oig.hhs.gov. Please refer to report number A-07-12-03174 in all correspondence.

Sincerely,

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

Enclosure

**Direct Reply to HHS Action Official:**

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

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MOST OF MISSOURI'S MEDICAID EXPENDITURES FOR THE QUARTER ENDED MARCH 31, 2009, WERE ADEQUATELY SUPPORTED AND ALLOWABLE

Daniel R. Levinson
Inspector General

May 2012
A-07-12-03174

# *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

### 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.

### 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, provided 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' Federal medical assistance percentage.

### Missouri Medicaid Program

In Missouri, the Department of Social Services (State agency) administers the Medicaid program. The State agency claims Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, standard Form CMS-64 (CMS-64 report). The CMS-64 report is the accounting statement that the State agency, pursuant to 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. This form shows Medicaid expenditures for the quarter being reported and any prior-period adjustments. It also accounts for any overpayments, underpayments, and refunds received by the State agency. The amounts reported must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is available at the time the claim is filed. Further, claims developed on the basis of estimates are not allowable.

For the quarter ended March 31, 2009, the State agency claimed approximately $1.43 billion (approximately $1.01 billion Federal share) in Federal Medicaid reimbursement.

## OBJECTIVE

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

## SUMMARY OF FINDINGS

For the quarter ended March 31, 2009, the majority of the Medicaid expenditures that the State agency claimed in the five line items (as well as two waivers) that we reviewed, which combined totaled approximately $1.13 billion (approximately $800 million Federal share), was adequately supported by actual recorded expenditures. However, the State agency claimed unallowable costs totaling $16,152 ($11,507 Federal share) on the CMS-64 report for 89 claims that we identified as duplicate claims, which the State agency had not reported as such prior to our review and for which the State agency had not issued a corresponding adjustment at the time of our review.

In addition, the State agency claimed $82,126 ($58,506 Federal share) for 2,784 Medicaid claims that, based on our review of the data and on comments provided by the State agency, may have been duplicates; we are setting aside these claims for adjudication by CMS.

We also noted a deficiency in the procedures used by the State agency to determine the amounts to deduct from certain line items for sterilization adjustments on the CMS-64 report. Specifically, the State agency used estimates to make these determinations: a procedure that is not permitted pursuant to section 2500(A)(1) of the CMS *State Medicaid Manual*.

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures should be strengthened.

## RECOMMENDATIONS

We recommend that the State agency:

- make an adjustment on the appropriate CMS-64 report for 89 Medicaid claims totaling $16,152 ($11,507 Federal share);

- work with CMS to determine which of the 2,784 potentially duplicate Medicaid claims were in fact duplicates and recover the costs claimed from them; and

- develop and implement enhanced policies and procedures to ensure that it claims Medicaid costs based on actual costs pursuant to Federal requirements.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all of our recommendations and described corrective action that it had taken or planned to take.

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

## TABLE OF CONTENTS

# 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.

### 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, provided 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' Federal medical assistance percentage (FMAP).[1] Section 5000 of the Recovery Act provides for these increases to help avert cuts in health care payment rates, benefits, or services and to prevent changes to income eligibility requirements that would reduce the number of individuals eligible for Medicaid.

### Missouri Medicaid Program

In Missouri, the Department of Social Services (State agency) administers the Medicaid program. With the Recovery Act funding, Missouri's FMAP for Medicaid costs increased from 63.19 percent to 71.24 percent for the quarter ended March 31, 2009.

### Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The State agency claims Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, standard Form CMS-64 (CMS-64 report). The CMS-64 report is the accounting statement that the State agency, pursuant to 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. This form shows Medicaid expenditures for the quarter being reported and any prior-period adjustments. It also accounts for any overpayments, underpayments, and refunds received by the State agency.

[1] The Education, Jobs, and Medicaid Assistance Act (P.L. No. 111-226) extended the recession adjustment period for the increased FMAP through June 30, 2011.

Pursuant to 42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, § 2500.2, the amounts reported on the CMS-64 report and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is available at the time the claim is filed. Further, claims developed on the basis of estimates are not allowable.

### Oversight of Quarterly Medicaid Statement of Expenditures

The CMS regional office staff conducts quarterly reviews of the CMS-64 report. During these reviews, CMS regional office staff members review the accounting records that the State agency used to support the CMS-64 report and perform additional procedures in accordance with the *CMS Financial Review Guide for the Quarterly Medicaid Statement of Expenditures*.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

### Scope

The State agency claimed Medicaid costs totaling approximately $1.43 billion (approximately $1.01 billion Federal share) for the quarter ended March 31, 2009. Our review covered five judgmentally selected line items on the CMS-64 report totaling approximately $679 million (approximately $474 million Federal share). These five lines comprised more than 47 percent of the State agency's claimed costs for the quarter.[2] The five line items were for Nursing Facilities Services, Inpatient Hospital Disproportionate Share Hospital Services, Prescribed Drugs, Outpatient Hospital Services, and Clinic Services.

In addition, the State agency claimed approximately $482 million (approximately $344 million Federal share) in waivers. We selected two waivers (the Medicaid Managed Care Organization waiver and the Home and Community Service waiver[3]) that totaled approximately $456 million (approximately $326 million Federal share).[4] On the basis of the costs associated with the five judgmentally selected line items and the two waivers, we sampled a total of approximately $1.13 billion (approximately $800 million Federal share).

[2] The amounts associated with the line items selected, and therefore the percentage cited, were based on the amounts reported on the base form of the CMS-64 report and did not include adjustments.

[3] The Home and Community Service waiver is claimed under various waiver numbers on the CMS-64 report as follows: (1) Aged and Disability waiver (waiver # 3), (2) AIDS waiver (waiver # 4), (3) Community Support waiver (waiver # 5), (4) Independent Living waiver (waiver # 6), (5) Mental Retardation and Developmental Disabilities waivers (waiver #s 7 and 8), and (6) Physical Disabilities waiver (waiver # 9).

[4] We derived the amounts associated with the waivers from the amount reported on the CMS-64 report without adjustments.

Our objective did not require a review of the State agency's overall internal control structure. Therefore, we limited our internal control review to the State agency's procedures for aggregating Medicaid costs on the CMS-64 report for the quarter ended March 31, 2009.

We conducted fieldwork at the State agency's offices in Jefferson City, Missouri, in January 2010.

**Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and applicable portions of the Missouri State Medicaid plan;

- interviewed CMS officials responsible for monitoring the CMS-64 report to gain an understanding of the process used by CMS to review the CMS-64 report;

- interviewed State agency officials to gain an understanding of their policies and procedures for reporting Medicaid costs on the CMS-64 report and of the systems used by the State agency for reporting Medicaid costs;

- judgmentally selected for review five line items and two waivers whose costs comprised more than 59 percent of the total costs claimed on the base and waiver forms of the CMS-64 report;

- reviewed the CMS-64 report for the quarter ended March 31, 2009, and compared the amounts claimed for Federal reimbursement to the information in the State agency's Medicaid Management Information System (MMIS)[5] and to the State agency's accounting records;

- reviewed the information in the State agency's MMIS and in the State agency's internal records to assess whether duplicate payments occurred and to identify any errors; and

- discussed our results with State agency officials in November 2011.

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.

[5] The MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services.

## FINDINGS AND RECOMMENDATIONS

For the quarter ended March 31, 2009, the majority of the Medicaid expenditures that the State agency claimed in the five line items (as well as two waivers) that we reviewed, which combined totaled approximately $1.13 billion (approximately $800 million Federal share), was adequately supported by actual recorded expenditures. However, the State agency claimed unallowable costs totaling $16,152 ($11,507 Federal share) on the CMS-64 report for 89 claims that we identified as duplicate claims, which the State agency had not reported as such prior to our review and for which the State agency had not issued a corresponding adjustment at the time of our review.

In addition, the State agency claimed $82,126 ($58,506 Federal share) for 2,784 Medicaid claims that, based on our review of the data and on comments provided by the State agency, may have been duplicates; we are setting aside these claims for adjudication by CMS.

We also noted a deficiency in the procedures used by the State agency to determine the amounts to deduct from certain line items for sterilization adjustments on the CMS-64 report. Specifically, the State agency used estimates to make these determinations: a procedure that is not permitted pursuant to section 2500(A)(1) of the CMS *State Medicaid Manual*.

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures should be strengthened.

### UNALLOWABLE AND POTENTIALLY UNALLOWABLE COSTS

#### Federal Requirements

Section 1902(a) of the Act states:

> A State plan for medical assistance must…. (37) provide for claims payment procedures which … (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.

Federal regulations at 42 CFR § 447.45 implement section 1902(a)(37) of the Act and state: "(f) *Prepayment and postpayment claims review*. (1) For all claims, the agency must conduct prepayment claims review consisting of … (iii) [v]erification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed." (Italics in original.)

#### Unallowable Costs

The State agency incorrectly claimed $16,152 ($11,507 Federal share) for 89 Medicaid claims that we identified as duplicate claims, which the State agency had not reported as such prior to

our review and for which the State agency had not issued a corresponding adjustment at the time of our review. For instance, the State agency paid three times (at a cost of $14.12 for each iteration) for the same prescription for the same Medicaid recipient on the same date of service from the same provider. As a result of our identification, the State agency agreed to recover two of the three claims.

### Potentially Unallowable Costs

The State agency claimed $82,126 ($58,506 Federal share) for 2,784 Medicaid claims that we identified as potentially duplicated claims and for which the State agency was unable to make a determination by the conclusion of our fieldwork. We are therefore setting aside these claims for adjudication by CMS. For instance, the State agency paid a provider's claims for subsequent hospital care three times for the same Medicaid recipient on the same date of services; however, the State agency's records indicated that a different performing provider performed these services. For this particular case, the State agency indicated that it was still reviewing these claims to determine whether or not any of these claims were duplicates.

### Inadequate Controls

The State agency did not have adequate controls in place to prevent and detect duplicate claims. A State agency official acknowledged that during our audit period there was a weakness in its system that allowed some claims to be paid twice; however, the official also stated that controls had improved since then.

## INCORRECT USE OF ESTIMATES

Section 2500(A)(1) of the CMS *State Medicaid Manual* states: "The amounts reported on Form HCFA-64 [CMS-64 report] and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed…. Claims developed through the use of … estimates are not allowable under any circumstances."

Costs claimed for sterilization procedures are reported on line 13 of the CMS-64 report and qualify for reimbursement at the enhanced FMAP rate.[6] According to the State agency, the costs claimed for sterilization procedures on line 13 of the CMS-64 report ($1,709,950 ($1,538,955 Federal share)) were actual expenditures obtained from claim information from the following three CMS-64 report line items: (1) the inpatient hospital services (reported on line 1A), (2) outpatient hospital services (reported on line 6), and (3) clinic services (reported on line 10). After assessing the actual amount to claim for line 13, the State agency then took this amount and divided it by three. This exact amount was then deducted from each of the three line items before submission of the CMS-64 report to CMS. Because the State agency used this procedure,

[6] Section 1903(a)(5) of the Act and 42 CFR §§ 433.10 and 433.15 provide for an enhanced FMAP rate of 90 percent for family planning services. Pursuant to section 4270 of the CMS *State Medicaid Manual*, the enhanced 90-percent funding is available for the cost of sterilization if a properly completed sterilization consent form is submitted in accordance with Federal regulations.

the amounts claimed for lines 1A, 6, and 10 were estimates, contrary to the provisions of Section 2500(A)(1) of the CMS *State Medicaid Manual*.

This error occurred because the State agency did not follow section 2500(A)(1) of the CMS *State Medicaid Manual*.

## INADEQUATE POLICIES AND PROCEDURES

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures should be strengthened.

## RECOMMENDATIONS

We recommend that the State agency:

- make an adjustment on the appropriate CMS-64 report for 89 Medicaid claims totaling $16,152 ($11,507 Federal share);

- work with CMS to determine which of the 2,784 potentially duplicate Medicaid claims were in fact duplicates and recover the costs claimed from them; and

- develop and implement enhanced policies and procedures to ensure that it claims Medicaid costs based on actual costs pursuant to Federal requirements.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all of our recommendations and described corrective action that it had taken or planned to take. The State agency said that it has to date reviewed approximately 65 percent of the potentially duplicate claims mentioned in our second recommendation and determined that they are not duplicates. The State agency added that it requires additional information from providers to complete its review of the other potentially duplicate claims, and that it will work with CMS to resolve these claims.

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

# APPENDIX

## APPENDIX: STATE AGENCY COMMENTS

Missouri Department of
SOCIAL SERVICES
*Your Potential. Our Support.*

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, INTERIM DIRECTOR
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March 29, 2012

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Most of Missouri's Medicaid Expenditures for the Quarter Ended March 31, 2009 Were Adequately Supported and Allowable", Report Number A-07-12-03174. For the quarter ended March 31, 2009, the Department of Social Services claimed approximately $1.43 billion (approximately $1.01 billion Federal share) in Medicaid costs. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: OIG recommends that the State agency make an adjustment on the appropriate CMS-64 report for 89 Medicaid claims totaling $16,152 ($11,507 Federal Share).

DSS Response: DSS agrees with this recommendation. The State has recovered the overpayments for these payments and the appropriate adjustments will be reported on the CMS-64.

Recommendation 2: OIG recommends that the State agency work with CMS to determine which of the 2,784 potentially duplicate Medicaid claims were in fact duplicates and recover the costs claims from them.

DSS Response: DSS agrees with this recommendation. The State has reviewed approximately 65% of the 2,784 claims and determined they are not duplicates. The state has already provided additional information for these claims to the OIG. The State's review of the remaining claims will require additional documentation from the provider. The State will work with CMS to resolve the remaining claims.

Recommendation 3: OIG recommends that the State agency develop and implement enhanced policies and procedures to ensure that it claims Medicaid costs based on actual costs pursuant to Federal requirements.

Patrick J. Cogley
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DSS Response: DSS agrees with this recommendation. The State's policies and procedures will be reviewed to incorporate additional accuracy checks as appropriate.

Please contact Jennifer Tidball, Director, Division of Finance and Administrative Services at 573/751-7533 if you have further questions.

Sincerely,

Brian Kinkade
Interim Director

BK/jc

cc: James G. Scott