

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IOWA DID NOT
ALWAYS MAKE CORRECT
MEDICAID CLAIM ADJUSTMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**Patrick J. Cogley
Regional Inspector General
for Audit Services**

**March 2015
A-07-14-01135**

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

Iowa used incorrect Federal medical assistance percentages because it processed the entire amount of adjusted Medicaid claims as prior-period expenditures, resulting in an overpayment of \$714,000 (Federal share) from October 2011 through September 2013.

WHY WE DID THIS REVIEW

Previous Office of Inspector General reviews found that States improperly adjusted Medicaid claims reported to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) at incorrect Federal medical assistance percentages (FMAPs). We, therefore, conducted a similar review of claim adjustments—which, for purposes of this report, represent increased payments made to private providers—submitted by the Iowa Department of Human Services (State agency), which administers the Medicaid program in that State.

The objective of this review was to determine whether the State agency used the correct FMAPs when it processed claim adjustments reported on the CMS-64 report.

BACKGROUND

The State agency uses the CMS-64 report to claim actual Medicaid expenditures and to process claim adjustments for each quarter. Claim adjustments occur for a variety of reasons, including corrections to inaccurate provider billings and retroactive changes in provider payment rates. Federal reimbursement for claim adjustments is available at the FMAP in effect at the time the State made the expenditure.

We reviewed 1,055,484 claim adjustments, totaling \$673 million (\$418 million Federal share), that were originally paid from October 2009 through September 2013. During this period, the State agency's FMAP ranged from 72.55 percent to 59.59 percent. The State agency subsequently adjusted these claims from October 2011 through September 2013, resulting in a payment difference.

WHAT WE FOUND

The State agency did not always use the correct FMAPs when processing claim adjustments reported on the CMS-64 report. Of the 1,055,484 claims we reviewed, the State agency processed 798,227 claims using the correct FMAPs. However, a portion of the Federal share for the remaining 257,257 claims was paid using the incorrect FMAPs. As a result, the State agency received \$713,955 (Federal share) more than it was entitled to. These errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$713,955 to the Federal Government,
- determine and refund any additional amounts related to claim adjustments that were made at incorrect FMAPs after our audit period, and
- ensure that it processes future adjustments in accordance with Federal requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not concur with our recommendations because, it said, its existing processes for reporting claim adjustments on the CMS-64 report are consistent with CMS guidance. The State agency also said that the evidence we reviewed lacked sufficiency and that, as a result, we overstated the amount in our recommended refund to the Federal Government.

After reviewing the State agency's comments, we maintain that all of our findings and recommendations remain valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews¹ found that States improperly adjusted Medicaid claims reported to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) at incorrect Federal medical assistance percentages (FMAPs). We, therefore, conducted a similar review of claim adjustments—which, for purposes of this report, represent increased payments made to private providers—submitted by the Iowa Department of Human Services (State agency), which administers the Medicaid program in that State.

OBJECTIVE

Our objective was to determine whether the State agency used the correct FMAPs when it processed claim adjustments reported on the CMS-64 report.

BACKGROUND

Medicaid Program

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, 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 Iowa, the State agency administers the Medicaid program.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

States use the standard CMS-64 report to report actual Medicaid expenditures for each quarter and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures and be supported by documentation. States also use the CMS-64 report to process claim adjustments. The State agency makes adjustments for a variety of reasons, including corrections to inaccurate provider billings and retroactive changes in provider payment rates.

The State agency uses its Medicaid Management Information System (MMIS)² to process claims. The State agency programmed its MMIS to identify the amounts of the claim adjustments and then assign specific FMAPs to report on the CMS-64 reports.

¹ *Maine Did Not Always Make Correct Medicaid Claim Adjustments* (A-01-12-00001), July 18, 2012, and *Massachusetts Did Not Always Make Correct Medicaid Claim Adjustments* (A-01-13-00003), September 29, 2014.

² MMIS is a computerized payment and information reporting system that States are required to use to process and pay Medicaid claims.

Federal Medical Assistance Percentages

The amount that the Federal Government reimburses to State Medicaid agencies, which is also referred to as the Federal share, is determined by the FMAP. The FMAP is a variable rate that is based on a State's relative per capita income. With regard to claim adjustments, Federal reimbursement is available at the FMAP in effect at the time the State made the expenditure.

For October 2009 through September 2013 (the period in which the claims we audited were originally paid), the State agency's FMAP ranged from 72.55 percent to 59.59 percent (Appendix A).

HOW WE CONDUCTED THIS REVIEW

We reviewed 1,055,484 claim adjustments, totaling \$673 million (\$418 million Federal share), that were originally paid from October 2009 through September 2013 and that were subsequently adjusted from October 2011 through September 2013, resulting in a payment difference.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B describes our audit scope and methodology.

FINDINGS

The State agency did not always use the correct FMAPs when processing claim adjustments reported on the CMS-64 report. Of the 1,055,484 claims we reviewed, the State agency processed 798,227 claims using the correct FMAPs. However, a portion of the Federal share for the remaining 257,257 claims was paid using the incorrect FMAPs. As a result, the State agency received \$713,955 (Federal share) more than it was entitled to. These errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements.

FEDERAL MEDICAID REQUIREMENTS

The Federal Government must reimburse the State at the FMAP rate in effect at the time the State made the expenditure (the Social Security Act, § 1903(a)(1)).

The CMS *State Medicaid Manual*, section 2500(D)(2), provides the following instruction to States: "When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider.... To establish the FMAP rate applicable to a given expenditure, determine when the expenditure was made." Section 2500.1 further instructs States to claim increasing adjustments for "cost settlements" and "other increasing adjustments"

involving private providers as current expenditures in the quarter in which the adjustments are made.

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN MAKING CLAIM ADJUSTMENTS

The State agency did not always use the correct FMAPs when processing claim adjustments reported on the CMS-64 report. A portion of the Federal share for 257,257 claims was paid using the incorrect FMAPs. As a result, the State agency received \$713,955 (Federal share) more than it was entitled to.

In the example below, the State agency made an adjustment based on a new payment rate. It made the adjustment by voiding a claim that it had processed and paid using the FMAP in effect at the time the claim was originally processed. It then processed an entirely new claim, including the adjustment amount, as a current expenditure that replaced the voided claim. The State agency reported the entire amount of the new claim on the CMS-64 report at the FMAP in effect for the original payment date. However, the State agency should have claimed the adjustment amount at the FMAP in effect when the State agency made the expenditure (for the adjustment); therefore, the State agency overstated the Federal share.

An Example of an Incorrect Claim Adjustment (Amounts are Rounded)				
Adjustment Made by the State Agency				
<u>Transaction Type</u>	<u>Payment Date</u>	<u>Paid</u>	<u>FMAP</u>	<u>Federal Share</u>
Original claim	8/30/2010	\$250	72.55%	\$181
Voided claim	6/24/2013	(\$250)	72.55%	(\$181)
New claim	6/24/2013	\$650	72.55%	\$472
Office of Inspector General Recalculation of the Adjustment				
<u>Transaction Type</u>	<u>Payment Date</u>	<u>Paid</u>	<u>FMAP</u>	<u>Federal Share</u>
Original claim	8/30/2010	\$250	72.55%	\$181
Adjusted claim	6/24/2013	\$400	59.59%	\$238
				\$419
Amount of the Incorrect Claim Adjustment: \$472 – \$419 = \$53				

These errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements. Specifically, as part of its process for claiming adjustments for private providers, the State agency programmed its MMIS to assign a prior-period FMAP instead of the FMAP in effect at the time the State made the expenditure (for the adjustment.)

RECOMMENDATIONS

We recommend that the State agency:

- refund \$713,955 to the Federal Government,
- determine and refund any additional amounts related to claim adjustments that were made at incorrect FMAPs after our audit period, and
- ensure that it processes future adjustments in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments, the State agency did not concur with our first two recommendations because, it said, its existing processes for reporting claim adjustments on the CMS-64 report are consistent with CMS guidance. In this regard, the State agency cited a July 24, 2014, CMS informational bulletin³ which instructed that Medicaid drug adjustments must be claimed at the FMAP or other matching rate at which the original expenditures were claimed. The State agency said that it was not aware of any Federal reporting documentation that requires drug expenditure adjustments to be reported differently than other Medicaid adjustments. The State agency added that its position, therefore, was that this CMS guidance applies to all categories of Medicaid payments.

In addition, the State agency said that it "... believes the evidence requested and reviewed by the OIG lacks sufficiency; and as a result, the proposed Federal refund is overstated." The State agency referred to the timeframe identified in our engagement letter and added that "... in limiting its audit timeframe to only claims adjusted between October 2011 and September 2013, the OIG does not account for those adjustments that resulted in a Federal expenditure understatement." By doing so—according to the State agency—we overstated the amount in our recommended refund to the Federal Government.

The State agency concurred with our third recommendation because, in keeping with its stated reasons for not concurring with our first two recommendations, it believes that its processes for reporting claim adjustments are in accordance with Federal requirements.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that all of our findings and recommendations remain valid.

³ CMS, Center for Medicaid and CHIP [Children's Health Insurance Program] Services, Informational Bulletin, subject: Clarifying Information for Quarterly Reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditure System (MBES), dated July 24, 2014.

The CMS informational bulletin that the State agency cited in its comments applies only to Medicaid drug expenditures, rebates, and offsets reported on the CMS-64 report after July 24, 2014. The bulletin does not cover all Medicaid expenditures. The relevant criteria underpinning our finding is in fact the CMS *State Medicaid Manual*, section 2500(D)(2), which instructs States to “... apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider.” This instruction applies to “cost settlements” and “other increasing adjustments.” Thus, we disagree with the State agency’s assertion that the CMS instructions for drug adjustments should be used for private provider adjustments.

With respect to the State agency’s comments about the change in our audit scope, we reserve the right to broaden—or narrow—the audit scopes that we communicate in our engagement letters to auditees. We make such changes only after careful consideration, and we communicate these decisions to auditees expeditiously, while still engaged in our audit work. For this review, we narrowed our audit scope to the most recent Federal fiscal years due to time and resource constraints. Although the FMAPs in effect for earlier quarterly reporting periods were higher (as shown in Appendix A), the fact remains that the State agency did not always process claim adjustments in accordance with Federal requirements. Accordingly, the essence of our third recommendation—that the State agency revise its procedures and strengthen its controls so that it correctly processes claim adjustments—remains valid.

APPENDIX A: FEDERAL MEDICAL ASSISTANCE PERCENTAGES

Time Period	FMAP Rate
October 2009 through December 2010 ⁴	72.55%
January 2011 through March 2011	69.68%
April 2011 through June 2011	67.76%
July 2011 through September 2011	62.63%
October 2011 through September 2012	60.71%
October 2012 through September 2013	59.59%

⁴ The increased FMAPs shown for this time period and the next reflect the provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, which 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 States with an estimated \$87 billion in additional Medicaid funding based on temporary increases in their FMAPs. This legislation specified that a State's increased FMAP during the recession adjustment period would be no less than its 2008 FMAP increased by 6.2 percentage points and that a State could receive an increase greater than 6.2 percentage points based on increases to its average unemployment rate. The Education Jobs and Medicaid Assistance Act, P.L. No. 111-226, extended the recession adjustment period for the increased FMAPs through June 30, 2011.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed all Medicaid claims adjustment data for private provider claims that were originally paid from October 2009 through September 2013 and that were subsequently increased from October 2011 through September 2013. We limited our review of internal controls to obtaining an understanding of the State agency's procedures for identifying claim adjustments and reporting the adjustments on the CMS-64 report.

We did not review the overall internal control structure of the State agency or the Medicaid program. We reviewed only the internal controls that pertained directly to our objective.

We conducted this audit from December 2013 through September 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed officials from the State agency, to gain an understanding of its procedures and controls for the processing of claim adjustments for private providers;
- obtained from the State agency quarterly reports of all increasing claim adjustments for private providers (reported on Line 7 of the CMS-64 report), which totaled 1,055,484 claims that were originally paid from October 2009 through September 2013 and that were subsequently adjusted from October 2011 through September 2013;
- reconciled the adjustments contained in the MMIS data to the adjustments reported on the CMS-64 report;
- calculated the correct Federal share for 257,257 unique Medicaid claims with their corresponding adjustments; and
- discussed the results of our review with State agency officials on September 4, 2014.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATE AGENCY COMMENTS



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

FEB 3 2015

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

RE: *Iowa Did Not Always Make Correct Medicaid Claim Adjustments*,
Draft Report, A-07-14-01135

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS) on the January 6, 2015, draft report concerning Office of Inspector General's (OIG) review of the Federal medical assistance percentage (FMAP) claims process at DHS.

DHS appreciates the opportunity to respond to the draft report and provide additional comments to be included in the final report. Questions about the attached response can be addressed to:

Jody Lane-Molnari, Executive Officer II
Division of Fiscal Management
Iowa Department of Human Services
Hoover State Office Building, 1st Floor SW
1305 E Walnut Street
Des Moines, IA 50319-0114

Email: jlanelmo@dhs.state.ia.us
Phone: 515-281-6027

Sincerely,

A handwritten signature in black ink that reads "C. M. Palmer".

Charles M. Palmer
Director

cc: Chris Bresette, Audit Manager

1305 E. Walnut Street, Des Moines, IA 50319-0114

**IOWA DEPARTMENT OF HUMAN SERVICES
RESPONSE TO OIG DRAFT REPORT:**

Iowa Did Not Always Make Correct Medicaid Claim Adjustments, Report A-07-14-01135

Background

Previous OIG reviews found that States improperly adjusted Medicaid claims reported to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) at incorrect Federal medical assistance percentages (FMAPs). Therefore, OIG conducted a similar review of claims adjustments, which represented increased payments made to private providers, submitted by the Iowa Department of Human Services (DHS), which administers the Medicaid program.

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, 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 Iowa, DHS administers the Medicaid program.

States use the standard CMS-64 report to report actual Medicaid expenditures for each quarter and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures and be supported by documentation. States also use the CMS-64 report to process claim adjustments. DHS makes adjustments for a variety of reasons, including corrections to inaccurate provider billings and retroactive changes in provider payment rates.

DHS uses its Medicaid Management Information Systems (MMIS) to process claims. DHS programmed its MMIS to identify the amounts of the claim adjustments and then assign specific FMAPs to report on the CMS-64 reports.

The amount that the Federal Government reimburses to State Medicaid agencies, which is also referred to as the Federal share, is determined by the FMAP. The FMAP is a variable rate that is based on a State's relative per capita income. With regard to claim adjustments, Federal reimbursement is available at the FMAP in effect at the time the State made the expenditure.

OIG Findings and Recommendations

Iowa DHS did not always use the correct FMAPs when processing claim adjustments reported on the CMS-64 report. Of the 1,055,484 claims reviewed, DHS processed 798,227 claims using the correct FMAPS. However, a portion of the Federal share for the remaining 257,257 claims was paid using the incorrect FMAPS. As a result, DHS received \$713,955 (Federal share) more than it was entitled to.

RE: A-07-14-01135

Based on the results of the audit, OIG finds these errors occurred because DHS did not have adequate internal controls to process claim adjustments in accordance with Federal requirements. Specifically, as part of its process for claiming adjustments for private providers, DHS programmed its MMIS to assign a prior-period FMAP instead of the FMAP in effect at the time the State made the expenditure (for the adjustment).

OIG recommends that DHS:

- Refund \$713,955 to the Federal government,
- Determine and refund any additional amounts related to claim adjustments that were made at incorrect FMAPs after our audit period, and
- Ensure that it processes future adjustments in accordance with Federal requirements.

DHS Response

OIG Recommendation #1 – Refund \$713,955 to the Federal Government.

DHS does not concur with this recommendation because its existing processes for reporting claim adjustments on the CMS-64 report are consistent with written CMS guidance.

In a July 24, 2014 informational bulletin, CMS provided the following direction for the reporting of increasing and decreasing adjustments for Medicaid drug expenditures:

All states are responsible for reporting their Medicaid drug expenditures, rebates, and offsets on the CMS-64. States must report Medicaid drug expenditures during the quarter in which the state incurs the expenditure. Any increasing adjustments to the original drug expenditures must be claimed at the FMAP or other matching rate at which the original expenditures were claimed. Additionally, states must report decreasing adjustments to drug expenditures, drug rebates, and drug offsets at the FMAP or matching rate at which the original Medicaid drug expenditure was claimed.

This guidance instructs States to claim increasing adjustments at the FMAP in place at the time of the original payment, which is Iowa's current practice. DHS is not aware of any Federal reporting documentation that requires drug expenditure adjustments to be reported differently from adjustments for other Medicaid service categories. Therefore, the DHS position is that this guidance applies to all Medicaid payments.

Furthermore, even if the above argument is rejected, DHS believes the evidence requested and reviewed by the OIG lacks sufficiency; and as a result, the proposed Federal refund is overstated.

On page 3 of its draft report, the OIG provides an example of an incorrect claim adjustment that resulted in a Federal expenditure overstatement of \$53. However, in limiting its audit timeframe to only claims adjusted between October 2011 and September 2013, the OIG does not account for those adjustments that resulted in a Federal expenditure understatement. During the American Recovery and Reinvestment Act of 2009 (ARRA) period, the State claimed increasing adjustments at a pre-ARRA FMAP rate. Based on the OIG methodology

outlined in the draft report, these adjustments should have been claimed at the increased ARRA rate. Below is an example providing further detail.

An Example of an Incorrect Claim Adjustment (Amounts are Rounded)				
Adjustment Made by the State Agency				
<u>Transaction Type</u>	<u>Payment Date</u>	<u>Paid</u>	<u>FMAP</u>	<u>Federal Share</u>
Original claim	8/30/2007	\$250	61.98%	\$155
Voided claim	6/24/2010	(\$250)	61.98%	(\$155)
New claim	6/24/2010	\$650	61.98%	\$403
Office of Inspector General Recalculation of the Adjustment				
<u>Transaction Type</u>	<u>Payment Date</u>	<u>Paid</u>	<u>FMAP</u>	<u>Federal Share</u>
Original claim	8/30/2007	\$250	61.98%	\$155
Adjusted claim	6/24/2010	\$400	72.55%	\$290
				\$445
Amount of the Incorrect Claim Adjustment: \$403 - \$445 = (\$42)				

Failure to account for these Federal expenditure understatements results in findings that are not representative of the actual impact and a refund calculation that is biased in favor of the Federal government.

This understatement of Federal expenditures would have been discovered had the OIG kept to the audit timeframe communicated in its original engagement letter¹. However, midway through the review the audit timeframe was changed to include only those adjustments processed between October 2011 and September 2013.

OIG Recommendation #2 – Determine and refund any additional amounts related to claim adjustments that were made at incorrect FMAPs after our audit period.

For the reasons outlined in the response to Recommendation #1, DHS does not concur with this recommendation.

OIG Recommendation #3 – Ensure that it processes future adjustments in accordance with Federal requirements.

DHS concurs with this recommendation and believes its processes are in accordance with Federal requirements.

¹ The original engagement letter communicated that the OIG would review adjustments processed for the period October 1, 2008 through September 30, 2012.