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## Part II

# Medicaid Reviews

Pursuant to Title XIX of the Social Security Act, Medicaid provides medical assistance to low-income individuals and those with disabilities. The Federal and State Governments jointly fund and administer Medicaid. 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. The FMAP for some categories of benefits or activities may be paid at an enhanced rate. For example, the FMAP for family planning expenditures is 90 percent, which is higher than the regular FMAP.

At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. At the State level, State agencies administer their Medicaid programs in accordance with CMS-approved State plans. Although the States have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable Federal requirements to receive a Federal share of costs.

## Prescription Drug Reimbursements and Rebates

### Medicaid Drug Payment Policy: Replacing Average Wholesale Price

ALMOST HALF OF THE STATES THAT USED AVERAGE WHOLESALE PRICE (AWP) TO SET REIMBURSEMENT FOR PRESCRIPTION DRUGS IN THE FIRST QUARTER OF 2011 DID NOT HAVE DEFINITIVE PLANS FOR HOW THEY WOULD REIMBURSE DRUGS AFTER FIRST DATABANK, A PRIMARY SOURCE OF DATA, STOPPED PUBLISHING AWP'S IN SEPTEMBER 2011. Most States (44 of 51) said they would prefer a single national benchmark to set Medicaid reimbursement rates, and 24 States specifically wanted a benchmark based on pharmacy acquisition costs. We recommended to CMS that it develop a national benchmark that accurately estimates acquisition costs and encourage States to consider it when determining Medicaid reimbursement for prescription drugs.

2011 JUL *Replacing Average Wholesale Price: Medicaid Drug Payment Policy.* OEI-03-11-00060. [Web Summary](#). [Full Text](#). See also OIG's March 2011 [Compendium, Part III](#), pp. 17 through 19, available on our Web site.

### Documentation for Pharmacy Prescription Drug Claims – Arkansas

FOR THE QUARTER ENDING DECEMBER 31, 2008, ARKANSAS REIMBURSED PHARMACIES AN ESTIMATED \$1.7 MILLION FOR MEDICAID OUTPATIENT DRUG CLAIMS THAT WERE NOT SUPPORTED BY PHARMACY RECORDS. Also, prescriptions were not always written on tamper-resistant pads as required by Federal statute, and pharmacies did not document verification of those prescriptions in accordance with Federal guidance. Our recommendations included that Arkansas determine the proper resolution for the unsupported claims we identified, remind pharmacies and physicians of CMS guidance to verify prescriptions that do not comply with Federal tamper-resistance requirements, and strengthen its review process to ensure that payments are made only for drugs that are supported by appropriate records.

2011 JUL *Review of Arkansas Medicaid Prescription Drug Claims for the Quarter Ending December 31, 2008.* A-06-09-00093. [Web Summary](#). [Full Text](#).

## Medicaid's Manufacturer Rebates Offset Rising Prices for Brand-Name Drugs

ALTHOUGH PRICES AND PAYMENT AMOUNTS FOR MEDICAID BRAND-NAME DRUGS INCREASED AT ABOUT THREE TIMES THE INFLATION RATE BETWEEN 2005 AND 2010, THE SIGNIFICANT INCREASE WAS OFFSET BY SAVINGS GENERATED BY THE MEDICAID DRUG REBATE PROGRAM. Taken as a whole, the results of this review indicate that price increases for brand-name drugs may not necessarily translate to corresponding increases in Medicaid costs. Because of the savings generated by the drug rebate program, Medicaid's net costs for brand-name drugs actually increased at a lower rate than other points of comparison, including the inflation rate. In fact, Medicaid's rebate-adjusted payment amounts for brand-name drugs declined at the median in 3 of 4 data years, lagging behind the inflation rate.

2011 AUG *Medicaid Brand-Name Drugs: Rising Prices Are Offset by Manufacturer Rebates.* OEI-03-10-00260. [Web Summary](#). [Full Text](#).

## Medicaid's Rebates for Brand-Name Drugs Result in Lower Costs Compared to Medicare Part D

ALTHOUGH PHARMACY REIMBURSEMENT AMOUNTS UNDER MEDICAID AND MEDICARE PART D WERE SIMILAR FOR MOST SELECTED BRAND-NAME DRUGS IN 2009, MEDICAID'S NET UNIT DRUG COSTS WERE MUCH LOWER THAN PART D'S BECAUSE MEDICAID HAS SUBSTANTIALLY HIGHER REBATES FOR BRAND-NAME DRUGS. Manufacturer rebates for generic drugs under both programs were negligible. We also found that Part D sponsors and State Medicaid agencies paid pharmacies roughly the same amount for brand name drugs. However, after accounting for rebates, Medicaid's net costs for selected brand-name drugs were much lower than Part D net costs. Medicaid recouped 45 percent of its drug spending on selected brand-name drugs in manufacturer rebates while Part D sponsors recouped 19 percent. We concluded that given the potential impact on beneficiary and Government expenditures, differences in how rebates are collected across Medicaid and Part D should be continually examined by CMS. Unlike Medicaid, Part D sponsors (or contractors acting on their behalf) negotiate rebates with drug manufacturers without any statutory requirements on rebate amounts. In fact, the law establishing the Part D program expressly prohibits the Government from instituting a price structure for the reimbursement of covered Part D drugs. This review was required by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), § 3313(b).

2011 AUG *Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D.* OEI-03-10-00320. [Web Summary](#). [Full Text](#).

## Medicaid Drug Rebate Collections – Nationwide Review

IN A NATIONWIDE FOLLOWUP TO A 2005 REVIEW OF MEDICAID DRUG REBATE PROGRAMS, WE FOUND THAT MANY STATES STILL NEED TO MAKE IMPROVEMENTS. States lack adequate assurance that all drug rebates due them are properly recorded and collected. We also examined the extent to which States had established controls over collecting rebates on single-source (brand name) physician-administered drugs, as required by the Deficit Reduction Act of 2005 (DRA). We found that six States and the District of Columbia did not establish controls over collecting such rebates. We recommended continued emphasis on States' submitting accurate and reliable information, placing priority on their billing and collecting of rebates, and collecting rebates for single-source physician-administered drugs.

2011 AUG *Nationwide Rollup Report for Medicaid Drug Rebate Collections.* A-06-10-00011. [Web Summary](#). [Full Text](#). See also *Multistate Review of Medicaid Drug Rebate Programs.* A-06-03-00048. July 2005. [Web Summary](#). [Full Text](#).

## Collection of Medicaid Rebates for Physician-Administered Drugs

MOST OF 49 RESPONDING STATES SELF-REPORTED THAT THEY MET OR EXCEEDED FEDERAL REQUIREMENTS TO COLLECT REBATES FOR CERTAIN PHYSICIAN-ADMINISTERED DRUGS; HOWEVER, 29 STATES REPORTED DIFFICULTIES WITH MANUFACTURER NONPAYMENT OF REBATES FOR THE DRUGS. The States attributed the difficulty mainly to inaccuracies in the drug code information that providers entered on claims. Because of incomplete and potentially inaccurate data provided by States, we were unable to calculate the total rebate dollars all States collected for physician-administered drugs and, therefore, could not determine the impact collecting such rebates had on reducing prescription drug expenditures. Federal law requires that States collect rebates on all claims for certain physician-administered drugs for Federal matching funds to be available. We recommended five steps to ensure States' compliance with rebate-related requirements for physician-administered drugs, including working with States to develop guidance for implementing system edits that increase the efficiency of physician-administered drug claim reviews.

2011 JUN *States' Collection of Medicaid Rebates for Physician-Administered Drugs.* OEI-03-09-00410. [Web Summary.](#) [Full Text.](#)

## California's Rebates for Medicaid Compound Drug Expenditures

WE ESTIMATED THAT CALIFORNIA FAILED TO INVOICE MANUFACTURERS FOR AND COLLECT \$26.7 MILLION (\$13.6 MILLION FEDERAL SHARE) IN REBATES FOR ELIGIBLE COMPOUND DRUG INGREDIENTS FOR A 24-QUARTER PERIOD ENDING JUNE 30, 2009. Pharmacists create compound drugs by combining two or more prescription or nonprescription drug products and then repackaging them into a new form. California's Rebate Accounting Information System was not designed to invoice rebates for compound drug ingredients, and its electronic claims for such expenditures did not comply with Federal requirements related to invoicing manufacturers for rebates and reporting drug utilization data to CMS. We recommended that California invoice manufacturers for the estimated \$26.7 million in rebates; refund to CMS the Federal share of the rebates; and strengthen internal controls, including modifying its rebate accounting system, to invoice manufacturers for eligible compound drug ingredients and report drug utilization data to CMS.

2011 MAY *Review of California's Invoicing of Rebates for Medicaid Compound Drug Expenditures-Electronic Claims.* A-09-10-02006. [Web Summary.](#) [Full Text.](#)

## 340B-Purchased Drugs: State Medicaid Policies and Oversight Activities

STATE MEDICAID AGENCIES LACK THE POLICIES AND INFORMATION THEY NEED TO OVERSEE REIMBURSEMENTS FOR DRUGS PURCHASED PURSUANT TO THE 340B Drug Discount Program (340B program). Our findings included that State Medicaid agencies do not have drug pricing information necessary to create prepayment system edits to prevent overpaying for 340B-purchased drugs and about half of States (25 of 51) do not have written policies for how 340B-covered entities are to bill Medicaid for reimbursement. The 340B program requires drug manufacturers to provide covered outpatient drugs to certain eligible health care entities at or below statutorily defined discount prices. Such entities include eligible community health centers, critical access hospitals, and children's hospitals. We recommended that the responsible Department of Health and Human Services (HHS) agencies direct all States to create 340B billing policies, inform States about tools to identify 340B-purchased drugs, share 340B ceiling prices with States, and improve the accuracy of 340B-related data tools. The Affordable Care Act requires the Secretary to issue new guidance describing methodologies available to covered entities for billing 340B-purchased drugs to State Medicaid agencies and develop procedures for covered entities to annually update their information in the Federal covered-entity database.

2011 JUN *State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs.* OEI-05-09-00321. Affordable Care Act. [Web Summary](#). [Full Text](#).

## Home, Community, and Personal Care Services

### New Jersey's Community Care Waiver Program Claims

NEW JERSEY IMPROPERLY CLAIMED AN ESTIMATED A \$903,000 FEDERAL SHARE OF MEDICAID REIMBURSEMENTS FOR COMMUNITY CARE WAIVER (CCW) PROGRAM SERVICES PROVIDED BY ELWYN NEW JERSEY (ELWYN). New Jersey's CCW program is included in its Medicaid Home- and Community-Based Services (HCBS) waiver program. Elwyn, which was New Jersey's largest provider of CCW services during our calendar year (CY) 2005–2007 review period, filed claims that did not comply with level-of-care and other Federal and State requirements. We recommended that New Jersey refund the Federal share and that the State and Elwyn claim reimbursement only for CCW services that are documented and allowable. We also recommended that New Jersey ensure and document that all State beneficiaries approved for CCW services have been assessed and certified to need an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care and ensure that such services are provided only to beneficiaries for whom there is a completed and approved individual habilitation plan.

Medicaid's HCBS waiver programs allow States to claim the Federal share of services not usually covered by Medicaid. HCBS are provided only to recipients who would, in the absence of such services, require the Medicaid-covered level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. New Jersey's CCW program provides reimbursement for services to individuals with intellectual disabilities who would otherwise require institutionalization in an ICF/MR.

2011 JUL *Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Elwyn New Jersey From January 1, 2005, Through December 31, 2007.* A-02-09-01033. [Web Summary](#). [Full Text](#).

### Pennsylvania's Aging Services Waiver Claims – Administrative Costs

PENNSYLVANIA IMPROPERLY CLAIMED A \$2.1 MILLION FEDERAL SHARE OF MEDICAID ADMINISTRATIVE COSTS FOR ITS HCBS WAIVER FOR INDIVIDUALS AGED 60 AND OVER (AGING WAIVER). Pennsylvania's Aging Waiver authorizes home- and community-based services for Medicaid beneficiaries aged 60 or older who are economically distressed and are clinically eligible for care in a skilled nursing facility. The \$2.1 million was not allowable because the State did not identify the claimed costs in the Aging Waiver or its cost allocation plan. The State also could not support a \$371,000 adjustment of a prior improper claim for training of skilled professional medical personnel. We set aside for further analysis and resolution a \$25.8 million Federal share of local agencies' administrative cost claims that were identified in the Aging Waiver but not the cost allocation plan and may have included costs that did not benefit the Aging Waiver. Our recommendations included that Pennsylvania refund \$2.1 million for administrative costs and \$371,000 to correct the adjustment error. We also recommended that Pennsylvania amend its cost allocation plan to identify all Aging Waiver administrative costs (including allocation methodologies) and work with CMS to resolve the \$25.8 million Federal share it claimed for local agencies' Aging Waiver administrative costs and adjust accordingly.

2011 JUN *Review of Administrative Costs Claimed by Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over.* A-03-10-00202. [Web Summary](#). [Full Text](#).

## New York's Traumatic Brain Injury Waiver Program Claims

NEW YORK IMPROPERLY CLAIMED ABOUT \$1.6 MILLION FEDERAL SHARE OF MEDICAID REIMBURSEMENT FOR TRAUMATIC BRAIN INJURY (TBI) WAIVER PROGRAM SERVICES PROVIDED BY BELVEDERE OF ALBANY, LLC (BELVEDERE). The claims did not comply with Federal and State requirements during CYs 2005 through 2007. We set aside for further analysis and resolution about \$2.1 million in claims for a Federal share of TBI services provided by Belvedere that may not have complied with Federal and State requirements. We recommended that the State refund the \$1.6 million we identified as improper and work with CMS to resolve the \$2.1 million in claims that may have been unallowable. Other recommendations included that New York require treatment centers to ensure and document that all beneficiaries approved for services have been assessed by certified individuals and are eligible for TBI waiver program services, train assessors on the Federal and State TBI waiver program requirements, and ensure that the provider documents services billed and claims reimbursement only for allowable TBI waiver program services. New York's TBI waiver program allows the State to claim Federal Medicaid reimbursement for home- and community-based services provided to individuals with TBIs who would otherwise require institutionalization in a nursing home.

2011 MAY *Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Belvedere of Albany, LLC, From January 1, 2005, Through December 31, 2007.* A-02-09-01006. [Web Summary](#). [Full Text](#).

## Maryland's Residential Rehabilitation Services for Children

WE WERE UNABLE TO DETERMINE WHETHER THE DOCUMENTATION MARYLAND SUBMITTED AS SUPPORT FOR SAMPLED CLAIMS WAS SUFFICIENT BECAUSE ITS STATE PLAN WAS UNCLEAR ABOUT CERTAIN KEY DEFINITIONS AND REQUIREMENTS. Specifically, the State plan was unclear about the definition of a residential rehabilitative service and the requirements for documenting claims for such services. We recommended that Maryland work with CMS to amend its State plan to define the services provided under the residential rehabilitation program, define the necessary documentation requirements for each service, and adjust its reimbursement methodology if needed to reflect costs for services provided.

2011 AUG *Review of Medicaid Residential Rehabilitation Services for Children in Maryland.* A-03-08-00209. [Web Summary](#). [Full Text](#).

## Federal Share of Medicaid Personal Care Services

THREE STATES IMPROPERLY CLAIMED ABOUT \$61.3 MILLION IN FEDERAL MATCHING FUNDS FOR PERSONAL CARE SERVICES (PCS) THAT DID NOT MEET FEDERAL AND/OR STATE REQUIREMENTS. We set aside an additional \$34.8 million for further analysis and resolution by the States and CMS. We recommended that the States refund the Federal share and work with CMS to resolve the amounts set aside. We also recommended improvements in guidance, controls, and monitoring. PCS, which are nonmedical services provided to assist with activities of daily living, such as bathing, dressing, and meal preparation, are generally furnished to individuals residing in their homes and not residing in institutional care settings, such as hospitals or nursing facilities. The three reviews completed in this semiannual period are part of the Office of Inspector General's (OIG) larger body of work on PCS.

- NEBRASKA – (Refund \$169,000; resolve \$4.5 million set aside.) *Nebraska Medicaid Payments for Personal Care Services.* A-07-10-03152. June, 2011. [Web Summary](#). [Full Text](#).
- NORTH CAROLINA – (Refund \$41.7 million.) *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina.* A-04-10-04003. June, 2011. [Web Summary](#). [Full Text](#).

- WASHINGTON STATE – (Refund \$19.4 million; resolve \$30.3 million set aside.) *Review of Medicaid Personal Care Services Claimed by Washington State*. A-09-09-00030. May, 2011. [Web Summary](#). [Full Text](#).

See also OIG's [Spotlight on Personal Care Services](#) and a related matter in our March, 2011 [Compendium, Part III](#), pp. 15 and 16, available on our Web site.

## Medicaid Services Provided in an Adult Day Health Setting

FOR THE 12 STATE MEDICAID PROGRAMS THAT ALLOW NURSING- AND THERAPY-FOCUSED ADULT DAY HEALTH SERVICES, APPROXIMATELY 43 PERCENT OF THERAPY SERVICES WERE PROVIDED BY STAFF WHO LACKED REQUIRED SUPERVISION. Beneficiaries received at least one health service on 60 percent of service days in our sample. On 34 percent of service days, meals and/or snacks were the only documented services provided. In some cases, documentation lacked appropriate physician orders or was inconsistent with plans of care. Within broad Federal Medicaid requirements, individual States establish the specific requirements that must be met for Medicaid reimbursement of adult day health services. Our recommendations included directing States to enforce supervision requirements for staff who provide therapy services in Medicaid adult day health centers, specifying what services are required for Medicaid reimbursement of adult day health services, and taking appropriate action to address the service providers that did not respond to repeated data requests.

2011 JUL *Medicaid Services Provided in an Adult Day Health Setting*. OEI-09-07-00500. [Web Summary](#). [Full Text](#).

## Medicaid Family Planning Programs

### States' Claims for Enhanced Federal Share of Family Planning Services

SOME STATES IMPROPERLY CLAIMED A 90-PERCENT FEDERAL SHARE FOR EXPENDITURES THAT WERE INELIGIBLE FOR THE ENHANCED RATE. We are reviewing family planning services claims in several States to determine whether enhanced Federal funding was improperly claimed and the resulting financial impact on the Medicaid program. Our recommendations, which vary somewhat among States, include refunding to the Federal Government both the improper reimbursements we identify in our reviews and those outside the scope of our reviews, establishing written procedures to ensure that future family planning costs are claimed correctly, ensuring that Medicaid Management Information System (MMIS) edits appropriately identify claims that are ineligible for reimbursement at the 90-percent enhanced rate, and discontinuing the claiming of ineligible expenditures at the enhanced rate. Reports of reviews completed in this semiannual period follow.

- OREGON – (Refund \$1.5 million.) The overpayment occurred because Oregon's MMIS controls did not properly distinguish claims eligible for reimbursement at the 90-percent enhanced rate from claims eligible for reimbursement at the regular rate. In December 2008, Oregon implemented a new MMIS and changed its internal controls to properly identify these claims. *Review of Medicaid Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009*. June 2011. A-09-10-02043. June, 2011. [Web Summary](#). [Full Text](#).
- KANSAS – (Refund \$2.4 million.) None of the 2,781 family planning claims related to child delivery and newborn services that were submitted by providers and claimed by Kansas at the enhanced 90-percent rate from July 1, 2005, through June 30, 2009, were allowable for the enhanced rate pursuant to Federal requirements. *Review of Child Delivery Claims and Newborn Claims Included in the Kansas Medicaid Family Planning Program*. A-07-10-04156. May, 2011. [Web Summary](#). [Full Text](#).

- OKLAHOMA – (Refund \$3.4 million.) From January 1, 2005, through December 31, 2009, Oklahoma improperly claimed \$17.4 million for hysterectomy expenditures at the enhanced family planning rate of 90 percent. The Federal Government pays its share of hysterectomy expenditures at the regular rate. *Review of Medicaid Hysterectomy Expenditures Claimed as Family Planning in Oklahoma for Calendar Years 2005 to 2009*. A-06-10-00047. May, 2011. [Web Summary](#). [Full Text](#).
- COLORADO. – (Refund \$2 million.) For the quarters ended March 2007 through September 2009, the State claimed additional costs for the same sterilization procedures, which resulted in almost \$2 million in unallowable Federal reimbursement. Although the State had an informal adjustment process to claim the costs correctly, the process was not effective beginning with the quarter ended March 2007. *Review of Additional Claims for Sterilization Procedures in the Colorado Medicaid Family Planning Program*. A-07-11-01096. May, 2011. [Web Summary](#). [Full Text](#).

## Other Medicaid Expenditures and Costs

### Medicaid Hospital Outlier Payments Followup

EIGHT STATE AGENCIES WE REVIEWED DID NOT CALCULATE MEDICAID INPATIENT HOSPITAL COST OUTLIER PAYMENTS IN A WAY THAT WOULD EFFECTIVELY LIMIT THE PAYMENTS TO EXTRAORDINARILY HIGH-COST CASES. To protect hospitals against large financial losses from extraordinarily high-cost cases, State agencies may supplement base payments with an additional “outlier” payment. Medicaid outlier payments are calculated using formulas that vary by State. The States we reviewed used outdated cost-to-charge ratios and did not reconcile Medicaid outlier payments upon settlement of cost reports. We recommended that CMS encourage all State agencies that make Medicaid outlier payments to use the most recent cost-to-charge ratios to calculate Medicaid outlier payments, reconcile Medicaid outlier payments upon cost report settlement or use an alternative method to ensure that outlier payments are more closely aligned with actual costs, and amend their State plans accordingly. The review is a followup to similar audits we conducted in 2004.

2011 JUL *Medicaid Hospital Outlier Payment Followup for Fiscal Years 2004 Through 2006*. A-07-10-04160. [Web Summary](#). [Full Text](#).

### Medicaid Payments for After-Hours Services Codes

IN GENERAL, WE DID NOT FIND A LARGE PROBLEM WITH INAPPROPRIATELY PAID AFTER-HOURS ADD-ON CODES. After-hours add-on codes compensate providers for the additional costs associated with providing services outside posted or normal business hours. Three States—North Carolina, Kentucky, and Massachusetts—made 77 percent of the \$8.1 million total in payments for after-hours add-on codes. Nationwide, 6 of the 3,228 billers for after-hours add-on codes were responsible for more than 12 percent (\$1 million) of the payments, and 46 billers were responsible for 50 percent of all such payments. Twenty-one States inappropriately paid \$99,822 for after-hours add-on codes. One biller in Kentucky accounted for 68 percent of the \$99,822 in inappropriate Medicaid payments. For the purposes of this review, inappropriate payments occurred when providers were reimbursed for after-hours add-on codes for places of service not allowed by the respective State Medicaid programs. We did not make recommendations in this report.

2011 MAY *Medicaid Payments for After-Hours Services*. OEI-07-11-00050. [Web Summary](#). [Full Text](#).

### Reconciliation of Expenditure Reports to Claims Data

MEDICAID EXPENDITURES THAT STATES REPORT QUARTERLY TO CMS ARE NOT ALWAYS CORRECT OR ADEQUATELY SUPPORTED. We are reviewing and reconciling line items on Medicaid quarterly expenditure reports in

selected States. All States must submit a Quarterly Medicaid Statements of Expenditures for the Medical Assistance Program (Form CMS-64) to CMS within 30 days after the end of each quarter. This form shows the disposition of Medicaid funds used to pay for medical and administrative expenditures for the quarter being reported and any prior-period adjustments. The expenditures reported on the Form CMS-64 report and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed. Each State must maintain an accounting system and supporting fiscal records to ensure that claims reported on the CMS-64 report are in accordance with applicable Federal requirements. Reviews completed in this semiannual period follow.

- **OKLAHOMA** – For the quarter ended December 31, 2008, Oklahoma generally claimed Federal reimbursement of about \$1 billion in Medicaid expenditures in accordance with Federal requirements. However, the State applied incorrect percentages, resulting in a Federal share overstatement of \$12,000; overlooked \$6,000 in expenditures, resulting in a Federal share understatement of about \$5,000; and received an enhanced family planning Federal share of \$127,000, the appropriate amount of which we could not determine. In addition, the State improperly received a \$2.1 million Federal share for additional payments in that quarter that were unallowable. We recommended that Oklahoma refund to the Federal Government \$2.1 million, claim a Federal credit of \$5,000 for overlooked expenditures, and work with CMS to resolve the allowability of the \$127,000 we questioned. We also recommended that the State improve coding and procedures and provide additional documentation to CMS. *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma.* A-06-09-00097. July, 2011. [Web Summary](#). [Full Text](#).
- **NEW YORK** – New York's claim for Federal reimbursement of Medicaid expenditures on the Form CMS-64 was adequately supported by actual recorded expenditures. Therefore, we made no recommendations. *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in New York State for the Quarter Ended September 30, 2009.* A-02-10-01020. April 2011. [Web Summary](#). [Full Text](#).
- **PUERTO RICO** – Puerto Rico's claim for Federal reimbursement of Medicaid expenditures on the Form CMS-64 was adequately supported by actual recorded expenditures. Therefore, we made no recommendations. *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Puerto Rico for the Quarter Ended September 30, 2009.* April 2011. A-02-10-01038. [Web Summary](#). [Full Text](#).

### Missouri's Medicaid Expenditures for Medicare Part A and Part B Premiums

DURING FISCAL YEAR (FY) 2009, MISSOURI MADE CALCULATION AND DUPLICATION ERRORS CAUSING IT TO OVERCLAIM ABOUT \$1.5 MILLION FOR THE FEDERAL SHARE OF MEDICARE PART B PREMIUMS THE STATE PAID UNDER THE BUY-IN PROGRAM. However, the State's claims for the Federal share of its Part A premium payments were claimed correctly. Federal law allows States to pay Medicare premiums on behalf of certain individuals who are entitled to both Medicare and some form of Medicaid benefits. The State can then claim the Federal share of such premium expenditures under Medicaid. This provision, called buy-in, has the effect of transferring part of the medical costs for eligible individuals from the federally and State-funded Medicaid program to the federally financed Medicare program. We recommended that Missouri refund to the Federal Government the \$1.5 million and strengthen internal controls to ensure that all Medicaid expenditures claimed for Federal reimbursement are in accordance with Federal requirements.

2011 JUL *Review of Medicaid Expenditures for Medicare Part A and Part B Premiums in Missouri.* A-07-10-03158. [Web Summary](#). [Full Text](#).

### West Virginia's Medicaid School-Based Services Reimbursement Rates

WEST VIRGINIA WAS OVERPAID \$22.8 MILLION FOR THE FEDERAL SHARE OF SCHOOL-BASED SERVICES BECAUSE IT INCLUDED COSTS IN THE CALCULATION OF ITS RATES THAT WERE NOT INCLUDED IN THE REIMBURSEMENT METHODOLOGY DESCRIBED IN THE APPROVED STATE PLAN. The errors occurred because the State did not provide adequate oversight of its consulting firm during the rate calculation process. We recommended that the State refund \$22.8 million to the Federal Government for FYs 2001 through 2003 and work with CMS to determine unallowable costs for FYs 2004 to the present, make the appropriate refund, develop more accurate school-based service rates, and make necessary revisions to the State plan.

2011 APR *Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia.* A-03-05-00203. [Web Summary](#). [Full Text](#).

### Illinois' Payments for A State-Owned Psychiatric Hospital

ILLINOIS IMPROPERLY CLAIMED AN \$82.9 MILLION FEDERAL SHARE OF PAYMENTS IT MADE TO A STATE-OWNED PSYCHIATRIC HOSPITAL THAT FAILED TO DEMONSTRATE COMPLIANCE WITH FEDERAL REQUIREMENTS. During the audit period, the hospital did not demonstrate compliance with special Medicare Conditions of Participation (CoP) because the State agency did not believe that such demonstration was necessary. We concluded that Illinois should refund the \$82.9 million; work with CMS to evaluate an additional \$12.6 million that we set aside for further analysis and resolution; identify and refund the Federal share of any other payments associated with the same type of noncompliance; and ensure that with regard to psychiatric hospitals, it claims Federal matching funds only for those hospitals that can demonstrate compliance with the special Medicare CoP.

2011 AUG *Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000, Through December 31, 2009.* A-05-10-00046. [Web Summary](#). [Full Text](#).

### Pennsylvania's Medicaid Administrative Costs Claimed for the Department of Aging's Direct Care Worker Initiative.

PENNSYLVANIA IMPROPERLY CLAIMED A \$1.7 MILLION FEDERAL SHARE OF MEDICAID FOR UNAUTHORIZED ADMINISTRATIVE COSTS FOR THE DIRECT CARE WORKER INITIATIVE, A RECRUITMENT AND RETENTION PROGRAM OF THE STATE'S DEPARTMENT OF AGING. The costs were supplemental to payments to direct care workers for direct medical services and included training and other nonadministrative expenses. The costs were not incurred to operate the Medicaid program, and CMS specifically prohibits claiming them as administrative costs. Local agencies operating the initiative reported that the funds were spent on bonuses, training, and recognition events. We recommended that the State refund \$1.7 million in Federal Medicaid reimbursement, refund the improperly claimed Federal share of any such costs claimed after our audit period, and discontinue all future claims to Medicaid for such costs.

2011 JUL *Review of Medicaid Administrative Costs Claimed for the Pennsylvania Department of Aging's Direct Care Worker Initiative.* A-03-10-00206. [Web Summary](#). [Full Text](#).

### Pennsylvania's Medicaid Administrative Costs Claimed for the Department of Aging's Healthy Steps Program

PENNSYLVANIA IMPROPERLY CLAIMED \$1.2 MILLION (FEDERAL SHARE) OF MEDICAID ADMINISTRATIVE COSTS FOR THE HEALTHY STEPS FOR OLDER ADULTS (HEALTHY STEPS) PROGRAM. Administrative cost claims to Medicaid must be directly related to the administration of the Medicaid program. The claimed costs were for the Department of Aging's payments for services to help older adults remain active and were not for

the administration of the Medicaid program. We recommended that Pennsylvania refund the \$1.2 million, refund the Federal share of any unallowable Healthy Steps costs claimed after our audit period, and discontinue all future claims for a Federal share of Medicaid for unallowable Healthy Steps costs.

2011 JUL *Review of Medicaid Administrative Costs Claimed for the Pennsylvania Department of Aging's Healthy Steps Program.* A-03-10-00205. [Web Summary](#). [Full Text](#).

### **Oregon's Medicaid Management Information System Expenditures**

OREGON IMPROPERLY CLAIMED \$566,000 (FEDERAL SHARE) OF CERTAIN EXPENDITURES RELATED TO ITS MMIS. WE SET ASIDE FOR FURTHER ANALYSIS AND RESOLUTION AN ADDITIONAL \$1.7 MILLION FEDERAL SHARE OF EXPENDITURES THAT MAY HAVE BEEN UNALLOWABLE. Of the \$31 million in MMIS expenditures we reviewed, Oregon claimed \$27.4 million correctly. The \$566,000 Federal share included employee salaries and fringe benefits and contractor and postage expenditures that were claimed at incorrect Federal reimbursement rates and unallowable contractor and employee expenditures. The \$1.7 million set aside for resolution was for contractor expenditures and employee salaries and fringe benefits that may have been unallowable. We recommended that Oregon refund \$566,000 to the Federal Government, work with CMS to determine which portions of the \$1.7 million were overpaid, and refund the amounts. We also recommended that Oregon strengthen its internal controls to ensure that its MMIS expenditures are claimed at correct reimbursement rates and are allowable for Medicaid reimbursement.

2011 AUG *Audit of Oregon's Medicaid Management Information System Expenditures for the Period October 1, 2007, Through September 30, 2009.* A-09-10-02017. [Web Summary](#). [Full Text](#).

## **Medicaid-Related Program Administration**

### **Practitioner Compliance With Requirements of the Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant – Greater New Orleans Area**

FOR THE PERIOD MARCH 1, 2007, THROUGH JANUARY 31, 2009, LOUISIANA PAID AN ESTIMATED \$13.6 MILLION OF FEDERAL GRANT FUNDS TO PRACTITIONERS THAT WERE NOT IN COMPLIANCE WITH FEDERAL REQUIREMENTS. CMS awarded Louisiana a \$50 million Federal grant to restore access to health care in communities impacted by Hurricane Katrina. The grant provided payments to licensed health care professionals for retention and recruitment. Louisiana did not follow existing policies and procedures or did not have policies and procedures adequate to ensure that its contracts obligated practitioners to meet a 3-year service requirement, that practitioners were monitored for compliance, and that corrective actions were taken. We recommended that Louisiana refund \$13.6 million to the Federal Government, implement adequate policies and procedures, monitor practitioners' compliance, and take corrective actions for those practitioners not in compliance after our audit period.

2011 JUL *Review of Practitioner Compliance With the Requirements of the Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area.* A-06-09-00051. [Web Summary](#). [Full Text](#).

### **States' Oversight of Medicaid Electronic Health Records Incentive Payments**

STATES' ABILITY TO ENSURE THE INTEGRITY OF MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PAYMENTS IS LIMITED. EHR systems are computerized recordkeeping systems that contain patients' health-related information, including medical history. Pursuant to Federal law, State Medicaid agencies may make Medicaid incentive payments directly to eligible practitioners and hospitals to adopt, implement, or

upgrade certified EHR systems. Practitioners and hospitals self-report their eligibility information to the States. Although the States we reviewed said they plan to verify at least half of eligibility requirements prior to making EHR incentive payments, we found that depending on the eligibility requirement, States may have none, some, or all of the data they need to verify eligibility prior to making payments. The lack of data limits both the number of eligibility requirements that States plan to verify prior to payment and the completeness of those verifications. Most States do not plan to start collecting all the necessary data because the effort would be resource intensive and not logistically practical. All the States we reviewed said they plan to audit eligibility requirements after payment. Between 2011 and 2019, the Federal Government will spend an estimated \$13.4 billion for Medicaid EHR programs. The Federal Government provides 100 percent funding to States for the cost of the incentive payments they make to practitioners and hospitals and 90 percent funding for administrative expenses and planning activities related to States' EHR incentive programs.

2011 JUL *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight.* OEI-05-10-00080. [Web Summary.](#) [Full Text.](#)

## Children's Health Insurance Program

### Children's Health Insurance Program: Underpaid Premium Refunds in Florida

BECAUSE OF INSURER REPORTING ERRORS, FLORIDA DID NOT RECEIVE PREMIUM REFUNDS OF \$3.1 MILLION (\$2 MILLION FEDERAL SHARE). Florida contracts with Florida Healthy Kids Corporation (FHKC), a not-for-profit corporation created by the Florida legislature in 1990 to provide health insurance to children eligible for the Children's Health Insurance Program (CHIP). FHKC enters into multiyear medical service agreements with insurers to provide health care services to CHIP participants in exchange for per-member, per-month capitated payments (premiums). If an insurer's total medical expenses are less than 85 percent of its total premiums received, it must refund 50 percent of the shortfall. The underpaid refunds occurred primarily because Florida and FHKC did not have policies and procedures requiring personnel to review insurers' reports and reconcile them to supporting records. We recommended that Florida credit the Federal Government \$2 million for its share of underpaid refunds and develop and implement oversight procedures to ensure that required refunds and reconciliations occur.

2011 JUN *Review of Florida's Children's Health Insurance Program Experience Adjustment and Refund Submission Reports.* A-04-10-06123. [Web Summary.](#) [Full Text.](#)