

# **Part II: Medicaid Reviews**

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## Part II:

# Medicaid Reviews

## Medicaid Services

Medicaid Services > Community Rehabilitation Providers > Federal Share > New York

### ■ **New York’s Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers**

New York State improperly claimed an estimated \$207.6 million in Federal Medicaid reimbursement for rehabilitation services submitted by community residence rehabilitation providers during calendar years (CY) 2004 through 2007.

New York State elected to include coverage of rehabilitation services provided to recipients residing in community residences (group homes and apartments) in its Medicaid program. Of the 100 claims in our random sample, 31 complied with Federal and State requirements, but 69 did not. The deficient claims lacked one or more elements such as the required physicians’ authorizations or reauthorizations for rehabilitation services, a service of at least 15 minutes, and/or a service plan reviewed and signed by a qualified mental health staff member.

We recommended that the State (1) refund \$207.6 million to the Federal Government and (2) work with the State’s Office of Mental Health to implement guidance to physicians regarding State regulations on the authorization of community residence rehabilitation services. The State disagreed with our first recommendation and agreed with our second recommendation. *Review of New York’s Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers*. A-02-08-01006.

[Full Report](#)

Medicaid Services > Nursing Homes > Federal Share > Washington State

### ■ **Washington State’s Medicaid Claims for Nonqualified Aliens**

Washington State claimed an estimated \$1.5 million (\$760,000 Federal share) for nursing home services provided to nonqualified alien beneficiaries without prior approval from a State medical consultant or to beneficiaries who were misclassified and not eligible for the Alien Emergency Medical (AEM) program.

The State also claimed \$6,000 (\$3,000 Federal share) for various medical services provided to treat conditions that were not authorized. Finally, the State claimed \$1.5 million (\$744,000 Federal share) for prescription drugs and \$369,000 (\$185,000 Federal share) for dental services that the State agency could not determine were

related to treating emergency medical conditions. Federal Medicaid funding is available to States for medical services provided to nonqualified aliens only when those services are necessary to treat an emergency medical condition. A nonqualified alien is an individual who is not a citizen or national of the United States and is not in a satisfactory immigration status.

We recommended that the State (1) refund \$763,000 to the Federal Government for nursing home and medical services that were improperly claimed, (2) work with the Centers for Medicare & Medicaid Services (CMS) to determine what portion of the \$1.9 million (\$929,000 Federal share) claimed for prescription drugs and dental services was related to emergency medical conditions and refund any improperly claimed amounts, (3) ensure that only nursing home claims that receive prior approval from a State medical consultant and that are eligible for the AEM program are claimed for reimbursement, (4) ensure that the Medicaid cards issued to nonqualified aliens limit services to those necessary to treat conditions defined as emergency medical conditions, and (5) ensure that the Medicaid Management Information System (MMIS) edits limit claims for services provided to nonqualified aliens to emergency medical conditions or to services approved by a State medical consultant. The State concurred with our recommendations. *Review of Washington State's Medicaid Claims for Nonqualified Aliens*. A-09-09-00039. [Full Report](#)

Medicaid Services > Family Planning > Federal Share > Washington State

### ■ Family Planning Services Claimed by Washington State

From October 1, 2005, through September 30, 2008, Washington State improperly claimed about \$18.7 million Federal share of medical services and supplies at the 90-percent enhanced rate for family planning that should have been claimed at the regular rate.

Contrary to State requirements, the claims for services did not contain approved primary diagnosis codes, and the claims for supplies did not contain approved therapeutic classification codes. By calculating the difference between what the State agency claimed and what it should have claimed, we determined that the Federal Government overpaid the State agency almost \$8.5 million in Federal share. This overpayment occurred because the State agency's MMIS controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular Federal medical assistance percentage (FMAP) rate. The Federal share of the Medicaid program is determined by the FMAP, which was 50 percent during our audit period; family planning claims were reimbursed at 90 percent.

We recommended that the State (1) refund \$8.5 million to the Federal Government and (2) identify and refund any overpayments for family planning claims before October 1, 2005, that did not contain approved primary diagnosis or therapeutic classification codes identifying the claims as eligible for reimbursement at the

90-percent rate. The State concurred with our findings and our first recommendation. Regarding our second recommendation, the State said that because it had implemented a new MMIS in May 2010, it was unable to review medical claims submitted before December 2005 or pharmacy claims submitted before April 2006. A-09-09-00049. *Review of Family Planning Services Claimed by Washington State During the Period October 1, 2005, Through September 30, 2008.* [Full Report](#)

Medicaid Services > Personal Care > Federal Share > 10-State Review

### ■ **Inappropriate Claims for Medicaid Personal Care Services**

Our 10-State review revealed that Medicaid paid about \$724 million for personal care services claims that we determined were inappropriate because personal care attendants' qualifications were undocumented. These claims represented 18 percent of our universe.

The qualifications most often undocumented were background checks, age, and education. We estimated that Medicaid paid an additional 2 percent of claims inappropriately because the respondents had no record of providing services to the beneficiaries. Respondents were agencies or individuals that State Medicaid agency officials indicated we should contact to request documentation to support attendants' qualifications. We reviewed claims paid from September 1, 2006, through August 31, 2007. We recommended that CMS work with States to ensure that Medicaid claims for personal care services provided by attendants with undocumented qualifications are not paid and take action regarding the inappropriately paid claims identified in our review. CMS concurred with both recommendations. *Inappropriate Claims for Medicaid Personal Care Services.* OEI-07-08-00430. [Full Report](#)

Medicaid Services > Personal Care > Federal Share > District of Columbia

### ■ **Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia**

From July 1, 2006, through September 30, 2007, the District of Columbia (the District) paid Tri-State Home Health and Equipment Services, Inc. (Tri-State), an estimated \$1.6 million (\$1.1 million Federal share) for personal care services that were not provided or that did not comply with the Medicaid plan or waiver requirements for allowable hours of service.

The District's Medicaid plan authorizes personal care services, which provide assistance with activities of daily living, including bathing, grooming, and eating, for up to 8 hours per day and 1,040 hours during any 12-month period. The District also provides personal care services through a section 1915(c) waiver that allows up to 16 hours of services per day.

We set aside for CMS's adjudication another \$1.2 million (\$808,000 Federal share) paid on behalf of 44 beneficiaries for whom Tri-State claimed hours of service under the waiver. Tri-State documented that it had submitted requests for waiver services for these beneficiaries but did not have evidence that it had received preauthorization for services under the waiver. We also determined that the District did not ensure that all of Tri-State's personal care aides met the District's qualification requirements.

We recommended that the District (1) refund the \$1.1 million Federal share for claims in excess of State plan limits paid without documentation of the required authorization, (2) refund \$5,000 for claims paid for services that were not provided, (3) work with CMS to determine the allowability of \$808,000 paid for waiver claims for which preauthorization of services was not adequately supported, (4) implement prepayment controls to monitor personal care service claims for compliance with Federal and District requirements, and (5) provide more effective monitoring of personal care aides' compliance with qualification requirements. The District concurred with our recommendations and described the actions that it had taken, or planned to take, to address them. *Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia.* A-03-08-00207. [Full Report](#)

Medicaid Services > Personal Care > Federal Share > North Carolina

### ■ **Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc.**

North Carolina improperly claimed an estimated \$1.3 million Federal share for unallowable personal care services during the period July 1, 2005, through June 30, 2007.

Of the 100 sampled claim line items in our random sample, 44 complied with Federal and State requirements, but 56 did not. Of the 56 items that were not compliant, 24 contained more than 1 deficiency. These deficiencies occurred because the State's Division of Medical Assistance did not have sufficient resources to adequately monitor Shipman Family Home Care, Inc.'s (Shipman) personal care services program for compliance with certain Federal and State requirements. Personal care services are generally furnished to individuals in their homes and not residing in hospitals, nursing facilities, or institutions.

We recommended that the State (1) refund the improperly claimed \$1.3 million Federal share to the Federal Government and (2) continue its efforts to implement additional procedures and controls for monitoring the providers of personal care services for compliance with Federal and State requirements. Shipman acknowledged that some of its claims were noncompliant but believed that these claims were anomalous and not representative of its general compliance efforts.

The State concurred with all of our findings and found the recommendations to be both reasonable and appropriate. *Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc.* A-04-09-04041. [Full Report](#)

Medicaid Services > Personal Care > Federal Share > New York

### ■ **Medicaid Personal Care Services Claims Made by Providers in New York State**

New York State improperly claimed an estimated \$100.3 million in Federal Medicaid reimbursement for personal care services claims submitted by providers during CYs 2004 through 2006.

Of the 100 claims in our sample, 61 complied but 31 did not comply with Federal and State requirements pertaining to nursing assessments, physicians' orders, nursing supervision, in-service training of personal care aides, or documentation of the time spent providing services. In addition, for the eight remaining claims in our sample, we estimated that the State claimed \$15.3 million for Consumer Directed Personal Assistance Program (CDPAP) claims that may not have complied with State requirements for physicians' orders and nursing assessments. Personal care services are generally furnished to individuals in their homes. Examples of personal care services include cleaning, shopping, grooming, and bathing.

We recommended that the State: (1) refund the improperly claimed \$100.3 million Federal share to the Federal Government; (2) improve its monitoring of the personal care services program to ensure compliance with Federal and State requirements; (3) work with CMS to resolve the eight CDPAP claims and, if applicable, refund the estimated \$15.3 million in unallowable payments; and (4) promulgate specific regulations related to claims submitted under the CDPAP. The State disagreed with our first recommendation and agreed with our remaining recommendations.

*Review of Medicaid Personal Care Services Claims Made by Providers in New York State.* A-02-08-01005. [Full Report](#)

## Medicaid Recovery Act Reviews

Medicaid > Recovery Act Funds > Increased Federal Share > Indiana

### ■ **Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Indiana for the Quarter Ending March 31, 2009**

Indiana's claim for Federal reimbursement of Medicaid expenditures on the Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) for the quarter ended March 31, 2009, was adequately supported by actual recorded expenditures.

The American Recovery and Reinvestment Act of 2009 (Recovery Act) provided fiscal relief to States to protect and maintain State Medicaid programs during an 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 FMAPs. CMS reimburses States based on the FMAP for the majority of Medicaid expenditures claimed. For the quarter ended March 31, 2009, Indiana's regular FMAP for Medicaid expenditures was 64.26 percent, and the temporarily increased FMAP was 73.23 percent. The report contained no recommendations. *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Indiana for the Quarter Ending March 31, 2009*. A-05-09-00091. [Full Report](#)

Medicaid > Recovery Act Funds > Increased Federal Share > Illinois

### ■ **Illinois' Prompt Pay Compliance Under the American Recovery and Reinvestment Act**

Illinois did not always comply with prompt-pay requirements for receiving the increased FMAP under the Recovery Act.

As a result, it improperly received approximately \$2.6 million in increased FMAP from February 18, 2009, through September 30, 2009. The State agency's initial prompt-pay calculations included several inaccuracies related to the 30/90-day prompt-pay requirements and the inclusion or exclusion of certain claims in the daily prompt-pay compliance calculation. The State agency also failed to adjust the Form CMS-64 for the quarter ended June 30, 2009, for expenditures not eligible for increased FMAP.

We recommended that the State (1) refund \$2.6 million to the Federal Government for unallowable increased FMAP and (2) ensure that calculations are performed in accordance with prompt-pay requirements. The State agreed that it had applied an incorrect prompt-pay standard and incorrectly excluded or included certain prompt-pay claims. To cover all corrections, State officials said they made an adjustment of \$2.5 million and reported it on the December 2009 Form CMS-64. *Review of Illinois' Prompt Pay Compliance Under the American Recovery and Reinvestment Act of 2009 From January 1, 2009, Through September 30, 2009*. A-05-09-00083.

[Full Report](#)

Medicaid > Recovery Act > Increased Federal Share > New Hampshire

### ■ **Medicaid Prompt Pay Requirements in New Hampshire**

We could not determine whether New Hampshire fully complied with prompt-pay requirements for receiving the increased Federal medical assistance percentage under the Recovery Act.



The State agency's policies and procedures did not ensure that it always recorded a claim's receipt date as the actual day that it received the claim. As a result, we could not rely on the State agency's receipt dates to verify that it met requirements. Federal regulations require State Medicaid agencies to pay 90 percent of all clean claims from practitioners within 30 days of receipt. A clean claim is one that can be processed without obtaining additional information from the provider or a third party.

We recommended that the State agency implement policies and procedures to ensure that it records a claim's receipt date as the actual day that it receives the clean Medicaid claim. Specifically, we recommend that the State agency record the receipt date as the day that it receives a claim (1) by mail for paper claims or (2) at the Translator for electronic claims. *Review of American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in New Hampshire*. A-01-10-00009. [Full Report](#)

Medicaid > Recovery Act > Increased Federal Share > Alabama

■ **Alabama's Compliance With the Reserve, or Rainy Day, Fund Requirement for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act**

Alabama complied with the Recovery Act reserve fund requirement for receiving increased FMAP.

For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. However, pursuant to section 5001(f)(3) of the Recovery Act, a State was not eligible for the increased FMAP if any amounts attributable (directly or indirectly) to such an increase were deposited or credited into any reserve, or rainy day, fund. Alabama did not use additional Medicaid funding to supplement any such account. Therefore, we have no recommendations.

As an additional matter, the State drew down about \$2.4 million in Federal Recovery Act funds that exceeded the amount of the Recovery Act expenditures reported on its Form CMS-64 reports for the audit period. The State agency did not provide an explanation for the excessive drawdown of Recovery Act funds, and we were unable to determine whether the excessive drawdowns were used for allowable Recovery Act purposes. *Review of Alabama's Compliance With the Reserve or Rainy Day Fund Requirement for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act*. A-04-10-03058. [Full Report](#)

## Medicaid Administration

Medicaid Administration > Payment Error Rate Measurement Program

### ■ Oversight and Evaluation of the Fiscal Year 2008 Payment Error Rate Measurement Program

CMS could not be assured that the Payment Error Rate Measurement (PERM) program produced a reasonable estimate of improper payments.

One State in our review did not maintain hospital information on a claim-by-claim basis, and we were not able to reconcile the State universes from four other States to their Forms CMS-64. The States' Medicaid fee-for-service and managed care universes for the fiscal year (FY) 2008 PERM program were or may have been incomplete or inaccurate. Federal law requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. In addition, for any program or activity with estimated improper payments exceeding \$10 million, the agency must report to Congress the actions to reduce those payments. CMS developed the PERM program to comply with Federal requirements for measuring improper Medicaid and Children's Health Insurance Program (CHIP) payments.

We recommended that CMS (1) require the one State that was found not to be maintaining hospital payment information on a claim-by-claim basis to begin doing so for use in future PERM reviews and (2) continue to work with all States, CMS Regional Offices, and statistical contractors on reconciling the PERM universes to State financial reports. CMS agreed with our recommendations and discussed the corrective actions it had taken or plans to take in response. *Oversight and Evaluation of the Fiscal Year 2008 Payment Error Rate Measurement Program*. A-06-09-00037.

[Full Report](#)

Medicaid Administration > Federal Share of Overpayments and Interest

### ■ Indiana's Reporting of Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008

For Federal FYs 2000 through 2008, we estimated that Indiana did not report Medicaid overpayments totaling \$61.6 million (\$38.9 million Federal share) in accordance with Federal requirements.

Also, the State did not report interest it collected on 24 overpayments totaling \$62,000 (\$39,000 Federal share) in accordance with Federal requirements. Federal law requires States to refund the Federal share of Medicaid overpayments. In addition, Federal regulations require States to refund interest earned on overpayments before requesting additional Federal funds.

We recommended that Indiana (1) include unreported Medicaid overpayments of \$61.6 million on the Form CMS-64 and refund the \$38.9 million Federal share to the Federal Government, (2) include unreported interest it collected on Medicaid recoveries totaling \$62,000 on the Form CMS-64 and refund the \$39,000 Federal share to the Federal Government, and (3) develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments and interest collected on the overpayments on the Form CMS 64. In written comments related to the first recommendation to refund the Federal share of unreported overpayments, the State provided additional documentation and indicated that most of the overpayments exceeding \$1 million that we initially identified in our draft report were repaid, reported, or resolved. As a result of the additional documentation, we revised our findings as reflected above. In response to the second recommendation related to interest earned on overpayment amounts, the State said it "routinely uses interest assessment" as a form of settlement with providers. The State's policies on interest are not in accordance with Federal regulations. The State agreed with our third recommendation about implementing internal controls. *Review of Indiana's Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008.* A-05-09-00021. [Full Report](#)

## Other Medicaid-Related Reviews

Other Medicaid-Related Reviews > Hurricane Katrina Grants

### ■ **Contract Signatures for the Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area**

From March 2007 through January 2009, Louisiana's Bureau of Primary Care and Rural Health (the Bureau) paid \$330,000 in grant funds to seven practitioners who may not have agreed to comply with the grant's terms and conditions.

We found that seven contracts did not contain authentic signatures. These errors occurred because the Bureau did not have adequate policies and procedures to ensure that employees processing the contracts were obtaining authentic signatures on the agreements from both parties before payments were made. CMS had awarded the Bureau a Professional Workforce Supply Grant (the grant) to restore access to health care in communities affected by Hurricane Katrina. Practitioners were required to submit applications for funding and sign contracts.

We recommended that the Bureau (1) obtain authentic signatures for the seven contracts that were not re-signed or refund the \$330,000 of grant funds to CMS, and (2) ensure that all of the contracts that were not part of our review contain authentic signatures. The Bureau said that some of the original contracts might not be on file. The Bureau also said that it had reviewed the remaining contracts but provided no

supporting documentation. Nothing in the Bureau's comments caused us to revise our recommendations. *Review of Contract Signatures for the Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area.*

A-06-09-00053. [Full Report](#)