Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

OHIO DID NOT ALWAYS MAKE CORRECT MEDICAID CLAIM ADJUSTMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Ohio did not always use the correct Federal medical assistance percentages when processing Medicaid claim adjustments, resulting in an overpayment of $151,000 (Federal share) to the State from October 2008 through June 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, Form CMS-64 (CMS-64) at incorrect Federal medical assistance percentages (FMAPs). We conducted a similar review of claim adjustments submitted by the Ohio Department of Medicaid (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.

BACKGROUND

The State agency uses the CMS-64 to claim actual Medicaid expenditures and to report claim adjustments for each quarter. Claim adjustments occur for a variety of reasons, including correcting 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. The State agency reports claim adjustments on specific lines of the CMS-64 for prior-period increases and decreases.

We reviewed 1,585,792 Medicaid claim adjustments, composed of 1,228,406 private and 357,386 public provider claims, totaling $59 million. These claims were originally paid from January 2008 through September 2012 and subsequently adjusted from October 2008 through June 2013. During the adjustment period, the State agency's FMAPs ranged from 63.58 percent to 73.71 percent.

WHAT WE FOUND

The State agency did not always use the correct FMAPs when processing Medicaid claim adjustments reported on the CMS-64. Of the 1,585,792 claim adjustments we reviewed, we determined that 1,204,718 adjustments (composed of 900,413 private and 304,305 public provider claims) used the correct FMAP or did not result in a payment difference. However, the remaining 381,074 claim adjustments were paid using incorrect FMAPs resulting in an overpayment to the State agency of $151,313 (Federal share). These errors occurred because the State agency did not have adequate internal controls to process all private and public claim adjustments in accordance with Federal requirements. Specifically, the State agency did not always report claim adjustments using the FMAP associated with the original claim when required.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $151,313 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 on our draft report, the State agency concurred with our recommendations and provided details about corrective actions.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews[1] 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, Form CMS-64 (CMS-64) at incorrect Federal medical assistance percentages (FMAPs). We conducted a similar review of Medicaid claim adjustments submitted by the Ohio Department of Medicaid (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.

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 Ohio, the State agency administers the Medicaid program.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

States use the standard CMS-64 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 and its attachments must be actual expenditures and be supported by documentation. States also use the CMS-64 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.

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

[1] See Appendix A for related OIG reports.

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

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 2008 through June 2013, the period in which the claims we audited were adjusted, the State agency's FMAPs ranged from 63.58 percent to 73.71 percent (see Appendix B for a chronology of FMAPs).

Federal Requirements

Federal Medical Assistance Percentage Rates for Reimbursement

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 instructions 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."

Federal Medical Assistance Percentage Rate for Private Versus Public Providers

Section 2500.2(E)(4) states: "Increasing adjustments related to *private providers* are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to *public providers* are considered adjustments to prior-period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency" (added emphasis).

HOW WE CONDUCTED THIS REVIEW

We reviewed 1,585,792 Medicaid claim adjustments, composed of 1,228,406 private and 357,386 public provider claims, totaling $59 million. These claims were originally paid from January 2008 through September 2012 and subsequently adjusted from October 2008 through June 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 C contains the details of our scope and methodology, and Appendix D contains applicable Federal requirements.

FINDINGS

The State agency did not always use the correct FMAPs when processing claim adjustments reported on the CMS-64. Of the 1,585,792 claim adjustments we reviewed, the State agency processed 1,204,718 claims using the correct FMAPs. However, the remaining 381,074 claim adjustments were paid using incorrect FMAPs. This use of incorrect FMAPs resulted in an overpayment of $151,313 (Federal share) to the State agency. These errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements. Specifically, the State agency did not always report claim adjustments using the FMAP associated with the original claim when required.

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN MAKING CLAIM ADJUSTMENTS

Contrary to Federal requirements, the State agency did not use the correct FMAPs when processing 381,074 Medicaid claim adjustments reported on the CMS-64. Of these, 241,041 claim adjustments resulted in a net overpayment of $952,243 (Federal share), and the remaining 140,033 claim adjustments resulted in a net underpayment of $800,930 (Federal share). As a result, the State agency received net overpayments totaling $151,313 (Federal share).

In the example in the table below, the State agency processed an increasing adjustment for a public provider claim as a current period expenditure. The State agency reported the adjustment amount of the replacement claim on the CMS-64 using the current period FMAP. However, since the claim was submitted by a public provider, the State agency should have claimed the adjustment at the FMAP in effect when the State agency made the expenditure for the original claim; therefore, the State agency overstated the Federal share.

Table: An Example of an Incorrect Claim Adjustment (Amounts are Rounded)

Adjustment Made by the State Agency

Transaction Type	Payment Date	Paid	FMAP	Federal Share
Original claim	3/25/2009	$110	70.25%	$77
Adjustment amount	7/15/2009	$534	72.34%	$386
				$463

Office of Inspector General Recalculation of the Adjustment

Transaction Type	Payment Date	Paid	FMAP	Federal Share
Original claim	3/25/2009	$110	70.25%	$77
Adjustment amount	7/15/2009	$534	70.25%	$375
				$452

Amount of the Incorrect Claim Adjustment: $463– $452 = $11

Such errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements. Specifically, the State agency did not always report claim adjustments using the original claim FMAP when required.

RECOMMENDATIONS

We recommend that the State agency:

- refund $151,313 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 on our draft report, the State agency concurred with our recommendations and provided details about corrective actions. The State agency comments are included in their entirety as Appendix E.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New York Made Correct Medicaid Claim Adjustments (A-02-14-01006)	A-02-14-01006	5/17/2016
North Carolina Did Not Always Make Correct Medicaid Claim Adjustments (A-04-14-00100)	A-04-14-00100	3/24/2016
Iowa Did Not Always Make Correct Medicaid Claim Adjustments (A-07-14-01135)	A-07-14-01135	3/26/2015
Massachusetts Did Not Always Make Correct Medicaid Claim Adjustments (A-01-13-00003)	A-01-13-00003	9/29/2014
Maine Did Not Always Make Correct Medicaid Claim Adjustments (A-01-12-00001)	A-01-12-00001	7/20/2012

APPENDIX B: FEDERAL MEDICAL ASSISTANCE PERCENTAGES

Time Period	FMAP Rate
October 2008 through March 2009	70.25%
April 2009 through September 2009	72.34%
October 2009 through September 2010	73.47%
October 2010 through December 2010	73.71%
January 2011 through March 2011	70.88%
April 2011 through June 2011	69.00%
July 2011 through September 2011	63.69%
October 2011 through September 2012	64.15%
October 2012 through September 2013	63.58%

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed all Medicaid claims adjustment data for private and public provider claims that were originally paid from January 2008 through September 2012 and that were subsequently adjusted from October 2008 through June 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.

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 our fieldwork at the State agency's office from December 2013 through March 2016.

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;
- obtained from the State agency a database of 6,849,091 Medicaid claim adjustments that were originally paid from January 2008 through June 2013 and that were subsequently adjusted from October 2008 through June 2013;
- reviewed 1,585,792 [3] Medicaid claim adjustments, composed of 1,228,406 private and 357,386 public provider claims, totaling $59 million that were originally paid from January 2008 through September 2012 and were subsequently adjusted from October 2008 through June 2013;
- reviewed a sample of 45 Medicaid claims and associated adjustments to confirm how the adjustments were reported on the CMS-64;
- calculated the correct Federal share for 381,074 unique Medicaid claim adjustments using the FMAP rate applicable on the date of payment; and
- discussed the results of our review with State agency officials.

[3] From the 6,849,091 adjustments we obtained from the State agency, we excluded 5,263,299 adjustments from our review because these claim adjustments (1) occurred in the same FMAP period as the original claim, (2) did not have a payment difference from the original claim, (3) contained a different type of provider as the original claim, or (4) did not have a matching original claim to determine the original claim payment amount and the FMAP rate used to determine the original Federal share.

APPENDIX D: FEDERAL REQUIREMENTS

SOCIAL SECURITY ACT

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)).

CENTERS FOR MEDICARE & MEDICAID SERVICES' 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, provides instructions for preparation of the CMS-64, such as:

> Section B - Expenditures Reported For Period –
>
> Line 6 - Expenditures In This Quarter. Report such items as waiver expenditures or other current quarter expenditures.
>
> Enter the total computable amount and Federal share of decreasing adjustments for recoveries, collections, cancelled checks, and overpayment on Line 9.D. Do not net these adjustments in Line 6.
>
> Line 7 - Adjustments Increasing Claims For Prior Quarters. - Enter the total computable amount and Federal share of adjustments increasing claims for expenditures in prior periods.
>
> Expenditures reported on Line 7 include only increasing adjustments made to private or public providers in prior quarters which were not previously reported. Report cost settlement and other increasing adjustments to private providers made in the current quarter for an earlier period on Line 6 as a current expenditure.
>
> Line 10B - Enter all decreasing adjustments for prior periods.

Section 2500.2(E)(4) states: "Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior-period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency."

Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

August 23, 2016

Sheri L. Fulcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: A-05-14-00017 Ohio Medicaid Claim Adjustments

Dear Ms. Fulcher,

Thank you for the opportunity to respond to the draft report issued by the OIG regarding their review of Ohio's Medicaid Claim Adjustment procedures and processes. The Ohio Department of Medicaid appreciates the OIG's comprehensive review of Ohio's process in reporting claim adjustments on the CMS-64 at the appropriate FMAP rate.

In the attached response to the draft report, ODM has provided a response for each recommendation made by the OIG in regards to this review.

If you have any questions or would like to discuss our responses further, please contact Angela Houck at (614) 752-3250 or angela.houck@medicaid.ohio.gov.

Sincerely,

/Michelle Horn/

Michelle Horn
CFO
Ohio Department of Medicaid

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OIG RECOMMENDATIONS

We recommend that the State agency:

- refund $151,313 to the Federal Government,

  - **ODM agrees that $151,313.00 will be returned to the federal Government via a decreasing adjustment on line 10 A of the CMS 64 for Quarter ending June 30, 2016. This refund is necessary because the ODM system was not mapped to take the differing FMAP adjustment procedures into account for public versus private providers. The issue was exacerbated by the ARRA funding percentage swings during the audit period.**

- determine and refund any additional amounts related to claim adjustments that were made at incorrect FMAPs after our audit period, and

  - **Determination of additional amounts related to post audit period claim adjustments that claimed incorrect FMAPs due to crossing of various FMAP periods will be identified and reported as increasing or decreasing adjustments as needed. Any adjustments should be reported on the CMS 64 for the July to September 2016 quarter, but will be reported no later than the October to December 2016 quarter.**

- ensure that it processes future adjustments in accordance with Federal requirements.

  - **Processes are under review and will be updated as needed to process future claim adjustments, with focus on Public providers, in accordance with Federal requirements regarding the appropriate FMAP. Requirements are being gathered and the fix to the MMIS system will be prioritized. Until the time that the fix is in place manual adjustments will be done to ensure the CMS 64 is reported correctly.**