Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VERMONT OBTAINED CMS APPROVAL TO REPORT CERTAIN PRIMARY CARE SERVICE EXPENDITURES IN THE INDIAN HEALTH SERVICE FACILITIES COLUMN ON THE CMS-64

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

Sheri L. Fulcher
Regional Inspector General
for Audit Services

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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.

INTRODUCTION

Vermont obtained CMS approval to report certain primary care service expenditures in the Indian Health Service Facilities column on the CMS-64.

WHY WE DID THIS REVIEW

The Federal Government pays a share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP). However, it reimburses States for services provided through Indian Health Service (IHS) facilities at an enhanced FMAP rate of 100 percent. Prior Office of Inspector General reviews[1] determined that State agencies incorrectly claimed expenditures as services provided through IHS facilities, therefore receiving unallowable Federal reimbursement. We conducted the current review to determine whether Vermont claimed Medicaid expenditures for IHS facilities at the enhanced FMAP rate in accordance with Federal requirements.

OBJECTIVE

Our objective was to determine whether the State agency correctly claimed Medicaid expenditures on the CMS-64 for IHS facilities at the enhanced FMAP rate from October 1, 2007 through September 30, 2014, in accordance with Federal requirements.

BACKGROUND

Medicaid Program: How It Is Administered and How States Claim Federal Reimbursement for Their Expenditures

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities and along with the Medicare program represents one of the largest areas of spending in the Federal Government. In contrast to the Medicare program, both the Federal and State governments jointly fund and administer the Medicaid program.

At the Federal level, the Centers for Medicare & Medicaid Services (CMS), an agency with the Department of Health and Human Services (DHHS), administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In Vermont, the Vermont Agency of Human Services (State agency) administers the Medicaid program. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income.

[1] *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma*, (A-06-09-00097, issued July 5, 2011) and *Indiana Incorrectly Reported Expenditures on the Form CMS-64 at the Enhanced Federal Medical Assistance Percentage Rate*, (A-05-14-00011, issued May 22, 2014).

Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time. Certain Medicaid services receive a higher FMAP, including family planning services (90 percent) and services provided through an Indian Health Service (IHS) facility (100 percent). CMS's *State Medicaid Manual* instructs States to use Column (c) of the base Form CMS-64.9[2] to report expenditures provided by IHS facilities. The State of Vermont does not provide IHS services under its Medicaid program.

Enhanced Federal Reimbursement of Certain Primary Care Service Expenditures

The Patient Protection and Affordable Care Act (ACA)[3] established an enhanced Medicaid FMAP reimbursement rate of 100 percent for primary care services provided in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

HOW WE CONDUCTED THIS REVIEW

We selected 4 quarters with a total of $5,723,835 in Medicaid expenditures that the State agency reported as IHS facility services in Column (c) of the CMS-64.9 from October 1, 2007 through September 30, 2014 (FFY 2008 through 2014). We reviewed supporting records that the State agency maintained. However, we did not evaluate claims submitted by providers to determine their validity.

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 A contains the details of our audit scope and methodology and Appendix B contains the Federal requirements related to reporting Medicaid expenditures at the enhanced FMAP rate.

FINDING

We found that the expenditures that the State agency reported in the IHS facilities' column of the CMS-64 were for primary care services not provided in an IHS facility. However, like services provided in IHS facilities, these primary care services had an FMAP reimbursement rate of 100 percent. The State agency had obtained CMS approval to report these expenditures in the IHS facilities column. Because Federal reimbursement was correct, this report does not include any recommendations.

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[2] *State Medicaid Manual* section 2500.2(A) instructs States to "Report payments made in a prior period but not included on the expenditure report for that period, and payments made as adjustments to amounts claimed in prior periods on Form 64.9p".

[3] The Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), is known as the Affordable Care Act.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From the audit period October 1, 2007 through September 30, 2014, we selected 4 quarters with a total of $5,723,835 in Medicaid expenditures that the State agency reported for IHS facilities in Column (c) of the CMS-64.9.

We limited our review of supporting documentation to records that the State agency maintained but did not evaluate claims submitted by providers to determine their validity. Our objective did not require a review of the overall internal control structure of the State agency. Therefore, we limited our internal control review to the State agency's procedures for reporting Medicaid expenditures on the CMS-64 report.

We conducted our audit work from January through March 2015.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations and the State plan;
- interviewed State agency officials to obtain an understanding of their policies and procedures for reporting Medicaid expenditures on the CMS-64 report;
- traced expenditures reported for IHS facilities to detailed records and analyzed those records; and
- discussed our results with the State agency.

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: FEDERAL REQUIREMENTS

FEDERAL REQUIREMENTS FOR REPORTING MEDICAID EXPENDITURES AT THE INDIAN HEALTH SERVICE FACILITIES RATE

Section 1905(b) of the Act and 42 CFR § 433.10(c)(2) authorize reimbursement for services provided through IHS facilities at 100 percent.

The CMS State Medicaid Manual (the Manual) section 2500.2(C) states the FMAP is 100 percent for services received by Indians through an IHS facility, whether operated by the IHS, an Indian Tribe, or a tribal organization. The Manual states to use Column (c) of Form CMS-64.9 to report expenditures for medical assistance made in accordance with the Indian Health Care Improvement Act (P.L. No. 94-437).

FEDERAL REQUIREMENTS FOR THE AFFORDABLE CARE ACT ENHANCED FMAP FOR PRIMARY CARE PHYSICIAN SERVICES

Section 1202(a)(1) of the Affordable Care Act amended section 1902(a)(13)(C) of the Act to authorize reimbursement for certain services provided by a primary care physician at 100 percent and defined said services.

Section 1202(1)(b) of the Affordable Care Act amended section 1905 of the Act to authorize an increased FMAP of 100 percent for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015.