Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORTH CAROLINA 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.

Lori S. Pilcher
Regional Inspector General
for Audit Services

March 2016
A-04-14-00100

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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

North Carolina did not always use the correct Federal medical assistance percentages when processing Medicaid claim adjustments, resulting in at least $1.5 million (Federal share) net overpayments for State fiscal years 2009 through 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 therefore conducted a similar review of the claim adjustments submitted by the North Carolina Division of Medical Assistance (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 Medicaid 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 corrections to inaccurate provider billings and retroactive changes in provider payment rates. Federal reimbursement for claim adjustments is available at the FMAP in effect at the time the State made the expenditure if the State files a claim within 2 years or meets an exception to timely filing requirements. For November 2003 through June 2013, the period in which the claims we audited were originally paid, the State agency's FMAP ranged from 62.85 percent to 74.98 percent.

We reviewed 9,167,230 Medicaid claim adjustments, composed of 9,138,334 private and 28,896 public provider adjustments, totaling $364 million ($255 million Federal share). These were originally paid from November 2003 through June 2013 and subsequently adjusted from July 2008 through June 2013, resulting in a payment difference.

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 9,167,230 claim adjustments we reviewed, it processed 7,300,700 (composed of 7,271,804 private and 28,896 public provider adjustments) using incorrect FMAPs. This use of incorrect FMAPs resulted in a net overpayment of $2,147,759 related to private provider adjustments and an underpayment of $573,515 related to public provider adjustments. The State agency processed the remaining 1,866,530 claim adjustments using incorrect FMAPs resulting in no impact. These errors occurred because the State agency's internal controls did not adequately ensure that it processed and reported all private and public provider claim adjustments in accordance with Federal requirements. As a

result, the State agency received $1,574,244 (Federal share) in net overpayments ($2,147,759 in overpayments less $573,515 in underpayments).

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $1,574,244 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 disagreed with our findings. It asserted that the FMAP continues to be correctly applied to the claim adjustments and the adjustments are being reported correctly. The State agency maintained that it collaborated with CMS on its policies and procedures (used for several years) for applying the appropriate FMAP to claim adjustments and that CMS revalidated them as part of the implementation of North Carolina's new Medicaid Management Information System in July 2013. The State agency also asserted that the private provider claim adjustments processed 2 years or more after the original paid claims did not violate the intent of the 2-year limit outlined in 45 CFR § 95.19 because the claims included credit adjustments that resulted in the collection of overpayments.

OUR RESPONSE

We acknowledge that the State agency implemented a new Medicaid Management Information System on July 1, 2013; however, Medicaid paid the claims that we reviewed prior to its implementation. Therefore, the State agency did not apply the policies and procedures implemented in July 2013 to the claim adjustments processed during our audit period. Accordingly, we maintain that the State agency did not adequately ensure that it processed and reported all private and public provider claim adjustments in accordance with Federal requirements. In addition, the exceptions outlined in 45 CFR § 95.7 and the CMS *State Medicaid Manual* (section 2500(D)(1)(b)(c) for claim adjustments processed and reported 2 years or more after the original paid claim) clearly established certain exceptions to the Federal time limit requirements applicable to public (not private) provider claim adjustments. Therefore, the private provider adjustments in question did not qualify as exceptions. Accordingly, we maintain that the State agency did not process and report these adjustments in accordance with Federal requirements.

We maintain that the State agency received $1,574,244 (Federal share) in net overpayments, and we continue to recommend that such amount be refunded to the Federal Government.

TABLE OF CONTENTS

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 therefore conducted a similar review of the claim adjustments submitted by the North Carolina Division of Medical Assistance (State agency), which administers the Medicaid program in that State.

OBJECTIVE

Our objective of this review was to determine whether the State agency used the correct FMAPs when it processed Medicaid 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 North Carolina, 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 report claim adjustments and make adjustments for any identified overpayment or underpayment of the FMAP. The State agency makes adjustments for a variety of reasons, including corrections to inaccurate provider billings and retroactive changes in provider payment rates.

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

[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.

Federal Medical Assistance Percentages

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

For November 2003 through June 2013, the period in which the claims we audited were originally paid, the State agency's FMAP ranged from 62.85 percent to 74.98 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).

Federal and State Time Limit Requirements for Payment of Medicaid Claims

Federal regulations state, "[W]e will pay a State for a State agency expenditure … only if the State files a claim with us for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure" (45 CFR § 95.7). However, the CMS *State Medicaid Manual*, section 2500(D)(1)(b)(c), established certain exceptions to Federal time limit requirements (see these exceptions in Appendix D).

HOW WE CONDUCTED THIS REVIEW

We reviewed 9,167,230 Medicaid claim adjustments, composed of 9,138,334 private and 28,896 public provider adjustments, totaling $364 million ($255 million Federal share). These claim adjustments were originally paid from November 2003 through June 2013 and subsequently adjusted from July 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 Medicaid claim adjustments reported on the CMS-64. Of the 9,167,230 claim adjustments we reviewed, it processed 7,300,700 (composed of 7,271,804 private and 28,896 public provider adjustments) using incorrect FMAPs. This use of incorrect FMAPs resulted in a net overpayment of $2,147,759 related to private provider adjustments and an underpayment of $573,515 related to public provider adjustments. The State agency processed the remaining 1,866,530 claim adjustments using incorrect FMAPs resulting in no impact.[3] These errors occurred because the State agency's internal controls did not adequately ensure that it processed and reported all private and public provider claim adjustments in accordance with Federal requirements. As a result, the State agency received $1,574,244 (Federal share) in net overpayments ($2,147,759 in overpayments less $573,515 in underpayments).

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN PROCESSING MEDICAID CLAIM ADJUSTMENTS: PRIVATE PROVIDERS

Contrary to Federal requirements, the State agency did not use the correct FMAPs when processing 9,138,334 private provider Medicaid claim adjustments reported on the CMS-64. Of these, 7,271,804 resulted in a net overpayment of $2,147,759 (Federal share).[4] However, the remaining 1,866,530 did not have a financial impact.

For 7,258,837 claims, the State agency submitted a void adjustment for the original claim using the current FMAP (instead of the prior-period FMAP in effect for the original claim) resulting in an underpayment to the State agency of $842,315.

[3] On its CMS-64s for July 2008 through September 2010, the State agency reported all increasing adjustments as current expenditures on line 6 and all decreasing adjustments as other collections on line 9.D. After September 2010, it reported all adjustments on line 6 of the CMS-64s as current expenditures, with decreasing adjustments netted against the new claims and increasing adjustments. Consequently, on its CMS-64s for July 2008 through June 2013, the State agency incorrectly reported all claim adjustments for private and public providers.

[4] On its CMS-64s for July 2008 through September 2010, the State agency incorrectly reported decreasing private provider claim adjustments on line 9.D (instead of on line 10.B for the credit and void adjustments). After September 2010, it reported all adjustments on line 6 of the CMS-64s as current expenditures, with decreasing adjustments netted against the new claims and increasing adjustments.

In addition, the State agency processed and reported 12,967 adjustments 2 years or more after the original paid claim. Consequently, it used the incorrect FMAP for these claim adjustments and received $2,990,074 (Federal share) in overpayments.

Federal regulations state, "[W]e will pay a State for a State agency expenditure … only if the State files a claim with us for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure" (45 CFR § 95.7). However, the CMS *State Medicaid Manual*, section 2500(D)(1)(b)(c), established certain exceptions to Federal time limit requirements (see these exceptions in Appendix D).

The State agency processed and reported 12,967 private provider claim adjustments 2 years or more after the original paid claim because it considered them to be "adjustments to prior year costs" or "audit exceptions," both of which would qualify as exceptions. However, these CMS-established exceptions to the Federal time limit requirements apply to public (not private) provider claim adjustments; therefore, the exceptions did not apply to the 12,967 claim adjustments.

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

Because its internal controls did not adequately ensure that it processed and reported all private provider claim adjustments in accordance with Federal requirements, the State agency received net overpayments totaling $2,147,759 (Federal share).

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN PROCESSING MEDICAID CLAIM ADJUSTMENTS: PUBLIC PROVIDERS

Contrary to Federal requirements, the State agency did not use the correct FMAPs when processing 28,896 public provider Medicaid claim adjustments reported on the CMS-64. "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 (CMS *State Medicaid Manual*, section 2500.2(E)(4))." However, the State agency paid all of these claim adjustments using the current FMAPs, resulting in an underpayment to the State agency of $573,515.[5]

In the example in the table below, the State agency processed a credit adjustment for the original claim and submitted a replacement claim using the current FMAP in effect on the date the credit adjustment and the replacement claims were paid. Instead, the State agency should have submitted only the new portion of the claim at the prior-period FMAP rate. Consequently, not using the correct FMAPs resulted in a $20 underpayment to the State agency.

[5] On its CMS-64s, the State agency incorrectly reported public provider claim adjustments on lines 6 and 9.D (instead of lines 7 and 10.B).

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	10/21/2008	$6,490	73.55%	$4,773
Credit claim	6/25/2009	($6,490)	74.51%	($4,836)
New claim	6/25/2009	$4,392	74.51%	$3,273
				$3,210

Office of Inspector General Recalculation of the Adjustment

Transaction Type	Payment Date	Paid	FMAP	Federal Share
Original claim	10/21/2008	$6,490	73.55%	$4,773
Adjusted claim	6/25/2009	($2,098)	73.55%	($1,543)
				$3,230

Amount of the Incorrect Claim Adjustment (Underpaid): $3,210 – $3,230 = ($20)

These errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements. Specifically, as part of its process for claiming adjustments for public providers, the State agency programmed its MMIS to assign the current FMAP for the credit adjustment and replacement claim, instead of the prior-period FMAP in effect for the original payment date.

Because its internal controls did not adequately ensure that it processed and reported all public provider claim adjustments in accordance with Federal requirements, the State agency was underpaid by $573,515.

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN PROCESSING MEDICAID CLAIM ADJUSTMENTS: NET OVERPAYMENTS

The State agency did not always use the correct FMAPs when processing Medicaid claim adjustments reported on the CMS-64. Of the 9,167,230 claim adjustments we reviewed, it processed 7,300,700 (composed of 7,271,804 private and 28,896 public provider adjustments) using incorrect FMAPs. This use of incorrect FMAPs resulted in a net overpayment of $2,147,759 related to private provider adjustments and an underpayment of $573,515 related to public provider adjustments. The State agency processed the remaining 1,866,530 using incorrect FMAPs resulting in no impact.

These errors occurred because the State agency's internal controls did not adequately ensure that it processed and reported all private and public provider claim adjustments in accordance with Federal requirements.

As a result, the State agency received $1,574,244 (Federal share) in net overpayments ($2,147,759 in overpayments less $573,515 in underpayments).

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,574,244 to the Federal Government,
- determine and refund any additional amounts related to claim adjustments that were made at incorrect FMAPS after our audit period, and
- ensure that it processes future adjustments in accordance with Federal requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our findings. It asserted that the FMAP continues to be correctly applied to the claim adjustments and the adjustments are being reported correctly. The State agency maintained that it collaborated with CMS on its policies and procedures (used for several years) for applying the appropriate FMAP to claim adjustments and that CMS revalidated them as part of the implementation of North Carolina's new MMIS in July 2013. The State agency also asserted that the private provider claim adjustments processed 2 years or more after the original paid claims did not violate the intent of the 2-year limit outlined in 45 CFR § 95.19 because the claims included credit adjustments that resulted in the collection of overpayments.

The State Agency comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge that the State agency implemented a new MMIS on July 1, 2013; however, Medicaid paid the claims that we reviewed prior to its implementation. Therefore, the State agency did not apply the policies and procedures implemented in July 2013 to the claim adjustments processed during our audit period. Accordingly, we maintain that the State agency did not adequately ensure that it processed and reported all private and public provider claim adjustments in accordance with Federal requirements. In addition, the exceptions outlined in 45 CFR § 95.7 and the CMS State Medicaid Manual (section 2500(D)(1)(b)(c) for claim adjustments processed and reported 2 years or more after the original paid claim) clearly established certain exceptions to the Federal time limit requirements applicable to public (not private) provider claim adjustments. Therefore, the private provider adjustments in question did not qualify as exceptions. Accordingly, we maintain that the State agency did not process and report these adjustments in accordance with Federal requirements.

We maintain that the State agency received $1,574,244 (Federal share) in net overpayments, and we continue to recommend that such amount be refunded to the Federal Government.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
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
October 2003 through June 2004	65.80%
July 2004 through September 2004	62.85%
October 2004 through September 2005	63.63%
October 2005 through September 2006	63.49%
October 2006 through September 2007	64.52%
October 2007 through September 2008	64.05%
October 2008 through March 2009	73.55%
April 2009 through September 2009	74.51%
October 2009 through December 2010	74.98%
January 2011 through March 2011	72.16%
April 2011 through June 2011	70.27%
July 2011 through September 2011	64.71%
October 2011 through September 2012	65.28%
October 2012 through June 2013	65.51%

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 November 2003 through June 2013 and that were subsequently adjusted from July 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 this audit from July 2014 through April 2015.

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 quarterly worksheets and reports of all claim adjustments reported on the CMS-64 and subsequently adjusted from July 2008 through June 2013;
- reconciled the adjustments contained in the worksheets to the adjustments reported on the CMS-64;
- corresponded with officials from Region IV CMS regarding the processing and reporting of claim adjustments on the CMS-64;
- obtained from the State agency 72,467,920[6] Medicaid line item adjustment records processed and paid during the period July 2008 through June 2013;
- reviewed 9,167,230 Medicaid claim adjustments, composed of 9,138,334 private and 28,896 public provider adjustments totaling $364 million ($255 million Federal share), that were originally paid from November 2003 through June 2013 and were subsequently adjusted from July 2008 through June 2013;

[6] We eliminated all Indian Health Services, Breast and Cervical Cancer, Family Planning and Refugee claims because these claims were reimbursed at an enhanced FMAP. In addition, we eliminated all individual claim adjustments that did not have a matching original claim because we were unable to determine the original claim payment amount and the FMAP rate used to determine the original Federal share.

- reviewed a judgmental sample of 68 provider payments to determine the reason the claim adjustments were processed and to confirm how the claim adjustments were reported on the CMS-64;

- calculated the correct Federal share for 9,167,230 unique Medicaid claims with their corresponding adjustments using the FMAP rate applicable on the date of payment;

- identified both private and public provider claim adjustments processed and reported 2 or more years after the original paid claim; and

- discussed the results of our review with State agency officials.

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 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)).

CODE OF FEDERAL REGULATIONS

"[W]e will pay a State for a State agency expenditure … only if the State files a claim with us for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure" (45 CFR § 95.7).

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."

Section 2500(D)(1)(b)(c) states:

> Expenditures made on or after October 1, 1979 must be filed within 2 years after the calendar quarter in which you made the expenditure unless they meet one of the following exceptions:
>
> (1) "Adjustments to prior year costs" include only public providers and adjustments to expenditures made based upon an interim rate. The rate is subject to final cost settlement provided that it is claimed within 2 years after the quarter in which it was made;
>
> (2) "Audit exceptions" include only adjustments to public providers for expenditures previously claimed under the Medicaid program made as the result of an independent audit finding. The audit finding must have been adopted by the Department of Health and Human Services OIG, Office of Audit or been an audit finding by the Government Accountability Office which is determined by CMS to be allowable ….

APPENDIX E: STATE AGENCY COMMENTS

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Brajer
Secretary

December 17, 2015

Lori S. Pilcher, Regional Inspector
General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3t41
Atlanta, GA 30303

Re: Report Number: A-04-14-00100

Dear Ms. Pilcher:

We have reviewed your draft report entitled *North Carolina Did Not Always Make Correct Medicaid Adjustments.* The following represents our response and corrective action plan to the Findings and Recommendations.

FINDINGS

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN PROCESSING MEDICAID CLAIM ADJUSTMENTS: PRIVATE PROVIDERS

Contrary to Federal requirements, the State agency did not use the correct FMAPs when processing 9,138,334 private provider Medicaid claim adjustments reported on the CMS-64. Of these, 7,271,804 resulted in a net overpayment of $2,147,759 (Federal share). However, the remaining 1,866,530 did not have a financial impact.

For 7,258,837 claims, the State agency submitted a void adjustment for the original claim using the current FMAP (instead of the prior-period FMAP in effect for the original claim) resulting in an underpayment to the State agency of $842,315.

In addition, the State agency processed and reported 12,967 adjustments 2 years or more after the original paid claim. Consequently, it used the incorrect FMAP for these claim adjustments and received $2,990,074 (Federal share) in overpayments.

Federal regulations state, "[W]e will pay a State for a State agency expenditure ... only if the State files a claim with us for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure" (45 CPR § 95.7). However, the CMS *State Medicaid Manual,* section 2500(D)(l)(b)(c), established certain exceptions to Federal time limit requirements (Appendix D).

The State agency processed and reported 12,967 private provider claim adjustments 2 years or more after the original paid claim because it considered them to be "adjustments to prior year costs" or "audit exceptions," both of which would qualify as exceptions. However, these CMS- established

exceptions to the Federal time limit requirements apply to public (not private) provider claim adjustments; therefore, the exceptions did not apply to the 12,967 claim adjustments.

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

Because its internal controls did not adequately ensure that it processed and reported all private provider claim adjustments in accordance with Federal requirements, the State agency received net overpayments totaling $2,147,759 (Federal share).

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN PROCESSING MEDICAID CLAIM ADJUSTMENTS: PUBLIC PROVIDERS

Contrary to Federal requirements, the State agency did not use the correct FMAPs when processing 28,896 public provider Medicaid claim adjustments reported on the CMS-64. "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 (CMS *State Medicaid Manual,* section 2500.2(E)(4))." However, the State agency paid all of these claim adjustments using the current FMAPs, resulting in an underpayment to the State agency of $573,515.

In the example in the table below, the State agency processed a credit adjustment for the original claim and submitted a replacement claim using the current FMAP in effect on the date the credit adjustment and the replacement claims were paid. Instead, the State agency should have submitted only the new portion of the claim at the prior-period FMAP rate. Consequently, not using the correct FMAPs resulted in a $20 underpayment to the State agency.

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	10/21/2008	$6,490	73.55%	$4,773
Credit claim	6/25/2009	($6,490)	74.51%	($4,836)
New claim	6/25/2009	$4,392	74.51%	$3,273
				$3,210

Office of Inspector General Recalculation of the Adjustment

Transaction Type	Payment Date	Paid	FMAP	Federal Share
Original claim	10/21/2008	$6,490	73.55%	$4,773
Adjusted claim	6/25/2009	($2,098)	73.55%	($1,543)

www.ncdhhs.gov
Tel 919-855-4800 • Fax 919-715-4645
Location: 101 Blair Drive • Adams Building • Raleigh, NC 27603
Mailing Address: 2001 Mail Service Center • Raleigh, NC 27699-2001
An Equal Opportunity / Affirmative Action Employer

$3,230

Amount of the Incorrect Claim Adjustment (Underpaid): $3,210 - $3,230 = ($20)

These errors occurred because the State agency did not have adequate internal controls to process claim adjustments in accordance with Federal requirements. Specifically, as part of its process for claiming adjustments for public providers, the State agency programmed its MMIS to assign the current FMAP for the credit adjustment and replacement claim, instead of the prior-period FMAP in effect for the original payment date.

Because its internal controls did not adequately ensure that it processed and reported all public provider claim adjustments in accordance with Federal requirements, the State agency was underpaid by $573,515.

INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN PROCESSING MEDICAID CLAIM ADJUSTMENTS: NET OVERPAYMENTS

The State agency did not always use the correct FMAPs when processing Medicaid claim adjustments reported on the CMS-64. Of the 9,167,230 claim adjustments we reviewed, it processed 7,300,700 (composed of 7,271,804 private and 28,896 public provider adjustments) using incorrect FMAPs. This use of incorrect FMAPs resulted in a net overpayment of $2,147,759 related to private provider adjustments and an underpayment of $573,515 related to public provider adjustments. The State agency processed the remaining 1,866,530 using incorrect FMAPs resulting in no impact.

These errors occurred because the State agency's internal controls did not adequately ensure that it processed and reported all private and public provider claim adjustments in accordance with Federal requirements.

As a result, the State agency received $1,574,244 (Federal share) in net overpayments ($2,147,759 in overpayments less $573,515 in underpayments).

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,574,244 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.

DHHS RESPONSE

Incorrect Federal Medical Assistance Percentages Used When Processing Medicaid Claim Adjustments: Private Providers, Public Providers, Net Overpayments

The Department disagrees with the finding.

www.ncdhhs.gov
Tel 919-855-4800 • Fax 919-715-4645
Location: 101 Blair Drive • Adams Building • Raleigh, NC 27603
Mailing Address: 2001 Mail Service Center • Raleigh, NC 27699-2001
An Equal Opportunity / Affirmative Action Employer

In 2012 the State Agency formally documented the policies and procedures for applying the appropriate FMAP to adjustment claims. These policies and procedures have been in use for several years and were originally implemented as a result of collaborative discussions with CMS to ensure the correct methodology was employed. During the planning and implementation of the new MMIS system (NCTracks), the policies and procedures were revalidated with CMS, formally documented and implemented into the new system by our fiscal agent upon going live in July 2013. These policies and procedures remain as our current methodology and NCTracks was certified by CMS with this methodology in place. It is the Department's position that the FMAP continues to be correctly applied to the adjustment claims and the adjustments are being reported correctly.

The finding additionally cites that adjustment claims were processed more than two years after the original paid claim and that these claims do not meet the exceptions to the two year limit as outlined in 45 CFR §95.19. The State Agency subsequently reviewed all of the sample adjustment claims selected by the OIG during their on-site review. The adjustment claims deemed exceptions included credit adjustments which resulted in the collection of overpayments. The State Agency considers the collection of overpayments a prudent and responsible action which did not violate the intent of the two year limit outlined in the CFR. Accordingly, the Department disagrees with this citation.

We greatly appreciate the professionalism of your review staff and the analysis provided in your review report.

If you need any additional information, please contact Mary R. Johnson at (919) 855-3738.

Sincerely,

/Richard O. Brajer/

Richard O. Brajer

ROB:mrj

cc: Dave Richard, Deputy Secretary of Medical Assistance
Trey Sutten, Director of Finance, Division of Medical Assistance
Rob Kindsvatter, Director of Compliance and Program Integrity, Division of Medical Assistance
Emery E. Milliken, General Counsel
Rod Davis, Chief Financial Officer
Joe Cooper, Chief Information Officer
Laketha M. Miller, Controller
Chet Spruill, Director, Office of Internal Audit
John E. Thompson, Manager, Risk Mitigation & Audit Monitoring, Office of Internal Audit

www.ncdhhs.gov
Tel 919-855-4800 • Fax 919-715-4645
Location: 101 Blair Drive • Adams Building • Raleigh, NC 27603
Mailing Address: 2001 Mail Service Center • Raleigh, NC 27699-2001
An Equal Opportunity / Affirmative Action Employer