



August 5, 2010

TO: Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of New York State's Compliance With the Prompt Pay Requirements for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-02-09-01037)

Attached, for your information, is an advance copy of our final report on New York State's compliance with the prompt pay requirements for the increased Federal medical assistance percentage under the American Recovery and Reinvestment Act of 2009. We will issue this report to the New York State Department of Health within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-09-01037.

Attachment



Office of Audit Services
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

August 6, 2010

Report Number: A-02-09-01037

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Daines:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of New York State's Compliance With the Prompt Pay Requirements for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009*. We will forward a copy of this report to the HHS action official noted below.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-02-09-01037 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF NEW YORK STATE'S
COMPLIANCE WITH THE
PROMPT PAY REQUIREMENTS FOR THE
INCREASED FEDERAL MEDICAL
ASSISTANCE PERCENTAGE UNDER
THE AMERICAN RECOVERY AND
REINVESTMENT ACT OF 2009**



Daniel R. Levinson
Inspector General

August 2010
A-02-09-01037

Office of Inspector General

<http://oig.hhs.gov>

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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.

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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 8L 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.

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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, the Centers for Medicare & Medicaid Services (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.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act will provide an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides these increases to help avert cuts in health care provider payment rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid. For Federal fiscal year 2009, these temporary FMAP increases ranged from 6.2 to nearly 14 percentage points, depending on State unemployment rates.

Pursuant to section 5001(f)(2)(A) of the Recovery Act, effective February 18, 2009, a State is not eligible for the increased FMAP for any claim received from a practitioner on days during any period in which the State did not comply with prompt pay requirements referenced at section 1902(a)(37)(A) of the Act. Pursuant to section 5001(f)(2)(B) of the Recovery Act, effective June 1, 2009, these requirements also apply to claims submitted by hospitals and nursing facilities. In this report, we refer to these subsections as the prompt pay requirement for receiving the increased FMAP under the Recovery Act.

Prompt Pay Requirements

Section 1902(a)(37)(A) of the Act and implementing regulations (42 CFR § 447.45) specify prompt pay requirements. Pursuant to 42 CFR § 447.45(d)(2), a State Medicaid agency “must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.” Pursuant to 42 CFR § 447.45(d)(3), a State Medicaid agency must pay 99 percent of such claims within 90 days of the date of receipt.^{1, 2}

Federal regulations define a clean claim as a claim that can be processed without obtaining additional information from the provider or a third party. Clean claims do not include claims from a provider that is under investigation for fraud or abuse or claims under review for medical necessity (42 CFR § 447.45(b)).³ CMS’s guidance defines the date of receipt as the actual date a State receives a claim from a provider. CMS further defines a claim’s payment date as either the payment check date, the date of an electronic funds transfer payment, the date that a payment is mailed, or the date on the Explanation of Benefits or denial notice for denied claims (CMS’s guidance, Appendix, section B).

New York State Medicaid Program

In New York, the Department of Health (State agency) administers the Medicaid program and oversees compliance with Federal and State requirements. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. Since 2000, the State agency has contracted with Computer Science Corporation (CSC) to operate the MMIS and serve as the fiscal agent for the State’s Medicaid program.

To ensure compliance with prompt pay requirements, the State agency’s contract with CSC includes prompt pay provisions. Pursuant to its contract with the State agency, CSC must adjudicate 90 percent of all claims within 30 calendar days of receipt and 99 percent of all claims within 90 days of receipt.

For the period January 1 through June 30, 2009, the State agency received 125,618,625 clean claims from applicable providers and made payments for these claims totaling approximately \$12.8 billion.⁴

¹ In general, a State Medicaid agency must pay all other claims within 12 months of the date of receipt.

² Because the Recovery Act was enacted on February 17, 2009, the first compliance date with respect to the prompt pay requirements for receiving the increased FMAP under the Recovery Act for practitioner claims was February 18, 2009. Therefore, claims received 30 days before this date (on January 20, 2009) were the first claims subject to 30-day requirement, and claims received 90 days before this date (on November 21, 2008) were the first claims subject to the 90-day requirement (CMS’s State Medicaid Director letter No. 09-004 (CMS’s guidance)).

³ Throughout our report, “claims” refers to clean claims as defined pursuant to 42 CFR § 447.45(b).

⁴ Pursuant to CMS guidance, the prompt pay requirements for receiving the increased FMAP under the Recovery Act apply to claims received from applicable providers—practitioners, nursing facilities, and hospitals—not to claims from managed care organizations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with the prompt pay requirement for receiving the increased FMAP.

Scope

We reviewed all Medicaid claims received by the State agency from applicable providers on each day for the 6-month period January 1 through June 30, 2009, and payments made to the providers for claims received during this period.

For receipt dates before June 1, 2009, we reviewed the applicable practitioner claims. For receipt dates of June 1, 2009, or later, we reviewed the applicable practitioner, hospital, and nursing facility claims.

We did not assess the State agency's overall internal control structure. We limited our review of internal controls to those applicable to our objective, which did not require an understanding of all internal controls over the Medicaid program. We reviewed the State agency's procedures for ensuring compliance with the prompt pay requirement for receiving the increased FMAP.

We performed our fieldwork at the State agency's offices in Albany, New York, and at CSC's office in Rensselaer, New York, from October 2009 through March 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid laws, regulations, and guidance;
- met with State agency officials to gain an understanding of the State agency's policies and procedures for ensuring compliance with prompt pay requirements;
- obtained and reviewed the prompt pay provisions of the State agency's contract with CSC;
- obtained from the State's MMIS the population of all claims received for each day during the period January 1 through June 30, 2009;
- validated the population of claims received by selecting a test week and verifying from the State's records that the number of claims received equaled the number of claims in the MMIS data for that week; and
- determined, for each date of receipt, whether the State agency complied with the prompt pay requirement for receiving the increased FMAP by:

- determining the number of clean claims received;
- determining, for each claim, the date of payment or denial;
- computing, for each claim, the number of days between the date of receipt and the date of payment or denial;
- determining the total number of claims paid or denied within 30 days and within 90 days; and
- calculating the percentage of claims paid or denied within 30 days and within 90 days.⁵

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS OF REVIEW

The State agency complied with the prompt pay requirement for receiving the increased FMAP. Specifically, the State agency paid 100 percent of the 125,618,625 clean claims it received from applicable providers within 30 days of the date of receipt. Therefore, we have no recommendations.

⁵ For each receipt date, we calculated these percentages by dividing the number of claims paid or denied within the specified period by the total claims received on that date.