



September 1, 2010

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

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

**SUBJECT:** Review of Pennsylvania's Compliance With the Prompt Payment Requirements of the American Recovery and Reinvestment Act of 2009 (A-03-09-00204)

Attached, for your information, is an advance copy of our final report on Pennsylvania's compliance with the prompt payment requirement for claims associated with the increased Federal medical assistance percentage under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, enacted February 17, 2009. We will issue this report to the Pennsylvania Department of Public Welfare 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](mailto:Robert.Vito@oig.hhs.gov) or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at [Stephen.Virbitsky@oig.hhs.gov](mailto:Stephen.Virbitsky@oig.hhs.gov). Please refer to report number A-03-09-00204.

Attachment



Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

September 7, 2010

Report Number: A-03-09-00204

Mr. Michael Stauffer  
Acting Deputy Secretary for Administration  
P.O. Box 2375  
Harrisburg, PA 17105-2375

Dear Mr. Stauffer:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Pennsylvania's Compliance With the Prompt Payment Requirements of 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-03-09-00204 in all correspondence.

Sincerely,

/Stephen Virbitsky/  
Regional Inspector General  
for Audit Services

**Direct Reply to 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 and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF PENNSYLVANIA'S  
COMPLIANCE WITH THE  
PROMPT PAYMENT REQUIREMENTS OF  
THE AMERICAN RECOVERY AND  
REINVESTMENT ACT OF 2009**



Daniel R. Levinson  
Inspector General

September 2010  
A-03-09-00204

# ***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 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 (FY) 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, and CMS guidance,<sup>1</sup> 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 payment 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 requirements as the prompt payment requirement for receiving the increased FMAP under the Recovery Act.

---

<sup>1</sup> State Medicaid Director Letter No. 09-004 (July 30, 2009).

## **Prompt Payment 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.<sup>2, 3</sup>

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)).<sup>4</sup> CMS’s guidance to States 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 State Medicaid Director letter No. 09-004, Appendix, section B).

Federal prompt payment regulations authorize CMS to “waive the requirements of paragraphs (d) (2) and (3) of this section upon request by an agency if ... [CMS] finds that the agency has shown good faith in trying to meet them” (42 CFR § 447.45(e)). The regulations (42 CFR § 447.45(e)(2)) further specify that the State agency’s request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

## **Pennsylvania State Medicaid Program**

In Pennsylvania, the Department of Public Welfare (State agency) administers the Medicaid program and oversees compliance with Federal and State requirements. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims.

Medicaid allows States to define “practitioner.” Accordingly, the Pennsylvania code (55 Pa. Code § 1150.2) defines a practitioner as “a person currently licensed under the law of a state to practice medicine, osteopathy, dentistry, podiatry, optometry, chiropractic or midwifery.”

---

<sup>2</sup> In general, a State Medicaid agency must pay all other claims within 12 months of the date of receipt.

<sup>3</sup> Because the Recovery Act was enacted on February 17, 2009, the first compliance date with respect to the prompt payment 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 the 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.)

<sup>4</sup> Throughout our report, “claims” refers to clean claims as defined pursuant to 42 CFR § 447.45(b).

For the period February 18, 2009, through September 30, 2009, the State agency made payments to applicable providers totaling approximately \$1.6 billion (\$1 billion Federal share).<sup>5</sup>

## **Pennsylvania’s Prompt Payment Waiver**

On September 23, 2009, the State agency requested a waiver of the prompt payment requirement. As required by 42 CFR § 447.45(e)(2), the State agency provided a timeline and actions taken toward compliance. By letter dated April 12, 2010, CMS issued a waiver of the prompt payment requirement for “practitioners’ claims that were received for payment during the period October 1, 2008, through February 18, 2009.”

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State agency complied with the prompt payment 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, nursing facility, and hospital claims.

We did not assess the State agency’s overall internal control structure. We reviewed the State agency’s internal controls to the extent necessary to accomplish our objective. We reviewed the State agency’s procedures for ensuring compliance with the prompt payment requirement for receiving the increased FMAP.

We performed our fieldwork at the State agency’s offices in Harrisburg, Pennsylvania during the period September 2009 through May 2010.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- reviewed the prompt payment requirements contained in the State agency’s State Medicaid plan;

---

<sup>5</sup> Pursuant to CMS guidance, the prompt payment requirements for receiving the increased FMAP under the Recovery Act apply to claims received from applicable providers—practitioners, nursing facilities, and those hospital costs submitted as claims—not to claims from managed care organizations.

- reviewed the State agency’s policies and procedures for complying with prompt payment requirements of the Recovery Act and current statutes and regulations;
- reviewed the State agency’s correspondence with its Medicaid providers concerning its payment policies;
- interviewed State agency personnel concerning its Medicaid claims processing methodology;
- reviewed a Medicaid claims database to identify the claims subject to the prompt payment requirements of the Recovery Act for Federal FY 2009;
- analyzed claims subject to the prompt payment requirements for each day from February 18, 2009, through September 30, 2009, for compliance with the prompt payment requirements of the Recovery Act;
- determined, for each date of receipt, whether the State agency complied with the prompt payment 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;<sup>6</sup>
- identified the Medicaid expenditures that qualified for the temporarily increased FMAP as well as those that did not qualify for the temporarily increased FMAP as reported on the CMS-64s for Federal FY 2009; and
- discussed our results 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

---

<sup>6</sup> 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.

## RESULTS OF AUDIT

Payments for claims received on all days from February 16, 2009, through September 30, 2009, complied with the prompt payment requirement for receiving the increased FMAP. Accordingly, all practitioner, nursing facility, and hospital claims received after May 31, 2009, met the requirements for an increased Federal share.

The State agency did not meet the 30-day prompt payment requirement for claims received on any day from January 20, 2009, through February 15, 2009, and did not meet the 90-day prompt payment requirement for claims received on November 29, 2008, and December 13, 2008. Practitioner claims the State agency received from February 19, 2009, through March 17, 2009, would not have been eligible for an increased FMAP. However, on September 23, 2009, during our review, the State agency requested a waiver of the prompt payment requirements for claims submitted by practitioners that were received by the State agency prior to February 18, 2009. On April 12, 2010, CMS granted the waiver of the prompt payment requirement for all claims the State agency received from October 1, 2008, through February 18, 2009. Therefore, we have no recommendations.