

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**VIRGINIA 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](mailto:Public.Affairs@oig.hhs.gov).*



**Brian P. Ritchie**  
Assistant Inspector General  
for Audit Services

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# *Office of Inspector General*

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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

*Virginia did not always use the correct Federal Medical Assistance Percentages when processing Medicaid claim adjustments. However, because Virginia processed all claim adjustments with incorrect rates, there was no net overpayment or underpayment.*

### 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) at incorrect Federal Medical Assistance Percentage (FMAP). We, therefore, conducted a similar review of claim adjustments submitted by the Virginia Department of Medical Assistance Services (State agency), which administers the Medicaid program in Virginia.

The objective of this review was to determine whether the State agency used the correct FMAP when it processed claim adjustments reported on Form CMS-64.

### BACKGROUND

The State agency uses the Form CMS-64 to claim actual Medicaid expenditures and to process 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. Federal reimbursement for claim adjustments is available at the FMAP in effect at the time the State made the expenditure.

We reviewed 4,199,205 claims and adjustments totaling \$345 million that were originally paid from November 2003 through December 2010. During this period, the State agency's FMAP ranged from 50.00 percent to 61.59 percent. The State agency subsequently adjusted these claims from October 2008 through December 2010, resulting in a payment difference.

### WHAT WE FOUND

The State agency did not always use the correct FMAP when processing claim adjustments reported on Form CMS-64. For the 1,394,562 original claims reviewed, we determined that the State agency did not use the correct FMAP when making 2,804,643 adjustments for these claims. The State agency used the current FMAP on the date the adjustment was made. In doing so, the State agency repaid to the Federal Government a higher amount than it received for the original claim. Furthermore, when the State agency submitted the revised claim, it received a higher FMAP payment than it should have received. Taking into consideration both of the errors, the net effect resulted in no overpayment or underpayment.

These errors occurred because the State agency did not have adequate procedures to process claim adjustments in accordance with Federal requirements and instead processed the whole amount of adjusted claims as new expenditures rather than treating only the adjusted portions as new expenditures.

## **WHAT WE RECOMMEND**

We recommend that the State agency develop procedures to process Medicaid claim adjustments in accordance with Federal requirements.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency agreed with our finding and concurred with our recommendation. However, due to the time and expense involved in changing the current claims processing system, it is delaying implementation until the current contract expires in June 2018 and a new claims processing system is adopted. The new claims processing system will incorporate procedures that implement our recommendation.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

Previous Office of Inspector General reviews<sup>1</sup> 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) at incorrect Federal Medical Assistance Percentage (FMAP). We, therefore, conducted a similar review of claim adjustments submitted by the Virginia Department of Medical Assistance Services (State agency), which administers the Medicaid program in Virginia.

### OBJECTIVE

The objective of this review was to determine whether the State agency used the correct FMAP when it processed claim adjustments reported on Form 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 Virginia, the State agency administers the Medicaid program.

#### Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

States use the standard Form 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 Form CMS-64 and its attachments must be actual expenditures and be supported by documentation. States also use Form 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) to process claims. The State agency programmed its MMIS to identify claim adjustment amounts and then assign a specific FMAP to report on Form CMS-64.

#### 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

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<sup>1</sup> See Appendix A for related OIG reports.

based on the 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 December 2010 (the period in which the claims we audited were originally paid), the FMAP for Virginia ranged from 50.00 percent to 61.59 percent (Appendix B).

## **HOW WE CONDUCTED THIS REVIEW**

We reviewed 4,199,205 claims and adjustments totaling \$345 million that were originally paid from November 2003 through December 2010. During this period, the State agency's FMAP ranged from 50.00 percent to 61.59 percent. The State agency subsequently adjusted these claims from October 2008 through December 2010, 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 audit scope and methodology.

## **FINDING**

The State agency did not always use the correct FMAP when processing claim adjustments reported on Form CMS-64. For the 1,394,562 original claims we reviewed, we determined that the State agency did not use the correct FMAP when making 2,804,643 adjustments to these claims. The State agency used the current FMAP on the date the adjustment was made. In doing so, the State agency repaid to the Federal Government a higher amount than it received for the original claim. Furthermore, when the State agency submitted the revised claim, it received a higher FMAP payment than it should have received. Taking into consideration both of the errors, the net effect resulted in no overpayment or underpayment.

These errors occurred because the State agency did not have adequate procedures to process claim adjustments in accordance with Federal requirements and instead processed the whole amount of adjusted claims as new expenditures rather than treating only the adjusted portions as new expenditures.

## **FEDERAL MEDICAID REQUIREMENTS**

The Federal Government must reimburse the State at the FMAP 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 instruction to States: “When reporting expenditures for Federal reimbursement, apply the FMAP 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 applicable to a given expenditure, determine when the expenditure was made.” Section 2500.1 further instructs States to claim increasing adjustments for “cost settlements” and “other increasing adjustments” involving private providers as current expenditures in the quarter in which the adjustments are made. The FMAP in effect when the adjustment is paid should be applied when the adjustment amount is submitted. The FMAP in effect for the original payment does not change.

## **INCORRECT FEDERAL MEDICAL ASSISTANCE PERCENTAGES USED WHEN MAKING CLAIM ADJUSTMENTS**

The State agency did not use the correct FMAP when processing claim adjustments reported on Form CMS-64. When processing an adjustment, the State agency used the FMAP in effect on the date of adjustment for the entire claim instead of only for the adjusted amount. However, the process the State agency followed resulted in no overpayment or underpayment.

The State agency calculated claim adjustments in two steps using the incorrect FMAP. In the first adjustment, the State agency reversed the entire original payment amount; in the second adjustment, it processed a new claim for the entire adjusted claim amount. The State agency’s MMIS uses the FMAP in effect when claims are processed, resulting in all adjustments being processed at the current FMAP regardless of the date of the original claim. Therefore, when the State agency reversed the original payment amount, the MMIS processed the reversal at the current FMAP in effect on the date of adjustment. The State agency then processed a new claim for the total adjusted amount, also at the current FMAP. Combined, the first and second adjustments resulted in a final adjusted Federal share equal to the correct adjusted Federal share.

The State agency should have processed only the adjusted portion of the claim, and not the total overall claim amount, at the current FMAP. For example, on February 20, 2009, the State agency made an original claim payment of \$7,078 with a Federal share of \$4,160 based on a 58.78 percent FMAP. On November 13, 2009, the State agency adjusted the claim to \$6,854, \$224 less than the original claim amount. Based on Federal guidelines, the State agency should have made a single negative adjustment of \$224 and, using the current 61.59 percent FMAP, returned a Federal share of \$138. When the adjustment is subtracted from the original Federal share of \$4,160, the total Federal share for this claim is \$4,022.

Instead, the State agency incorrectly processed the claim adjustment using the two steps outlined above. First the State agency reversed the entire amount of the original claim at the 61.59 percent FMAP in effect on the date of adjustment, returning a \$4,359 Federal share. By using the current FMAP, the State agency returned to the Federal government \$199 more than the original Federal share it received. The State agency then processed a new claim for the total

amount of \$6,854 using the 61.59 percent current FMAP, resulting in a Federal share of \$4,221. By using the current FMAP in this calculation, the State agency received \$199 more than it should have been reimbursed.

Even though the State agency used the incorrect FMAP, the \$199 overpayment it received was offset by the extra \$199 it initially gave back to the Federal government when it reversed the original claim.

The State agency made these errors because it did not have adequate procedures to process claim adjustments in accordance with Federal requirements. Instead, it processed the entire amount of the adjusted claims as new expenditures rather than treating only the adjustments as new expenditures.

### **RECOMMENDATION**

We recommend that the State agency develop procedures to process Medicaid claim adjustments in accordance with Federal requirements.

### **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency agreed with our finding and concurred with our recommendation. However, due to the time and expense involved in changing the current claims processing system, it is delaying implementation until the current contract expires in June 2018 and a new claims processing system is adopted. The new claims processing system will incorporate procedures that implement our recommendation. The State agency's comments appear in their entirety as Appendix D.

**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

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

**APPENDIX B: FEDERAL MEDICAL ASSISTANCE PERCENTAGES**

<b>Time Period</b>	<b>Enhanced FMAP Rate</b>
April 2003 through September 2003	54.40%
October 2003 through March 2004	53.48%
April 2004 through September 2008	50.00%
October 2008 through March 2009	58.78%
April 2009 through December 2010	61.59%

## **APPENDIX C: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

For the period from October 2008 through December 2010, we reviewed Medicaid claims that were at risk for having overpayments. We limited our review of internal controls to obtaining an understanding of the State agency's procedures for performing claim adjustments and reporting the adjustments on the Form CMS-64.

We performed fieldwork from May 2014 through October 2014 at the State agency in Richmond, Virginia.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed officials from the State agency;
- gained an understanding of how the State agency develops Form CMS-64;
- reconciled Form CMS-64 for the quarter ending September 30, 2009;
- identified 4,199,205 claims and adjustments totaling \$345 million that were originally paid from November 2003 through December 2010 and that were subsequently adjusted from October 2008 through December 2010, resulting in a payment difference;
- calculated the correct Federal share for 1,394,562 Medicaid claims and their corresponding adjustments; 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: STATE AGENCY COMMENTS**



**COMMONWEALTH of VIRGINIA**  
*Department of Medical Assistance Services*

CYNTHIA B. JONES  
DIRECTOR

SUITE 1300  
600 EAST BROAD STREET  
RICHMOND, VA 23219  
804786-7933  
800343-0634 (TDD)  
[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

August 8, 2016

Mr. Jason C. Jelen  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, Pennsylvania 19106-3499

Re: Draft Audit Report Number A-03-14-00204

Dear Mr. Jelen:

Thank you for sending us the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Virginia Did Not Always Use The Correct Federal Medical Assistance percentage When Adjusting Medicaid Claims*.

The Department of Medical Assistance Services (DMAS), Virginia's state Medicaid agency has reviewed the document and concurs with DHHS's finding associated with Page 3 of the document under the section 'Incorrect Federal Medical Assistance Percentages Used When Making Claim Adjustments'. DMAS's current Medicaid Management Information System (MMIS) was implemented in July, 2003 with CMS Certification being received in 2014 for all subsystems of the MMIS, including the Financial Subsystem retroactive to July 2003. This subsystem is the area where the FMAP rates are stored and maintained based on FMAP rate changes over the lifetime of the MMIS. The current MMIS financial processing is a 'cash' based process meaning the expenditures and credits are associated to the point in time when payment was made and adjustment expenditures are not associated with when the original claims were paid or expended.

We do agree with the finding that the net effect of over payment and under payment related to original and adjustment claims processing to the Federal Government for this audit period resulted in no overpayment or underpayment. At the same time, we are in agreement that the DMAS agency has to update our procedures to process claims adjustment in accordance with

Federal requirements – CMS State Medicaid Manual, Section 2500 (D)(2) instead of processing the whole amount of adjusted claims as new expenditures rather than treating only the adjusted portions as new expenditures.

The following is DMAS's response the DHHS's Recommendation on Page 4 of the document:

Since the current MMIS financial processing is a 'cash' based process system, incorporating this change now would warrant a complete system redesign and it would take up to two years. The current contract with our fiscal agent Xerox ends on June 30, 2018.

DMAS is currently in the process of procuring a new Medicaid Enterprise Solution (MES) to replace the current MMIS. The Agency has issued five Request for Proposals (RFP) to replace the current VaMMIS (Virginia Medicaid Management Information System) and will be awarding the contracts before the end of the year. The new MES is to be based on the MITA 3.0 framework associated to CMS's Seven Standards and Conditions vision and is planned for a timeframe to begin July 1, 2018. For the new DMAS MES Financial Management Solution (FMS) that will be a separate financial processing for the MES, we have reviewed the processes associated to the adjustments of claims or other MES financial payments and have ensured that the process to reverse the expenditures at the original FMAP rate and to expend only the adjusted portion of the adjustment claim at the current FMAP rate will be included in the operational implementation of the PMS.

Due to the costly redesign, the time it will take to incorporate the requirement in the current VaMMIS and the audit finding which states the net effect of the errors resulted in no overpayment or underpayment to the Federal government, we have made a conscious decision to incorporate this change as part of the new MES procurement instead of incorporating it to the current VaMMIS.

If you have any questions or comments about our corrective action plan, please do not hesitate to call me at (804)786-8099, or contact Paul Kirtz, Internal Audit Director, at (804) 225-4162 or through email at [Paul.Kirtz@dmas.virginia.gov](mailto:Paul.Kirtz@dmas.virginia.gov).

Sincerely,

/Cynthia B. Jones/