

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ARKANSAS DID NOT MAKE
SUPPLEMENTAL PAYMENTS IN
ACCORDANCE WITH FEDERAL
REQUIREMENTS**

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



**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

**September 2017
A-06-15-00042**

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: September 2017
Report No. A-06-15-00042

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

To encourage primary care providers (providers) to participate in the Medicaid program, the Affordable Care Act (ACA) required States to pay increased Medicaid payments (supplemental payments) to eligible providers in calendar years (CYs) 2013 and 2014. The States received a 100-percent Federal matching rate for any supplemental payment. The Arkansas Department of Human Services (State agency) claimed approximately \$73.1 million in supplemental payments to providers in CYs 2013 and 2014 for fee-for-service claims.

Our objective was to determine whether the State agency made the supplemental payments to providers in accordance with Federal requirements.

How OIG Did This Review

Our review covered 8,936 supplemental payments, totaling \$73.1 million paid to providers for services during CYs 2013 and 2014. We selected a stratified random sample of 120 supplemental payments totaling almost \$2.2 million. For any supplemental payments for ineligible codes, we determined to be in error the supplemental payment multiplied by the difference between the regular Federal medical assistance percentage (FMAP) and the 100-percent FMAP. For any other issues (e.g., incorrect rate or units), we determined to be in error the difference between the supplemental payment made and the amount that should have been paid. For any supplemental payments made to ineligible providers, we determined to be in error the entire Federal share that the State agency claimed as a supplemental payment.

Arkansas Did Not Make Supplemental Payments in Accordance With Federal Requirements

What OIG Found

Arkansas did not always make the supplemental Medicaid payments in accordance with Federal requirements. Sixteen of the 120 supplemental payments in our stratified random sample were correct. For 88 of the remaining 104 supplemental payments, Arkansas incorrectly calculated the amount of the payments. An additional six supplemental payments were correctly calculated but were made to ineligible providers. The remaining 10 supplemental payments were both calculated incorrectly and were made to ineligible providers.

On the basis of our sample results, we estimated that Arkansas improperly received at least \$7.1 million in additional Federal share, of which we will recommend recovery of approximately \$3 million.

What OIG Recommends and State Agency Comments

We recommend that Arkansas refund approximately \$3 million to the Federal Government for the Federal share associated with the inappropriate supplemental payments.

Arkansas concurred with our findings and stated its commitment to working with CMS to resolve any monetary paybacks identified in the report.

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INTRODUCTION

WHY WE DID THIS REVIEW

To encourage primary care providers (providers) to participate in the Medicaid program, the Affordable Care Act (ACA) required States to pay increased Medicaid payments (supplemental payments) to eligible providers in calendar years (CYs) 2013 and 2014.¹ The States received a 100-percent Federal matching rate for any supplemental payment. The Arkansas Department of Human Services (State agency) claimed \$73,111,430 in supplemental payments to providers in CYs 2013 and 2014 for fee-for-service claims.

OBJECTIVE

Our objective was to determine whether the State agency made the supplemental payments to providers in accordance with Federal requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to eligible 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.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter. CMS uses the information on the CMS-64 reports to calculate the reimbursement due to the States for the Federal share of Medicaid expenditures. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on the State's relative per capita income. During our audit period, Arkansas' FMAP ranged from 70.10 percent to 70.88 percent.

Federal Requirements Related to Supplemental Medicaid Payments

Section 1202 of the ACA amended the Social Security Act (the Act) to require State Medicaid agencies to make supplemental Medicaid payments for certain evaluation and management

¹ On March 23, 2010, the Patient Protection and Affordable Care Act, P.L. No. 111-148, was enacted and, on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. No. 111-152, was enacted. These public laws are collectively known as the Affordable Care Act.

(E&M) and vaccine services furnished by a provider specializing in family medicine, general internal medicine, or pediatric medicine and subspecialties within these groups.² The supplemental payment is the difference between the regular Medicaid payment and the Medicare Part B rates in effect in CYs 2013 and 2014 or the rate that would be applicable using the CY 2009 Medicare conversion factor (CF), whichever is higher.³ Additionally, the ACA established a 100-percent FMAP for the supplemental payment.

To receive the increased FMAP, the State agency had to amend its State plan to reflect the increase in fee schedule payments in CYs 2013 and 2014. The State plan amendment (SPA) had to identify all E&M and vaccine administration codes⁴ (codes) for which Arkansas would reimburse providers at the Medicare rate in CYs 2013 and 2014.⁵ The State also had to identify all codes that were not reimbursed under Medicaid as of July 1, 2009 (because they were added after that date), and specify whether or not the State would make supplemental payments to providers for these added codes.

To be eligible for supplemental payments, first, a provider had to self-attest to specializing in family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association.⁶ Then, as part of that attestation, the provider had to specify that he or she was board certified by the appropriate professional association with such a specialty or subspecialty or that at least 60 percent of the Medicaid codes billed by the provider during the most recently completed CY were for eligible codes. The Federal regulation required States to pay providers based on their self-attestation alone.

Arkansas Medicaid Provider Supplemental Payments

Effective January 1, 2013, the State agency amended its State plan to reflect the increase in fee schedule payments in CYs 2013 and 2014. The State plan identified all eligible codes for which the State agency would reimburse at the increased rates in CYs 2013 and 2014. The State plan also identified eligible codes for which the State agency did not reimburse as of July 1, 2009. Although the State agency could have included these codes for the supplemental payment, the State agency opted not to. The State agency's fiscal intermediary, HP Enterprise Services, calculated the supplemental payment amounts for providers that attested to their eligibility, and the State agency made the payments quarterly.

² Specifically, section 1202 of HCERA added new subsections 1902(a)(13)(C), 1902(jj), and 1905(dd) to the Act.

³ The CF is part of the formula for the Medicare payment rates in the Physician Fee Schedule. To determine the payment rate for a particular service, the sum of the geographically adjusted Relative Value Units is multiplied by a CF in dollars.

⁴ 42 CFR § 447.400(c) (listing eligible codes).

⁵ 42 CFR § 447.410.

⁶ 42 CFR § 447.400(a).

HOW WE CONDUCTED THIS REVIEW

Our review covered 8,936 supplemental payments, totaling \$73,111,430 paid to providers for services provided during CYs 2013 and 2014. We excluded all supplemental payments of less than \$100. We selected a stratified random sample of 120 supplemental payments to determine whether payments were made in accordance with the ACA. The 120 supplemental payments totaled \$2,174,191.

For any supplemental payments for ineligible codes, we determined to be in error the supplemental payment multiplied by the difference between the regular FMAP and the 100-percent FMAP. For any other issues (e.g., incorrect rate or units), we determined to be in error the difference between the supplemental payment made and the amount that should have been paid. For any supplemental payments made to ineligible providers, we determined to be in error the entire Federal share that the State agency claimed as a supplemental payment.

We estimated the total overpayments made to all providers in our sample. However, CMS guidance to the States declared that CMS will not extrapolate any ineligible provider errors found during a State review of provider eligibility and will only require repayment for the ineligible providers in the sample.⁷ Therefore, to be conservative, our recommended recovery amount will include the sum of erroneous payments made to ineligible providers and a projection of ineligible code and calculation errors.⁸

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates for the total overpayment projection, and Appendix D contains our sample results and estimates for the recoverable improper payments.

⁷ CMS Qs & As on the Increased Medicaid Payment for Primary Care CMS 2370-F, available online at: <https://www.medicaid.gov/affordable-care-act/provisions/downloads/q-anda-managed-care-increased-payments-for-pcps.pdf>. Accessed on June 22, 2017.

⁸ Some payments to ineligible providers contained ineligible codes, calculation errors, or both, which were included in our recoverable projection. The correctly calculated portion of the supplemental payments to ineligible providers was then added to our recoverable projection to get our total recommended recovery.

FINDINGS

The State agency did not always make the supplemental Medicaid payments in accordance with Federal requirements. Sixteen of the 120 supplemental payments in our stratified random sample were correct. For 88 of the remaining 104 supplemental payments, the State agency incorrectly calculated the amount of the payments. An additional six supplemental payments were correctly calculated but were made to ineligible providers. The remaining 10 supplemental payments were both calculated incorrectly and were made to ineligible providers. On the basis of our sample results, we estimated that the State agency improperly received at least \$7,189,330 in additional Federal share, of which we will recommend recovery of \$3,007,734.

PROVIDER QUARTERLY SUPPLEMENTAL PAYMENTS WERE INCORRECT

Effective January 1, 2013, the State agency amended its State plan to reflect the supplemental payment for the difference between the Medicaid rates in effect July 1, 2009, and the applicable 2013 or 2014 Medicare rates. The SPA also listed 41 codes for which the State agency did not pay as of July 1, 2009, and for which it would not pay the supplemental payments (ineligible codes).

Of the 98 supplemental payments that were incorrectly calculated, the State agency made 92 supplemental payments to providers for ineligible codes, resulting in an overpayment of \$145,529. In addition, we identified 34⁹ supplemental payments in our sample that had various calculation errors, such as an incorrect rate or incorrect number of units, resulting in a net underpayment of \$647. In total, we identified \$144,882 in overpayments, which we used to create our projections.

The State agency was unable to provide an explanation for including the ineligible codes or the rate and unit errors.

PROVIDERS DID NOT MEET ELIGIBILITY REQUIREMENTS

Federal regulations required States to make payments to providers who (1) self-attest to specializing in family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by one of the specified professional associations, and (2) further attest that they are board certified in that specialty or subspecialty and/or that at least 60 percent of all Medicaid codes billed by the provider during the prior CY were for specified codes (42 CFR § 447.400(a)).

The State agency made supplemental payments to 16 out of 120 providers in our sample who were not eligible for such increased payments and claimed 100-percent Federal share.

⁹ Twenty-eight of the 34 supplemental payments with calculation errors also had ineligible codes. Six supplemental payments only had calculation errors.

Specifically, we determined that 3 providers who attested to being board certified were certified in an ineligible specialty, and 13 providers who attested to meeting the 60-percent threshold in fact did not.

The three providers who attested to being board certified in an eligible specialty were certified in specialty designations that were ineligible to receive the supplemental payments (dermatology, neurology, and emergency medicine) but received a total of \$5,763 in supplemental payments in our sample.

The 13 providers who did not meet the 60-percent threshold received a total of \$189,389 in supplemental payments in our sample. For example, one provider received a supplemental payment of \$52,795, but only 55 percent of the provider's Medicaid claims in the previous year were for eligible codes. Another provider received a supplemental payment of \$529 despite only 28 percent of that provider's Medicaid claims being for eligible codes in the previous year.

As a result, the State agency inappropriately received \$195,152 in Federal share for all the supplemental payments to 16 ineligible providers.

Of these 16, 10 contained ineligible codes, calculation errors, or both totaling \$11,121, which was included in estimating our recoverable projection. The remaining \$184,031 was added to our recoverable projection amount to get our total recommended recovery. However, the entire \$195,152 was included in estimating our total overpayment projection.

RECOMMENDATION

We recommend that the State agency refund \$3,007,734 to the Federal Government for the Federal share associated with the inappropriate supplemental payments.

AUDITEE COMMENTS

In written comments on our draft report, the State agency concurred with our findings and stated its commitment to working with CMS to resolve any monetary paybacks identified in the report. The State agency's comments appear in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 8,936 supplemental payments, totaling \$73,111,430, paid to providers for services during the period January 1, 2013, through December 31, 2014. We excluded all supplemental payments of less than \$100. We selected a stratified random sample of 120 supplemental payments obtained from the State agency.

We limited our review of the State agency's internal controls to those that were applicable to the selected payments because our objective did not require an understanding of all internal controls related to the increased provider care payments. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the State agency, but we did not assess the completeness of the file.

We performed our audit work in Little Rock, Arkansas, from August 2015 through November 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's approved SPA;
- interviewed State agency officials to understand their policies and procedures related to the supplemental payments;
- obtained 9 Excel spreadsheets from the State agency with all supplemental payments made to providers and combined them into one Excel spreadsheet;
- reconciled the supplemental payments reported on the CMS-64 with the supplemental payments made to providers;
- selected a stratified random sample of 120 supplemental payments from the sample frame;
- reviewed providers that received the 120 supplemental payments for eligibility by verifying that they were appropriately certified or that at least 60 percent of claims billed by or paid to them were for eligible codes;¹⁰

¹⁰ To verify board certification, we used Lexis-Nexis and/or board websites for the American Board of Medical Specialties, the American Board of Physician Specialties, and the American Osteopathic Association.

- reviewed the 120 supplemental payments to verify that the State agency calculated them correctly and paid only for eligible codes;
- estimated the Federal share the State agency improperly received; and
- discussed the results of our audit with the State agency.

See Appendix B for the details of our statistical sampling methodology, Appendix C for our sample results and estimates for the total overpayment projection, and Appendix D for our sample results and estimates for the recoverable improper payments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of quarterly supplemental payments made to providers for services that were provided from January 1, 2013, through December 31, 2014.

SAMPLING FRAME

The sampling frame was an Excel spreadsheet containing 8,936 provider quarterly supplemental payments totaling \$73,111,430 for 3,671,459 claim lines for services provided during the period January 1, 2013, through December 31, 2014.

The sampling frame excluded provider quarterly supplemental payments of less than \$100.

SAMPLE UNIT

The sample unit was a quarterly supplemental payment made to a Medicaid provider.

SAMPLE DESIGN

We used a stratified random sample consisting of four strata, based on provider eligibility and payment amount (Table 1).

Table 1: Detail of Payments by Stratum

Stratum	Number of Payments	Value of Payments
1 – 60% eligibility, under \$20,000	3,811	\$19,775,349
2 – 60% eligibility, greater than or equal to \$20,000	602	22,637,599
3 – Board certification eligibility, under \$20,000	4,070	15,879,591
4 – Board certification eligibility, greater than or equal to \$20,000	453	14,818,891
TOTAL	8,936	\$73,111,430

SAMPLE SIZE

We selected a sample size of 120 quarterly supplemental payments, 30 payments in each stratum.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units across the four strata from 1 to 8,936. After generating the random numbers for each stratum, we selected the corresponding quarterly supplemental payments.

ESTIMATION METHODOLOGY

Using the OIG/OAS statistical software, we estimated the total Federal share amount that the State agency improperly received for supplemental payments in our sampling frame. This estimate accounted for supplemental payments that were calculated incorrectly or made to ineligible providers. We also estimated the total Federal share amount that is recoverable by estimating the supplemental payments that were calculated incorrectly and then adding the value of the sample payments made to ineligible providers.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES FOR TOTAL OVERPAYMENT PROJECTION

Table 2: Sample Details and Results

Stratum	Sample Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Improper Payments	Value of Improper Payments
1	3,811	\$19,775,349	30	\$118,235	24	\$33,667
2	602	22,637,599	30	1,000,798	30	215,270
3	4,070	15,879,591	30	78,124	20	10,874
4	453	14,818,891	30	977,034	30	69,101
Total	8,936	\$73,111,430	120	\$2,174,191	104	\$328,912

**Table 3: Estimated Value of the Federal Share That the State Agency Improperly Received
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$11,115,289
Lower limit	\$7,189,330
Upper limit	\$15,041,249

APPENDIX D: SAMPLE RESULTS AND ESTIMATES FOR RECOVERABLE IMPROPER PAYMENTS

Table 4: Sample Results for Errors Due to Improper Payments and Ineligible Providers

Stratum	Number of Payments with Calculation Errors	Value of Improper Payments Due to Calculation Errors	Number of Payments Made to Ineligible Providers	Value of Improper Payments Made to Ineligible Providers
1	21	\$4,962	9	\$28,705
2	30	65,707	4	149,563
3	17	5,112	3	5,763
4	30	69,101	0	0
Total	98	\$144,882	16	\$184,031

Table 5: Estimated Value of the Federal Share That the State Agency Improperly Received Due to Calculation Errors

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$3,685,757
Lower limit	\$2,823,703
Upper limit	\$4,547,811

Table 6: Calculation of Recoverable Improper Payments

Estimated value of the Federal share improperly received due to calculation errors	\$2,823,703 ¹¹
Sample value of Federal share improperly received due to ineligible providers	\$184,031
Total Recoverable	\$3,007,734

¹¹ To be conservative, we estimated the impact of the State agency’s calculation errors on the Federal share using the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual improper payment total 95 percent of the time.

APPENDIX E: AUDITEE COMMENTS



Division of Medical Services

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August 11, 2017

Patricia Wheeler
Regional Inspector General of Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Report Number A-6-15-00042

Dear Ms. Wheeler:

The Arkansas Department of Human Services Division of Medical Services (DMS) is in receipt of the draft report provided by the Department of Health and Human Services, Office of Inspector General (OIG) entitled "*Arkansas Did Not Make Supplemental Payments In Accordance With Federal Requirements*", dated July 3, 2017. DMS staff has reviewed the OIG's findings and related documents and has provided a response below.

Finding – Provider Quarterly Supplemental Payments were incorrect.

The State Plan Amendment (SPA) approved by CMS listed 41 procedure codes that the State excluded from the supplemental payment. Most of the 41 codes are not covered by Arkansas Medicaid. Twelve of the codes, that were listed in the SPA to be excluded, are payable to Arkansas Medicaid providers and they were included in the supplemental payment. The 12 procedure codes were eligible evaluation and management codes. The State does not know why the codes were listed in the SPA to be excluded from the supplemental payment.

Arkansas paid an incorrect supplemental payment rate for a few codes during calendar year 2014 and there also was an issue with only one unit paying on the supplemental payment when more than one unit had paid on the original claim.

Response: The State concurs with OIG's findings. The Physician Supplemental Payment was paid for dates of service in calendar years 2013 and 2014. Arkansas made the last supplemental payment for calendar year 2013 and 2014 dates of service in 2016.

Finding – Providers did not meet eligibility requirements.

Thirteen of the providers who were found to be non-eligible by OIG had self-attested that they were eligible because 60% of their Medicaid claims included eligible codes.

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Patricia Wheeler
August 11, 2017
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Three providers that were tested by OIG did not have a board certification in an approved specialty. Providers participating in the supplemental payment were required to self-attest that they qualified for the payment. The requirements to qualify for the supplemental payment were published on the Arkansas Medicaid website and providers could attest on-line or on a paper form.

Response: The State concurs with OIG's findings. The Physician Supplemental Payment was paid for dates of service in calendar years 2013 and 2014. Arkansas made the last supplemental payment for calendar year 2013 and 2014 dates of service in 2016.

We are committed to working with CMS to resolve any monetary paybacks identified in the report.

If you have any questions or need additional information, please contact Lynn Burton at (501) 682-1857.

Sincerely,

/Dawn Stehle/

Dawn Stehle
DHS Deputy Director for Health and Medicaid Director