



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

June 24, 2011

Report Number: A-07-11-03165

Mr. Charles M. Palmer
Director
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, IA 50319-0114

Dear Mr. Palmer:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Iowa for the Quarter Ended March 31, 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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 do not hesitate to call me at (816) 426-3591, or contact Greg Tambke, Audit Manager, at (573) 893-8338, extension 30, or through email at Greg.Tambke@oig.hhs.gov. Please refer to report number A-07-11-03165 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

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 & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF THE
QUARTERLY MEDICAID STATEMENT
OF EXPENDITURES FOR THE
MEDICAL ASSISTANCE PROGRAM
IN IOWA FOR THE QUARTER ENDED
MARCH 31, 2009**



Daniel R. Levinson
Inspector General

June 2011
A-07-11-03165

Office of Inspector General

<http://oig.hhs.gov>

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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.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security 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. In Iowa, the Department of Human Services (the State agency) administers the Medicaid program.

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures with supporting documentation.

State Medicaid programs must provide certain medical services, including inpatient and outpatient hospital, physician, and family planning services. States also may offer certain optional services, such as outpatient prescription drugs, as long as the services are included in their approved State plans.

OBJECTIVE

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

SUMMARY OF FINDINGS

For the quarter ended March 31, 2009, the majority of the Medicaid costs that the State agency claimed in the eight reviewed line items (as well as a waiver), which totaled approximately \$524.2 million (approximately \$361.2 million Federal share), was adequately supported by actual recorded expenditures. However, the State agency incorrectly paid:

- \$10,659 (\$7,869 Federal share) for 58 outpatient and co-insurance claims that were duplicates of claims previously paid. These duplicate payments occurred due to errors in manual adjustments and data entry errors. The State agency recovered 50 of the 58 duplicate payments totaling \$9,500 (\$7,014 Federal share) before the beginning of our review. Accordingly, \$1,158 (\$855 Federal share) of the incorrect payments had not been recovered prior to our identification of these duplicates.
- \$9,249,304 (\$6,828,761 Federal share) for two claims to different physicians because in each case the State agency copied the provider number into the amount to pay, a data entry error that resulted in payments up to 886 times higher than the next largest payment

to any physician. The State agency identified the errors before the checks were cashed and canceled the payments before submission of the CMS-64 report. However, the identification of this error took place outside the framework of both the State agency's existing policies and procedures and the internal controls that were in place at the time.

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures, as well as some internal controls, can be strengthened.

RECOMMENDATIONS

We recommend that the State agency:

- recover the \$1,158 (\$855 Federal share) for the eight claims not recovered and
- continue to strengthen policies and procedures and internal controls, particularly those involving manual adjustments and data entry procedures, to ensure that Medicaid payments to providers are not duplicates and are reasonable for the procedures being performed.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with both of our recommendations and described corrective action that it had taken or planned to implement.

The State agency's comments are included in their entirety as the Appendix.

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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 administer and fund 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 plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Iowa, the Department of Human Services (the State agency) administers the Medicaid program.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of each State's claimed medical assistance costs 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), Public Law Number 111-5, enacted February 17, 2009, provides 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 provides an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs.¹ Section 5000 of the Recovery Act provides for these increases to help avert cuts in health care payment rates, benefits, or services and to prevent changes to income eligibility requirements that would reduce the number of individuals eligible for Medicaid. Sections 5001(a), (b), and (c) of the Recovery Act provide that a State's increased FMAP during the recession adjustment period will be no less than its 2008 FMAP increased by 6.2 percentage points, and that a State may receive an increase greater than 6.2 percentage points based on increases to its average unemployment rate.

With the Recovery Act funding, Iowa's FMAP for Medicaid costs increased from 62.62 percent to 68.82 percent for the quarter ended March 31, 2009.

¹The Education, Jobs, and Medicaid Assistance Act (P.L. No. 111-226) extended the recession adjustment period for the increased FMAP through June 30, 2011.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures with supporting documentation.

Quarterly Medicaid Statement of Expenditures Oversight

On a quarterly basis, CMS Regional office staff members perform a desk review on the amounts reported on the CMS-64 report, a review that is designed to provide CMS with limited assurance that the report complies with applicable Federal laws, regulations, and policy guidance and is filed in compliance with CMS reporting requirements.

Medicaid Management Information System

Section 1903(R)(1) of the Act states that, to receive Federal funding for the use of automated data systems in administration of the Medicaid program, a State must have a mechanized claims processing and information retrieval system. Pursuant to chapter 11, section 11100, of the CMS *State Medicaid Manual*, this mechanized system is the Medicaid Management Information System (MMIS). An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. This system may be operated by either a State agency or a fiscal agent, which is a private contractor hired by the State agency.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

Scope

The State agency claimed Medicaid costs totaling approximately \$557.4 million (approximately \$384.1 million Federal share) for the quarter ended March 31, 2009. Our review covered eight judgmentally selected line items on the CMS-64 report totaling approximately \$449.5 million (approximately \$309.8 million Federal share), which constituted approximately 80 percent of the State agency's claimed costs for the quarter.² The eight line items were for Inpatient Hospital Services, Nursing Facilities Services, Physicians' Services, Prescribed Drugs, Outpatient

² We obtained the costs that the State agency claimed and the judgmentally selected costs that we reviewed from the Form 64.9 Base of the CMS-64 report; however, these amounts did not include adjustments. Although we reviewed the adjustments for the eight selected line items, the net adjustments were immaterial.

Hospital Services, Intermediate Care Facility (Public), Intermediate Care (Private), and Coinsurance.

In addition, the State agency claimed approximately \$194.0 million (approximately \$134.0 million Federal share) in waivers. Of the claimed waivers, we judgmentally selected the waiver that had the largest amount of associated costs (Waiver Number 15, Waiver Name “MR”) that totaled approximately \$74.7 million (approximately \$51.4 million Federal share).³ On the basis of the costs associated with the eight judgmentally selected line items as well as the costs associated with the selected waiver, we sampled a total of approximately \$524.2 million (approximately \$361.2 million Federal share).

Our objective did not require a review of the State agency’s overall internal control structure. Therefore, we limited our internal control review to the State agency’s procedures for aggregating and reporting Medicaid costs on the CMS-64 report for the quarter ended March 31, 2009.

We conducted fieldwork at the State agency in Des Moines, Iowa, from March 1, 2010, through March 5, 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, and applicable portions of the Iowa State Medicaid plan;
- interviewed CMS officials responsible for monitoring the CMS-64 report to gain an understanding of the process used by CMS to review the CMS-64 report;
- interviewed State agency officials to gain an understanding of their policies and procedures for reporting Medicaid costs on the CMS-64 report and of the systems used by the State agency for reporting Medicaid costs;
- judgmentally selected for review eight line items, whose costs comprised approximately 80 percent of the total costs claimed on the base form of the CMS-64 report, as well as the waiver with the largest amount of associated costs;
- reviewed the CMS-64 report for the quarter ending March 31, 2009, and compared the amounts claimed for Federal reimbursement to the information in the State agency’s MMIS and to the State agency’s accounting records;

³ We obtained the waiver-related costs that the State agency claimed and the judgmentally selected costs that we reviewed from the Forms 64.9 Waiv on the CMS-64 report; however, these amounts did not include adjustments. Although we reviewed the adjustments for the selected waiver, the net adjustments were immaterial.

- reviewed the information in the State agency’s MMIS to assess whether duplicate payments occurred and to identify any errors in the MMIS data; and
- discussed our results with the State agency on January 26, 2011.

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 objective.

FINDINGS AND RECOMMENDATIONS

For the quarter ended March 31, 2009, the majority of the Medicaid costs that the State agency claimed in the eight reviewed line items (as well as a waiver), which totaled approximately \$524.2 million (approximately \$361.2 million Federal share), was adequately supported by actual recorded expenditures. However, the State agency incorrectly paid:

- \$10,659 (\$7,869 Federal share) for 58 outpatient and co-insurance claims that were duplicates of claims previously paid. These duplicate payments occurred due to errors in manual adjustments and data entry errors. The State agency recovered 50 of the 58 duplicate payments totaling \$9,500 (\$7,014 Federal share) before the beginning of our review. Accordingly, \$1,158 (\$855 Federal share) of the incorrect payments had not been recovered prior to our identification of these duplicates.
- \$9,249,304 (\$6,828,761 Federal share) for two claims to different physicians because in each case the State agency copied the provider number into the amount to pay, a data entry error that resulted in payments up to 886 times higher than the next largest payment to any physician. The State agency identified the errors before the checks were cashed and canceled the payments before submission of the CMS-64 report. However, the identification of this error took place outside the framework of both the State agency’s existing policies and procedures and the internal controls that were in place at the time.

Although the State agency’s internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures, as well as some internal controls, can be strengthened.

DUPLICATE PAYMENTS

Federal Requirements

Section 1902(a) of the Act states: “A State plan for medical assistance must.... (37) provide for claims payment procedures which ... (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider

of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.”

Federal regulations at 42 CFR § 447.45 implement section 1902(a)(37) of the Act and state: “(f) *Prepayment and postpayment claims review*. (1) For all claims, the agency must conduct prepayment claims review consisting of ... (iii) [v]erification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed.” (Italics in original.)

Incorrect Provider Payments

The State agency incorrectly paid 58 outpatient and co-insurance claims to Medicaid providers totaling \$10,659 (\$7,869 Federal share) for claims that were duplicates of claims previously paid. These duplicate payments occurred due to errors in manual adjustments and data entry errors. The State agency identified the following specific reasons why these errors occurred:

- Some providers submitted claims in hardcopy form without revenue codes and also submitted these claims electronically as either an inpatient or outpatient claim, which resulted in these claims being coded manually as Part B crossover claims and paid twice.⁴
- The State agency’s MMIS did not check for duplicate payments when issuing gross adjustments.⁵ Because these gross adjustments involved previously paid claims, they constituted duplicate payments.
- The State agency could not enter the procedure code into the MMIS because the procedure code was not annotated on the *Explanation of Medicare Benefits* paper form for that beneficiary.
- The State agency entered the incorrect procedure codes on the claims.

State agency officials informed us that as a result of these errors, the State agency implemented the following procedures to reduce or eliminate duplicate payments (we did not verify these corrective actions):

- Crossover claims that do not have procedure codes are returned to the provider for additional information. This procedure was implemented in October 2010.
- Claims editing has been implemented to increase edits that look at historical paid claims and access claim types for potential duplicates. This procedure was implemented in July 2010.

⁴ A crossover claim is a claim that has been approved for payment by Medicare and sent to Medicaid for payment towards the Medicaid deductible and coinsurance within the Medicaid program limits.

⁵ Gross adjustment requests are force payments or recoupments generated within the MMIS. A gross adjustment request does not have to be related to a specific claim.

- New data mining tools have been implemented to search for potential duplicate claims. This procedure was implemented in November 2010.

The State agency recovered 50 of the 58 duplicate payments totaling \$9,500 (\$7,014 Federal share) before the beginning of our review. Accordingly, \$1,158 (\$855 Federal share) of the incorrect payments had not been recovered prior to our identification of these duplicates.

DATA ENTRY ERRORS

Federal Requirements

Pursuant to 2 CFR pt. 225, *Cost Principles for State, Local and Indian Tribal Governments* (formerly Office of Management and Budget Circular A-87), Appendix A, § C.2:

Reasonable Costs. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally-funded. In determining reasonableness of a given cost, consideration shall be given to:

- a. Whether the cost was of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award.
- b. The restraints or requirements imposed by such factors as: sound business practices; arm's-length bargaining; Federal, State and other laws and regulations; and, terms and conditions of the Federal award.
- c. Market prices for comparable goods or services.
- d. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the Federal Government.
- e. Significant deviations from the established practices of the governmental unit which may unjustifiably increase the Federal award's cost.

The CMS *State Medicaid Manual*, section 11300, "General Requirements," requires that each State agency's MMIS have minimum edits to ensure that the data field contents are proper, accurate, and reasonable.

Incorrect Provider Payments

During our review, State agency officials made us aware of an error which they had identified and corrected prior to the submission of the CMS-64 report for the quarter ended

March 31, 2009. However, the identification of this error took place outside the framework of both the State agency's existing policies and procedures and the internal controls that were in place at the time.

During the quarter under review, data entry errors at the State agency level (involving copying and pasting of information) caused incorrect payments to be made to two physicians because in each case the State agency copied the provider number into the amount to pay. The two errors totaled a combined \$9,249,304 (\$6,828,761 Federal share). The State agency identified the errors before the checks were cashed and cancelled the payments before submission of the CMS-64 report. The amounts of the checks were far in excess of what the State agency would reasonably pay to any physician for any procedure during our review period. The two checks that were incorrectly issued to the two physicians were 16 times and 886 times, respectively, more than the next largest payment made to any physician during our review period.

State agency personnel identified these data entry errors during an ad hoc review of stale dated checks.⁶ The State agency's procedure was to review stale dated checks after 180 days subsequent to their issuance. Because the two incorrect checks would not have been more than 180 days old at the time that the State agency submitted its CMS-64 report for that quarter, the State agency's procedure would not ordinarily have detected these incorrect payments.

State agency officials confirmed that the State agency did not have any official written policy or procedure that would have prevented the error at the time of our audit. However, as a result of this error, the State agency informed us that it subsequently instituted two new procedures: (1) to review the 10 highest provider payments for each daily run cycle, and (2) to prohibit the copying and pasting of information to the claims data during data entry. According to the State agency, these procedures were implemented in April 2009.

INADEQUATE POLICIES AND PROCEDURES AND INTERNAL CONTROLS

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures, as well as some internal controls, can be strengthened.

RECOMMENDATIONS

We recommend that the State agency:

- recover the \$1,158 (\$855 Federal share) for the eight claims not recovered and
- continue to strengthen policies and procedures and internal controls, particularly those involving manual adjustments and data entry procedures, to ensure that Medicaid

⁶ Stale dated checks are checks for which the financial institution has notified the issuer (in this case, the State agency) that the checks have not been cashed.

payments to providers are not duplicates and are reasonable for the procedures being performed.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with both of our recommendations and described corrective action that it had taken or planned to implement.

The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS



STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

MAY 13 2011

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Iowa*, Report Number: A-07-11-03165

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS) on the April 20, 2011 draft report concerning Office of Inspector General's (OIG) *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Iowa*.

DHS appreciates the opportunity to respond to the draft report and provide additional comments to be included in the final report. Questions about the attached response can be addressed to:

Jody Lane-Molnari, Executive Officer
Division of Fiscal Management
Iowa Department of Human Services
Hoover State Office Building, 1st Floor SW
1305 E Walnut Street
Des Moines, IA 50319-0114

Email: janemo@dhs.state.ia.us
Phone: 515-281-6027

Sincerely,

A handwritten signature in black ink, appearing to read "C.M. Palmer".

Charles M. Palmer
Director

cc: Greg Tambke, Audit Manager
Attachment

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**Iowa Department of Human Services
Response to OIG Draft Report**

**Review of the Quarterly Statement of Expenditures
For the Medical Assistance Program in Iowa
Audit Report Number: A-07-11-03165**

Background

Pursuant to Title XIX of the Social Security 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. In Iowa, the Department of Human Services (the State agency) administers the Medicaid program.

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures with supporting documentation.

State Medicaid programs must provide certain medical services, including inpatient and outpatient hospital, physician, and family planning services. States also may offer certain optional services, such as outpatient prescription drugs, as long as the services are included in their approved State plans.

OIG Findings and Recommendation

For the quarter ended March 31, 2009, the majority of the Medicaid costs that the State agency (DHS) claimed in the eight reviewed line items (as well as a waiver), which totaled approximately \$524.2 million (approximately \$361.2 million Federal share), were in accordance with Federal requirements and adequately supported by detailed records. However, the State agency incorrectly paid:

- \$10,659 (\$7,869 Federal share) for 58 outpatient and co-insurance claims that were duplicates of claims previously paid. These duplicate payments occurred due to errors in manual adjustments and data entry errors. The State agency recovered 50 of the 58 duplicate payments totaling \$9,500 (\$7,014 Federal share) before the beginning of our review. Accordingly, \$1,158 (\$855 Federal share) of the incorrect payments had not been recovered prior to our identification of these duplicates.

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- \$9,249,304 (\$6,828,761 Federal share) for two claims to different physicians because in each case the State agency copied the provider number into the amount to pay, a data entry error that resulted in payments up to 886 times higher than the next largest payment to any physician. The State agency identified the errors before the checks were cashed and canceled the payments before submission of the CMS-64 report. However, the identification of this error took place outside the framework of both the State agency's existing policies and procedures and the internal controls that were in place at the time.

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that were reviewed for this quarter were claimed correctly, these findings indicate that some policies and procedures, as well as some internal controls, can be strengthened.

OIG recommends that DHS:

- Recover the \$1,158 (\$855 Federal share) for the eight claims not recovered; and
- Continue to strengthen policies and procedures and internal controls, particularly those involving manual adjustments and data entry procedures, to ensure that Medicaid payments to providers are not duplicates and are reasonable for the procedures being performed.

DHS Response

DHS concurs with both of the recommendations as detailed below. Following are the corrective actions taken and planned for the findings:

- Upon issuance of the final report and formal request for repayment, DHS will work with the Kansas City Regional CMS office to make the necessary adjustment to refund the federal share (\$855) for the eight claims not recovered.

Program improvements have been implemented and additional improvements are planned as specified in the following:

Program Improvements Already Implemented

- Cross over claims that do not have procedure codes are returned to the provider for additional information. This process was implemented in October 2010.
- Correct Coding Initiative (CCI) and claims editing has been implemented to increase the edits that look at historical paid claims and across claim types for potential duplicates. CCI was implemented July 1, 2010.
- New data mining tools were implemented November 11, 2010 to perform look backs for duplicate claims.

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- Operational procedures and policies have been implemented to prohibit identified staff from using cut and paste keying when entering gross adjustments. This change was implemented in April 2009.
- A report was created that identifies the top 10 payments each payment cycle. The report is reviewed to look for payments out of the ordinary. This was implemented in April 2009. It is not uncommon for inpatient claims to have large dollar amounts, so the report has since been modified to exclude claims that are electronically submitted and focus on claims that are manually keyed.
- Since July 2010, all claim types from the weekly payment cycle for claims that appear to be "outliers" are being reviewed. The focus of this review is on claims paid that are higher than submitted charges and on the highest dollar amount of paid claims for each claim type. This has resulted in adding max units values to certain J-codes and surgery codes in the MMIS.

Program Improvements Planned

- A planning process is underway to require providers to enumerate consistently between Medicare and Medicaid at the time the provider enrolls or re-enrolls with Medicaid.