



December 8, 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 Washington State's Medicaid Claims for Nonqualified Aliens
(A-09-09-00039)

Attached, for your information, is an advance copy of our final report on Washington State's Medicaid claims for nonqualified aliens. We will issue this report to the Washington State Department of Social and Health Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-09-00039.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

December 15, 2010

Report Number: A-09-09-00039

Mr. Doug Porter
Medicaid Director, Administrator
Health Care Authority
676 Woodland Square Loop
P.O. Box 42700
Olympia, WA 98504-2700

Dear Mr. Porter:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Washington State's Medicaid Claims for Nonqualified Aliens*. 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 (415) 437-8360, or contact Janet Tursich, Audit Manager, at (206) 615-2063 or through email at Janet.Tursich@oig.hhs.gov. Please refer to report number A-09-09-00039 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
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
WASHINGTON STATE'S
MEDICAID CLAIMS FOR
NONQUALIFIED ALIENS**



Daniel R. Levinson
Inspector General

December 2010
A-09-09-00039

Office of Inspector General

<http://oig.hhs.gov>

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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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

Section 1903(v) of the Social Security Act (the Act) and Federal regulations (42 CFR § 440.255) state that Federal Medicaid funding is available to States for medical services provided to nonqualified aliens only when those services are necessary to treat an emergency medical condition. A nonqualified alien is an individual who is not a citizen or national of the United States and is not in a satisfactory immigration status.

The Act and Federal regulations define an emergency medical condition as a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Further, Federal regulations specify that there must be "sudden onset" of the condition. The Centers for Medicare & Medicaid Services (CMS) allows States to identify which conditions qualify as emergency medical conditions.

In Washington State, the Department of Social and Health Services (the State agency) administers the Medicaid program. The State agency reimburses providers for emergency medical services provided to nonqualified aliens under the Alien Emergency Medical (AEM) program. The Washington Administrative Code, section 388-500-0005, uses the definition of an emergency medical condition contained in Federal regulations. The State agency's policies and procedures for the AEM program are contained in its *Eligibility A-Z Manual* (the Manual). The Manual contains a list of medical conditions defined as emergency medical conditions.

To qualify for the AEM program, an individual must meet all eligibility requirements for the Medicaid program except for citizenship and have a condition that is listed in the Manual or have prior approval from a State medical consultant for medical conditions that are not listed in the Manual. Once the State agency has deemed an individual eligible for the AEM program, he or she is certified for a minimum of 3 months and receives a medical assistance identification card (Medicaid card), which states that the individual is authorized to receive emergency and related services. During calendar years (CY) 2006 and 2007, pursuant to the Washington Administrative Code, nursing home services required prior approval from a State medical consultant, who was responsible for determining whether the services were needed to treat an emergency medical condition.

During our audit period (July 1 through December 31, 2006), the State agency claimed approximately \$52.9 million for services provided to nonqualified aliens. We expanded our review to include \$6.7 million of nursing home claims for CYs 2006 and 2007 (of which \$1.3 million was in our audit period).

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement for services provided to nonqualified aliens in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always claim Federal reimbursement for services provided to nonqualified aliens in accordance with Federal and State requirements:

- Contrary to the Washington Administrative Code, the State agency claimed \$1,519,801 (\$759,901 Federal share) for nursing home services provided without prior approval from a State medical consultant. In addition, the State agency informed us that some beneficiaries were misclassified and not eligible for the AEM program.
- Contrary to the Manual, the State agency claimed \$6,353 (\$3,177 Federal share) for various medical services provided to treat conditions that were not on the Manual's list of qualifying emergency medical conditions and not otherwise authorized. This deficiency occurred because the Medicaid cards issued to nonqualified aliens allowed them to receive services for conditions that were not defined as emergency medical conditions. In addition, the State agency's Medicaid Management Information System (MMIS) did not have edits limiting claims for services provided to nonqualified aliens to treatment of conditions that the State agency defined as emergency medical conditions or to services that had been approved by a State medical consultant.
- The State agency claimed \$1,488,979 (\$744,490 Federal share) for prescription drugs and \$369,454 (\$184,727 Federal share) for dental services that the State agency could not determine were related to treating emergency medical conditions. This deficiency occurred because the Medicaid card was not effective in limiting services to treatment of only conditions defined as emergency medical conditions. In addition, the claims did not include diagnostic codes identifying the conditions for which drugs and dental services had been ordered. Therefore, the State agency could not determine whether it properly claimed \$1,858,433 (\$929,217 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund \$763,078 to the Federal Government for nursing home services (\$759,901 Federal share) and various medical services (\$3,177 Federal share) that were improperly claimed,
- work with CMS to determine what portion of the \$1,858,433 (\$929,217 Federal share) claimed for prescription drugs and dental services was related to emergency medical conditions and refund any improperly claimed amounts,
- ensure that only nursing home claims that receive prior approval from a State medical consultant and that are eligible for the AEM program are claimed for reimbursement,
- ensure that the Medicaid cards issued to nonqualified aliens limit services to those necessary to treat conditions defined as emergency medical conditions, and

- ensure that the MMIS edits limit claims for services provided to nonqualified aliens to treatment of conditions that the State agency has defined as emergency medical conditions or to services approved by a State medical consultant.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency concurred with our recommendations and stated that it had already refunded \$759,901 to the Federal Government for nursing home services that were improperly claimed in CYs 2006 and 2007. Because the State agency provided its comments in multiple emails, we have not attached the comments to this report.

Our review of the State agency's accounting records confirmed that the State agency refunded to the Federal Government \$759,901 for improperly claimed nursing home services.

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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 low-income 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.

Emergency Medical Services for Nonqualified Aliens

Pursuant to section 401(b)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. No. 104-93), an alien who is not a qualified alien¹ is not eligible for any Federal public benefit except for medical assistance under Title XIX of the Act for “care and services necessary for the treatment of an emergency medical condition (as defined in section 1903(v) of such Act) of the alien involved and [that] are not related to an organ transplant procedure.”

Section 1903(v) of the Act and Federal regulations (42 CFR § 440.255) state that Federal Medicaid funding is available to States for medical services provided to nonqualified aliens only when those services are necessary to treat an emergency medical condition. For the purposes of this report, a nonqualified alien is an individual who is not a citizen or national of the United States and is not in a satisfactory immigration status.² This category includes aliens who are not qualified under section 401 of the PRWORA and qualified aliens subject to the 5-year bar³ specified in section 403 of the PRWORA.

The Act and Federal regulations define an emergency medical condition as a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Further, Federal regulations specify that there must be “sudden onset” of the condition. CMS allows States to identify which conditions qualify as emergency medical conditions.

¹ A qualified alien is defined in section 431(b) of the PRWORA as (1) an alien lawfully admitted for permanent residence, (2) an alien granted asylum, (3) a refugee admitted to the United States, (4) an alien paroled into the United States for a period of at least 1 year, (5) an alien whose deportation is being withheld, or (6) an alien granted conditional entry.

² Section 1137(d)(1)(B)(iii) of the Act states that “the term ‘satisfactory immigration status’ means an immigration status which does not make the individual ineligible for benefits under the applicable program.”

³ The 5-year bar applies to legal aliens who entered the United States on or after August 22, 1996, and who are not eligible for Medicaid for a period of 5 years from the date they entered the country as legal aliens.

Washington State's Alien Emergency Medical Program

In Washington State, the Department of Social and Health Services (the State agency) administers the Medicaid program. The State agency reimburses providers for emergency medical services provided to nonqualified aliens under the Alien Emergency Medical (AEM) program. The State agency claims Federal reimbursement for AEM expenditures on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

The Washington State plan limits coverage of nonqualified aliens to care and services necessary for treatment of an emergency medical condition. The Washington Administrative Code, section 388-500-0005, uses the definition of an emergency medical condition contained in Federal regulations.

The State agency's policies further define an emergency medical condition as one in which a patient's condition will become an emergency medical condition within days to weeks if the patient is not treated. The State agency's policies and procedures for the AEM program are contained in its *Eligibility A–Z Manual* (the Manual). The Manual contains a list of medical conditions defined as emergency medical conditions (Appendix A).

To qualify for the AEM program, an individual must meet all eligibility requirements for the Medicaid program except for citizenship and have a condition that is listed in the Manual or have prior approval from a State medical consultant for medical conditions that are not listed in the Manual. Once the State agency has deemed an individual eligible, he or she is certified for a minimum of 3 months and receives a medical assistance identification card (Medicaid card), which states that the individual is authorized to receive emergency and related services.⁴ The Medicaid card for the AEM program looks identical to the regular Medicaid card except for the words "Emergency and Related Services. PA [Prior Approval] May Be Required."

The State agency grants certification periods longer than 3 months for certain medical conditions. For example, the following conditions all have a 12-month certification period: amputation of limb—traumatic; cancer requiring surgery, radiation, or chemotherapy; HIV-positive with complications or opportunistic infections; renal failure, either acute or requiring dialysis; insulin-dependent diabetes mellitus; post-organ-transplant care; and tuberculosis.

During calendar years (CY) 2006 and 2007, pursuant to the Washington Administrative Code, nursing home services required prior approval from a State medical consultant, who was responsible for determining whether the services were needed to treat an emergency medical condition.

⁴ Pregnant women who qualify for the AEM program receive a Medicaid card that states "CNP" (Categorically Needy Person). Pregnant women are eligible for labor and delivery services in addition to emergency and related services. Prenatal care services are not covered.

Medicaid Management Information System

The State agency's Medicaid Management Information System (MMIS) processes AEM claims. A contractor, Affiliated Computer Services, operates the MMIS. The MMIS processes claims based on eligibility information in the State agency's Automated Client Eligibility System. For the AEM program, the MMIS classifies nonqualified aliens as either undocumented aliens or legal aliens under the 5-year bar.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal reimbursement for services provided to nonqualified aliens in accordance with Federal and State requirements.

Scope

Our audit covered the 6-month period ended December 31, 2006. During this period, the State agency processed 151,482 claims totaling \$52,874,921 (\$26,437,461 Federal share) for services provided to nonqualified aliens. (Appendix B provides a summary of these claims.) We expanded our review to include \$6,652,896 (\$3,326,448 Federal share)⁵ of nursing home claims for CYs 2006 and 2007.

We relied on the MMIS database that the State agency provided to us to identify the State agency's claims under the AEM program. We did not contact medical service providers or review client medical records as part of this audit. We did not review the eligibility of nonqualified aliens for Medicaid. We did not reconcile the \$6,652,896 of nursing home claims for CYs 2006 and 2007 (except for the \$1,273,996 in our 6-month audit period) because the dollar amount could not be separated from the total on the Form CMS-64.

For the 6-month audit period, we judgmentally selected 50 claims totaling \$138,186 (\$69,093 Federal share) to determine whether the State agency claimed services provided to nonqualified aliens for conditions that the State agency did not define or approve as emergency medical conditions.

For the 6-month audit period, we reviewed prescription drug claims totaling \$1,504,967 (\$752,484 Federal share) and dental service claims totaling \$369,454 (\$184,727 Federal share).

We conducted our fieldwork at the State agency in Olympia, Washington.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations;

⁵ This amount included \$1,273,996 (\$636,998 Federal share) of nursing home claims in our 6-month audit period.

- reviewed the State agency’s policies and procedures and AEM program instructions related to the payment of AEM claims for services provided to nonqualified aliens (contained in the Manual);
- obtained an understanding of the State agency’s MMIS for processing AEM claims;
- reviewed the State agency’s internal controls for ensuring that only emergency services provided to nonqualified aliens were claimed on the Form CMS-64;
- reconciled \$52,874,921 of AEM claims to the amount reported on the Form CMS-64;
- judgmentally selected 50 claims from the MMIS database totaling \$138,186 for services provided to nonqualified aliens (based on our evaluation of higher risk areas), consisting of 10 claims for labor and delivery services, 10 claims for dialysis services, 7 claims for cancer treatments, 6 claims for nursing home services, 1 claim for a dental service, and 16 claims for services to treat other medical conditions;⁶
- reviewed the MMIS database to identify all claims for prescription drugs and dental services that did not contain diagnosis codes; and
- interviewed CMS and 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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not always claim Federal reimbursement for services provided to nonqualified aliens in accordance with Federal and State requirements:

- Contrary to the Washington Administrative Code, the State agency claimed \$1,519,801 (\$759,901 Federal share) for nursing home services provided without prior approval from a State medical consultant. In addition, the State agency informed us that some beneficiaries were misclassified and not eligible for the AEM program.
- Contrary to the Manual, the State agency claimed \$6,353 (\$3,177 Federal share) for various medical services provided to treat conditions that were not on the Manual’s list of qualifying emergency medical conditions and not otherwise authorized. This deficiency occurred because the Medicaid cards issued to nonqualified aliens allowed them to receive services for conditions that were not defined as emergency medical conditions.

⁶ We considered higher risk areas to be services for conditions that did not appear to meet the definition of an emergency medical condition, such as contraception, eye care, and medical equipment.

In addition, the State agency's MMIS did not have edits limiting claims for services provided to nonqualified aliens to treatment of conditions that the State agency defined as emergency medical conditions or to services that had been approved by a State medical consultant.

- The State agency claimed \$1,488,979 (\$744,490 Federal share) for prescription drugs and \$369,454 (\$184,727 Federal share) for dental services that the State agency could not determine were related to treating emergency medical conditions. This deficiency occurred because the Medicaid card was not effective in limiting services to treatment of only conditions defined as emergency medical conditions. In addition, the claims did not include diagnostic codes identifying the conditions for which drugs and dental services had been ordered. Therefore, the State agency could not determine whether it properly claimed \$1,858,433 (\$929,217 Federal share).

FEDERAL AND STATE REQUIREMENTS

Pursuant to section 1903(v)(1) of the Act:

... no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. ... Payment shall be made under this section for care and services that are furnished to an alien ... only if—(A) such care and services are necessary for the treatment of an emergency medical condition of the alien, (B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title ... and (C) such care and services are not related to an organ transplant procedure.

Pursuant to section 1903(v)(3) of the Act:

... the term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(A) placing the patient’s health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.

Federal regulations (42 CFR § 440.255) use the same definition of an emergency medical condition as the Act, with one additional requirement: There must be “sudden onset” of the condition.

The Washington State plan, Attachment 2.6-A, page 2, section 3(c), states that each individual covered under the plan is residing in the United States and “[i]s either an alien who is not a qualified alien, as defined in P.L. [No.] 104-193, as amended, or who is a qualified alien Subject to the five-year bar in section 403 of that Act, who entered the United States August 22, 1996 or

later. (Coverage of such otherwise eligible aliens is limited to care and services necessary to treat an emergency medical condition of the alien.)”

The Washington Administrative Code, section 388-438-0110(7)(f), states that nursing facility services provided to nonqualified aliens are not covered unless they are approved by the State agency’s medical consultant.

IMPROPERLY CLAIMED SERVICES FOR NONQUALIFIED ALIENS

Nursing Home Services Claimed Without Prior Approval

The State agency improperly claimed \$1,519,801 (\$759,901 Federal share) for nursing home services. Contrary to the Washington Administrative Code, some services were provided without prior approval from a State medical consultant. In addition, the State agency informed us that some beneficiaries were misclassified and not eligible for the AEM program.

Our judgmental selection of 50 claims included 6 claims for nursing home services. For one of these claims, representing \$5,851 (\$2,926 Federal share), the services did not receive prior approval from a State medical consultant as required. State agency officials told us that they believed they were no longer claiming nursing home costs under the AEM program.

We informed the State agency that there were 575 claims for nursing home services, totaling \$1,273,996, in our 6-month audit period. Based on the results of our judgmental sample, we asked the State agency to review all nursing home claims under the AEM program for CYs 2006 and 2007. The State agency determined that \$2,888,179 of the \$6,652,896⁷ claimed for nursing home services in this period was unallowable according to section 388-438-0110(7)(f) of the Washington Administrative Code and some beneficiaries were misclassified and not eligible for the AEM program. In addition, the State agency found that it had already removed \$1,368,378 from the AEM program in July 2007 for nursing home services. The State agency informed us that it needed to remove \$1,519,801 of additional unallowable nursing home costs and refund \$759,901 to the Federal Government.

Medical Services Claimed for Treatment of Conditions Not Defined as Emergency Medical Conditions

The State agency improperly claimed \$6,353 (\$3,177 Federal share) for various medical services not allowed by its policies for the AEM program. Our judgmental selection of 50 claims included 43 claims for medical services. Of these claims, 17 claims totaling \$6,353 (\$3,177 Federal share) were for services to treat conditions that the State agency did not define as emergency medical conditions or that a State medical consultant did not approve:

- 5 claims for services related to contraception;
- 5 claims for eye care, including fitting of contact lenses and glasses;

⁷ The \$6.7 million includes the \$1.3 million from our 6-month audit period.

- 3 claims for medical equipment (i.e., a blood pressure monitor, hearing aid, and sleep apnea device);
- 2 claims for office visits not related to treatment of emergency medical conditions;
- 1 claim for sterilization; and
- 1 claim for a legal abortion.

The remaining 26 services were to treat conditions that the State agency defined as emergency medical conditions.

This deficiency occurred because the beneficiary Medicaid card was not effective in limiting services to treatment of only conditions defined as emergency medical conditions. The beneficiary presented the Medicaid card to the provider and received service in spite of the information printed on the card: “Emergency and Related Services. PA May Be Required.” In addition, the MMIS did not have edits to limit payments only to services for conditions defined as emergency medical conditions or that had been approved by a State medical consultant.

Prescription Drugs and Dental Services Claimed That May Not Have Been for Treatment of Emergency Medical Conditions

The State agency claimed \$1,488,979 (\$744,490 Federal share) for prescription drugs and \$369,454 (\$184,727 Federal share) for dental services that the State agency could not determine were related to treating emergency medical conditions. This deficiency occurred because the Medicaid card was not effective in limiting services to treatment of only conditions defined as emergency medical conditions. In addition, the claims did not include diagnostic codes identifying the conditions for which drugs and services had been ordered. Therefore, the State agency could not determine whether it properly claimed \$1,858,433 (\$929,217 Federal share).

Prescription Drug Claims

When we attempted to sample prescription drug claims from the MMIS database, we determined that 99 percent of prescription drug claims did not include diagnostic codes. These codes identify the physician’s diagnosis of the condition associated with the service or drug. Without a diagnostic code on the claim, the State agency could not determine from the claim data whether the drug was prescribed to treat a medical condition that it had defined or approved as an emergency medical condition.

When we asked the State agency about the missing diagnostic codes for drug claims, State agency officials said that they had conducted a risk assessment of the AEM program for the period October 2004 through June 2005.⁸ This assessment, on page 6, noted: “The MMIS system does not normally include diagnosis codes with a pharmacy claim. It is therefore, difficult to determine if any of these claims represent prescriptions to treat an emergent medical

⁸ *Alien Emergency Medical Risk Assessment Project*, prepared by the State agency’s Health and Recovery Services Administration, Division of Business and Finance, Office of Finance, dated September 28, 2005.

condition.” As part of this assessment, the State agency reviewed 25,050 drug claims and found that only 7 percent of these claims could be associated with a condition that was “almost always emergent.” For the remaining 93 percent, the State agency could not associate a diagnosis with an emergency medical condition. Examples of prescription drugs that the State agency could not determine were related to treating emergency medical conditions were drugs used to treat Alzheimer’s disease, depression, and glaucoma.

Dental Service Claims

Our judgmental selection of 50 claims included one dental service claim for dentures. Because the Medicaid card was not effective in limiting services to treatment of only conditions that the State agency defined as emergency medical conditions and this claim did not include a diagnostic code, the State agency could not determine whether the service was to treat an emergency medical condition. When we reviewed the MMIS database to identify dental claims, we determined that none of them contained diagnostic codes; however, the claims did include procedure codes. Procedure codes did not identify whether the services were to treat emergency medical conditions but did identify procedures such as restorations (fillings), oral evaluations and examinations (periodic and comprehensive), and preventive services (cleanings and fluoride treatments).

RECOMMENDATIONS

We recommend that the State agency:

- refund \$763,078 to the Federal Government for nursing home services (\$759,901 Federal share) and various medical services (\$3,177 Federal share) that were improperly claimed,
- work with CMS to determine what portion of the \$1,858,433 (\$929,217 Federal share) claimed for prescription drugs and dental services was related to emergency medical conditions and refund any improperly claimed amounts,
- ensure that only nursing home claims that receive prior approval from a State medical consultant and that are eligible for the AEM program are claimed for reimbursement,
- ensure that the Medicaid cards issued to nonqualified aliens limit services to those necessary to treat conditions defined as emergency medical conditions, and
- ensure that the MMIS edits limit claims for services provided to nonqualified aliens to treatment of conditions that the State agency has defined as emergency medical conditions or to services approved by a State medical consultant.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency concurred with our recommendations and stated that it had already refunded \$759,901 to the Federal Government for nursing home

services that were improperly claimed in CYs 2006 and 2007. Because the State agency provided its comments in multiple emails, we have not attached the comments to this report.

Our review of the State agency's accounting records confirmed that the State agency refunded to the Federal Government \$759,901 for improperly claimed nursing home services.

APPENDIXES

**APPENDIX A: LIST OF EMERGENCY MEDICAL CONDITIONS IN
WASHINGTON STATE'S 2006 ELIGIBILITY A-Z MANUAL**

Amputation of limb—traumatic
Appendicitis—acute
Asphyxia (strangling/drowning)
Asthma attack—acute
Bowel obstruction, infarction, or perforation
Cancer (requiring surgery, radiation, or chemotherapy)
Cardiac arrest/heart attack/acute myocardial infarction
Cerebral vascular accident, stroke
Coma
Concussion
Convulsion/seizure
Deep vein thrombosis
Diabetic keto-acidosis
Dislocation of joints
Ectopic pregnancy
Electrocution
Eye injury
Fracture
Gangrene
HIV-positive with complications or opportunistic infections
Hypothermia
Infection, cellulitis, or abscess
Infectious cholecystitis—acute
Insulin-dependent diabetes mellitus
Laceration of artery, nerve, or tendon
Laceration or cut requiring sutures, staples, or glue
Liver failure—acute
Malignant hypertension
Meningitis—viral, bacterial, or fungal
Pancreatitis—acute
Pneumothorax
Poisoning due to food, drugs, or overdose
Post-organ-transplant care, including immunosuppressant medication
Pyelonephritis—acute
Renal failure—acute or requiring dialysis
Respiratory failure/breathing cessation
Sunstroke/heatstroke
Traumatic brain injury
Traumatic injury
Tuberculosis
Ulcer (peptic or gastric) with bleeding, perforation, and/or obstruction

**APPENDIX B: TOTAL CLAIMS FOR SERVICES PROVIDED TO
NONQUALIFIED ALIENS**
(July 1 Through December 31, 2006)

Category of Claims	Claim Amount	No. of Claims
Labor and Delivery	\$35,996,275	84,380
Renal Failure	2,413,081	2,394
Cancer Treatments	1,770,984	3,064
Services for Other Medical Conditions	9,546,164	17,531
Nursing Home Services	<u>1,273,996</u>	<u>575</u>
Total Medical Conditions	\$51,000,500	107,944
Prescription Drugs	1,504,967	39,304
Dental Services	<u>369,454</u>	<u>4,234</u>
Total	\$52,874,921	151,482

Note: The dollar amounts shown represent both the State and Federal shares. For reporting purposes, we used a Federal medical assistance percentage (FMAP) of 50 percent for the audit period. The actual FMAP during the audit period ranged from 50.00 percent to 50.12 percent.