
Part II: Medicaid Reviews

Part II: Medicaid Reviews

Table of Contents

Hospitals	1
Medicaid Disproportionate Share Hospital Payment Distribution	1
Other Services, Equipment, and Supplies.....	2
Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services	2
Arizona’s Medicaid Claims for School-Based Health Services	3
New Jersey’s Medicaid Claims for School-Based Health Services	3
Prescription Drugs	4
Medicaid Compound Drug Expenditures in California.....	4
Medicaid Administration.....	5
Excluded Medicaid Providers: Analysis of Enrollment.....	5
Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program.....	6
Analysis of Improper Payments Identified in the Payment Error Rate Measurement Program.....	6
Reporting Medicaid Overpayments in Michigan	7
Tennessee’s Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.....	7
Compliance With the Recovery Act’s Political Subdivision Requirement.....	8
Compliance With the Recovery Act’s Medicaid Eligibility Requirements	8
Compliance With the Recovery Act’s Prompt Pay Requirements.....	9
Compliance With the Recovery Act’s Medicaid Expenditure Base Requirements	9
New Jersey’s Compliance With the Recovery Act’s Reserve Fund Requirements	10
Other Medicaid-Related Issues	10
Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area	10
Hurricane-Related Uncompensated Care Claims in Louisiana	11
Medicaid and Children’s Health Insurance Program Concurrent Enrollees in Florida.....	11

NOTE: Summaries of OIG audit and evaluation reports in this publication contain rounded figures. Monetary amounts in case narratives are rounded to the next lower dollar, where appropriate.

Part II: Medicaid Reviews

Hospitals

Medicaid > Hospitals > Disproportionate Share Payments

Medicaid Disproportionate Share Hospital Payment Distribution

During Federal fiscal years (FY) 2003 through 2007, most of the seven selected States (Kansas, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas) reimbursed State-owned institutions for mental disease (IMD) and other State-owned hospitals the highest proportion of uncompensated care costs. The Medicaid disproportionate share hospital (DSH) program requires States to make special payments, known as DSH payments, to hospitals that serve unusually large numbers of low-income and/or uninsured patients. The Federal Government reimburses States for a percentage of their DSH payments.

We classified hospitals according to four categories: State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals. In comparing DSH payments between hospital categories, we found that three of the seven States reimbursed State-owned IMDs the highest proportion of uncompensated care costs, three other States reimbursed other State-owned hospitals the highest proportion of uncompensated care costs, and one State reimbursed private hospitals the highest proportion of uncompensated care costs.

In analyzing the relationship between DSH payments and uncompensated care costs for all of the hospitals classified as DSH hospitals in the seven States, we found that, in the aggregate, State-owned IMDs received DSH payments averaging 92 percent of their uncompensated care costs, other State-owned hospitals received DSH payments averaging 95 percent of their uncompensated care costs, local public hospitals received DSH payments averaging 69 percent of their uncompensated care costs, and private hospitals received DSH payments averaging 38 percent of their uncompensated care costs.

We recommended that the Centers for Medicare & Medicaid Services (CMS) evaluate how DSH payments are distributed among hospital categories and consider requesting congressional legislation to ensure a more even distribution of payments based on uncompensated care costs. CMS concurred with our recommendation and noted that recent congressional action may affect DSH payments. ([A-07-09-04150](#))

Other Services, Equipment, and Supplies

[Medicaid](#) > [Services](#) > [Children](#)

Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services

Most children in nine selected States are not fully benefitting from Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive screening services. Services provided under the EPSDT benefit are intended to screen, diagnose, and treat children eligible for EPSDT services at early, regular intervals to avoid or minimize childhood illness. EPSDT services cover four health-related areas: medical, vision, hearing, and dental. Complete medical screenings under the EPSDT benefit must include the following five age appropriate components: a comprehensive health and developmental history, a comprehensive unclothed physical examination, appropriate immunizations according to age and health history, appropriate laboratory tests, and health education. This study focused on medical, vision, and hearing screenings.

Seventy-six percent of children, or 2.7 million children, in 9 selected States did not receive all of the required number of medical, vision, and hearing screenings. Forty-one percent of children did not receive any required medical screenings. In addition, more than half of children did not receive any required vision or hearing screenings. Fifty-five percent of children in the nine States received a medical screening during the study period. Of these children, 59 percent lacked at least one component of a complete medical screening. The component that children were missing most often was appropriate laboratory tests.

Officials from all nine selected States identified strategies to improve participation in the EPSDT and the completeness of medical screenings. However, additional efforts are required.

Based on these findings, we recommended that CMS (1) require States to report vision and hearing screenings, (2) collaborate with States and providers to develop effective strategies to encourage beneficiary participation in EPSDT screenings, (3) collaborate with States and providers to develop education and incentives for providers to encourage complete medical screenings, and (4) identify and disseminate promising State practices for increasing children's participation in EPSDT screenings and providers' delivery of complete medical screenings.

CMS concurred with most of our recommendations and stated that it is undertaking efforts in conjunction with States and national experts to improve the provision of EPSDT services. Specifically, CMS concurred, in part, with our first recommendation and concurred with our other three recommendations. ([OEI-05-08-00520](#))

Medicaid > Services > Children

Arizona’s Medicaid Claims for School-Based Health Services

Arizona did not always claim Federal reimbursement for Medicaid school-based health services in accordance with Federal and State requirements. Of the 100 sampled student-months from the period January 1, 2004, to June 30, 2006, 46 had 1 or more school-based health services that were not allowable. Based on our sample results, we estimated that the State was improperly reimbursed at least \$21.3 million in Federal Medicaid funds for school-based health services. Medicaid pays for medical services provided to children under Part B of the Individuals with Disabilities Education Act of 2004 (IDEA) through a child’s individualized education plan. In addition to meeting other Federal and State requirements, school-based health services must be (1) actually furnished, (2) fully documented, (3) provided by an individual who meets Federal and State qualification requirements, (4) prescribed or referred by a physician or another appropriate professional, and (5) provided to eligible recipients.

We recommended that Arizona (1) refund to the Federal Government \$21.3 million for unallowable school-based health services, (2) review periods after our audit period and make appropriate financial adjustments for any unallowable school-based health services, (3) strengthen its oversight of the Direct Service Claiming program to ensure that claims for school-based health services comply with Federal and State requirements, and (4) revise its policy manuals to ensure compliance with Federal and State requirements. Arizona concurred with our second, third, and fourth recommendations but did not concur with our recommended refund. We continue to recommend that Arizona refund the \$21.3 million. ([A-09-07-00051](#))

Medicaid > Services > Children

New Jersey’s Medicaid Claims for School-Based Health Services

In two reviews, we found that New Jersey’s claims for reimbursement of Medicaid school-based health services submitted by its billing agents did not fully comply with Federal and State requirements. In addition to meeting other Federal and State requirements, school-based health services must be (1) referred or prescribed by a physician or another appropriate professional, (2) provided by an individual who meets Federal and State qualification requirements, (3) fully documented, (4) actually furnished, and (5) documented in the child’s individualized education plan. During our audit periods, New Jersey contracted with separate billing agents to help administer its Medicaid school-based health services program under contingency-fee-based agreements. The results of our reviews follow:

- Billing agent A. Based on our sample results for the period July 27, 2003, through October 4, 2006, we estimated that New Jersey was improperly reimbursed \$8 million in Federal Medicaid funds. Of the 100 school-based health claims in our sample, 51 did not comply with Federal and State requirements. The 51 claims pertained to services that were not (1) provided or supported, (2) in compliance with referral or prescription requirements,

(3) in compliance with Federal provider qualification requirements, or (4) documented in the child's plan.

We recommended that New Jersey refund \$8 million to the Federal Government, provide proper and timely guidance on Federal Medicaid criteria to its school-based health providers, and improve its monitoring of school-based health providers' claims to ensure compliance with Federal and State requirements. New Jersey disagreed with our recommended refund and provided additional documentation for claims questioned in our draft report. New Jersey also questioned our sampling methodology. After reviewing the additional documentation, we revised our findings and reduced the recommended refund to \$8 million. We maintain that our sampling methodology was valid. ([A-02-07-01051](#))

- **Billing agent B.** Based on our sample results for the period April 6, 2005, through June 27, 2007, we estimated that New Jersey was improperly reimbursed \$5.6 million in Federal Medicaid funds. Of the 100 school-based health claims in our sample, 36 did not comply with Federal and State requirements. The 36 claims pertained to services that were not (1) provided or supported, (2) in compliance with referral or prescription requirements, (3) in compliance with Federal provider qualification requirements, and (4) documented in the child's plan.

We recommended that New Jersey refund \$5.6 million to the Federal Government and consider the results of this review in its evaluation of our prior recommendations to ensure that its school-based health providers comply with Federal and State requirements. New Jersey disagreed with our recommended refund and provided additional documentation for claims questioned in our draft report. New Jersey also questioned our sampling methodology. After reviewing the additional documentation, we revised our findings and reduced the recommended refund to \$5.6 million. We maintain that our sampling methodology was valid. ([A-02-07-01052](#))

Prescription Drugs

[Medicaid > Prescription Drugs > Federal Share](#)

Medicaid Compound Drug Expenditures in California

California's claims for reimbursement of Medicaid compound drug expenditures for FYs 2004 and 2005 did not fully comply with Federal requirements. Of the \$29.5 million (Federal share) reviewed, \$383,000 represented expenditures for compound drug ingredients that were not eligible for Medicaid coverage because the drugs were dispensed after their termination dates. In addition, the State claimed \$1.3 million for compound drug ingredients that were not listed on the quarterly drug tapes and that may not have been eligible for Federal reimbursement. Medicaid generally covers outpatient drugs if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. Under the Medicaid drug rebate program, CMS provides the States with a quarterly Medicaid drug tape, which lists all covered outpatient

drugs, indicates each drug's termination date if applicable, and specifies whether the Food and Drug Administration (FDA) has determined the drug to be less than effective. CMS guidance instructs the States to use the tape to verify coverage of the drugs for which they claim reimbursement.

We recommended that California (1) refund \$383,000 for expenditures for compound drug ingredients that were not eligible for Medicaid coverage, (2) work with CMS to resolve \$1.3 million in expenditures for compound drug ingredients that were not listed on the quarterly drug tapes and that may not have been eligible for Medicaid coverage, and (3) ensure that claimed Medicaid compound drug expenditures comply with Federal requirements. California agreed with our second recommendation and did not specifically address our other recommendations. ([A-09-08-00034](#))

Medicaid Administration

Medicaid > Administration > Provider Enrollment

Excluded Medicaid Providers: Analysis of Enrollment

Of 188 providers from 26 States who had been excluded by OIG subsequent to their enrollment, 8 had disclosed false ownership information at the time of enrollment. Another 8 of the 188 had criminal convictions before they enrolled and committed health care-related crimes after they enrolled. Of the 188 excluded providers, 88 had Federal or State tax liens before or after they enrolled in Medicaid and 24 had a history of tax debt, criminal convictions, or false disclosures before they enrolled.

We examined the providers' backgrounds before and after they enrolled to gather information related to potential weaknesses in States' provider enrollment procedures. In addition, we surveyed the 26 States that enrolled the 188 providers about the procedures they used to enroll the providers and the process they currently use to enroll providers.

Pursuant to Federal regulations at 42 CFR § 455.104 and 42 CFR § 455.106, States require providers to disclose information on ownership and control of an entity and criminal convictions related to Federal health care programs. However, the regulations do not require States to verify this information. We found that States impose few enrollment requirements beyond those mandated by Federal regulations. Over half of the excluded providers were subject to no State enrollment requirements beyond the Federal regulations when they enrolled in Medicaid. CMS agreed with our results. ([OEI-09-08-00330](#))

Medicaid > Administration > Payment Error Rate

Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program

We were unable to determine whether the Payment Error Rate Measurement (PERM) program produced a reasonable estimate of improper FY 2007 fee-for-service and managed care payments for both Medicaid and the Children's Health Insurance Program (CHIP) because (1) CMS's statistical contractor sampled payments from State universes that were or may have been incomplete or inaccurate, (2) the estimate of improper CHIP payments did not meet the required precision levels, and (3) CMS did not review States' repricing actions.

The Improper Payments Information Act of 2002 (IPIA) requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. CMS developed the PERM program to comply with requirements for measuring improper Medicaid program and CHIP payments. The PERM program has measured improper payments made in the fee-for-service, managed care, and eligibility components of Medicaid and CHIP since FY 2007.

We recommended that CMS (1) continue to work with the States, CMS regional offices, and the statistical contractor on reconciling the PERM universes to State financial reports; (2) work with the Office of Management and Budget (OMB) to establish new PERM precision-level requirements; (3) request the States to verify the accuracy of all repriced claims and submit documentation supporting the repricing; and (4) test repriced claims for accuracy. CMS agreed with our findings and proposed corrective actions. ([A-06-08-00078](#))

Medicaid > Administration > Payment Error Types

Analysis of Improper Payments Identified in the Payment Error Rate Measurement Program

Of 1,356 PERM program medical review errors that we analyzed for FYs 2006 and 2007, 4 types accounted for 78 percent of the errors and 95 percent of the net improper Medicaid overpayments. The four error types were insufficient documentation, no documentation, services that violated State policies, and medically unnecessary services. Of the 202 PERM program data-processing errors that we analyzed for the same period, 4 types accounted for 8 percent of the errors and 64 percent of the net improper Medicaid overpayments. The four error types were pricing errors, noncovered services, rate cell errors for managed care claims, and errors in the logic edits of claim-processing systems. The PERM program annually measures improper payments based on sampled Medicaid claims in 17 States (including the District of Columbia as a State); each State is chosen once every 3 years.

We recommended that, for future years, CMS develop and provide to the States analytical data similar to the data in this report and encourage the States to use the data to help ensure that payments, including those funded by the American Recovery and Reinvestment Act of 2009

(Recovery Act), comply with Federal requirements. CMS concurred and said that it would implement the recommendation starting with the FY 2010 measurement cycle. ([A-06-09-00079](#))

Medicaid > Administration > Federal Share

Reporting Medicaid Overpayments in Michigan

In two reviews summarized below, we determined that Michigan did not report all Medicaid overpayments in accordance with Federal requirements. Federal law requires States to refund the Federal share of a Medicaid overpayment made to a provider, and Federal regulations require States to refund the Federal share at the end of the 60-day period following the date of discovery, whether or not the State has recovered the overpayment.

- Fiscal years 2008 and 2009. For Federal fiscal years 2008 and 2009, we estimated that Michigan did not report Medicaid overpayments totaling \$2.3 million (\$1.3 million Federal share) in accordance with Federal requirements. The State also did not report all Medicaid overpayments within the 60-day time requirement. Because the State did not report some overpayments and was not prompt in reporting others, the Federal Government incurred a potentially higher interest expense. We recommended that the State (1) include unreported Medicaid overpayments of \$2.3 million on Form CMS-64 and refund \$1.3 million to the Federal Government and (2) develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments on Form CMS-64. The State concurred with our recommendations. ([A-05-09-00103](#))
- First quarter of fiscal year 2010. Our review found that for the quarter ended December 31, 2009, Michigan did not report \$3 million (\$2.2 million Federal share) in Medicaid overpayments in accordance with Federal requirements because of a clerical error. The State did not properly report these overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on Form CMS-64. We recommended that the State (1) include unreported Medicaid overpayments of \$3 million on Form CMS-64 and refund \$2.2 million to the Federal Government and (2) develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments. The State concurred with our recommendations and said that it had included the \$3 million on a subsequent Form CMS-64. ([A-05-10-00061](#))

Medicaid > Administration > Recovery Act

Tennessee's Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

We found that Tennessee's claim for Federal reimbursement of expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program for the quarter ended December 31, 2008, was adequately supported by actual recorded expenditures. The Recovery Act 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' Federal medical assistance percentages (FMAP). For the majority of Medicaid expenditures claimed, CMS reimburses States based on the FMAP, which varies depending on a State's relative per capita income. For the quarter ended December 31, 2008, Tennessee's regular FMAP for Medicaid expenditures was 64.28 percent, and the temporarily increased FMAP was 73.25 percent. This report contains no recommendations. ([A-04-09-04040](#))

Medicaid > Administration > Recovery Act

Compliance With the Recovery Act's Political Subdivision Requirement

New York State complied with the political subdivision requirement for receiving the increased FMAP under the Recovery Act. Specifically, the State did not require its social services districts (i.e., political subdivisions) to contribute a greater percentage of the non-Federal share of Medicaid expenditures than the percentage required under the State Medicaid plan on September 30, 2008. A State is not eligible for the increased FMAP if it requires its political subdivisions to pay a greater percentage of the non-Federal share of Medicaid expenditures than the percentage required under the State Medicaid plan on September 30, 2008. This report contains no recommendations. ([A-02-09-01029](#))

Medicaid > Administration > Recovery Act

Compliance With the Recovery Act's Medicaid Eligibility Requirements

As described below, five States that we reviewed complied with Recovery Act eligibility requirements during the first three quarters of Federal FY 2009. Accordingly, we made no recommendations. Pursuant to the Recovery Act, States generally are not eligible for FMAP increases for quarters during the recession adjustment period in which their Medicaid eligibility standards, methodologies, or procedures are more restrictive than those in effect on July 1, 2008.

- Louisiana, Minnesota, New Hampshire, and Rhode Island. In all four States, the Medicaid eligibility standards, methodologies, and procedures during the audit period were not more restrictive than those in effect on July 1, 2008. ([A-06-09-00100](#); [A-05-10-00014](#); [A-01-10-00002](#); [A-01-09-00007](#))
- Texas. Texas made one policy change after July 1, 2008, that resulted in more restrictive Medicaid eligibility standards, methodologies, and procedures during the audit period. However, in accordance with the Recovery Act, the State reinstated the less restrictive policy before July 1, 2009. The State also made administrative policy changes that did not affect the eligibility process. ([A-06-09-00099](#))

Compliance With the Recovery Act's Prompt Pay Requirements

With one exception that was concurrently resolved, we found New York and Pennsylvania to be in sufficient compliance with prompt pay requirements for receiving an increased FMAP under the Recovery Act. Federal regulations require States to pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt. A clean claim is a claim that can be processed without obtaining additional information from the provider or a third party. The results of our reviews follow.

- New York. For the 6-month period January 1 through June 30, 2009, New York State complied with the prompt pay requirement for receiving an increased FMAP. Specifically, the State paid 100 percent of the 125,618,625 clean claims that it received from applicable providers within 30 days of the date of receipt. This report has no recommendations. ([A-02-09-01037](#))
- Pennsylvania. Pennsylvania complied with the prompt pay requirement for receiving an increased FMAP for claims received on all days from February 16, 2009, through September 30, 2009. In addition, all practitioner, nursing facility, and hospital claims received after May 31, 2009, met the requirements for an increased Federal share. The State did not meet the 30-day prompt pay requirement for claims received on any day from January 20, 2009, through February 15, 2009, and for claims received on November 29, 2008, and December 13, 2008. However, during our review, the State requested a waiver of the prompt pay requirement for claims submitted by practitioners that were received by the State before February 18, 2009. CMS granted the waiver; therefore, we have no recommendations. ([A-03-09-00204](#))

Compliance With the Recovery Act's Medicaid Expenditure Base Requirements

Reviews in two States of the Recovery Act's Medicaid expenditure base requirements had mixed results as described below. Pursuant to the Recovery Act, States must have policies and procedures in place to segregate Medicaid expenditures that qualify for the temporarily increased FMAP during the recession adjustment period and to ensure that those Medicaid expenditures that do not qualify are not claimed for reimbursement at the temporarily increased FMAP. We reviewed two States' compliance with this requirement for the period October 1, 2008, through March 31, 2009, as follows:

- Colorado. Colorado's \$142 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act, and the expenditures were supported by the State's accounting records. Colorado had policies and procedures in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that those Medicaid expenditures that did not

qualify were not claimed for reimbursement at the temporarily increased FMAP. However, the State had not documented all of its policies and procedures. We recommended that Colorado document all of its policies and procedures for claiming the temporary FMAP increase. The State partially concurred with our recommendation. ([A-07-09-02767](#))

- Delaware. Delaware's \$60 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act, and the expenditures were supported by the State's accounting records. The State had policies and procedures in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that those Medicaid expenditures that did not qualify were not claimed for reimbursement at the temporarily increased FMAP. The State had correctly documented and disseminated these policies and procedures. This report contains no recommendations. ([A-03-09-00202](#))

Medicaid > Administration > Recovery Act

New Jersey's Compliance With the Recovery Act's Reserve Fund Requirements

Our review found that New Jersey complied with the Recovery Act reserve fund requirement for receiving the increased FMAP. Specifically, the State did not use additional Medicaid funding to supplement any reserve account. Under the Recovery Act, a State is not eligible for the increased FMAP if any amounts attributable (directly or indirectly) to such an increase are deposited in or credited to any reserve, or "rainy day," fund. We made no recommendations. ([A-02-09-01030](#))

Other Medicaid-Related Issues

Other Issues > Gulf Coast Hurricanes

Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area

We were not able to express an opinion on \$26 million that Louisiana awarded to health care professionals from March 1 through December 31, 2007, because we discovered after our fieldwork was complete that practitioner contracts may have been improperly signed. In addition, of the \$5.3 million that the State awarded to 100 sampled awardees during the period, \$1.4 million was not awarded to 20 awardees in accordance with the grant terms. Based on our sample results, we estimated that the State did not award \$5.8 million of grant funds to 85 awardees in accordance with the grant terms. The \$50 million Federal grant, which covered the period March 1, 2007, through September 30, 2012, funded payments to licensed health care professionals for their retention and recruitment in communities impacted by Hurricane Katrina.

We recommended, among other things, that the State (1) cancel the undistributed awards related to the \$1.4 million in grants that were not awarded according to the grant terms and (2) credit the grant account for distributed awards. The State generally agreed with our findings and recommendations. ([A-06-08-00026](#))

Other Issues > Gulf Coast Hurricanes

Hurricane-Related Uncompensated Care Claims in Louisiana

Louisiana did not always claim reimbursement for services provided by one hospital in accordance with Federal and State laws and regulations or with the approved provisions of the uncompensated care pool (UCCP) plan. In response to Hurricane Katrina, the Deficit Reduction Act of 2005 authorized Federal funding for the total costs of medically necessary uncompensated care furnished to evacuees and affected individuals without other coverage in eligible States. CMS approved Louisiana's UCCP plan to reimburse providers for medically necessary services provided to Hurricane Katrina evacuees and affected individuals and to Hurricane Rita evacuees without other coverage.

Of the \$3.7 million in costs claimed for services provided to 86 patients, \$3.4 million was unallowable. Louisiana claimed the unallowable costs because it (1) did not have procedures to ensure that it claimed uncompensated care costs only for services covered under the Medicaid plan; (2) relied on the hospital to verify that the costs claimed were based on actual inpatient days; (3) did not offset its uncompensated care claim by payments received from other sources on behalf of the patients; and (4) did not have procedures to verify that patients whose costs were claimed under the Hurricane Rita UCCP were, in fact, evacuees.

We recommended that Louisiana refund to CMS the \$3.4 million in unallowable costs claimed. Because the State's authorization to obtain Federal reimbursement for hurricane-related uncompensated care has ended, we made no procedural recommendations. The State disagreed with our findings and recommendation. Nothing in the State's comments caused us to revise our findings or recommendation. ([A-06-09-00084](#))

Other Issues > CHIP > Federal Share

Medicaid and Children's Health Insurance Program Concurrent Enrollees in Florida

Based on our sample results, we estimated that from April 1, 2007, through March 31, 2008, Florida claimed \$5.3 million in Federal financial participation (FFP), or matching funds, for CHIP enrollees who were concurrently enrolled in CHIP and Medicaid for a total 65,121 enrollment-months. If an individual is eligible for Medicaid, he or she is ineligible for CHIP. The Federal Government uses enhanced FMAPs to determine the amount of FFP for State expenditures in CHIP. The concurrent enrollments occurred primarily because (1) Medicaid enrollment can be retroactive for up to 3 months, during which time the individual may also

have been enrolled in CHIP, and (2) the State agency's partners did not have adequate internal controls to prevent or correct concurrent enrollments promptly.

We recommended that the State (1) make a financial adjustment of \$5.3 million on Form CMS-21 for FFP claimed on behalf of CHIP enrollees who were also enrolled concurrently in Medicaid, (2) make regular financial adjustments on future Forms CMS-21 to correct FFP claimed on behalf of CHIP enrollees who are enrolled concurrently in Medicaid, and (3) develop additional policies and procedures to prevent or recoup CHIP payments made on behalf of individuals who are enrolled concurrently in Medicaid. The State disagreed with our overall findings. ([A-04-09-03046](#))