

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MISSOURI CLAIMED UNALLOWABLE
MEDICAID PAYMENTS FOR INDIVIDUALS
WITH INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES IN
INTERMEDIATE CARE FACILITIES**

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



**Gloria L. Jarmon
Deputy Inspector General**

June 2013
A-07-12-03180

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EXECUTIVE SUMMARY

Missouri claimed \$7.2 million of unallowable Medicaid payments for services provided to individuals with intellectual and developmental disabilities in intermediate care facilities during State fiscal year 2011.

WHY WE DID THIS REVIEW

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) provide housing and supportive services to individuals with intellectual and developmental disabilities. Medicaid reimburses ICFs/MR for services. A previous Office of Inspector General review found that another State did not always comply with Federal requirements when claiming Medicaid payments for ICFs/MR.

The Social Security Act requires that payments for services be consistent with efficiency and economy. In addition, the Centers for Medicare & Medicaid Services (CMS) *State Medicaid Manual* requires that amounts that States report for Medicaid reimbursement represent actual expenditures with supporting documentation.

The objectives of this review were to determine whether (1) Medicaid payment rates for ICFs/MR met the Federal requirement that payment for services be consistent with efficiency and economy and (2) Federal reimbursement for Medicaid payments to ICFs/MR was claimed in accordance with Federal requirements.

BACKGROUND

The Department of Social Services, Missouri HealthNet Division (State agency), administers the provision and payment of Medicaid services. ICFs/MR include State-operated and privately operated facilities. These facilities receive reimbursement based on a predetermined per diem rate.

The CMS-approved Missouri State Medicaid plan, Attachment 4-19D, page 224, specifies that reimbursements to State-operated ICFs/MR are based solely on the individual Medicaid recipient's days of care, multiplied by the facility's per diem rate, plus an additional payment from the supplemental enhancement pool; this additional payment is known as the Upper Payment Limit (UPL). The Missouri State Medicaid plan, Attachment 4-19D, page 174, also specifies that reimbursements to privately operated ICFs/MR are based on the individual Medicaid recipient's days of care multiplied by the facility's per diem rate. There is no additional UPL payment for privately operated ICFs/MR.

Each quarter, State Medicaid agencies report ICF/MR expenditures on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The amounts reported must be actual expenditures that have supporting documentation. Medicaid payments for State-operated ICFs/MR are claimed on

line 4a of the CMS-64 report; Medicaid payments for privately operated ICFs/MR are claimed on line 4b of the CMS-64 report. CMS uses the CMS-64 report to reimburse States for the Federal share of Medicaid expenditures.

WHAT WE FOUND

During State fiscal year (FY) 2011 (July 1, 2010, through June 30, 2011), the Medicaid payment rates for ICFs/MR appeared to meet the Federal requirement that payment for services be consistent with efficiency and economy. However, the State agency did not always claim Federal reimbursement for Medicaid payments to State-operated ICFs/MR in accordance with Federal requirements. Specifically, the State agency claimed a total of \$10,010,234 (\$7,170,414 Federal share) in unallowable Medicaid payments for State FY 2011, which consisted of:

- duplicate Medicaid payments totaling \$9,850,026 (\$7,053,604 Federal share) that were a result of the same UPL payments being claimed for reimbursement for the quarter ended December 2010 and again for the quarter ended March 2011 and
- unsupported Medicaid payments totaling \$160,208 (\$116,810 Federal share) that we identified during our reconciliation of total expenditures claimed on the CMS-64 reports to actual claims.

These errors occurred because the State agency did not have adequate internal controls and procedures in place to prevent the claiming of unallowable Medicaid payments.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$7,170,414 to the Federal Government and
- develop and implement sufficient internal controls and procedures, including those pertaining to reconciliations of payments to claimed costs, to prevent the claiming of duplicate or unsupported Medicaid payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially agreed with our first recommendation. Specifically, the State agency agreed to refund the entire \$7,170,414 that we questioned. However, the State agency believed that the entire overpayment was attributable to UPL overclaiming. The State agency agreed with our second recommendation and described corrective action that it had implemented.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to change our findings or recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) provide housing and supportive services to individuals with intellectual and developmental disabilities. Medicaid reimburses ICFs/MR for these services. A previous Office of Inspector General review found that another State did not always comply with Federal requirements when claiming Medicaid payments for ICFs/MR.¹

The Social Security Act requires that payments for services be consistent with efficiency and economy. In addition, the Centers for Medicare & Medicaid Services (CMS) *State Medicaid Manual* requires that amounts that States report for Medicaid reimbursement represent actual expenditures with supporting documentation.

OBJECTIVES

Our objectives were to determine whether (1) Medicaid payment rates for ICFs/MR met the Federal requirement that payment for services be consistent with efficiency and economy and (2) Federal reimbursement for Medicaid payments to ICFs/MR was claimed in accordance with Federal requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), reports 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. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income.²

¹ *Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive* (A-02-11-01029), issued May 17, 2012.

² Pursuant to the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, as amended by P.L. No. 111-226, States' FMAPs were temporarily increased for the period October 1, 2008, through June 30, 2011.

Missouri Medicaid Program

In Missouri, the Department of Social Services, Missouri HealthNet Division (State agency), administers the provision and payment of Medicaid services. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

Missouri Intermediate Care Facilities for the Mentally Retarded

In Missouri, the Department of Mental Health, Division of Developmental Disabilities, oversees ICFs/MR. Both State-operated and privately operated ICFs/MR receive reimbursement based on predetermined per diem payment rates, which are derived from each facility's actual total costs.

The CMS-approved Missouri State Medicaid plan, Attachment 4-19D, page 224, specifies that reimbursements to State-operated ICFs/MR are based solely on the individual Medicaid recipient's days of care, multiplied by the ICF/MR's per diem payment rate, plus an additional payment from the supplemental enhancement pool; this additional payment is known as the Upper Payment Limit (UPL).³ Medicaid payments for State-operated ICFs/MR are claimed on line 4a of the CMS-64 report.

The Missouri State Medicaid plan, Attachment 4-19D, page 174, also specifies that reimbursements to privately operated ICFs/MR are based on the individual Medicaid recipient's days of care multiplied by the ICF/MR's per diem payment rate. There is no additional UPL payment for privately operated ICFs/MR. Medicaid payments for privately operated ICFs/MR are claimed on line 4b of the CMS-64 report.

HOW WE CONDUCTED THIS REVIEW

We reviewed Medicaid payments to State-operated ICFs/MR totaling \$73,454,420 (\$52,842,477 Federal share) and Medicaid payments to privately operated ICFs/MR totaling \$6,100,155 (\$4,428,412 Federal share), for which the State agency claimed Federal reimbursement during State fiscal year (State FY) 2011 (July 1, 2010, through June 30, 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 objectives.

Appendix A contains details of our audit scope and methodology, and Appendix B contains details on the Federal and State requirements related to ICFs/MR.

³ The Missouri State Medicaid plan, Attachment 4.19-D, page 229, allows for each State-operated ICF/MR to be paid an annual supplement, payable in quarterly installments, to increase aggregate reimbursements to State-operated ICFs/MR to the amount that the State reasonably estimates would have been paid under Medicare Payment Principles.

FINDINGS

During State FY 2011, the Medicaid payment rates for ICFs/MR appeared to meet the Federal requirement that payment for services be consistent with efficiency and economy. However, the State agency did not always claim Federal reimbursement for Medicaid payments to State-operated ICFs/MR in accordance with Federal requirements. Specifically, the State agency claimed a total of \$10,010,234 (\$7,170,414 Federal share) in unallowable Medicaid payments for State FY 2011, which consisted of:

- duplicate Medicaid payments totaling \$9,850,026 (\$7,053,604 Federal share) that were a result of the same UPL payments being claimed for reimbursement for the quarter ended December 2010 and again for the quarter ended March 2011 and
- unsupported Medicaid payments totaling \$160,208 (\$116,810 Federal share) that we identified during our reconciliation of total expenditures claimed on the CMS-64 reports to actual claims.

These errors occurred because the State agency did not have adequate internal controls and procedures in place to prevent the claiming of unallowable Medicaid payments.

MEDICAID PAYMENT RATES APPEARED TO MEET FEDERAL REQUIREMENT

Section 1902(a)(30)(A) of the Social Security Act requires that payment for services be consistent with efficiency and economy.

Medicaid payment rates for ICFs/MR appeared to meet the Federal requirement that payment for services be consistent with efficiency and economy. The average payment rate in Missouri for State-operated ICFs/MR during State FY 2011 was approximately \$517, as compared with the average payment rate for privately operated ICFs/MR of approximately \$204 during the same timeframe. However, we found the difference to be justified based on our observations when conducting onsite visits at the State-operated and privately operated ICFs/MR. We found that the State-operated ICFs/MR provided services to more beneficiaries with more complex needs, operated larger facilities, had greater staffing needs, and provided a wider range of services. In addition, the State-operated ICFs/MR actual total costs were much higher than the actual total costs at the privately operated ICFs/MR based on our review of the rate calculations.

STATE AGENCY CLAIMED DUPLICATE MEDICAID PAYMENTS

Federal requirements (42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, § 2500.2) state that the amounts reported on the CMS-64 report and its attachments must represent actual expenditures with supporting documentation.

The State agency claimed Federal reimbursement for duplicate Medicaid payments to State-operated ICFs/MR during the quarter ended March 2011. Specifically, the State agency claimed the same UPL payments for State-operated ICFs/MR during the quarter ended December 2010 and again during the quarter ended March 2011.

These duplicate payments were unallowable and, therefore, were not claimed in accordance with Federal requirements. As a result, the State agency claimed unallowable Medicaid payments totaling \$9,850,026 (\$7,053,604 Federal share) during State FY 2011.

STATE AGENCY CLAIMED UNSUPPORTED MEDICAID PAYMENTS

Federal requirements (42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, § 2500.2) state that the amounts reported on the CMS-64 report and its attachments must represent actual expenditures with supporting documentation.

The State agency claimed unsupported Medicaid payments for State-operated ICFs/MR during State FY 2011. Specifically, we identified unsupported Medicaid payments during our reconciliation of total expenditures claimed on the CMS-64 reports to actual claims for State-operated ICFs/MR during State FY 2011. As a result of these errors, the State agency overstated total expenditures on the CMS-64 reports during State FY 2011.

These unsupported payments received by the State agency were unallowable and, therefore, were not claimed in accordance with Federal requirements. As a result, the State agency claimed unallowable Medicaid payments totaling \$160,208 (\$116,810 Federal share) during State FY 2011.

STATE AGENCY DID NOT HAVE ADEQUATE CONTROLS AND PROCEDURES

On the basis of our audit results, the State agency claimed a total of \$10,010,234 (\$7,170,414 Federal share) in unallowable Medicaid payments. These errors occurred because the State agency did not have adequate internal controls and procedures in place to prevent the claiming of these payments. Specifically, the State agency's controls did not specify that the State agency perform reconciliations of payments to claimed costs to ensure that it did not claim duplicate or unsupported Medicaid payments.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$7,170,414 to the Federal Government and
- develop and implement sufficient internal controls and procedures, including those pertaining to reconciliations of payments to claimed costs, to prevent the claiming of duplicate or unsupported Medicaid payments.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially agreed with our first recommendation. The State agency agreed to refund the entire \$7,170,414 (Federal share) that we questioned, but its calculation of the duplicate Medicaid payments differed from the amount that we calculated. Specifically, the State agency said that it had refunded \$7,106,579 on its CMS-64 report for the quarter ended December 31, 2012, and added that it would refund the remaining \$63,835 through an adjustment on its CMS-64 report for the quarter ended June 30, 2013. In addition, the State agency said that the \$63,835 was related to the overclaiming of the UPL rather than to unsupported payments. The State agency agreed with our second recommendation and described corrective action that it had implemented.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to change our findings, our recommendations, or our calculations of the duplicate Medicaid payments. In developing our finding that the duplicate Medicaid payments were a result of the same UPL payments being claimed for reimbursement for the quarter ended December 2010 and again for the quarter ended March 2011, we used actual total costs for our calculations that were supported by the UPL letters provided by the State agency.

OTHER MATTERS

Federal requirements (42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, § 2500.2) state that the amounts reported on the CMS-64 report and its attachments must represent actual expenditures with supporting documentation. In conjunction with these requirements, the CMS-64 Medicaid Budget and Expenditure System and State Children's Health Insurance Budget and Expenditure System (MBES CBES), Category of Service Line Definitions, provides guidance on the category of services claimed on each line of the CMS-64 report.⁴

As stated in Appendix A, the State agency claimed Federal reimbursement for Medicaid payments to State-operated ICFs/MR totaling \$73,812,074 (\$53,102,649 Federal share) during State FY 2011. The State agency claimed Federal reimbursement for Medicaid payments to privately operated ICFs/MR totaling \$185,016,084 (\$133,582,903 Federal share) during the same time period. Of these claimed amounts, we reviewed payments to State-operated ICFs/MR totaling \$73,454,420 (\$52,842,477 Federal share) and payments to privately operated ICFs/MR totaling \$6,100,155 (\$4,428,412 Federal share) in this audit.

⁴ The MBES CBES is a Web-based application that State Medicaid agencies use to report budgeted and actual expenditures for Medicaid and the Children's Health Insurance Program.

During our review, we also identified Medicaid payments totaling \$357,654 (\$260,172 Federal share) for which the State agency claimed reimbursement on line 4a of the CMS-64 reports for State FY 2011 but that involved services not associated with ICFs/MR. In addition, we identified Medicaid payments totaling \$178,915,929 (\$129,154,491 Federal share) for which the State agency claimed reimbursement on line 4b of the CMS-64 reports for State FY 2011 but that involved services not associated with ICFs/MR.

Services not associated with ICFs/MR but for which payments were claimed on lines 4a and 4b of the CMS-64 reports included (but were not limited to) alcohol and/or drug assessments, psychiatric diagnostic interview examinations, crisis intervention services, targeted case management services, and other community treatment and rehabilitation services.

We removed these claimed payments from our audit scope for this review. We have asked the State agency to give us supporting documentation for these Medicaid payments and will review these payments in a subsequent audit to determine whether these expenditures were allowable.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

The State agency claimed Federal reimbursement for Medicaid payments to State-operated ICFs/MR totaling \$73,812,074 (\$53,102,649 Federal share) during State FY 2011. The State agency claimed Federal reimbursement for Medicaid payments to privately operated ICFs/MR totaling \$185,016,084 (\$133,582,903 Federal share) during the same period. We did not review \$357,654 (\$260,172 Federal share) and \$178,915,929 (\$129,154,491 Federal share) that the State agency claimed on lines 4a and 4b, respectively, of the CMS-64 reports for State FY 2011; see “Other Matters.” Therefore, for the current audit we reviewed Medicaid payments to State-operated ICFs/MR totaling \$73,454,420 (\$52,842,477 Federal share) and Medicaid payments to privately operated ICFs/MR totaling \$6,100,155 (\$4,428,412 Federal share) for which the State agency claimed Federal reimbursement during State FY 2011. (See the tables below).

Table 1: State-Operated ICFs/MR – Line 4a

	Total Computable	Federal Share
CMS-64 report	\$73,812,074	\$53,102,649
Less: amount not associated with ICFs/MR	357,654	260,172
Total amount reviewed	\$73,454,420	\$52,842,477

Table 2: Privately Operated ICFs/MR – Line 4b

	Total Computable	Federal Share
CMS-64 report	\$185,016,084	\$133,582,903
Less: amount not associated with ICFs/MR	178,915,929	129,154,491
Total amount reviewed	\$6,100,155	\$4,428,412

We did not perform a detailed review of the State agency’s internal controls because our objectives did not require us to do so. We limited our review to the controls that pertained directly to our objectives.

We conducted fieldwork at the State agency in Jefferson City, Missouri; at State-operated and privately operated ICFs/MR in St. Louis, Missouri; and at a State-operated ICF/MR in Marshall, Missouri; from June through November 2012.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, Federal and State regulations, and the approved Missouri State Medicaid plan;

- held discussions with officials from CMS, the State agency, the Missouri Department of Mental Health, and the Missouri Division of Finance and Administrative Services to gain an understanding of Missouri's per diem rate methodology;
- interviewed officials while conducting onsite visits at two State-operated ICFs/MR to gain an understanding of how ICFs/MR are managed and these facilities' procedures for claiming Medicaid reimbursement;
- interviewed officials while conducting onsite visits at a privately operated ICF/MR to gain an understanding of the facility's operations and procedures for claiming Medicaid reimbursement;
- determined the basis for the State-operated and privately operated ICFs/MR per diem rates and verified the calculations;
- compared the State-operated ICFs/MR per diem rates with the privately operated ICFs/MR per diem rates for State FY 2011;
- requested, received, and reviewed MMIS claim payment data for State-operated and privately operated ICFs/MR for State FY 2011;
- reconciled MMIS claim payment data for State-operated and privately operated ICFs/MR to the Medicaid payments claimed on the CMS-64 reports for State FY 2011; and
- discussed the results of our review with State agency officials on January 22, 2013.

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

APPENDIX B: FEDERAL AND STATE REQUIREMENTS RELATED TO MEDICAID PAYMENTS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

FEDERAL REQUIREMENTS

Section 1902(a)(30)(A) of the Social Security Act requires that payments for services be consistent with efficiency and economy.

Section 1903(A)(1) of the Social Security Act authorizes payment to the States of an amount equal to the FMAP of the total amount expended during the quarter as medical assistance under an approved State plan.

Federal regulations (42 CFR § 430.30(c)) state:

- (1) The State must submit Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to the [CMS] central office (with a copy to the regional office) not later than 30 days after the end of each quarter.
- (2) This report is the State's accounting of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of estimates.

FEDERAL GUIDELINES

The CMS *State Medicaid Manual*, § 2500.2, provides instructions for the preparation of the CMS-64 report and states (§ 2500.2.A): "Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed." (Emphasis in original.)

STATE REQUIREMENTS

The Missouri State Medicaid plan, Attachment 4-19D, page 224, provides the Retrospective Reimbursement Plan for State-Operated Facilities for ICF/MR Services: "The Missouri Medical Assistance Program shall reimburse qualified providers of ICF/MR services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate and the payment from the supplemental enhancement pool as described in (5)[1] less any payments made by recipients as described in sections (4) and (5)."

The Missouri State Medicaid plan, Attachment 4-19D, page 174, provides the Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services: "The Missouri Medical assistance program shall reimburse qualified providers of ICF/MR services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate less any payments made by recipients."

The Missouri State Medicaid plan, Attachment 4.19-D, page 229, provides instruction on the Supplemental Enhancement Payment Pool: “Each state-owned and operated facility for the mentally retarded (ICF/MR) will be paid an annual supplement, payable in quarterly installments, to increase aggregate reimbursement to state-owned and operated ICFs/MR to the amount that the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 C.F.R. 447.257, 447.272, and 447.304.”

REPORTING REQUIREMENTS

The CMS-64 MBES CBES Category of Service Line Definitions provide guidance on the category of services claimed on each line of the CMS-64 report:

4A—Intermediate Care Facility Services – Public Providers – Mentally Retarded (ICF/MR) (See 42 CFR 440.150).

These include services provided in an institution for the mentally retarded or persons with related conditions if:

- The primary purpose of the institution is to provide health or rehabilitative services to such individuals;
- The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and
- The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009.

NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency....

4B—Intermediate Care Facility Services – Private Providers – Mentally Retarded (ICF/MR). (See 42 CFR 440.150).

These include services provided in an institution for the mentally retarded or persons with related conditions if:

- The primary purpose of the institution is to provide health or rehabilitative services to such individuals;

- The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and
- The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009.

NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency.

APPENDIX C: STATE AGENCY COMMENTS



JEREMIAH W. (JAY) NIXON, GOVERNOR • ALAN O. FREEMAN, DIRECTOR

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May 2, 2013

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

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Missouri Claimed Unallowable Medicaid Payments for Individuals With Intellectual and Developmental Disabilities in Intermediate Care Facilities", Report Number A-07-12-03180. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: The OIG recommends that the State agency refund \$7,170,414 to the Federal Government.

DSS Response: The DSS partially agrees with this recommendation. The questioned costs included \$7,053,604 FFP for duplicate Medicaid payments. DSS believes the duplicate claim of regular FFP was for \$6,280,902, grossed up to \$9,924,004 total computable. With the ARRA enhanced rate, the FFP total claimed in error from duplicate Medicaid payments was \$7,106,579. This amount was returned on the CMS-64 report for the quarter ending December 31, 2012.

DSS believes the balance of questioned costs is related to the overclaiming of UPL, not unsupported Medicaid payments. In response to this finding, an adjustment of \$86,230 (\$63,835 federal share) will be made on the CMS-64 report for the quarter ending June 30, 2013.

Recommendation 2: The OIG recommends that the State agency develop and implement sufficient internal controls and procedures, including those pertaining to reconciliations of payments to claimed costs, to prevent the claiming of duplication or unsupported Medicaid payments.

RELAY MISSOURI

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Patrick Cogley
May 2, 2013
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DSS Response: The DSS agrees with this recommendation. A new process was implemented June 30, 2012, to reconcile the draws to the claim in order to prevent duplicate claiming on the CMS-64 report.

Please contact Jennifer Tidball, Director, Division of Finance and Administrative Services at (573)751-7533 if you have further questions.

Sincerely,

A handwritten signature in cursive script that reads "Alan O. Freeman". The signature is written in black ink and is positioned above the printed name and title.

Alan O. Freeman
Director

AOF/jc