DEPARTMENT OF HEALTH AND HUMAN SERVICES **Office of Inspector General**
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

August 2, 2006

Report Number: A-04-05-03003

Mr. Glenn Jennings, Commissioner
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621

Dear Mr. Jennings:

Enclosed for your information are two copies of the Department of Health and Human Services, Office of Inspector General final report entitled "Audit of the Kentucky Medicaid Agency's Buy-In of Medicare Parts A and B." A copy of this report will be forwarded to the action official shown on page 3 for his review and any action deemed necessary.

The objective of our audit was to determine whether the State Medicaid agency paid Medicare premiums only for individuals eligible for the State buy-in program.

During the conversion to a new buy-in system in 2004, the State Medicaid agency erroneously paid approximately $4 million ($2.8 million Federal share) in Medicare Part B premiums for 4,816 individuals who were not eligible for the State buy-in program. These erroneous payments occurred because the State Medicaid agency did not adequately test changes made to its buy-in system.

During the periods before and after its conversion to a new buy-in system, the State Medicaid agency generally paid Medicare premiums for individuals who were eligible for the State buy-in program. However, the State Medicaid agency inappropriately claimed $41,307 ($29,290 Federal share) in Medicare premiums for periods when nine beneficiaries were ineligible because it did not reconcile the Centers for Medicare & Medicaid Services's (CMS) monthly Medicare premium billing files to the State Medicaid agency's eligibility records.

We recommend the following:

- The State Medicaid agency should refund to the Federal Government $2,770,494 (Federal share) in Medicare premiums claimed for the 4,816 ineligible beneficiaries added during the buy-in system conversion period.

- The State Medicaid agency should adequately test all future changes to its buy-in system prior to implementation.

- The State Medicaid agency should refund to the Federal Government $29,290 (Federal share) in Medicare premiums claimed for the periods when the nine beneficiaries (Appendix B) were ineligible.

- The State Medicaid agency should develop adequate internal controls to ensure that it pays Medicare premiums only for individuals eligible for its buy-in program. The internal controls should include policies and procedures for:

    - reconciling the Medicare billings from CMS to the State's buy-in system and investigating and correcting exceptions to determine erroneous additions and to recover premiums in accordance with the Commissioner's Decision[1] and

    - identifying and removing deceased individuals from the buy-in rolls and recovering all the premiums paid after the month of death.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports are made available to members of the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to call me or John Drake, Audit Manager, at (404) 562-7755 or through e-mail at john.drake@oig.hhs.gov. To facilitate identification, please refer to report number A-04-05-03003 in all correspondence.

Sincerely,

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosures

[1]To prevent hardships on individuals, the Commissioner, Social Security Administration, issued a regulation limiting retroactive deletions to 2 months from the month in which the buy-in system receives the deletion request (CMS "State Buy-In Manual," Section 430, Commissioner's Decision).

Direct Reply to HHS Action Official:

Renard L. Murray
Associate Regional Administrator, Region IV
Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
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Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF THE KENTUCKY MEDICAID AGENCY'S BUY-IN OF MEDICARE PARTS A AND B

Daniel R. Levinson
Inspector General

August 2006
A-04-05-03003

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

There are several categories of individuals eligible for both Medicare and Medicaid, each having specific income and resource requirements tied to the Federal poverty level. "Dual eligibles" are individuals who are eligible for benefits under both Medicare and Medicaid. These individuals receive benefits under both programs because they are poor and either elderly or disabled. While dual eligibles are eligible for Medicare Part A enrollment for hospital care and Part B insurance coverage for physician care, many cannot afford Medicare cost sharing requirements.

Section 1843 of the Social Security Act addresses this problem by creating an arrangement, known as the "buy-in program," under which participating States with Medicaid plans use Medicaid funds to pay the Medicare cost-sharing requirements for dual eligibles. This arrangement has the effect of transferring part of the medical costs for dual eligibles from the State and federally financed Medicaid program to the federally financed Medicare program.

At the Federal level, the Centers for Medicare & Medicaid Services (CMS) has overall responsibility for the administration of the buy-in program. In Kentucky, the Cabinet for Health and Family Services, Department for Medicaid Services (the State Medicaid agency) is responsible for administering the State's buy-in program.

From November 1, 2003, through July 31, 2005, the State Medicaid agency paid Medicare premiums totaling $217.44 million to buy in Medicaid beneficiaries. The $217.44 million consisted of $18.97 million for Part A monthly premiums and $198.47 million for Part B monthly premiums.

During the last quarter of 2004, State officials became aware of potential problems with the State's buy-in program. As a result, CMS requested that we perform an audit of the Medicare Parts A and B buy-in program in Kentucky. Our audit covered November 1, 2003, through July 31, 2005.

OBJECTIVE

Our objective was to determine whether the State Medicaid agency paid Medicare premiums only for individuals eligible for the State buy-in program.

SUMMARY OF FINDINGS

During the conversion to a new buy-in system in 2004, the State Medicaid agency erroneously paid approximately $4 million ($2.8 million Federal share) in Medicare Part B premiums for 4,816 individuals who were not eligible for the State buy-in program. These

erroneous payments occurred because the State Medicaid agency did not adequately test changes made to its buy-in system.

During the periods before and after its conversion to a new buy-in system, the State Medicaid agency generally paid Medicare premiums for individuals who were eligible for the State buy-in program. However, the State Medicaid agency inappropriately claimed $41,307 ($29,290 Federal share) in Medicare premiums for periods when nine beneficiaries were ineligible because it did not reconcile CMS's monthly Medicare premium billing files to the State Medicaid agency's eligibility records.

RECOMMENDATIONS

- The State Medicaid agency should refund to the Federal Government $2,770,494 (Federal share) in Medicare premiums claimed for the 4,816 ineligible beneficiaries added during the buy-in system conversion period.

- The State Medicaid agency should adequately test all future changes to its buy-in system prior to implementation.

- The State Medicaid agency should refund to the Federal Government $29,290 (Federal share) in Medicare premiums claimed for the periods when the nine beneficiaries (Appendix B) were ineligible.

- The State Medicaid agency should develop adequate internal controls to ensure that it pays Medicare premiums only for individuals eligible for its buy-in program. The internal controls should include policies and procedures for:

    - reconciling the Medicare billings from CMS to the State's buy-in system and investigating and correcting exceptions to determine erroneous additions and to recover premiums in accordance with the Commissioner's Decision[1] and

    - identifying and removing deceased individuals from the buy-in rolls and recovering all the premiums paid after the month of death.

State Agency Comments

In written comments to the draft report, State agency officials agreed with our findings and recommendations. The complete text of the State's comments is included as Appendix C.

[1]To prevent hardships on individuals, the Commissioner, Social Security Administration, issued a regulation limiting retroactive deletions to two months from the month in which the buy-in system receives the deletion request (CMS "State Buy-In Manual," Section 430, Commissioner's Decision).

TABLE OF CONTENTS

Page

INTRODUCTION

BACKGROUND

Medicaid's Role in Filling Medicare's Gap

There are several categories of individuals eligible for both Medicare and Medicaid, each having specific income and resource requirements tied to the Federal poverty level. "Dual eligibles" are individuals who are eligible for benefits under both Medicare and Medicaid. These individuals receive benefits under both programs because they are poor and either elderly or disabled. While dual eligibles are eligible for Medicare Part A enrollment for hospital care and Part B insurance coverage for physician care, many cannot afford Medicare cost sharing requirements.

Section 1843 of the Social Security Act (the Act) addresses this problem by creating an arrangement, known as the "buy-in program," under which participating States with Medicaid plans use Medicaid funds to pay the Medicare cost-sharing requirements for dual eligibles. This arrangement has the effect of transferring part of the medical costs for dual eligibles from the State and federally financed Medicaid program to the federally financed Medicare program.

The monthly Medicare premiums the States pay on behalf of dual eligibles are considered vendor payments and are reimbursable under Medicaid. States use the Federal Medical Assistance Percentage (FMAP) to calculate the amount reimbursable. Section 1905(b) of the Act specifies the formula for calculating the annual FMAPs for each State. During the last 10 years, Kentucky's FMAP has ranged from 69.26 percent to 73.04 percent.

Administering the Buy-In Program

At the Federal level, the Centers for Medicare and Medicaid Services (CMS) has overall responsibility for the administration of the buy-in program. In Kentucky, the Cabinet for Health and Family Services, Department for Medicaid Services (the State Medicaid agency) is responsible for administering the State's buy-in program.

From November 2003 through July 2005, the State Medicaid agency paid $217.44 million in Medicare premiums on behalf of individuals enrolled in its buy-in program. The $217.44 million consisted of $18.97 million for Part A monthly premiums and $198.47 million for Part B monthly premiums.

During the last quarter of 2004, Kentucky State officials became aware of potential problems with the State's buy-in program. In numerous instances, the State added ineligible individuals to and deleted eligible individuals from its Medicare Part B buy-in rolls during conversion to a new automated buy-in system. Kentucky's Cabinet for Justice and Public Safety performed a preliminary investigation of the problem and requested that

CMS conduct an audit. As a result, CMS requested that the Office of Inspector General perform an audit of the Medicare Parts A and B buy-in program in Kentucky.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State Medicaid agency paid Medicare premiums only for individuals eligible for the State buy-in program.

Scope

Our audit included $209.9 million of the $217.4 million the State Medicaid agency paid in Medicare Parts A and B buy-in premiums from November 2003 through July 2005. We did not audit the balance of $7.5 million because CMS could not provide us with timely information needed for our review.

We did not review the overall internal control structure of the State Medicaid agency. Our review of internal controls was limited to obtaining an understanding of the State Medicaid agency's procedures for paying Medicare premiums and claiming reimbursement for premiums from the Federal Government. We conducted fieldwork at the Cabinet for Health and Family Services, the Cabinet for Justice and Public Safety, and the Auditor of Public Accounts in Frankfort, Kentucky. We also performed fieldwork at the CMS regional office in Atlanta, Georgia.

Methodology

To accomplish our audit objective, we:

- reviewed Federal and State regulations and policies and procedures related to buy-in agreements;
- reviewed the CMS "State Buy-In Manual" and Kentucky's buy-in agreement;
- reviewed applicable working papers prepared by and held discussions with the Kentucky Auditor of Public Accounts and Cabinet for Justice and Public Safety;
- interviewed personnel from CMS, the Social Security Administration (SSA), the State Medicaid agency, the State's fiscal agent, and Public Consulting Group;
- obtained the files of monthly Medicare premiums billed by CMS for the State's dual eligibles from November 1, 2003, through July 31, 2005;

- tested a listing of 4,816 individuals erroneously added to the State's Medicare Part B buy-in program for the conversion month of October 2004 to confirm the individuals' ineligibility for buy-in; and

- selected and reviewed random samples of monthly Medicare premiums billed by CMS.[1]

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

During the conversion to a new buy-in system in 2004, the State Medicaid agency erroneously paid approximately $4 million ($2.8 million Federal share) in Medicare Part B premiums for 4,816 individuals who were not eligible for the State buy-in program. These erroneous payments occurred because the State Medicaid agency did not adequately test changes made to its buy-in system.

During the periods before and after the conversion to a new buy-in system, the State Medicaid agency generally paid Medicare premiums for individuals who were eligible for the State buy-in program. However, the State Medicaid agency inappropriately claimed $41,307 ($29,290 Federal share) in Medicare premiums for periods when nine beneficiaries were ineligible because it did not reconcile CMS's monthly Medicare premium billing files to the State Medicaid agency's eligibility records.

[1]The samples consisted of:

- 100 Medicare Part A premiums billed by CMS under the old buy-in system from November 2003 through September 2004;

- 30 Medicare Part A premiums billed by CMS under the new buy-in system from October 2004 through July 2005;

- 100 Medicare Part B premiums billed by CMS under the old buy-in system from December 2003 through September 2004; and

- 30 Medicare Part B premiums billed by CMS under the new buy-in system from November 2004 through July 2005.

The 2 samples of 30 showed no errors. The 2 samples of 100 did not contain the minimum number of six errors required by Office of Audit Services' policy for projecting results to the population. Therefore, instead of making a projection, we reported our actual results.

To calculate our actual results, we determined the total period of ineligibility for each individual and retroactively calculated the amount the State Medicaid agency inappropriately claimed for Federal reimbursement.

FEDERAL REQUIREMENTS

Under a State Buy-In Agreement, States may enroll eligible individuals in the Premium Hospital Insurance Program (Medicare Part A) and the Supplementary Medical Insurance Program (Medicare Part B) and pay their premiums. The statutory authority for the buy-in program is Section 1843 of the Act.

SSA and CMS may add individuals to the State's buy-in program through the billing process, but it is the State Medicaid agency's responsibility to review these additions to confirm their eligibility and to verify the accuracy and validity of the data in the processing systems. If information in the systems is erroneous, it is the State Medicaid agency's responsibility to either correct the errors or have CMS correct them. If the State Medicaid agency determines that a recipient is ineligible, the State may delete the recipient from the buy-in rolls (CMS "State Buy-In Manual," Chapters 4, 5, and 7).

Originally, when an individual was retroactively deleted from the buy-in program, SSA withheld money from the individual's Social Security benefit check to recover the premiums. However, to prevent hardships on individuals, the SSA Commissioner issued a regulation limiting retroactive deletions to two months from the month in which the buy-in system receives the deletion request (CMS "State Buy-In Manual," Section 430, Commissioner's Decision).

In cases when a participant in the buy-in program dies, the effective deletion date from the State's buy-in account should be the month and year of death (42 CFR § 407.48). States are allowed to recover from CMS all premium payments made after the month in which an individual dies.

CONVERSION PERIOD

During the 2004 conversion period, the State Medicaid agency inappropriately added 4,816 ineligible beneficiaries to the State buy-in program. In some cases, these erroneous additions resulted in retroactive refunds of payments for Medicare premiums to ineligible beneficiaries. A reconciliation of CMS's monthly billing records for October 2004 to the State's buy-in eligibility records disclosed that 4,576 of the 4,816 beneficiaries did not meet Federal and State eligibility requirements, 239 had died, and 1 had moved out of the State.

The State Medicaid agency initially paid approximately $5 million ($3.5 million Federal share) for the 4,816 ineligible beneficiaries. Subsequently, the State Medicaid agency was able to recover premium payments from CMS totaling $48,085 ($33,467 Federal share) made after the month of death for the 239 deceased individuals (42 CFR § 407.48) and for the 1 individual who had moved out of the State. In addition, the State Medicaid agency was able to recover $914,018 ($636,157 Federal share) applicable to the 4,576 ineligible individuals. This recovery represented premium payments for the month of November 2004 plus the 2 prior months, which was consistent with the Commissioner's Decision

(CMS "State Buy-In Manual," Section 430). Of the remaining $4 million, the State Medicaid agency had not returned to the Federal Government the $2.8 million Federal share. (See Appendix A.)

The addition of 4,816 ineligible beneficiaries occurred in 2004 because the State Medicaid agency did not adequately test changes made to its buy-in system.

OUTSIDE CONVERSION PERIOD

Our review of 260 monthly billings showed that the State Medicaid agency generally paid Medicare premiums for individuals who were eligible for the State buy-in program during the periods before and after the conversion period.

However, we did identify nine individuals who were not eligible for the State buy-in program.

- Four deceased individuals were still being covered by Medicare Part A (130 months paid, 86 months not recovered).

- One individual with excess income and resources was covered by Medicare Part A (19 months paid, none recovered).

- Two deceased individuals were still being covered by Medicare Part B (3 months paid, 3 months recovered).

- One individual with excess income and resources was covered by Medicare Part B (14 months paid, none recovered).

- One individual did not meet the buy-in eligibility criteria for Medicare Part B (123 months paid, none recovered).

The State Medicaid agency inappropriately claimed $41,307 ($29,290 Federal share) in Medicare premiums for periods when these nine beneficiaries (Appendix B) were ineligible.

The State Medicaid agency continued to claim the Medicare premiums for these nine beneficiaries because it did not reconcile CMS's monthly Medicare premium billing files to the State Medicaid agency's eligibility records.

RECOMMENDATIONS

- The State Medicaid agency should refund to the Federal Government $2,770,494 (Federal share) in Medicare premiums claimed for the 4,816 ineligible beneficiaries added during the buy-in system conversion period.

- The State Medicaid agency should adequately test all future changes to its buy-in system prior to implementation.

- The State Medicaid agency should refund to the Federal Government $29,290 (Federal share) in Medicare premiums claimed for the periods when the nine beneficiaries (Appendix B) were ineligible.

- The State Medicaid agency should develop adequate internal controls to ensure that it pays Medicare premiums only for individuals eligible for its buy-in program. The internal controls should include policies and procedures for:

    - reconciling the Medicare billings from CMS to the State's buy-in system and investigating and correcting exceptions to determine erroneous additions and to recover premiums in accordance with the Commissioner's Decision[2] and

    - identifying and removing deceased individuals from the buy-in rolls and recovering all the premiums paid after the month of death.

State Agency Comments

In written comments to the draft report, State agency officials agreed with our findings and recommendations. State agency officials agreed to refund:

- $2,770,494 (Federal share) in Medicare premiums claimed for the 4,816 ineligible beneficiaries added during the buy-in system conversion period and

- $29,290 (Federal share) in Medicare premiums claimed for periods when the nine beneficiaries were ineligible.

State agency officials agreed to adequately test all further changes to its buy-in system before implementation.

In regard to the remaining procedural recommendations, State agency officials outlined steps that they have taken or plan to take to develop internal controls to ensure that Medicare premiums are paid only for individuals eligible for the State's buy-in program.

The complete text of the State agency's comments is included as Appendix C.

[2]To prevent hardships on individuals, the Commissioner, SSA, issued a regulation limiting retroactive deletions to 2 months from the month in which the buy-in system receives the deletion request (CMS "State Buy-In Manual," Section 430, Commissioner's Decision).

APPENDIXES

APPENDIX A

Calculation of Medicare Part B Premiums Paid for Ineligible Individuals Added During October 2004

Premiums for Individuals Erroneously Bought-In	$4,942,698
Less: Premiums Recovered	962,103
Erroneous Payments Less Recoveries	$3,980,595
FFP Rate Applied	x 69.60%
Federal Share of Overpayments	$2,770,494

APPENDIX B

Calculation of Medicare Premiums Paid for Ineligible Individuals Before and After the Conversion

Medicare Part A

Item Number	Billing Month Selected	Date of Death	Erroneous Payments for Billing Month Selected	Erroneous Payments for All Months	Federal Share	Time Period and Issue
1	05/04	N/A	$343	$ 7,099	$ 5,116	02/01/03 - 10/31/04 Excess income and resources
3	11/03	10/31/02	316	7,174	5,167	11/01/02 – 08/31/04 Deceased
40	03/04	01/25/02	0	3,190	2,231	02/01/02 – 10/31/04 Deceased – Recovered $7,541 from CMS for 12/01/02 – 10/31/04
73	11/03	09/06/03	0	0	0	Recovered $948 from CMS
86	02/04	10/20/98	0	16,630	11,698	11/01/98 – 10/31/04 Deceased – Recovered $5,958 from CMS for 05/01/03 – 10/31/04
Total for Medicare Part A (Amounts exclude recoveries)			$659	$34,093	$24,212	

Medicare Part B

Item Number	Billing Month Selected	Date of Death	Erroneous Payments for Billing Month Selected	Erroneous Payments for All Months	Federal Share	Time Period and Issue
51	05/04	N/A	$ 67	$ 6,321	$ 4,432	04/01/95 – 07/31/05 Did not meet buy-in eligibility criteria
54	05/04	04/19/04	0	0	0	Deceased - Recovered $66.60 from CMS
58	05/04	N/A	67	893	646	08/01/03 – 09/31/04 Excess income and resources
97	09/04	08/28/04	0	0	0	Deceased - Recovered $133.20 from CMS
Total for Medicare Part B (Amounts exclude recoveries)			$134	$ 7,214	$ 5,078	

	Erroneous Payments for Billing Month Selected	Erroneous Payments for All Months	Federal Share
Medicare Parts A and B (Amounts exclude recoveries)	$793	$41,307	$29,290

CABINET FOR HEALTH AND FAMILY SERVICES
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Glenn Jennings
Commissioner

July 18, 2006

Lori S. Pilcher
Regional Inspector General for Audit Services
Suite 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303

Re: Report A-04-05-03003

Dear Ms. Pilcher:

The Department for Medicaid Services has reviewed the Audit of the Kentucky Medicaid Agency's Buy-In of Medicare Parts A and B. Enclosed you will find the formal response to the audit's recommendations including the status of actions taken to improve the Kentucky Buy-In process.

If you have any questions or comments about our responses, please do not hesitate to call Ms. Jan Howell, Deputy Commissioner, at (502) 564-4321.

Sincerely,

Glenn Jennings
Commissioner

Enclosure

Xc: Jan Howell

GJ/JEH

Response to Report A-04-05-03003

In response to the Department of Health and Human Services, Office of Inspector General draft report (A-04-05-03003) entitled "Audit of the Kentucky Medicaid Agency's Buy-In of Medicare Parts A and B," the Department for Medicaid Services would like to submit the following comments. These comments specifically address the recommendations that appear on pages ii and 5 of the report.

HHS OIG Audit Recommendation Bullet 1:
The State Medicaid agency should refund to the Federal Government $2,770,494 (Federal share) in Medicare premiums claimed for the 4,816 ineligible beneficiaries added during the buy-in system conversion period.

Kentucky Medicaid Response:
The Department for Medicaid Services concurs with the finding that it should refund the Federal Government the $2,770,494 (Federal share) in Medicare premiums claimed for the 4,816 ineligible beneficiaries added during the buy-in system conversion period.

HHS OIG Audit Recommendation Bullet 2:
The State Medicaid agency should adequately test all future changes to its buy-in system prior to implementation.

Kentucky Medicaid Response:
The State Medicaid Agency will adequately test all further changes to its buy-in system prior to implementation. With the transition to the Department's new fiscal agent, Electronic Data Systems (EDS), a new, more comprehensive system development lifecycle has been implemented as standard operating procedure. Also, the Department will now be able to involve its buy-in contractor, Public Consulting Group (PCG), in the design and testing of any changes to the buy-in system.

It should also be noted here that the Department for Medicaid Services monitored the implementation of the redesigned buy-in system and took immediate action once the incorrect payments were detected. The system fix that corrected the inclusion of the ineligible members was in place before the next month's processing.

HHS OIG Audit Recommendation Bullet 3:
The State Medicaid agency should refund to the Federal Government $29,290 (Federal share) in Medicare premiums claimed for the periods when the 9 beneficiaries (see Appendix B) were ineligible.

Kentucky Medicaid Response:
The Department for Medicaid Services concurs with the finding that it should refund to the Federal Government the $29,290 (Federal share) in Medicare premiums claimed for the periods when the 9 beneficiaries were ineligible.

Response to Report A-04-05-03003

HHS OIG Audit Recommendation Bullet 4:
The State Medicaid agency should develop adequate internal controls to ensure that it pays Medicare premiums only for individuals eligible for its buy-in program. The internal controls should include policies and procedures for:

- ***reconciling the Medicare billings from CMS to the State's buy-in system and investigating and correcting exceptions to determine erroneous additions and to recover premiums in accordance with the Commissioner's Decision[1] and***
- ***identifying and removing deceased individuals from the buy-in rolls and recovering all the premiums paid after the month of death.***

Kentucky Medicaid Response:
KY CHFS had requested that Public Consulting Group (PCG) develop a comprehensive and detailed monthly process for reviewing the Medicare Buy-In program transaction processing. The requirements ensure that only eligible members are included in the KY Buy-In population and that safeguards are developed to eliminate the processing of invalid transactions. The process utilizes both systematic edits and manual review steps. All systematic steps receive a supplemental manual quality control review which ensures that any anomalies in the data files are thoroughly reviewed prior to being loaded into the state's systems. Currently, all transactions submitted to CMS through the Buy-In process are reviewed by the PCG Buy-In specialist team.

KY CHFS performs oversight of the entire Buy-In program. All design documents were submitted to CHFS for review and approval. The State's contractor was required to develop processes and documentation designed to follow all guidelines established by the CMS State Buy-In Manual. Should it be necessary to recover premiums for incorrectly accreted members, the contractor will adhere to the retroactive deletion rule established by the SSA Commissioner.

The revised process was thoroughly tested through parallel processing of KY Buy-In files from October 2005 to February 2006. Test findings were reviewed with CHFS staff throughout the parallel testing timeframe and results benchmarked against the legacy system. Feedback from CHFS was used to modify and revise processes as necessary. This process was finalized at the end of the parallel processing period and is in the production phase. The state's contractor now performs all necessary monthly processes related to Buy-In for KY. Below is a summary of the quality control steps taken each month in Kentucky Buy-In process.

1. Review Buy-In A and B Billing Files from CMS
    a. Rejected transaction codes from CMS
        i. Aggregate transaction codes
        ii. Establish monthly error rate for codes submitted
        iii. Develop list of recipients within Loop between KY and CMS (Ex. Accept/Reject)
    b. Acceptance Records

Response to Report A-04-05-03003

i. Review acceptance records to ensure accuracy

c. Deletion Records
   i. Review records for deletion to ensure accuracy
   ii. Develop list of recipients within Loop between KY and CMS (Ex. Death Deletion)

d. DMS staff reviews/monitors Report Q1205-R03 (Buy-In Accretion – Deletion Rejection Report)

e. DMS staff reviews/monitors Report Q1205-R01 (Entitlement/Buy-In Verification Report)

2. Create Open List
   a. Identify newly eligible Buy-In recipients each month
   b. Review output on KY MMIS and CMS data files
   c. Address questions developed during Open List to CHFS staff
   d. Revise Open List based on feedback from manual review
3. Create Closed List
   a. Identify recipients with closed Buy-In benefits each month
      i. Change in Medicaid program/status code which makes the member ineligible for the Buy-In program
      ii. Date of death review
      iii. DMS staff reviews/monitors Report Q1205-R02 (Buy-In Death Report)
   b. Review output on KY MMIS and CMS data files
   c. Address questions developed during Closed List to CHFS staff
   d. Revise Closed List based on manual review
4. Perform file integrity checks using the following:
   a. Check for Null Medicare ID
   b. Name not populated
      i. Matches to populate the name
   c. Check and add Gender code if missing
   d. Invalid date in Date of Birth field
   e. SSN not populated
      i. Populate the correct SSN
   f. Invalid BIEC
      i. Correct invalid BIEC
   g. Transaction code not valid
   h. Transaction code date review
   i. Transaction code 75 date check
   j. Medicare ID populated
   k. EDB Medicare ID different than KY eligibility and Bendex
      i. Perform a multiple file comparison to obtain the correct Medicare ID
   l. EDB Name mismatch
      i. Perform a multiple file comparison to obtain the correct name
   m. EDB DOB mismatch
      i. Perform a multiple file comparison to obtain the correct DOB

Response to Report A-04-05-03003

5. Submit Buy-In A and B Input Files to CMS based on the Buy-In A and B Billing File Review, the Open List and the Closed List.

   In addition, the state now has a complete audit trail of the validation checks performed on each individual transaction reported on the Buy-In transaction file.