DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

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

July 27, 2011

Report Number: A-07-10-02757

Ms. Kim Malsam-Rysdon
Secretary
Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Dear Ms. Malsam-Rysdon:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of South Dakota's Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries from October 2008 Through September 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact James Korn, Audit Manager, at (303) 844-7153 or through email at James.Korn@oig.hhs.gov. Please refer to report number A-07-10-02757 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
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Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SOUTH DAKOTA'S BUY-IN OF MEDICARE PART B PREMIUMS FOR MEDICAID BENEFICIARIES FROM OCTOBER 2008 THROUGH SEPTEMBER 2009

Daniel R. Levinson
Inspector General

July 2011
A-07-11-02757

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In South Dakota, the Department of Social Services (State agency) is responsible for administering the Medicaid program.

Section 1843 of the Act authorizes States to enter into agreements with CMS to use Medicaid funds to pay the Medicare Parts A and B premium payments of eligible individuals, a provision of the Act that we will refer to as the Medicaid buy-in program. The purpose of the Medicaid buy-in program is to permit States to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and meet certain eligibility requirements. The Medicaid buy-in program has the effect of transferring part of the medical costs for eligible individuals from the federally- and State-financed Medicaid program to the federally-financed Medicare program.

Accordingly, Medicare Parts A and B premiums paid by the States on behalf of individuals enrolled in the Medicaid buy-in program are considered vendor payments and are generally reimbursable under Medicaid at the Federal Medical Assistance Percentage (FMAP), which is State-specific and calculated pursuant to section 1905(b) of the Act. For fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009), South Dakota's FMAP ranged from 68.75 percent to 70.64 percent.

The State agency determines eligibility for Medicaid, based upon household income and circumstances, and provides Medicaid buy-in assistance to three categories of eligible beneficiaries through its Medicare Savings Program. The three categories are Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI beneficiary). Eligibility determinations for these three categories are based upon varying relationships between household income, on the one hand, and the Federal poverty level and Supplemental Security Income limit (as determined by the Social Security Administration) on the other. For eligible beneficiaries classified as either QMBs or SLMBs, the State agency receives Federal reimbursement at the FMAP rate under the Medicaid buy-in program. For eligible beneficiaries classified as QI beneficiaries, the State agency receives 100 percent Federal reimbursement under this program pursuant to Section 1933(d) of the Act.

The State agency claimed approximately $18.9 million (approximately $13.5 million Federal share) for Medicare Part B premiums paid during FY 2009 on behalf of eligible beneficiaries under the Medicaid buy-in program.

OBJECTIVE

Our objective was to determine whether, during FY 2009, the State agency (a) claimed Medicaid reimbursement for Medicare Part B premiums it paid on behalf of eligible beneficiaries in accordance with Federal requirements and (b) adequately maintained the eligibility status of QI beneficiaries.

SUMMARY OF FINDINGS

The State agency did not always comply with Federal requirements when claiming Medicaid reimbursement for Medicare Part B premiums it paid on behalf of eligible beneficiaries during FY 2009. The State agency claimed Medicaid reimbursement of $289 (Federal share) for Medicare Part B monthly premiums from an unallowable retroactive period. These unallowable payments occurred because the State agency lacked controls to ensure that the retroactive period for QI beneficiaries occurred no earlier than January 1 of that calendar year.

The State agency overpaid its Medicare Part B Premium liability payment by $10,000 due to a CMS billing error. The State agency did not identify the error and subsequently claimed Medicaid reimbursement of $6,875 (Federal share) for Medicare Part B premium assistance that was in excess of the total Medicare premium liability of eligible beneficiaries in the November 2008 billing period. The State agency did not identify the billing error because it lacked controls to ensure that, for each eligible beneficiary, the monthly billing notice matched the monthly premium liability recorded by the State agency.

In addition, although the State agency had adequate controls to verify the eligibility of Medicaid buy-in beneficiaries, it did not adequately maintain the supporting fiscal records to document the eligibility status of those beneficiaries. As a result, we could not determine the total premium payments paid during FY 2009 on behalf of QI beneficiaries, for whom the State agency received 100 percent Federal reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- make a financial adjustment of $289 on its next Federal quarterly expenditure report to correct the unallowable retroactive payments;

- work with CMS to resolve the $10,000 billing error identified in the November 2008 billing period;

- assess its automated systems and procedures to identify and implement improvements necessary to maintain complete and accurate eligibility status information for each Medicare premium payment transaction; and

- strengthen internal controls by developing and implementing policies and procedures to:

- prevent Medicaid reimbursement for retroactive periods earlier than January 1 of the calendar year in which an individual who has met all QI beneficiary eligibility criteria applied for assistance; and

- review Medicare billing amounts and claim Medicaid reimbursement for only Medicare Part B premium assistance payments paid on behalf of eligible beneficiaries.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and described corrective actions that it implemented or planned to implement.

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

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STATE AGENCY COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In South Dakota, the Department of Social Services (State agency) is responsible for administering the Medicaid program.

Medicaid's Role in Paying Medicare Part B Premiums

Section 1843 of the Act authorizes States to enter into agreements with CMS to use Medicaid funds to pay the Medicare Parts A and B premium payments of eligible individuals, a provision of the Act that we will refer to as the Medicaid buy-in program. The purpose of the Medicaid buy-in program is to permit States to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and meet certain eligibility requirements. The Medicaid buy-in program has the effect of transferring part of the medical costs for eligible individuals from the federally- and State-financed Medicaid program to the federally-financed Medicare program.

Accordingly, Medicare Parts A and B premiums paid by the States on behalf of individuals enrolled in the Medicaid buy-in program are considered vendor payments and are generally reimbursable under Medicaid at the Federal Medical Assistance Percentage (FMAP), which is State-specific and calculated pursuant to section 1905(b) of the Act.[1] For fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009), South Dakota's FMAP ranged from 68.75 percent to 70.64 percent.

Administering the Medicaid Buy-In Program

The State agency determines eligibility for Medicaid, based upon household income and circumstances, and provides Medicaid buy-in assistance to three categories of eligible beneficiaries through its Medicare Savings Program. Pursuant to Section 1902(a)(10)(E) of the Act, the eligibility requirements for each category are as follows:

- For classification as a Qualified Medicare Beneficiary (QMB), an eligible beneficiary's income does not exceed 100 percent of the Federal poverty level, and his or her resources do not exceed twice the Supplemental Security Income (SSI) limit determined by the Social Security Administration.

[1] 42 U.S.C. § 1396d(b); CMS *State Buy-In Manual*, Pub. No. 24, chapter 1, section 110.

- For classification as a Special Low-Income Medicare Beneficiary (SLMB), an eligible beneficiary's income is above 100 percent, but does not exceed 120 percent, of the Federal poverty level, and his or her resources do not exceed twice the SSI limit.

- For classification as a Qualified Individual (QI beneficiary), an eligible beneficiary's income is above 120 percent, but less than 135 percent, of the Federal poverty level, his or her resources do not exceed twice the SSI limit, and he or she is not otherwise eligible for Medicaid.

The State agency is responsible for establishing internal procedures and systems to identify individuals eligible to be classified as eligible beneficiaries, communicating this information to CMS, and responding to actions taken by CMS on individual cases. Accordingly, the State agency is responsible for the accuracy of the eligible beneficiaries' eligibility status and is required to routinely update eligibility information in the CMS master file. If the information in the systems is erroneous, it is the State agency's responsibility to correct, or have CMS correct, the errors.[2] Using the CMS master file, CMS prepares a billing notice to the State agency that provides the monthly Medicare Part B premium due. Along with the billing notice, CMS provides the State agency with electronic billing files.

Through the use of eligibility codes, individuals in the Medicaid buy-in program are grouped into various eligibility categories. These eligibility codes identify individuals in the Medicaid buy-in program whose premiums are eligible to be claimed for Federal reimbursement.[3]

For eligible beneficiaries classified as either QMBs or SLMBs, the State agency receives Federal reimbursement at the FMAP rate under the Medicaid buy-in program. For eligible beneficiaries classified as QI beneficiaries, the State agency receives 100 percent Federal reimbursement under this program pursuant to Section 1933(d) of the Act.

The State agency claimed approximately $18.9 million (approximately $13.5 million Federal share) for Medicare Part B premiums paid during FY 2009 on behalf of eligible beneficiaries under the Medicaid buy-in program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether, during FY 2009, the State agency (a) claimed Medicaid reimbursement for Medicare Part B premiums it paid on behalf of eligible beneficiaries in accordance with Federal requirements and (b) adequately maintained the eligibility status of QI beneficiaries.

[2] CMS *State Buy-In Manual*, Pub. No. 24, chapter 2, section 200(F) and chapter 4, section 410; CMS *Medicare State Buy-In Manual*, Pub. No. 100-15, chapter 5, sections 500 and 510 (Internet-only manual).

[3] CMS *State Buy-In Manual*, Pub. No. 24, chapter 4, section 400, and chapter 8, sections 805 and 810.

Scope

Our audit included approximately $18.9 million (approximately $13.5 million Federal share) of Medicare Part B premiums paid by the State agency on behalf of eligible beneficiaries during FY 2009.

We limited our consideration of the State agency's internal controls to obtaining an understanding of the processes for determining the eligibility of eligible beneficiaries and claiming Medicaid reimbursement for Medicare Part B premium buy-in assistance payments for FY 2009.

We performed our fieldwork at the State agency in Pierre, South Dakota, from March through July 2010.

Methodology

To accomplish our objective, we:

- reviewed the Federal and State regulations, policies, and procedures related to the Medicaid buy-in program, including the CMS *State Medicaid Manual*, the CMS *State Buy-In Manual*, and South Dakota's Buy-In Agreements;

- interviewed CMS and State agency personnel to gain an understanding of the procedures for determining eligibility and claiming Federal reimbursement;

- analyzed beneficiary eligibility data from the State agency's SS09 system[4] and the State agency's MMIS to verify the completeness and integrity of the data;

- analyzed the data from the SS09 system to determine whether retroactive payments conformed to Federal requirements;

- reconciled the Medicare Part B premium payments data from the SS09 system with the billing notices;

- selected a simple random sample of 100 items from the total Medicare Part B premium payments made during FY 2009;

- evaluated the 100 sampled items to determine whether the individuals qualified for the Medicaid buy-in program; and

- discussed the results of our review with State agency officials on April 5, 2011.

[4] SS09 is one of the State agency's eligibility systems. SLMB and QI beneficiary applications are entered on the SS09 system and updated nightly on the State agency's Medicaid Management Information System (MMIS).

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

FINDINGS AND RECOMMENDATIONS

The State agency did not always comply with Federal requirements when claiming Medicaid reimbursement for Medicare Part B premiums it paid on behalf of eligible beneficiaries during FY 2009. The State agency claimed Medicaid reimbursement of $289 (Federal share) for Medicare Part B monthly premiums from an unallowable retroactive period. These unallowable payments occurred because the State agency lacked controls to ensure that the retroactive period for QI beneficiaries occurred no earlier than January 1 of that calendar year.

The State agency overpaid its Medicare Part B Premium liability payment by $10,000 due to a CMS billing error. The State agency did not identify the error and subsequently claimed Medicaid reimbursement of $6,875 (Federal share) for Medicare Part B premium assistance that was in excess of the total Medicare premium liability of eligible beneficiaries in the November 2008 billing period. The State agency did not identify the billing error because it lacked controls to ensure that, for each eligible beneficiary, the monthly billing notice matched the monthly premium liability recorded by the State agency.

In addition, although the State agency had adequate controls to verify the eligibility of Medicaid buy-in beneficiaries, it did not adequately maintain the supporting fiscal records to document the eligibility status of those beneficiaries. As a result, we could not determine the total premium payments paid during FY 2009 on behalf of QI beneficiaries, for whom the State agency received 100 percent Federal reimbursement.

MEDICAID REIMBURSEMENT FROM UNALLOWABLE RETROACTIVE PERIOD

Pursuant to CMS's *State Medicaid Manual*, chapter 5, retroactive eligibility (of up to 3 months prior to application) applies if an eligible beneficiary met all QI beneficiary eligibility criteria in the retroactive period, and if the retroactive period occurred no earlier than January 1 of that calendar year.

The State agency claimed Medicaid reimbursement of $289 (Federal share) for Medicare Part B monthly premiums from an unallowable retroactive period. Specifically, the State agency received Medicaid reimbursement for a $675 Medicare Part B premium payment it had made in March 2009 that included retroactive payments of $289 for the last 3 months of calendar year 2008. The eligible beneficiary had applied for the Medicare Part B premium assistance on January 8, 2009, and the State agency had determined that the individual met the QI beneficiary eligibility criteria. Because the application date occurred after January 1, 2009, the State agency should not have claimed Medicaid reimbursement for retroactive payments that extended back

into the previous calendar year. State agency officials said that they were not aware of the January 1 retroactive period requirement for QI beneficiaries.

MEDICAID REIMBURSEMENT IN EXCESS OF CASH ASSISTANCE PAYMENTS

Pursuant to Federal regulations at 42 CFR § 431.625(d), States may claim the Federal share for certain individuals if these recipients are receiving cash assistance under specified Federal programs.

The State agency overpaid its Medicare Part B Premium liability payment by $10,000 due to a CMS billing error. The State agency did not identify the error and subsequently claimed Medicaid reimbursement of $6,875 (Federal share) for Medicare Part B premium assistance that was in excess of the total Medicare premium liability of eligible beneficiaries in the November 2008 billing period.

For this billing period, the State agency's Debit/Credit report from MMIS showed that the State agency's Medicare Part B premium liability totaled $1,560,156. However, CMS's billing notice showed that the State agency's Medicare Part B premium liability payment for this billing period totaled $1,570,156, a $10,000 discrepancy whose cause neither the State agency nor we could determine. The State agency used Medicaid funds to pay the full Medicare Part B premium liability payment of $1,570,156, as required, and it claimed Federal reimbursement on the basis of that payment amount. However, the State agency's actual premium liability for the month was $1,560,156. Thus, the State agency overpaid Medicare $10,000 for Part B premium assistance that was in excess of the total Medicare premium liability of eligible individuals in the November 2008 billing period. Because the error was not discovered, the State agency subsequently claimed Medicaid reimbursement of $6,875 (Federal share) for the Medicare billing error.

INCOMPLETE AND INACCURATE ELIGIBILITY DATA

Pursuant to Federal regulations at 42 CFR § 433.32(a), each State Medicaid agency must maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements.

The State agency did not adequately maintain and track the eligibility status of its eligible beneficiaries. As a result, we could not determine the total premium payments paid in FY 2009 on behalf of QI beneficiaries, for whom the State agency received 100 percent Federal reimbursement.

The State agency maintained the eligibility status of its eligible beneficiaries in two automated systems: the MMIS and the SS09 system. Beneficiary eligibility status sometimes differed between the two systems and between those systems and beneficiary case files. In our review of 100 sampled transactions, we found 11 instances in which the eligibility status in the automated systems did not match the eligibility status documented in the beneficiary's case file. For example, in one case, the State agency approved a beneficiary for the SLMB eligibility group;

however, MMIS showed this individual as being eligible for the QI beneficiary category. The State agency would have received additional, unallowable Federal reimbursement (in this example, $28) as a result of this error. State agency officials were not aware of the incomplete and conflicting eligibility information in the data systems and were unable to provide the transactions for the population of FY 2009 QI beneficiaries.

Under the provisions of the Medicaid buy-in program, the State agency receives a higher percentage of Federal participation for the QI beneficiary category than for the SLMB and QMB beneficiary categories. Consequently, it is important to have an accounting system and supporting fiscal records by beneficiary category to assure that claims for Federal funds are in accord with applicable Federal requirements.

INTERNAL CONTROLS NOT ALWAYS ADEQUATE

Although the State agency had adequate controls to verify the eligibility of Medicaid buy-in beneficiaries, it lacked controls to ensure that the retroactive period for QI beneficiaries occurred no earlier than January 1 of that calendar year. The State agency also lacked controls to ensure that, for each eligible beneficiary, the monthly billing notice matched the monthly premium liability recorded by the State agency. In addition, the State agency did not adequately maintain the supporting fiscal records to document the eligibility status of its Medicaid buy-in beneficiaries.

RECOMMENDATIONS

We recommend that the State agency:

- make a financial adjustment of $289 on its next Federal quarterly expenditure report to correct the unallowable retroactive payments;

- work with CMS to resolve the $10,000 billing error identified in the November 2008 billing period;

- assess its automated systems and procedures to identify and implement improvements necessary to maintain complete and accurate eligibility status information for each Medicare premium payment transaction; and

- strengthen internal controls by developing and implementing policies and procedures to:

    - prevent Medicaid reimbursement for retroactive periods earlier than January 1 of the calendar year in which an individual who has met all QI beneficiary eligibility criteria applied for assistance; and

    - review Medicare billing amounts and claim Medicaid reimbursement for only Medicare Part B premium assistance payments paid on behalf of eligible beneficiaries.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and described corrective actions that it implemented or planned to implement.

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

APPENDIX

APPENDIX: AUDITEE COMMENTS

DEPARTMENT OF SOCIAL SERVICES
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DSS
Strong Families - South Dakota's Foundation and Our Future

July 11, 2011

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

Dear Mr. Cogley:

Re: Report Number A-07-10-02757

Thank you for the opportunity to respond to the draft report *Review of South Dakota's Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries from October 2008 through September 2009.* For ease of reference we have summarized each finding with the corrective action plan.

Finding
The state agency claimed Medicaid reimbursement of $289 for Medicare Part B premiums from a retroactive period.

Corrective Action
We concur with this finding. The Department of Social Services (DSS) will make a financial adjustment of $289 on its next federal quarterly expenditure report. The Department has also notified field staff of this issue and is studying appropriate changes to the eligibility systems to ensure that the retroactive period for QI beneficiaries occurs no earlier than January 1 of the applicable calendar year.

Finding
The state agency overpaid its Medicare Part B Premium liability payment by $10,000 due to a CMS billing error.

Corrective Action

We concur that it appears CMS billed DSS in error for $10,000. DSS has controls in place to reconcile internal records to CMS billing. DSS will work with CMS to verify that an overpayment was made to CMS and adjust subsequent quarterly federal reports as directed by CMS.

Finding
The state agency did not adequately maintain the supporting fiscal records to document the eligibility status of all beneficiaries.

Corrective Action
DSS concurs with this finding and addressed this issue prior to receipt of the OIG report. While changes to information systems are being implemented, a secondary report was created so that any discrepancies can be identified and corrected if necessary in the MMIS before the monthly buy-in file is sent to CMS.

If you have any questions, please feel free to contact myself or Brenda Tidball-Zeltinger.

Sincerely,

Kim Malsam-Rysdon

Kim Malsam-Rysdon
Secretary

Cc: Carrie Johnson, Director of Economic Assistance
Larry Iversen, Director of Medical Services
Brenda Tidball-Zeltinger, Chief Financial Officer