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

Washington, D.C. 20201

July 13, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Lori S. Pilcher/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Expenditures for Medicare Part A and Part B Premiums in Missouri (A-07-10-03158)

Attached, for your information, is an advance copy of our final report on Medicare Part A and Part B premiums in the Missouri Medicaid program. We will issue this report to the Missouri Department of Social Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-10-03158.

Attachment

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 20, 2011

Report Number: A-07-10-03158

Mr. Ronald J. Levy
Director
Missouri Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102-1527

Dear Mr. Levy:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Expenditures for Medicare Part A and Part B Premiums in Missouri*. 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 Greg Tambke, Audit Manager, at (573) 893-8338, extension 30, or through email at Greg.Tambke@oig.hhs.gov. Please refer to report number A-07-10-03158 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
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID EXPENDITURES FOR MEDICARE PART A AND PART B PREMIUMS IN MISSOURI

Daniel R. Levinson
Inspector General

July 2011
A-07-10-03158

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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 Missouri, the Department of Social Services, Missouri HealthNet Division (State agency), administers the Medicaid program.

The State agency claims Medicaid expenditures and the associated Federal share on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The CMS-64 report is an accounting statement that the State agency, in accordance with 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. The expenditures reported on the CMS-64 report and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and that is available at the time the claim is filed. In addition, 42 CFR § 433.32(a) requires that the State agency maintain an accounting system and supporting fiscal records to assure that claims reported on the CMS-64 report are in accordance with applicable Federal requirements.

Section 1843 of the Act allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. The buy-in program allows participating State Medicaid programs to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in the Medicare Part A and Part B programs and to pay the monthly premiums on behalf of those individuals. The State agency can then claim the monthly premium expenditures on the CMS-64 report so that it can be reimbursed for the associated Federal share.

The State agency claimed Medicaid expenditures totaling approximately $5.9 billion (approximately $4.2 billion Federal share) during fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009). As part of these Medicaid expenditures, the State agency claimed approximately $152 million (approximately $111 million Federal share) for Medicare Part A and Part B premiums paid for dual eligibles under the buy-in program.

OBJECTIVE

Our objective was to determine whether the Medicaid expenditures for Medicare Part A and Part B premiums that the State agency claimed for Federal reimbursement under the buy-in program during FY 2009 were allowable pursuant to Federal requirements.

SUMMARY OF FINDINGS

During FY 2009, the State agency claimed the Medicaid expenditures for Medicare Part A premiums pursuant to Federal requirements but did not claim the Medicaid expenditures for Medicare Part B premiums pursuant to Federal requirements and guidance. Specifically, the State agency did not claim the correct expenditures for Medicare Part B premiums in the first and second quarters of FY 2009 because it made a calculation error when transferring the expenditures from its accounting system to the CMS-64 reports. In addition, for the third quarter of FY 2009, the State agency overclaimed expenditures because it made a duplication error when completing the CMS-64 report. As a result of these errors, the State agency overclaimed $2,059,574 ($1,491,862 Federal share) in Medicaid expenditures for Medicare Part B premiums during FY 2009.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,491,862 to the Federal Government for overclaimed Medicaid expenditures for Medicare Part B premiums and

- strengthen internal controls to ensure that all Medicaid expenditures claimed for Federal reimbursement are in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and described corrective actions that it had taken. The State agency's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

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 Missouri, the Department of Social Services, Missouri HealthNet Division (State agency), administers the Medicaid program.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of each State's claimed medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. In addition, pursuant to section 1933(d) of the Act, the FMAP is equal to 100 percent for certain qualifying individuals who are eligible to receive limited medical assistance.[1] During fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009), Missouri's FMAP ranged from 71.24 percent to 73.27 percent.[2]

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The State agency claims Medicaid expenditures and the associated Federal share on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The CMS-64 report is an accounting statement that the State agency, in accordance with 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. Each quarter's CMS-64 report shows the disposition of Medicaid funds used to pay for medical and administrative expenditures for the quarter being reported, as well as any prior-period adjustments.

The expenditures reported on the CMS-64 report and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and that is available at the time the claim is filed. In addition, 42 CFR § 433.32(a) requires that the State agency maintain an accounting system and supporting fiscal records to

[1] Pursuant to section 1902(a)(10)(E)(iv) of the Act, these "qualified individuals" are persons who are entitled to Medicare Part A and meet specific income and resource limits, but are not otherwise eligible for Medicaid.

[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.

assure that claims reported on the CMS-64 report are in accordance with applicable Federal requirements.

Medicaid's Role in Paying Medicare Part A and Part B Premiums

Section 1843 of the Act allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. The buy-in program allows participating State Medicaid programs to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in the Medicare Part A and Part B programs and to pay the monthly premiums on behalf of those individuals. The State agency can then claim the monthly premium expenditures on the CMS-64 reports. The buy-in program has the effect of transferring part of the medical costs for eligible individuals from the federally and State-funded Medicaid program to the federally financed Medicare program.

The monthly Medicare Part A and Part B premiums that the State agencies pay on behalf of individuals enrolled in the buy-in program are reimbursable under Medicaid at the applicable FMAP.

Administering the Buy-In Program

At the Federal level, CMS has overall responsibility for administering the buy-in program. CMS maintains a buy-in master file that contains information on beneficiaries eligible for enrollment in the buy-in program. CMS uses the buy-in master file to prepare monthly billing notices known as Summary Accounting Statements for each State agency's Medicare Part A and Part B premium liability and to identify those premiums eligible to be claimed by each State agency for Federal reimbursement.

Missouri Medicaid Program

In Missouri, the State agency is responsible for administering the State's buy-in program. Those responsibilities include establishing internal procedures and systems to identify individuals eligible for buy-in, communicating this information to CMS, and coordinating as necessary with CMS on individual cases. The State agency is also responsible for the accuracy of the individuals' eligibility codes and is required to routinely update these codes, including the mandatory buy-in eligibility codes, in CMS's buy-in master file. The Missouri Division of Finance and Administrative Services provides budgeting, financial, and support services to the State agency. Specifically, the Division of Finance and Administrative Services, Receipts and Grants Management Section, in conjunction with the State agency, completes the CMS-64 reports.

The State agency claimed Medicaid expenditures totaling approximately $5.9 billion (approximately $4.2 billion Federal share) during FY 2009. As part of these Medicaid expenditures, the State agency claimed approximately $152 million (approximately $111 million Federal share) for Medicare Part A and Part B premiums paid for dual eligibles under the buy-in program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Medicaid expenditures for Medicare Part A and Part B premiums that the State agency claimed for Federal reimbursement under the buy-in program during FY 2009 were allowable pursuant to Federal requirements.

Scope

We reviewed approximately $152 million (approximately $111 million Federal share) in Medicaid expenditures that the State agency claimed for Medicare Part A and Part B premiums under the buy-in program during FY 2009. The State agency claimed approximately $6 million (approximately $4 million Federal share) for Medicare Part A premiums and approximately $146 million (approximately $107 million Federal share) for Medicare Part B premiums on the FY 2009 CMS-64 reports.

Our objective did not require a review of the State agency's overall internal control structure. Therefore, we limited our internal control review to the State agency's procedures for reporting Medicaid expenditures on the CMS-64 reports during FY 2009.

We conducted fieldwork at the State agency in Jefferson City, Missouri, from December 2010 to February 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance and applicable portions of the Missouri State Medicaid plan;

- interviewed State agency officials to gain an understanding of their policies and procedures for reporting Medicaid expenditures on the CMS-64 reports;

- reconciled the Medicaid expenditures for Medicare Part A and Part B premiums claimed on the CMS-64 reports to the State agency's accounting system records and the CMS Summary Accounting Statements during FY 2009; and

- discussed our results with State agency officials on February 15, 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 objective.

FINDINGS AND RECOMMENDATIONS

During FY 2009, the State agency claimed the Medicaid expenditures for Medicare Part A premiums pursuant to Federal requirements but did not claim the Medicaid expenditures for Medicare Part B premiums pursuant to Federal requirements and guidance. Specifically, the State agency did not claim the correct expenditures for Medicare Part B premiums in the first and second quarters of FY 2009 because it made a calculation error when transferring the expenditures from its accounting system to the CMS-64 reports. In addition, for the third quarter of FY 2009, the State agency overclaimed expenditures because it made a duplication error when completing the CMS-64 report. As a result of these errors, the State agency overclaimed $2,059,574 ($1,491,862 Federal share) in Medicaid expenditures for Medicare Part B premiums during FY 2009.

UNALLOWABLE EXPENDITURES CLAIMED

Federal Requirements and Guidance

Pursuant to 42 CFR § 430.30(c): "*Expenditure reports*. (1) The State must submit Form CMS–64 … 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." (Italics in original.)

Federal regulations (42 CFR § 433.32(a)) require that the State agency "[m]aintain an accounting system and supporting fiscal records to assure that claims [reported on the CMS-64 report] for Federal funds are in accord with applicable Federal requirements…."

Pursuant to CMS's *State Medicaid Manual*, chapter 2, section 2500(A)(1), "Reported Expenditures": "The amounts reported on Form HCFA-64 [CMS-64] and its attachments must be actual expenditures…. Claims developed through the use of sampling, projections, or other estimating techniques are considered estimates and are not allowable under any circumstances."

Overclaimed Expenditures

The State agency did not claim Medicaid expenditures for Medicare Part B premiums on the CMS-64 reports for the first three quarters of FY 2009 pursuant to Federal requirements and guidance. The State agency overclaimed $2,059,574 ($1,491,862 Federal share) in Medicaid expenditures for Medicare Part B premiums.

State agency officials acknowledged that the Medicaid expenditures reported for the Medicare Part B premiums on the CMS-64 reports for the first three quarters of FY 2009 were incorrect. State agency officials stated that the expenditures for Medicare Part B premiums were overclaimed because the State agency made a calculation error when transferring the Medicaid expenditures from the State agency's accounting system to the CMS-64 reports for the first and second quarters of FY 2009. State officials also said that the State agency made a duplication error when completing the CMS-64 report for the third quarter of FY 2009.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,491,862 to the Federal Government for overclaimed Medicaid expenditures for Medicare Part B premiums and

- strengthen internal controls to ensure that all Medicaid expenditures claimed for Federal reimbursement are in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and described corrective actions that it had taken. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • RONALD J. LEVY, DIRECTOR

P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING • JEFFERSON CITY, MO 65102-1527
573-751-4815 • 573-751-3203 FAX

June 17, 2011

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Federal Office Building
601 East 12th Street, Room 429
Kansas City, MO 64106

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Review of Medicaid Expenditures for Medicare Part A and Part B Premiums in Missouri," Report Number A-07-10-03158. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: OIG recommends that the State agency refund $1,491,862 to the Federal Government for overclaimed Medicaid expenditures for Medicare Part B premiums.

DSS Response: DSS agrees with this recommendation. DSS will adjust the CMS-64 for quarter ending June 30, 2011 to refund $1,491,862 to the Federal Government.

Recommendation 2: OIG recommends that the State agency strengthen internal controls to ensure that all Medicaid expenditures claimed for Federal reimbursement are in accordance with Federal requirements.

DSS Response: DSS agrees with this recommendation. The State's written procedures to claim Medicare Part B premium payments were revised to incorporate additional accuracy checks beginning with the first quarter of FFY11.

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

Sincerely,

Ronald J. Levy
Director