January 30, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

/Brian Ritchie/ for
FROM: Gloria L. Jarmon
Deputy Inspector General for Audit Services

SUBJECT: Review of Nebraska's Medicaid Payments for Dual Eligible Individuals' Medicare Part A Deductibles and Coinsurance (A-07-11-03161)

Attached, for your information, is an advance copy of our final report on Nebraska's Medicaid payments for dual eligible individuals' Medicare Part A deductibles and coinsurance. We will issue this report to the Nebraska Department of Health & Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to contact 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-07-11-03161 in all correspondence.

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

February 6, 2012

Report Number: A-07-11-03161

Ms. Vivianne M. Chaumont
Director, Division of Medicaid & Long Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South, 3rd Floor
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Ms. Chaumont:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Nebraska's Medicaid Payments for Dual Eligible Individuals' Medicare Part A Deductibles and Coinsurance*. 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-07-11-03161 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 and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEBRASKA'S MEDICAID PAYMENTS FOR DUAL ELIGIBLE INDIVIDUALS' MEDICARE PART A DEDUCTIBLES AND COINSURANCE

Daniel R. Levinson
Inspector General

February 2012
A-07-11-03161

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 and 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:

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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 Nebraska, the Department of Health & Human Services (State agency) administers the Medicaid program.

Pursuant to Title XVIII of the Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS contracts with fiscal intermediaries or Medicare administrative contractors to process and pay Medicare Part A claims submitted by providers. Medicare Part A covers inpatient hospital services and skilled nursing care.

"Dual eligibles" are individuals who are entitled to both Medicare and some form of Medicaid benefits. There are various groups of dual eligibles, including but not limited to Qualified Medicare Beneficiary (QMB) without full Medicaid (QMB Only), QMB with full Medicaid (QMB Plus), Specified Low-Income Beneficiary with full Medicaid (SLMB Plus), and Full Benefit Dual Eligible (FBDE). These eligibility groups are qualified to have their Medicare Part A deductibles and coinsurance paid for by the Medicaid program.

After the Medicare contractor pays a Medicare Part A claim for a dual eligible and assesses the Medicare Part A deductibles and coinsurance, the contractor forwards the claim information to the appropriate State's Medicaid program. The State Medicaid program determines, based on the guidelines established in its State plan, whether to pay part or all of the Medicare Part A deductibles and coinsurance and then pays the provider through the usual Medicaid payment system. We refer to such claims as crossover claims.

The Nebraska State plan requires coordination of Medicaid with Medicare and provides methods and standards for the payment of crossover claims. The State plan limits the payment of Medicare Part A deductibles and coinsurance for QMB Only, QMB Plus, SLMB Plus, and FBDE beneficiaries to the State Medicaid plan rate for all Medicare Part A services except for Medicare-only services, inpatient hospital services provided in small rural hospitals, services provided by skilled nursing units in small rural hospitals, and hospice care.

To execute the provisions of the State plan, the State agency should compare the Medicare payment to the State Medicaid plan rate for each crossover claim to determine the allowable payment of Medicare Part A deductibles and coinsurance. Based on this comparison and on the particular eligibility group, the allowable payment is either (1) the amount by which the State Medicaid plan rate exceeds the actual Medicare payment, limited by the Medicare Part A deductibles and coinsurance (for the QMB Only and QMB Plus eligibility groups), or (2) the

amount by which the State Medicaid plan rate exceeds the actual Medicare payment (for the SLMB Plus and FBDE eligibility groups).

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately $1.6 billion (approximately $1.1 billion Federal share) during fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009). As part of these Medicaid payments, the State agency claimed approximately $19.0 million (approximately $13.0 million Federal share) for payments for Medicare Part A deductibles and coinsurance.

OBJECTIVE

Our objective was to determine whether the Medicaid payments for Medicare Part A deductibles and coinsurance that the State agency claimed for Federal reimbursement during FY 2009 were allowable pursuant to Federal requirements and the approved State plan.

SUMMARY OF FINDING

During FY 2009, the State agency did not claim Medicaid payments for Medicare Part A deductibles and coinsurance pursuant to Federal requirements and the approved State plan. Specifically, the State agency did not limit payment of Medicare Part A deductibles and coinsurance to State Medicaid plan rates as required under the State plan, resulting in 60 of the 100 claims in our sample being improperly paid.

These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. Based on the results of our sample, we estimate that the State agency claimed unallowable Medicaid payments of $8,283,081 ($5,519,029 Federal share) during FY 2009.

RECOMMENDATION

We recommend that the State agency refund $5,519,029 to the Federal Government for unallowable Medicaid payments for Medicare Part A deductibles and coinsurance.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our finding or with the two recommendations in the report.

With respect to our first recommendation, the State agency said that the relevant section of the Nebraska State plan was amended in 2004 to add hospice services, but with no intention of changing the payment methodology for payment of Medicare coinsurance and deductibles from the methodology established prior to the 2004 State plan amendment. The State agency attributed the change to a “scribe’s error.”

With respect to the second recommendation (which called for the State agency to compare the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part A

deductibles and coinsurance for each crossover claim), the State agency said that it had corrected the "scribe's error" by submitting a State plan amendment, which CMS approved on November 2, 2011.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we removed the second recommendation, but we maintain that our finding and the remaining recommendation are valid. A "scribe's error" does not exempt the State agency from its responsibility to follow the documented and approved State plan that was in effect during our audit period.

We removed our second recommendation because it is no longer applicable to payments from July 1, 2011, going forward. The State plan amendment, which CMS approved on November 2, 2011, removes the State Medicaid plan rate limits on the payment of deductibles and coinsurance for all Medicare Part A services effective July 1, 2011.

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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 administer and fund 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 Nebraska, the Department of Health & Human Services (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 payments 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. During fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009), Nebraska's FMAP ranged from 65.74 percent to 67.79 percent.[1]

Medicare Program

Pursuant to Title XVIII of the Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS, which administers the program, contracts with fiscal intermediaries or Medicare administrative contractors[2] to process and pay Medicare Part A claims submitted by providers. Medicare Part A covers inpatient hospital services and skilled nursing care.

Dual Eligibles

"Dual eligibles" are individuals who are entitled to both Medicare and some form of Medicaid benefits. There are various groups of dual eligibles, including but not limited to Qualified Medicare Beneficiary (QMB) without full Medicaid (QMB Only), QMB with full Medicaid (QMB Plus), Specified Low-Income Beneficiary with full Medicaid (SLMB Plus), and Full

[1] 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.

[2] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P. L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

Benefit Dual Eligible (FBDE). These eligibility groups are qualified to have their Medicare Part A deductibles and coinsurance paid for by the Medicaid program.[3]

Medicaid's Role in Paying Medicare Part A Deductibles and Coinsurance

After the Medicare contractor pays a Medicare Part A claim for a dual eligible and assesses the Medicare Part A deductibles and coinsurance, the contractor forwards the claim information to the appropriate State's Medicaid program. The State Medicaid program determines, based on the guidelines established in its State plan, whether to pay part or all of the Medicare Part A deductibles and coinsurance and then pays the provider through the usual Medicaid payment system. We refer to such claims as crossover claims.

For beneficiaries classified in the QMB Only and QMB Plus eligibility groups, States are mandated to pay Medicare Part A deductibles and coinsurance. Pursuant to section 1902(n)(2) of the Act, the Medicare payment for a service plus the Medicaid payment for any Medicare Part A deductibles and coinsurance may exceed the State Medicaid plan rate for the service. Section 1902(n)(2) also says, however, that a State is not required to pay for Medicare Part A deductibles and coinsurance on behalf of QMB Only and QMB Plus beneficiaries to the extent that the Medicare payment for the service exceeds what the State Medicaid program would have paid on behalf of a Medicaid-only recipient. If a State caps its Medicare Part A deductible and coinsurance coverage pursuant to section 1902(n)(2) of the Act and the Medicare payment for a service is equal to or exceeds the State Medicaid plan rate, the State makes no payment for Medicare Part A deductibles and coinsurance. If, on the other hand, the Medicare payment is less than the State Medicaid plan rate for a service, the State pays the Medicare Part A deductibles and coinsurance up to the difference between the amount paid by Medicare and the State Medicaid plan rate.

For beneficiaries classified in the SLMB Plus and FBDE eligibility groups, States are not mandated to pay Medicare Part A deductibles and coinsurance. However, because SLMB Plus and FBDE beneficiaries are entitled to full Medicaid benefits, they may be entitled to have Medicare Part A deductibles and coinsurance paid on their behalf when a service is covered by both Medicare and Medicaid. For Medicaid-covered services, the State agency will pay the difference between the State Medicaid plan rate and the Medicare payment.

In all cases, the amount paid by the State, if any, is payment in full for Medicare Part A deductibles and coinsurance.

Nebraska Medicaid Program

In Nebraska, the State agency is responsible for processing crossover claims. Those responsibilities include establishing internal controls and systems, which include policies and

[3] There are also other groups of dual eligible beneficiaries who are not qualified to have their Medicare Part A deductibles and coinsurance paid for by the Medicaid program: Specified Low-Income Medicare Beneficiary without full Medicaid (SLMB Only), Qualified Disabled and Working Individual, and Qualified Individual.

procedures to accurately pay Medicare Part A deductibles and coinsurance in accordance with the State plan.

The State agency must comply with certain Federal requirements pursuant to section 1902(a)(1) of the Act and implementing regulations (42 CFR § 431.50), which provide that a State plan for medical assistance is mandatory upon the State and all of its political subdivisions.

The Nebraska State plan requires coordination of Medicaid with Medicare and provides methods and standards for the payment of crossover claims. The State plan limits the payment of Medicare Part A deductibles and coinsurance for QMB Only, QMB Plus, SLMB Plus, and FBDE beneficiaries to the State Medicaid plan rate for all Medicare Part A services except for Medicare-only services, inpatient hospital services provided in small rural hospitals, services provided by skilled nursing units in small rural hospitals, and hospice care.

To execute the provisions of the State plan, the State agency should compare the Medicare payment to the State Medicaid plan rate for each crossover claim to determine the allowable payment of Medicare Part A deductibles and coinsurance. Based on this comparison and on the particular eligibility group, the allowable payment is either (1) the amount by which the State Medicaid plan rate exceeds the actual Medicare payment, limited by the Medicare Part A deductibles and coinsurance (for the QMB Only and QMB Plus eligibility groups), or (2) the amount by which the State Medicaid plan rate exceeds the actual Medicare payment (for the SLMB Plus and FBDE eligibility groups).[4]

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately $1.6 billion (approximately $1.1 billion Federal share) during FY 2009. As part of these Medicaid payments, the State agency claimed approximately $19.0 million (approximately $13.0 million Federal share) for payments for Medicare Part A deductibles and coinsurance.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Medicaid payments for Medicare Part A deductibles and coinsurance that the State agency claimed for Federal reimbursement during FY 2009 were allowable pursuant to Federal requirements and the approved State plan.

Scope

We reviewed approximately $19.0 million (approximately $13.0 million Federal share) in Medicaid payments that the State agency made and claimed for Federal reimbursement for Medicare Part A deductibles and coinsurance during FY 2009.

[4] Because SLMB Plus and FBDE beneficiaries are entitled to full Medicaid benefits, they may be entitled to have Medicare Part A deductibles and coinsurance paid on their behalf when a service is covered by both Medicare and Medicaid.

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 paying Medicare Part A deductibles and coinsurance.

We conducted fieldwork at the State agency in Lincoln, Nebraska, in March 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal requirements and the Nebraska State Medicaid plan;
- interviewed State agency officials to gain an understanding of their policies and procedures for claiming Medicare Part A deductibles and coinsurance;
- requested and received from the State agency crossover claim data for Medicare Part A deductibles and coinsurance totaling 14,306 data records, each equaling 1 crossover claim;
- selected and reviewed a simple random sample of 100 paid crossover claims from our sampling frame of 14,306 crossover claims (Appendixes A and B) and, for each sampled crossover claim:
    - reviewed Medicare's payment and Medicare Part A deductible and coinsurance amounts,
    - reviewed the State Medicaid plan rate,
    - compared Medicare's payment to the State Medicaid plan rate to determine the allowable and unallowable (if any) Medicaid payment of Medicare Part A deductible and coinsurance amounts, and
    - verified that the beneficiary in question was in one of the four eligibility groups (QMB Only, QMB Plus, SLMB Plus, or FBDE) of dual eligibles;
- computed the overpayment amount by estimating the unallowable Medicaid payments at the lower limit of the 90-percent confidence interval (Appendix B); and
- discussed our results with State agency officials on July 28, 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATION

During FY 2009, the State agency did not claim Medicaid payments for Medicare Part A deductibles and coinsurance pursuant to Federal requirements and the approved State plan. Specifically, the State agency did not limit payment of Medicare Part A deductibles and coinsurance to State Medicaid plan rates as required under the State plan, resulting in 60 of the 100 claims in our sample being improperly paid.

These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. Based on the results of our sample, we estimate that the State agency claimed unallowable Medicaid payments of $8,283,081 ($5,519,029 Federal share) during FY 2009.

UNALLOWABLE MEDICAID PAYMENTS CLAIMED

Federal Requirements

Section 1902(a)(1) of the Act states: "A State plan for medical assistance must—(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them …."

Federal regulations (42 CFR § 431.50(b)(1)) expand upon this provision of the Act by requiring that the State plan "… will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State."

Section 1902(a)(10)(E) of the Act states that a State plan must provide "for making medical assistance available for [M]edicare cost-sharing [deductibles and coinsurance] … for qualified [M]edicare beneficiaries [QMB Only and QMB Plus]…."

Section 1902(n)(2) of the Act states: "… a State is not required to provide any payment for any expenses incurred relating to payment for deductibles [or] coinsurance … [on behalf of a QMB Only or QMB Plus] to the extent that payment under title XVIII [Medicare] for the service would exceed the payment amount that otherwise would be made under the State plan [State Medicaid plan rate] under this title for such service if provided to an eligible recipient other than a [M]edicare beneficiary."

Section 1902(a)(30)(A) of the Act states that a State plan must "provide such methods and procedures relating to … the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care …."

The Act does not mandate that States pay Medicare Part A deductibles or coinsurance for SLMB Plus or FBDE beneficiaries. However, because SLMB Plus and FBDE beneficiaries are entitled to full Medicaid benefits, they may be entitled to have Medicare Part A deductibles and coinsurance paid on their behalf when a service is covered by both Medicare and Medicaid.

State Plan Requirements

The Nebraska State plan, section 3.2(b), requires coordination of Medicaid with Medicare and provides methods and standards for payment of Medicare Part A deductibles and coinsurance. Supplement 1 to Attachment 4.19-B of the State plan limits payment of Medicare Part A deductibles and coinsurance on behalf of QMB Only and QMB Plus beneficiaries to the amount, if any, by which the State Medicaid plan rate exceeds the Medicare payment, except for Medicare-only services, inpatient hospital services provided in small rural hospitals, services provided by skilled nursing units in small rural hospitals, and hospice care. The State plan specifies that the State agency pays for Medicare Part A deductibles and coinsurance for these services irrespective of the State Medicaid plan rate. Supplement 1 to Attachment 4.19-B of the State plan also limits payment of Medicare Part A deductibles and coinsurance on behalf of SLMB Plus and FBDE beneficiaries to the amount, if any, by which the State Medicaid plan rate exceeds the Medicare payment, except for inpatient hospital services provided in small rural hospitals, services provided by skilled nursing units in small rural hospitals, and hospice care.

Unallowable Medicaid Payments

The State agency did not claim Medicaid payments for Medicare Part A deductibles and coinsurance pursuant to Federal requirements and the approved State plan. Contrary to the provisions of the State plan, the State agency did not limit payment of Medicare Part A deductibles and coinsurance to State Medicaid plan rates. When we compared the Medicare payment to the State Medicaid plan rate for the 100 sampled claims, we found that 60 of the 100 claims were improperly paid. For those 100 claims, the State agency paid $169,074 but should have paid $95,781, a difference of $73,293 ($48,829 Federal share).

Medicare Payments Not Compared to State Medicaid Plan Rates

The State agency should have compared the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part A deductibles and coinsurance for each crossover claim. The table on the following page presents three examples, using actual values drawn from the claims we sampled, for the calculation of allowable Medicare Part A deductibles and coinsurance.

Sample Crossover Claims

	Medicare		Medicaid			
Claim	Payment	Medicare Part A Deductibles and Coinsurance	State Medicaid Plan Rate	Payment	Allowable Payment for Medicare Part A Deductibles and Coinsurance	Unallowable Payment for Medicare Part A Deductibles and Coinsurance
A	$3,240	$1,024	$3,080	$1,024	$0	$1,024
B	7,060	1,068	7,960	1,068	900	168
C	32,148	625	39,337	625	625	0

Notes: Claim A: State Medicaid plan rate is lower than Medicare payment.
Claim B: State Medicaid plan rate is higher than Medicare payment.
Claim C: State Medicaid plan rate is higher than Medicare payment.

These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. Based on the results of our sample, we estimate that the State agency claimed unallowable Medicaid payments of $8,283,081 ($5,519,029 Federal share).

RECOMMENDATION

We recommend that the State agency refund $5,519,029 to the Federal Government for unallowable Medicaid payments for Medicare Part A deductibles and coinsurance.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our finding or with the two recommendations in the report.

With respect to our first recommendation, the State agency stated: "The section of the Nebraska state plan that was reviewed by the OIG [Office of Inspector General] was Attachment 4.19-B Supplemental 1, page two [NE SPA 04-02]. This section of the Nebraska State plan was revised in 2004 to add hospice services. There was no intention of changing the payment methodology for payment of Medicare coinsurance and deductibles from the methodology described in NE SPA 91-24." The State agency added, "The change to page two was a scribe's error."

With respect to the second recommendation (which called for the State agency to compare the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part A deductibles and coinsurance for each crossover claim), the State agency said that it had corrected the "scribe's error" by submitting a State plan amendment, which CMS approved on November 2, 2011.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we removed the second recommendation in our draft report, but we maintain that our finding and the remaining recommendation are valid.

Section 1902(a)(1) of the Act states: "A State plan for medical assistance must—(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them …." Pursuant to section 1903(a) of the Act, once a State plan is approved, a State becomes eligible to receive Federal reimbursement for a specified percentage "of the total amount expended … as medical assistance under the State plan." Only those expenditures for medical assistance made by a State in accordance with the State plan are eligible for Federal reimbursement. The Nebraska State plan, Supplement 1 to Attachment 4.19-B, in effect during our audit period (NE SPA 04-02) limits payment of Medicare Part A deductibles and coinsurance to the State Medicaid plan rate, except for Medicare-only services, inpatient hospital services provided in small rural hospitals, services provided by skilled nursing units in small rural hospitals, and hospice care. The relevant provisions of NE SPA 04-02 are unambiguous and not open to interpretation. A "scribe's error" does not exempt the State agency from its responsibility to follow the documented and approved State plan that was in effect during our audit period.[5]

We removed our second recommendation because it is no longer applicable to payments from July 1, 2011, going forward. The State plan amendment, which CMS approved on November 2, 2011, removes the State Medicaid plan rate limits on the payment of deductibles and coinsurance for all Medicare Part A services effective July 1, 2011.

[5] The State agency did not explain what it meant by the term "scribe's error," but we note that page 2 of Supplement 1 to Attachment 4.19-B in NE SPA 04-02 is vastly different in both form and substance from the same page in NE SPA 91-24.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicare Part A crossover claims paid by the Nebraska Department of Health & Human Services (State agency) on behalf of dual eligibles for fiscal year (FY) 2009 (October 1, 2008, through September 30, 2009). Dual eligibles are individuals who are entitled to both Medicare and some form of Medicaid benefits.

SAMPLING FRAME

We developed a database of paid crossover claims for dual eligibles' Medicare Part A deductibles and coinsurance for FY 2009.[1] The database contained 3,632,771 lines of data totaling $59,689,266.

We excluded the following from the database:

- 2,325,390 lines of claims worth zero dollars and
- 1,291,946 lines of paid crossover claims for dual eligibles' Medicare Part B deductibles and coinsurance in the amount of $40,784,728.

We grouped the remaining line items (which consisted of both debits and credits) by claim number and summed them by line-paid amount to get a listing of crossover claims that the State agency paid. This eliminated an additional 533 line items.

We then excluded 596 crossover claims for which the sum of the line-paid amount was equal to or less than $2. The remaining crossover claims constituted our sampling frame of 14,306 claims totaling $19,247,240 ($12,850,249 Federal share) for FY 2009, from which we drew our random sample.

A paid crossover claim is based on the claim number. A claim number is the same for the original claim and adjustments. Each crossover claim shows when the service was provided, who provided the service, who received the service, the payment made by Medicare, the payment made by the dual eligible, any copayment, and the remaining Medicare Part A deductibles and coinsurance forwarded to Medicaid.

SAMPLE UNIT

A sample unit was one crossover claim (for a dual eligible during a given time period) paid by the State agency.

[1] After the Medicare contractor pays a Medicare Part A claim for a dual eligible and assesses the Medicare Part A deductibles and coinsurance, the claim information is forwarded to the appropriate State's Medicaid program. We refer to such claims as crossover claims.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 sample units (claims) for review.

SOURCE OF THE RANDOM NUMBERS

We generated random numbers using the Office of Inspector General, Office of Audit Services, statistical software RAT-STATS.

ESTIMATION METHODOLOGY

We used the variable appraisal program in RAT-STATS to estimate the unallowable Medicaid payments for dual eligibles' Medicare Part A deductibles and coinsurance. Because the Federal medical assistance percentage (FMAP) matching rate varied from year to year, we also used the RAT-STATS variable appraisal program to estimate the total FMAP reimbursed to Nebraska for unallowable dual eligibles' Medicare Part A deductibles and coinsurance. We calculated the FMAP amount for each sample item by applying the applicable FMAP rate to the total amount determined to be in error for the sample item.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size	Value of Frame	Sample Size	Number of Errors	Total Value of Sample	Value of Errors (Federal Share)
14,306	$19,247,240	100	60	$169,074	$48,829

ESTIMATES OF UNALLOWABLE MEDICAID PAYMENTS
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$6,985,525
Lower limit	5,519,029
Upper limit	8,452,022

APPENDIX C: STATE AGENCY COMMENTS

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska
Dave Heineman, Governor

November 16, 2011

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services, Region VII
601 East 12th Street, Room 0429
Kansas City, Missouri 64106

RE: Report Number A-07-11-03161

Dear Mr. Cogley:

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care is pleased to have the opportunity to respond to the Draft Audit Report entitled *Review of Nebraska's Medicaid Payments for Dual-Eligible Individuals' Medicare Part A Deductibles and Coinsurance.* DHHS strives to report Medicaid expenditures in compliance with current Federal and State law, policies, and procedures and is committed to working to resolve issues identified in this audit review.

DHHS' specific responses to each of the preliminary findings and recommendations identified in the Draft Audit Report follow:

OIG FINDING #1: The State agency did not claim Medicaid payments for Medicare Part A deductibles and coinsurance pursuant to Federal requirements and the approved State plan. Contrary to the provisions of the State plan, the State agency did not limit payment of Medicare Part A deductibles and coinsurance by State Medicaid plan rates.

OIG RECOMMENDATION #1: Refund $5,519,029 to the Federal Government for unallowable Medicaid payments for Medicare Part A deductibles and coinsurance.

DHHS RESPONSE: DHHS does not concur with this finding or recommendation. The section of the Nebraska state plan that was reviewed by the OIG was Attachment 4.19-B Supplemental 1, page two. This section of the Nebraska state plan was revised in 2004 to add hospice services. There was no intention of changing the payment methodology for payment of Medicare coinsurance and deductibles from the methodology described in NE SPA 91-24. The intention of NE SPA 04-02 is clearly indicated in the subject field for

NE SPA 04-02 on the form 179 (see attached form 179 for NE SPA 04-02). The change to page two was a scribe's error.

The fact that Medicaid correctly pays the Medicare coinsurance and deductible amount is further demonstrated by the change to Item 1, page three of Attachment 4.19-B Supplement 1 (NE SPA 10-09). Page three of Attachment 4.19-B, Supplement 1, Item 1 describes a special rate method for nursing facility services, to limit payments to State plan rates. There would have been no need to change page three if in fact the State was paying the State Medicaid plan rate already.

OIG FINDING #2: The State agency should have compared the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part A deductibles and coinsurance for each crossover claim.

OIG RECOMMENDATION #2: Develop and implement policies and procedures to ensure that the State agency compares the Medicare payment to the State Medicaid Plan rate to determine the allowable Medicare Part A deductibles and coinsurance for each crossover claim.

DHHS RESPONSE: DHHS does not concur with this finding or recommendation. To correct the scribe's error to NE State Plan Attachment 4.19-B, Supplement 1, Page two, the State agency has submitted NE SPA 11-27. The scribe's error has been discussed with the Centers for Medicare and Medicaid Services (CMS) and CMS approved the correction, November 2, 2011.

Should you have any questions, do not hesitate to contact me.

Sincerely,

Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

Attachment

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 04-002	2. STATE Nebraska
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE March 1, 2004	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 1905(o) of the Act; CFR 418; SMM, Ch 4, Sect 4306 & 4307; P.L. 105-33	7. FEDERAL BUDGET IMPACT: a. FFY 2004 $ 97,500 b. FFY 2005 $ 1,300,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 7 Attachment 3.1-A, Item 18, Pages 1-3 Attachment 3.1-B, Page 6 Attachment 4.19-B, Item 18, Page 1 of 2 Attachment 4.19-B, Item 18, Page 2 of 2 Supplement 1 to Attachment 4.19-B, Page 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, Page 7 Attachment 3.1-B, Page 6 Supplement 1 to Attachment 4.19-B, Page 2

10. SUBJECT OF AMENDMENT:
Addition of Hospice Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Margaret Booth HHS-F&S 301 Centennial Mall South Lincoln, Nebraska 68509
13. TYPED NAME: Robert J. Seiffert	
14. TITLE: Administrator	
15. DATE SUBMITTED: March 22, 2004	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 22, 2004	18. DATE APPROVED: May 3, 2004
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2004	20. SIGNATURE OF REGIONAL OFFICIAL: //Thomas W. Lenz-signature//
21. TYPED NAME: Thomas W. Lenz	22. TITLE: Associate Regional Administrator for DMCH
23. REMARKS:	

FORM HCFA-179 (07-92)