DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

June 13, 2012

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

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

SUBJECT: Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance for Outpatient Services (A-07-11-03172)

Attached, for your information, is an advance copy of our final report on Montana's Medicaid payments for dual eligible individuals' Medicare Part B deductibles and coinsurance. We will issue this report to the Montana Department of Public Health and Human 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-07-11-03172.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

June 18, 2012

Report Number: A-07-11-03172

Ms. Mary E. Dalton
State Medicaid Director
Department of Public Health and Human Services
P.O. Box 4210
Helena, MT 59604-4210

Dear Ms. Dalton:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance for Outpatient Services*. 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-07-11-03172 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

MONTANA DID NOT PROPERLY PAY MEDICARE PART B DEDUCTIBLES AND COINSURANCE FOR OUTPATIENT SERVICES

Daniel R. Levinson
Inspector General

June 2012
A-07-11-03172

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 Montana, the Department of Public Health and 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, carriers, or Medicare administrative contractors to process and pay Medicare Part B outpatient claims submitted by providers. Medicare Part B outpatient services include laboratory, radiology, and surgery services submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital outpatient departments, rural health clinics, and community mental health centers.

"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 B deductibles and coinsurance paid for by the Medicaid program.

After the Medicare contractor pays a Medicare Part B claim for a dual eligible and assesses the Medicare Part B 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 B deductibles and coinsurance and then pays the provider through the usual Medicaid payment system. We refer to such claims as crossover claims.

The Montana 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 B deductibles and coinsurance for QMB Only, QMB Plus, SLMB Plus, and FBDE beneficiaries to the State Medicaid plan rate for all Medicare Part B outpatient services.

To execute the provisions of the State plan for Medicare Part B outpatient services, 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 B 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 to the Medicare Part B 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 $918 million (approximately $702 million 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 $6.2 million (approximately $4.8 million Federal share) for payments for Medicare Part B deductibles and coinsurance for outpatient services.

OBJECTIVE

Our objective was to determine whether the State agency claimed Medicaid payments for Medicare Part B deductibles and coinsurance for outpatient services in accordance with Federal requirements and the approved State plan.

SUMMARY OF FINDING

During FY 2009, the State agency did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance for outpatient services in accordance with Federal requirements and the approved State plan. Specifically, for 79 of the 100 claims in our sample, the State agency did not limit payment of Medicare Part B deductibles and coinsurance to State Medicaid plan rates as required under the State plan.

These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so. Based on the results of our sample, we estimate that the State agency claimed unallowable Medicaid payments of $1,451,873 ($1,113,789 Federal share) during FY 2009.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,113,789 to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance and

- develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part B deductibles and coinsurance for each crossover claim for outpatient services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our finding and with the two recommendations in the report.

With respect to our first recommendation, the State agency said that it revised the State plan in April 2001 and that the page listing the services that are covered at full coinsurance and deductible for Medicare was inadvertently not submitted with the revised plan. The State agency added that it never intended to change the payment methodology.

With respect to our second recommendation, the State agency said that it has submitted a State plan amendment to CMS to correct the State plan amendment from 2001.

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 maintain that our finding and recommendations are valid. The omission of a page from the submitted revised State plan 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.

In regard to our second recommendation, we acknowledge that the State agency has submitted a new State plan amendment to CMS. The State agency should develop and implement policies and procedures to ensure that it follows the 2001 State plan amendment until CMS approves the new State plan amendment.

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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 Montana, the Department of Public Health and 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), Montana's FMAP ranged from 76.29 percent to 77.14 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, carriers, or Medicare administrative contractors[2] to process and pay Medicare Part B outpatient claims submitted by providers. Medicare Part B outpatient services include laboratory, radiology, and surgery services submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital outpatient departments, rural health clinics, and community mental health centers.

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

[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.

(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 B deductibles and coinsurance paid for by the Medicaid program.[3]

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

After the Medicare contractor pays a Medicare Part B outpatient claim for a dual eligible and assesses the Medicare Part B deductibles and coinsurance, the contractor forwards the claim information to the appropriate State's Medicaid program. The State Medicaid program then determines, based on the guidelines established in its State plan, whether to pay part or all of the Medicare Part B deductibles and coinsurance and 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 B 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 B 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 B 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 B 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 B 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 B 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 B deductibles and coinsurance. However, because SLMB Plus and FBDE beneficiaries are entitled to full Medicaid benefits, they may be entitled to have Medicare Part B 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 B deductibles and coinsurance.

[3] There are other groups of dual eligible beneficiaries who are not qualified to have their Medicare Part B 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.

Montana Medicaid Program

In Montana, the State agency is responsible for processing crossover claims. Those responsibilities include establishing systems and internal controls, which include policies and procedures to accurately pay Medicare Part B 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 Montana 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 B deductibles and coinsurance for QMB Only, QMB Plus, SLMB Plus, and FBDE beneficiaries to the State Medicaid plan rate for all Medicare Part B services except mental health services subject to the Medicare psychiatric reduction, inpatient hospital ancillary services with Medicare Part B coverage only, services provided in federally qualified health centers, and nursing facility services, which are paid at special rates.

Montana uses codes to distinguish among several groups of crossover claims. Medicare outpatient claims from institutional providers are assigned a "W" code. Claims for services that are paid at special rates are not assigned a "W" code. In the remainder of this report, we refer to services set forth in claims assigned a "W" code as outpatient services.

To execute the provisions of the State plan for Medicare Part B outpatient services, 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 B 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 to the Medicare Part B 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 $918 million (approximately $702 million Federal share) during FY 2009. As part of these Medicaid payments, the State agency claimed approximately $6.2 million (approximately $4.8 million Federal share) for payments for Medicare Part B deductibles and coinsurance for outpatient services.

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Medicaid payments for Medicare Part B deductibles and coinsurance for outpatient services in accordance with Federal requirements and the approved State plan.

Scope

We reviewed approximately $6.2 million (approximately $4.8 million Federal share) in Medicaid payments for outpatient services that the State agency made and claimed for Federal reimbursement for Medicare Part B deductibles and coinsurance during FY 2009.

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 B deductibles and coinsurance.

We conducted fieldwork at the State agency in Helena, Montana, in March and April 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal requirements and the Montana State Medicaid plan;
- interviewed State agency officials to gain an understanding of their policies and procedures for claiming Medicare Part B deductibles and coinsurance;
- requested and received from the State agency crossover claim data for paid Medicare Part A and Medicare Part B deductibles and coinsurance;
- analyzed the crossover claim data and developed a database of payments to providers for Medicare Part B deductibles and coinsurance for outpatient services totaling 68,160 data records, each equaling 1 crossover claim;
- selected and reviewed a simple random sample of 100 paid crossover claims from our sampling frame of 68,160 crossover claims (Appendixes A and B) and, for each sampled crossover claim:
    - reviewed Medicare's payment and Medicare Part B 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 B 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;

- estimated 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 April 7, 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 RECOMMENDATIONS

During FY 2009, the State agency did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance for outpatient services in accordance with Federal requirements and the approved State plan. Specifically, for 79 of the 100 claims in our sample, the State agency did not limit payment of Medicare Part B deductibles and coinsurance to State Medicaid plan rates as required under the State plan.

These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so. Based on the results of our sample, we estimate that the State agency claimed unallowable Medicaid payments of $1,451,873 ($1,113,789 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 B 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 B deductibles and coinsurance paid on their behalf when a service is covered by both Medicare and Medicaid.

State Plan Requirements

The Montana State plan, section 3.2(b), requires coordination of Medicaid with Medicare and provides methods and standards for payment of Medicare Part B deductibles and coinsurance for outpatient services. Supplement 1 to Attachment 4.19-B of the State plan limits payment of Medicare Part B 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. Supplement 1 to Attachment 4.19-B of the State plan also limits payment of Medicare Part B deductibles and coinsurance for outpatient services on behalf of SLMB Plus and FBDE beneficiaries to the amount, if any, by which the State Medicaid plan rate exceeds the Medicare payment.

Unallowable Medicaid Payments

The State agency did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance for outpatient services in accordance with 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 B deductibles and coinsurance to State Medicaid plan rates for 79 of the 100 sampled claims. For those 100 claims, the State agency paid $8,669 but should have paid $5,244, a difference of $3,425 ($2,627 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 B deductibles and coinsurance for each crossover claim.

The table below presents three examples, using actual values drawn from the claims we sampled, for the calculation of allowable Medicare Part B deductibles and coinsurance.

Sample Crossover Claims for Outpatient Services

	Medicare		Medicaid			
Claim	Payment	Medicare Part B Deductibles and Coinsurance	State Medicaid Plan Rate	Payment	Allowable Payment for Medicare Part B Deductibles and Coinsurance	Unallowable Payment for Medicare Part B Deductibles and Coinsurance
A	$98	$30	$78	$30	$0	$30
B	446	105	480	105	34	71
C	9	95	134	95	95	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. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so. Based on the results of our sample, we estimate that the State agency claimed unallowable Medicaid payments of $1,451,873 ($1,113,789 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,113,789 to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance and

- develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part B deductibles and coinsurance for each crossover claim for outpatient services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our finding and with the two recommendations in the report.

With respect to our first recommendation, the State agency said that it revised the State plan in April 2001 and that the page listing the services that are covered at full coinsurance and deductible for Medicare was inadvertently not submitted with the revised plan. The State agency added that it never intended to change the payment methodology.

With respect to our second recommendation, the State agency said that it has submitted a State plan amendment to CMS to correct the State plan amendment from 2001.

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 maintain that our finding and recommendations 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 Montana State plan, Supplement 1 to Attachment 4.19-B, in effect during our audit period (MT SPA 01-010) limits payment of Medicare Part B deductibles and coinsurance to the State Medicaid plan rate, except for nursing facility services. The relevant provisions of MT SPA 01-010 are unambiguous and not open to interpretation. The omission of a page from the submitted revised State plan 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]

In regard to our second recommendation, we acknowledge that the State agency has submitted a new State plan amendment to CMS. The State agency should develop and implement policies and procedures to ensure that it follows the 2001 State plan amendment until the new State plan amendment is effective.

[5] The State agency did not provide us with the page it claims to have been missing from the revised State plan, but we note that each page of Supplement 1 to Attachment 4.19-B, in effect during our audit period (MT SPA 01-010) is substantially different from the versions they superseded (MT SPA 92-04). Moreover, Supplement 1 to Attachment 4.19-B, in effect during our audit period (MT SPA 01-010) appears to be complete.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicare Part B crossover claims for outpatient services paid by the Montana Department of Public Health and 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 B deductibles and coinsurance for outpatient services for FY 2009.[1] The initial database received from the State agency contained 304,920 lines of paid crossover Medicare Part A and Medicare Part B claims totaling $15,952,701.

We excluded the following from the initial database:

- 11,284 adjusted claims totaling $192 ("1" or "2" in the claim adjustment status code column);[2]
- 18,062 claims with a reimbursement of $2 or less, totaling $21,260;
- 3,534 lines of paid crossover Medicare Part A claims totaling $3,720,572; and
- 203,880 lines of paid crossover Medicare Part B claims that were not crossover Medicare Part B claims for outpatient services (any claim that did not have a "W" in the claim input form code column),[3] totaling $5,970,383.

The remaining crossover claims for dual eligibles' Medicare Part B deductibles and coinsurance for outpatient services constituted our sampling frame of 68,160 claims totaling $6,240,294 for FY 2009, from which we drew our random sample.

Each crossover claim for outpatient services 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 individual, any copayment, and the remaining deductibles and coinsurance crossed over to Medicaid.

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

[2] The claim adjustment status code is "0" for an original claim, "1" or "2" for an adjustment, and "F" for the final adjusted claim. We included only original claims or final adjusted claims in the database that we developed.

[3] A paid crossover claim for outpatient services is any claim that contains a "W" in the claim input form code. We included only crossover Medicare Part B claims for outpatient services in the database that we developed.

SAMPLE UNIT

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

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 B 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 Montana for unallowable dual eligibles' Medicare Part B 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)
68,160	$6,240,294	100	79	$8,669	$2,627

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

Point estimate	$1,790,352
Lower limit	1,113,789
Upper limit	2,466,915

APPENDIX C: STATE AGENCY COMMENTS

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210
(406) 444-5622
FAX (406) 444-1970

April 12, 2012

Report number: A-07-11-03172

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

Dear Mr. Cogley:

This letter is in response to the audit of Montana's payment for dual eligible recipient's premiums, deductibles and coinsurance that was conducted by the U.S. Department of Health and Human Services, Office of Inspector General (OIG). Montana Department of Public Health and Human Services (DPHHS) expresses our appreciation for the opportunity to review and comment on the draft report and is committed to working to resolve issues identified in this audit review. This response provides written comments for each recommendation contained in the report.

OIG Finding #1: During FY 2009 the State agency did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance for outpatient services in accordance with Federal requirements and the approved State plan. The State agency did not limit payment of Medicare Part B deductibles and coinsurance to State Medicaid plan rates as required under the State plan.

OIG Recommendation #1: Refund $1,113,789 to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance.

DPHHS Response: DPHHS respectfully disagrees with this finding. The section of the State plan that contained attachment 4.19-B; supplement 1, three pages in length, was reviewed by the OIG auditors. This section of the state plan was revised in April 2001 to summarize Medicare crossover payment methodology and explain how services are paid at a special rate. In this 2001 revision the page that contained the services that are covered at full coinsurance and deductible for Medicare was inadvertently not submitted with the revised state plan in 2001. The detail that explains how crossover claims were paid and still continue to pay was not changed in the state plan amendment. It was never the intent for Montana to change the payment methodology. Public notice was never given that Montana was going to decrease payment and our

administrative rule 37.85.406 (18) (a) (b) (c) (d) has continued to be consistent with the payment methodology described in the detail on page 3 from the 1992 version of the state plan, the page that was inadvertently left out of the revised submission to CMS in 2001.

OIG Finding #2: The State agency did not compare the Medicare payments to the state Medicaid plan rate. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so.

OIG recommendation #2: Develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part B deductibles and coinsurance for each crossover claim for outpatient services.

DPHHS Response: DPHHS respectfully disagrees with this finding. DPHHS has submitted a State plan amendment to the Centers for Medicare and Medicaid Services (CMS) to correct the state plan amendment from 2001, by submitting additional detail describing the services that allow for the payment of the Medicare deductibles and coinsurance as outlined in the 1992 version of the State Plan and under our Administrative Rules of Montana.

The State of Montana would also like to request that the title of the draft report is changed to reflect what the audit covered; *Review of Montana's Medicaid payments for Dual Eligible Individual's Medicare Part Be Deductibles and Coinsurance.*

Montana appreciated the opportunity to work with the U.S. Department of Health and Human Services, OIG. If you have any questions regarding the responses above, please contact Jeff Buska, Administrator, Quality Assurance Division, 406-444-5401.

Signed:

Mary E. Dalton

Mary E. Dalton
State Medicaid Director

Attachment

Cc Laurie Lamson, Operation Services Branch Manager
Duane Preshinger, Medicaid System Support Program Director
Jeff Buska, Quality Assurance Division Administrator
Terri Thompson, Program Compliance Bureau Chief
Dave Schiefen, TPL Supervisor