Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IOWA DID NOT PROPERLY PAY SOME MEDICARE PART A AND PART B DEDUCTIBLES AND COINSURANCE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Patrick J. Cogley
Regional Inspector General

November 2012
A-07-12-03178

Office of Inspector General

https://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 Iowa, the Department of Human Services (State agency) administers the Medicaid program.

As part of the implementation of its Medicaid program, States can submit demonstration waiver requests to CMS under the provisions of section 1115 of the Act. These demonstration waivers, upon approval, allow exceptions to certain requirements and limitations of the Act. Two approved demonstration waivers in Iowa are the IowaCare demonstration waiver and the Family Planning demonstration waiver. The IowaCare demonstration waiver provides services and coverage to individuals not normally eligible for either Medicaid or Medicare. The Family Planning demonstration waiver provides specific services and coverage to individuals not normally eligible for Medicaid.

In addition to the demonstration waivers, section 1902 of the Act allows States to provide Medicaid services and coverage for an optional-coverage group of women who have been screened for breast or cervical cancer and need treatment, but who are not otherwise covered under creditable coverage (i.e. Medicare).

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 permanent kidney disease. CMS contracts with fiscal intermediaries, carriers, or Medicare administrative contractors (Medicare contractors) to process and pay Medicare Part A and Part B claims submitted by providers.

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

After the Medicare contractor pays a Medicare Part A or Part B claim for a dual eligible and assesses the Medicare Part A or 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 A or 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 State agency claimed Federal reimbursement for Medicaid payments totaling approximately $3.34 billion (approximately $2.27 billion Federal share) during fiscal year (FY) 2011 (October 1, 2010, through September 30, 2011). As part of these Medicaid payments, the State agency claimed approximately $107.9 million (approximately $73.8 million Federal share) for payments for Medicare Part A and Part B deductibles and coinsurance.

OBJECTIVE

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

SUMMARY OF FINDINGS

During FY 2011, the State agency did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, the State agency did not limit:

- enrollment in the IowaCare demonstration waiver to persons not otherwise eligible for Medicare (unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance due to this error totaled $157,168 ($106,177 Federal share));

- enrollment in the optional breast or cervical cancer treatment to persons not otherwise covered under creditable coverage (i.e. Medicare) (unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance due to this error totaled $46,012 ($33,976 Federal share)); and

- Medicaid payments for Medicare Part A and Part B deductibles and coinsurance made on behalf of women under the Family Planning demonstration waiver to those services listed as allowable (unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance due to this error totaled $8,291 ($7,462 Federal share)).

Based on the results of our audit, the State agency claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance of $211,471 ($147,615 Federal share) during FY 2011.

RECOMMENDATIONS

We recommend that the State agency:

- refund $147,615 to the Federal Government; and

- ensure that Medicaid payments for Medicare Part A and Part B deductibles and coinsurance are allowable under Federal requirements and the approved State plan, specifically by limiting:

- IowaCare enrollment to persons not otherwise eligible for Medicare;

- optional breast or cervical cancer treatment enrollment to persons not otherwise covered under creditable coverage (i.e. Medicare); and

- Medicaid payments for Medicare Part A and Part B deductibles and coinsurance made on behalf of women under the Family Planning demonstration waiver to those services listed as allowable.

STATE AGENCY COMMENTS

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

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

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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 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 Iowa, the Department of 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. Certain Medicaid services receive a higher FMAP, including family planning services[1] and breast or cervical cancer treatment.[2] During fiscal year (FY) 2011 (October 1, 2010, through September 30, 2011), Iowa's FMAP ranged from 62.63 percent to 72.55 percent.[3]

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 permanent kidney disease. CMS contracts with fiscal intermediaries, carriers, or Medicare administrative contractors (Medicare contractors) to process and pay Medicare Part A and Part B claims submitted by providers.

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] Section 1903(a)(5) of the Act and 42 CFR §§ 433.10 and 433.15 provide for an enhanced FMAP rate of 90-percent for family planning services.

[2] Pursuant to CMS's letter to State Health Officials, dated January 4, 2001: "The Federal matching rate for the new eligibility group [breast or cervical cancer treatment] is equal to the enhanced Federal Medical Assistance Percentage (FMAP) used in the State Children's Health Insurance Program (SCHIP) (described in § 2105(b) of the Social Security Act (the Act))."

[3] 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.

(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 and Part B deductibles and coinsurance paid for by the Medicaid program.[4]

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

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

Iowa Medicaid Program

Iowa State Plan

In Iowa, 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 A and Part B deductibles and coinsurance in accordance with the State plan.

Demonstration Waivers in Iowa

States can submit demonstration waiver requests to CMS under the provisions of section 1115 of the Act. These demonstration waivers, upon approval, allow exceptions to certain requirements and limitations of the Act. Two approved demonstration waivers in Iowa are the IowaCare demonstration waiver and the Family Planning demonstration waiver. The IowaCare demonstration waiver provides services and coverage to individuals not normally eligible for either Medicaid or Medicare. The Family Planning demonstration waiver provides specific services and coverage to individuals not normally eligible for Medicaid.

Breast or Cervical Cancer Treatment

In addition to the demonstration waivers, section 1902 of the Act allows States to provide Medicaid services and coverage for an optional-coverage group of women who have been screened for breast or cervical cancer and need treatment, but who are not otherwise covered under creditable coverage (i.e. Medicare).

[4] There are other groups of dual eligible beneficiaries who are not qualified to have their Medicare Part A and 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.

Medicaid Payments Claimed by the State Agency During Fiscal Year 2011

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately $3.34 billion (approximately $2.27 billion Federal share) during FY 2011 (October 1, 2010, through September 30, 2011). As part of these Medicaid payments, the State agency claimed approximately $107.9 million (approximately $73.8 million Federal share) for payments for Medicare Part A and Part B deductibles and coinsurance.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed approximately $107.9 million (approximately $73.8 million Federal share) in Medicaid payments for crossover claims that the State agency claimed for Federal reimbursement for Medicare Part A and Part B deductibles and coinsurance during FY 2011.

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 and Part B deductibles and coinsurance.

We conducted fieldwork at the State agency in Des Moines, Iowa, in March 2012.

Methodology

To accomplish the objective, we reviewed:

- applicable Federal requirements and the approved Iowa State plan;
- reviewed the demonstration waiver requirements;
- interviewed State agency officials to gain an understanding of their policies, procedures, and internal controls for claiming Medicare Part A and Part B deductibles and coinsurance;
- requested and received from the State agency crossover claim data for paid Medicare Part A and Part B deductibles and coinsurance;
- analyzed crossover claim data and developed three datasets of payments to providers for Medicare Part A and Part B deductibles and coinsurance for: (1) the IowaCare

demonstration waiver, (2) breast or cervical cancer treatment, and (3) the Family Planning demonstration waiver;

- reviewed 100 percent of the crossover claim data in the three datasets;

- computed the unallowable Medicaid payments for each dataset; and

- discussed our results with State agency officials on July 26, 2012.

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 2011, the State agency did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, the State agency did not limit:

- enrollment in the IowaCare demonstration waiver to persons not otherwise eligible for Medicare (unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance due to this error totaled $157,168 ($106,177 Federal share));

- enrollment in the optional breast or cervical cancer treatment to persons not otherwise covered under creditable coverage (i.e. Medicare) (unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance due to this error totaled $46,012 ($33,976 Federal share)); and

- Medicaid payments for Medicare Part A and Part B deductibles and coinsurance made on behalf of women under the Family Planning demonstration waiver to those services listed as allowable (unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance due to this error totaled $8,291 ($7,462 Federal share)).

Based on the results of our audit, the State agency claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance of $211,471 ($147,615 Federal share) during FY 2011.

UNALLOWABLE MEDICAID PAYMENTS CLAIMED

IowaCare Medicaid Payments

Federal regulations (42 CFR § 431.420(a)(2)) state: "States must comply with the [special] terms and conditions of the agreement between the Secretary [of Health and Human Services] and the State to implement a State demonstration project [waiver]."

The agreement between CMS and the State agency regarding the IowaCare demonstration waiver specifies, as part of the special terms and conditions, that the expansion population is comprised of persons "… not otherwise eligible for Medicaid or Medicare."

The State agency did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with Federal requirements. Specifically, the State agency did not comply with the special terms and conditions of its agreement with CMS when implementing the approved IowaCare demonstration waiver. Under the IowaCare demonstration waiver's special terms and conditions, expansion population enrollment is limited to persons not otherwise eligible for Medicaid or Medicare.

During our review of the crossover claims, we found Medicaid payments for Medicare Part A and Part B deductibles and coinsurance for persons enrolled in IowaCare, which meant that these persons were, in fact, eligible for Medicare. Therefore, contrary to the provisions of the IowaCare demonstration waiver, the State agency did not limit expansion population enrollment during FY 2011 to persons not eligible for Medicare. As a result, the State agency claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance of $157,168 ($106,177 Federal share) for 325 persons enrolled in the IowaCare demonstration waiver program.

Breast or Cervical Cancer Treatment Medicaid Payments

Sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa)(4) of the Act define a group of women who qualify for the breast or cervical cancer treatment as individuals who "… are not otherwise covered under creditable coverage …." Federal regulations (42 U.S.C. § 300gg(c)(1)) define creditable coverage as "… coverage of the individual under … Part A or [P]art B of [T]itle XVIII of the Social Security Act [Medicare] …."

Further, Section 1902(a) 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 …." In addition, Federal regulations (42 CFR § 431.50(b)(1)) expand upon this provision of the Act by requiring that the State plan "… be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State."

The Iowa State plan, Attachment 2.2-A, provides for an optional coverage group of women who "… have been screened for breast or cervical cancer … and need treatment …" and who "… [a]re not otherwise covered under creditable coverage …."

The State agency did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, the State agency did not comply with enrollment requirements for optional breast or cervical cancer treatment. Under the approved State plan, enrollment is limited to persons not otherwise covered under creditable coverage (i.e. Medicare).

During our review of the crossover claims, we found Medicaid payments for Medicare Part A and Part B deductibles and coinsurance for persons enrolled in breast or cervical cancer treatment, which meant that these persons were, in fact, eligible for Medicare. Therefore, contrary to the enrollment requirements for optional breast or cervical cancer treatment, the State agency did not limit enrollment during FY 2011 to persons not eligible for creditable coverage (i.e. Medicare). As a result, the State agency claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance of $46,012 ($33,976 Federal share) for 28 persons enrolled in breast or cervical cancer treatment.

Family Planning Medicaid Payments

Federal regulations (42 CFR § 431.420(a)(2)) state: "States must comply with the [special] terms and conditions of the agreement between the Secretary [of Health and Human Services] and the State to implement a State demonstration project [waiver]."

The agreement between CMS and the State agency regarding the Family Planning demonstration waiver specifies, as part of the special terms and conditions, that Federal financial participation for the "… services (including prescriptions) provided to women under the family planning demonstration [waiver] will be … described in Attachment B." Attachment B of the waiver is a list of allowable services and corresponding procedure codes. The list includes procedure codes, a description of the code, and the Federal reimbursement rate for each code.

The State agency did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with Federal requirements. Specifically, the State agency did not comply with the special terms and conditions of its agreement with CMS in implementing the approved Family Planning demonstration waiver, because it did not limit Medicaid payments during FY 2011 for Medicare Part A and Part B deductibles and coinsurance, made on behalf of women under the waiver, to allowable services. As a result, the State agency claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance of $8,291 ($7,462 Federal share) for services provided to 28 women that were unallowable under the Family Planning demonstration waiver.

RECOMMENDATIONS

We recommend that the State agency:

- refund $147,615 to the Federal Government; and

- ensure that Medicaid payments for Medicare Part A and Part B deductibles and coinsurance are allowable under Federal requirements and the approved State plan, specifically by limiting:

    - IowaCare enrollment to persons not otherwise eligible for Medicare;

    - optional breast or cervical cancer treatment enrollment to persons not otherwise covered under creditable coverage (i.e. Medicare); and

- Medicaid payments for Medicare Part A and Part B deductibles and coinsurance made on behalf of women under the Family Planning demonstration waiver to those services listed as allowable.

STATE AGENCY COMMENTS

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

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

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

Iowa Department of Human Services

Terry E. Branstad, Governor
Kim Reynolds, Lt. Governor
Charles M. Palmer, Director

OCT 16 2012

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

RE: *Iowa Did Not Properly Pay Some Medicare Part A and Part B Deductibles and Coinsurance*, Draft Report, A-07-12-03178

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS) on the September 24, 2012, draft report concerning Office of Inspector General's (OIG) review of the deductible and coinsurance process at DHS.

DHS appreciates the opportunity to respond to the draft report and provide additional comments to be included in the final report. Questions about the attached response can be addressed to:

Jody Lane-Molnari, Executive Officer II
Division of Fiscal Management
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Hoover State Office Building, 1st Floor SW
1305 E Walnut Street
Des Moines, IA 50319-0114

Email: jlanemo@dhs.state.ia.us
Phone: 515-281-6027

Sincerely,

C M Palmer

Charles M. Palmer
Director

cc: Greg Tambke, Audit Manager

RE: A-07-11-03178

IOWA DEPARTMENT OF HUMAN SERVICES
RESPONSE TO OIG DRAFT REPORT:

Iowa Did Not Properly Pay Some Medicare Part A and Part B Deductibles and Coinsurance, Report A-07-12-03178

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. 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 Iowa, the Department of Human Services (DHS) administers the Medicaid program.

As part of the implementation of its Medicaid program, states can submit demonstration waiver requests to CMS under the provisions of section 1115 of the Act. These demonstration waivers, upon approval, allow exceptions to certain requirements and limitations of the Act. Two approved demonstration waivers in Iowa are the IowaCare demonstration waiver and the Iowa Family Planning Network (IFPN) demonstration waiver. The IowaCare demonstration waiver provides services and coverage to individual not normally eligible for either Medicaid or Medicare. The IFPN demonstration waiver provides specific services and coverage to individuals not normally eligible for Medicaid.

In addition to the demonstration waivers, section 1902 of the Act allows states to provide Medicaid services and coverage for an optional-coverage group of women who have been screened for breast or cervical cancer and need treatment, but who are not otherwise covered under creditable coverage (i.e., Medicare).

"Dual eligibles" are individual 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 (QBM 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 and Part B deductibles and coinsurance paid by the Medicaid program.

After the Medicare contractor pays a Medicare Part A or part B claim for a dual eligible and assesses the Medicare part A or 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 their State Plan, whether to pay part of all of the Medicare Part A or Part B deductibles and coinsurance, and then pays the provider through the usual Medicaid payment system. These are referred to as crossover claims.

RE: A-07-11-03178

OIG Findings and Recommendations

Iowa DHS claimed federal reimbursement for Medicaid payments totaling approximately $3.34 billion (approximately $2.27 billion federal share) during federal fiscal year 2011. As part of these Medicaid payments, DHS claimed approximately $107.9 million (approximately $73.8 million federal share) for payments for Medicare Part A and Part B deductibles and coinsurance.

OIG found that during FFY11, DHS did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with the federal requirements and the approved State Plan. Specifically, DHS did not limit:

- Enrollment in the IowaCare demonstration waiver to persons not otherwise eligible for Medicare. This resulted in unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance and an error of $157,168 ($106,177 federal share);
- Enrollment in the optional Breast or Cervical Cancer Treatment (BCCT) program to persons not otherwise covered under credible coverage (i.e., Medicare). This resulted in unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance and an error of $46,012 ($33,976 federal share);
- Medicaid payments for Medicare Part A and Part B deductibles and coinsurance made on behalf of women under the IFPN demonstration waiver to those services listed as allowable. This resulted in unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance and an error of $8,291 ($7,462 federal share).

Based on the results of the audit, OIG finds that DHS claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance of $211,471 ($147,615 federal share).

OIG recommends that DHS:

- Refund $147,615 to the federal government; and
- Ensure that Medicaid payments for Medicare Part A and Part B deductibles and coinsurance are allowable under federal requirements and the approved State Plan, specifically by limiting:
    - IowaCare enrollment to persons not otherwise eligible for Medicare;
    - Optional BCCT program enrollment to persons not otherwise covered under credible coverage (i.e., Medicare); and\
    - Medicaid payments for Medicare Part A and Part B deductibles and coinsurance made on behalf of women under the IFPN demonstration waiver to those services listed as allowable.

RE: A-07-11-03178

DHS Response

The Iowa Department of Human Services concurs with the recommendation as to the refund of $147,615 to the federal government. Please see the discussion for each of the findings and recommendations as detailed below which address the corrective actions taken and planned for each finding.

IowaCare Medicaid Payments

In OIG's evaluation, DHS did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with federal requirements. The agreement between CMS and DHS regarding the IowaCare demonstration waiver specifies, as part of the special terms and conditions, that the expansion population is comprised of persons "... not otherwise eligible for Medicaid or Medicare."

In the review of the crossover claims, DHS claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance for 325 persons enrolled in the IowaCare demonstration waiver program, when in fact, these persons were eligible for Medicare.

Response:

The Iowa Department of Human Services concurs with the referenced finding and the recommendation.

To address this finding, DHS has taken and will take the following actions:

- On September 17, 2012, DHS notified Income Maintenance Workers not to approve or renew IowaCare for individuals who are enrolled in Medicare. Additionally, a listing of IowaCare cases with Medicare was generated. The action was taken on the approximately 500 cases to cancel eligibility with timely notice effective November 1, 2012.
- A new process was implemented in October 2012 to send a notice to the Income Maintenance Worker when an IowaCare member becomes newly eligible for Medicare.
- Rules regarding timely notice prevent retroactive cancellation of eligibility. It is possible that there will occasionally be members who have dual eligibility until timely notice can be provided to cancel IowaCare coverage.

Breast or Cervical Cancer Treatment Program Medicaid Payments

In OIG's evaluation, DHS did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with federal requirements and the approved State Plan. The State Plan provides for an optional coverage group of women who "... have been screened for breast or cervical cancer ... and need treatment ..." and who "... are not otherwise covered under creditable coverage ...."

RE: A-07-11-03178

In the review of the crossover claims, DHS claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance for 28 persons enrolled in the BCCT program, when in fact, these persons were eligible for Medicare.

Response:

The Iowa Department of Human Services concurs with the referenced finding and the recommendation.

To address this finding, DHS has taken and will take the following actions:

- A report is generated each month listing BCCT members who have other insurance, including Medicare, in the current month. Additionally a notice, requesting cancellation and that an automatic redetermination be conducted, is sent to the Income Maintenance Worker upon identification that the BCCT member has Medicare.
- Rules regarding timely notice prevent retroactive cancellation of eligibility. It is possible that there will occasionally be members who have dual eligibility until timely notice to cancel the BCCT coverage can be provided.

Family Planning Medicaid Payments

In OIG's evaluation, DHS did not always claim Medicaid payments for Medicare Part A and Part B deductibles and coinsurance in accordance with federal requirements. The agreement between CMS and DHS regarding the IFPN waiver specifies, as part of the special terms and conditions, that federal financial participation for the "... services (including prescriptions) provided to women under the family planning demonstration [waiver] will be ... described in Attachment B." Attachment B is a list of allowable services and corresponding procedure codes.

In the review of the crossover claims, DHS claimed unallowable Medicaid payments for Medicare Part A and Part B deductibles and coinsurance for services provided to 28 women that were unallowable services as described in Attachment B of the IFPN demonstration waiver.

Response:

The Iowa Department of Human Services concurs with the referenced finding and the recommendation.

To address this finding, DHS has taken and will take the following actions:

- Issue 33849 has been opened with the CORE MMIS team to add the following system edit. For a cross-over claim, if the member only has IFPN waiver eligibility, if the claim does not have a procedure and/or diagnosis matching the IFPN waiver program, deny the claim for co-insurance and deductible payment. The edit is expected to be in place by November 30, 2012.