Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

UTAH DID NOT PROPERLY PAY SOME MEDICARE 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

January 2014
A-07-13-03191

Office of Inspector General

https://oig.hhs.gov/

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EXECUTIVE SUMMARY

Utah claimed approximately $660,000 of unallowable Medicaid payments for Medicare deductibles and coinsurance for services during Federal fiscal years 2011 and 2012.

WHY WE DID THIS REVIEW

Medicaid pays for Medicare deductibles and coinsurance to providers on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. In Utah, the Department of Health, Division of Medicaid & Health Financing (State agency), administers the Medicaid program. Previous Office of Inspector General reviews found that other States did not always claim Medicaid payments for Medicare deductibles and coinsurance (crossover claims) in accordance with Federal requirements and the approved State plan.

The objective of this review was to determine whether the State agency claimed Medicaid payments for Medicare deductibles and coinsurance in accordance with Federal requirements and the approved State plan.

BACKGROUND

In Utah, 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 deductibles and coinsurance in accordance with the State plan.

To execute the provisions of the State plan for Medicare 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 deductibles and coinsurance. Based on this comparison, the allowable payment is the lesser of (1) the Medicaid-allowed charge minus the Medicare payment or (2) the sum of the Medicare deductibles and coinsurance.

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately $3.6 billion (approximately $2.7 billion Federal share) during Federal fiscal years (FYs) 2011 and 2012 (October 1, 2010, through September 30, 2012). As part of these Medicaid payments, the State agency claimed approximately $31.4 million (approximately $23.2 million Federal share) for payments for Medicare deductibles and coinsurance.

WHAT WE FOUND

During FYs 2011 and 2012, the State agency did not always claim Medicaid payments for Medicare deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, the State agency did not limit payment of Medicare deductibles and coinsurance by State Medicaid plan rates as required under the State plan. Because Federal requirements provide that a State plan for medical assistance is mandatory upon the State and all of its political subdivisions, these claims thus violated Federal requirements as well as the requirements of the State plan.

These errors occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate as required by the State plan. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so for all Medicare crossover claims. As a result, the State agency claimed unallowable Medicaid payments of $905,354 ($660,453 Federal share) during FYs 2011 and 2012.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $660,453 to the Federal Government for unallowable Medicaid payments for Medicare deductibles and coinsurance and

- develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State plan, to determine the allowable Medicare deductibles and coinsurance for all crossover claims.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it had taken or planned to take. The State agency also provided additional documentation as to the dollar amounts associated with some of our findings. After reviewing that documentation, we have accepted those revised dollar amounts and revised the references to them for this final report.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicaid pays for Medicare deductibles and coinsurance to providers on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. In Utah, the Department of Health, Division of Medicaid & Health Financing (State agency), administers the Medicaid program. Previous Office of Inspector General reviews (Appendix A) found that other States did not always claim Medicaid payments for Medicare deductibles and coinsurance (crossover claims) in accordance with Federal requirements and the approved State plan.

OBJECTIVE

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

BACKGROUND

Medicaid Program

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.

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), reports actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The reported amounts must be actual expenditures with supporting documentation. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a 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 Federal fiscal years (FYs) 2011 and 2012 (October 1, 2010, through September 30, 2012), Utah's FMAP ranged from 70.99 percent to 80.78 percent.[1]

Medicare Program

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS, which administers the program, contracts with Medicare contractors to process and pay Medicare claims submitted by providers.

[1] Under the provisions of 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.

Medicare helps cover medically necessary inpatient services, nursing home services, doctors' services and tests, outpatient care, home health services, and durable medical equipment.

Medicaid's Role in Paying Medicare Deductibles and Coinsurance for Dual Eligibles

"Dual eligibles" are individuals who are entitled to both Medicare and some form of Medicaid benefits. A dual eligible may be classified into one of several groups. Several of these groups are qualified to have their Medicare deductibles and coinsurance paid for by the Medicaid program.

After the Medicare contractor pays a Medicare claim for a dual eligible and assesses the Medicare deductibles and coinsurance, the contractor forwards the crossover claim information to the appropriate State's Medicaid program. The State Medicaid program determines, on the basis of the requirements established in its State plan, whether to pay part or all of the Medicare deductibles and coinsurance and then pays the provider through the usual Medicaid payment system.[2] In all cases, the amount paid by the State, if any, is payment in full for Medicare deductibles and coinsurance.

Appendix B contains an explanation of the dual eligible groups and details of Medicaid's role in paying Medicare deductibles and coinsurance.

Utah Medicaid Program

In Utah, 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 deductibles and coinsurance in accordance with the State plan.

The Utah 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 deductibles and coinsurance to four specified groups of dual eligible beneficiaries. Payment is limited by the State plan rate for all Medicare services.

To execute the provisions of the State plan for Medicare 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 deductibles and coinsurance. Based on this comparison, the allowable payment is the lesser of (1) the Medicaid-allowed charge minus the Medicare payment or (2) the sum of the Medicare deductibles and coinsurance.

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately $3.6 billion (approximately $2.7 billion Federal share) during FYs 2011 and 2012. As part of these Medicaid payments, the State agency claimed approximately $31.4 million (approximately $23.2 million Federal share) for payments for Medicare deductibles and coinsurance.

[2] The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

HOW WE CONDUCTED THIS REVIEW

We reviewed claimed Medicaid payments for Medicare deductibles and coinsurance totaling approximately $31.4 million (approximately $23.2 Federal share) for which the State agency claimed Federal reimbursement during FYs 2011 and 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 objectives.

Appendix C contains details of our audit scope and methodology.

FINDINGS

During FYs 2011 and 2012, the State agency did not always claim Medicaid payments for Medicare deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, the State agency did not limit payment of Medicare deductibles and coinsurance by State Medicaid plan rates as required under the State plan. Because Federal requirements provide that a State plan for medical assistance is mandatory upon the State and all of its political subdivisions, these claims thus violated Federal requirements as well as the requirements of the State plan.

These errors occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate as required by the State plan. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so for all Medicare crossover claims. As a result, the State agency claimed unallowable Medicaid payments of $905,354 ($660,453 Federal share) during FYs 2011 and 2012.

STATE AGENCY CLAIMED UNALLOWABLE MEDICAID PAYMENTS

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

The Utah State plan, section 3.2(b), requires coordination of Medicaid with Medicare and provides methods and standards for payment of Medicare deductibles and coinsurance. In addition, the State plan (Supplement 1 to Attachment 4.19-B) limits payment of Medicare deductibles and coinsurance on behalf of beneficiaries to the amount, if any, by which the State Medicaid plan rate exceeds the Medicare payment.

Details on the Federal and State requirements related to Medicaid payments for Medicare deductibles and coinsurance appear in Appendix D.

Contrary to these Federal and State requirements, the State agency did not always limit payment of Medicare deductible and coinsurance claims to the State plan rate. For those claims, the State agency paid $31,376,348 but should have paid $30,470,994, a difference of $905,354 ($660,453 Federal share).

STATE AGENCY DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The State agency did not compare the Medicare payments to the State Medicaid plan rate to determine the allowable Medicare deductibles and coinsurance for all crossover claims. The table below presents three examples, using actual values drawn from the claims we reviewed, in determining the allowable Medicare deductibles and coinsurance.

Sample Crossover Claims

	Medicare		Medicaid			
Claim	Payment	Medicare Deductibles and Coinsurance	State Medicaid Plan Rate	Payment	Allowable Payment for Medicare Deductibles and Coinsurance	Unallowable Payment for Medicare Deductibles and Coinsurance
A	$15,405	$1,156	$11,225	$1,156	$0	$1,156
B	503	126	537	126	34	92
C	26	6	27	1	1	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 have policies and procedures requiring it to compare the Medicare payment to the State Medicaid plan rate for all Medicare crossover claims. As a result, the State agency claimed unallowable Medicaid payments of $905,354 ($660,453 Federal share) during FYs 2011 and 2012.

RECOMMENDATIONS

We recommend that the State agency:

- refund $660,453 to the Federal Government for unallowable Medicaid payments for Medicare deductibles and coinsurance and

- develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State plan, to determine the allowable Medicare deductibles and coinsurance for all crossover claims.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it had taken or planned to take. The State agency also provided additional documentation as to the dollar amounts associated with some of our findings. After reviewing that documentation, we have accepted those revised dollar amounts and revised the references to them for this final report.

The State agency's comments appear in their entirety as Appendix E.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Review of Nebraska's Medicaid Payments for Dual Eligible Individuals' Medicare Part A Deductibles and Coinsurance	A-07-11-03161	2/6/2012
Nebraska Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance	A-07-11-03168	2/29/2012
Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance for Outpatient Services	A-07-11-03172	6/18/2012
Iowa Did Not Properly Pay Some Medicare Part A and Part B Deductibles and Coinsurance	A-07-12-03178	11/20/2012

APPENDIX B: DUAL ELIGIBLE GROUPS AND DETAILS OF MEDICAID'S ROLE IN PAYING MEDICARE DEDUCTIBLES AND COINSURANCE

Dual eligibles may be classified into several groups, 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.[3]

After the Medicare contractor pays a Medicare claim for a dual eligible and assesses the Medicare deductibles and coinsurance, the contractor forwards the crossover claim information to the appropriate State's Medicaid program. The State Medicaid program then determines, on the basis of the requirements established in its State plan, whether to pay part or all of the Medicare deductibles and coinsurance and then pays the provider through the usual Medicaid payment system (the MMIS).

For beneficiaries classified in the QMB Only and QMB Plus eligibility groups, States are mandated to pay Medicare deductibles and coinsurance. Federal statute permits Medicare payment for a service, plus the Medicaid payment for any Medicare deductibles and coinsurance, to exceed the State plan rate for the service (the Act, § 1902(n)(2)). This statute adds, however, that a State is not required to pay for Medicare 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 deductible and coinsurance coverage, and the Medicare payment for a service is equal to or exceeds the State Medicaid plan rate, the State makes no payment for Medicare 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 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 deductibles and coinsurance. However, because SLMB Plus and FBDE beneficiaries are entitled to full Medicaid benefits, they may be entitled to have Medicare 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.

The Utah 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 deductibles and coinsurance for QMB Only, QMB Plus, SLMB Plus, and FBDE beneficiaries by the State Medicaid plan rate for all Medicare services.

[3] There are other groups of dual eligible beneficiaries who are not qualified to have their Medicare deductibles and coinsurance paid for by the Medicaid program: SLMB without full Medicaid, Qualified Disabled and Working Individual, and Qualifying Individual.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid payments totaling $31,376,348 ($23,162,302 Federal share) for services whose payments were limited by the State Medicaid plan rate that the State agency made and claimed for Federal reimbursement for Medicare deductibles and coinsurance for FYs 2011 and 2012. We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed audit work from June to August 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and the State Medicaid plan;
- interviewed State agency officials to gain an understanding of their policies and procedures for claiming Medicare deductibles and coinsurance;
- requested and received from the State agency crossover claim data for paid Medicare deductibles and coinsurance;
- analyzed the crossover claim data and developed a database of payments to providers for Medicare deductibles and coinsurance for services whose payments are limited by the State Medicaid plan rate;
- reviewed all 488,422 crossover claims for FYs 2011 and 2012 and, for each crossover claim:
    - reviewed Medicare's payment and Medicare 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 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; and
- discussed the results of our review with State agency officials on September 17, 2013.

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 objectives.

APPENDIX D: FEDERAL AND STATE REQUIREMENTS RELATED TO MEDICAID PAYMENTS FOR MEDICARE DEDUCTIBLES AND COINSURANCE

FEDERAL REQUIREMENTS

The Act, section 1902(a), 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."

The Act, section 1902(n)(1), states:

> In the case of medical assistance furnished under this title for [M]edicare cost-sharing respecting the furnishing of a service or item to a qualified [M]edicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified [M]edicare beneficiaries.[4]

The Act, section 1902(n)(2), states: "In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for [M]edicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a [M]edicare beneficiary."

STATE REQUIREMENTS

The Utah State plan, section 3.2(b), requires coordination of Medicaid with Medicare and provides methods and standards for payment of Medicare deductibles and coinsurance.

The Utah State plan, Supplement 1 to Attachment 4.19-B, states:

> Medicaid payment for Medicare crossover claims will be the allowed Medicaid payment rate less any amounts paid by Medicare and other payors. In the event Medicaid does not have a price for codes included on a crossover claim, the Medicaid price will be 80 percent of the Medicare price.

[4] Title XVIII of the Act promulgates the Medicare program.

APPENDIX E: STATE AGENCY COMMENTS

State of Utah

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SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

January 03, 2013

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

Dear Mr. Cogley:

Thank you for the opportunity to respond to the audit entitled "Utah Did Not Properly Pay Some Medicare Deductibles and Coinsurance" (Report # A-07-13-03191). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff has spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with the recommendations in this report. Our response describes the actions the Department plans to take to implement the recommendations. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing

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Response to Recommendations

Recommendation 1

> *Refund $687,401 to the Federal Government for unallowable Medicaid payments for Medicare deductibles and coinsurance and;*

Division response:

We concur with this recommendation.

The amount that the Division will pay back to CMS is $660,453.42 instead of the $687,401 initially identified. Once all required programming changes were applied to the identified claims, the overpayment amount was recalculated to be $660,453.42.

The Federal share of this refund amount will be returned to CMS and reported on the Quarterly CMS-64, line 10A.

Contact: Rick Platt, Director, Bureau of Financial Services, DMHF 801-538-7015
Anticipated Implementation Date: Refunds will be compliant with 42 CFR 433.320.

Recommendation 2

> *Develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State Plan, to determine the allowable Medicare deductibles and coinsurance for all crossover claims.*

Division response:

We concur with this recommendation.

The Division has made the majority of the corrections necessary in the MMIS to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State Plan, to determine the allowable Medicare deductibles and coinsurance for all crossover claims. Final programming adjustments will be completed by April 1, 2014.

Contact: Rick Platt, Director, Bureau of Financial Services, DMHF 801-538-7015
Anticipated Implementation Date: April 1, 2014.