



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



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May 24, 2012

Report Number: A-03-10-00201

Ms. Cynthia B. Jones
Director
Virginia Department of Medical Assistance Services
600 East Broad Street, suite 1300
Richmond, VA 23219

Dear Ms. Jones:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Virginia's Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries from January 2008 Through December 2009*. 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, or contact Leonard Piccari, Audit Manager, at (215) 861-4493 or through email at Leonard.Piccari@oig.hhs.gov. Please refer to report number A-03-10-00201 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF VIRGINIA'S BUY-IN OF
MEDICARE PART B
PREMIUMS FOR MEDICAID
BENEFICIARIES FROM JANUARY 2008
THROUGH DECEMBER 2009**



Daniel R. Levinson
Inspector General

May 2012
A-03-10-00201

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

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.

“Dual eligibles” are low-income individuals who are eligible for benefits under both Medicare and Medicaid because they are either elderly or disabled. Section 1843 of the Social Security Act allows State Medicaid programs to enroll certain dual eligibles in the Medicare Part A and B programs and to pay the monthly premiums on behalf of those individuals. Medicaid generally reimburses the State for the premiums at the Federal Medical Assistance Percentage rate.

In Virginia, the Department of Medical Assistance Services (State agency), is responsible for administering the Medicaid program. For the period January 2008 through December 2009, the State agency paid \$338 million for Part B premiums on behalf of Medicaid beneficiaries. Of the \$338 million it paid for premiums, the State agency claimed \$306 million as eligible for a Federal share of \$168 million.

OBJECTIVE

Our objective was to determine whether the State agency claimed a Federal share for Medicare Part B premiums it paid on behalf of Medicaid beneficiaries in accordance with Federal requirements.

SUMMARY OF FINDING

The State agency generally claimed a Federal share for Medicare Part B premiums it paid on behalf of Medicaid beneficiaries in accordance with Federal requirements. However, the State agency incorrectly claimed \$15,834 (Federal share) for 19 beneficiaries. This occurred because the State agency’s Medicaid Management Information System reports did not accurately identify the proper buy-in codes for some beneficiaries under the Railroad Retirement system and the State agency did not correct, or have CMS correct, the errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$15,834 to the Federal Government,
- refund any overpayments claimed for railroad retirement beneficiaries before and after our audit period, and

- assure that beneficiaries under the Railroad Retirement system are claimed correctly.

STATE AGENCY COMMENTS

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

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STATE AGENCY COMMENTS	

INTRODUCTION

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 Virginia, the Department of Medical Assistance Services (State agency), is responsible for administering the Medicaid program.

Medicaid's Role in Paying Medicare Part B Premiums

“Dual eligibles” are low-income individuals who are eligible for benefits under both Medicare and Medicaid because they are either elderly or disabled. Section 1843 of the Act allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. Under the buy-in program, participating State Medicaid programs enroll certain dual eligibles in the Medicare Part A (hospitalization) and B (supplemental insurance) programs and pay the monthly premiums on behalf of those individuals. In Virginia, the State agency, through the Virginia Department of Social Services, and local social service departments determine eligibility for Medicaid based upon household income and circumstances. The State agency provides Medicaid buy-in assistance to certain categories of eligible beneficiaries defined in section 1902(a)(10)(E) of the Act.

Monthly Medicare Part A and B premiums the State pays on behalf of individuals enrolled under State buy-in agreements are considered vendor payments and most are reimbursed under Medicaid at the Federal Medical Assistance Percentage (FMAP). The FMAP is State-specific and calculated pursuant to section 1905(b) of the Act. For the quarters ending March 2008 through December 2009, Virginia's FMAP ranged from 50 percent to 61.59 percent for all eligibility codes except Qualified Individuals, for which the FMAP is 100 percent.

United States Railroad Retirement Board

The United States Railroad Retirement Board is an independent agency in the executive branch of the United States Government created in 1935 to administer a social insurance program providing retirement benefits to the country's railroad workers. In connection with the retirement program, the Railroad Retirement Board has administrative responsibilities under the Social Security Act for certain benefit payments, including railroad workers' Medicare coverage. States may receive a Federal share for Part B premium payments made for dual eligible low-income railroad retirement beneficiaries.

Administering the Medicaid Buy-In Program

At the Federal level, CMS has overall responsibility for administering the buy-in program. CMS maintains a master file that contains relevant information for beneficiaries eligible for buy-in.

The master file identifies individual beneficiaries by their unique Medicare health insurance code (HIC) number. For beneficiaries eligible for Social Security, the HIC consists of the beneficiary's 9-digit social security number plus a suffix. For beneficiaries eligible for the railroad retirement program, the Medicare HIC is a 6-digit or 9-digit railroad retirement number plus a prefix.¹ CMS uses the buy-in master file to prepare monthly billing notices for the States' payment of beneficiaries' Part A and B premiums and to provide the State agency with electronic billing files that identify the Federal reimbursement that States may claim.

States are responsible for establishing internal procedures and systems to identify individuals eligible for buy-in, to communicate this information to CMS, and to respond to actions taken by CMS on individual cases. Accordingly, Virginia codes the eligibility status for premium payment assistance using the State's Aid Category codes. This information is entered into the Medicaid Management Information System (MMIS), using both a beneficiaries' State Identification number and Federal Medicare HIC number. The MMIS groups the various Aid Categories into CMS's buy-in codes. CMS's buy-in codes identify the level of Federal reimbursement the State may claim for each beneficiary. The State Agency communicates changes in buy-in eligibility to CMS through the monthly reports generated by the MMIS.

The State agency is responsible for the accuracy of the beneficiaries' eligibility status and is required to routinely update eligibility information in the CMS master file. If the information in the systems is erroneous, it is the State agency's responsibility to correct, or have CMS correct, the errors.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed a Federal share for Medicare Part B premiums it paid on behalf of Medicaid beneficiaries in accordance with Federal requirements.

Scope

For the period January 2008 through December 2009, the State agency paid \$338 million for Part B premiums on behalf of Medicaid beneficiaries. Of the \$338 million it paid for premiums, the State agency claimed \$306 million as eligible for a Federal share of \$168 million.

Our review of internal controls was limited to obtaining an understanding of the State agency's procedures for the following: determining Medicare buy-in eligibility, identifying and reporting to CMS individuals in eligible buy-in categories, recording and paying Medicare premiums as billed by CMS, and claiming a Federal share as applicable. We conducted fieldwork at the State Medicaid agency in Richmond, Virginia from March through October 2010.

¹ During 1964 the Railroad Retirement Board stopped issuing 6-digit HIC numbers and began using social security numbers with the prefixes.

Methodology

To accomplish our audit objective, we:

- reviewed the Federal and State regulations, policies, and procedures related to the Medicaid buy-in program, including the CMS *State Medicaid Manual*, the CMS *State Buy-In Manual*, and Virginia's Buy-In Agreements;
- held discussions with Virginia's State Auditors;
- interviewed personnel from CMS, the State agency, and the State's fiscal agent;
- obtained electronic billing files from the State agency and analyzed the monthly Part B premiums for the State's Part B buy-ins;
- obtained and analyzed the financial records for all categories of Part B premiums recorded monthly by the State agency;
- obtained and compared CMS's monthly Summary Accounting Statements (billing notices) for Part B premiums to the claims for Federal share and to the State agency wire transfer documents;
- reconciled the Federal share claimed by the State agency to the Federal share that should have been claimed based on the buy-in eligibility codes in the CMS buy-in master file; and
- obtained a file of all MMIS transactions for beneficiaries that the State claimed for buy-in during our audit period.

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

The State agency generally claimed a Federal share for Medicare Part B premiums it paid on behalf of Medicaid beneficiaries in accordance with Federal requirements. However, the State agency incorrectly claimed \$15,834 for 19 beneficiaries. This occurred because the State agency's MMIS reports did not accurately identify the proper buy-in codes for some beneficiaries under the Railroad Retirement system and the State agency did not correct, or have CMS correct, the errors.

STATE MEDICAID AGENCY CLAIMED EXCESS FEDERAL SHARE

Federal Requirements

Federal Regulations (42 CFR §§ 407.40 to 407.42) allow States to enroll individuals who are eligible for benefits under both the Medicare and Medicaid programs in the Medicare Part B program. Federal regulations (42 CFR § 431.625(d)) also state that States may claim Federal reimbursement for certain individuals if these recipients are receiving cash assistance under specified Federal programs or if they meet certain exceptions. The *State Buy-In Manual* requires States to establish internal procedures and systems to identify individuals eligible for buy-in, to communicate that information, and to respond to action taken by CMS on individual cases. CMS has designed buy-in codes so that States can identify the category of assistance for each beneficiary. The States are responsible for the accuracy of the buy-in codes.²

Buy-in Codes For Railroad Retirement Beneficiaries

The State Agency received \$15,834 in improper Federal reimbursements because reports generated by the MMIS and submitted to CMS for billing did not properly identify the buy-in eligibility code for 19 railroad retirement beneficiaries. The State agency claimed:

- \$18,332 in overpayments for 17 beneficiaries and
- \$2,498 in underpayments for 2 beneficiaries.

These errors occurred because of a processing flaw in the MMIS system. The State agency properly coded changes to the Aid Category for each beneficiary. However, the MMIS system did not recognize the changes for railroad retirement beneficiaries and therefore did not group them into the proper buy-in eligibility codes. The State agency did not identify the errors and therefore did not correct them or have CMS correct them.

ACTION TAKEN

State agency officials said that these errors continued after our audit period and indicated they would reduce the Federal share for these and other beneficiaries pending the results of our review. The State agency also reviewed railroad retirement beneficiaries for the month of June 2010 and found \$1,565 in Federal reimbursement it should not have claimed: \$1,701 in overpayments for 25 beneficiaries and \$136 in underpayments for 2 beneficiaries.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$15,834 to the Federal Government,

² CMS *State Buy-In Manual*, Pub. No. 24, chapter 2, section 200(F) and chapter 4, section 410.

- refund any overpayments claimed for railroad retirement beneficiaries before and after our audit period, and
- assure that beneficiaries under the Railroad Retirement system are claimed correctly.

STATE AGENCY COMMENTS

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

APPENDIX

APPENDIX: STATE AGENCY COMMENTS



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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April 16, 2012

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General, Audit Services
The Public Ledger Building, Suite 316
150 South Independence Mall West
Philadelphia, PA 19106

RE: Draft Audit Report Number A-03-10-00201

Dear Mr. Virbitsky:

Thank you for your letter dated March 15, 2012, providing the Department of Medical Assistance Services (DMAS) the opportunity to review and comment on the Department of Health and Human Services, Office of Inspector General (OIG) draft report number A-03-10-00201 entitled "Review of Virginia's Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries from January 2008 Through December 2009". We concur with your finding and will continue corrective action as indicated in the response below.

OIG Recommendation

The OIG summary of findings concluded that Virginia incorrectly claimed federal funds for 19 Railroad Beneficiaries (RRB) in the amount of \$15, 834. The OIG recommended that: 1) Virginia refund the \$15, 834 in overpayments, 2) Virginia refund any overpayments claimed for the period after the audit period, and ensure that RRB members are now claimed correctly, and 3) Virginia refund any overpayments identified prior to the audit period.

DMAS Response

For the period of the audit, DMAS concurs with the finding of the OIG. The MMIS reported these RRB members buy-in codes as those for which Virginia should receive 50% Federal Financial Participation (FFP). This was erroneous as FFP was not

Mr. Stephen Virbitsky
April 16, 2012
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appropriate for these members. Virginia received 50% FFP for these RRB members and these funds will be returned to the Centers for Medicare and Medicaid Services (CMS).

Since the end of the audit period, Virginia has reimbursed CMS the 50% FFP received for RRB members for whom FFP was claimed inappropriately. The reimbursement process began with January 2010. DMAS utilized data provided by CMS for buy-in transactions for Medicare Part B premium payments to determine those RRB for whom FFP was erroneously claimed. For the period of January through May 2010, the DMAS Fiscal Division utilized the CARS system for the return of these funds. The Fiscal Division corrected the status of these members as being those for which no FFP was appropriate and then returned the funds received for those members. Beginning in June 2010, DMAS provided reimbursement to CMS by adjusting the CMS 64, also known as the "bill," until action was completed in July of 2011 to insure the MMIS reported all RRB members buy-in transactions appropriately. Therefore Virginia does not owe any additional funding since the end date of the audit period.

DMAS is currently researching whether any inappropriate payments were received prior to the beginning of the audit. A determination as to whether or not RRB member's buy-in transaction codes were reported correctly and reimbursement of funds is appropriate prior to January 2008 is in process. DMAS will report its findings to CMS along with any identified inappropriate payments received.

If you have any questions, please do not hesitate to contact our Director of Internal Audit, Paul Kirtz at (804) 225-4162.

Sincerely,



Cynthia B. Jones
DMAS Director

Cc: Scott Crawford
Tom Edicola
Karen Stephenson
Paul Kirtz