



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



July 24, 2012

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

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Nevada Improperly Claimed Federal Reimbursement for Medicare Part B
Premiums Paid on Behalf of Medicaid Beneficiaries (A-09-11-02024)

Attached, for your information, is an advance copy of our final report on Nevada's claims for Federal reimbursement for Medicare Part B premiums that it paid on behalf of Medicaid beneficiaries under the buy-in program. We will issue this report to the Nevada Department of 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 Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-11-02024.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION IX
90 - 7TH STREET, SUITE 3-650
SAN FRANCISCO, CA 94103

July 25, 2012

Report Number: A-09-11-02024

Mr. Michael J. Willden
Director
Nevada Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Willden:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries*. 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 Doug Preussler, Audit Manager, at (415) 437-8360 or through email at Doug.Preussler@oig.hhs.gov. Please refer to report number A-09-11-02024 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
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**

**NEVADA IMPROPERLY CLAIMED
FEDERAL REIMBURSEMENT
FOR MEDICARE PART B
PREMIUMS PAID ON BEHALF OF
MEDICAID BENEFICIARIES**



Daniel R. Levinson
Inspector General

July 2012
A-09-11-02024

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

Section 1843 of the Social Security Act allows State Medicaid programs to enter into an arrangement with the Centers for Medicare & Medicaid Services (CMS) known as the buy-in program. The buy-in program allows a participating State Medicaid program to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in the Medicare Part B program (Part B) and to pay the monthly premiums on their behalf. The State may then claim the monthly premium expenditures for Federal reimbursement.

The Social Security Administration (SSA) notifies CMS of individuals' eligibility for the buy-in program when those individuals apply for Medicare and also appear to be eligible for Medicaid. CMS adds the individuals to the appropriate State's buy-in program (called public welfare additions in this report). According to sections 480 and 482 of CMS's *State Buy-In Manual*, Pub. No. 24, each State is responsible for (1) coordinating with SSA and CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions, (2) verifying the validity of public welfare additions, and (3) taking corrective action on erroneous public welfare additions. When a State determines that an individual already enrolled in the buy-in program is ineligible, it may submit to CMS a deletion request to remove the individual from the buy-in program retroactively.

States claim Medicaid expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. According to section 2500.A.1 of CMS's *State Medicaid Manual*, Pub. No. 45, the expenditures reported on the Form CMS-64 and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed. In addition, 42 CFR §§ 433.32(a) and (b) require that the State maintain an accounting system and retain supporting records to ensure that claims for Federal funds are in accordance with applicable Federal requirements.

In Nevada, the Department of Health and Human Services (State agency) administers the Medicaid program, including the State's buy-in program. In addition to carrying out its responsibilities related to public welfare additions, the State agency is responsible for enrolling certain dual eligibles in the buy-in program (called State additions in this report) and paying the monthly Part B premiums on their behalf. Those responsibilities include establishing internal procedures and systems to identify individuals eligible for the buy-in program and communicating this information to CMS. The State agency is also responsible for the accuracy of the individuals' eligibility information.

For the quarters ended December 31, 2007, through September 30, 2009, we reviewed approximately \$74.0 million (\$45.3 million Federal share) that the State agency claimed on the Form CMS-64 for Part B premiums paid under the buy-in program. This amount included premiums paid for both public welfare and State additions.

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal requirements when claiming Federal reimbursement for Part B premiums that it paid on behalf of Medicaid beneficiaries.

SUMMARY OF FINDINGS

The State agency did not always comply with Federal requirements when claiming Federal reimbursement for Part B premiums that it paid on behalf of Medicaid beneficiaries. Specifically, the State agency improperly claimed \$194,891 (Federal share):

- The State agency improperly claimed \$179,096, which represented the Federal share of \$336,005 in Part B premiums paid for ineligible individuals. The State agency did not delete ineligible individuals from the buy-in program when it determined that they were ineligible or refund the Federal share of the Part B premiums that it claimed for ineligible individuals.
- For \$903,161 in Part B premiums that the State agency claimed for public welfare additions, we judgmentally selected 18 of these additions and determined that the State agency improperly claimed \$24,898 (\$15,795 Federal share) for 7 individuals who had been erroneously added. The State agency did not verify the eligibility of individuals added through the public welfare addition procedure or take corrective action on erroneous public welfare additions. In addition, the State agency did not coordinate with SSA or CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions. Because our judgmental selection identified unallowable claims for erroneous additions, some of the remaining claims likely are unallowable. Therefore, we have set aside \$878,263 for resolution by CMS and the State agency.

For approximately \$72.8 million of the Part B premiums claimed on the Form CMS-64, the State agency did not have adequate supporting documentation. The State agency could not provide documentation to support that the Part B premiums claimed were for eligible individuals and could not identify the Federal share claimed for those premiums. For this reason, we could not determine whether the State agency's claims were allowable. Therefore, we have set aside approximately \$72.8 million for resolution by CMS and the State agency.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$194,891 (Federal share) for unallowable Part B premiums claimed,
- work with CMS to determine whether any portion of the \$878,263 in Part B premiums claimed for public welfare additions was unallowable and refund the Federal share of any unallowable amount claimed,

- work with CMS to determine the allowability of the approximately \$72.8 million in Part B premiums for which the State agency did not have adequate supporting documentation and refund the Federal share of any unallowable amount claimed,
- delete ineligible individuals from the buy-in program when it determines that they are ineligible and refund the Federal share of the Part B premiums claimed for those individuals,
- verify the eligibility of individuals added to the buy-in program through the public welfare addition procedure and take corrective action on erroneous public welfare additions,
- coordinate with SSA and CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions, and
- ensure that it can support the Federal share claimed for each Part B premium.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency described actions that it had taken or planned to take to address our findings and recommendations. Regarding the third recommendation, the State agency did not concur with the language in the finding related to inadequate support for Part B premiums. The State agency requested that we modify this language to exclude the dollar amount of \$72.8 million and focus on the need for the State agency and CMS to perform the reconciliation for the period reviewed. The State agency said that our report does not discuss why electronic billing files could not be acquired from CMS for the quarters ended December 31, 2007, and March 31, 2008. The State agency added that without this documentation from its responsible division or from CMS, our methodology could not be completed for two of the eight quarters reviewed.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding the finding related to the third recommendation, reporting the \$72.8 million is necessary to identify the unsupported amount that CMS and the State agency should work to resolve. Pursuant to Federal regulations and CMS guidance, the State agency is responsible for maintaining sufficient documentation to support its claim, regardless of the availability of Part B premium billing data from CMS. Nothing in the State agency's comments caused us to revise our finding or the related recommendation.

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STATE AGENCY COMMENTS

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 Nevada, the Department of 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 a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. States with a lower per capita income relative to the national average are reimbursed a greater share of their costs. States with a higher per capita income are reimbursed a lesser share. By law, the FMAPs cannot be lower than 50 percent. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, enacted February 17, 2009, authorized the States to receive higher FMAPs. The FMAPs for Nevada's Medicaid expenditures for fiscal years 2008 and 2009 were 52.64 percent and 63.93 percent, respectively.¹

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

States claim Medicaid expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The Form CMS-64 is an accounting statement that the State, in accordance with 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. Each quarter's Form CMS-64 shows the disposition of Medicaid funds used to pay for medical and administrative expenditures for the quarter being reported, as well as any prior-period adjustments.

According to section 2500.A.1 of CMS's *State Medicaid Manual* (Medicaid Manual), Pub. No. 45, the expenditures reported on the Form CMS-64 and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed. In addition, 42 CFR §§ 433.32(a) and (b) require that the State maintain an accounting system and retain supporting records to ensure that claims for Federal funds are in accordance with applicable Federal requirements.

¹ Pursuant to section 1933(d) of the Act, the FMAP is equal to 100 percent for certain individuals.

Medicaid's Role in Paying Medicare Part B Premiums in the Buy-In Program

Section 1843 of the Act allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. The buy-in program allows a participating State Medicaid program to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in the Medicare Part B program (Part B) and to pay the monthly premiums on their behalf. The State may then claim the monthly premium expenditures for Federal reimbursement at the applicable FMAP. The buy-in program has the effect of transferring part of the medical costs for eligible individuals from the federally and State-funded Medicaid program to the federally funded Medicare program.

Administration of the Buy-In Program

At the Federal level, CMS has overall responsibility for administering the buy-in program. CMS maintains a master file that contains information on individuals eligible for enrollment in the buy-in program. CMS uses updates provided by the States to amend the buy-in master file. CMS uses the buy-in master file to prepare monthly billing notices known as Summary Accounting Statements (billing notices) for each State's Part B premium liability and to identify those premiums eligible to be claimed by each State for Federal reimbursement. In addition to sending billing notices to the States, CMS sends electronic billing files that list by individual the Part B premiums.

The Social Security Administration (SSA) notifies CMS of individuals' eligibility for the buy-in program when those individuals apply for Medicare and also appear to be eligible for Medicaid. CMS adds the individuals to the appropriate State's buy-in program (called public welfare additions in this report). According to sections 480 and 482 of CMS's *State Buy-In Manual* (Buy-In Manual), Pub. No. 24, each State is responsible for (1) coordinating with SSA and CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions, (2) verifying the validity of public welfare additions, and (3) taking corrective action on erroneous public welfare additions.

When a State determines that an individual already enrolled in the buy-in program is ineligible, the State may submit to CMS a deletion request, which results in the retroactive removal of the individual from the buy-in program. CMS refunds the Part B premiums paid by the State for that individual through a credit on the billing notice. However, CMS limits the retroactivity of the deletion date to 2 months from the month in which CMS receives the deletion request. This limits the amount that CMS will credit to the State to no more than 3 months of Part B premiums paid by the State.

Nevada's Buy-In Program

The State agency administers Nevada's buy-in program. In addition to carrying out its responsibilities related to public welfare additions, the State agency is responsible for enrolling certain dual eligibles in the buy-in program and paying the monthly Part B premiums on behalf of those individuals (called State additions in this report). The State agency's other responsibilities include establishing internal procedures and systems to identify individuals eligible for the buy-in program, communicating this information to CMS, and coordinating with

CMS on individual cases. The State agency is also responsible for the accuracy of the individuals' eligibility information and is required to routinely update this information in CMS's buy-in master file.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with Federal requirements when claiming Federal reimbursement for Part B premiums that it paid on behalf of Medicaid beneficiaries.

Scope

For the quarters ended December 31, 2007, through September 30, 2009, we reviewed approximately \$74.0 million (\$45.3 million Federal share) that the State agency claimed on the Form CMS-64 for Part B premiums paid under the buy-in program. This amount included premiums paid for both public welfare and State additions.

Our objective did not require a review of the State agency's overall internal control structure. Therefore, we limited our review of internal controls to obtaining an understanding of the State agency's policies and procedures for identifying and reporting to CMS those individuals eligible for the buy-in program, recording and paying Part B premiums billed by CMS, and claiming Federal reimbursement.

We conducted fieldwork at the State agency in Carson City, Nevada.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed applicable portions of the Nevada State Medicaid plan and State agency policies and procedures related to the buy-in program;
- interviewed CMS and State agency officials;
- obtained from CMS and analyzed the electronic billing files of Part B premiums billed to the State agency for the months April 2008 through September 2009;²
- compared CMS's electronic billing files with its billing notices and the State agency's claims for Federal reimbursement on the Form CMS-64;

² Neither the State agency nor CMS could provide Part B premium data for the months October 2007 through March 2008. (See the section entitled "Unsupported Claims on the Form CMS-64.")

- compared CMS's billing notices for Part B premiums with the State agency's claims for Federal reimbursement on the Form CMS-64 and the State agency's payment records;
- obtained and reviewed the State agency's reports that listed individuals who were ineligible for but not deleted from the buy-in program and
 - matched the individuals with the premiums billed for those individuals in CMS's electronic billing files,
 - calculated the premiums that the State agency paid for those individuals after they had become ineligible,
 - calculated the premiums that CMS had credited and not credited to the State agency, and
 - calculated the Federal shares of the State agency claims for the credited and uncredited Part B premiums using the lowest FMAPs applicable for the quarters in which those premiums were claimed;³ and
- from CMS's electronic billing files, judgmentally selected 30 transactions for additions to the buy-in program, including 18 public welfare addition transactions, and
 - reviewed eligibility records to determine whether the State agency had determined that the 30 individuals were eligible for the entire period of the transaction,
 - identified the remaining public welfare addition transactions in CMS's electronic billing files,
 - reduced the transaction amounts by the deletions related to those transactions, and
 - calculated the Federal shares of the State agency claims for the monthly Part B premiums using the lowest FMAPs applicable for the quarters in which those premiums were claimed.

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.

³ Because the State agency did not have adequate supporting documentation to identify the individual Part B premiums claimed, we could not determine the individual FMAPs.

FINDINGS AND RECOMMENDATIONS

The State agency did not always comply with Federal requirements when claiming Federal reimbursement for Part B premiums that it paid on behalf of Medicaid beneficiaries. Specifically, the State agency improperly claimed \$194,891 (Federal share):

- The State agency improperly claimed \$179,096, which represented the Federal share of \$336,005 in Part B premiums paid for ineligible individuals. The State agency did not delete ineligible individuals from the buy-in program when it determined that they were ineligible or refund the Federal share of the Part B premiums that it claimed for ineligible individuals.
- For \$903,161 in Part B premiums that the State agency claimed for public welfare additions, we judgmentally selected 18 of these additions and determined that the State agency improperly claimed \$24,898 (\$15,795 Federal share) for 7 individuals who had been erroneously added. The State agency did not verify the eligibility of individuals added through the public welfare addition procedure or take corrective action on erroneous public welfare additions. In addition, the State agency did not coordinate with SSA or CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions. Because our judgmental selection identified unallowable claims for erroneous additions, some of the remaining claims likely are unallowable. Therefore, we have set aside \$878,263 for resolution by CMS and the State agency.

For approximately \$72.8 million of the Part B premiums claimed on the Form CMS-64, the State agency did not have adequate supporting documentation. The State agency could not provide documentation to support that the Part B premiums claimed were for eligible individuals and could not identify the Federal share claimed for those premiums. For this reason, we could not determine whether the State agency's claims were allowable. Therefore, we have set aside approximately \$72.8 million for resolution by CMS and the State agency.

MISSED DELETIONS OF INELIGIBLE INDIVIDUALS

Federal Requirements

Pursuant to sections 1902(a)(10)(E), 1903(a)(1), and 1905(a) and (p)(3) of the Act and Federal regulations (42 CFR §§ 431.625(d)(1) and (2)), Federal reimbursement is available only for Part B premiums paid on behalf of an individual who meets the eligibility requirements for a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI)⁴ or was a recipient or deemed a recipient of money payments under relevant provisions of the Act.⁵

⁴ QMBs, SLMBs, and QIs are defined in sections 1902(a)(10)(E) and 1905(p)(1) and (2) of the Act.

⁵ The regulations at 42 CFR § 431.625 have not been amended since 1988 and do not mention QMBs, SLMBs, or QIs. Nevertheless, the Act controls and Federal reimbursement is available for premium payments made on their behalf.

Section 420 of the Buy-In Manual says: “States are required to submit deletion actions [for individuals in the buy-in program] within a specified time frame when Medicaid eligibility has been terminated by the State.”

Section 430 of the Buy-In Manual states:

When the “buy-in program” was implemented in July 1966 States were allowed to delete individuals on a retroactive basis As a result, the individual was held responsible for the entire premium amount. In effect, a hardship condition was placed on the individual In 1972, the Commissioner of [SSA] issued a regulation to prevent this hardship on the individual. The regulation, commonly referred to as the “Commissioner’s Decision”, limits the retroactivity of the deletion date to 2 months from the month in which the buy-in system receives the deletion request.

Unallowable Claims for Missed Deletions

For the quarters ended June 30, 2008, through September 30, 2009, the State agency claimed \$573,520 in Part B premiums for 1,055 individuals whom the State agency did not delete from the buy-in program when it determined that they had become ineligible. When the State agency discovered that these individuals were ineligible, it deleted them from the program retroactively and received credits from CMS for the Part B premiums paid, totaling \$237,515. The State agency subsequently refunded the Federal share to the Federal Government on the Form CMS-64 for these premiums. However, CMS did not credit the remaining \$336,005 in Part B premiums because they were beyond the limit CMS set on credits for deletions pursuant to the SSA Commissioner’s Decision. Contrary to sections 1902(a)(10)(E), 1903(a)(1), and 1905(a) and (p)(3) of the Act and Federal regulations, the State agency did not refund to the Federal Government \$179,096 (Federal share) that it received for those premiums.

We calculated the Federal shares of the State agency claims for the Part B premiums using the lowest FMAPs applicable for the quarters in which those premiums were claimed. According to the State agency, it did not refund the \$179,096 (Federal share) because of a lack of communication between the State agency divisions responsible for processing deletions and claiming and refunding the Federal share.

ERRONEOUS PUBLIC WELFARE ADDITIONS OF INELIGIBLE INDIVIDUALS

Federal Requirements

Section 480 of the Buy-In Manual states: “The Public Welfare ... [addition] procedure is initiated by [SSA] when an individual files an application for Medicare and appears to be eligible for Medicaid.” Section 480 also states: “In order to minimize the number of erroneous [public welfare additions], each State should coordinate with its [CMS] and SSA [regional office] to establish a [public welfare] verification procedure”

Section 482 of the Buy-In Manual states:

If the State determines that a [public welfare addition] ... is erroneous, the State may protest the action. It must react to the [public welfare addition] before the end of the fourth month following the month in which it received notification of the [public welfare addition] on its billing file. If the State does not react timely, the State becomes responsible for the premium liability until it submits a deletion action In that situation, the Commissioner's Decision, which limits the retroactivity of deletions to processing month minus two, is applicable and the State is liable for all premiums from the month of [addition] through the month of deletion.

Unallowable and Set-Aside Claims for Public Welfare Additions

For \$903,161 in Part B premiums that the State agency claimed for public welfare additions for the quarters ended June 30, 2008, through September 30, 2009, we judgmentally selected 18 of these additions and determined that the State agency improperly claimed \$24,898 (\$15,795 Federal share) for 7 individuals who were not eligible for the buy-in program. Specifically, the State agency's eligibility records indicated that these individuals were ineligible for portions of the periods that the public welfare additions covered. We calculated the Federal shares of the State agency claims for the unallowable Part B premiums using the lowest FMAPs applicable for the quarters in which those premiums were claimed. The State agency claimed these premiums because it did not verify the eligibility of individuals added through the public welfare addition procedure and take corrective action on erroneous public welfare additions. The State agency also did not coordinate with SSA or CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions.

Because our judgmental selection identified unallowable claims for erroneous additions, some of the remaining claims likely are unallowable. Therefore, we have set aside \$878,263 for resolution by CMS and the State agency.

INADEQUATE DOCUMENTATION TO SUPPORT PART B PREMIUMS

Federal Requirements

Pursuant to 42 CFR §§ 433.32(a) and (b), States are required to “[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements ...” and “[r]etain records”

According to section 2497.3 of the Medicaid Manual, States “... must have a record-keeping system which assures that documentation supporting a claim is regularly maintained, easily retrieved, and in readily reviewable form.” Section 2500.A.1 of the Medicaid Manual states that amounts reported on the Form CMS-64 “... must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed.” Section 2500.A.1 also states that “... the amount claimed on the

Form [CMS-64] is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records.”

Section 2497.4 of the Medicaid Manual states that when a claim for Federal reimbursement is filed, “... it must be supported by sufficient documentation to assure that the expenditure was made on behalf of an eligible recipient”

Unsupported Claims on the Form CMS-64

The State agency did not have adequate supporting documentation for approximately \$72.8 million in Part B premiums that it claimed on the Form CMS-64s for the quarters ended December 31, 2007, through September 30, 2009. The State agency provided only summary information to support the amounts claimed and could not identify the individual Part B premiums claimed. Although the summary information supported that the Part B premiums were paid, this information did not support that the premiums claimed were for eligible individuals. In addition, the State agency did not retain all documents to support the eligibility of some individuals for the buy-in program. Specifically, the State agency destroyed many Medicaid applications that it received before August 2005. According to the State agency, these records were destroyed after it inadvertently deleted its record retention policies in July 2008 and before it reinstated those policies in September 2008.

CMS provided us with electronic billing files that included Part B premium data that supported the \$56.2 million that the State agency claimed for the quarters ended June 30, 2008, through September 30, 2009. However, these files did not support the Federal share claimed for each Part B premium because the State agency could not identify which FMAP it applied to each Part B premium.

Because the State agency could not provide adequate supporting documentation, we could not determine whether the State agency’s claims were allowable. Therefore, we have set aside approximately \$72.8 million for resolution by CMS and the State agency.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$194,891 (Federal share) for unallowable Part B premiums claimed,
- work with CMS to determine whether any portion of the \$878,263 in Part B premiums claimed for public welfare additions was unallowable and refund the Federal share of any unallowable amount claimed,
- work with CMS to determine the allowability of the approximately \$72.8 million in Part B premiums for which the State agency did not have adequate supporting documentation and refund the Federal share of any unallowable amount claimed,

- delete ineligible individuals from the buy-in program when it determines that they are ineligible and refund the Federal share of the Part B premiums claimed for those individuals,
- verify the eligibility of individuals added to the buy-in program through the public welfare addition procedure and take corrective action on erroneous public welfare additions,
- coordinate with SSA and CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions, and
- ensure that it can support the Federal share claimed for each Part B premium.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency described actions that it had taken or planned to take to address our findings and recommendations. The State agency commented that it had hired a third-party firm to work on a corrective action plan for (1) the findings related to the first and second recommendations and (2) the fourth through seventh recommendations. The State agency said that it would work with CMS to adjust the appropriate quarterly Federal reports to refund the \$194,891 identified in the first recommendation. The State agency also said it would work with CMS to verify that the \$878,263 identified in the second recommendation does not contain any erroneous public welfare additions and will adjust any subsequent quarterly Federal reports as directed by CMS.

Regarding the third recommendation, the State agency did not concur with the language in the finding related to inadequate support for Part B premiums. The State agency requested that we modify this language to exclude the dollar amount of \$72.8 million and focus on the need for the State agency and CMS to perform the reconciliation for the period reviewed.

The State agency said that our report does not discuss why electronic billing files could not be acquired from CMS for the quarters ended December 31, 2007, and March 31, 2008. The State agency added that without this documentation from its responsible division or from CMS, our methodology could not be completed for two of the eight quarters reviewed. The State agency agreed that the documentation it provided us was inadequate but stated that it believes that it has the ability to regenerate files to materially tie back to the amounts reported on the CMS-64 for each quarter during the review period. The State agency said that it would work with CMS to reconcile these amounts and will adjust any subsequent quarterly Federal reports as directed by CMS. The State agency also said that it had hired a third-party firm to review the processes related to the Part B buy-in.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding the finding related to the third recommendation, reporting the \$72.8 million is necessary to identify the unsupported amount that CMS and the State agency should work to

resolve. CMS maintains electronic billing files of Part B premiums billed for the previous 2 years. Because we requested data files from CMS in March 2010, CMS could not provide data for the quarters ended December 31, 2007, and March 31, 2008. Pursuant to 42 CFR §§ 433.32(a) and (b) and the Medicaid Manual, the State agency is responsible for maintaining sufficient documentation to support its claim, regardless of the availability of Part B premium billing data from CMS. In addition, for the data obtained from CMS for the months April 2008 through September 2009, the State agency could not identify which FMAP it applied to each Part B premium. Nothing in the State agency's comments caused us to revise our finding or the related recommendation.

**OTHER MATTER:
MISSED STATE ADDITIONS OF ELIGIBLE INDIVIDUALS**

Section 110 of the Buy-In Manual states:

Buy-In coverage groups include all individuals eligible to enroll in Medicare who are receiving or are eligible for a category of assistance under Medicaid as specified in the State's Buy-In Agreement or who are reported by the State to be a member of one of its coverage groups.

The State must buy-in for everyone who is a member of a buy-in coverage group which the State has elected to include in its Buy-In Agreement.

Section 200.F. of the Buy-In Manual states: "The State is responsible for ... [e]stablishing internal procedures and systems to identify individuals eligible for buy-in, to communicate these data to [CMS], and to respond to action taken by [CMS] on individual cases ... and [t]he timely payment of Medicare premiums on behalf of the individuals within its jurisdiction who are eligible for State buy-in."

The State agency did not always add individuals to the buy-in program when they became eligible. During the billing months April 2008 through September 2009, the State agency initiated retroactive additions covering 1 year or more for 294 individuals with Part B premiums totaling \$593,986. The premiums averaged \$2,020 per individual during the periods covered by these retroactive State additions. As a result, the State agency placed a potential financial burden on eligible individuals, who had to pay their own Part B premiums for coverage until the State agency added them to the buy-in program.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS



Brian Sandoval
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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MICHAEL J. WILLDEN
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CHARLES DUARTE
Administrator

March 30, 2012

Lori A. Ahlstrand
Regional Inspector General for Audit Services
U.S. Department of Health & Human Services
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

RE: Audit Report A-09-11-02024

Dear Ms. Ahlstrand:

Per your request, the Nevada Department of Health and Human Services (DHHS) has reviewed the draft audit report dated January 17, 2012. The report addresses *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums on Behalf of Medicaid Beneficiaries* for the quarters ended December 31, 2007, through September 30, 2009. The DHHS responses to the findings and recommendations in the report are as follows:

A. OIG Finding and Recommendation

The State agency improperly claimed \$179,096, which represented the Federal share of \$336,005 in Part B premiums paid for ineligible individuals. The State agency did not delete ineligible individuals from the buy-in program when it determined that they were ineligible or refund the Federal share of the Part B Premiums that it claimed for ineligible individuals.

Department Response

The Division of Health Care Financing and Policy (DHCFP) hired a third party firm to work with DHCFP and the Division of Welfare and Supportive Services (DWSS) on a corrective action plan related to the above finding. DHCFP will work with CMS to adjust the appropriate quarterly Federal report to refund the amount identified above.

B. OIG Finding and Recommendation

For \$903,161 in Part B premiums that the State agency claimed for public welfare additions, we judgmentally selected 18 of these additions and determined that the State agency claimed \$24,898 (\$15,795 Federal share) for 7 individuals who had been erroneously added. The State agency did not verify the eligibility of individuals added through the public welfare addition procedure or take corrective action on erroneous public welfare additions. In addition, the State agency did not coordinate with SSA or

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CMS Regional offices to establish procedures to reduce the number of erroneous public welfare additions. Because our judgmental selection identified unallowable claims for erroneous additions, it is likely some of the remaining claims are unallowable. Therefore, we have set aside \$878,263 for resolution by CMS and the State agency.

Department Response

The DHCFP hired a third party firm to work with DHCFP and the DWSS on a corrective action plan related to the above finding. DHCFP will work with CMS to adjust the appropriate quarterly Federal report to refund the amount identified above.

DHCFP will also work with CMS to verify that the set aside amount does not contain any erroneous additions. If any erroneous additions are identified, DHCFP will adjust any subsequent quarterly federal reports as directed by CMS.

C. OIG Finding and Recommendation

For approximately \$72.8 million of the Part B premiums claimed on the CMS-64, the State agency did not have adequate supporting documentation. The State agency could not provide documentation to support that the Part B premiums claimed were for eligible individuals and could not identify the Federal share claimed for those premiums. Because the State agency could not provide adequate supporting documentation, we could not determine whether the State agency's claims were allowable. Therefore, we set aside approximately \$72.8 million for resolution by CMS and the State agency.

Department Response

DHCFP does not concur with the language in this finding reported on page five of the draft report. An outside reader of the report may believe that there is potential for the entire \$72.8 million of total computable to be disallowed. DHCFP agrees that documentation provided at the time of the review was not adequate to meet the needs of the OIG reviewers. DHCFP has contracted with a third party firm to review the process at both DHCFP and DWSS related to Medicare Part B Buy-In. Based on our initial discussions, it appears that documentation can be generated from the DWSS to re-create the information at the time of each quarter to materially reconcile back to the amounts reported.

On page eight of the draft report, it explains that CMS was able to provide electronic billing files that the State agency claimed for the quarters ended June 30, 2008, through September 30, 2009. The report does not discuss why the electronic billing files could not be acquired from CMS for the quarters ended December 31, 2007, and March 31, 2008. The missing documentation for a portion of the review period does not appear to have been available from either the DHCFP or CMS. Without this data, the methodology employed on pages four and five of the draft report could not be completed for two of the eight quarters under review.

As stated earlier, DHCFP and DWSS believe they have the ability to regenerate files from the public welfare reporting system to materially tie back to the amounts reported on the CMS-64 for each quarter during the review period. DHCFP will work with CMS

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to reconcile the FMAP for all quarters to the amount reported on the CMS-64 and adjust any subsequent quarterly federal reports as directed by CMS.

DHCFP respectfully requests that the language in this finding be modified to exclude the dollar amount and focus on the need for the State agency and CMS to perform the reconciliation for the period reviewed.

D. OIG Recommendation

The State agency should delete ineligible individuals from the buy-in program when it determines that they are ineligible and refund the Federal share of Part B premiums claimed for those individuals.

Department Response

The DHCFP hired a third party firm to work with DHCFP and the DWSS on a corrective action plan related to the above recommendation. As part of the corrective action plan, policies will be established to capture potential refunds and return the Federal share of ineligible claims back to CMS through the quarterly reporting process.

E. OIG Recommendation

The State agency should verify the eligibility of individuals added to the buy-in program through the public welfare addition procedure and take corrective action on erroneous public welfare additions.

Department Response

The DHCFP hired a third party firm to work with DHCFP and the DWSS on a corrective action plan related to the above recommendation. As part of the corrective action plan, policies will be established to capture any erroneous public welfare additions and refund the Federal share of ineligible claims back to CMS through the quarterly reporting process.

F. OIG Recommendation

The State agency should coordinate with SSA and CMS regional offices to establish procedures to reduce the number of erroneous public welfare additions.

Department Response

The DHCFP hired a third party firm to work with DHCFP and the DWSS on a corrective action plan related to the above recommendation. As part of the corrective action plan, policies will be established to document formal communications between DWSS and both SSA and CMS regional offices concerning additions to ensure erroneous public welfare additions are reduced.

G. OIG Recommendation

The State agency should ensure that it can support the Federal share for each Part B premium.

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Department Response

The DHCFP hired a third party firm to work with DHCFP and the DWSS on a corrective action plan related to the above recommendation. As part of the corrective action plan, a reconciliation process will be implemented to tie individuals on the CMS electronic billing files to the files maintained by DWSS. In addition, the reconciliation process will incorporate tying individuals based on eligibility to the corresponding FMAP rate and reconciling the total to the amount reported on the quarterly CMS-64 reports.

If you have any questions or comments please feel free to contact Leah Lamborn at 775 684-3668 or LCLamborn@dncfp.nv.gov.

Sincerely,



Charles Duarte
Administrator

Cc: Michael J. Willden, Director, Department of Health and Human Services
Michael Torvinen, Deputy Director of Finance, DHHS
Lynn Carrigan, Chief Financial Officer
Diane Comeaux, Administrator, DWSS
Leah Lamborn, Chief of Accounting & Budget