

Department of Health and Human Services

OFFICE OF  
INSPECTOR GENERAL

MICHIGAN CLAIMED IMPROPER  
MEDICAID REIMBURSEMENT  
FOR SOME  
MEDICARE PART B PREMIUMS

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Daniel R. Levinson  
Inspector General

March 2014  
A-05-12-00035

# *Office of Inspector General*

<https://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov>

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.

## **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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION V  
233 NORTH MICHIGAN, SUITE 1360  
CHICAGO, IL 60601

March 6, 2014

Report Number: A-05-12-00035

Mr. James K. Haveman  
Director  
Michigan Department of Community Health  
Capitol View Building  
201 Townsend Street  
Lansing, MI 48913

Dear Mr. Haveman:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Michigan Claimed Improper Medicaid Reimbursement for Some Medicare Part B Premiums*. We will forward a copy 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, the final report will be posted at <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Stephen Slamar, Audit Manager, at (312) 353-7905 or through email at [Stephen.Slamar@oig.hhs.gov](mailto:Stephen.Slamar@oig.hhs.gov). Please refer to report number A-05-12-00035 in all correspondence.

Sincerely,

Sheri L. Fulcher  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

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

## EXECUTIVE SUMMARY

*Michigan made improper claims of at least \$516,912 and could not support its claims of \$139.5 million for Federal Medicaid reimbursements of Medicare Part B premiums.*

### WHY WE DID THIS REVIEW

Participating State Medicaid agencies are allowed to pay the monthly Medicare Part B premiums for certain Medicaid beneficiaries who are entitled to both Medicare and Medicaid benefits. The premium payments are made in cooperation with the Centers for Medicare & Medicaid Services (CMS) under what is known as the “buy-in program.” A State may claim Medicaid reimbursement for the Federal share of the Medicare Part B premiums it paid for eligibly enrolled individuals. The State must maintain an accounting system and retain supporting records to ensure the propriety of its claims for Medicaid reimbursement of the Part B premiums. Prior Office of Inspector General reviews found States improperly claimed Medicaid reimbursement for Medicare Part B premiums they paid on behalf of Medicaid beneficiaries who did not qualify for the buy-in program.

The objective was to determine whether the Michigan Department of Community Health (DCH) properly claimed Federal Medicaid reimbursement for Medicare Part B premiums in compliance with Federal regulations.

### BACKGROUND

In Michigan, DCH administers the Medicaid program, including the buy-in program. DCH is responsible for ensuring that Medicare Part B premiums are paid on behalf of only Medicaid beneficiaries who qualify for the buy-in program. A separate State agency, the Michigan Department of Human Services (DHS), is responsible for determining whether an individual is eligible for Medicaid and the buy-in program. An individual’s eligibility for the buy-in program is based on having an income that is within defined ranges of the Federal poverty level.

### HOW WE CONDUCTED THIS REVIEW

We reviewed the available documentation DCH retained to support its claims for Federal Medicaid reimbursement of \$606.5 million (\$410.1 million Federal share) in Part B premiums it paid through the buy-in program for the quarters ended December 31, 2007, through March 31, 2010. DCH did not have sufficient audit evidence for \$232.8 million (\$139.5 million Federal share) in Part B premiums paid during the quarters ended December 31, 2007, through September 30, 2008. DCH had audit evidence documenting the remaining \$373.7 million (\$270.6 million Federal share) in Part B premiums paid and claimed for reimbursement during the quarters ended December 31, 2008, through March 31, 2010. We assessed this documentation and determined \$20.1 million in Part B premiums to be at risk of being ineligible for Federal reimbursement. We identified at-risk premiums as those assigned with a “Does Not Have Buy-In” status code. We randomly selected for review 100 beneficiaries’ premium payments that were included in the \$20.1 million of at-risk payments and analyzed in detail their eligibility for the buy-in program.

## WHAT WE FOUND

DCH claimed Federal Medicaid reimbursement for some Medicare Part B premiums it paid on behalf of beneficiaries who were ineligible for the buy-in program. Of the 100 beneficiaries we randomly selected for review, 85 were eligible for enrollment in the buy-in program, and the Medicare Part B premiums that DCH paid on their behalf were allowable. The remaining 15 beneficiaries were ineligible for the buy-in program, and the Medicare Part B premiums that DCH paid on their behalf were unallowable. On the basis of our sample results, we estimated that DCH improperly claimed at least \$516,912 (Federal share) in Medicare Part B premiums it paid for individuals ineligible for enrollment in the buy-in program for the quarters ended December 31, 2008, through March 31, 2010. The improper Part B premium payments are attributable to: (1) DHS's making postpayment eligibility changes in the beneficiary's coverage status, (2) the beneficiary's not meeting the eligibility requirements for enrollment in the buy-in program, or (3) the beneficiary's not having Medicaid coverage.

For the quarters ended December 31, 2007, through September 30, 2008, DCH claimed \$232.8 million (\$139.5 million Federal share) for Part B premiums it paid on behalf of beneficiaries it could not readily identify nor document as eligible for the buy-in program. DCH retained only summary information that did not identify the beneficiaries whose premiums were included in the total payment amount. Without specific beneficiary information, DCH could not provide documented support that the Part B premiums it paid were for only qualified enrolled participants in the buy-in program.

## WHAT WE RECOMMEND

We recommend that DCH:

- refund \$516,912 (Federal share) to the Federal Government for improper Part B premiums claimed;
- strengthen coordination efforts with DHS, CMS, and Social Security Administration officials to ensure appropriate corrective action is taken in verifying changes reported in a beneficiary's eligibility status; and
- work with CMS to determine the allowability of the \$139.5 million (Federal share) in Part B premiums claimed for Medicaid reimbursement for which DCH had inadequate support and refund any unallowable amount claimed.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH COMMENTS AND  
OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, DCH disagreed with our findings. DCH stated that it followed the intent of Federal regulations in claiming reimbursement of Medicare Part B premiums under the buy-in program and described its procedures for ensuring that its claims meet Federal requirements. DCH also stated that data supporting its claims are available for review by the auditors.

The procedures DCH described in its comments did not prevent it from claiming Part B premiums for 15 ineligible beneficiaries in our sample. In addition, during our review, we requested supporting information for the amounts that DCH claimed on the Form CMS-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. While DCH provided some information used by DCH buy-in staff, DCH did not provide during our review the data tables mentioned in its comments on the draft report. After considering DCH's comments, we maintain our findings and recommendations are valid.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review.....	1
Objective.....	1
Background.....	1
Medicaid: How It Is Administered.....	1
Medicaid Allows Payment of Medicare Part B Premiums Under the Buy-In Program.....	2
CMS Administers the Federal Buy-In Program.....	2
How We Conducted This Review.....	3
FINDINGS .....	3
Michigan Paid Individual Part B Premiums for Beneficiaries Who Were Not Eligible for the Buy-In Program.....	4
Michigan Had Inadequate Documentation for Some of the Part B Premiums It Claimed.....	5
RECOMMENDATIONS.....	6
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE .....	6
Improper Part B Premiums Claimed.....	6
Inadequate Documentation .....	7
APPENDIXES	
A: Audit Scope and Methodology .....	8
B: Statistical Sampling Methodology .....	10
C: Sample Results and Estimates.....	12
D: Federal Requirements for the Buy-In Program.....	13
E: Michigan Department of Community Health Comments .....	14

## INTRODUCTION

### WHY WE DID THIS REVIEW

Participating State Medicaid agencies are allowed to pay the monthly Medicare Part B premiums for certain Medicaid beneficiaries who are entitled to both Medicare and Medicaid benefits. The premium payments are made in cooperation with the Centers for Medicare & Medicaid Services (CMS) under what is known as the “buy-in program.” A State may claim Medicaid reimbursement for the Federal share of the Medicare Part B premiums it paid for eligibly enrolled individuals. The State must maintain an accounting system and retain supporting records to ensure the propriety of its claims for Medicaid reimbursement of the Part B premiums. Prior Office of Inspector General reviews found States improperly claimed Medicaid reimbursement for Medicare Part B premiums they paid on behalf of Medicaid beneficiaries who did not qualify for the buy-in program.<sup>1, 2, 3</sup>

### OBJECTIVE

Our objective was to determine whether the Michigan Department of Community Health (DCH) properly claimed Federal Medicaid reimbursement for Medicare Part B premiums in compliance with Federal regulations.

### BACKGROUND

#### Medicaid: How It Is Administered

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. In contrast to the Medicare program, the Federal and State Governments jointly fund and administer the Medicaid program.

At the Federal level, CMS, an agency within the Department of Health and Human Services, administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

DCH administers Michigan’s Medicaid program, including its buy-in program. The DCH’s responsibilities include ensuring that Part B premiums are paid only on behalf of Medicaid beneficiaries who qualify for the buy-in program, communicating monthly buy-in eligibility information to CMS, coordinating with CMS and Michigan’s Department of Human Services

---

<sup>1</sup> *Arizona Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries* (A-05-11-02009) issued March 29, 2012.

<sup>2</sup> *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries* (A-09-11-02024) issued July 25, 2012.

<sup>3</sup> *New Jersey Did Not Always Claim Medicaid Reimbursement for Medicare Part B Premiums in Accordance with Federal Requirements* (A-02-10-01025) issued August 7, 2013.

(DHS) on individual cases, and routinely checking the accuracy of the CMS's buy-in program master file. DHS has the responsibility for determining whether an individual is eligible for Medicaid benefits and also qualifies for the buy-in program.

States claim Medicaid expenditures for Federal reimbursement on the Form CMS-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. Form CMS-64 is an accounting statement that the State must submit to CMS within 30 days after the end of each quarter.

### **Medicaid Allows Payment of Medicare Part B Premiums Under the Buy-In Program**

State Medicaid programs may enter into an arrangement with CMS known as the buy-in program.<sup>4</sup> Under the buy-in program, a participating State Medicaid program pays the monthly Medicare Part B premiums for certain eligible individuals who are entitled to both Medicare and some form of Medicaid benefits. The State may claim Federal reimbursement for the monthly premium expenditures at the applicable Federal Medical Assistance Percentage (FMAP), which varies depending on the State's relative per capita income.

An individual's eligibility for the buy-in program is based on having an income that is within the range of 100 percent to 135 percent of the Federal poverty level. The income ranges are divided into three categories defined in Michigan's State plan and related Federal requirements.<sup>5</sup> In addition, Medicaid beneficiaries may qualify for the buy-in program if they are receiving benefits under certain programs established by the Act, such as Title XVI.<sup>6</sup>

### **CMS Administers the Federal Buy-In Program**

CMS has overall responsibility for administering the buy-in program and maintains an electronic master buy-in program file that contains information on eligible individuals. Each State provides CMS with updates regarding the enrollees in their buy-in program, which CMS uses to amend the master file. Each month, CMS sends each State both summary and detailed information from the master buy-in program file. The summary information is contained in Summary Accounting Statements (CMS billing notices), which show the State's total Part B premium liability. The detailed information is contained in electronic billing files that identify the beneficiaries and their related premiums that are eligible to be claimed by each State for Federal reimbursement.

---

<sup>4</sup> The Social Security Act (the Act), § 1843.

<sup>5</sup> Individuals who meet the income and other requirements for at least one of the following three categories are eligible for the buy-in program: (1) Qualified Medicare Beneficiary (QMB), (2) Specified Low-Income Medicare Beneficiary (SLMB), and (3) Qualifying Individual (QI). In Michigan, a QI is sometimes referred to as an Additional Low Income Medicare Beneficiary.

<sup>6</sup> Title XVI of the Act covers supplemental security income (SSI) for the aged, blind, and disabled.

## HOW WE CONDUCTED THIS REVIEW

We reviewed the available documentation DCH retained to support its claims for Federal Medicaid reimbursement of \$606.5 million (\$410.1 million Federal share) in Part B premiums it paid through the buy-in program for the quarters ended December 31, 2007, through March 31, 2010. DCH did not have sufficient audit evidence for \$232.8 million (\$139.5 million Federal share) in Part B premiums paid during the quarters ended December 31, 2007, through September 30, 2008. DCH had audit evidence documenting the remaining \$373.7 million (\$270.6 million Federal share) in Part B premiums paid and claimed for reimbursement during the quarters ended December 31, 2008, through March 31, 2010. We assessed this documentation and considered \$20.1 million in Part B premiums to be at risk of being ineligible for Federal reimbursement. We identified at-risk premiums as those that had an assigned Medicare Buy-In Status (MBS) code of "00-Does Not Have Buy-In." We randomly selected for review 100 beneficiaries' related premium payments that were included in the \$20.1 million of at-risk payments and performed a detailed analysis of the beneficiaries' eligibility for the buy-in program.

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 A contains the details of our audit scope and methodology. Appendixes B and C detail our sample methodology, results, and estimates. Appendix D contains the Federal eligibility and documentation requirements for the buy-in program.

## FINDINGS

DCH claimed Federal Medicaid reimbursement for some Medicare Part B premiums it paid on behalf of beneficiaries who were ineligible for the buy-in program. Of the 100 beneficiaries we randomly selected for review, 85 were eligible for enrollment in the buy-in program, and the Medicare Part B premiums that DCH paid on their behalf were allowable. The remaining 15 beneficiaries were ineligible for the buy-in program, and the Medicare Part B premiums that DCH paid on their behalf were unallowable.

On the basis of our sample results, we estimated that DCH improperly claimed at least \$516,912 (Federal share) in Medicare Part B premiums it paid for individuals ineligible for enrollment in the buy-in program for the quarters ended December 31, 2008, through March 31, 2010. Also, for the quarters ended December 31, 2007, through September 30, 2008, DCH claimed \$139.5 million (Federal share) for Part B premiums it paid on behalf of beneficiaries that DCH could not readily identify nor document as eligible for the buy-in program.

## MICHIGAN PAID INDIVIDUAL PART B PREMIUMS FOR BENEFICIARIES WHO WERE NOT ELIGIBLE FOR THE BUY-IN PROGRAM

Under the buy-in program, Federal reimbursement is available only for Part B premiums paid for certain individuals who are entitled to both Medicare and some form of Medicaid.<sup>7</sup> These individuals must meet the eligibility requirements for at least one of the three categories of buy-in program eligibility. In addition, individuals who are eligible for Medicaid and receiving benefits under certain programs established by the Act, such as Title XVI, may be eligible for the buy-in program.

For 15 beneficiaries selected for review, DCH claimed \$3,668 (Federal share) in Part B premiums it paid on their behalf. These 15 beneficiaries did not meet the eligibility requirements of the buy-in program for at least some months. DCH claimed:

- \$1,771 (Federal share) related to 10 beneficiaries DHS considered ineligible for the buy-in program<sup>8</sup> after DCH claimed Federal reimbursement of these Part B premiums on a Form CMS-64;
- \$1,075 (Federal share) related to 1 beneficiary who, (1) for 14 months, qualified for a Michigan program<sup>9</sup> that made the beneficiary ineligible for the buy-in program for those months and, (2) for 2 months, had Part B premiums paid inappropriately because DHS changed the beneficiary's eligibility postpayment;
- \$621 (Federal share) related to 2 beneficiaries who were enrolled in a Michigan program that made the beneficiaries ineligible for coverage under the buy-in program; and
- \$201 (Federal share) related to 2 beneficiaries who did not have Medicaid coverage and thus did not qualify for the buy-in program.

The eligibility records that we reviewed included updates and indicated that these 15 individuals were ineligible for select periods of time. DCH claimed these Part B premiums for Federal reimbursement on the basis of assigned MBS codes that were not accurate relative to the updated eligibility records we reviewed. The discrepancies occurred because DHS did not coordinate or communicate these eligibility changes with DCH to ensure DCH took appropriate and timely action and claimed proper Federal reimbursements. Specifically, DCH did not refund \$3,668 (Federal share) to the Federal Government for Federal reimbursements that it received for the improper premiums we identified.

---

<sup>7</sup> Sections 1902(a)(10)(E), 1903(a)(1), 1905(p)(1) and (3) of the Act; 42 CFR §§ 431.625(d)(1) and (2).

<sup>8</sup> The eligibility changes made by DHS resulted in the beneficiaries' coverage changing to "Not Eligible, No Coverage," which contradicts the assigned MBS codes that DCH used at the time these premiums were claimed on the Form CMS-64.

<sup>9</sup> The program was the Adult Medical Program, which provides basic medical care to low-income adults who do not qualify for Medicaid.

We calculated the Federal reimbursements for these unallowable Part B premiums using the applicable FMAP for the quarters in which those premiums were claimed. On the basis of our sample results, we estimated that DCH improperly claimed at least \$516,912 (Federal share) in Part B premiums for the quarters ended December 31, 2008, through March 31, 2010.

#### MICHIGAN HAD INADEQUATE DOCUMENTATION FOR SOME OF THE PART B PREMIUMS IT CLAIMED

States are required to maintain an accounting system and retain supporting records to ensure that claims for Federal funds are in accordance with applicable Federal requirements. These supporting records must be retained for 3 years from the date of submission for a final expenditure report.<sup>10</sup> CMS's *State Medicaid Manual* requires that States have a recordkeeping system to ensure that documentation supporting a claim is regularly maintained, easily retrieved, and in readily reviewable form. Dollar amounts reported on the Form CMS-64 must reflect actual expenditures for which all supporting documentation is in readily reviewable form and is available at the time the claim is filed.

DCH did not retain complete and adequate supporting documentation for \$139.5 million (Federal share) in Part B premiums that it claimed for Federal reimbursement on the Form CMS-64s for the quarters ended December 31, 2007, through September 30, 2008.<sup>11</sup> Specifically, DCH did not retain the electronic billing files related to the CMS billing notices received during this period. These electronic billing files identify the beneficiaries on whose behalf Part B premiums were paid by DCH each month. Also, DCH used these files in maintaining its database of buy-in recipients on a monthly basis. This documentation is necessary to ensure that DCH claims only Part B premiums paid on behalf of beneficiaries eligible for the buy-in program. DCH did retain summary information, such as CMS billing notices, internal payment vouchers, and memorandums that reconciled to DCH's total quarterly Part B premium payment amounts claimed.

Without complete documentation to identify the beneficiaries whose Part B premiums were paid by DCH under the buy-in program, we were unable to determine whether the \$139.5 million (Federal share) in Part B premiums claimed for Federal reimbursement for the quarters ended December 31, 2007, through September 30, 2008, complied with Federal requirements.

---

<sup>10</sup> 42 CFR §§ 433.32(a) and (b).

<sup>11</sup> In May 2010, DCH was notified of the Office of Inspector General's (OIG) intentions to review DCH's buy-in program, which included Part B premiums claimed on the Form CMS-64 for the quarters ended December 2007 through September 2008. Therefore, DCH was required to retain adequate documentation related to these Part B premiums claimed until OIG completed its review (42 CFR § 433.32(c)).

## RECOMMENDATIONS

We recommend that DCH:

- refund \$516,912 (Federal share) to the Federal Government for improper Part B premiums claimed;
- strengthen coordination efforts with DHS, CMS, and Social Security Administration officials to ensure appropriate corrective action is taken in verifying changes reported in a beneficiary's eligibility status; and
- work with CMS to determine the allowability of the \$139.5 million (Federal share) in Part B premiums claimed for Medicaid reimbursement for which DCH had inadequate support and refund any unallowable amount claimed.

### MICHIGAN DEPARTMENT OF COMMUNITY HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DCH disagreed with our findings. After considering DCH's comments, we maintain our findings and recommendations are valid. DCH's comments are included in their entirety as Appendix E.

#### Improper Part B Premiums Claimed

##### *Michigan Department of Community Health Comments*

In claiming Federal Medicaid reimbursement of Medicare Part B premiums under its buy-in program, DCH stated that it followed the intent of 42 CFR §§ 407.48(a) and 407.48(c), which state when buy-in coverage ends. For the 15 beneficiaries whom we found did not meet the eligibility requirements of the buy-in program for some months, DCH stated that appropriate action had been taken in accordance with these Federal regulations and with the CMS's *State Buy-In Manual* for claiming Federal Medicaid reimbursement. DCH stated that its incoming premium file is matched against DCH eligibility records on a monthly basis. Any record that does not match DCH eligibility records on the day of the match is placed on a buy-in program error report for further analysis by the appropriate staff. The staff ends buy-in coverage on the last day of the month for individuals determined ineligible or who have died.

##### *Office of Inspector General Response*

We acknowledge that DCH: (1) performs a monthly process of matching CMS electronic billing files to DCH eligibility records and (2) takes actions to resolve the discrepancies in its matching process. However, these actions did not prevent DCH from claiming Part B premiums for 15 individuals in our sample. For these 15 ineligible beneficiaries, DHS did not coordinate nor

communicate with DCH to ensure timely resolution of the eligibility changes made and recoup any improper Federal reimbursements resulting from such untimely resolutions. The eligibility records affecting the questioned premiums were updated several months after the premium payments had been paid. The updates indicated that the beneficiaries were ineligible for the buy-in program for select months and the sampled premium payments were questioned. No attempt was made to reimburse the Federal share of the buy-in premiums for the months that the beneficiaries were determined to be ineligible. The questioned premiums remained unresolved and improperly paid. Therefore, we continue to recommend that DCH refund \$516,912 (Federal share) in improper Part B premiums claimed for the quarters ended December 31, 2008, through March 31, 2010.

### **Inadequate Documentation**

#### *Michigan Department of Community Health Comments*

DCH acknowledged that the original CMS data files were not maintained until the fall of 2008. However, the data were imported into tables for use by buy-in staff and are available for review by the auditors.

#### *Office of Inspector General Response*

During our review, we requested supporting information for the amounts that DCH claimed on the CMS-64. While DCH provided some information used by DCH buy-in staff, DCH did not provide the data tables mentioned in its comments on the draft report. The information that DCH provided during our review did not enable us to identify the specific beneficiary premiums included in the monthly CMS billing notices that DCH used to prepare the CMS-64s for the quarters ended December 31, 2007, through September 30, 2008. Therefore, we continue to recommend that DCH work with CMS to determine the allowability of the \$139,516,888 (Federal share) in Part B premiums claimed when preparing its CMS-64s for the quarters ended December 31, 2007, through September 30, 2008, and refund any unallowable amount claimed.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

DCH claimed \$410.1 million for the quarters ended December 31, 2007, through March 31, 2010. DCH had audit evidence documenting \$270.6 million of the \$410.1 million it claimed. Of the \$270.6 million, based on our analysis of the supporting documentation, we considered \$20.1 million of those payments to be at risk as ineligible for Federal reimbursement. We randomly selected a sample of 100 beneficiaries whose premium payments were included in the \$20.1 million of at-risk payments and performed a detailed analysis of their eligibility for the buy-in program.

We limited our review of internal controls to obtaining an understanding of the DCH's policies and procedures for identifying and reporting 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 DCH office in Lansing, Michigan, and the OIG field offices in Madison, Wisconsin, and St. Paul, Minnesota, from January 2012 through March 2013.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed applicable portions of the State plan and DCH's policies and procedures related to the buy-in program;
- reviewed DCH's Single Audit reports performed by the Michigan Office of the Auditor General to assess risk in Michigan's buy-in program;
- interviewed CMS and State officials;
- obtained electronic billing files supporting the Part B premiums billed by CMS for the months August 2008 through March 2010;<sup>12</sup>
- compared the electronic billing files with the CMS billing notices and the DCH's claims for Federal reimbursement on the Form CMS-64;

---

<sup>12</sup> DCH did not retain adequate Part B premium data for September 2007 through November 2008. We obtained electronic data files for August 2008 through December 2008 from CMS, and DCH provided the data files for December 2008 through March 2010. CMS has readily available the most recent 24 months of billed Part B premium data. As a result, we did not have complete electronic billing files to test the Part B premiums billed and claimed on the Form CMS-64 for the quarters ended December 31, 2007, through September 30, 2008. DCH had been notified in May 2010 of the OIG's intentions to review its buy-in program that included Part B premiums claimed on the Form CMS-64 for these quarters.

- compared CMS's billing notices for Part B premiums with the DCH's claims for Federal reimbursement on the CMS-64 and the DCH's payment records;
- assessed the reliance and accuracy of MBS codes assigned by DHS;<sup>13</sup>
- identified a sampling frame of 36,409 beneficiaries with 66,432 debit transactions (i.e., premiums paid) totaling \$20,147,902 that DHS had assigned an MBS code that indicated the premiums were not eligible for Federal reimbursement but nevertheless were claimed on a Form CMS-64;
- selected a random sample of 100 beneficiaries that had premium transactions with an assigned MBS code "00" totaling \$41,993 (\$31,064 Federal share);
- obtained eligibility documentation for the 100 sampled beneficiaries' premium transactions to determine their eligibility for the buy-in program;
- estimated the Federal share of unallowable Part B premiums claimed, using the applicable FMAP for the beneficiary's eligible buy-in category and quarter in which those premiums were claimed; and
- discussed our findings with DCH officials.

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.

---

<sup>13</sup> In assessing the accuracy of the premium detail provided, we identified inconsistencies in the MBS codes assigned by DHS. As a result, we identified a sampling frame of Part B premium transactions considered at risk of being unallowable and claimed for Federal reimbursement. These transactions were assigned the MBS code "00—Does Not Have Buy-In." We found the assigned MBS codes did not always agree with the monthly eligibility files.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of beneficiaries with Part B premiums paid under Michigan's buy-in program for the period October 1, 2008, through March 31, 2010.

### SAMPLING FRAME

The sampling frame consisted of 36,409 beneficiaries with 66,432 debit transactions (i.e., Part B premiums) totaling \$20,147,902. Each transaction had the characteristic of having an assigned MBS code of "00-Does Not Have Buy-In."

### SAMPLE UNIT

The sample unit was a beneficiary's related Part B premium transactions with an assigned MBS code of "00-Does Not Have Buy-In" during our entire 18-month audit period.

### SAMPLE DESIGN

We used a simple random sample.

### SAMPLE SIZE

We selected a sample of 100 beneficiaries with Part B premium transactions totaling \$41,993 (\$31,064 Federal share).

### SOURCE OF RANDOM NUMBERS

We generated the random numbers with OIG Office of Audit Services (OAS) statistical software.

### METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiaries in our sample frame. After generating 100 random numbers, we matched the random numbers with the items in the sampling frame. We then created a list of sample items and related debit transactions.

### ESTIMATION METHODOLOGY

We estimated unallowable payments of Medicare Part B premiums. Because the FMAP rate varied, we also estimated the total Federal share reimbursed to Michigan for unallowable Medicare Part B premiums.<sup>14</sup> We calculated the Federal share by multiplying the premium amounts by applicable FMAPs (Appendix D) for the quarters in which the premiums were claimed.

---

<sup>14</sup> The Federal share or Federal financial participation is the amount that the Federal Government reimburses to State Medicaid agencies and is determined by the FMAP rates applied to the claimed Medicaid expenditures.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Sampling Frame Size	Value of Frame (Total)	Sample Size	Value of Sample Items (Total)	Value of Sample Items (Federal Share)	Number of Sample Errors	Value of Errors (Total)	Value of Errors (Federal Share)
36,409	\$20,147,902	100	\$41,993	\$31,064	15	\$4,794	\$3,668

Table 2: Estimate of Unallowable Part B Premium Payments  
(Limits Calculated for a 90-Percent Confidence Interval)

	<u>Total Unallowable</u>	<u>Federal Share<sup>15</sup></u>
Point Estimate	\$1,745,484	\$1,335,431
Lower Limit	\$601,707	\$516,912
Upper Limit	\$2,889,261	\$2,153,950

<sup>15</sup> We calculated the Federal share by multiplying the premium amounts by the applicable FMAPs for the quarters in which the premiums were claimed on the Form CMS-64. The applicable FMAP rates are cited in Appendix D.

**APPENDIX D: FEDERAL REQUIREMENTS  
FOR THE BUY-IN PROGRAM**

**ELIGIBILITY REQUIREMENTS FOR CLAIMING  
PART B PREMIUM PAYMENTS**

Section 1843 of the Act allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. Participating State Medicaid agencies are allowed to pay the monthly Medicare Part B premiums for Medicaid beneficiaries who are entitled to both Medicare and Medicaid benefits and meet the buy-in program qualifications. The State may then claim the monthly premium expenditures for Federal reimbursement at the applicable FMAP as authorized by section 1903(a)(1) of the Act.

Michigan's FMAP during our audit period is shown in Table 3:

**Table 3: Federal Medical Assistance Percentage in Michigan**

Period (Quarters Ended)	FMAP
December 31, 2007, through September 30, 2008	58.10 percent
December 31, 2008, through March 31, 2009	69.58 percent
June 30, 2009, through September 30, 2009	70.68 percent
December 31, 2009, through March 31, 2010	73.27 percent

However, for the quarters ended December 31, 2007, through March 31, 2010, the FMAP was 100 percent for any individual who qualified for the buy-in program by meeting the specific requirements of the QI category.

Pursuant to sections 1902(a)(10)(E), 1903(a)(1), 1905(p)(1) and (3) of the Act and Federal regulations (42 CFR §§ 431.625(d)(1) and (2)),<sup>16</sup> Federal reimbursement is available only for Part B premiums paid on behalf of an individual who meets the eligibility requirements of a QMB; a SLMB; a QI; or a recipient or deemed recipient receiving benefits under certain titles of the Act, including Title IV-A or XVI.

Sections 1902(a)(10)(E) and 1905(p)(1) and (3) of the Act list the eligibility requirements for specified beneficiaries:

- **QMB:** An individual who is entitled to Medicare Part A benefits, has income that does not exceed 100 percent of the Federal poverty level, and has resources that do not exceed twice the limit for SSI eligibility.

<sup>16</sup> The regulations at 42 CFR §§ 431.625(d)(1) and (2) have not been amended since 1988 and do not mention QMBs, SLMBs, or QIs. However, the Act allows Federal reimbursement for such premium payments paid on behalf of beneficiaries eligible for these specific categories.

- **SLMB:** An individual who is entitled to Medicare Part A benefits, has income above 100 percent but less than 120 percent of the Federal poverty level, and has resources that do not exceed twice the limit for SSI eligibility.
- **QI:** An individual who is entitled to Medicare Part A benefits, has income of at least 120 percent but less than 135 percent of the Federal poverty level, has resources that do not exceed twice the limit for SSI eligibility, and is not otherwise eligible for Medicaid.

## DOCUMENTATION REQUIREMENTS FOR CLAIMING PART B PREMIUMS

Pursuant to 42 CFR §§ 433.32(a) and (b), States are required to “(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements; (b) Retain records for 3 years from date of submission of a final expenditure report ....”

According to section 2497.3 of the CMS’s *State Medicaid Manual*, States “must have a recordkeeping system which assures that documentation supporting a claim is regularly maintained, easily retrieved, and in readily reviewable form.” Section 2497.4 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 ....”

Section 2500.A.1 of the CMS’s *State 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.” This section 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.”

APPENDIX E: MICHIGAN DEPARTMENT OF COMMUNITY HEALTH COMMENTS



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JAMES K. HAVEMAN  
DIRECTOR

November 5, 2013

Ms. Sheri L. Fulcher  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Audit Services, Region V  
233 North Michigan Avenue, Suite 1380  
Chicago, Illinois 60601

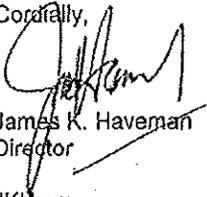
Re: Report Number (A-05-12-00035)

Dear Ms. Fulcher:

Enclosed is the Michigan Department of Community Health's response to the draft report entitled "Michigan Claimed Improper Medicaid Reimbursement for Some Medicare Part B Premiums during December 31, 2007, through September 30, 2008."

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Pam Myers at (517) 373-1508.

Cordially,

  
James K. Haveman  
Director

JKH:pm

Enclosure

cc: Nick Lyon  
Tim Becker  
Steve Filton  
Pam Myers

CAPITOL VIEW BUILDING • 201 TOWNSEND STREET • LANSING, MI 48913  
www.michigan.gov • 517-373-3740

(SCH-1272 (02/13))

Michigan Claimed Improper Medicaid Reimbursement  
for some Medicare Part B Premiums  
December 31, 2007 through March 31, 2010  
(A-05-12-00035)

Finding

The DCH claimed Federal Medicaid reimbursement for some Medicare Part B premiums it paid on behalf of beneficiaries who were ineligible for the buy-in program. Of the 100 beneficiaries we randomly selected for review, 85 were eligible for enrollment in the buy-in program, and the Medicare Part B premiums that DCH paid on their behalf were allowable. The remaining 15 beneficiaries were ineligible for the buy-in program, and the Medicare Part B premiums that DCH paid on their behalf were unallowable.

On the basis of our sample results, we estimated that the DCH improperly claimed at least \$516,912 (Federal share) in Medicare Part B premiums it paid for individuals ineligible for enrollment in the buy-in program for the quarters ended December 31, 2008 through March 31, 2010. Also for the quarters ended December 31, 2007, through September 30, 2008, the DCH claimed \$139.5 million (Federal share) for Part B premiums it paid on behalf of beneficiaries that DCH could not readily identify nor document as eligible for the buy-in program.

Recommendations

We recommend that DCH:

- refund \$516,912 (Federal share) to the Federal Government for improper Part B premiums claimed;
- strengthen coordination efforts with DHS, CMS, and Social Security Administration officials to ensure appropriate corrective action is taken in verifying changes reported in a beneficiary's eligibility status; and
- work with CMS to determine the allowability of the \$139.5 million (Federal share) in Part B premiums claimed for Medicaid reimbursement for which the DCH had inadequate support and refund any allowable amount claimed.

DCH Response

The DCH disagrees with the findings contained in the audit report. As noted in the audit, the buy-in program is a program that pays Medicare premiums for eligible beneficiaries, DCH and CMS determined eligible. The incoming premium file is matched against DCH eligibility records on a monthly basis. Any record that does not match DCH eligibility records on the day of the match are placed on a buy-in program error report for further analysis by buy-in staff. Buy-in premiums are always prepaid one month in advance. DCH believes they are following the intent of 42 CFR 407.48(a), which indicates that coverage ends on the last day of the month in which the individual dies and 42 CFR 407.48(c) which states buy-in coverage ends as follows: On the last day of the last month for which he or she is eligible for inclusion in the group, if CMS determines ineligibility or receives a

Michigan Claimed Improper Medicaid Reimbursement  
for some Medicare Part B Premiums  
December 31, 2007 through March 31, 2010  
(A-05-12-00035)

State ineligibility notice by the 25<sup>th</sup> day of the second month after the month in which the individual becomes ineligible for inclusion in the group.

- For the 9 of the 10 beneficiaries identified when the beneficiary was placed on DCH's error code report, eligibility was reviewed and a deletion notice was sent to CMS on the next outgoing data file. For the remaining individual we received a status code of 19 as of November, the beneficiary passed away November 13, 2009. DCH would be eligible for the entire premium for November.
- For the one beneficiary noted, DCH received an 1180 code from CMS, which indicates that CMS has established a buy-in record for an SSI recipient going back to January 2008. The effective date is based on the SSI eligibility date; per the State Buy-In Manual DCH cannot opt out of payment for SSI recipients. The beneficiary was subsequently identified on the buy-in program error report and a deletion code was sent by buy-in staff on the next outgoing file to CMS.
- For the two beneficiaries identified, the state had received an 1180 code from CMS which indicates SSI. CMS retroactively charged DCH for buy-in for these two beneficiaries. The beneficiaries were subsequently identified on the buy-in program error report and deletion codes were sent by buy-in staff on the next outgoing file to CMS.
- For one of the two beneficiaries, CMS identified the person as having retroactive SSI enrollment. DCH was required to reimburse for the Medicare premium. For both of these beneficiaries as soon as they were identified on the buy-in program error report deletion codes were sent by buy-in staff on the next outgoing file to CMS.

DCH acknowledges that the original CMS data files were not maintained until the fall of 2008. However, the data was imported into tables for use by buy-in staff and is available for review by the auditors.

Additional Details

On page 7 of the audit report, the scope indicates: We conducted fieldwork at the DCH office in Lansing, Michigan, and the OIG field offices in Madison, Wisconsin, and St. Paul, Minnesota, from January 2012 through March 2013. The actual audit started on June 2, 2010 with a telephone entrance conference. The auditors were subsequently onsite in Lansing the week of June 7, 2010. The auditors were onsite again in July 2010 and September 2010.