DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

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Report Number: A-07-07-01040

Ms. Vivianne M. Chaumont
Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mail South
Lincoln, Nebraska 68509

Dear Ms. Chaumont:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Nebraska Medicare Part D Contributions to the Centers for Medicare & Medicaid Services for 'Full-Duals.' " We will forward a copy of this report to the HHS action official noted below.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-07-07-01040 in all correspondence.

Sincerely,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosure

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, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEBRASKA MEDICARE PART D CONTRIBUTIONS TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES FOR "FULL-DUALS"

Daniel R. Levinson
Inspector General

August 2008
A-07-07-01040

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established the Medicare Part D prescription drug benefit. Under Part D, which began January 1, 2006, the Medicare program subsidizes the prescription drug benefit for Medicaid recipients. To defray a portion of Medicare's cost, each State is required to make contributions to the Centers for Medicare & Medicaid Services (CMS) on behalf of the State's recipients who are eligible for both full Medicaid benefits and Medicare (full-duals). CMS automatically enrolls full-duals in the Medicare Part D program and makes payments on their behalf to prescription drug plans (PDP).

Each State is required to submit to CMS a monthly report, referred to as the MMA file, which identifies all of the State's full-duals and any retroactive Medicaid enrollment changes for prior months. CMS uses the MMA file to verify the Medicare eligibility of the reported full-duals and to determine the amount of each State's contribution. CMS subsequently sends each State a report, referred to as the MMA return file, which identifies the individuals determined to be full-duals and the State's required contribution for each full-dual.

In Nebraska, the Nebraska Department of Health and Human Services (Nebraska) is required to make monthly contributions to CMS for the State's full-duals. From January through October 2006, Nebraska made contributions for 288,567 beneficiary-months. (A beneficiary-month represents a payment for one beneficiary for one month.)

We reviewed a statistical sample of 300 of 20,414 beneficiary-months for which CMS made payments to PDPs but Nebraska did not make contributions to CMS.

OBJECTIVE

Our objective was to determine whether Nebraska made required monthly contributions to CMS for all full-duals from January through October 2006.

RESULTS OF REVIEW

For the 300 sampled beneficiary-months, Nebraska (1) was not required to make contributions to CMS because the beneficiaries were not actually full-duals in the sampled months or were not identified in Nebraska's Medicaid eligibility records or (2) made subsequent retroactive contributions to CMS.

This report makes no recommendations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Part D Prescription Drug Benefit

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended Title 18 of the Social Security Act to establish the Medicare Part D prescription drug benefit. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare and Medicaid programs, contracts with prescription drug plans (PDP) to offer the Medicare Part D benefits to eligible individuals.

Under Part D, which began January 1, 2006, the Medicare program subsidizes the prescription drug benefit for Medicaid recipients. Beneficiaries who are eligible for both full Medicaid benefits and Medicare are considered full-benefit, dually eligible beneficiaries (full-duals). CMS automatically enrolls beneficiaries identified as full-duals in the Medicare Part D program and begins making monthly subsidy payments to PDPs on behalf of the full-duals. CMS's payments to PDPs continue for the entire following year unless the full-dual opts out of Medicare Part D or dies.

States' Contributions for Full-Duals

Section 103 of the MMA requires the 50 States and the District of Columbia to make monthly contributions to CMS to defray a portion of Medicare's cost of providing the Part D drug benefit to full-duals. A State's contribution is determined, in part, by the number of full-duals in the State each month. Each State is required to submit to CMS a monthly report, referred to as the MMA file, which identifies all of the State's full-duals and any retroactive Medicaid enrollment changes for prior months. CMS uses the MMA file to verify the Medicare eligibility of the reported full-duals and to determine the amount of each State's contribution. CMS subsequently sends each State a report, referred to as the MMA return file, which identifies the individuals determined to be full-duals and the amount the State must pay for its portion of the Part D drug benefit.

Nebraska Department of Health and Human Services

In Nebraska, the Nebraska Department of Health and Human Services (Nebraska) is required to make monthly contributions to CMS for the State's full-duals. From January through October 2006, when the required contribution was $97 for each full-dual, Nebraska made monthly contributions for 288,567 beneficiary-months.[1]

[1] A beneficiary-month represents a payment for Part D drug coverage for one beneficiary for one month. As we will discuss in the Scope section below, we did not review those instances for which Nebraska made a payment and CMS did not make a corresponding monthly payment.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Nebraska made required monthly contributions to CMS for all full-duals from January through October 2006.

Scope

Our review covered the period January through October 2006. As we reviewed each month separately, we performed the following analysis to determine the beneficiary-months to review.

- We compared the full-duals—for whom CMS paid a PDP—to the MMA file.
- We only reviewed those instances of payments from CMS to a PDP for which there were positive payments made (by Nebraska to CMS) for the specific month being reviewed.
- We did not review contribution payments that Nebraska made on behalf of beneficiaries for whom CMS did not make a corresponding payment to a PDP.

We then limited our review to 20,414 beneficiary-months, which represented the difference between the 308,981 beneficiary-months for which CMS paid PDPs and the 288,567 beneficiary-months for which Nebraska paid CMS on behalf of full-duals. (See the Appendix.)

We limited our internal control review to obtaining an overall understanding of Nebraska's policies and procedures for reporting full-duals and making contributions to CMS.

We conducted our fieldwork at Nebraska's offices in Lincoln, Nebraska, from July 2006 through February 2007.

Methodology

To accomplish our objective:

- We reviewed applicable Federal and State requirements.
- We reviewed CMS and Nebraska policies and procedures for reporting full-duals, including any changes related to Medicaid eligibility.
- We reviewed Nebraska's data used to create the MMA file.
- We reviewed CMS's systems, including the Medicare Advantage Prescription Drug (MARx) system (to determine the payments that CMS made to the PDPs) and the Medicare Beneficiary Database (to verify PDP enrollment, beneficiary residency, and payment information).

- We selected, from the 20,414 beneficiary-months mentioned above, a 10-stratum statistical sample of 300 beneficiary-months (30 beneficiary-months per stratum), as shown in the Appendix. We analyzed this statistical sample to determine whether Nebraska was, for any of these sampled cases, required to make a monthly contribution payment. Specifically, for each of the sampled beneficiary-months, we used Nebraska's Eligibility Verification System and Medicaid Management Information System, to verify Medicaid eligibility in the State of Nebraska.

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.

RESULTS OF REVIEW

For the 300 sampled beneficiary-months, Nebraska (1) was not required to make contributions to CMS because the beneficiaries were not actually full-duals in the sampled months or were not identified in Nebraska's Medicaid eligibility records or (2) made subsequent retroactive contributions to CMS.

This report makes no recommendations.

APPENDIX

SAMPLING DESIGN, METHODOLOGY, AND ESTIMATES

OBJECTIVE

Our objective was to determine whether Nebraska should have made monthly contributions to the Centers for Medicare & Medicaid Services (CMS) for all full-duals from January through October 2006.

POPULATION

The population consisted of 20,414 beneficiary-months, which represented the difference between the 308,981 beneficiary-months for which CMS paid prescription drug plans (PDP) and the 288,567 beneficiary-months for which Nebraska paid CMS on behalf of full-duals for the period January through October 2006, as shown in Table 1.

Table 1: Identification of the Population

		Number of Beneficiary-Months		
Stratum	Month	CMS Payments to PDPs (A)	Nebraska Contributions to CMS (B)	Sample Population (A Minus B)
1	January	31,004	29,501	1,503
2	February	31,192	29,432	1,760
3	March	31,250	29,350	1,900
4	April	31,183	29,201	1,982
5	May	31,037	28,997	2,040
6	June	30,866	28,836	2,061
7	July	30,684	28,686	2,180
8	August	30,684	28,454	2,230
9	September	30,500	28,217	2,283
10	October	30,368	27,893	2,475
Total		**308,981**	**288,567**	**20,414**

SAMPLE DESIGN

The audit used a stratified random sample design. We stratified the sample population by month (January through October 2006). We used the Office of Inspector General, Office of Audit Services (OAS), statistical software RAT-STATS to generate the random numbers used to select the sample.

SAMPLE SIZE

The statistical sample consisted of 30 beneficiary-months from each stratum, for a total of 300 beneficiary-months.