DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 1 1 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Review of Illinois Medicare Part D Contributions to the Centers for Medicare & Medicaid Services for "Full-Duals" (A-05-07-00009)

Attached is an advance copy of our final report on Illinois Medicare Part D contributions to the Centers for Medicare & Medicaid Services (CMS) for "full-duals." Full-duals are beneficiaries who are eligible for both full Medicaid benefits and Medicare. We will issue this report to the Illinois Department of Healthcare and Family Services (the State agency) within 5 business days.

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, the Medicare program subsidizes the drug benefit for Medicaid beneficiaries. To defray a portion of Medicare's cost, each State is required to make contributions to CMS on behalf of the State's full-duals. CMS determines the contribution amount based on the State's monthly MMA file, which identifies the State's full-duals and any retroactive Medicaid enrollment changes for prior months. After verifying the Medicare eligibility of the reported full-duals, CMS sends each State an MMA return file, which identifies the individuals determined to be full-duals and the State's required contribution.

Our objective was to determine whether the State agency made required monthly contributions to CMS for all full-duals from January through October 2006. We reviewed a statistical sample of 300 of the 246,027 beneficiary-months for which CMS made payments to prescription drug plans but the State agency did not make contributions to CMS.

Contrary to Federal requirements, the State agency did not make contributions to CMS for 22 of the 300 sampled beneficiary-months. Although the State agency's monthly MMA file included full-dual information for 18 of the 22 beneficiary-months, CMS did not include the information in the MMA return file that identifies the amount billed to the State agency. For the remaining four beneficiary-months, the State agency did not include full-dual information in its MMA file, nor did CMS in its MMA return file and the amount billed to the State agency. These conditions

occurred because neither the State agency nor CMS reconciled the MMA and MMA return files to ensure that required contributions were identified for all full-duals. As a result, the State agency did not contribute an estimated $2.1 million to CMS.

For the remaining 278 sampled beneficiary-months, the State agency (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 the State agency's Medicaid eligibility records or (2) made subsequent retroactive contributions to CMS.

We recommend that the State agency:

- work with CMS to develop a process for reconciling the MMA file to the MMA return file to ensure that required contributions are identified and made for all full-duals and

- identify and accurately report all full-duals to CMS in the MMA file.

In its comments on our draft report, the State agency concurred with the recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Marc Gustafson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-07-00009.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

JUN 16 2008

Report Number: A-05-07-00009

Mr. Barry S. Maram
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763

Dear Mr. Maram:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Illinois 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 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.

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 do not hesitate to call me at (312) 353-2618, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through e-mail at Jaime.Saucedo@oig.hhs.gov. Please refer to report number A-05-07-00009 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

June 2008
A-05-07-00009

Office of Inspector General

http://oig.hhs.gov

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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.

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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 beneficiaries. 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 beneficiaries 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 premium and cost-sharing payments on their behalf to prescription drug plans.

Each State is required to submit to CMS a monthly report, referred to as the "MMA file," that 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," that identifies the individuals determined to be full-duals and the State's required contribution for each full-dual.

In Illinois, the Department of Healthcare and Family Services (the State agency) is required to make monthly contributions to CMS for the State's full-duals. From January through October 2006, the State agency made contributions for 2,137,116 beneficiary-months. (A beneficiary-month represents a payment for one beneficiary for 1 month.) We reviewed a statistical sample of 300 of the 246,027 beneficiary-months for which CMS made payments to prescription drug plans but the State agency did not make contributions to CMS.

OBJECTIVE

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

SUMMARY OF FINDINGS

Contrary to Federal requirements, the State agency did not make contributions to CMS for 22 of the 300 sampled beneficiary-months from January through October 2006. Although the State agency's monthly MMA file included full-dual information for 18 of the 22 beneficiary-months, CMS did not include the information in the MMA return file that identifies the amount billed to the State agency. For the remaining four beneficiary-months, the State agency did not include full-dual information in its MMA file, nor did CMS in its MMA return file and the amount billed to the State agency. These conditions occurred because neither the State agency nor CMS reconciled the MMA and MMA return files to ensure that required contributions were identified for all full-duals. As a result, the State agency did not contribute an estimated $2.1 million to CMS.

For the remaining 278 sampled beneficiary-months, the State agency (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 the State agency's Medicaid eligibility records or (2) made subsequent retroactive contributions to CMS.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to develop a process for reconciling the MMA file to the MMA return file to ensure that required contributions are identified and made for all full-duals and

- identify and accurately report all full-duals to CMS in the MMA file.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency concurred with the recommendations. We have included the State agency's comments as Appendix B.

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 the Social Security Act to establish the Medicare Part D prescription drug benefit.[1] 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 benefit to eligible individuals.[2]

Under Part D, which began January 1, 2006, the Medicare program subsidizes the prescription drug benefit for Medicaid beneficiaries. 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[3] and begins making monthly premium and cost-sharing subsidy payments to PDPs on behalf of the full-duals.[4] 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(b) 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.[5] 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," that identifies all of the State's full-duals and any retroactive Medicaid enrollment changes for prior months.[6] 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," that identifies the individuals determined to be full-duals and the amount that the State must pay for its portion of the Part D drug benefit.[7]

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[1]P.L. No. 108-173, Social Security Act, §§ 1860D-1–1860D-42, 42 U.S.C. §§ 1395w-101–1935w-152 and 1396u-5.

[2]Although CMS contracts with both stand-alone PDPs and Medicare Advantage plans to administer the Part D program, this report deals only with stand-alone PDPs.

[3]42 CFR § 423.34(d) (outlines the automatic enrollment rules).

[4]42 CFR § 423.315(d) (explains low-income subsidies).

[5]42 U.S.C. § 1396u-5.

[6]42 CFR § 423.910(d).

[7]42 CFR § 423.910(e).

Illinois Department of Healthcare and Family Services

In Illinois, the Department of Healthcare and Family Services (the State agency) is required to make monthly contributions to CMS for the State's full-duals. From January through October 2006, when the required contribution was $115 for each full-dual,[8] the State agency made monthly contributions for 2,137,116 beneficiary-months.[9]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency 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. We limited our review to 246,027 beneficiary-months, which represented the difference between the 2,383,143 beneficiary-months for which CMS paid PDPs and the 2,137,116 beneficiary-months for which the State agency paid CMS on behalf of full-duals.

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

We conducted our fieldwork at the State agency in Springfield, Illinois, from October 2006 through March 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- reviewed CMS and State agency policies and procedures for reporting full-duals, including any changes related to Medicaid eligibility;
- reviewed State agency data used to create the MMA file;
- reviewed the CMS MMA return file and matched the file to CMS payments to PDPs for full-duals;

[8]The $115 contribution represents the monthly amount that CMS billed Illinois during calendar year 2006 for each full-dual.

[9]A beneficiary-month represents a payment for Part D drug coverage for one beneficiary for 1 month.

- identified 246,027 beneficiary-months for which CMS made payments to PDPs but the State agency did not make corresponding contributions to CMS; and

- selected from the 246,027 beneficiary-months a 10-stratum statistical sample of 300 beneficiary-months (30 beneficiary-months per stratum), as shown in Appendix A, and reviewed:

    - CMS and State agency information to determine whether the beneficiary was a full-dual for each sampled beneficiary-month and

    - State agency beneficiary information through April 2007 to determine whether the individual had been retroactively added or dropped from the MMA file after the sampled beneficiary-month.

Based on our sample results, we estimated, as shown in Appendix A, the number of beneficiary-months for which the State agency did not make required contributions to CMS. We multiplied that number by $115, the required contribution for each full-dual, to estimate the total required amount that the State agency did not contribute to CMS. We did not recommend monetary recovery of the estimated amount because the sample results did not include, as required by our sampling and estimation policy, a minimum of six errors in each stratum.

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.

FINDINGS AND RECOMMENDATIONS

Contrary to Federal requirements, the State agency did not make contributions to CMS for 22 of the 300 sampled beneficiary-months from January through October 2006. Although the State agency's monthly MMA file included full-dual information for 18 of the 22 beneficiary-months, CMS did not include the information in the MMA return file that identifies the amount billed to the State agency. For the remaining four beneficiary-months, the State agency did not include full-dual information in its MMA file, nor did CMS in its MMA return file and the amount billed to the State agency. These conditions occurred because neither the State agency nor CMS reconciled the MMA and MMA return files to ensure that required contributions were identified for all full-duals. As a result, the State agency did not contribute an estimated $2.1 million to CMS.

For the remaining 278 sampled beneficiary-months, the State agency (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 the State agency's Medicaid eligibility records or (2) made subsequent retroactive contributions to CMS.

PROGRAM REQUIREMENTS

Federal regulations (42 CFR §§ 423.908 and 423.910) require States to make contributions to CMS for Part D drug benefits assumed by Medicare on behalf of full-duals. Pursuant to 42 CFR § 423.910(d), each State must submit to CMS a monthly electronic MMA file that identifies all full-duals in the State. The file must include, among other things, data on Medicaid enrollment for the current month and retroactive enrollment changes for prior months.

Federal regulations (42 CFR § 423.910(e)) require CMS to perform data matches as necessary to identify the number of full-duals in a State and to establish the State's contribution. Section 2 of CMS's "MMA State File Specifications and Data Dictionary" instructions state that CMS will then send the MMA return file to the State.[10]

SOME STATE CONTRIBUTIONS NOT MADE

For 22 of the 300 sampled beneficiary-months, the State agency did not make required contributions to CMS for full-duals. Based on these sample results, we estimated that the State agency did not pay CMS approximately $2.1 million for an estimated 18,283 beneficiary-months.

The State Agency Identified Full-Duals but Did Not Make Contributions

Although the State agency reported full-dual information for 18 of the 22 beneficiary-months in its MMA file, CMS did not include these full-duals in the MMA return file that identifies the amount billed to the State agency. As a result, the State agency did not make contributions to CMS on behalf of these full-duals. We could not determine why CMS's MMA return file did not include the 18 full-duals.

The State Agency Did Not Identify Full-Duals

For four beneficiary-months, the State agency did not identify the full-duals in its MMA file, nor did CMS in its MMA return file that identifies the amount billed to the State agency. As a result, the State agency did not make contributions to CMS on behalf of these full-duals. We could not determine why the State agency did not identify the four full-duals.

LACK OF A RECONCILIATION PROCESS

Federal and State regulations and guidance do not require a reconciliation of the MMA and MMA return files. In addition, neither the State agency nor CMS reconciled the files to ensure that all full-duals were identified and that contributions were made on their behalf.

[10]The "MMA State File Specifications and Data Dictionary" is an instructional guide created by CMS to assist States in preparing and submitting State data to satisfy Federal reporting requirements at 42 CFR § 432.910(d). Available online at http://www.cms.gov/States/Downloads/MMADataDictionary.pdf. Accessed on February 20, 2008.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to develop a process for reconciling the MMA file to the MMA return file to ensure that required contributions are identified and made for all full-duals and

- identify and accurately report all full-duals to CMS in the MMA file.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency concurred with the recommendations and described its current reconciliation processes and its efforts to ensure accurate reporting of dual eligibility. We have included the State agency's comments as Appendix B.

APPENDIXES

SAMPLING DESIGN, METHODOLOGY, AND ESTIMATES

OBJECTIVE

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

POPULATION

The population consisted of differences, in beneficiary-months, between CMS's payments to prescription drug plans (PDP) for full-duals and the State agency's contributions to CMS 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)**	**State Agency Contributions to CMS (B)**	**Sample Population (A Minus B)**
1	January	229,622	210,420	19,202
2	February	234,634	213,946	20,688
3	March	236,464	214,387	22,077
4	April	235,456	212,447	23,009
5	May	238,156	214,616	23,540
6	June	241,563	217,053	24,510
7	July	243,040	215,977	27,063
8	August	238,806	211,548	27,258
9	September	239,040	210,389	28,651
10	October	246,362	216,333	30,029
Total		**2,383,143**	**2,137,116**	**246,027**

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.

ESTIMATION METHODOLOGY

We used RAT-STATS to estimate the number of beneficiary-months for which the State agency did not make required contributions to CMS. We then multiplied that estimate by $115, the required monthly contribution payable to CMS for each full-dual, to estimate the total dollar amount of errors.

OAS sampling and estimation policy requires a minimum of six errors per stratum to recommend monetary recovery of a statistically estimated amount. Because we did not identify at least six errors in any stratum, we did not recommend monetary recovery of our statistical estimate.

SAMPLE RESULTS AND ESTIMATES

Based on the 22 errors found in our sample, we estimated that for 18,283 beneficiary-months, the State agency did not make required contributions to CMS totaling approximately $2.1 million from January through October 2006. (See Tables 2 and 3.)

Table 2: Number of Beneficiary-Months Without Required Contributions

Stratum	Sample Size	Sampled Beneficiary-Months With No Contributions	Estimated Beneficiary-Months With No Contributions
1	30	1	640
2	30	1	690
3	30	5	3,680
4	30	3	2,301
5	30	2	1,569
6	30	1	817
7	30	1	902
8	30	3	2,726
9	30	1	955
10	30	4	4,004
Total	**300**	**22**	**18,283**[1]

[1]Does not add to total because of rounding differences in the statistical software.

Table 3: Estimated Number of Beneficiary-Months for Which the State Agency Did Not Make Required Contributions
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	18,283*
Lower limit	12,057
Upper limit	24,509

*18,283 beneficiary-months × $115 = $2,102,545.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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April 10, 2008

Marc Gustafson
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
233 North Michigan Avenue
Chicago, IL 60601

Re: Report Number A-05-07-00009

Dear Mr. Gustafson:

We have reviewed the draft report, "Review of Illinois Medicare Part D Contributions to the Centers for Medicare & Medicaid Services for "Full-Duals" "covering the period of January 1, 2006 through October 31, 2006 and the recommendations made by your office. We appreciate having the opportunity to comment upon the draft report.

Attached please find our responses to the draft audit report. If you have any questions or comments about our response to the audit, please contact Peggy Edwards, External Audit Liaison, at (217) 785-9764 or through e-mail at Peggy.Edwards@illinois.gov.

Sincerely,

Barry S. Maram

Barry S. Maram
Director

Attachment

cc: Peggy Edwards
Ed Harvey
Marie VonDeBur
Theresa Eagleson
Jacquetta Ellinger

Attachment Response
Report Number: A-05-07-00009

Recommendation:

- Work with CMS to develop a process for reconciling the MMA file to the MMA return file to ensure that required contributions are identified and made for all full-duals and

Response:

The Department concurs with the recommendation. The Department's current reconciliation processes include verifying that the monthly CMS Billing Notice for "State Contribution for Prescription Drug Benefit" matches the summary line on the MMA return file received from CMS. Also, the total records sent on the Department's MMA monthly submittal is compared to records received on the MMA return file. Dual eligibility status is tracked on a monthly basis for records submitted to CMS. Records re-determined by CMS are not presently evaluated. CMS has access to more timely Medicare data than States and the Department has a slight delay in loading MMIS data to its' reporting data warehouse. These factors, as well as retroactive eligibility, play a role in determining eligibility status.

In an effort to provide better reconciliation of the MMA submission file with the CMS response file, the Department will coordinate with CMS to more directly identify and address specific eligibility changes returned by CMS.

Recommendation:

- Identify and accurately report all full-duals to CMS in the MMA file.

Response:

The Department concurs with the recommendation. The Department, as it has since the inception of the MMA monthly process, continuously seeks to identify and accurately report all dual eligible persons to CMS in the MMA file submission. To that end, we seek the most accurate data from multiple sources in order to determine dual eligibility. In an effort to ensure the accuracy of MMA reporting, the Department will continue to seek new ways to monitor, enhance, and reconcile file submissions.