DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 27, 2012

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

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Arizona Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries (A-09-11-02009)

Attached, for your information, is an advance copy of our final report on Arizona'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 Arizona Health Care Cost Containment System 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-09-11-02009.

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

March 29, 2012

Report Number: A-09-11-02009

Mr. Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Arizona 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-09-11-02009 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

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

Daniel R. Levinson
Inspector General

March 2012
A-09-11-02009

Office of Inspector General

http://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:

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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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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.

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THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://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.

EXECUTIVE SUMMARY

BACKGROUND

Section 1843 of the Social Security Act (the 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 behalf of those individuals. The State may then claim the monthly premium expenditures for Federal reimbursement.

A State may claim Federal reimbursement for the 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) or was a recipient or deemed a recipient of money payments under certain titles of the Act, including Title IV-A and Title XVI. In this report, we refer to these eligibility categories as "the specified categories." A State may not claim Federal reimbursement for an individual who does not meet the eligibility requirements for at least one of the specified categories.

In Arizona, the Arizona Health Care Cost Containment System (State agency) administers the Medicaid program, including the State's buy-in program. The State agency is responsible for 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 ensuring the accuracy of the eligibility codes assigned to individuals. These codes group individuals in the buy-in program into eligibility categories and identify individuals whose Part B premiums are eligible or ineligible for Federal reimbursement.

For the period October 1, 2007, through September 30, 2009, the State agency claimed for Federal reimbursement approximately $304 million for Part B premiums paid under the buy-in program. We reviewed $49 million in Part B premiums that the State agency claimed for individuals assigned an eligibility code that indicated the premiums were not eligible for Federal reimbursement. We reviewed a stratified random sample of 200 monthly Part B premium payments to determine whether the premiums were allowable for Federal reimbursement.

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 FINDING

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. Of the 200 sampled payments, 114 complied with Federal requirements. However, 86 sampled

payments totaling $5,877 (Federal share) did not comply with Federal requirements. Specifically, the State agency claimed Federal reimbursement for Part B premiums paid on behalf of individuals who did not meet the eligibility requirements of any of the specified categories.

The State agency submitted unallowable claims because, according to State agency officials, it believed that CMS guidance permitted claiming of Federal reimbursement for Part B premium payments for individuals who were not eligible for any of the specified categories. However, after discussions with CMS, we concluded that this guidance did not permit Federal reimbursement to be claimed for Part B premium payments for individuals who were not eligible for any of the specified categories. Based on our sample results, we estimated that the State agency improperly claimed $13,052,176 in Federal reimbursement for ineligible Part B premiums.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $13,052,176 (Federal share) for unallowable Part B premiums claimed and

- review claims for Part B premiums paid before our audit period and refund the Federal share of any unallowable amounts claimed.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our recommendations. The State agency said that CMS's letters to the State Medicaid directors dated November 24, 1997, and December 14, 2000 (CMS letters), entitled the State agency to claim Federal reimbursement for Part B premiums paid on behalf of individuals who did not meet the eligibility requirements for QMBs, SLMBs, or QIs. The State agency also said that because the Federal regulations at 42 CFR § 431.625(d)(1) had not been updated to include the QMB, SLMB, and QI eligibility categories, the regulations "cannot constitute a universal rule" governing eligibility for Federal share and thus cannot be read as contradicting the CMS letters. Finally, the State agency said that even if it were not authorized to claim Federal reimbursement for the Part B premiums paid on behalf of individuals who did not meet the eligibility requirements of the specified categories, it should not be required to refund the amounts at issue because there has been little to no real adverse financial impact on the Federal Government.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

The CMS letters acknowledge that States may pay, at their option, the Part B premiums for individuals who are eligible for full Medicaid benefits but are not QMBs, SLMBs, or QIs. However, these letters do not indicate that Federal reimbursement is available for Part B

premiums paid on behalf of all such individuals. The Act and Federal regulations provide that Federal reimbursement is available only for Part B premiums paid on behalf of individuals who meet the QMB, SLMB, or QI eligibility requirements or are recipients or deemed recipients of money payments under relevant provisions of the Act. Although the Federal regulations at 42 CFR § 431.625(d)(1) have not been updated to address the QMB, SLMB, and QI eligibility categories, the regulations are still applicable to other eligibility categories. In addition, the State agency should not interpret the CMS letters as establishing standards contrary to Federal law and regulations because Federal law and regulations take precedence. Finally, the State agency was required to follow the language of the Act and Federal regulations regardless of the financial impact on the Federal Government.

Nothing in the State agency's comments caused us to revise our finding or recommendations.

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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 Arizona, the Arizona Health Care Cost Containment System (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 FMAP may not 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 Arizona's Medicaid expenditures for fiscal years 2008 and 2009 ranged from 66.20 percent to 75.93 percent.

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.

Medicaid's Role in Paying Medicare Part B Premiums

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 behalf of those individuals. 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.

A State may claim Federal reimbursement for the 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)[1] or was a recipient or deemed a recipient of money payments under certain titles of the Act, including Title IV-A and Title XVI.[2] In this report, we refer to these eligibility categories as "the specified categories." A State may not claim Federal reimbursement for the Part B premiums paid on behalf of an individual who does not meet the eligibility requirements for at least one of the specified categories.

Pursuant to sections 1902(a)(10)(E) and 1905(p)(1) and (2) of the Act, the eligibility requirements for QMBs, SLMBs, and QIs are as follows:

- **QMB:** An eligible individual 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.

- **SLMB:** An eligible individual is entitled to 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 eligible individual is entitled to 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.[3]

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 for each State's Part B premium liability and to identify those premiums eligible to be claimed by each State for Federal reimbursement.

[1] Pursuant to section 1933(d) of the Act, the FMAP is 100 percent for QIs.

[2] Title IV-A of the Act covers the Temporary Assistance to Needy Families program. Title XVI of the Act covers supplemental security income (SSI) for the aged, blind, and disabled.

[3] In accordance with its State plan, Arizona does not consider resources when determining QMB, SLMB, or QI eligibility.

Arizona's Buy-In Program

The State agency administers Arizona's buy-in program and is responsible for enrolling certain dual eligibles in the program and paying the monthly Part B premiums on behalf of the individuals. Those 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 ensuring the accuracy of the eligibility codes assigned to individuals and is required to routinely update these codes in CMS's buy-in master file. These codes group individuals in the buy-in program into eligibility categories and identify individuals whose Part B premiums are eligible or ineligible for Federal reimbursement.

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 period October 1, 2007, through September 30, 2009, the State agency claimed for Federal reimbursement approximately $304 million ($223 million Federal share) for Part B premiums paid under the buy-in program. We reviewed $49 million in Part B premiums that the State agency claimed for individuals assigned an eligibility code that indicated the premiums were not eligible for Federal reimbursement.

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 Phoenix, Arizona, from December 2010 to April 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed applicable portions of the Arizona State Medicaid plan and State agency policies and procedures related to the buy-in program;
- interviewed CMS and State agency officials;

- obtained and analyzed the State agency's electronic data files of monthly Part B premiums that the State agency paid under the buy-in program for the months October 2007 through December 2009;[4]

- compared the State agency's electronic data files with CMS's monthly billing notices, the State agency's payment records, and the State agency's claims for Federal reimbursement on the Form CMS-64;

- obtained CMS's electronic billing files for Part B premiums billed to the State agency for the months January through October 2010;[5]

- adjusted the Part B premium payment amounts to reflect all prior-period deletions as of October 2010 for those premiums with an eligibility code that indicated the premiums were not eligible for Federal reimbursement;

- identified a sampling frame of 511,741 monthly Part B premium payments for which the State agency assigned an eligibility code that indicated the premiums were not eligible for Federal reimbursement, totaling $49,129,853 ($34,903,558 Federal share), but nevertheless claimed on the Form CMS-64;[6]

- selected from the sampling frame a stratified random sample of 200 monthly Part B premium payments totaling $19,198 ($13,619 Federal share);

- obtained eligibility documentation for the individuals associated with the 200 sampled payments and reviewed:

    - documents from the State agency's eligibility systems to identify whether the State agency had determined that the individuals were eligible for Medicaid and enrolled in Medicare Part A,

    - the State agency's income worksheets and eligibility systems to determine whether the individuals met QMB, SLMB, or QI eligibility requirements, and

    - documents from the State agency's eligibility systems to determine whether the individuals were recipients or deemed recipients of money payments under relevant provisions of the Act;

- adjusted the sampled payments to reflect all prior-period adjustments as of October 2010; and

[4] We obtained files of Part B premiums paid after our audit period to identify any adjustments and deletions that applied to Part B premiums claimed during our audit period. Deletions are transactions that remove individuals from the buy-in program.

[5] We obtained files of Part B premiums paid after our audit period to identify any adjustments and deletions that applied to Part B premiums claimed during our audit period.

[6] We calculated the Federal share by multiplying the premium amounts by the lowest applicable FMAPs for the quarters in which the premiums were claimed.

- estimated the Federal shares of the State agency claims for the unallowable monthly Part B premium payments using the lowest FMAPs applicable for the quarters in which those premiums were claimed.

See Appendix A for our sample design and methodology and Appendix B for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

The State agency did not always comply with Federal requirements when claiming Federal reimbursement for Part B premiums that it paid on behalf of Medicaid beneficiaries. Of the 200 sampled payments, 114 complied with Federal requirements. However, 86 sampled payments totaling $5,877 (Federal share) did not comply with Federal requirements. Specifically, the State agency claimed Federal reimbursement for Part B premiums paid on behalf of individuals who did not meet the eligibility requirements of any of the specified categories.

The State agency submitted unallowable claims because, according to State agency officials, it believed that CMS guidance permitted claiming of Federal reimbursement for Part B premium payments for individuals who were not eligible for any of the specified categories. However, after discussions with CMS, we concluded that this guidance did not permit Federal reimbursement to be claimed for Part B premium payments for individuals who were not eligible for any of the specified categories. Based on our sample results, we estimated that the State agency improperly claimed $13,052,176 in Federal reimbursement for ineligible Part B premiums.

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)),[7] Federal reimbursement is available only for Part B premiums paid on behalf of individuals who meet the QMB, SLMB, or QI eligibility requirements or are recipients or deemed recipients of money payments under relevant provisions of the Act.

[7] 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.

PART B PREMIUM PAYMENTS NOT ELIGIBLE FOR FEDERAL REIMBURSEMENT

For 86 sampled payments totaling $5,877 (Federal share), the State agency claimed Federal reimbursement for Part B premiums paid on behalf of individuals who did not meet the eligibility requirements of any of the specified categories. 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. Based on our sample results, we estimated that the State agency improperly claimed $13,052,176 in Federal reimbursement for ineligible Part B premiums.

Most of the individuals whose Part B premiums were ineligible for Federal reimbursement had incomes that exceeded amounts specified in the QMB, SLMB, and QI eligibility requirements and were not recipients or deemed recipients of money payments under relevant provisions of the Act. The State agency submitted unallowable claims because, according to State agency officials, it believed that enclosures in CMS's letters to the State Medicaid directors dated November 24, 1997, and December 14, 2000 (CMS letters), permitted claiming of Federal reimbursement for Part B premiums for dual eligibles who did not meet the eligibility requirements of any of the specified categories. However, based on discussions with CMS, we concluded that the CMS guidance did not permit claiming of Federal reimbursement for Part B premium payments for individuals who were not eligible for any of the specified categories.[8]

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $13,052,176 (Federal share) for unallowable Part B premiums claimed and

- review claims for Part B premiums paid before our audit period and refund the Federal share of any unallowable amounts claimed.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our recommendations. The State agency said that the CMS letters entitled the State agency to claim Federal reimbursement for Part B premiums paid on behalf of individuals who did not meet the eligibility requirements for QMBs, SLMBs, or QIs. The State agency also said that because the Federal regulations at 42 CFR § 431.625(d)(1) had not been updated to include the QMB, SLMB, and QI eligibility categories, the regulations "cannot constitute a universal rule" governing eligibility for Federal share and thus cannot be read as contradicting the CMS letters. Finally, the State agency said that even if it were not authorized to claim Federal reimbursement for the Part B premiums paid on behalf of individuals who did not meet the eligibility

[8] CMS issued a section 1115 waiver, effective October 22, 2011, that allows the State agency to claim for Federal reimbursement the Part B premiums for certain dual eligibles who do not meet the eligibility requirements of any of the specified categories.

requirements of the specified categories, it should not be required to refund the amounts at issue because there has been little to no real adverse financial impact on the Federal Government.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

The CMS letters acknowledge that States may pay, at their option, the Part B premiums for individuals who are eligible for full Medicaid benefits but are not QMBs, SLMBs, or QIs. However, these letters do not indicate that Federal reimbursement is available for Part B premiums paid on behalf of all such individuals. The Act and Federal regulations provide that Federal reimbursement is available only for Part B premiums paid on behalf of individuals who meet the QMB, SLMB, or QI eligibility requirements or are recipients or deemed recipients of money payments under relevant provisions of the Act. Although the Federal regulations at 42 CFR § 431.625(d)(1) have not been updated to address the QMB, SLMB, and QI eligibility categories, the regulations are still applicable to other eligibility categories. In addition, the State agency should not interpret the CMS letters as establishing standards contrary to Federal law and regulations because Federal law and regulations take precedence. Finally, the State agency was required to follow the language of the Act and Federal regulations regardless of the financial impact on the Federal Government.

Nothing in the State agency's comments caused us to revise our finding or recommendations.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of the monthly Medicare Part B (Part B) premium payments that the Arizona Health Care Cost Containment System (State agency) claimed for Federal reimbursement for the audit period (October 1, 2007, through September 30, 2009).

SAMPLING FRAME

The sampling frame consisted of 511,741 monthly Part B premium payments with a buy-in eligibility code that identified the premiums as not eligible for Federal reimbursement. These payments represented either payments on behalf of a beneficiary who had ongoing eligibility for the buy-in program or a beneficiary who had been added to the buy-in program (addition). The State agency claimed $49,129,853 in monthly Part B premiums and received at least $34,903,558[1] in Federal reimbursement for these payments.

SAMPLE UNIT

The sample unit was a monthly Part B premium payment for a beneficiary.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into two strata: (1) monthly Part B premium payments with a transaction code indicating that the individuals had ongoing eligibility and (2) monthly Part B premium payments with transaction codes indicating additions to the buy-in program.

Stratum	Description	No. of Premium Payments	Value of Premium Payments[2]	Federal Share
1	Ongoing eligibility	447,746	$43,004,383	$30,578,128
2	Additions	63,995	6,125,470	4,325,430
Total		**511,741**	**$49,129,853**	**$34,903,558**

SAMPLE SIZE

We selected 100 sample units from each stratum, resulting in a total sample size of 200 monthly Part B premium payments.

[1] We calculated the Federal share by multiplying the premium amounts by the lowest applicable Federal medical assistance percentages (FMAP) for the quarters in which the premiums were claimed.

[2] We adjusted the premium payment amounts to reflect all prior-period deletions as of October 2010.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software to generate 100 random numbers for each stratum.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 100 random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We calculated the Federal share by multiplying the premium amounts by the lowest applicable FMAPs for the quarters in which the premiums were claimed. We used the OIG/OAS statistical software to estimate the Federal reimbursement for the unallowable Part B premium payments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results by Stratum

Stratum	Sampling Frame Size	Value of Frame (Federal Share)[1]	Sample Size	Value of Sample (Federal Share)[2]	No. of Unallowable Premium Payments	Value of Unallowable Premium Payments (Federal Share)
1	447,746	$30,578,128	100	$6,862	45	$3,089
2	63,995	4,325,430	100	6,757	41	2,788
Total	**511,741**	**$34,903,558**	**200**	**$13,619**	**86**	**$5,877**

Estimates of Unallowable Premium Payments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$15,614,632
Lower limit	13,052,176
Upper limit	18,177,089

[1] We calculated the Federal share by multiplying the premium amounts by the lowest applicable FMAPs for the quarters in which the premiums were claimed.

[2] We adjusted the premium payment amounts to reflect all prior-period adjustments and deletions as of October 2010.

APPENDIX C: STATE AGENCY COMMENTS

Janice K. Brewer, Governor
Thomas J. Betlach, Director

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Phone: 602-417-4000
www.azahcccs.gov

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

February 14, 2012

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Region IX
Office of Inspector General
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

RE: OIG Report Number A-09-11-02009

Dear Ms. Ahlstrand:

Thank you for the opportunity to review and comment on the U.S. Department of Health and Human Services, Office of Inspector General draft report entitled "Arizona Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries." We appreciate the efforts and professionalism of the OIG audit team of Lisa Sivongxay, Troy Butcher and Joannalyn Agbayani. We believe they made an effort to understand the AHCCCS Part B Premium Buy-In process and the underlying reasons for how and why the premiums were claimed.

The following are the responses to the two recommendations:

Recommendation 1: refund to the Federal Government $ 13,052,176 (Federal Share) for unallowable Part B premiums claimed

Response: We do not concur and assert that Arizona is entitled to and appropriately claimed Federal Financial Participation (FFP) for the Part B premiums subject to recommendation 1.

This assertion is based on the following:

Arizona claimed Part B Premiums paid for dual eligible members who qualify for Medicaid under section 1903(f)(4)(C) of the Social Security Act (SSA), 42 U.S.C. § 1396b(f)(4)(C)[1]. Arizona is entitled to FFP for the individuals in question under the terms of two separate State

[1] These dual eligible individuals are enrolled in the Arizona Long Term Care System with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.

Medicaid Directors Letters[2] (SMDLs) issued by the Centers for Medicare and Medicaid Services (CMS) on November 24, 1997 and December 14, 2000. These letters provide that, at the State's option, Medicare cost-sharing is available for individuals eligible for both Medicaid and Medicare, but whose income exceeds 100% of the Federal Poverty Level (FPL).

The first letter, issued by the Health Care Financing Administration (HCFA) on November 24, 1997, lists "**Non-QMBs**" as a category of dual eligibles for which FFP is available for the cost of Medicare Part B premiums. *See* Letter from Sally K. Richardson, HCFA, to Medicaid Directors (Nov. 24, 1997). The 1997 letter expressly states that for non-QMBs, "[p]ayment of Medicare Part B premiums is optional. *FFP* equals FMAP." *Id.* ¶ 2 (emphasis added). Three years later, on December 14, 2000, HCFA issued another SMDL again advising States that FFP is available for Part B premiums paid for non-QMB dual eligibles. *See* Timothy M. Westmoreland, HCFA, to State Medicaid Directors (Dec. 14, 2000). In defining "**Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2)**," the 2000 letter clarifies that "*[p]ayment by Medicaid* of Medicare Part B premiums is a State option . . . . *FFP* equals FMAP." *Id.* at 4 ¶ 7 (emphasis added). Taken together, the two letters expressly inform States that FFP is available for Medicare Part B premium payments made for dual eligibles who are not QMBs, SLMBs, Qualified Disabled and Working Individuals (QDWIs), or QI-1s.

Arizona justifiably relied upon the two letters as authority for claiming FFP for the cost of Medicare Part B premiums for the dual eligibles coded as MAO. Arizona began using the "M" code for dual eligibles for whom the State paid Part B premiums in June 1998, *after* HCFA issued the first State Medicaid Directors Letter clarifying that FFP is available for payment of such premiums for non-QMBs. Arizona should not be penalized for taking action that CMS's own guidance had apparently authorized.

Additionally, subsequent to the start of this audit, CMS has asserted that Arizona's FFP claim for Part B premiums subject to this finding is not in accordance with 42 C.F.R. § 431.625(d)(1), and sections 110 and 180 of the State Buy-in Manual, which prohibit FFP for state payment of Part B premiums for non-cash MAO individuals. It is inappropriate to read these provisions so broadly.

The regulation, 42 C.F.R. § 431.625(d)(1), provides that "FFP is not available in State expenditures for Medicare Part B premiums unless the recipients receive money payments under the [Social Security] Act," subject to certain exceptions not relevant here, *see id.* § 431.625(d)(1),(2). This language, which dates back to 1969,[3] cannot be read literally. As you know, Congress subsequently created the QMB, SLMB, QI-1, and other categories expanding

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[2] Copies of both letters were previously provided to OIG. Please let us know if you would like additional copies of those State Medicaid Director Letters.

[3] Subsection (d)(1) of the current regulation had been codified at 45 C.F.R. § 249.41(c)(1), which provided as follows: "There will be no Federal financial participation in the monthly insurance premium under [Medicare], part B . . . which the . . . State pays on behalf of nonmoney payment individuals eligible to receive [Medicaid]." 34 Fed. Reg. 1324 (Jan. 28, 1969).

FFP for Part B premiums paid for individuals in addition to those receiving cash assistance.[4] There is no doubt that FFP is available for payment of Part B premiums for QMBs, SLMBs, and QI-1s. *See* SSA § 1902(a)(10)(E), 42 U.S.C. § 1396a(a)(10)(E). Nevertheless, 42 C.F.R. § 431.625(d)(1) has not been amended to recognize this. Thus, 42 C.F.R. § 431.625(d)(1) cannot constitute a universal rule governing FFP eligibility for State payment of Part B premiums. It therefore should not be read as contradicting the SMDLs, which clarify that FFP is available for dual eligibles such as those at issue in Recommendation 1.

Similarly, sections 110 and 180 of the State Buy-In Manual should not be read to prohibit FFP for Part B premiums for the dual eligibles in question here. Section 110 of the Buy-In Manual provides that only "a cash assistance recipient, a deemed cash recipient, a [QMB], or a [SLMB] . . . is subject to the Federal matching formula." This section of the Buy-In Manual was last updated and published in 1996. Section 110 is plainly incomplete. It does not list QI-1s as individuals eligible for cost-sharing because Congress did not amend the Medicaid statute to make FFP available for QI-1s until the following year. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4732(a), 111 Stat. 251, 520 (1997) (amending SSA § 1902(a)(10)(E), 42 U.S.C. § 1396a(a)(10)(E), to add clause (iv)). Like the regulation discussed above, section 110 does not comprehensively list every category of recipient eligible for FFP relating to State payment of Part B premiums.

State Buy-In Manual Section 180 also fails to provide a universal rule governing when FFP is available for Part B premiums paid by the State. This section does not even identify the specific categories of dual eligibles listed in section 110 for whom such FFP is available. Instead, section 180 asserts generally that non-cash MAO recipients do not "qualify for Federal matching," which, as shown above, is clearly incorrect. Thus, neither 42 U.S.C. § 431.625(d)(1), nor sections 110 and 180 of the State Buy-In Manual can be read as comprehensively defining the dual eligible categories eligible for FFP. They certainly cannot provide a basis for disregarding the explicit guidance in the SMDLs, and denying Federal matching for the dual eligibles at issue here.

Finally, even if CMS concludes that Arizona was not authorized to receive FFP for its Part B premium payments for the non-cash MAO individuals, CMS still ought to allow the claims as a matter of fairness and equity. Absent the availability of FFP (which the SMDLs appeared to authorize), Arizona would not have paid the Part B premiums on behalf of these individuals, who were Medicaid-eligible by reason of the special income standard applicable to persons who meet the institutional level of care requirement. *See* SSA § 1903(f)(4)(C), 42 U.S.C. § 1396b(f)(4)(C) (special income limit as an exception to the limitations on FFP). Instead, these persons would have been expected to pay the premiums themselves from their income, which would, at a minimum, exceed 120 percent of the FPL, and could be as high as 300 percent of the Social Security Income (SSI) income level. This ordinarily would not have imposed a financial burden for the individuals because the amounts expended for Part B premiums would generally qualify as incurred medical expenses that would be deducted from income in the post-eligibility income

[4] *See* Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9403(a), 100 Stat. 1874 (1986) (amending SSA § 1902(a)(10), 42 U.S.C. § 1396a(a)(10) to add subparagraph (E)).

determination. *See* 42 C.F.R. § 435.725(c)(4). This would have reduced the share of costs of long-term care that these persons are required to bear. *See id.* § 435.832. By the same token, this would result in a higher payment by the State to the long-term care providers, and thus, a *higher FFP contribution.* In this way, the FFP not contributed to Part B premium payments made by the State would have been paid in the form of a greater Federal contribution to the cost of care provided to these dual eligibles.

The foregoing describes conceptually why it would not be equitable to pursue the FFP refunding in this case. The actual operation in Arizona's case is somewhat more complicated because virtually all services are provided through managed care plans. This means that FFP is not paid for specific services rendered to Medicaid recipients, but rather as the federal share of capitation payments that cover the cost of all the care provided to enrolled recipients. But the net effect of having the dual eligibles pay their own Part B premiums is the same. The capitation rates are established based on the anticipated payments to be made to the participating providers. Like the case posited above, health plan payments for long-term care and thus, capitation payments, in which the federal government shares, would be higher due to the reduced share paid by recipients who are bearing the cost of their Part B coverage.

Accordingly, Arizona does not think it right that it should be penalized when it was entitled to rely upon guidance previously provided by CMS (which the Departmental Appeals Board has consistently held that states should follow), and there has been little to no real adverse financial impact on the federal government. In these circumstances, it would not be appropriate for Arizona to refund the amounts at issue. Additionally, in an effort to clear up the ambiguity of CMS directives related to this issue, on October 21, 2011, the Secretary approved a demonstration project for Arizona that includes expenditure authority that allows it to claim FFP for cost of Medicare Part B premiums paid on behalf of non-Qualified Medicare Beneficiaries (QMB) who are dually eligible for Medicare and Medicaid with incomes up to 300 percent of the Federal Benefit Rate.

Recommendation 2: review claims for Part B premiums paid before our audit period and refund the Federal share of any unallowable amounts claimed.

Response: We do not concur for the reasons expressed in the response to Recommendation 1.

Should you or your staff have any questions regarding this response, please feel free to contact Jim Cockerham at (602) 417-4059.

Sincerely,

Thomas J. Betlach
Director