

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**COLORADO DID NOT
PROPERLY PAY SOME
MEDICARE PART B
DEDUCTIBLES AND COINSURANCE**

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Deputy Inspector General**

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A-07-13-03189**

Office of Inspector General

<https://oig.hhs.gov/>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Colorado claimed approximately \$1.7 million of unallowable Medicaid payments for Medicare Part B deductibles and coinsurance for services during Federal fiscal years 2011 and 2012.

WHY WE DID THIS REVIEW

Medicaid pays for Medicare deductibles and coinsurance to providers on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. In Colorado, the Department of Health Care Policy and Financing (State agency) administers the Medicaid program. Previous Office of Inspector General reviews found that other States did not always claim Medicaid payments for Medicare deductibles and coinsurance (crossover claims) in accordance with Federal requirements and the approved State plan.

The objective of this review was to determine whether the State agency claimed Medicaid payments for Medicare Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan.

BACKGROUND

In Colorado, the State agency is responsible for processing crossover claims. Those responsibilities include establishing systems and internal controls, which include policies and procedures to accurately pay Medicare Part B deductibles and coinsurance in accordance with the State plan.

To execute the provisions of the State plan for Medicare Part B services, the State agency should compare the Medicare payment to the State Medicaid plan rate for each crossover claim to determine the allowable payment of Medicare Part B deductibles and coinsurance. Based on this comparison, the allowable payment is the lower of (1) the Medicaid-allowed charge minus the Medicare payment or (2) the sum of the Medicare deductible and coinsurance.

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately \$9.0 billion (approximately \$4.8 billion Federal share) during Federal fiscal years (FYs) 2011 and 2012 (October 1, 2010, through September 30, 2012). As part of these Medicaid payments, the State agency claimed approximately \$64.3 million (approximately \$34.3 million Federal share) for payments for Medicare Part B deductibles and coinsurance.

WHAT WE FOUND

During FYs 2011 and 2012, the State agency did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, for 30 of the 100 claims in our sample, the State agency did not limit payment of Medicare Part B deductibles and coinsurance by State Medicaid plan rates as required under the State plan. Because Federal requirements provide that a State plan for

medical assistance is mandatory upon the State and all of its political subdivisions, these 30 claims thus violated Federal requirements as well as the requirements of the State plan.

These errors occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate as required by the State plan. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so for all Medicare Part B crossover claims. On the basis of our sample results, we estimate that the State agency claimed unallowable Medicaid payments of at least \$3,139,895 (\$1,670,386 Federal share) during FYs 2011 and 2012.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$1,670,386 to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance and
- develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State plan, to determine the allowable Medicare Part B deductibles and coinsurance for all crossover claims.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not concur with our recommendations. The State agency said that our audit findings and recommendations were based on a minor technical variation in routine claim processing, contradicted the policy guidance provided by the State plan and CMS guidelines, and were based on a hypothetical repricing exercise.

Nothing in the State agency's comments caused us to change our findings or recommendations. We asked State agency staff to reprice claims because that was a necessary step in allowing us to determine the State Medicaid plan rate.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicaid pays for Medicare deductibles and coinsurance to providers on behalf of some individuals who are entitled to both Medicare and Medicaid benefits (dual eligibles). In Colorado, the Department of Health Care Policy and Financing (State agency) administers the Medicaid program. Previous Office of Inspector General reviews (Appendix A) found that other States did not always claim Medicaid payments for Medicare deductibles and coinsurance (crossover claims) in accordance with Federal requirements and the approved State plan.

OBJECTIVE

Our objective was to determine whether the State agency claimed Medicaid payments for Medicare Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan.

BACKGROUND

Medicaid Program

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.

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), reports actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The reported amounts must be actual expenditures with supporting documentation. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. During Federal fiscal years (FYs) 2011 and 2012 (October 1, 2010, through September 30, 2012), Colorado's FMAP ranged from 50.00 percent to 61.59 percent.¹

Medicare Program

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS, which administers the program, contracts with Medicare contractors to process and pay Medicare Part B claims submitted by

¹ Under the provisions of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, as amended by P.L. No. 111-226, States' FMAPs were temporarily increased for the period October 1, 2008, through June 30, 2011.

providers. Medicare Part B helps cover medically necessary doctors' services and tests, outpatient care, home health services, and durable medical equipment.

Medicaid's Role in Paying Medicare Part B Deductibles and Coinsurance for Dual Eligibles

"Dual eligibles" are individuals who are entitled to both Medicare and some form of Medicaid benefits. A dual eligible may be classified into one of several groups. Several of these groups are qualified to have their Medicare Part B deductibles and coinsurance paid for by the Medicaid program.

After the Medicare contractor pays a Medicare Part B claim for a dual eligible and assesses the Medicare Part B deductibles and coinsurance, the contractor forwards the crossover claim information to the appropriate State's Medicaid program. The State Medicaid program determines, on the basis of the requirements established in its State plan, whether to pay part or all of the Medicare Part B deductibles and coinsurance and then pays the provider through the usual Medicaid payment system.² In all cases, the amount paid by the State, if any, is payment in full for Medicare Part B deductibles and coinsurance.

Appendix B contains an explanation of the dual eligible groups and details of Medicaid's role in paying Medicare Part B deductibles and coinsurance.

Colorado Medicaid Program

In Colorado, the State agency is responsible for processing crossover claims. Those responsibilities include establishing systems and internal controls, which include policies and procedures to accurately pay Medicare Part B deductibles and coinsurance in accordance with the State plan.

The Colorado State plan requires coordination of Medicaid with Medicare and provides methods and standards for the payment of crossover claims. The State plan limits the payment of Medicare Part B deductibles and coinsurance to four specified groups of dual eligible beneficiaries. Payment is limited by the State plan rate for all Medicare Part B services.

To execute the provisions of the State plan for Medicare Part B services, the State agency should compare the Medicare payment to the State Medicaid plan rate for each crossover claim to determine the allowable payment of Medicare Part B deductibles and coinsurance. Based on this comparison, the allowable payment is the lower of (1) the Medicaid-allowed charge minus the Medicare payment or (2) the sum of the Medicare deductible and coinsurance.

The State agency claimed Federal reimbursement for Medicaid payments totaling approximately \$9.0 billion (approximately \$4.8 billion Federal share) during FYs 2011 and 2012. As part of these Medicaid payments, the State agency claimed approximately \$64.3 million (approximately \$34.3 million Federal share) for payments for Medicare Part B deductibles and coinsurance.

² The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

HOW WE CONDUCTED THIS REVIEW

We reviewed claimed Medicaid payments for Medicare Part B deductibles and coinsurance totaling \$64,293,032 (\$34,278,043 Federal share) for which the State agency claimed Federal reimbursement during FYs 2011 and 2012.

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 C contains details of our audit scope and methodology, Appendix D contains details of our sample design and methodology, and Appendix E contains our sample results and estimates.

FINDINGS

During FYs 2011 and 2012, the State agency did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan. Specifically, for 30 of the 100 claims in our sample, the State agency did not limit payment of Medicare Part B deductibles and coinsurance by State Medicaid plan rates as required under the State plan. Because Federal requirements provide that a State plan for medical assistance is mandatory upon the State and all of its political subdivisions, these 30 claims thus violated Federal requirements as well as the requirements of the State plan.

These errors occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate as required by the State plan. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so for all Medicare Part B crossover claims. On the basis of our sample results, we estimate that the State agency claimed unallowable Medicaid payments of at least \$3,139,895 (\$1,670,386 Federal share) during FYs 2011 and 2012.

STATE AGENCY CLAIMED UNALLOWABLE MEDICAID PAYMENTS

The State agency must comply with certain Federal requirements (the Social Security Act (the Act), § 1902(a)(1)) and implementing regulations (42 CFR § 431.50(b)(1)), which provide that a State plan for medical assistance is mandatory upon the State and all of its political subdivisions.

The Colorado State plan, section 3.2(b), requires coordination of Medicaid with Medicare and provides methods and standards for payment of Medicare Part B deductibles and coinsurance. In addition, the State plan (Supplement 1 to Attachment 4.19-B) limits payment of Medicare Part B deductibles and coinsurance on behalf of beneficiaries to the amount, if any, by which the State Medicaid plan rate exceeds the Medicare payment.

Details on the Federal and State requirements related to Medicaid payments for Medicare Part B deductibles and coinsurance appear in Appendix F.

Contrary to these Federal and State requirements, the State agency did not limit payment of Medicare Part B deductible and coinsurance claims for 30 of the 100 sampled claims. For those 100 claims, the State agency paid \$4,802 but should have paid \$2,831, a difference of \$1,971 (\$1,047 Federal share).

STATE AGENCY DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The State agency did not compare the Medicare payments to the State Medicaid plan rate to determine the allowable Medicare Part B deductibles and coinsurance for all crossover claims. The table below presents three examples, using actual values drawn from the claims we sampled, for the calculation of allowable Medicare Part B deductibles and coinsurance.

Sample Crossover Claims

Claim	Medicare		Medicaid			
	Payment	Medicare Part B Deductibles and Coinsurance	State Medicaid Plan Rate	Payment	Allowable Payment for Medicare Part B Deductibles and Coinsurance	Unallowable Payment for Medicare Part B Deductibles and Coinsurance
A	\$204	\$51	\$0	\$51	\$0	\$51
B	478	120	530	120	52	68
C	51	13	77	13	13	0

Notes: Claim A: State Medicaid plan rate is lower than Medicare payment.
 Claim B: State Medicaid plan rate is higher than Medicare payment.
 Claim C: State Medicaid plan rate is higher than Medicare payment.

These discrepancies occurred because the State agency did not have policies and procedures requiring it to compare the Medicare payment to the State Medicaid plan rate for all Medicare Part B crossover claims. On the basis of our sample results, we estimate that the State agency claimed unallowable Medicaid payments of at least \$3,139,895 (\$1,670,386 Federal share) during FYs 2011 and 2012.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$1,670,386 to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance and
- develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State plan, to determine the allowable Medicare Part B deductibles and coinsurance for all crossover claims.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our recommendations. The State agency said that our audit findings and recommendations were based on a minor technical variation in routine claim processing, contradicted the policy guidance provided by the State plan and CMS guidelines, and were based on a hypothetical repricing exercise.

The State agency said that the claims that were identified in this audit were processed and paid correctly according to the payment rules programmed in the MMIS. According to the State agency, the State plan specifies the use of a “lower of” pricing logic to compare a Medicaid price to the Medicare payment. The State agency said that it had been consistent in both the interpretation and the intent of this “lower of” pricing rule, “applying the same pricing logic to all Medicare crossover claims.” The State agency added that it is not required to identify, through the State plan, “every nuance or instance” in which the MMIS cannot fully price a Medicare crossover claim because of the differences in reimbursement methodologies between Medicare and Medicaid.

The State agency also stated that the State plan covers basic requirements and the individualized content that reflects the characteristics of the State agency’s reimbursement process. Moreover, according to the State agency, a technical addition to the State plan to clarify circumstances under which the Medicare coinsurance plus deductible amount is paid when the “lower of” pricing logic is not specified would constitute a “minor technical clarification” and would not reach the threshold to justify our recommendations. In addition, the State agency said that our recommendations are contrary to the goals of the program as described in the administrative guidelines from CMS.

Lastly, the State agency said that it did not believe that we procured proper and sufficient evidence during the audit to provide a reasonable basis for the recommendations. The State agency said that we based our recommendations on the results of a “hypothetical re-pricing exercise that assumed the claims were not crossover claims, but instead Medicaid-only claims” (emphasis in original).

The State agency’s comments are included in their entirety as Appendix G.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency’s comments caused us to change our findings, our recommendations, or our calculations of the unallowable Medicaid payments.

Section 1902 of the Act provides that a State submit a plan that meets all Federal requirements in order to establish a Medicaid program. As specified in section 1903(a)(1) of the Act and 42 CFR § 430.10, only those Medicaid expenditures made by a State in accordance with the State plan are eligible for Federal reimbursement. The State plan must contain all information necessary for CMS to determine whether the plan can be approved to serve as the basis for the receipt of FFP, and the plan must be amended to reflect any material change in State policy or operation of

the State's Medicaid program (42 CFR §§ 430.10 and 430.12(c)). State claim processing and payment systems, such as the MMIS, must process and pay claims in accordance with the approved State plan.

The Colorado State plan (Supplement 1 to Attachment 4.19-B) in effect during our audit period limits payment of Medicare Part B deductibles and coinsurance to the lower of (1) the State Medicaid-allowed charge minus the Medicare payment or (2) the sum of the Medicare deductible and coinsurance. The State plan contains no exceptions to this rule, a fact that the State agency acknowledged in its comments. Although the State agency said that it had consistently paid crossover claims in accordance with the rules programmed in its MMIS, those rules are inconsistent with the Colorado State plan. We also note that the Colorado Office of the State Auditor, in the Statewide Single Audits for the State fiscal years ended June 30, 2009, June 30, 2010, and June 30, 2011, found that the State plan did not identify exclusions from the "lower of" pricing methodology. The State agency responded to all three of these Statewide Single Audits by saying that it would either (1) discontinue the exclusions and start paying all claims using the "lower of" pricing logic or (2) modify its State plan. To date, neither of those actions has been executed.

Regarding the State agency's comments on our audit methodology, we asked State agency staff to reprice claims as Medicaid-only not as a hypothetical exercise, but rather to allow us to determine the State Medicaid plan rate—a necessary step that was central to our ability to audit this program. That is, it was necessary to determine the State Medicaid plan rate so that we could compare the Medicare payment to the State Medicaid plan rate, as required by the State plan, to thereby determine the allowable Medicare Part B deductibles and coinsurance for each crossover claim.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Review of Nebraska's Medicaid Payments for Dual Eligible Individuals' Medicare Part A Deductibles and Coinsurance</i>	A-07-11-03161	2/6/2012
<i>Nebraska Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance</i>	A-07-11-03168	2/29/2012
<i>Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance for Outpatient Services</i>	A-07-11-03172	6/18/2012
<i>Iowa Did Not Properly Pay Some Medicare Part A and Part B Deductibles and Coinsurance</i>	A-07-12-03178	11/20/2012

APPENDIX B: DUAL ELIGIBLE GROUPS AND DETAILS OF MEDICAID'S ROLE IN PAYING MEDICARE PART B DEDUCTIBLES AND COINSURANCE

Dual eligibles may be classified into several groups, including but not limited to Qualified Medicare Beneficiary (QMB) without full Medicaid (QMB Only), QMB with full Medicaid (QMB Plus), Specified Low-Income Beneficiary with full Medicaid (SLMB Plus), and Full Benefit Dual Eligible (FBDE). These eligibility groups are qualified to have their Medicare Part B deductibles and coinsurance paid for by the Medicaid program.³

After the Medicare contractor pays a Medicare Part B claim for a dual eligible and assesses the Medicare Part B deductibles and coinsurance, the contractor forwards the crossover claim information to the appropriate State's Medicaid program. The State Medicaid program then determines, on the basis of the requirements established in its State plan, whether to pay part or all of the Medicare Part B deductibles and coinsurance and then pays the provider through the MMIS.

For beneficiaries classified in the QMB Only and QMB Plus eligibility groups, States are mandated to pay Medicare Part B deductibles and coinsurance. Federal statute permits Medicare payment for a service, plus the Medicaid payment for any Medicare Part B deductibles and coinsurance, to exceed the State plan rate for the service (the Act, § 1902(n)(2)). This statute adds, however, that a State is not required to pay for Medicare Part B deductibles and coinsurance on behalf of QMB Only and QMB Plus beneficiaries to the extent that the Medicare payment for the service exceeds what the State Medicaid program would have paid on behalf of a Medicaid-only recipient. If a State caps its Medicare Part B deductible and coinsurance coverage, and the Medicare payment for a service is equal to or exceeds the State Medicaid plan rate, the State makes no payment for Medicare Part B deductibles and coinsurance. If, on the other hand, the Medicare payment is less than the State Medicaid plan rate for a service, the State pays the Medicare Part B deductibles and coinsurance up to the difference between the amount paid by Medicare and the State Medicaid plan rate.

For beneficiaries classified in the SLMB Plus and FBDE eligibility groups, States are not mandated to pay Medicare Part B deductibles and coinsurance. However, because SLMB Plus and FBDE beneficiaries are entitled to full Medicaid benefits, they may be entitled to have Medicare Part B deductibles and coinsurance paid on their behalf when a service is covered by both Medicare and Medicaid. For Medicaid-covered services, the State agency will pay the difference between the State Medicaid plan rate and the Medicare payment.

The Colorado State plan requires coordination of Medicaid with Medicare and provides methods and standards for the payment of crossover claims. The State plan limits the payment of Medicare Part B deductibles and coinsurance for QMB Only, QMB Plus, SLMB Plus, and FBDE beneficiaries by the State Medicaid plan rate for all Medicare Part B services.

³ There are other groups of dual eligible beneficiaries who are not qualified to have their Medicare Part B deductibles and coinsurance paid for by the Medicaid program: SLMB without full Medicaid, Qualified Disabled and Working Individual, and Qualifying Individual.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid payments totaling \$64,293,032 (\$34,278,043 Federal share) for services whose payments were limited by the State Medicaid plan rate that the State agency made and claimed for Federal reimbursement for Medicare Part B deductibles and coinsurance for FYs 2011 and 2012. We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency in Denver, Colorado, in March 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and the State Medicaid plan;
- interviewed State agency officials to gain an understanding of their policies and procedures for claiming Medicare Part B deductibles and coinsurance;
- requested and received from the State agency crossover claim data for paid Medicare Part B deductibles and coinsurance;
- analyzed the crossover claim data and developed a database of payments to providers for Medicare Part B deductibles and coinsurance for services whose payments are limited by the State Medicaid plan rate;
- selected and reviewed a simple random sample of 100 crossover claims from our sampling frame of 588,804 crossover claims (Appendixes D and E) and, for each sampled crossover claim:
 - reviewed Medicare's payment and Medicare Part B deductible and coinsurance amounts,
 - reviewed the State Medicaid plan rate,
 - compared Medicare's payment to the State Medicaid plan rate to determine the allowable and unallowable (if any) Medicaid payment of Medicare Part B deductible and coinsurance amounts, and
 - verified that the beneficiary in question was in one of the four eligibility groups (QMB Only, QMB Plus, SLMB Plus, or FBDE) of dual eligibles;

- estimated the unallowable Medicaid payments at the lower limit of the 90-percent confidence interval (Appendix E); and
- discussed the results of our review with State agency officials on July 11, 2013.

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 D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population was obtained from the State agency's MMIS and consisted of Medicare Part B crossover claims totaling \$64,293,032 paid by the State agency on behalf of dual eligibles for FYs 2011 and 2012.

SAMPLING FRAME

The initial database received from the State agency consisted of eight text files, one file for each quarter in our audit period. This database contained 1,766,334 Medicare Part B crossover claims.

We reviewed the file and eliminated:

- 65,132 claims that were adjusted and
- 248,951 claims with reimbursements equal to or less than \$2.

We also eliminated 863,447 claims on the basis of the results of a probe sample we conducted in which we found no errors. The probe sample consisted of 40 claims representing all of the different reimbursement type codes. If we found no errors with certain reimbursement type codes, we eliminated all claims with those reimbursement type codes.

The resulting file constituted our sampling frame of 588,804 Medicare Part B crossover claims totaling \$33,844,394, from which we drew our random sample.

SAMPLE UNIT

A sampling unit was one paid Medicare Part B crossover claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 sample units of paid Medicare Part B crossover claims.

SOURCE OF RANDOM NUMBERS

We generated random numbers with the Office of Inspector General, Office of Audit Services, statistical software RAT-STATS.

ESTIMATION METHODOLOGY

We used RAT-STATS to estimate the unallowable payments for deductible and coinsurance costs. Because the FMAPs varied from year to year, we also estimated the total Federal reimbursements to the State agency for unallowable deductible and coinsurance costs. We calculated the FMAP amount for each sampled item by applying the applicable FMAP rate to the total amount determined to be in error for the sample item. We used the lower limit of the 90-percent two-sided confidence interval to estimate the unallowable payment for deductible and coinsurance costs.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size	Frame Value	Sample Size	Number of Errors	Total Value of Sample	Value of Errors (Federal Share)
588,804	\$33,844,394	100	30	\$4,802	\$1,047

ESTIMATES OF UNALLOWABLE FEDERAL REIMBURSEMENT (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$6,166,427
Lower limit	1,670,386
Upper limit	10,662,467

APPENDIX F: FEDERAL AND STATE REQUIREMENTS RELATED TO MEDICAID PAYMENTS FOR MEDICARE PART B DEDUCTIBLES AND COINSURANCE

FEDERAL REQUIREMENTS

The Act, section 1902(a), states: “A State plan for medical assistance must—(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them”

Federal regulations (42 CFR § 431.50(b)(1)) expand upon this provision of the Act by requiring that the State plan “... will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State.”

The Act, section 1902(n)(1), states:

In the case if medical assistance furnished under this title for [M]edicare cost-sharing respecting the furnishing of a service or item to a qualified [M]edicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified [M]edicare beneficiaries.⁴

The Act, section 1902(n)(2), states: “In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for [M]edicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a [M]edicare beneficiary.”

STATE REQUIREMENTS

The Colorado State plan, section 3.2(b), requires coordination of Medicaid with Medicare and provides methods and standards for payment of Medicare deductibles and coinsurance.

The Colorado State plan, Supplement 1 to Attachment 4.19-B, states:

A. For QMBs, Other Medicaid Recipients [SLMB Plus and FBDE], and Dual Eligibles [QMB Plus], the reimbursement methodology for [Medicare] Part A and Part B services is as follows:

Medicaid payment is calculated by comparing the Medicaid allowed charge minus the Medicare payment to the sum of the Medicare coinsurance and deductible. Medicaid pays the lower of the two values.

⁴ Title XVIII of the Act promulgates the Medicare program.

APPENDIX G: STATE AGENCY COMMENTS



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

October 23, 2013

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VII
601 E. 12th St., Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

The Department of Health Care Policy and Financing (Department) submits this response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) report entitled *Colorado Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance* (A-07-13-03189). The OIG report contains the following recommendations:

- Refund \$1,670,386 to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance, and
- Develop and implement policies and procedures to ensure that it [the Department] compares the Medicare payment to the State Medicaid plan rate, as required by the State plan, to determine the allowable Medicare Part B deductibles and coinsurance for all crossover claims.

The Department does not concur with either of the recommendations. For the specific reasons discussed below, a corrective action plan is not warranted. Because the Medicaid reimbursement calculation differs fundamentally from the Medicare payment methodology, the subject claims reviewed have no corresponding price when they crossover from Medicare. In addition, the State Plan adequately describes what Medicaid pays for crossover claims from Medicare.

“Lower of” Pricing Methodology for Crossover Claims

The State Plan specifies that the Department uses a “lower of” pricing logic to compare a valid Medicaid price versus the Medicare coinsurance plus deductible amount. When a valid Medicaid price does not exist, the result is not a value of zero but instead is “not specified”. In these cases, the “lower of” pricing logic in the claims system calculates the Medicare coinsurance plus deductible amount. The claims that were identified in this audit were processed and paid correctly according to the payment rules programmed in the claims system. Colorado Medicaid has been consistent in both our interpretation and the intent of our “lower of” pricing rule, applying the same pricing logic to all Medicare crossover claims. The following examples illustrate this consistency:

1. Freestanding Federally Qualified Health Centers (FQHC)/Rural Health Centers (RHC) providers: The Department is required to pay a bundled rate for an FQHC/RHC visit. To accomplish this, the

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Department requires a specific revenue code (which is reimbursed at a provider number/revenue code specific rate.) Since Medicare crossover claims contain detail line level payments for revenue codes that differ from the Medicaid bundled rate billing requirement, no valid comparison can be made between Medicare and Medicaid detail line paid amounts. Therefore, the Department reimburses the provider the Medicare coinsurance plus deductible amount.

2. Professional Services billed by Nursing Facility providers: The Department reimburses Nursing Facilities an all-inclusive per diem rate for accommodation revenue codes. Any professional service performed that is not included in the per diem rate must be billed separately by the professional who performed the service using a 1500/837P claim form. Since no valid comparison can be made, the Department reimburses the Medicare coinsurance plus deductible amount
3. Freestanding Dialysis Center providers: The Department pays a bundled rate for Dialysis services. To accomplish this, the Department requires a specific range of dialysis revenue codes, which are reimbursed at a provider number/revenue code specific rate. Since Medicare Crossover claims contain detail level payments for revenue codes that differ from the Medicaid billing requirement, no valid comparison can be made between Medicare and Medicaid detail line paid amounts. Therefore, the Department reimburses the provider the Medicare coinsurance plus deductible amount.
4. Professional Claims: For some procedure codes, the Medicaid program billing requirements differ from the requirements of the Medicare program. Since no valid comparison can be made between Medicare and Medicaid detail line paid amounts, the Department reimburses the Medicare coinsurance plus deductible amount.

State Plan Requirements

The Colorado State Plan describes the general rule for payment of crossover claims in Attachment 4.19-B, Supplement 1, but does not provide a list of exceptions to this general rule in the sort of instances noted above where there is no Medicaid rate that corresponds to a Medicare rate. However, the Department is not required to identify through the State Plan every nuance or instance in which the Medicaid Management Information System (MMIS) cannot fully price a Medicare crossover claim because of the differences in reimbursement methodologies between Medicare and Medicaid. Rather, the State Plan covers basic requirements and the individualized content that reflects the characteristics of the Department's reimbursement process according to 42 C.F.R. § 430.12(a). No change has occurred to the processing of Medicare crossover claims since the State Plan language was approved by the Centers for Medicare and Medicaid Services (CMS). The Department applies the general rule for payment of Medicare crossover claims when that rule is applicable. A technical addition to the State Plan to clarify circumstances where the Medicare coinsurance plus deductible amount is paid when the "lower of" pricing logic is not specified would constitute a minor technical clarification and does not reach the threshold to justify the audit recommendations in this report.

Centers for Medicare and Medicaid Services' Policy

The recommendations contained in the draft report are contrary to the goals of the program as described in the administrative guidance from CMS. See "*Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs)*" (CM Information Bulletin, June 7, 2013), providing that the State must document that it has properly processed all claims for cost-sharing liability from Medicare-certified providers even if that service is not covered by Medicaid. The State of Colorado has consistently paid such cost sharing according to the rules programmed in its MMIS in accordance with such guidance. Payments of Part B deductibles and

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coinsurance in cases where no valid comparison may be made does not convert such payments into “unallowable Medicaid payments” as the report suggests. Hence, to deem such payments as unallowable contradicts the policy guidance provided by CMS.

Audit Methodology

The Department does not believe that proper and sufficient evidence was procured during this audit to provide a reasonable basis for or to justify CMS’s recommendations. Specifically, the recommendations are based upon the results of a hypothetical re-pricing exercise that assumed the claims were not crossover claims, but instead Medicaid-only claims. The Department was required to expend an inordinate amount of employees’ time, (approximately 180 hours,) to re-price claims to derive dollar amounts that are either not State Plan benefits or are adjudicated by MMIS pursuant to a different methodology. Such an exercise illustrates the hypothetical nature of these amounts, which do not constitute meaningful evidence. Neither do these hypothetical amounts provide a reasonable basis to estimate “unallowable Medicaid payments.” To calculate reimbursement amounts by re-pricing claims results in a purely theoretical amount in the audit report. Accordingly, there is no legal authority for basing a recovery on such speculative analysis.

Conclusion

The Department disputes the recommendations and finds no justification to refund any amount related to this audit. The Department has been consistent in both our interpretation and the intent of our “lower of” pricing rule, applying the same pricing logic to all Medicare crossover claims. The audit findings are based on a minor technical variation in routine claims processing, contradict the policy guidance provided by CMS and general State Plan guidelines, and is based on a hypothetical re-pricing exercise. Such findings fail to justify a change to the State Plan. The Department cannot concur with the audit recommendations in this report.

Sincerely,



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Executive Director

Cc: Mr. Richard Allen
Associate Regional Administrator for
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