A REPORT
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ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Arizona Health Care Cost Containment System—Medicaid Eligibility Determination

June • 2012
REPORT NO. 12-02

Debra K. Davenport
Auditor General

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June 6, 2012

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Mr. Tom Betlach, Director
Arizona Health Care Cost Containment System

Mr. Clarence Carter, Director
Department of Economic Security

Transmitted herewith is a report of the Auditor General, *A Performance Audit of the Arizona Health Care Cost Containment System (AHCCCS)—Medicaid Eligibility Determination*. This report is in response to an October 26, 2010, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, AHCCCS agrees with all of the findings and plans to implement all of the recommendations. The report also includes a response from the Department of Economic Security.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on June 7, 2012.

Sincerely,

Debbie Davenport
Auditor General

Attachment

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Arizona Health Care Cost Containment System—Medicaid Eligibility Determination

REPORT HIGHLIGHTS
PERFORMANCE AUDIT

Our Conclusion

The Arizona Health Care Cost Containment System (AHCCCS), which operates the State's Medicaid program, shares responsibility for determining applicant eligibility with the Department of Economic Security (DES). AHCCCS and DES accurately determined eligibility for almost all Medicaid applicants. However, we calculated that 5.92 percent of the eligibility determinations are at risk for processing errors, and 1.11 percent of eligibility determinations are at risk for being incorrect. Therefore, we estimated that AHCCCS is paying between approximately $3.5 and $4.8 million in monthly capitation payments for enrolled but ineligible members. AHCCCS should implement a corrective action plan to address the errors that occur in calculating and verifying income and resources. AHCCCS should also increase its electronic verification of applicants' citizenship.

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Medicaid applicants must be approved through eligibility determination process

Majority of AHCCCS program operates under managed care model—Medicaid is a federal healthcare program for certain low-income individuals and families that is jointly funded by federal and state governments. AHCCCS is Arizona's state program that provides these benefits to eligible persons primarily through a managed care system. Under this system, AHCCCS contracts with health plans, which coordinate and pay for the medical services AHCCCS members receive from healthcare providers. To cover the costs of coordinating and paying for members' healthcare, the contracted health plans receive monthly capitation payments for each enrolled member.

AHCCCS and DES determine eligibility for the Medicaid program—To receive Medicaid services, all applicants must satisfy various Medicaid eligibility requirements and be approved through an eligibility determination process.

Eligibility requirements are established by federal regulations and state law and require documentation of U.S. citizenship or qualified alien status, state residency, and income at or below the prescribed federal poverty level threshold. In Arizona, AHCCCS and DES share responsibility for determining eligibility for Medicaid applicants. As of July 1, 2011, DES performed approximately 82 percent of the eligibility determinations and AHCCCS performed about 11 percent of them. About 7 percent of AHCCCS members are automatically eligible for Medicaid services, such as children born to women who are on Medicaid.

Number of Eligibility Determinations
and Percentage Approved as Eligible
December 1, 2011 through December 31, 2011

Agency	Determinations Performed	Percentage Approved
DES	261,854	55.7%
AHCCCS	13,815	58.7
Total	275,669	55.8

AHCCCS should take some additional actions to strengthen eligibility determination process

5.92 percent of eligibility determination cases are at risk for processing errors—Although AHCCCS and DES appropriately determined the eligibility of approximately 94 percent of applicants, 5.92 percent of eligibility determination cases are at risk for processing errors based on our review of a representative sample of 279 eligibility determinations.[1] We found that 16 of the 279 eligibility determinations had processing errors, including 9 that did not have verification or documentation of income. For example, in one determination, the caseworker relied on the applicant's statement of income instead of documentation from the employer. Subsequent documentation showed that the applicant understated monthly income by approximately $380. In another case, the applicant's monthly

[1] The 5.92 percent is a weighted error rate we calculated. See the report's Appendix B, pages b-iii through b-iv.

income was understated by about $650.

For 7 of the 16 determinations with errors, caseworkers miscalculated the amount of income or resources. Eligibility is based on monthly income, and errors may occur when the caseworker converts weekly or biweekly income into monthly income. For example, in one determination, the caseworker incorrectly entered a monthly income in the computer system that was approximately $1,065 less than should have been entered.

Processing errors create potential for incorrect eligibility determinations—For 13 of the 16 determinations with errors, the processing errors did not result in an incorrect Medicaid eligibility determination. However, in three cases, the processing errors were of sufficient magnitude to result in incorrect eligibility determinations. In these instances, the caseworkers did not properly verify or correctly calculate the income amount used to make the eligibility determination. As a result, AHCCCS inappropriately paid $2,359 in capitation payments for these three members over a 7-month period.

Although the number of incorrect eligibility determinations was a small part of the sample cases, they become more important when projected over all Medicaid eligibility determinations AHCCCS and DES performed. Based on the incorrect eligibility determinations identified in the sample, we calculated an incorrect eligibility determination rate of 1.11 percent for the acute care and long-term care programs tested. This means that of the approximately $414 million in monthly capitation payments that AHCCCS makes for its members in the programs tested, we estimated that AHCCCS is paying its health plans approximately $3.5 to $4.8 million monthly for enrolled but ineligible members.

Most error types consistent with federal review—Every 3 years, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, conducts a Payment Error Rate Measurement (PERM) review to evaluate the accuracy of Medicaid eligibility determinations. The types of errors we identified were similar to the eligibility determination errors identified by the federal fiscal year 2008 PERM review. This PERM review found that Arizona's error rate was 2.2 percent, which was below the national eligibility error rate of 6.7 percent for the 17 states reviewed that year. AHCCCS received another PERM review in federal fiscal year 2011, and the results are expected in November 2012.

Monies cannot be recovered, but AHCCCS should implement corrective action plan—AHCCCS should develop a corrective action plan that will help it and DES to correct the kinds of processing errors this audit identified as well as to minimize their frequency going forward. Minimizing errors is important because AHCCCS cannot recover the approximately $3.5 to $4.8 million in monthly capitation payments made to health plans and providers for ineligible members after AHCCCS and DES officially determined that those members were eligible for Medicaid services unless the information used to make the determinations is proven to be fraudulent. The corrective action plan should include additional caseworker training in areas that are error-prone, and AHCCCS should also assess whether its income and resource policies need clarification.

AHCCCS and DES should make greater use of electronic matching to verify citizenship requirements—Although caseworkers consistently verified social security numbers using electronic matching, they did not consistently use electronic matching to verify income or citizenship. DES has two electronic income verification systems it can use to make such verifications and in June 2011, it enhanced its use of one of these systems for income verification. However, both AHCCCS and DES should make greater use of electronic matching to verify citizenship. In addition, the 2010 Federal Patient Protection and Affordable Care Act requires states to expand their use of electronic verification by 2014, including interfaces with the Social Security Administration for citizenship verification and the Department of Homeland Security for immigration status.

Recommendations:

AHCCCS should:

- Develop a corrective action plan to minimize eligibility determination errors.
- Ensure that it and DES make greater use of electronic means to verify citizenship.

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The Office of the Auditor General has conducted a performance audit of the Arizona Health Care Cost Containment System (AHCCCS) pursuant to an October 26, 2010, resolution of the Joint Legislative Audit Committee. This audit is the second in a series of audits conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq and focuses on whether the State's Medicaid eligibility determinations meet federal and state requirements. The first audit found that AHCCCS has processes in place that help it comply with state and federal requirements for coordinating the payment of healthcare benefits with other responsible parties. The third report will examine AHCCCS' processes for managing Medicaid fraud cases. A fourth report will address the statutory sunset factors.

Medicaid applicants must be approved through an eligibility determination process

Majority of AHCCCS program operates under managed care model

AHCCCS was established to administer Arizona's Medicaid program, which provides healthcare for certain low-income individuals and families living in Arizona. Medicaid is a federal healthcare program for low-income individuals and families that is jointly funded by the federal and state governments. AHCCCS was implemented in October 1982 as the nation's first state-wide Medicaid program designed to provide medical services to eligible persons primarily through a managed care system. Under a managed care system, AHCCCS contracts with entities, known as health plans, which coordinate and pay for the medical services AHCCCS members receive from registered AHCCCS healthcare providers, such as physicians and hospitals. To cover the costs of coordinating and paying for members' healthcare, the contracted health plans receive monthly capitation payments (see textbox).

Capitation payment—A fixed monthly amount paid in advance to AHCCCS' contracted health plans for each enrolled member. At least annually, based on information such as the historical use and cost of medical services provided and inflation data, capitation payment amounts are determined using mathematical and statistical methods. Monthly capitation amounts paid to AHCCCS' contracted health plans can vary by individual based on factors such as age, gender, geographical service area, and program (see examples below):

Examples of average *Acute Care* monthly capitation rates[1]					Average *Arizona Long Term Care System* monthly capitation rate[1]
Age <1 Male/Female	Age 1-13 Male/Female	Age 14-44 Female	Age 14-44 Male	Age 45+ Male/Female	
$460	$97	$222	$138	$347	$3,000

[1] See page 2 for explanation of Acute Care and Arizona Long Term Care System programs.

Source: Auditor General staff analysis of AHCCCS information contained in its contracts, actuarial certifications, and Acute Care and Arizona Long Term Care System rates effective October 1, 2011.

Approximately 90 percent of AHCCCS' members are enrolled with its contracted health plans in managed care. For the remaining members, known as fee-for-service members, AHCCCS reimburses registered healthcare providers directly.[1] According to the Kaiser Family Foundation, as of October 2010, 47 states and the District of Columbia used managed care programs to some degree, but only 9 states, including Arizona, had 80 percent or more of their members enrolled in comprehensive managed care programs.[2,3]

AHCCCS members receive a full range of medical services under the following three primary programs:

- **Acute Care—**As shown in Table 1 (see page 3), the majority of AHCCCS' members are enrolled in its Acute Care program. This Medicaid program provides a wide range of healthcare services, such as inpatient and outpatient hospital services, physician services, immunizations, and laboratory and x-ray services to children, pregnant women, and other low-income adults.

- **Arizona Long Term Care System (ALTCS)—**A small percentage of members receive services under ALTCS. The ALTCS program provides acute care, behavioral health, long-term care, and case management services to individuals who are elderly, physically disabled, or developmentally disabled and meet the criteria for institutionalization.

- **KidsCare—**Children under age 19 may receive medical services under KidsCare, the name given to Arizona's federal Children's Health Insurance Program. Children may qualify for KidsCare if their family's income exceeds the limit allowed for Medicaid, but is still below the federally established amount for this program. Children enrolled in KidsCare receive the same medical services available under Arizona's Acute Care program. New enrollment in the KidsCare Program has been frozen since January 1, 2010, due to lack of funding, and AHCCCS has established a waiting list of applicants. However, effective May 1, 2012 through January 1, 2014, AHCCCS will be receiving monies from three hospitals that will allow AHCCCS to provide coverage for 21,700 children in what is being called KidsCare II.[4] This state-wide program will offer the same benefits, but has a lower income eligibility threshold than the KidsCare program.

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[1] AHCCCS reimburses providers on a fee-for-service basis for (1) individuals receiving services under the Federal Emergency Services program, or (2) Native American members who choose to receive services through a tribal fee-for-service contractor.

[2] Comprehensive managed care is defined as inpatient hospital services and any of the following services, or any three of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) Federally Qualified Center services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment services; (7) family planning services; (8) physicians' services; and (9) home health services.

[3] Kaiser Family Foundation. (2010). *Medicaid enrollment in comprehensive managed care as a share of total Medicaid enrollment, October 2010.* Retrieved January 31, 2012, from www.statehealthfacts.org

[4] Laws 2011, Ch. 234, §2 allows AHCCCS, subject to U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approval, to authorize any political subdivision to provide monies necessary to qualify for federal matching monies to provide healthcare coverage to persons who would have been eligible pursuant to A.R.S. §36-2901.01.

Table 1: AHCCCS Enrollment by Program
At July 1, 2009, 2010, 2011, and May 1, 2012

Program	2009	2010	2011	2012
Acute Care	1,174,598	1,272,118	1,300,674	1,223,577
Arizona Long Term Care System	48,673	50,241	51,314	52,253
KidsCare	51,838	30,445	17,649	10,966
Total	1,275,109	1,352,804	1,369,637	1,286,796

Source: Auditor General staff analysis of the AHCCCS July 1, 2009, 2010, and 2011, and May 1, 2012, *Population Highlights* reports.

AHCCCS receives federal, state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program.

AHCCCS receives federal monies along with state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program. As shown in Table 2 (see page 4), during fiscal year 2012, AHCCCS estimates that its revenues will total more than $8.4 billion, with approximately $5.66 billion coming from the federal government, approximately $2.16 billion from the State, about $341 million from the counties, and $275 million from other sources. AHCCCS' estimated expenditures for fiscal year 2012 total nearly $8.4 billion, with about $6.4 billion, or 76 percent, going toward capitation payments. AHCCCS' estimated revenues and expenditures for fiscal year 2012 are each approximately $1.2 billion less than fiscal years 2010 and 2011 because some changes were made to Arizona's Medicaid program during the 2011 legislative session. For example, enrollment in Arizona's Medicaid program for some individuals, such as childless adults, is no longer being accepted.[1] In addition, the federal matching rate returned to its typical level starting in fiscal year 2012. Specifically, the American Recovery and Reinvestment Act of 2009 and additional federal legislation increased the federal matching rate from approximately 66 percent to between 71 and 76 percent from October 1, 2008 through June 30, 2011. This change and the changes to the Arizona Medicaid program resulted in the fiscal year 2012 estimated federal government revenues being approximately $1.4 billion lower. However, the State's estimated revenue did not show a similar decrease, in part due to the reduction in the federal matching rate that required the State to contribute more of each dollar spent.

States must determine eligibility for Medicaid services

To receive Medicaid services, all applicants must satisfy various Medicaid eligibility requirements and be approved for Medicaid through an eligibility determination process. AHCCCS shares the responsibility for determining applicant eligibility with the Department of Economic Security (DES). Federal regulations and state laws establish the various eligibility requirements, including income thresholds, citizenship, and state

[1] In December 2011, the Arizona Court of Appeals upheld the State's decision to stop new enrollment for childless adults, indicating that it was a political decision that was not subject to judicial resolution. In February 2012, the Arizona Supreme Court refused to review the Appeals Court's decision.

Table 2: Schedule of Revenues, Expenditures, and Changes in Fund Balance[1]
Fiscal Years 2010 through 2012
(In Thousands)
(Unaudited)

	2010 (Actual)	2011 (Actual)	2012[2] (Estimate)
Revenues:			
Federal government[3]	$ 7,229,797	$ 7,077,440	$ 5,663,201
State government[3]	1,720,054	2,012,179	2,163,412
County government[3]	247,043	277,663	341,131
Other[4]	302,363	272,449	275,024
Total revenue	9,499,257	9,639,731	8,442,768
Expenditures and transfers:			
Capitated payments—			
Acute care	4,181,191	4,163,405	3,150,673
Long-term care	1,940,629	1,957,650	1,959,774
KidsCare	91,795	55,095	36,068
Mental health and Children's Rehabilitation Services[5]	1,413,917	1,422,241	1,234,025
Fee-for-service—			
Acute care	847,605	874,121	759,836
Long-term care	119,705	127,138	134,366
Other[6]	685,871	805,577	898,318
Administrative	177,092	163,936	180,616
Total expenditures	9,457,805	9,569,163	8,353,676
Transfers to the State General Fund	2,699	1,268	1,244
Net transfers to other state agencies[7]	39,213	38,184	41,928
Total expenditures and transfers	9,499,717	9,608,615	8,396,848
Net change in fund balance	(460)	31,116	45,920
Fund balance, beginning of year	685	225	31,341
Fund balance, end of year	$ 225	$ 31,341	$ 77,261

1 The table includes all AHCCCS financial activity except the Healthcare Group. The Healthcare Group provides medical coverage primarily to small, uninsured businesses and is managed as a self-supporting operation.

2 The estimates for fiscal year 2012 revenues and expenditures are significantly less than fiscal years 2010 and 2011 because multiple changes were made to the Medicaid program and the State's contribution during the 2011 legislative session that affected fiscal year 2012. See page 3 for additional information.

3 Consists of all monies that originally came from the federal, state, or county governments, including monies passed through other entities, such as other state agencies.

4 Amounts primarily consist of monies that were authorized for use on AHCCCS expenditures by the Legislature or voters, such as tobacco litigation monies, gaming revenues, and tobacco tax monies administered by AHCCCS. For example, Proposition 204 (November 2000) authorized the use of tobacco settlement monies to increase the number of people eligible for coverage in AHCCCS. Similarly, Proposition 202 (November 2002) provides a portion of gaming revenues to be used for a trauma and emergency services program.

5 Amounts consist of capitated mental health and Children's Rehabilitation Services expenditures that were passed through to the Arizona Department of Health Services. Beginning in fiscal year 2012, the Children's Rehabilitation Services appropriation was moved to AHCCCS; therefore, AHCCCS no longer passes through these monies to the Department and instead makes payments directly to the providers.

6 Amounts consist of various other expenditures that were not paid as capitated payments or fee-for-service. For example, reinsurance, a stop-loss program for partial reimbursement after a deductible is met, is included in this category.

7 Amounts primarily consist of monies transferred to the Arizona Departments of Health Services and Economic Security for monies appropriated by the Legislature to these agencies. Specifically, the Legislature appropriated over $35 million each year in fiscal years 2010 through 2012 to the Department of Health Services for behavioral health services from the tobacco tax monies AHCCCS administers. Similarly, approximately $3 million each year was appropriated to the Department of Economic Security in fiscal years 2010 through 2012 from county contributions for administration costs for Proposition 204 (November 2000) implementation.

Source: Auditor General staff analysis of the AHCCCS fiscal year 2010 and 2011 financial statements audited by an independent certified public accounting firm and AHCCCS-prepared fiscal year 2012 estimates dated January 24, 2012, that are primarily composed of fiscal year 2012 appropriations.

residency. As the State's Medicaid agency, AHCCCS is ultimately responsible for ensuring the accuracy of Arizona's eligibility determinations and has established processes to help ensure accuracy, such as caseworker training and quality control reviews of its own and DES' eligibility determinations.

AHCCCS and DES determine eligibility for the Medicaid program—

AHCCCS, as the State's Medicaid agency, is required to determine eligibility for the Medicaid program. However, as allowed, AHCCCS has entered into an intergovernmental agreement with DES to perform Medicaid eligibility determinations on its behalf. DES performs Medicaid eligibility determinations in conjunction with eligibility determinations for other federal public assistance programs, such as the Supplemental Nutrition Assistance Program (formerly called food stamps) and the Temporary Assistance for Needy Families program. Although DES performed approximately 82 percent of the Medicaid eligibility determinations as of July 1, 2011, it performs the eligibility determinations for only one program: AHCCCS' Acute Care program. Typical applicants for this program include families with dependent children, pregnant women, and some adults who do not have children.

AHCCCS performed about 11 percent of the eligibility determinations as of July 1, 2011. It completes determinations for ALTCS, KidsCare, and the Supplemental Security Income-Medical Assistance Only population, which is part of the Acute Care program. Additionally, about 7 percent of AHCCCS members are automatically eligible for Medicaid services such as children born to women who are on Medicaid or individuals who have been determined eligible for other programs, such as, aged, blind, or disabled individuals in the U.S. Social Security Administration's Supplemental Security Income Cash program. In most cases, as prescribed in federal regulation, both AHCCCS and DES must redetermine the eligibility of Medicaid recipients at least every 12 months.[1] According to AHCCCS and DES information, as illustrated in Table 3, more than 275,000 combined initial and renewal determinations were completed in December 2011, with approximately 56 percent being determined eligible.

Table 3: Number of Eligibility Determinations and Percentage Approved as Eligible December 1, 2011 through December 31, 2011

Agency	Determinations Performed	Percentage Approved
DES	261,854	55.7%
AHCCCS	13,815	58.7
Total	275,669[1]	55.8

[1] This number does not include AHCCCS members who are automatically eligible for Medicaid services, such as individuals in the U.S. Social Security Administration's Supplemental Security Income Cash program.

Source: Auditor General staff analysis of initial and renewal AHCCCS- and DES-prepared application reports.

Federal regulations and state laws establish Medicaid eligibility requirements—

AHCCCS and DES must determine each applicant's eligibility in accordance with federal and state requirements. These requirements focus on applicants' financial status and other conditions, such as legally residing in the United States. These federal eligibility criteria are incorporated in AHCCCS' feder-

[1] In October 2011, CMS approved Arizona's Medicaid program for another 5-year period. However, CMS did not approve AHCCCS to conduct redeterminations every 6 months instead of every 12 months as requested by the State.

ally approved State Plan (see textbox). Specific requirements include:

> **State Plan—**The State Plan is a comprehensive written statement submitted by AHCCCS and approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services describing the nature and scope of Arizona's Medicaid program.
>
> Source: OMB Circular A-133, Compliance Supplement March 2011.

- **United States citizen or qualified alien—**Applicants must reside in the United States as either a citizen or a qualified alien, who is a person admitted to the U.S. legally in a specific classification.[1] Documents that prove citizenship or qualified alien status include a U.S. passport, naturalization certificate, permanent resident card, or U.S. public birth record. AHCCCS and DES can verify that an applicant is a U.S. citizen or qualified alien through electronic means, such as an electronic match with Arizona Vital Records, or by obtaining original documents from applicants such as birth certificates that can be copied and maintained in its files.

- **Verified social security number—**Applicants must have a verified social security number with the U.S. Social Security Administration. AHCCCS and DES electronically verify this by matching the applicant's social security number, name, and date of birth provided by the applicant with data from the U.S. Social Security Administration.

- **Arizona resident—**Applicants must be residents of Arizona. AHCCCS and DES verify residency with documents including rent or mortgage receipts, an Arizona driver's license, or utility bills or receipts, but consistent with federal regulation, will also accept the applicant's residency declaration on the application unless there is evidence to the contrary.

- **Income limits—**Applicants' or their family's income must be at or below a specific percentage of the federally established poverty guidelines, commonly referred to as the federal poverty level (FPL). The FPL threshold varies by age and other factors, such as whether the applicant is pregnant. For example, as of April 2011, the threshold for families with children in the Acute Care program was 100 percent of the FPL, which means that the monthly income limit for a family of four is $1,863. In addition, with approval from the federal government, states can expand their Medicaid programs to cover people whose coverage is not required by the federal government. For example, in the November 2000 general election, voters expanded eligibility for Arizona's Medicaid program. This expansion, outlined in A.R.S. §36-2901.01, is commonly referred to as Proposition 204. Proposition 204 expanded Arizona's Medicaid coverage to all eligible individuals, including childless adults, with incomes at or below 100 percent of the FPL. However, due to state budget difficulties, new enrollments

[1] According to federal law, aliens who are legally in the U.S. but who are not qualified aliens and aliens who are not legally in the U.S. may be determined eligible to receive emergency services, but do not qualify for full AHCCCS coverage.

in this program were stopped on July 8, 2011.[1] AHCCCS and DES staff verify applicants' income through electronic or other means, such as pay stubs; and they must also document their verification.

- **Signed application—**Applicants are required to sign, under the penalty of perjury, an application. Applicants can apply for Medicaid benefits through a variety of means, such as online, in person at an AHCCCS or DES office, or by mail.

After an application is received, the caseworker verifies the information provided and either approves or denies the applicant for Medicaid benefits.[2] AHCCCS and DES must maintain a case record of the facts used to support its eligibility determinations.

AHCCCS has established processes to help ensure eligibility determinations meet requirements—As the State's Medicaid agency, AHCCCS is ultimately responsible for ensuring the accuracy of Arizona's eligibility determinations and has established processes to help ensure accuracy. For example, AHCCCS and DES have established extensive policies and procedures that help guide staff through the eligibility determination process. In addition, both agencies provide training to staff on the process. For example, classes cover topics such as income, citizenship, and residency. AHCCCS is also responsible for conducting two federally required quality control reviews, one on a monthly basis and the other every three years, to determine the accuracy of its and DES' eligibility determinations. Following these reviews, AHCCCS and DES must identify the reason errors occurred and take steps to prevent similar errors from occurring in the future.

Staffing and expenditures

AHCCCS and DES have allocated 2,841 full-time equivalent (FTE) positions to the eligibility determination function. Specifically, as of December 1, 2011, AHCCCS reported that it allocated 533 FTE positions to eligibility determination. Of these positions, 26 were vacant for a vacancy rate of just under 5 percent. Seventy-nine percent of the filled positions were for caseworkers and the rest included support staff such as quality control, training, and policy staff. In addition, as of September 16, 2011, DES reported that it allocated 2,308 FTE positions to the eligibility determination process. Of these positions, 520 were vacant for a vacancy rate of approximately 23 percent.

As shown in Table 4 (see page 8), it cost approximately $97 million in fiscal year 2011 to operate the eligibility process, of which approximately $69.4 million was transferred to DES. The monies used to support this program consist of federal and state monies.

[1] See footnote 1, page 3.

[2] Under federal regulations, AHCCCS has no more than 45 days to either approve or deny an applicant for most eligibility programs and must redetermine eligibility at least every 12 months.

Table 4: Division of Member Services Eligibility Determination Expenditures by Office and Transfers to DES[1] Fiscal Year 2011 (Unaudited)

	Federal	State	Total
Division of Member Services offices:			
Field Operations Administration	$ 11,908,074	$ 7,375,819	$ 19,283,893
Quality Compliance Administration	749,358	553,068	1,302,426
Member Database Management Administration	832,359	282,511	1,114,870
Office of Automation	736,293	269,006	1,005,299
Administrative Services Office	843,284	3,183,250	4,026,534
Program Support Administration	471,740	353,737	825,477
Total Division of Member Services eligibility determination expenditures	15,541,108	12,017,391	27,558,499
Transfers to the Department of Economic Security	31,542,570	37,832,712	69,375,282
Total eligibility determination expenditures and transfers	$ 47,083,678	$ 49,850,103	$ 96,933,781

1 The Division of Member Services' (Division) expenditures include only the Division's direct costs for eligibility-related functions. According to AHCCCS, it is not required to allocate overhead costs to various administrative functions because it is the single state agency for Medicaid and the Children's Health Insurance Program. Therefore, it claims such costs in accordance with CMS regulations. The transfers to DES include DES' indirect costs because it performs eligibility determinations for several different federal programs and has a cost allocation plan to allocate indirect costs to various programs.

Source: Auditor General staff analysis of AHCCCS-prepared eligibility determination expenditures and transfers to DES for fiscal year 2011.

FINDING 1

The Arizona Health Care Cost Containment System (AHCCCS) should take some additional steps to further strengthen the eligibility determination process. AHCCCS and the Department of Economic Security (DES) accurately determined eligibility for almost all Medicaid applicants. However, auditors calculated that 5.92 percent of the eligibility determinations are at risk for processing errors, and 1.11 percent of the eligibility determinations are at risk for being incorrect. Therefore, auditors estimated that AHCCCS is paying between approximately $3.5 and $4.8 million in monthly capitation payments for enrolled but ineligible members. To help further ensure that Medicaid monies are spent only on those members who meet eligibility requirements, AHCCCS should develop and implement a corrective action plan to address the errors identified. In addition, AHCCCS should increase its use of available electronic means for verifying citizenship to further enhance its eligibility determination process.

AHCCCS should take some additional actions to strengthen the eligibility determination process

5.92 percent of individual eligibility determinations are at risk for processing errors

Although AHCCCS and DES appropriately determined the eligibility for approximately 94 percent of individuals who applied for Medicaid services, 5.92 percent of eligibility determination cases are at risk for processing errors.[1,2] Auditors reviewed a representative sample of 279 individuals enrolled in either an AHCCCS Acute Care or Arizona Long Term Care System (ALTCS) program in April 2011 to determine the rate at which caseworkers were making processing errors (see Appendix B, pages b-i through b-ix, for additional information on the sample). To assess the accuracy of the eligibility determination for the 279 enrolled members, auditors focused their work on six key eligibility criteria established in AHCCCS' state plan and eligibility policies that are consistent with federal regulation (see textbox).

Six key eligibility criteria reviewed

- United States citizenship or qualified alien status
- Valid social security number
- Arizona residency
- Income requirements
- Signed application
- Resource limits for the Arizona Long Term Care System (ALTCS)

Source: Auditor General staff analysis of AHCCCS' State Plan and eligibility policies.

Auditors' review determined that AHCCCS and DES correctly processed approximately 94 percent of eligibility determinations. However, for 16 of the 279 eligibility determinations, auditors identified processing errors. Auditors calculated a processing error rate for the population of 5.92 percent. These processing errors involved problems related to correctly calculating and verifying income or resources, both critical components of the eligibility determination process. Auditors did not identify any problems with other

[1] As indicated in the Introduction (see page 5), AHCCCS has an intergovernmental agreement with DES to conduct Medicaid eligibility because DES performs this function for other programs, such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families program.

[2] The 5.92 percent is a weighted error rate calculated by auditors. See Appendix B, pages b-iii through b-iv, for more information on this calculation.

eligibility criteria, such as citizenship or residency, for the 279 eligibility determination cases reviewed. Processing errors specifically included the following:

- **Lack of sufficient documentation showing caseworkers verified income—** For 9 of the 16 eligibility determinations where auditors identified processing errors, AHCCCS and/or DES caseworkers did not verify or document, as required, the individual's or family's income. AHCCCS and DES policies require that caseworkers document verification of reported income (see textbox). Based on auditors' review of the 279 cases, caseworkers appropriately used a variety of sources including pay stubs, third-party databases, and employer statements to verify and document reported income (see Table 5). However, auditors found that policies for income verification and documentation were not followed for 9 of the cases reviewed, resulting in insufficient verification and documentation of income. For example:

Income requirements

Income requirements vary by age and other factors such as whether the applicant is pregnant, and are based on federally determined poverty guidelines. For example, an individual can make up to $908 per month and still qualify, while a family of 4 can make up to $1,863 per month. For each additional family member, the income limit increases by $318 per month.

Source: Auditor General staff analysis of information provided by AHCCCS.

Table 5: Income Verification Sources Used by AHCCCS and DES to Confirm Reported Income
April 2011

Verification Type	Example(s)	Form of Electronic Verification (Yes or No)	Number of Verifications (Percentage of Total)[1]
Electronic verification	Third-party databases such as The Work Number (see pages 14-15)	Yes	111 (37.0%)
Third-party documentation	Pay stubs, bank statements, and child support statements showing income amounts	No	100 (33.3%)
Informal employer verification	Note from employer corroborating applicant's reported income	No	62 (20.7%)
Self-declaration[2]	Applicant's self-reported income information	No	27 (9.0%)

1 Auditors' review of 279 eligibility determinations resulted in 300 instances of income verification because some households had multiple income sources. In addition, as noted in the bulleted paragraph above, auditors also found that policies for income verification and documentation were not followed for 9 of the cases reviewed.

2 Although caseworkers relied on a self-declaration of reported income for these cases, caseworkers may also have checked other verification sources such as The Work Number or the State Verification Exchange System in an effort to verify reported income.

Source: Auditor General staff analysis of 279 eligibility determinations for members active in an AHCCCS Acute Care or ALTCS program in April 2011.

- In one eligibility determination, the caseworker relied on the applicant's statement of reported income and did not verify the reported income through an employer's statement or pay stubs. AHCCCS subsequently determined that the applicant's monthly income was approximately $380 more than the amount the caseworker used to make the determination.

- In another eligibility determination, the caseworker did not appropriately obtain income verification documentation. AHCCCS subsequently obtained verification showing that the monthly income allocated to the applicant should have been approximately $650 higher.

In these two examples, the processing errors were not of sufficient magnitude to change the determination that these applicants were eligible for Medicaid. Nonetheless, it is important to verify and document income as required, because the amount of income is a key factor for determining individual and/or family eligibility for Medicaid.

- **Income or resource miscalculations**—For 7 of the 16 eligibility determinations where auditors identified processing errors, AHCCCS and/or DES caseworkers miscalculated the individual's or family's amount of income or resources. All applicants must meet income requirements and ALTCS applicants must also meet resource requirements (see textbox). Therefore, correctly determining income and resources is an essential component of the eligibility determination process. Using various documents obtained during the application process, caseworkers must often calculate and input income and resource information into a computerized eligibility system. For example, income eligibility is determined based on monthly income, and caseworkers must manually convert weekly and biweekly income amounts into monthly income amounts. The caseworker must then enter the calculated amount into the eligibility system so that eligibility can be determined.

ALTCS resource requirements

For single applicants in the ALTCS program, countable resources cannot exceed $2,000.

Countable resources include:

- Financial accounts, such as savings accounts
- Life insurance or burial funds in excess of $1,500
- Cash, stocks, and bonds

Not countable resources include:

- The home that the applicant lives in
- One vehicle
- Household and personal belongings

Source: Auditor General staff analysis of ALTCS eligibility policies.

The calculations that caseworkers must make can lead to mistakes. For example, in one determination, the caseworker incorrectly input an applicant's monthly income into the computer system, entering approximately $1,065 per month less than should have been entered. In another determination, the caseworker did not include approximately $550 in social security survivor's benefits in an applicant's monthly income calculation. Although only one of the seven income/resource

miscalculations auditors identified resulted in an incorrect Medicaid benefits determination, it is important to correctly calculate and enter income and resource information because these amounts are key determinants in whether an individual is eligible for Medicaid.

Processing errors create potential for incorrect eligibility determinations

Three of the 16 processing errors resulted in an incorrect eligibility determination.

For 13 of the 16 determinations with processing errors, the errors that auditors identified were not of sufficient magnitude to cause incorrect eligibility determinations, such as certifying applicants as eligible when they actually were not. However, for three of the sampled determinations, the processing errors were of sufficient magnitude to result in incorrect determinations. In these instances, caseworkers did not properly verify or correctly calculate the income amount used to make the eligibility determination. In the first case, there was no documentation in the member's case file to support the eligibility determination. AHCCCS later determined that the member was not eligible because the income verification information that AHCCCS later found showed that the member exceeded the income limit. In October 2011, this individual was not reapproved for Medicaid services because she did not meet the income requirements. In the second case, the caseworker incorrectly entered net earnings instead of gross earnings, and therefore the income reported was $92 less than it should have been. If the amount had been entered correctly, the member's income would have been approximately $62 over the income limit. In the third case, AHCCCS was not able to provide income verification as required for the period under review and absent this verification, the applicant should not have been approved for Medicaid benefits. As a result, AHCCCS inappropriately paid approximately $2,359 in capitation payments for these three members over a 7-month period.[1]

Although the incorrect eligibility determinations resulting in erroneous payments were small within the actual sample of cases reviewed, they become more important when projected across all Arizona Medicaid eligibility determinations performed by AHCCCS and DES. Specifically, auditors calculated an incorrect eligibility determination rate of 1.11 percent for the acute care and long-term care programs tested. Therefore, of the approximately $414 million in monthly capitation payments that AHCCCS makes for its members in the programs tested, auditors estimated that AHCCCS is paying its health plans between approximately $3.5 and $4.8 million in monthly capitation payments for enrolled but ineligible members (see Appendix B, pages b-v through b-vi, for auditors' calculation of this range).[2]

[1] The capitation dollars paid in error were calculated based on monthly capitation payments that AHCCCS made for each member between the date of the erroneous determination and the end of the period for which auditors had capitation payment data—July 31, 2011. These capitation dollars do not include payments AHCCCS made for children's rehabilitation or mental health services.

[2] Auditors' estimates of the capitation payment amounts made for enrolled but ineligible members do not include payments made for children's rehabilitation or mental health services.

Most error types consistent with federal review

The types of errors auditors found are consistent with those identified by the most recent federally required Payment Error Rate Measurement (PERM) review (see textbox). Arizona was 1 of 17 states that underwent the PERM review in federal fiscal year 2008. This PERM review found that Arizona's eligibility error rate was 2.2 percent, which was lower than the national eligibility error rate of 6.7 percent reported by the review. Arizona had the third lowest eligibility error rate of the 17 states under review. The federal fiscal year 2008 PERM review error rate for Arizona of 2.2 percent included eligibility errors in three categories: 1) incorrect eligibility determinations due to members being approved for Medicaid, but not meeting the requirements, 2) members for whom eligibility could not be determined because the case record contained insufficient documentation, and 3) cases where the State should have paid a greater percentage of the member's institutional care costs when these are shared costs. Auditors similarly identified eligibility errors in the first two categories for the sample of 279 determination cases reviewed, but did not test these cases for the third category. Arizona received another PERM review in federal fiscal year 2011, and CMS is expected to notify Arizona of the results by November 2012.

Payment Error Rate Measurement (PERM) review

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requires state Medicaid agencies to undergo a PERM review every 3 years to evaluate the accuracy of Medicaid eligibility determinations, and managed care and fee-for-service payments. A contractor determines the sample size on behalf of the federal government based on the eligibility error rate found in the previous PERM review, and then AHCCCS quality compliance staff conduct the PERM review on behalf of the federal government. For the eligibility determination portion of the PERM review, AHCCCS staff review all documentation that the caseworker used to approve or deny Medicaid eligibility for each case in the sample to confirm that the eligibility determination was correct.

Source: Auditor General staff review of PERM guidance documents and Arizona's federal fiscal year 2008 PERM report.

AHCCCS should implement plan to reduce errors made during eligibility determinations

AHCCCS should take several steps, through the development of a corrective action plan, to correct the kinds of errors this audit identified, as well as to minimize their frequency going forward. Minimizing errors is important because AHCCCS cannot recover monies paid for someone it incorrectly determined eligible unless the information used to make the determination is proven to be fraudulent. Specifically, AHCCCS management explained that the State is not able to recover any of the monies inappropriately paid to the health plans and/or providers for these members because these monies were provided to the health plans and providers to cover the healthcare costs of members who the State had determined eligible and enrolled in one of its contracted health plans. However, according to AHCCCS policy, if a caseworker suspects fraud or abuse during the application process, they are responsible for making a referral to AHCCCS' Office of the Inspector General. The Office investigates providers and members who are suspected of fraud, recovers

overpayments, issues administrative sanctions, and refers cases for criminal prosecution.

AHCCCS previously implemented actions to correct eligibility determination errors identified during the federal fiscal year 2008 PERM review. Its corrective actions focused on implementing a new electronic file imaging system, rewriting areas of unclear policy, and issuing policy training bulletins to caseworkers specific to the errors found. Although both AHCCCS and DES took these steps, given the complicated nature of determining and verifying income, such as ensuring that all sources and amounts of income have been identified, appropriately calculated, and verified, errors are still being made. Therefore, AHCCCS should develop a corrective action plan that will help ensure that it and DES correct the types of income and resource verification and calculation errors identified in this audit as well as minimize their frequency going forward. Similar to corrective action strategies implemented by other states to reduce eligibility errors, AHCCCS' plan should include additional caseworker training, particularly in areas determined to be error-prone, and assessing whether it needs to clarify its income and resource policies. Additionally, the plan should focus on enhancing the supervisory review of income and resource requirements for Medicaid determinations. One way this could be done would be to assess whether new or experienced caseworkers are making errors and further target supervisory review.

AHCCCS should develop a corrective action plan that includes additional training, policy clarification, and enhanced supervisory review.

AHCCCS should increase its use of electronic matching to verify citizenship requirements

To further enhance its eligibility determination process, AHCCCS should increase its use of available electronic means for verifying citizenship. Caseworkers consistently verified social security numbers using electronic matching, but not income or citizenship. AHCCCS and DES provide caseworkers with electronic means for verifying social security numbers, income, and citizenship (see textbox, page 15). Caseworkers used the electronic interface with the Social Security Administration to verify the social security number of the applicant in all 279 eligibility determinations auditors reviewed.

AHCCCS' and DES' use of electronic matches to verify reported income was either less successful or less frequent. Specifically, as shown in Table 5 (see page 10), caseworkers were able to use electronic matches, such as The Work Number, to verify income 37 percent of the time for the 279 determinations auditors reviewed. Although auditors found that DES caseworkers used electronic means in additional cases to verify reported income, these electronic matches did not produce the information needed to verify the reported income. Additionally, for some of the eligibility determinations performed by DES, it did not use electronic means to verify the reported income. As a result, the remaining income verifications were completed through other means, such as pay stubs, bank statements, employer statements,

and applicant's self-reporting of income. However, according to a DES policy, as of June 2011, information from the Work Number is viewed through DES' eligibility system for new and renewal applicants age 16 and older who have a valid social security number. According to a DES official, this change will increase DES' use of this electronically verified income information during the eligibility process.[1]

Finally, the use of electronic verification for citizenship was also less frequent. As shown in Table 6 (see page 16), caseworkers verified citizenship with hard-copy documents, such as birth certificates, instead of electronic matches such as the AHCCCS Citizenship Verification System, for 72 percent of the 279 determinations. To further enhance its eligibility determination process, AHCCCS should ensure that it and DES make greater use of the available electronic means for verifying citizenship. Although auditors did not identify problems with citizenship for the 279 eligibility determinations reviewed, electronic verification would offer the opportunity to streamline the eligibility process. Specifically, verifying citizenship electronically may require interagency cooperation to share data and costs to improve information technology, but it reduces unnecessary paperwork for families without sacrificing accuracy and eases the administrative burden on the agency.[2,3,4]

Electronic verification sources

Income verification:

- **State Verification Exchange System (SVES)—**This system obtains information from other sources such as Unemployment Insurance and the Social Security Administration.
- **The Work Number—**An automated online employment and income verification system which allows DES or AHCCCS to retrieve employment and/or payroll verification from participating employers.

Social security number verification:

- **Wire Third Party Query System (WTPY)—**Interface with the Social Security Administration to verify the applicant's social security number.

Citizenship and qualified alien status verification:

- **AHCCCS Citizenship Verification System—**A Web-based birth records match with Arizona Vital Records to verify birth records for individuals born in Arizona 1950 and later.
- **Systematic Alien Verification for Entitlements (SAVE) —**Verifies the authenticity of the document the applicant provided to prove his/her alien status.

Source: Auditor General staff summary of AHCCCS and DES eligibility policies and procedures.

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1 Auditors' review of a representative sample of the 279 individuals enrolled in either an AHCCCS Acute Care or ALTCS program did not identify that AHCCCS needed to increase its use of electronic matches for income verification. AHCCCS conducts Medicaid eligibility determinations for the ALTCS program. As indicated in the Introduction (see page 2), this program is for individuals who are elderly or disabled. Auditors' review of the ALTCS determinations found these individuals had unearned income, such as social security income, and not earned income. In addition, AHCCCS used an electronic match to verify unearned income for most determinations.

2 Kaiser Commission on Medicaid and the Uninsured. (2011). *Holding steady, looking ahead: Annual findings of a 50-state survey of eligibility rules, enrollment, and renewal procedures, and cost sharing practices in Medicaid and CHIP, 2010-2011*. Washington, DC: The Henry J. Kaiser Family Foundation.

3 Cohen, A., Dutton, M., Griffin, K., Woods, G., & Manatt Health Solutions. (2008). *Streamlining renewal in Medicaid and SCHIP: Strategies from other states and lessons for New York.* New York, NY: Author.

4 Dorn, S. (2009). *Express lane eligibility and beyond: How automated enrollment can help eligible children receive Medicaid and Chip: A catalog of state policy options*. Washington, DC: Urban Institute, Health Policy Center.

Table 6: Citizen and Qualified Alien Status Verification Sources Used by AHCCCS and DES April 2011

Verification Type	Example(s)	Percentage of Total (279)
Third-party documentation	Birth certificate, passport, naturalization certificate	72%
Electronic verification	AHCCCS Citizenship Verification System, Systematic Alien Verification for Entitlements	28

Source: Auditor General staff analysis of 279 eligibility determinations for members active in an AHCCCS Acute Care or ALTCS program in April 2011.

Electronic verification will be required by the Affordable Care Act and is being increasingly adopted by other states to verify citizenship

The 2010 Federal Patient Protection and Affordable Care Act (Act) directs states to expand their use of electronic verification for Medicaid eligibility by 2014.[1] For example, under the Act's proposed rules, Medicaid eligibility verification will include interfaces with agencies such as the Social Security Administration for citizenship verification, and immigration status through the Department of Homeland Security. Although not all of the federal rules are promulgated nor are all of the processes in place within the federal government for Arizona to fully implement the electronic Medicaid eligibility verification requirements of the Act, Arizona has begun planning for implementation. Specifically, in February 2012, according to an AHCCCS official, the State began developing some of the requirements that will allow it to operate a Health Benefit Exchange.[2] This Exchange is intended to enable, among other things, the electronic verification of Medicaid eligibility requirements and make determinations as close to real time as possible.

Many states have already begun to use the electronic verification for citizenship that will be required by the Act. According to Kaiser Foundation statistics, 40 states have established an electronic data match with the federal Social Security Administration to verify citizenship status for parents applying for Medicaid as of January 2012.[3] This

1 The constitutionality of portions of the Patient Protection and Affordable Care Act is under review by the United States Supreme Court. The case involves numerous parties. Oral arguments were heard in late March 2012 with a ruling expected sometime in late June 2012.

2 According to the Act, no later than January 1, 2014, each state shall establish an American Health Benefit Exchange, administered by a governmental or nonprofit entity established in the state, that makes qualified health plans available to qualified individuals and employers.

3 Kaiser Foundation updates the states' use of the Social Security Administration Data Match as part of its dynamic Web Site. See http://www.statehealthfacts.org/comparemaptable.jsp?ind=899&cat=4

represents an increase of 12 states since January 2011.[1] Although Arizona has not established this match, most states, including California and Texas, have established this match. State experience with this option found that this match accurately verified citizenship in 94 percent of cases, while easing the state's administrative workload and eliminating unnecessary paperwork for applicants. AHCCCS indicated that it has not established an interface with the Social Security Administration to verify citizenship because of concerns about having to grant an applicant temporary eligibility in cases where the social security number could not be verified through the match.[2]

Most states have established the electronic verification for citizenship that is required by the Act.

Recommendations:

1.1 AHCCCS should develop a corrective action plan that will help ensure that it and DES correct the types of income and resource verification and calculation errors identified in this audit as well as to minimize their frequency going forward. This plan should include:

   a. Providing additional caseworker training, particularly in areas determined to be error-prone;

   b. Assessing whether it needs to clarify its income and resource policies; and

   c. Enhancing the supervisory review of income and resource requirements for Medicaid determinations.

1.2 AHCCCS should ensure that it and DES make greater use of the available electronic means for verifying citizenship, such as the AHCCCS Citizenship Verification System.

[1] Kaiser Commission on Medicaid and the Uninsured. (2011). *Holding steady, looking ahead: Annual findings of a 50-state survey of eligibility rules, enrollment, and renewal procedures, and cost sharing practices in Medicaid and CHIP, 2010-2011*. Washington, DC: The Henry J. Kaiser Family Foundation.

[2] Section 1902 of the Social Security Act requires that if the citizenship information submitted by the state Medicaid agency cannot be verified by the Social Security Administration, the applicant will be granted 90 days of temporary Medicaid eligibility, during which time the applicant would have to provide documentation to verify citizenship status. After 90 days, if the applicant's citizenship cannot be resolved, the state Medicaid agency would remove the individual from the rolls within 30 days.

APPENDIX A

This appendix provides information on the methods auditors used to meet the audit objectives.

This performance audit was conducted 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.

The Auditor General and staff express appreciation to the Arizona Health Care Cost Containment System (AHCCCS) Director and his staff and the Department of Economic Security (DES) Director and his staff for their cooperation and assistance throughout the audit.

Methodology

Auditors used the following specific methods to meet the audit's objectives:

- To gain an understanding about the state and federal requirements for performing eligibility determination, auditors reviewed the Code of Federal Regulations, the Office of Management and Budget Circular A-133 Compliance Supplement Catalog of Federal Domestic Assistance 93.778 Medical Assistance Program, AHCCCS' State Plan for Medicaid, the intergovernmental agreement between AHCCCS and DES, and AHCCCS' and DES' eligibility policies and procedures; and conducted interviews with AHCCCS and DES staff.[1]

- To determine the rate at which AHCCCS and DES caseworkers were making processing errors on Medicaid eligibility determinations, auditors met with agency staff to identify relevant eligibility and payment data systems, reviewed systems information, and ultimately obtained eligibility records and payment data for all members active in April 2011. Auditors used the data to select a representative sample of 279 eligibility determinations. Auditors used this sample to assess whether AHCCCS and DES were appropriately determining eligibility, calculate an error rate, and construct an estimate of the monthly capitation payments made for enrolled but ineligible members (see Appendix B, pages b-i through b-ix, for technical information on the sample, error rates, and projection methodology).

- Auditors' work on internal controls involved reviewing AHCCCS' and DES' written policies and procedures for guiding eligibility work, including its quality control processes. For example, auditors observed a case review conducted by AHCCCS' Quality Compliance Administration; reviewed the federal fiscal year 2008 Arizona Payment Error Rate Measurement (PERM) findings, corrective action plan, and associated manuals; interviewed consultants responsible for providing states with sampling requirements; and reviewed the Medicaid Eligibility Quality Control review process. In addition, auditors reviewed information technology change management controls for both AHCCCS' and DES' eligibility systems and the reconciliation process between these eligibility systems and AHCCCS' Prepaid Medical Management Information System.

[1] As indicated in the Introduction section (see pages 1 through 8), AHCCCS has an intergovernmental agreement with DES to conduct Medicaid eligibility because DES performs this function for other programs, such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families program.

- To ensure the eligibility and payment data was generally complete and accurate for the purposes of selecting a representative sample and developing estimates of capitation payments made for enrolled but ineligible members, auditors conducted various tests such as comparing number of records and capitation data received from AHCCCS to published population figures and capitation rates. Auditors determined the data was generally complete and accurate for the audit's purposes.

- To evaluate AHCCCS' use of electronic verification during the eligibility determination process and efforts to prepare for federal healthcare reform, auditors reviewed the 2010 Patient Protection and Affordable Care Act (Act); U.S. Department of Health Services, Centers for Medicare and Medicaid Services' proposed rules associated with implementation of the Act; electronic data matches with the U.S. Social Security Administration; and information prepared by AHCCCS staff involved with the Act's implementation. In addition, auditors obtained information on other states' use of electronic verification from the Henry J. Kaiser Family Foundation and Urban Institute.

- The information used to develop the report's Introduction included AHCCCS documents published on its Web site, such as information about court decisions; AHCCCS' fiscal year 2010 and 2011 audited financial statements; and information from AHCCCS and DES administrators and staff, including internal staffing reports.

APPENDIX B
Technical Methods

This appendix provides information on the methods auditors used to select their sample, estimate eligibility processing and eligibility determination error rates, and develop an estimate of capitation payments the Arizona Health Care Cost Containment System (AHCCCS) is making to its contracted health plans for ineligible members.

Contents:

- Sample selection (pages b-i through b-iii);
- Eligibility processing error rate estimates (pages b-iii through b-iv);
- Eligibility determination error rate estimate (page b-iv);
- Incorrect capitation payment estimate (pages b-v through b-vi);
- Sample demographics (page b-vii); and
- Glossary of statistical terms used in this appendix (pages b-viii through b-ix).

Sampling, error rate estimate, and projection methodology

Process for selecting the sample

To select a representative sample, auditors completed the following activities:

- **Identifying the population**—Because auditors focused on assessing eligibility determinations, auditors identified the original population from which to draw a sample as any member with an eligibility record in a single month. Auditors then obtained the eligibility records for each member enrolled in an AHCCCS healthcare program at any point during April 2011. For each member enrolled, auditors obtained all of the eligibility records associated with that member during June 1, 2010 through July 31, 2011. Some members had more than one eligibility record because of changes to their eligibility that may have qualified them for a different AHCCCS program. Each change results in a new eligibility record. An eligibility record includes information such as the eligibility code for the specific program the member is enrolled in, and the beginning and ending dates of the enrollment. AHCCCS members receive medical services under three primary programs: KidsCare and Arizona's two Medicaid programs—Arizona Long Term Care System (ALTCS) and Acute Care (see Introduction, page 2, for more information on these three programs). The Acute Care program has several subprograms that cover specific populations, such as low-income families with children, or pregnant women. Auditors grouped members' eligibility records by programs/subprograms using the eligibility codes included in the data. This resulted in a population of 2,120,900 eligibility records for 1,495,203 members (see Population and sampling frame textbox).

Population and sampling frame

	Population	Sampling Frame	Percentage of Population
Records	2,120,900	1,460,094	69%
Members	1,495,203	1,183,559	79%

- **Identifying the sampling frame**—Auditors narrowed the 2,120,900 records in the population to only those members with active records in the ALTCS program and the three largest Acute Care subprograms: Families with Children, S.O.B.R.A. Child, and AHCCCS Care. This population was identified as the audit sampling frame and although it was smaller than the original population, it still represented the majority of AHCCCS records

and members (see textbox, page b-i). The sampling frame excluded records for members who fell outside the scope of the audit, such as members whose eligibility is determined by the Foster Care Program, automatic re-determinations (6-month extensions), and determinations made in part by outside entities, such as the U.S. Social Security Administration for individuals who are aged, blind, or disabled and qualify for Supplemental Security Income.

- **Selecting a stratified random sample—**Auditors designed an embedded stratified random sample for the audit. The procedures and processes for determining eligibility for the AHCCCS programs auditors tested are the same; however, the level of income an individual is allowed to have varies, and the ALTCS program has a resource limit (see Finding 1, textbox, page 11). Auditors randomly selected 280 members stratified first by program and then by subprogram.[1] The first stratification differentiated Acute Care and ALTCS. Acute Care represented the majority of records in the population while ALTCS represented less than 5 percent of all records in the population, but a significant amount of the capitation payments. Auditors then further stratified Acute Care into three subprograms that accounted for more than 66 percent of all Acute Care records. The member's active record was used as a surrogate for the member and could be selected only one time. For the Acute Care program, auditors selected a random sample proportionate to the size of 250 members' eligibility records from the sampling frame, stratified by program, which resulted in sampling 116 members from Families with Children, 82 members from S.O.B.R.A. Child, and 52 members from AHCCCS Care. For the ALTCS program no further stratification was necessary and auditors randomly sampled 30 members.[2] This stratum is oversampled when combined with the Acute Care strata, but the sample proportions were adjusted to account for the oversampling *post hoc*. Auditors wanted to ensure that the sample size for all strata were large enough to draw conclusions and make projections, if necessary, by strata to the members in the population (see stratified random sample textbox).

Stratified random sample

Program	Records	Percentage	Sample Size
Families with Children	653,073	46.4%	116
S.O.B.R.A. Child	459,486	32.7	82
AHCCCS Care	293,524	20.9	52
Total Acute Care	1,406,083	100.00%	
ALTCS	54,011		29
Total	1,460,094		279

- **Adjusting the population for projection purposes—**Auditors adjusted the sampling frame to account for the oversampling and to exclude any members not subject to testing, e.g. inactive members and foster care children. These *post hoc* adjustments resulted in a final population of 1,169,351 active members, 1,394,500 eligibility records, and minor changes to the strata proportions used in weighting (see Adjusted population textbox, page b-iii). The proportions used in weighting error rates and projections are representative of the final adjusted

[1] Auditors' initial sample size was 280; however, one member record was dropped from the initial sample of 30 for ATLCS because it was inactive. Auditors did not replace that item as the stratum was oversampled and the loss of one case was negligible to the sample.

[2] See footnote 1.

population. The sample has a 95 percent level of confidence with a sample precision of plus/minus 3 percent.

Adjusted population[1]

	Population	Sampling Frame	Adjusted Population	Adjusted Population as a Percentage of Population
Records	2,120,900	1,460,094	1,394,500	66%
Members	1,495,203	1,183,559	1,169,351	78%

[1] The adjusted population is the sampling frame minus inactive records and other records not subject to testing (see page b-ii).

- **Ensuring representativeness of the sample**—Auditors compared key demographics of the sampled members' records, such as age and geographical location, to the sampling frame population to ensure that the sample was representative of the sampling frame population. This was done with the initial sampling frame and then again for the adjusted population. There were no statistical differences between the sample and the initial sampling frame or the sample and the final population (see Sample demographics, page b-vii).

Steps for estimating processing errors

Auditors calculated a processing error rate. Processing errors are mistakes made during the eligibility determination process, such as a caseworker not documenting income verification or miscalculating the applicant's income (see Finding 1, pages 9 through 17). To determine the rate at which processing errors were likely to occur in the population, auditors estimated a weighted processing error rate based on sample results. A weighted error rate is commonly used to minimize any design effects and reduce sampling error. The weighted processing error rate also accounts for any variation among the strata that could unwittingly bias the estimated rate of processing error. Auditors took the following steps to estimate the rate at which processing errors were likely to occur in the population: (Also see Processing error rates textbox, page b-iv.)

- **Determining the unweighted processing error rate**—This rate represents the number of processing errors for a stratum as a proportion of the sample size. For example, the unweighted processing error rate for the AHCCCS Care program is 4/52 = 7.69 percent.

- **Calculating the weighted processing error rate**—This rate is calculated by multiplying the unweighted processing error rate for a stratum by the proportion of the population represented by that stratum. For example, the weighted processing error rate for the AHCCCS Care program is: 0.0769 x 0.2055 = 1.58 percent.

- **Estimating a total weighted processing error rate**—This rate is calculated by summing the weighted error rates of each stratum. This calculation resulted in a

Processing error rates

Program	Adjusted Records[1]	Percentage of Adjusted Records[1]	Sample Size	Processing Errors	Processing Error Rate Unweighted	Processing Error Rate Weighted
Families with Children	628,591	45.08%	116	7	6.03%	2.72%
S.O.B.R.A. Child	425,584	30.52	82	4	4.88	1.49
AHCCCS Care	286,622	20.55	52	4	7.69	1.58
ALTCS	53,703	3.85	29	1	3.45	0.13
Total	1,394,500	100.00%	279	16		5.92%

[1] Population proportions were adjusted to exclude inactive and other records not subject to testing (see page b-ii).

weighted stratified error rate of 5.92 percent that can be projected to the members in the population.[1]

Process for calculating an incorrect eligibility determination rate

For those members with processing errors resulting in an incorrect eligibility determination, auditors computed an incorrect eligibility determination rate (see Finding 1, pages 9 through 17). The incorrect eligibility determination rate represents the probability in the population of a member having at least one processing error on their last determination that also resulted in an incorrect eligibility determination. This rate was calculated as follows:

- **Determining the percentage of processing errors resulting in incorrect eligibility determinations—**From the sample, auditors found that 3 of the 16 members' processing errors resulted in an incorrect eligibility determination (see Finding 1, pages 9 through 17). Therefore, the percentage of processing errors resulting in incorrect eligibility determinations is 3/16 = 0.1875, or 18.75 percent.

- **Calculating the incorrect eligibility determination rate—**This rate is determined by multiplying the weighted processing error rate by the percentage of incorrect eligibility determinations, or 0.0592 x 0.1875 = 0.0111, or 1.11 percent.

[1] T-tests of difference of proportions (alpha=.05) showed that there were no statistical differences between the error rates by strata.

Steps for estimating incorrect capitation payments

Incorrect determinations can be tied directly to capitation payments made in error. To construct an estimate of the monthly capitation payments made for enrolled but ineligible members, auditors completed the following procedures: (Also see textbox, page b-vi.)

- **Projecting the number of incorrect eligibility determinations in the population by stratum—**Auditors estimated the number of members in the population that would have incorrect eligibility determinations. This number is determined by:

  - Multiplying the unduplicated number of members in the population used for projection purposes (1,169,351) by the incorrect eligibility determination rate, or 1,169,351 x 0.0111 = 12,980. This number represents the number of members who are projected to be ineligible for Medicaid; and,

  - Apportioning the number of ineligible members (12,980) among the strata by multiplying 12,980 by the percentage of members in each stratum. For example, for the AHCCCS Care program the projected number of members with eligibility determination errors would be 12,980 x 0.2055 = 2,668.

- **Determining an average capitation payment for each stratum—**Auditors used the capitation payments made for each member in the sample during the period June 1, 2010 through July 31, 2011, to develop an average per member, per month capitation payment for each stratum.[1] Auditors did not include fee-for-service dollars in this calculation because there was an insufficient number of members in our sample with fee-for-service payments to develop a valid average fee-for service payment by stratum. As reported in the Introduction (see page 2), approximately 90 percent of AHCCCS members are enrolled in managed care programs and their healthcare costs are covered through monthly capitation payments made to contracted health plans. Capitation payment amounts also do not include payments made for children's rehabilitative or mental health services.

- **Estimating the monthly incorrect capitation payment in the population—**To determine the estimated incorrect monthly capitation payment for the population, auditors multiplied the average per member, per month capitation payment for each stratum by the number of members in the stratum projected to have incorrect determinations. This calculation for S.O.B.R.A. Child, for example, is 3,961 x $127.65 = $505,622. The calculation was made for each stratum and summed to compute a total monthly estimate.

[1] In addition to the monthly capitation payments, auditors' analysis included some other types of capitation payments such as lump sum payments for births that included the costs of prenatal care and the actual costs of the birth, and subsidies for rural hospitals.

Projected estimate, lower, and upper monthly incorrect capitation payments

Program	Percentage of Members[1]	Projected Members Incorrectly Determined	Average Per Member Per Month Capitation Payment[2]	Monthly Incorrect Capitation Payment Estimate	Lower Bound	Upper Bound
Families with Children	45.08%	5,851	$ 175.40	$1,026,265	$ 887,421	$1,165,168
S.O.B.R.A. Child	30.52	3,961	127.65	505,622	449,851	561,353
AHCCCS Care	20.55	2,668	454.07	1,211,459	1,002,688	1,420,230
ALTCS	3.85	500	2,812.53	1,406,265	1,184,615	1,627,915
Total	100.00%	12,980		$4,149,611	$3,524,575	$4,774,666

1 Population proportions were adjusted to exclude inactive and other records not subject to testing (see page b-ii).

2 For the time period June 1, 2010 through July 31, 2011.

- **Developing a monthly incorrect capitation payment range**—Using the average monthly incorrect capitation payment for each stratum, auditors estimated monthly incorrect capitation payments for the population. Auditors also established upper and lower bounds around that estimate, meaning that 95 percent of the time the monthly amount of incorrect capitation payments would fall within the established range.

Sample demographics

Gender	Adjusted Population[1]	Sample
Male	46.66%	43.01%
Female	53.34	56.99
Total	100.00%	100.00%
Age		
<1	0.11%	0.00%
1-13	41.97	37.28
14-44	44.65	46.59
45+	13.27	16.13
Total	100.00%	100.00%
Race		
Asian/Pacific Islander	1.81%	1.79%
Black	7.20	8.96
Cuban/Haitian	0.00	0.00
Caucasian/White	35.14	31.54
Hispanic	39.94	39.78
Native American	11.45	11.83
Other	0.20	0.00
Unknown/unspecified	4.26	6.09
Total	100.00%	100.00%
County		
Apache	2.34%	1.79%
Cochise	1.90	2.51
Coconino	2.20	2.15
Gila	1.09	1.08
Graham	0.66	0.72
Greenlee	0.10	0.00
La Paz	0.33	0.00
Maricopa	54.67	60.93
Mohave	3.71	1.79
Navajo	2.94	1.43
Pima	15.05	13.98
Pinal	3.61	3.94
Santa Cruz	1.12	0.72
Yavapai	2.62	2.15
Yuma	3.88	2.87
Multiple	3.78	3.94
Total	100.00%	100.00%

[1] The adjusted population is the sampling frame minus inactive records or other records not subject to testing (see page b-ii).

Statistical glossary

Bias—Any source of systematic error in random probability sampling that is not identified and accounted for when estimates to the population are made. Common sources are disproportionate sampling, non-coverage of certain subpopulations, or dependence among observed sampling units.

Confidence interval—An estimated range of values calculated from sample data to include the unknown population value. The interval is constructed around a point estimate from the sample such as a sample mean, and constructed for the population at a specified level of confidence (95 percent or 99 percent) to assure that 95 or 99 percent of the time, the point estimate (mean) will fall within that interval in the population. A confidence interval allows for random error when projecting a mean value onto the population. A confidence level at alpha = 0.05 means that there is less than a 5 percent chance that the interval will not contain the mean.

Confidence level—The specific probability of obtaining some result from the sample that does not exist in the population. The confidence level establishes how confident you are that you are not making a mistake in rejecting the null hypothesis. A 95 percent confidence level implies that 95 times out of 100 you would not be making a mistake in rejecting the null hypothesis of no difference in the population.

Design effects—Bias created in statistical estimates when complex sampling techniques are used. Methodological procedures have been developed to minimize design effects, such as weighting and adjusting for measurable design effects.

Embedded stratified random sample—A complex sampling design where layers of stratification are used to maximize sampling efficiency and minimize sampling error.

Expected error rate—The amount of time you would expect to reject the null hypothesis when it should not have been rejected. This number is also known as the significance level for the test and is calculated as 100 minus the confidence level. By definition, a 95 percent confidence level implies an expected error rate of 5 percent. The expected error rate is also called the Type I or alpha level of the test of differences. Most tests are conducted with an expected error rate of 5 percent or less, which means that less than 5 percent of the time would you expect to incorrectly reject the null.

Population—The group of items that the sample represents. The number of units in the population is often denoted N.

Probability or random sample—A sample drawn from a population using a random mechanism so that every element of the population has a known chance of ending up in the sample. This type of sample can be generalized to the population so that events observed in the sample can be projected to the population with confidence.

Sample size—The number of units in the sample, often denoted n.

Sampling error—Error created by unequal probability of selection in random sampling. Unequal probabilities can be created by disproportionate sampling and many other sources of sampling bias.

Sampling (or sample) frame—The target population from which the sample is selected. Operationally, the sampling frame may differ from the overall population.

Significance level—The specific probability that the hypothesis test erroneously rejects the null hypothesis when the null hypothesis is true. In most tests, the null hypothesis is the hypothesis of no difference, i.e. that there is no difference between the means or proportions of the two groups tested. When this hypothesis is rejected, it means the two groups have the same mean or proportion, i.e. there is no difference between the two groups. Hypotheses are tested at a specified level of significance called the significance level. The significance level is usually set at 5 percent or less. It is also known as the Type I or alpha level.

Stratified random sample—In a stratified random sample, subsets of the sampling frame are selected separately, but randomly, from different categories or strata, typically based upon a categorical variable of some kind such as program or geography.

Stratum—In stratified random sampling, the sample is drawn separately from different subsets of the population. Each such subset is called a stratum. The plural of stratum is strata.

T-test—A small sample statistical test to determine if there is a significant difference between two groups in the population based on the data from the sample. The t-test should be used when samples are relatively small, < 30, and the distribution is known to be approximately normal. The t-test can also be applied for samples of 30 to 120 as it is a more precise test than its large-sample counterpart, the z-test. For sample sizes >120, the t-distribution converges to the normal distribution, thus making the t-test equivalent to the large sample test, the z-test. The test is usually set at a confidence level (see below).

Upper and lower bounds of a confidence interval—Also known as confidence limits, the upper and lower bounds are the values that define the range of the confidence interval. The upper and lower bounds of a 95 percent confidence interval are the 95 percent confidence limits and can be interpreted as the probability that the estimate will fall in that interval. Ninety-five percent of the time, the interval will contain the estimate and the estimate would not fall in the interval only 5 percent of the time.

AGENCY RESPONSE

Janice K. Brewer, Governor
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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

May 29, 2012

Debra K. Davenport, CPA
Auditor General
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2910 North 44th Street, Suite 410
Phoenix, AZ 85018

RE: Medicaid Eligibility Determination Performance Audit,
Revised Draft Report dated May 23, 2012

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the Arizona Health Care Cost Containment System (AHCCCS) Medicaid Eligibility Determination Performance Audit. We appreciate the professionalism and efforts of the audit team and believe that implementation of the findings will enhance the efficiency and effectiveness of the AHCCCS eligibility process.

The past several years have proven challenging for State government and AHCCCS. Since the beginning of the Great Recession, the AHCCCS Division of Member Services has faced a 39% reduction in staffing. The Department of Economic Security (DES) has experienced a 15% reduction in Family Assistance Administration staff. Despite these reductions, the counter-cyclical nature of the AHCCCS program has resulted in an increased workload. In December 2007, approximately 198,000 determinations for Medicaid benefits were made. As documented in your report, in December 2011 this number rose to 261,854, representing a 32% increase.

Your findings of a 1.11% error rate are commendable under these circumstances, particularly when compared to the 2008 Payment Error Rate Measurement (PERM) national eligibility error rate of 6.7%. The report recommends sound process improvements that should and will be made. However, the fact that both agencies have carried on through these incredibly challenging times with an eligibility error rate of only 1.11%, is a testament to the dedication and professionalism of the staff at AHCCCS and DES.

A recent employee survey of the AHCCCS Division of Member Services employees demonstrates the level of dedication that exists:

- 90% are proud to be an AHCCCS employee
- 90% feel a sense of loyalty and commitment to AHCCCS
- 94% understand clearly what is expected of them at work
- 90% receive the assistance and guidance they need to do their job well

Given all that the agency has been through, it is important to highlight these inspiring results before delving into the details of the report.

The following responses address the recommendations proposed in the Revised Draft report:

Recommendation #1.1:

AHCCCS should develop a corrective action plan that will help ensure that it and DES correct the types of income and resource verification and calculation errors identified in this audit, and to minimize their frequency going forward. This plan should include:

a. Additional case worker training, particularly in areas determined to be error-prone;
b. An assessment of the need to clarify income and resource policies and;
c. Enhanced supervisory review of income and resource requirements for Medicaid determinations.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. In order to use limited resources most efficiently, (The AHCCCS Division of Member Services has 39% fewer staff now as compared to 2007), these findings and recommendations will be addressed in concert with the 2010 PERM Corrective Action Plan, to be developed and implemented late this year upon receipt of final PERM results.

Recommendation #1.2:

AHCCCS should ensure that it and DES make greater use of the available electronic means for verifying citizenship, such as the AHCCCS Citizenship Verification System.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. As noted in your report, we have been very proactive in implementing electronic verification sources such as The Work Number and the AHCCCS Citizenship Verification System. Also, as stated in the report, the use of additional electronic means, such as SSA citizenship data, is planned for system development in support of the ACA. The AHCCCS Citizenship Verification System is limited to information about individuals who were born in Arizona since 1950. Further, additional information, not currently available in all cases (e.g. mother's maiden name, place of birth), may be necessary to make effective use of this system, particularly when working with applicants who have common names. Although the transient nature of the population seeking benefits is another barrier to effective use of these data, we will explore additional opportunities for eligibility staff to check this system prior to requesting birth certificates or other forms of documentation. We propose to analyze options related to this recommendation as part of the corrective action plan development described in the response to recommendation #1.1.

Again, I would like to thank the Auditor General and staff for their time and effort in evaluating the AHCCCS Medicaid Eligibility Determination program. We appreciate the professional approach of the audit team as well as their cooperative attitude with AHCCCS staff.

Sincerely,

Thomas J. Betlach
Director

DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

Janice K. Brewer
Governor

Clarence H. Carter
Director

JUN 01 2012

Ms. Debbie Davenport
Auditor General
State of Arizona
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the revised preliminary report draft of the performance audit of the Arizona Health Care Cost Containment System (AHCCCS)—Medical Eligibility Determination.

We are happy to learn that the partnership between AHCCCS and DES has resulted in a 1.11 percent eligibility error rate, and will continue to work towards improving to an even higher level of accuracy.

Sincerely,

Clarence H. Carter
Director

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