DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

APR 30 2008

Report Number: A-03-07-00214

Carlos Cano, M.D.
Interim Director
Department of Health
District of Columbia
815 North Capitol Street N.E.
Washington, DC 20002

Dear Dr. Cano:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in the District of Columbia and Maryland for July 1, 2005, Through June 30, 2006." We will forward a copy to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me, or contact Mr. Eugene G. Berti, Jr., Audit Manager, at (215) 861-4474 or through e-mail at Gene.Berti@oig.hhs.gov. Please refer to report number A-03-07-00214 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
223 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR SERVICES PROVIDED TO BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN THE DISTRICT OF COLUMBIA AND MARYLAND FOR JULY 1, 2005, THROUGH JUNE 30, 2006

THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

Daniel R. Levinson
Inspector General

April 2008
A-03-07-00214

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid eligibility in each State is generally based on residency. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. The States' Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' Medicaid agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The States' Medicaid agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

For the audit period July 1, 2005, through June 30, 2006, the District of Columbia (the District) Department of Health (State agency) paid approximately $10 million for services provided to beneficiaries who were Medicaid eligible and receiving benefits in the District and Maryland. During the audit period, Maryland paid approximately $6 million for Medicaid services for these same beneficiaries. The States' agencies made these payments on behalf of the beneficiaries using a variety of possible payment systems, such as monthly capitation payments to managed care organizations or fee-for-service payments to providers who rendered the services.

OBJECTIVE

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in Maryland.

FINDINGS

For the period from July 1, 2005, through June 30, 2006, we estimate that the State agency paid:

- $1,902,080 (Federal share $1,331,456) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in Maryland and

- $3,944,006 (Federal share $2,760,805) for Medicaid services provided to beneficiaries whose residence could not be determined from the information in the State agency's and Maryland Medicaid agency's case files.

The Medicaid payments were made on behalf of these beneficiaries because the State agency and Maryland's Medicaid agency did not share all available Medicaid eligibility information and because the State agency did not verify the addresses of Medicaid beneficiaries who received Supplemental Security Income or who were children.

RECOMMENDATIONS

We recommend that the State agency work with the Maryland Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status, and

- reducing the amount of payments, estimated to be $1,902,080 ($1,331,456 Federal share), made on behalf of beneficiaries residing in Maryland.

We also recommend that the State agency:

- determine the place of residence associated with beneficiaries who received services totaling $3,944,006 (Federal share $2,760,805), but whose residency could not be established, and

- verify addresses of all beneficiaries including those on Supplemental Security Income and children.

STATE AGENCY COMMENTS

In a letter dated March 27, 2008 the State agency advised us of actions it was taking to implement our recommendations. We included the State agency response as Appendix B.

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INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The District of Columbia (the District) Department of Health (State agency) manages the District's Medicaid program.

States' Medicaid agencies (States' agencies) make payments for medical services provided to eligible beneficiaries using a variety of possible payment systems, such as capitation payments to managed care organizations or fee-for-service payments to medical providers. A capitation payment is a specified amount of money paid to a health plan, such as a Health Maintenance Organization, contracted to provide a comprehensive set of services to a beneficiary. A fee-for-service payment is the amount paid directly to a provider for services rendered to a beneficiary.

Federal regulation 42 CFR § 435.403(a) states that States' agencies must provide Medicaid services to eligible residents of the State. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. Federal regulation 42 CFR § 435.930 states that a State agency must furnish Medicaid services to recipients until they are determined to be ineligible. Pursuant to 42 CFR § 431.211, if a recipient is determined to be ineligible the State agency must notify the recipient at least 10 days before the State agency takes action to terminate the Medicaid services. However, if the State agency determines that the recipient has been accepted for Medicaid services in another State, advance notice to terminate benefits is not required (42 CFR § 431.213 (e)).

Pursuant to 42 CFR § 435.916, the States' agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The States' agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in Maryland.[1]

Scope

For the audit period of July 1, 2005, through June 30, 2006, the State agency paid approximately $10 million for services provided to beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in the District and Maryland. From the universe of 10,088 beneficiary-months,[2] we selected a random sample of 100 beneficiary-months with payments totaling $96,250.

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the procedures used to identify Medicaid-eligible individuals who moved from the District and enrolled in the Maryland Medicaid program.

We performed our fieldwork at the State agency offices in the District, and in Baltimore, Hyattsville, and Rockville, Maryland, from April through July 2007.

Methodology

To accomplish our audit objective, we obtained eligibility data from the District and Maryland Medicaid Management Information Systems (MMIS)[3] for the period of July 1, 2005, through June 30, 2006. We matched the Social Security numbers, beneficiary names, and dates of birth from the District and Maryland MMIS data to identify 8,165 beneficiaries who were Medicaid eligible in both States.

The State agency provided MMIS payment data files for the beneficiaries with Medicaid eligibility and payments with dates of services that occurred during the 12-month audit period. For each beneficiary who was Medicaid-eligible and receiving Medicaid benefits in both the District and Maryland, we combined all dates of service for a single beneficiary-month and matched the payment data files, between States, by Social Security number, date of birth, and month of service.

---

[1] A separate report has been issued to the Maryland Department of Health and Mental Hygiene to address payments made on behalf of beneficiaries who should not have been Medicaid-eligible in Maryland due to their eligibility in the District.

[2] A beneficiary-month included all payments for Medicaid services provided to one beneficiary during one month.

[3] MMIS is a mechanized claims processing and information retrieval system that States are required to use to record Title XIX program and administrative costs, report services to recipients, and report selected data to CMS.

We used the Office of Inspector General, Office of Audit Service's statistical sample software RATS-STATS' random number generator to select 100 random beneficiary-months with paid dates of services in both the District and Maryland. In the District, the statistical sample included $19,602 in managed care payments and $76,648 in fee for service payments, for a total of $96,250. The selected beneficiary-months were for services provided to beneficiaries with Medicaid eligibility in both States during the same month. See the Appendix for more information regarding the sampling methodology.

We used the State agency's MMIS data to verify that beneficiaries were enrolled in the Medicaid program and payments were made to providers. In addition, we reviewed the Medicaid application files and other supporting documentation in both States for each of the 100 beneficiary months to establish in which State the beneficiary had permanent residency in the sampled months. We determined whether any beneficiaries were eligible for Medicaid in both States during the sampled beneficiary-month.

We sought assistance from the Social Security Administration and the United States Postal Service to determine whether they could provide information about the beneficiary's residence when the application file lacked evidence as to where the beneficiary resided.

Based on the sample beneficiary-months we estimated the total amount of payments that the State agency made on behalf of beneficiaries who should not have been Medicaid-eligible, and the total amount of payments for beneficiaries whose residence could not be determined.

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

FINDINGS AND RECOMMENDATIONS

For the period from July 1, 2005, through June 30, 2006, we estimate the State agency paid:

- $1,902,080 (Federal share $1,331,456) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in Maryland and

- $3,944,006 (Federal share $ 2,760,805) for Medicaid services provided to beneficiaries whose residence could not be determined from the information in the State agency's or Maryland's Medicaid agency's case files.

The following chart shows the results of our statistical sample of 100 beneficiary-months.

Summary of Sampled Beneficiary-Month Payments

Type of Payment	Number	Amount Paid
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	44	$18,855
Undetermined	15	$39,096[4]
Allowable (Eligible Beneficiaries)	41	$38,299
Totals	**100**	**$96,250**

Payments were made by both States on behalf of beneficiaries who should not have been Medicaid eligible in the District and whose residence could not be determined because the State agency and the Maryland Medicaid agency did not share all available Medicaid eligibility information and because the State agency did not verify residences of Medicaid beneficiaries who received Supplemental Security Income or who were children. Of these sampled payments, 33 of the unallowable payments and 8 of the undetermined payments were monthly capitation payments made by both States. Additionally, 7 unallowable payments and 5 of the undetermined payments were monthly capitation payments in one State and fee-for-service payments in the other State. As a result, duplicate payments were made for services provided to these beneficiaries.

PAYMENTS FOR MARYLAND MEDICAID-ELIGIBILE BENEFICIARIES

We estimate that the State agency paid approximately $1,902,080 (Federal share $1,331,456) for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits due to their Medicaid eligibility in Maryland.

Federal and State Requirements

Federal regulation 42 CFR § 435.403(j)(3) states, "The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid [emphasis added]."

Federal regulation 42 CFR § 435.916 provides that the States' agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect

[4]Two beneficiary-months with payments totaling $31,696 comprised 81 percent of the undetermined total.

their eligibility. The States' agencies must promptly redetermine eligibility when they receive information of changes in beneficiaries' circumstances that may affect their eligibility.

Each State agency has specific criteria defining eligibility and residency.[5] The District's State Plan Attachment 2.6-A states that individuals are eligible for Medicaid if they are residents of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address. District policy generally allows for no known overlap with another State's eligibility period for new residents. The Code of Maryland, (COMAR) 10.09.24.05 states that in order to be eligible for Medicaid, a person shall be a resident of Maryland. Maryland allows overlap with another State's Medicaid eligibility during the month in which a beneficiary moves to the State.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the District's assistance application informs beneficiaries of the responsibility to inform the agency within 10 days of any change that may affect their benefits or the amount of their benefits.

Beneficiaries With Concurrent Eligibility

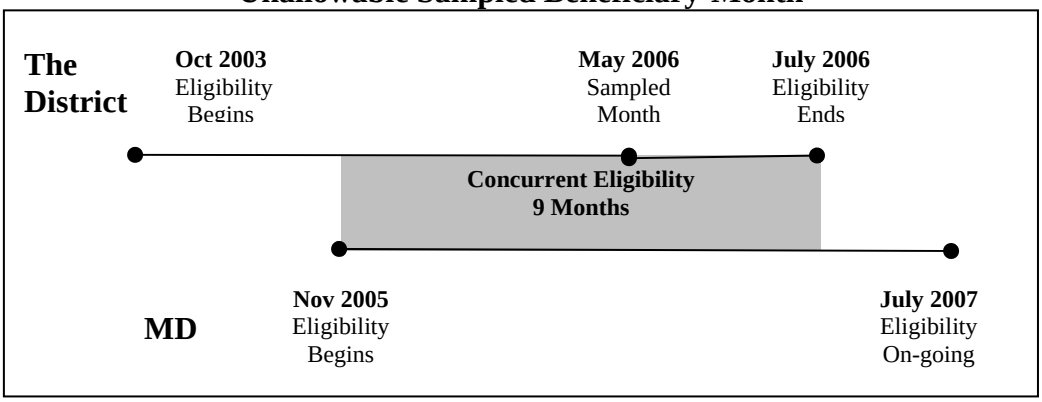
From a random sample of 100 beneficiary-months with Medicaid payments totaling $96,250, the State agency paid $18,855 for 44 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in the District.

Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer residents of the District during the 44 sampled beneficiary-months.

In one example, a beneficiary, associated with a payment for one of the unallowable sampled beneficiary-months, moved from the District and established residency in Maryland. The District beneficiary eligibility period began October 29, 2003, and continued until July 31, 2006. The Maryland eligibility period started November 1, 2005, and the beneficiary was still eligible for benefits at the end of our fieldwork.

[5]The State agency placed some of its adoption and nursing care beneficiaries in our sample into neighboring states. In each of these situations, the State agency was responsible for the beneficiary's Medicaid services, despite the beneficiary's residence in another State.

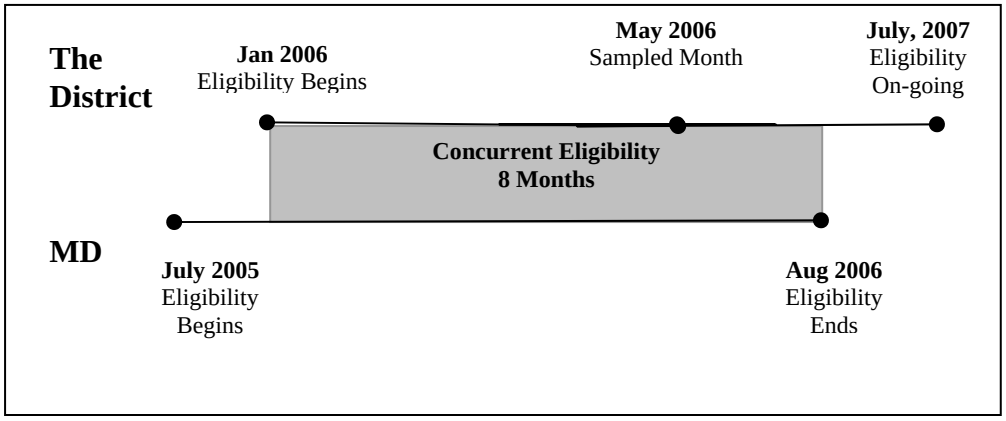
Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month



Maryland Medicaid records document that the beneficiary's family moved and established residency in Maryland prior to the sample beneficiary-month (May 2006). As a result, the State agency should not have made payments for the sampled beneficiary-month.

In contrast, a different beneficiary, associated with a payment for a sampled beneficiary-month, moved from Maryland and established residency in the District. The Maryland eligibility period began July 1, 2005, and continued until August 31, 2006. The District eligibility period began in January 1, 2006, and was on-going at the end of our fieldwork.

Exhibit 2. Period of Concurrent Eligibility for an Allowable Sampled Beneficiary-Month



The District Medicaid records indicated that the beneficiary moved from Maryland and established residency in the District in January 2006. The beneficiary provided the State agency with verification of the beneficiary's residency. Because the beneficiary was a District resident, the State agency appropriately made the Medicaid payments on behalf of the beneficiary for the sampled beneficiary-month (May 2006).

PAYMENTS ON BEHALF OF BENEFICIARIES WHOSE RESIDENCE COULD NOT BE DETERMINED

Pursuant to 42 CFR § 435.916, the States' agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. Each State agency has specific criteria defining eligibility and residency. The District's State Plan Attachment 2.6-A states that individuals are eligible for Medicaid if they are residents of the State, regardless of whether or not the individual maintains their residence permanently or maintains it at a fixed address. Similarly, COMAR 10.09.24.05 states that in order to be eligible for Medicaid a person shall be a resident of Maryland.

Based on our review of information in the State agency and Maryland Medicaid agency files, we could not determine the residency status of 15 sampled beneficiaries, identified as residents eligible for Medicaid services in both the District and Maryland:

- The State agency paid $37,362 for services provided to seven Supplemental Security Income beneficiaries based on notification received from the Social Security Administration. Neither the State agency nor the Maryland Medicaid agency knew when, or if, the beneficiary moved to the other State.

- The State agency paid $1,358 for services provided to five beneficiaries whose files lack any evidence to support residency status.

- The State agency paid $269 for services provided to two children claimed as residents by relatives in both States, and $107 for services provided to one child claimed as a resident by relatives in one State and the other State's Adoption agency.

In total, the State agency made payments totaling $39,096 for these 15 sampled beneficiaries. We estimate that the State agency could save a maximum of $3,944,006 (Federal share $2,760,805) if it determined the State of residence for all beneficiaries.

INSUFFICIENT SHARING OF ELIGIBILITY DATA AND INSUFFICIENT RESIDENCE VERIFICATION

The payments were made for services provided to beneficiaries who should not have been Medicaid eligible because the State agency and the Maryland Medicaid agency did not share all available Medicaid eligibility information, and did not verify the addresses of Medicaid beneficiaries who received Supplemental Security Income or who were children.

RECOMMENDATIONS

We recommend that the State agency work with the Maryland Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status, and

- reducing the amount of payments, estimated to be $1,902,080 ($1,331,456 Federal share), made on behalf of beneficiaries residing in Maryland.

We also recommend the State agency:

- determine the place of residence associated with beneficiaries who received services totaling $3,944,006 (Federal share $2,760,805), but whose residency could not be established, and

- verify addresses of all beneficiaries including those on Supplemental Security Income and children.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency advised us of actions it was taking to implement our recommendations. Regarding our first recommendation, the State agency said that it will amend its on-line data exchange agreement with Maryland to increase the number of users in the Maryland system. It will work closely with the Maryland eligibility agency to reduce the amount of payments made on behalf of beneficiaries residing in Maryland.

Regarding our second recommendation, the State agency stated that it was in the process of sending notices to all customers whose residency could not be verified and to those who have been identified as living in Maryland. The State agency also said that it will revise its standard operating procedures to include verification of residence for cases accreted to its system. This will assist in determining residences for beneficiaries who received services in the District.

We included the State Agency response as Appendix B.

APPENDIXES

SAMPLING METHODOLOGY

UNIVERSE

The universe included beneficiary-months for services provided to Medicaid beneficiaries with concurrent eligibility in the District and Maryland during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 10,088 beneficiary-months totaling $10,078,439 in Medicaid payments for services provided to beneficiaries in the District.

SAMPLE DESIGN

We used a statistical random sample for this review. We used the Office of Inspector General, Office of Audit Services' statistical sampling software RATS-STATS to select the random sample.

RESULTS OF SAMPLE

The results of our review are as follows:

ERRORS

Number of Beneficiary-Months	Sample Size	Value of Sample	Number of Errors	Value of Errors
10,088	100	$96,250	44	$18,855

Based on the errors found in the sample data, the point estimate is $1,902,080 with a lower limit at the 90% confidence level of $912,232. The precision of the 90% confidence interval is plus or minus $989,848 or 52.04%.

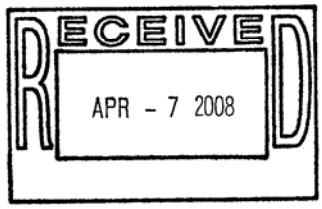
UNDETERMINED

Number of Beneficiary-Months	Sample Size	Value of Sample	Number of Undetermined	Value of Undetermined
10,088	100	$96,250	15	$39,096

Based on the undetermined residences found in the sample data, the point estimate is $3,944,006 with a lower limit at the 90% confidence level of $9,421. The precision of the 90% confidence interval is plus or minus $3,934,585 or 99.76%.

STATE AGENCY RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration



Office of the Senior Deputy Director

March 27, 2008

Mr. Stephen Virbitsky
Regional Inspector General
Office of the Inspector General
Office of Audit Services, Region III
Department of Health and Human Services
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 191106-3499

RE: **Report Number A-03-07-00214 - Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in DC & MD for 07/01/05 through 06/30/06**

Dear Mr. Virbitsky:

I am writing in response to the above referenced report. This letter responds to your findings on determining eligibility for Medicaid eligible individuals residing in Maryland and receiving benefits in the District of Columbia (DC).

The agency responsible for determining Medicaid eligibility in DC is the Income Maintenance Administration (IMA), which is part of the Department of Human Services (DHS). As such, the response to your findings has been prepared by IMA but is being forwarded to you by the Medicaid agency, the Medical Assistance Administration (MAA).

Based on the recommendations in your findings, IMA has presented the following comments with respect to each one:

Recommendation 1: That the State Agency work with the Maryland Medicaid agency to share available Medicaid eligibility information for use in:

- Determining accurate beneficiary eligibility status, and
- Reducing the amount of payments, estimated to be $1,902,080 ($1,331,456 federal share), made on behalf of beneficiaries residing in Maryland.

Response to Recommendation 1: DHS/IMA has an existing on-line data exchange agreement with Maryland. To facilitate timely and accurate determination of eligibility, the District has

STATE AGENCY RESPONSE

initiated an amended agreement to increase the number of District users in the Maryland system.

IMA will work closely with the Maryland eligibility agency to reduce the amount of payments made on behalf beneficiaries residing in Maryland.

Recommendation 2: Determine the place of residence associated with beneficiaries who received services totaling $3,944,006 (federal share $2,760,805), but whose residency could not be established, and verify address of all beneficiaries including those on Supplemental Security Income and children.

Response to Recommendation 2: IMA is in the process of sending notices to all customers whose residency could not be verified and to those who have been identified as living in Maryland. We will also revise our standard operating procedures to include verification of residence for cases accreted to our system. This process will assist IMA in determining the place of residence associated with beneficiaries who received the referenced services.

If additional information is needed, please Sharon Cooper-Deloatch from IMA. Her contact information is as follows:

Sharon Cooper-Deloatch
Administrator
DHS/IMA
645 H Street, NE
Washington, DC 20002
Sharon.Cooper-Deloatch@dc.gov
(202) 698-3900 Office
(202) 724-2041 Fax

Sincerely,

Robert T. Maruca
Senior Deputy Director

cc: Carlos Cano, MD, DOH
Julie Hudman, Office of the City Administrator
Sharon Cooper-Deloatch, IMA