



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

REGION V
OFFICE OF
INSPECTOR GENERAL

April 14, 2008

Report Number: A-05-07-00058

Sandra Shewry, Director
California Department of Health Care Services
MS 0000
P.O. Box 997413
Sacramento, California 95899-7413

Dear Ms. Shewry:

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 California and Arizona for July 1, 2005, Through June 30, 2006." We will forward a copy of this report to the HHS action official noted below for review and any action deemed necessary.

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

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to contact Mike Barton, Audit Manager, at (614) 469-2543 or through e-mail at Mike.Barton@oig.hhs.gov. Please refer to report number A-05-07-00058 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Marc Gustafson".

Marc Gustafson
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
233 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
CALIFORNIA AND ARIZONA FOR
JULY 1, 2005, THROUGH
JUNE 30, 2006**

**CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES**



Daniel R. Levinson
Inspector General

April 2008
A-05-07-00058

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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 the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid eligibility in each State is 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 California Department of Health Care Services (State agency) paid approximately \$2.7 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in California and Arizona.

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 in California due to their eligibility in Arizona.

SUMMARY OF FINDINGS

The State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible in California due to their eligibility in Arizona. The Medicaid payments were made on behalf of these beneficiaries because the State agency and Arizona's Medicaid agency did not share all available Medicaid eligibility information. As a result, for the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$154,470 (\$77,235 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible to receive Medicaid benefits.

RECOMMENDATIONS

We recommend that the State agency work with the Arizona 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 \$154,470 (\$77,235 Federal share), made on behalf of beneficiaries residing in Arizona.

STATE AGENCY'S COMMENTS

In its comments on our draft report, the State agency generally agreed with our recommendations. We have included the State agency's comments 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 the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The California Department of Health Care Services (State agency) manages the California Medicaid program.

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 it receives 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 in California due to their eligibility in Arizona.¹

¹A separate report will be issued to the Arizona Health Care Cost Containment System to address payments made on behalf of beneficiaries who should not have been Medicaid-eligible in Arizona due to their eligibility in California.

Scope

For the audit period of July 1, 2005, through June 30, 2006, the State agency paid approximately \$2.7 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in California and Arizona. From the universe of 3,837 beneficiary-months,² we selected a random sample of 100 beneficiary-months with payments totaling \$156,230.

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 California and enrolled in the Arizona Medicaid program.

We performed our fieldwork at county Medicaid offices in California and at the State Medicaid office in Phoenix, Arizona from June 2007 through January 2008.

Methodology

To accomplish our audit objective, we obtained eligibility data from the California and Arizona Medicaid Management Information Systems (MMIS)³ for the period of July 1, 2005, through June 30, 2006. We matched Social Security numbers and dates of birth from California's and Arizona's MMIS data to identify beneficiaries who were Medicaid-eligible in the two States.

The State agency provided the MMIS payment data files for the beneficiaries with Medicaid eligibility and payments with dates of services that occurred during the 12-month period. For each beneficiary who was Medicaid-eligible and receiving Medicaid benefits in California and Arizona, 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.

We used the Office of Inspector General, Office of Audit Services' statistical sample software RATS-STATS random number generator to select 100 beneficiary-months with paid dates of services in both California and Arizona. In California, the statistical sample included payments totaling \$156,230. 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.

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

³MMIS 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 State agency's MMIS data to verify that the beneficiaries were enrolled in the Medicaid program and that payments were made to providers. In addition, for each of the 100 beneficiary-months, we reviewed the Medicaid application files and other supporting documentation in both States to establish in which State the beneficiary had permanent residency in the sampled month. Based on the sample results, we estimated the total amount of payments that the State agency paid on behalf of beneficiaries who should not have been Medicaid-eligible.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible in California due to their eligibility in Arizona. From a random sample of 100 beneficiary-months with Medicaid payments totaling \$156,230, the State agency paid \$4,026 for 24 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in California. The remaining 76 payments were for services provided to beneficiaries who were eligible to receive the benefits. The payments were made on behalf of ineligible beneficiaries because the State agency and Arizona's Medicaid agency did not share all available Medicaid eligibility information. As a result, for the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$154,470 (\$77,235 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in Arizona.

PAYMENTS FOR ARIZONIA MEDICAID-ELIGIBLE BENEFICIARIES

We estimate that the State agency paid approximately \$154,470 (\$77,235 Federal share) for services provided to beneficiaries in California who should not have been eligible to receive Medicaid benefits due to their eligibility in Arizona.

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 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. California Administrative Code Title 22, § 50167(a)(10) and § 50320.1 state that California residency is a requirement for Medicaid eligibility. Similarly, the Arizona Policy Manual 529.00(a) states that a customer must be a resident of Arizona to be eligible for benefits.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the California Medicaid assistance application informs beneficiaries of the responsibility to inform the agency within 10 days of any change in living arrangements or any other event that would affect their eligibility for assistance.

Beneficiaries With Concurrent Eligibility

From a random sample of 100 beneficiary-months with Medicaid payments totaling \$156,230, the State agency paid \$4,026 for 24 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in California.

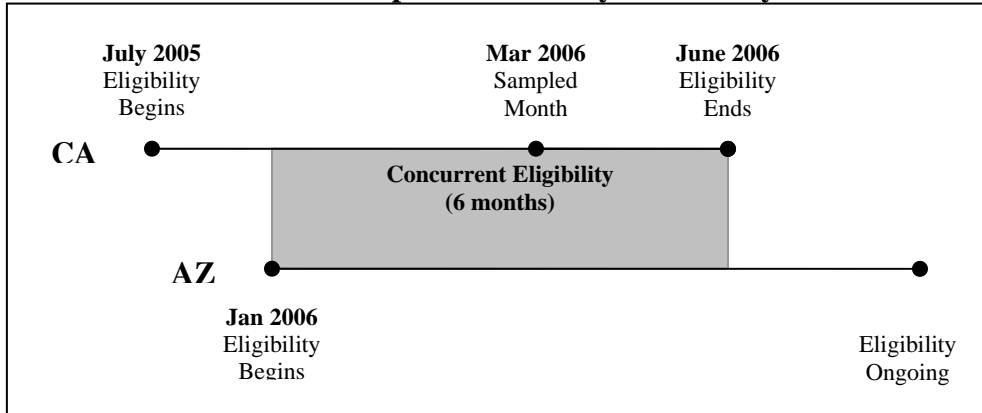
Summary of Sampled Beneficiary-Month Payments

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	76	\$152,204
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	24	4,026
Totals	100	\$156,230

Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer California residents during the 24 beneficiary-months.

In one example, a beneficiary, associated with a payment for one of the sampled beneficiary-months, moved from California and established residency in Arizona. The California eligibility period was July 1, 2005, through June 30, 2006. The Arizona eligibility period started January 1, 2006 and the beneficiary was still eligible for benefits at the end of our fieldwork.

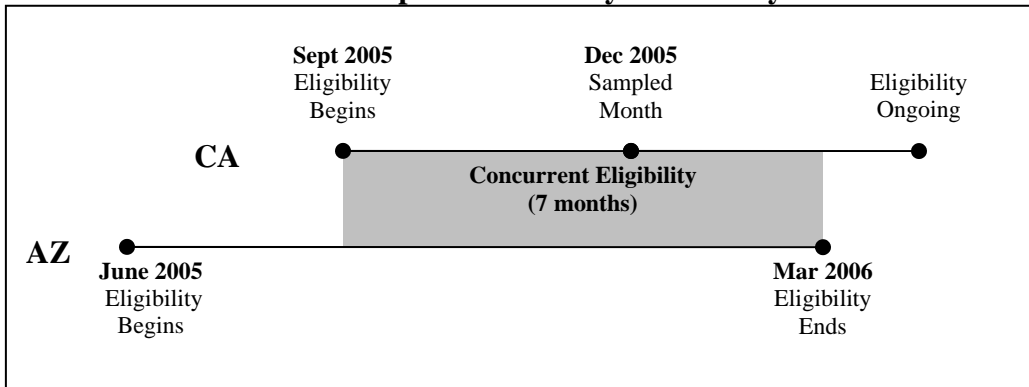
Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month Payment



Arizona Medicaid records document that the beneficiary’s family moved from California and established residency in Arizona in January 2006. As a result, the State agency should not have made the payment for the sampled beneficiary-month (March 2006).

In contrast, a different beneficiary, associated with a payment for a sampled beneficiary-month, moved from Arizona and established residency in California. The California eligibility period started September 1, 2005 and the beneficiary was still eligible for Medicaid benefits at the time of our fieldwork. The Arizona eligibility period was June 1, 2005, through March 30, 2006.

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



The California Medicaid records indicated that the beneficiary moved from Arizona and established residency in California in September 2005. The beneficiary provided the State agency documentation verifying residency. Because the beneficiary was a California resident, the Medicaid payments made by the State agency on behalf of the beneficiary for the sampled beneficiary-month (December 2005) were allowable.

INSUFFICIENT SHARING OF ELIGIBILITY DATA

The payments were made for services provided to beneficiaries who should not have been Medicaid-eligible because the State agency and the Arizona Medicaid agency did not share all available Medicaid eligibility information. The State agency did not promptly identify all changes in beneficiary eligibility and residency.

RECOMMENDATIONS

We recommend that the State agency work with the Arizona 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 \$154,470 (\$77,235 Federal share), made on behalf of beneficiaries residing in Arizona.

STATE AGENCY'S COMMENTS

In its comments on our draft report, the State agency generally agreed with our recommendations. The State agency stated that it will continue to work with counties to coordinate eligibility evaluation efforts with Arizona and other states, when potentially applicable. We have included the State agency's comments as Appendix B.

APPENDIXES

SAMPLING METHODOLOGY

POPULATION

The population included beneficiary-months with services provided to Medicaid beneficiaries with concurrent eligibility in California and Arizona during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 3,837 beneficiary-months with California Medicaid payments totaling \$2,747,462 for services provided to beneficiaries.

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:

Number of Beneficiary-Months	Sample Size	Value of Sample	Number of Errors	Value of Errors
3,837	100	\$156,230	24	\$4,026

Based on the errors found in the sample data, the point estimate is \$154,470 with a lower limit at the 90% confidence level of \$77,383. The precision of the 90% confidence interval is plus or minus \$77,087 or 49.9%.



SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

APR 02 2008

Marc Gustafson
Regional Inspector General for Audit Services
Office of Inspector General
233 North Michigan Avenue
Chicago, IL 60601

Dear Mr. Gustafson:

The California Department of Health Care Services (DHCS) has prepared its response to the Office of Inspector General's (OIG) draft report entitled "Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in California and Arizona for July 1, 2005, Through June 30, 2006" (A-05-07-00058). DHCS appreciates the work performed by the OIG and the opportunity to respond to the draft report.

Please contact Stan Rosenstein, Chief Deputy Director, Health Care Programs, at (916) 440-7400 if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Sandra Shewry".

Sandra Shewry
Director

cc: See next page

Marc Gustafson

Page 2

APR 02 2008

cc: Stan Rosenstein
Chief Deputy Director
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Sacramento, CA 95899-7413

California Department of Health Care Services' Response to the
Office of Inspector General's Draft Report Entitled

*"Medicaid Payments for Services Provided to Beneficiaries With Concurrent
Eligibility in California and Arizona for July 1, 2005, Through June 30, 2006"*

Recommendation:

We recommend that the State agency work with the Arizona 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 \$154,470 (\$77,235 Federal share), made on behalf of beneficiaries residing in Arizona.

Response:

California will continue to work with its counties to coordinate eligibility evaluation efforts with Arizona and other states, when potentially applicable. This audit has demonstrated the superior efforts that our county eligibility workers are currently making in this area. It is important to note the following:

1. Based on the Office of Inspector General's (OIG) projections, \$154,470 (\$77,235 Federal share) was at risk. This represents less than 0.0005 percent of the State's \$36 billion in annual Medi-Cal expenditures.
2. The auditors determined that potentially 24 beneficiaries who received California benefits actually lived in Arizona. There are two potential problems with this from the California perspective:
 - a. The auditors had access to Arizona case files and automated system documentation that is not normally available to California eligibility workers. Because of this, the eligibility workers could not reasonably be held accountable for this information.
 - b. It is unclear whether the beneficiary's, in the particular cases in question, provided information to California eligibility workers that was inconsistent with California eligibility.

Because of these factors, the OIG projections of at risk funds are probably excessive.

California is very proud of its efforts in this review area. DHCS is in the process of discussing these findings with county staff and will continue to strive for excellence in this area.