



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-03-07-00215

John M. Colmers  
Secretary  
Department of Health and Mental Hygiene  
201 West Preston Avenue  
Baltimore, Maryland 21201

Dear Mr. Colmers:

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 Maryland and the District of Columbia 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.

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 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](mailto:Gene.Berti@oig.hhs.gov). Please refer to report number A-03-07-00215 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  
MARYLAND AND THE DISTRICT OF  
COLUMBIA FOR JULY 1, 2005,  
THROUGH JUNE 30, 2006**

**MARYLAND DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE**



Daniel R. Levinson  
Inspector General

April 2008  
A-03-07-00215

# *Office of Inspector General*

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at H<http://oig.hhs.gov>

Pursuant to the principles of the Freedom of Information Act, 5U.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 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 Maryland Department of Health and Mental Hygiene (State agency) paid approximately \$6.2 million for services provided to beneficiaries who were Medicaid eligible and receiving benefits in Maryland and the District of Columbia (the District). During the audit period, the District paid approximately \$10 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 the District.

### **FINDINGS**

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

- \$2,022,127 (Federal share \$1,011,064) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in the District and
- \$346,784 (Federal share \$173,392) for Medicaid services provided to beneficiaries whose residence could not be determined from the information in the State agency's and the District's Medicaid agency case files.

The Medicaid payments were made on behalf of these beneficiaries because the State agency and the District'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 District 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 \$2,022,127 (\$1,011,064 Federal share), made on behalf of beneficiaries residing in the District.

We also recommend that the State agency:

- determine the place of residence associated with beneficiaries who received services totaling \$346,784 (Federal Share \$173,392), but whose residency could not be established and
- verify addresses of all beneficiaries.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its comments on our draft report, the State agency concurred with our first three recommendations, but did not concur with our estimated savings. The State agency also said that it had determined one of the 15 sampled cases in our second finding was a duplicate. The State agency did not concur with our final recommendation that it verify addresses for those beneficiaries who receive SSI but agreed to work with the District to automate the exchange of information more quickly.

The State agency did not provide specific cases in our sample that would indicate our analysis is in error. Therefore, we continue to support our estimates of potential savings. Our random sample did include two different months of payments for the same beneficiary. Because our sample consisted of beneficiary months, not unique beneficiaries, this did not result in a duplicate sample item. The State agency's comments are included as Appendix B.

**TABLE OF CONTENTS**

|  | <u>Page</u> |
|--|-------------|
| <b>INTRODUCTION</b> .....                            | 1           |
| <b>BACKGROUND</b> .....                              | 1           |
| <b>OBJECTIVE, SCOPE AND METHODOLOGY</b> .....        | 2           |
| Objective.....                                       | 2           |
| Scope.....   | 2           |
| Methodology.....                                     | 2           |
| <b>FINDINGS AND RECOMMENDATIONS</b> .....            | 3           |
| <b>PAYMENTS FOR THE DISTRICT</b>                     |             |
| <b>MEDICAID-ELIGIBLE BENEFICIARIES</b> .....         | 4           |
| Federal and State Requirements.....                  | 4           |
| Beneficiaries With Concurrent Eligibility .....      | 5           |
| <b>PAYMENTS ON BEHALF OF BENEFICIARIES</b>           |             |
| <b>WHOSE RESIDENCE COULD NOT BE DETERMINED</b> ..... | 7           |
| <b>INSUFFICIENT SHARING OF ELIGIBILITY DATA</b>      |             |
| <b>AND INSUFFICIENT RESIDENCE VERIFICATION</b> ..... | 7           |
| <b>RECOMMENDATIONS</b> .....                         | 8           |
| <b>STATE AGENCY COMMENTS</b> .....                   | 8           |
| <b>OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....    | 8           |
| <b>APPENDIXES</b>                                    |             |
| A - SAMPLING METHODOLOGY                             |             |
| B – STATE AGENCY COMMENTS                            |             |



## 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 Maryland Department of Health and Mental Hygiene (State agency) manages the Maryland 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 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 the District of Columbia (the District).<sup>1</sup>

### **Scope**

For the audit period of July 1, 2005, through June 30, 2006, the State agency paid approximately \$6.2 million for services provided to beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in Maryland and the District. From the universe of 10,088 beneficiary-months,<sup>2</sup> we selected a random sample of 100 beneficiary-months with payments totaling \$35,929.

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 Maryland and enrolled in the District's Medicaid program.

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

### **Methodology**

To accomplish our audit objective we obtained eligibility data from the Maryland and the District Medicaid Management Information Systems (MMIS)<sup>3</sup> for the period of July 1, 2005, through June 30, 2006. We matched the Social Security numbers, beneficiary names, and dates of birth from Maryland and the District 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 Maryland and the District, we combined all dates of service for a single beneficiary-month and

---

<sup>1</sup>A separate report has been issued to the District Department of Health to address payments made on behalf of beneficiaries who should not have been Medicaid eligible in the District due to their Medicaid eligibility in Maryland.

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

<sup>3</sup>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.

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 Service's statistical sample software RATS-STATS' random number generator to select 100 random beneficiary-months with paid dates of services in both Maryland and the District. In Maryland, the statistical sample included \$22,424 in managed care payments and \$13,505 in fee-for-service payments, for a total of \$35,929. 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 also determined whether any sampled beneficiaries were eligible for Medicaid in both States during the sampled beneficiary-month.

We sought assistance from both 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 sampled 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:

- \$2,022,127 (Federal share \$1,011,064) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in the District and
- \$346,784 (Federal share \$173,392) for Medicaid services provided to beneficiaries whose residence could not be determined from the information in the State agency's or the District 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**

| <b>Type of Payment</b>   | <b>Number</b> | <b>Amount Paid</b> |
|--|---------------|--------------------|
| Unallowable<br>(Beneficiaries Who<br>Should Not Have<br>Been Eligible) | 41            | \$20,045           |
| Undetermined   | 15            | 3,438              |
| Allowable<br>(Eligible<br>Beneficiaries)                               | 44            | 12,446             |
| <b>Totals</b>  | <b>100</b>    | <b>\$35,929</b>    |

Payments were made by both States on behalf of beneficiaries who should not have been Medicaid eligible in Maryland and whose residence could not be determined because the State agency and the District 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, 26 of the unallowable payments and 8 of the undetermined payments were monthly capitation payments made by both States. Additionally, 12 unallowable payments and 5 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 THE DISTRICT MEDICAID-ELIGIBLE BENEFICIARIES**

We estimate that the State agency paid approximately \$2,022,127 (\$1,011,064 Federal share) for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits due to their Medicaid eligibility in the District.

**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.<sup>4</sup> The Code of Maryland Regulations, (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 period during the month that the beneficiary moves to the State. 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 the individual maintains the residence permanently or maintains it at a fixed address. Generally the District policy allows for no known overlap with another States Medicaid eligibility period for new residents.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the Maryland Medicaid application informs the beneficiaries/beneficiary representatives of their responsibility to report all changes within 10 working days.

### **Beneficiaries With Concurrent Eligibility**

From a random sample of 100 beneficiary-months with Medicaid payments totaling \$35,929, the State agency paid \$20,045 for 41 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Maryland.

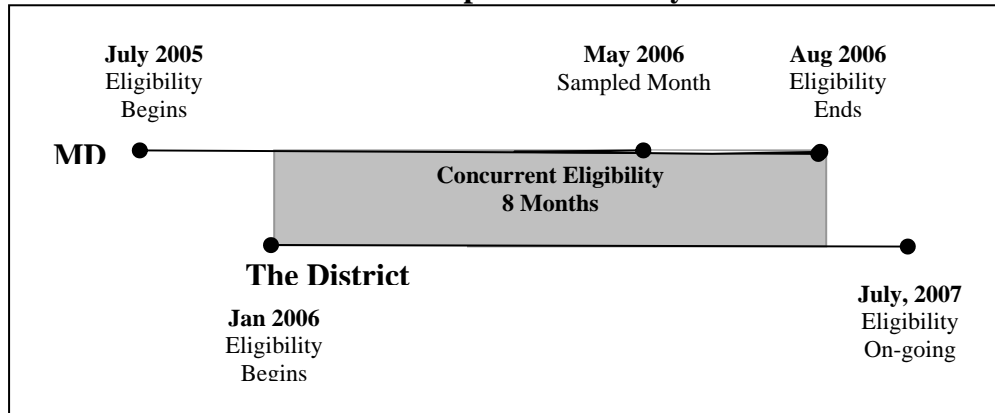
Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer Maryland residents during the 41 beneficiary-months.

In one example, a beneficiary, associated with a payment for one of the unallowable sampled beneficiary-months, 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 started January 1, 2006 and the beneficiary was still eligible for benefits at the end of our fieldwork.

---

<sup>4</sup>The District placed some of its adoption and nursing care beneficiaries in our sample in Maryland. In each of these situations the District was responsible for the beneficiary's Medicaid services, despite the beneficiary's residence in another State.

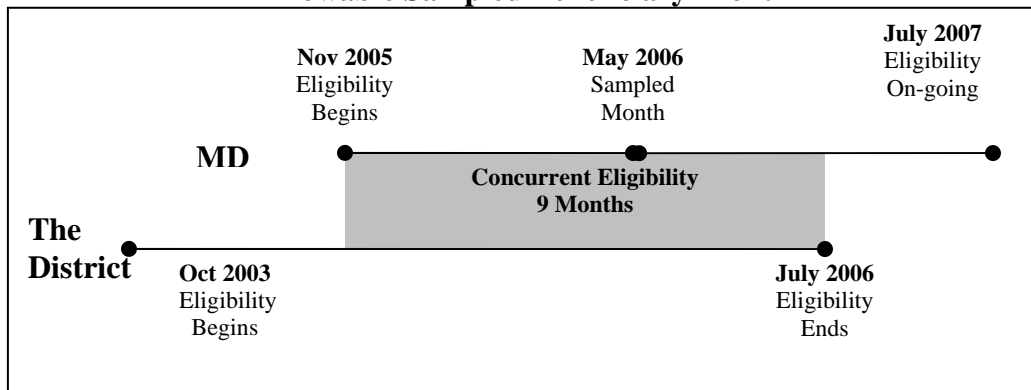
**Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month**



The District Medicaid records document that the beneficiary’s family moved and established residency in the District prior to the sampled 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 the District and established residency in Maryland. The District eligibility period began October 1, 2003, and continued until July 31, 2006. The Maryland eligibility period began November 1, 2005, and was on-going at the end of our fieldwork.

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



The Maryland Medicaid records indicated that the beneficiary’s family moved from the District in November 2005 and established residency in Maryland. The beneficiary’s mother provided the State agency with verification of the beneficiary’s residency. Because the beneficiary was a Maryland 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 COMAR 10.09.24.05 states that in order to be eligible for Medicaid a person shall be a resident of Maryland. Similarly, 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.

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

- The State agency paid \$2,034 for services provided to seven Supplemental Security Income beneficiaries based on notification received from the Social Security Administration. Neither the State agency nor the District Medicaid agency knew when, or if, the beneficiary moved to the other State.
- The State agency paid \$1,077 for services provided to five beneficiaries whose files lack any evidence to support residency status.
- The State agency paid \$149 for services provided to two children claimed as residents by relatives in both States, and \$178 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 \$3,438 for these 15 sampled beneficiaries. We estimate that the State agency could save a maximum of \$346,784 (Federal share \$173,392) 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 District 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 District 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 \$2,022,127 (\$1,011,064 Federal share), made on behalf of beneficiaries residing in the District.

We also recommend the State agency:

- determine the place of residence associated with beneficiaries who received services totaling \$346,784 (Federal Share \$173,392), but whose residency could not be established and
- verify addresses of all beneficiaries.

## **STATE AGENCY COMMENTS**

In its comments on our draft report, the State agency concurred with our first three recommendations, but did not concur with our estimated savings. The State agency cited circumstances in which regulations would mandate payment on behalf of non-resident individuals. The State agency also said that it had determined one of the 15 sampled cases in our second finding was a duplicate. The State agency did not concur with our final recommendation that it verify addresses for those beneficiaries who receive SSI. By agreement, the Social Security Administration provides the information for some of these beneficiaries. However, the State agency agreed to work with the District to automate the exchange of information more quickly. The State agency's comments are included as Appendix B.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

In our review we analyzed the sample based on the regulations, described in the Background of this report, that establish the circumstances under which a State agency must provide Medicaid services. For example, regulations require that the State provide a 10 days notice before terminating benefits of an individual it has found ineligible (42 CFR § 431.211). However, no notice is required if the State agency determines that the individual has been accepted for Medicaid services in another State (42 CFR § 431.213(e)). The State agency did not provide specific cases in our sample that would indicate our analysis is in error. Therefore, we continue to support our estimates of potential savings. Our random sample did include two different months of payments for the same beneficiary. Because our sample consisted of beneficiary months, not unique beneficiaries, this did not result in a duplicate sample item.



# **APPENDIXES**

## SAMPLING METHODOLOGY

### UNIVERSE

The universe included beneficiary-months for services provided to Medicaid beneficiaries with concurrent eligibility in Maryland and the District during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 10,088 beneficiary-months totaling \$6,183,056 in Medicaid payments for services provided to beneficiaries in Maryland.

### 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

| <b>Number of<br/>Beneficiary-Months</b> | <b>Sample<br/>Size</b> | <b>Value of<br/>Sample</b> | <b>Number of<br/>Errors</b> | <b>Value of<br/>Errors</b> |
|---|------------------------|----------------------------|-----------------------------|----------------------------|
| 10,088                                  | 100                    | \$35,929                   | 41                          | \$20,045                   |

Based on the errors found in the sample data, the point estimate is \$2,022,127 with a lower limit at the 90 percent confidence level of \$1,047,182. The precision of the 90 percent confidence interval is plus or minus \$974,946 or 48.21 percent.

#### UNDETERMINED

| <b>Number of<br/>Beneficiary-Months</b> | <b>Sample<br/>Size</b> | <b>Value of<br/>Sample</b> | <b>Number of<br/>Undetermined</b> | <b>Value of<br/>Undetermined</b> |
|---|------------------------|----------------------------|-----------------------------------|----------------------------------|
| 10,088                                  | 100                    | \$35,929                   | 15                                | \$3,438                          |

Based on the undetermined residences found in the sample data, the point estimate is \$346,784 with a lower limit at the 90 percent confidence level of \$175,865. The precision of the 90 percent confidence interval is plus or minus \$170,919 or 49.29 percent.

STATE AGENCY COMMENTS

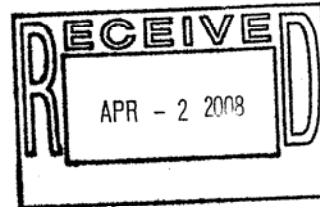


STATE OF MARYLAND  
**DHMH**

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

April 1, 2008



Mr. Stephen Virbitsky  
Regional Inspector General for Audit Services  
U.S. Department of Health and 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

RE: Draft Report # A-03-7-00215

Dear Mr. Virbitsky:

We have reviewed the draft report "Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Maryland and the District of Columbia for July 1, 2005 through June 30, 2006" and the recommendations made by your office. We appreciate having the opportunity to comment upon the draft.

The stated objective of the review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been made Medicaid-eligible due to their eligibility in the District of Columbia. The OIG reviewed a randomly selected sample of beneficiary months, estimated the total amount of payments that the State agency made on behalf of beneficiaries who should not have been Medicaid-eligible and provide recommendations. Those recommendations and our responses are provided as follows:

**Recommendation:** That the State agency work with the District 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 \$2,022,127 (\$1,011,064 Federal share), made on behalf of beneficiaries residing in the District.

We concur with the recommendation that we work with the District Medicaid agency to share information. The Office of Eligibility Services will work closely with the District Medicaid agency to initiate a discussion.

## STATE AGENCY RESPONSE

Mr. Stephen Virbitsky  
April 1, 2008  
Page Two

We do not concur with the OIG's estimate of the amount of payments that can be reduced. Federal regulations, including those cited below, mandate or permit payments on behalf of individuals who are absent from or non-residents of a state. Per 42 CFR 431.52 and 435.403, the State must make Medicaid payments on behalf of individuals who are absent from or no longer residents of the State. Per 42 CFR 435.914(a), the State must make the individual eligible up to three months prior to the month of application if the individual met the eligibility requirements during that time and received services that would have been covered under the Medicaid plan. Per 42 CFR 435.914(b), for individuals who are not retroactively eligible, the State may make eligibility effective on the first day of the month of application. Per 42 CFR 435.930, the State must continue to provide Medicaid to recipients until they are determined ineligible. Per 42 CFR 431.211, the State agency cannot terminate an individual who it has found ineligible until it provides at least 10 days notice of such action. Finally, per 42 CFR 435.145 and 435.909, the State must automatically provide Medicaid to individuals who have been determined eligible for certain programs, such as SSI.

The State believes that some payments cited were allowable, even mandated, under Federal policy. However, as stated above, the State will contact the District to review and clarify policies and processes for individuals who move between the two states.

**Recommendation:** That the State agency determine the place of residence associated with beneficiaries who received services totaling \$346,784 (Federal share \$173,392) whose residence could not be established and verify addresses of all beneficiaries including those on Supplemental Security Income (SSI) and children.

We concur with the recommendation to determine the place of residence associated with certain beneficiaries and have initiated research on the 15 sampled cases cited. To date, we have determined that one of the 15 is a duplicate.

Regarding the recommendation to verify the addresses of beneficiaries receiving SSI, Maryland has a section 1634 agreement with the Social Security Administration (SSA) whereby SSA determines Medicaid eligibility when determining the SSI eligibility of an applicant. Per Federal regulations at 42 CFR 435.120 and 435.909, the State must automatically provide Medicaid, without requiring a separate application, to individuals who receive or who are deemed to be receiving SSI. Therefore, Maryland relies on the information, including address, supplied by SSA to add or delete a case from Medicaid. We can explore with our partner the Department of Human Resources steps to automate the exchange of information more quickly.

**STATE AGENCY RESPONSE**

Mr. Stephen Virbitsky  
April 1, 2008  
Page Three

Maryland does verify the address of Medicaid applicants, including children, who are not automatically entitled to Medicaid due to their eligibility for other programs.

Again, thank you for the opportunity to respond to the draft audit findings. Please direct any questions to Patricia Nowakowski, Director, Office of Eligibility Services, at (410) 767-8180.

Sincerely,



John M. Colmers  
Secretary

cc: John G. Folkemer  
Cheryl Camillo  
Tom Russell  
Patricia Nowakowski  
Kevin McGuire, DHR