



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

REGION V
OFFICE OF
INSPECTOR GENERAL

January 25, 2008

Report Number: A-05-06-00070

Jeffrey M. Wells
Director, Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
Room W-461
402 West Washington Street
Indianapolis, Indiana 46207-7083

Dear Mr. Wells:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG) final report entitled "Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Indiana and Illinois for July 1, 2005, Through June 30, 2006." We will forward a copy of this report 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 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-05-06-00070 in all correspondence.

Sincerely,

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

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Mr. Jeffrey M. Wells

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
INDIANA AND ILLINOIS FOR
JULY 1, 2005, THROUGH
JUNE 30, 2006**

**INDIANA FAMILY AND SOCIAL
SERVICES ADMINISTRATION**



Daniel R. Levinson
Inspector General

January 2008
A-05-06-00070

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 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 Indiana Family and Social Services Administration (State agency) paid approximately \$1.8 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Indiana and Illinois.

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 Illinois.

SUMMARY OF FINDINGS

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$236,578 (\$148,936 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible because of their Medicaid eligibility in Illinois. The Medicaid payments were made on behalf of these beneficiaries because the State agency and Illinois' Medicaid agency did not share all available Medicaid eligibility information.

RECOMMENDATIONS

We recommend that the State agency work with the Illinois 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 \$236,578 (\$148,936 Federal share), made on behalf of beneficiaries residing in Illinois.

STATE AGENCY'S COMMENTS

In written comments on our draft report, the State agency stated that it takes proactive approaches beyond the routine eligibility process to reduce the amount of payments made on behalf of ineligible beneficiaries. The State agency signed a contract with an outside vendor to improve the eligibility application and management processes and believes this action will significantly reduce case file errors for all changes, including residency changes. The State agency also stated that it required the contractor to evaluate process documentation to ensure it fully supports residency change actions by making contact with other States, including Illinois. The State agency's comments are included 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 Indiana Family and Social Services Administration (State agency) manages the Indiana 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 due to their eligibility in Illinois.¹

¹A separate report will be issued to the Illinois Department of Healthcare and Family Services to address payments made on behalf of beneficiaries who should not have been Medicaid-eligible in Illinois due to their eligibility in Indiana.

Scope

For the audit period of July 1, 2005, through June 30, 2006, the State agency paid approximately \$1.8 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Indiana and Illinois. From the universe of 5,241 beneficiary-months,² we selected a random sample of 100 beneficiary-months with payments totaling \$29,241.

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 Indiana and enrolled in the Illinois Medicaid program.

We performed our fieldwork at the State agencies' offices in Indianapolis, Indiana and Springfield, Illinois from November 2006 through June 2007.

Methodology

To accomplish our audit objective, we obtained eligibility data from the Indiana and Illinois 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 Indiana's and Illinois' 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 Indiana and Illinois, 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 Service's statistical sample software RATS-STATS' random number generator to select 100 beneficiary-months with paid dates of services in both Indiana and Illinois. In Indiana, the statistical sample included payments totaling \$29,241. The selected beneficiary-months were for services provided to beneficiaries with Medicaid eligibility in both States during the same month. See Appendix A 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 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 July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$236,578 (\$148,936 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in Illinois. From a random sample of 100 beneficiary-months with Medicaid payments totaling \$29,241 the State agency paid \$4,514 for 29 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Indiana. The remaining 71 payments were for services provided to beneficiaries who were eligible to receive the benefits. The payments were made on behalf of beneficiaries who should not have been eligible because the State agency and Illinois' Medicaid agency did not share all available Medicaid eligibility information.

PAYMENTS FOR ILLINOIS MEDICAID-ELIGIBLE BENEFICIARIES

We estimate that the State agency paid approximately \$236,578 (\$148,936 Federal share) for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits due to their eligibility in Illinois.

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. The Indiana Code 12-15-4-4(2) states that Medicaid should be granted to eligible applicants who, among other requirements, are residents of Indiana. Similarly, the Illinois Administrative Code Section 120.311 states that, in order to be eligible for Medicaid, an individual must be a resident of Illinois.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the Indiana 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 \$29,241 the State agency paid \$4,514 for 29 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Indiana.

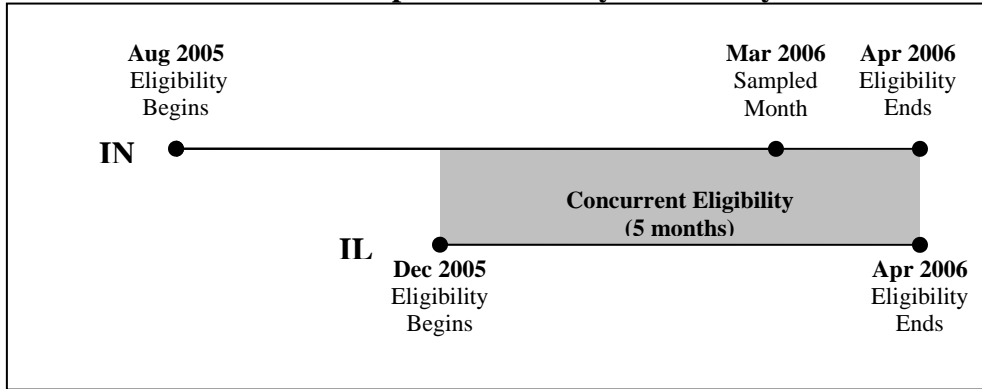
Summary of Sampled Beneficiary-Month Payments

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	71	\$24,727
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	29	4,514
Totals	100	\$29,241

Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer Indiana residents during the 29 beneficiary-months.

In one example, a beneficiary, associated with a payment for one of the sampled beneficiary-months, moved from Indiana and established residency in Illinois. The Indiana eligibility period was August 1, 2005, through April 30, 2006. The Illinois eligibility period was December 1, 2005, through April 30, 2006.

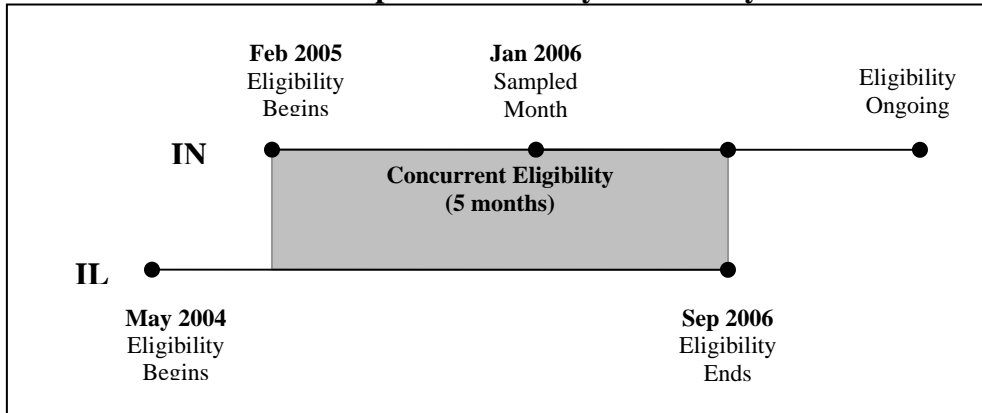
Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month Payment



Illinois Medicaid records indicated that the beneficiary moved from Indiana and established residency in Illinois in October 2005. However, Indiana Medicaid records did not contain any information that the beneficiary notified the State agency of the change in residency. Because the beneficiary was not an Indiana resident, 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 Illinois and established residency in Indiana. The Indiana eligibility period started February 1, 2005 and the beneficiary was still eligible for Medicaid benefits at the time of our fieldwork. The Illinois beneficiary eligibility period was May 1, 2004, through September 31, 2006.

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



Indiana Medicaid records document that the beneficiary's family moved from Illinois and established residency in Indiana prior to the sampled beneficiary-month (January 2006). As a result, the Medicaid payments made by the State agency on behalf of the beneficiary for the sampled beneficiary-month (January 2006) 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 Illinois 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 Illinois 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 \$236,578 (\$148,936 Federal share), made on behalf of beneficiaries residing in Illinois.

STATE AGENCY'S COMMENTS

In written comments on our draft report, the State agency stated that it takes proactive approaches beyond the routine eligibility process to reduce the amount of payments made on behalf of ineligible beneficiaries. The State agency signed a contract with an outside vendor to improve the eligibility application and management processes and believes this action will significantly reduce case file errors for all changes, including residency changes. The State agency also stated that it required the contractor to evaluate process documentation to ensure it fully supports residency change actions by making contact with other States, including Illinois. The State agency's comments are included as Appendix B.

APPENDIXES

SAMPLING METHODOLOGY

POPULATION

The population included beneficiary-months with services provided to Medicaid beneficiaries with concurrent eligibility in Indiana and Illinois during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 5,241 beneficiary-months with Indiana Medicaid payments totaling \$1,787,723 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
5,241	100	\$29,241	29	\$4,514

Based on the errors found in the sample data, the point estimate is \$236,578 with a lower limit at the 90% confidence level of \$160,817. The precision of the 90% confidence interval is plus or minus \$75,761 or 32.02%.



Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

January 18, 2008

Mr. Marc Gustafson
Regional Inspector General for Audit Services
Office of Audit Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Response to Draft Report A-05-06-00070

Dear Mr. Gustafson:

This letter is in response to the draft audit report "Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Indiana and Illinois for July 1, 2005 Through June 30, 2006." The Office of Medicaid Policy and Planning (OMPP) appreciates the opportunity to comment on the recommendation provided by your office.

This audit review considered whether or not the State inappropriately made payments on behalf of members due to the member's residence in another state, specifically Illinois. The State of Indiana's Medicaid program is administered in partnership between the Family and Social Services Administration's Office of Medicaid Policy and Planning (OMPP) and the Division of Family Resources (DFR). The OMPP acts as the Single State Agency and is responsible for the claims payment process, including the Medicaid Management Information System. The OMPP holds a Memorandum of Understanding with DFR to complete the eligibility determinations of potential Medicaid and State Children's Health Insurance Program applicants. DFR is further responsible for the processing of reported changes, completing timely redeterminations and the termination of enrollment in the Medicaid program due to ineligibility.

As noted in the audit background, there are several federal regulations that specify when states must provide Medicaid services to eligible state residents and at which point those services may be discontinued. According to 42 CFR § 435.930, services continue to be furnished to all eligible individuals until they are found to be ineligible. As a result, often overlapping months of eligibility occur between a recipient's current and prior state of residence even when each state is accurately following the discontinuance requirements of the program. To be found ineligible due to this non-financial eligibility criteria requires that States are made aware that residency has

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been established in another state. According to federal regulation, the primary indication that the residency requirement has been met occurs when an individual is living in a state with the intention to remain there permanently or for an indefinite period of time. (42 CFR § 433.403 (i)). Therefore, a change in residency must occur prior to state action.

Recipients are required to report changes within ten (10) days of the change. This requirement may be found in the Indiana eligibility Program Policy Manual located in the Continuing Case Processing section 2215.00.00, as well as described in the "Notice Regarding Rights and Responsibilities" signed by applicants of Medicaid. In addition, eligibility segments may extend until the end of the following month due to notice and system process requirements. If a member fails to report a change, yet information is received from another state, including Illinois, that the member has applied there for medical assistance DFR follows proper action procedures. DFR reciprocates this activity and reports to other states when a member has moved to Indiana. If the information is not provided in either circumstance, continued case processing requires that DFR conduct redeterminations of member eligibility at least once every twelve months. Failure by the member to participate in the redetermination of their eligibility results in immediate case closure.

Unfortunately, as the audit report has identified and Indiana is aware, this routine action may be several months after the proper notice should have been received. Therefore, Indiana takes proactive approaches beyond the routine process to reduce the amount of payments made on behalf of ineligible recipients. Indiana does participate in the Public Assistance Reporting Information System (PARIS) developed to share information to verify recipient circumstances. Formally, Indiana began to provide and receive data in 2006 in recognition of the potential to prevent improper payments. This was assigned as a project within DFR and discrepant notices were sent out to members to confirm residency. The results found many data entry errors regarding social security numbers in the files. Much less often there was a case closure due to confirmation that the recipient had left Indiana. As noted by the PARIS project staff themselves, state resources must be spent to "filter" the data to look for the most likely overlapping matches. Currently, this match review activity has been placed on hold due to a significant change in the way that DFR conducts business. A contract has been signed to allow an outside vendor to manage the caseloads previously handled by the local county office staff. The objective of this contract is to improve the system infrastructure that supports the eligibility application and management processes thereby improving the overall handling of cases. Indiana believes that this will significantly reduce case file error for all changes, including the handling of residency changes. Upon transition, DFR will be reviewing all data mining mechanisms, including the PARIS project. DFR will look for the most effective management tools available that may overcome the weaknesses of the PARIS data.

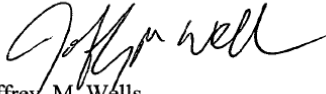
In consideration of the OIG recommendations, DFR has required that the contractor evaluate process documentation to ensure it fully supports residency change actions including making contact with other states, including Illinois. The State Regional Managers have been made aware that this activity should be stressed during training. To particularly reduce concerns with the neighboring state of Illinois, Indiana staff will communicate with Illinois regarding proper change reporting contacts.

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Overall, Indiana considers that the appropriate mechanisms regarding state residency requirements are followed, as supported by the low instances in which overlapping months of eligibility resulted in improper payments. Additional communication and documentation will augment the current processes in place which ensure that the right people are receiving the right services at the right time.

Should your office have additional questions, please feel free to contact Catherine Snider, Program Integrity Manager, at (317) 234-2927.

Sincerely,



Jeffrey M. Wells
Director of Medicaid