



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

REGION V
OFFICE OF
INSPECTOR GENERAL

May 5, 2008

Report Number: A-05-07-00057

Anthony Rodgers
Director
Arizona Health Care Cost Containment System
801 E. Jefferson Street
Phoenix, Arizona 46207-7083

Dear Mr. Rodgers:

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 Arizona and California 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-05-07-00057 in all correspondence.

Sincerely,


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

**ARIZONA HEALTH CARE COST
CONTAINMENT SYSTEM**



Daniel R. Levinson
Inspector General

May 2008
A-05-07-00057

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 Arizona Health Care Cost Containment System (the State agency) paid approximately \$1.2 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Arizona and California.

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 Arizona due to their eligibility in California.

SUMMARY OF FINDINGS

The State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible in Arizona due to their eligibility in California. The Medicaid payments were made on behalf of these beneficiaries because the State agency and California'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 \$500,131 (\$335,477 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 California 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 \$500,131 (\$335,477 Federal share), made on behalf of beneficiaries residing in California.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency acknowledged its obligation to verify an applicant's residency and promptly redetermine eligibility when it receives information that may affect a beneficiary's eligibility. The State agency identified two areas that impact the results that to a large extent are outside its ability to control, and several technical issues that it believes would reduce the amount of the Office of Inspector General reported payments made on behalf of beneficiaries residing in California. The State agency has taken several steps to increase efficiency and allow it to obtain information affecting beneficiaries' eligibility more quickly, including participation in the Public Assistance Reporting Information System program, implementation of a mid-month eligibility begin date, and WEB (internet) access that will allow beneficiaries to update information on-line.

We have reviewed the State agency's comments and maintain that our findings remain valid. The reported payments were made on behalf of beneficiaries who should not have been Medicaid-eligible in Arizona due to their eligibility in California. The sharing of data and other steps noted by the State agency should reduce the amount of payments made on behalf of beneficiaries residing in California.

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 Arizona Health Care Cost Containment System (the State agency) manages the Arizona 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 Arizona due to their eligibility in California.¹

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

Scope

For the audit period of July 1, 2005, through June 30, 2006, the State agency paid approximately \$1.2 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Arizona and California. From the universe of 3,837 beneficiary-months,² we selected a random sample of 100 beneficiary-months with payments totaling \$27,607.

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 Arizona and enrolled in the California Medicaid program.

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

Methodology

To accomplish our audit objective, we obtained eligibility data from the Arizona and California 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 Arizona's and California'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 Arizona and California, 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 RAT-STATS random number generator to select 100 beneficiary-months with paid dates of services in both Arizona and California. In Arizona, the statistical sample included payments totaling \$27,607. 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 the beneficiaries were enrolled in the Medicaid program and that payments were made to providers. In addition, for each

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.

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 Arizona due to their eligibility in California. From a random sample of 100 beneficiary-months with Medicaid payments totaling \$27,607, the State agency paid \$13,034 for 50 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Arizona. The remaining 50 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 California'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 \$500,131 (\$335,477 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in California.

PAYMENTS FOR CALIFORNIA MEDICAID-ELIGIBLE BENEFICIARIES

We estimate that the State agency paid approximately \$500,131 (\$335,477 Federal share) for services provided to beneficiaries in Arizona who should not have been eligible to receive Medicaid benefits due to their eligibility in California.

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

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the Arizona 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 \$27,607 the State agency paid \$13,034 for 50 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Arizona.

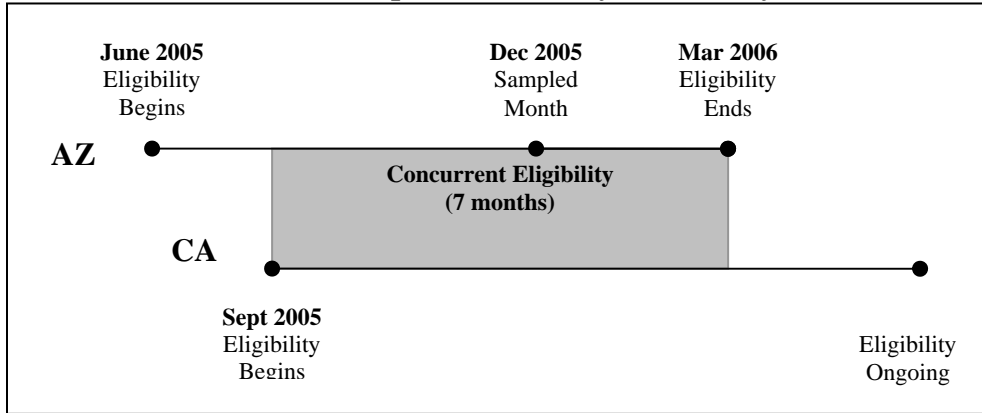
Summary of Sampled Beneficiary-Month Payments

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	50	\$14,573
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	50	13,034
Totals	100	\$27,607

Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer Arizona residents during the 50 beneficiary-months.

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

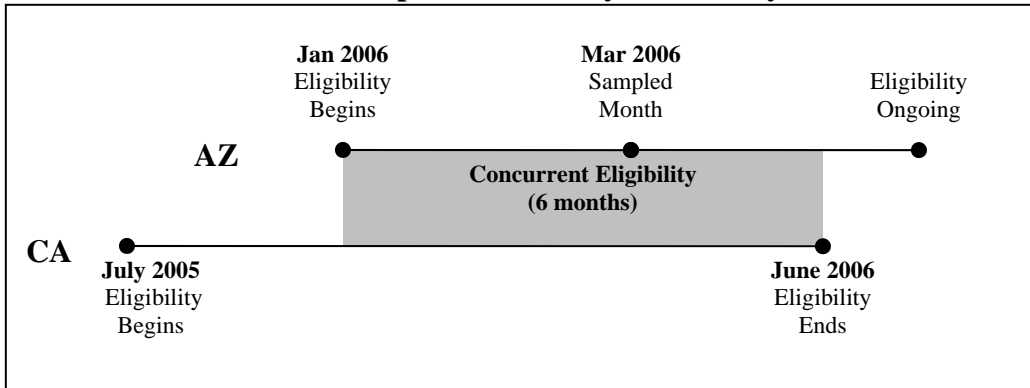
Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month Payment



California Medicaid records document that the beneficiary’s family moved from Arizona and established residency in California in September 2005. As a result, the State agency should not have made the payment for the sampled beneficiary-month (December 2005).

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

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



The Arizona Medicaid records indicated that the beneficiary moved from California and established residency in Arizona in January 2006. The beneficiary provided the State agency documentation verifying residency. Because the beneficiary was an Arizona resident, the Medicaid payments made by the State agency on behalf of the beneficiary for the sampled beneficiary-month (March 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 California 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 California 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 \$500,131 (\$335,477 Federal share), made on behalf of beneficiaries residing in California.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, the State agency acknowledged its obligation to verify an applicant's residency and promptly redetermine eligibility when it receives information that may affect a beneficiary's eligibility. The State agency identified two areas that impact the results that to a large extent are outside its ability to control, and several technical issues that it believes would reduce the amount of the Office of Inspector General (OIG) reported payments made on behalf of beneficiaries residing in California. The State agency has taken several steps to increase efficiency and allow it to obtain information affecting beneficiaries' eligibility more quickly, including participation in the Public Assistance Reporting Information System program, implementation of a mid-month eligibility begin date, and WEB (internet) access that will allow beneficiaries to update information on-line.

We have reviewed the State agency's comments and maintain that our findings remain valid. The reported payments were made on behalf of beneficiaries who should not have been Medicaid-eligible in Arizona due to their eligibility in California. The sharing of data and other steps noted by the State agency should reduce the amount of payments made on behalf of beneficiaries residing in California. The State agency's comments related to issues it believes would reduce the OIG reported payments are addressed separately.

SSI Cash Cases

The State agency stated that it cannot control the information received from the Social Security Administration (SSA) for the Supplemental Security Income (SSI) Cash beneficiaries whose Medicaid eligibility in Arizona is determined solely by SSA. The State agency stated that there is a delay in SSA reporting that a beneficiary has moved to

another State because SSA requires the beneficiary to physically present themselves at a local SSA office in the new State. The State agency recommends that the OIG clarify the difficulties associated with SSI Cash cases and adjust the findings accordingly.

Although we acknowledge the State agency relied on SSA for notice of a change in residency for SSI Cash beneficiaries, it also could have received notification of Medicaid eligibility from the California Medicaid agency if the two agencies had shared available eligibility information. The California Medicaid agency had information that a beneficiary was receiving Medicaid benefits in California.

Accounting for Other Factors – Member Non-Compliance

The State agency stated that the methodology for conducting the sample and findings against Arizona should be limited to only those cases where Arizona was responsible for verifying that eligibility was not current in another state. In cases reviewed, the majority of beneficiaries did not report their move, and many did not report receipt of benefits in another state. The State agency stated that States cannot share data that they do not have. The State agency recommended that the OIG report reflect that the reported errors were due to residency changes not being reported by the member, California, SSA, or any other source of information.

As stated in the report, the reported payments were made because the State agency and the California Medicaid agency did not share available Medicaid eligibility information. We determined that the California Medicaid agency did have information establishing the beneficiaries as California residents but did not share the information with the State agency. Consequently, we recommended that the State agency work with the California Medicaid agency to share available Medicaid information. The sharing of data between States should allow both State Medicaid agencies to process information affecting eligibility more quickly.

Beneficiaries with Concurrent Eligibility

The State agency stated that in one example within the report, a beneficiary was still eligible for benefits at the end of the OIG's fieldwork, but it is unclear in which state the beneficiary was receiving services and may appear that Arizona did not terminate the member. The State agency recommends that the report be clear that Arizona terminated the member and that the beneficiary was enrolled with California's Medicaid program.

The report example illustrated that the period of on-going eligibility was in California and that the beneficiary was terminated from the Arizona Medicaid program effective March 2006.

Timing Issues Regarding Selected Sample

The State agency noted that for four sample items, the associated beneficiaries were terminated on the earliest date possible after receiving notification of information

affecting eligibility. The State agency believes these cases should not be included in the report findings as the cases relate to timing issues beyond the State agency's control.

We do not dispute that the State agency terminated the beneficiaries' enrollments as soon as it received notification of the change affecting eligibility. However, the State agency could have received the notification in prior months if it and the California Medicaid agency shared available Medicaid eligibility information in a more timely manner.

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 Arizona and California during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 3,837 beneficiary-months with Arizona Medicaid payments totaling \$1,169,836 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 RAT-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	\$27,607	50	\$13,034

Based on the errors found in the sample data, the point estimate is \$500,131 with a lower limit at the 90% confidence level of \$295,583. The precision of the 90% confidence interval is plus or minus \$204,548 or 40.9%.



Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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April 9, 2008

Marc Gustafson
Regional Inspector General for Audit Services
Office of Inspector General, Region V
U.S. Department of Health and Human Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: Report Number A-05-07-00057; "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in Arizona and California for July 1, 2005, through June 30, 2006."

Dear Mr. Gustafson:

Enclosed, please find Arizona's response to the Office of Inspector General draft report entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in Arizona and California for July 1, 2005, through June 30, 2006."

If you have any questions regarding Arizona's comments, please contact Monica Coury at 602-417-4019.

Sincerely,

Anthony D. Rodgers
Director

Enclosure

cc: Mike Barton, OIG
Lisa Eves, OIG
Ronald Reepen, CMS, Region IX

Arizona Health Care Cost Containment System
Response to Office of Inspector General Report Number A-05-07-00057

Background

On March 10, 2008, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) issued a draft report entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in Arizona and California for July 1, 2005, through June 30, 2006" (OIG Report). The OIG conducted its review of the Arizona Health Care Cost Containment System (AHCCCS) for the period of July 1, 2005 through June 30, 2006 to determine whether AHCCCS made payments on behalf of beneficiaries who should not have been Medicaid-eligible in Arizona due to their eligibility in California.

For the audit period of July 1, 2005 through June 30, 2006, AHCCCS paid approximately \$1.2 million for services provided to beneficiaries who were Medicaid eligible and receiving benefits in Arizona and California. To place this in perspective during the same time period total spending for AHCCCS programs was \$6.4 billion. The OIG reviewed a random sample of 100 beneficiary months, from a universe of 3,837 beneficiary months. Based on the random sample, the OIG Report concluded that the State paid \$13,034 for 50 beneficiary months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Arizona. From this sample, the OIG estimated the State to have paid \$500,131 (\$335,477 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in California.

Arizona's Response Summary

Arizona takes seriously its obligation to verify an applicant's residency and promptly redetermines eligibility when it receives information about changes in a beneficiary's circumstances that may affect eligibility. AHCCCS has identified two significant areas that impact the results that to a large extent are outside the ability of the agency to control.

1. SSI Cash Cases that are dependent on actions taken by the Social Security Administration
2. Member non-compliance with the requirement that AHCCCS be notified regarding residency changes.

In addition AHCCCS has identified several technical issues that should be factored into the report.

AHCCCS has taken three important steps that will improve future results.

1. AHCCCS now participates in the PARIS program which allows the state to match eligibility records with other states to look for duplication. Of course one significant impediment is that California is one of the states that currently does not participate.
2. AHCCCS has implemented a mid-month eligibility begin date.
3. AHCCCS has over 24,000 members that currently have individual WEB access that will allow them in the near future to conveniently update information like residency on-line.

Detailed Concerns

SSI Cash Cases

Ten cases reviewed by the OIG involved SSI cash recipients (case numbers 2, 7, 40, 45, 47, 58, 66, 83, 84 and 85). Arizona cannot control the information it receives from SSA for the SSI Cash beneficiaries whose Medicaid eligibility in AZ is determined solely by SSA. There is a delay in SSA reporting that a beneficiary has moved to another state because SSA requires that the beneficiary physically present themselves at a local SSA office in their new state. Because the cash benefits are automatically deposited, there is often no hurry for the beneficiary to report the move until they have an immediate medical need. These SSI Cash cases account for \$2,038.25 of the random sample, which, using the OIG's methodology, would comprise ~\$78,207.65 for the total amount paid for services to beneficiaries with concurrent eligibility.

Recommendation: The OIG should clarify the difficulties associated with SSI Cash cases and adjust the findings against Arizona accordingly.

Accounting for Other Factors – Member Non-Compliance

The methodology for conducting the sample and findings against Arizona should be limited to only those cases where Arizona was responsible for verifying that eligibility was not current in another state. Arizona cannot control whether a member notifies AHCCCS of a move or whether another state will verify if eligibility is current in Arizona. In some instances, however, Arizona can and does verify whether an applicant is eligible in another state if the member lists their previous address from another state or responds to the question on the application asking if benefits were received in another state. The draft OIG Report lists the main factor of duplicate payments as the states not sharing information. In cases reviewed, the majority did not report their move, and many did not report receipt of benefits in another state. The states cannot share data that they do not have.

Recommendation: In Arizona's review of the sampled cases, 23 were due to the change in residency not being reported by the member, California, SSA, or any other source of information. This would lower the actual amount paid for services provided to beneficiaries with concurrent eligibility by \$7,815.34. The OIG Report should be updated to reflect this.

Beneficiaries with Concurrent Eligibility

The OIG Report also provided examples of its findings of concurrent eligibility. In one example on page four, the OIG Report states that an AHCCCS member moved from Arizona to California. The OIG Report states the beneficiary was still eligible for benefits at the end of the OIG's fieldwork, but it is unclear in which state the beneficiary was receiving services and may appear to the reader that Arizona did not terminate the member.

Recommendation: The OIG Report should be clear that Arizona terminated the member and that the beneficiary was enrolled with California's Medicaid program.

Timing Issues Regarding Selected Sample

The OIG Report incorporates case numbers 23, 48, 52 and 79 that were examples of members disenrolled for the earliest date possible after notification allowing for notice of adverse action. Arizona believes these cases should not be included in the OIG Report findings as the cases relate to timing issues beyond the State's control. Disenrollment occurred as soon as was possible, which was within the same month that notice was received by Arizona from the beneficiary or other source. The random sample coincidentally incorporated these particular months.

Recommendation: Arizona believes these cases should not be included in the findings against the State. These cases represent \$522.41.

Residency Verification Initiatives

Since the audit period, Arizona has taken various steps to increase efficiency and allow AHCCCS to obtain changes in member information affecting eligibility more quickly. Some of these changes are highlighted below.

PARIS Implementation

Arizona has participated in the PARIS system since February 2007. As part of PARIS, Arizona shares demographic information on its TANF, Food Stamp and Medicaid beneficiaries with other states to increase the accuracy of eligibility determinations for public assistance programs and decrease the potential for improper payments from state and federal tax dollars. There are currently 44 states and/or jurisdictions that participate in PARIS. California, Texas, North Dakota, Iowa, Vermont and New Hampshire still do not participate.

As neighboring states, there is a lot of migration between California, Texas and Arizona. California and Texas also have large populations, and California in particular has a very large Medicaid population. As California does not participate in PARIS; Arizona should not be penalized for a neighboring state's non-participation.

Arizona estimates that it has saved \$55,386 through its participation in PARIS.

Mid-Month Eligibility Begin Dates

On May 25, 2006, AHCCCS made a change with the Arizona Department of Economic Security (DES), the State agency that conducts Medicaid eligibility, to accept and update eligibility begin dates equal to or after a beneficiary's move into the State or release from incarceration or institutionalization. These records no longer roll back to the first day of the first eligible month. Applicants at DES are asked for the date they moved to Arizona. If that date is in the month of application, the eligibility can begin no sooner than that date.

An average of about 800 members have this delayed eligibility begin date each month due to a move to Arizona from another state. Arizona estimates a savings of \$ \$66,400 per month based on an average of 10 fewer days of capitation at an average of \$ 8.30 per day acute capitation times 800 members because of this change.

Member Web Access

On October 15, 2007, Arizona initiated member website access through www.myahcccs.com. Here, members can view their own active healthcare and health plan enrollment and link to their enrollment verification. AHCCCS anticipates being able to receive more timely information through this site and help beneficiaries become more involved in their health care.

Six Month Guarantee/Loss of Contact

Arizona has found that there are instances when correspondence has been returned because the member has actually moved out of the state. Starting June 2, 2008, AHCCCS will implement a rule change that will no longer allow a guarantee period to be created for members who have been terminated for a loss of contact. This change will prevent the issue in samples 11, 86, and 87, which had total payments of \$684.46.