DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

MAY 15 2008

Report Number: A-04-07-03033

Mark Trail, Chief Officer of Medical Assistance
Georgia Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W., Suite 37
Atlanta, Georgia 30303

Dear Mr. Trail:

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 Georgia and Florida 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 call me, or contact John Drake, Audit Manager, at (404) 562-7755 or through e-mail at John.Drake@oig.hhs.gov. Please refer to report number A-04-07-03033 in all correspondence.

Sincerely,

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR SERVICES PROVIDED TO BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN GEORGIA AND FLORIDA FOR JULY 1, 2005, THROUGH JUNE 30, 2006

Daniel R. Levinson
Inspector General

May 2008
A-04-07-03033

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 http://oig.hhs.gov

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. The Georgia Department of Community Health (State agency) manages the Georgia Medicaid program.

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 State Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State 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 State 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 State agency paid approximately $7.9 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Georgia and Florida.

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 Florida.

SUMMARY OF FINDINGS

The State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible in Georgia due to their eligibility in Florida. From a statistical random sample of 100 beneficiary-months totaling $83,014 in Medicaid services, the State agency made payments for 29 beneficiary-months totaling $45,311 for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Georgia. The remaining 71 beneficiary-months were for services to beneficiaries who were eligible to receive the benefit. The State agency made payments on behalf of beneficiaries who were not eligible in Georgia because the State agency and Florida'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

$4,331,642 ($2,621,510 Federal share) on behalf of beneficiaries who should not have been eligible due to their Medicaid eligibility in Florida.

RECOMMENDATIONS

We recommend that the State agency work with the Florida 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 $4,331,642 ($2,621,510 Federal share), made on behalf of beneficiaries residing in Florida.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations. The State agency outlined several actions it has taken or plans to take in response to the audit findings.

The State agency's comments are included in their entirety as Appendix B.

TABLE OF CONTENTS

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 Georgia Department of Community Health (State agency) manages the Georgia Medicaid program.

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 State Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State 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 State Medicaid 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 Florida.[1]

Scope

For the audit period July 1, 2005, through June 30, 2006, we identified 13,681 beneficiary-months[2] with payments totaling approximately $7.9 million that the State agency made on behalf of beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in Georgia and Florida. From this universe, we selected a statistical random sample of 100 beneficiary-months with payments totaling $83,014.

[1]A separate report will be issued to the Florida Agency for Healthcare Administration to address payments made on behalf of beneficiaries who should not have been Medicaid-eligible in Florida due to their eligibility in Georgia.

[2]A beneficiary-month included all payments for Medicaid services provided to one beneficiary during 1 month.

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 Georgia and enrolled in the Florida Medicaid program.

We performed our fieldwork at the State agency offices in Atlanta, Georgia, from May 2007 through February 2008.

Methodology

To accomplish our audit objective, we obtained eligibility data from the Georgia and Florida 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 Georgia's and Florida'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 both Georgia and Florida, 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's statistical sample software random number generator to select 100 beneficiary-months with paid dates of services in both Georgia and Florida. In Georgia, the statistical sample included payments totaling $83,014. The selected beneficiary-months were for services provided on behalf of 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 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.

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

FINDINGS AND RECOMMENDATIONS

The State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible in Georgia due to their eligibility in Florida. From a statistical random sample of 100 beneficiary-months totaling $83,014 in Medicaid services, the State agency made payments for 29 beneficiary-months totaling $45,311 for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Georgia. The remaining 71 beneficiary-months were for services to beneficiaries who were eligible to receive the benefit. The State agency made payments on behalf of beneficiaries who were not eligible in Georgia because the State agency and Florida'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 $4,331,642 ($2,621,510 Federal share) on behalf of beneficiaries who should not have been eligible due to their Medicaid eligibility in Florida.

PAYMENTS ON BEHALF OF CONCURRENTLY ELIGIBLE BENEFICIARIES

Federal and State Requirements

Federal regulations (42 CFR § 435.403(j)(3)) state, "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 regulations (42 CFR § 435.916) provide that the State agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State 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 State 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 Georgia State Plan states that an individual must be a resident of the State to be eligible. The Georgia Medicaid Manual Volume II/MA, MT 10 - 04/04 Section 2225-1 states, that in order to be eligible for Medicaid, the applicant must be a resident of Georgia. Similarly, the Florida Economic Self-Sufficiency Public Assistance Manual section 1430.0300 states that "[i]n order to receive Medicaid, all individuals must be eligible on the factor of residency."

The Medicaid application is a way to notify State agencies of changes in a beneficiary's residency status. For example, the Georgia assistance application informs beneficiaries of the responsibility to inform the agency within 10 days of any change in income and circumstances.

Beneficiaries With Concurrent Eligibility

From a statistical random sample of 100 beneficiary-months with Medicaid payments totaling $83,014, the State agency paid $45,311 for 29 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Georgia.

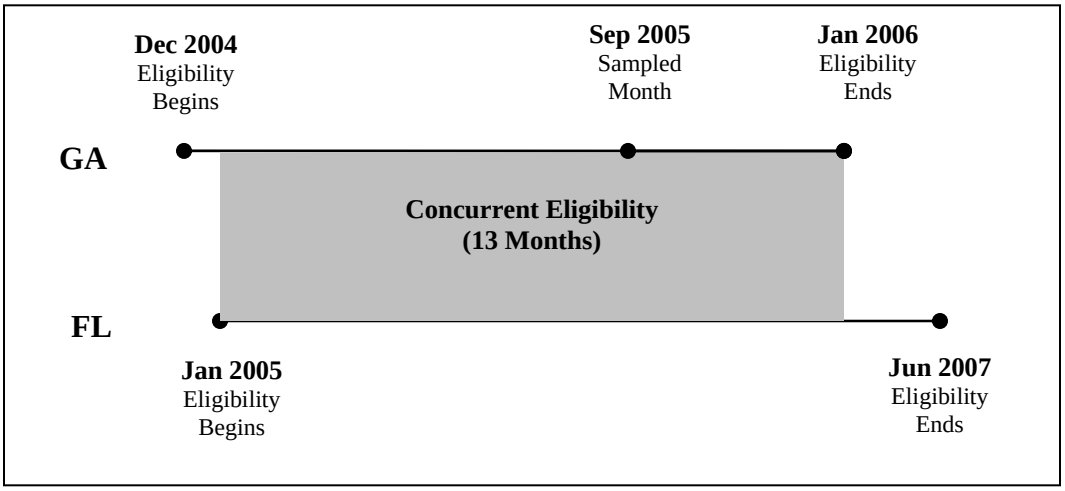
Summary of Sampled Beneficiary-Month Payments

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	71	$37,703
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	29	45,311
Totals	100	$83,014

Medicaid applications, client statements, job status letters, information obtained from the Social Security Administration and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer Georgia residents during the 29 beneficiary-months.

In one example, a beneficiary, associated with a payment for one of the sampled beneficiary-months, moved from Georgia and established residency in Florida. The Georgia eligibility period was December 1, 2004, through January 31, 2006. The Florida eligibility period was January 1, 2005, through June 30, 2007. Exhibit 1 depicts the period of concurrent eligibility for this instance.

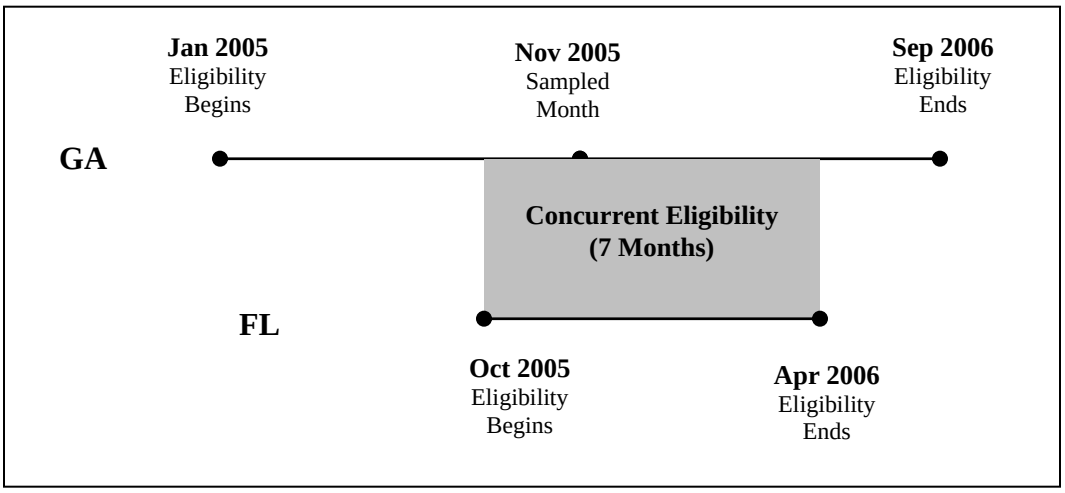
Exhibit 1- Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month Payment



Florida Medicaid records document that the beneficiary's family moved from Georgia and established residency in Florida in January 2005, which was prior to the sampled beneficiary-month (September 2005). As a result, the State agency made unallowable Medicaid payments on behalf of the beneficiary for the sampled beneficiary-month.

In contrast, a different beneficiary, associated with a payment for a sampled beneficiary-month, moved from Florida and established residency in Georgia. The Georgia eligibility period was January 1, 2005, through September 30, 2006. The Florida eligibility period was October 1, 2005, through April 30, 2006. Exhibit 2 depicts the period of concurrent eligibility for this instance.

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



Georgia Medicaid records document that the beneficiary's family moved from Florida and established residency in Georgia in January 2005, which was prior to the sampled beneficiary-month (November 2005). Because the beneficiary was a Georgia resident, the State agency made allowable Medicaid payments on behalf of the beneficiary for the sampled beneficiary-month.

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 Florida 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 Florida 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 $4,331,642 ($2,621,510 Federal share), made on behalf of beneficiaries residing in Florida.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations. The State agency outlined several actions it has taken or plans to take in response to the audit findings. Those actions include: working with Florida and other States that participate in the Public Assistance Reporting Information System to share Medicaid eligibility information; introducing a data broker information technology application in March 2008 to improve the efficiency and accuracy of the State's Medicaid eligibility determination process; and reviewing and documenting residency as a targeted element, starting May 2008, during its monthly review for eligibility accuracy.

The State agency's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

POPULATION

The population included beneficiary-months with services provided to Medicaid beneficiaries with concurrent eligibility in Georgia and Florida during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 13,681 beneficiary-months with Georgia Medicaid payments totaling $7,936,032 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's statistical sampling software to select the random sample.

ESTIMATION METHODOLOGY

We used the Department of Health and Human Services, Office of Inspector General, Office of Audit Services's Ratio Estimator program to appraise the sample results.

RESULTS OF SAMPLE

The results of our review are as follows:

Number of Beneficiary-Months	13,681
Sample Size	100
Value of Sample	$83,014
Number of Errors	29
Value of Errors	$45,311

Based on the errors found in the sample data, the point estimate is $4,331,642. The precision at the 90 percent confidence level is plus or minus $3,451,752 or 79.69 percent.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

April 30, 2008

Mr. Peter J. Barbera, Regional Inspector General
Office of Audit Services
Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Mr. Barbera:

The Department of Community Health (DCH) appreciates the opportunity to review the draft of the audit report number A-04-07-03033 entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in Georgia and Florida for July 1, 2005 through June 30, 2006." Likewise, we appreciate the opportunity provided to comment on the validity of the facts and reasonableness of the recommendations the report contains. DCH has carefully reviewed the report as well as held a formal exit conference with Amelia Wentz Senior Auditor from the Office of Inspector General (OIG).

The State of Georgia has policy in place that supports the Federal regulation requiring that State agencies re-determine eligibility at least every twelve months. Georgia defines specific criteria related to residency that is examined at each application and review. Additionally, Georgia emphasizes on the application, review information, and during the interview and review process the need to report any changes, including address changes, to the department by individuals within ten days of the change being made.

In the methodology it is explained that OIG, "reviewed the Medicaid applications files and other supporting documentation in both States to establish in which State the beneficiary had permanent residency in the sampled month." The lack of corresponding documentation was the determining factor in establishing the final residency decision. However, no direct contact was made with the members to actually establish which State of residency was correct for the individual. It would have been beneficial on the twenty-one cases found to be lacking documentation for follow up with the individual to have been made to definitively establish residency. This methodology would be consistent with PERM procedures.

Additionally, it would be beneficial for the State of Georgia to have an idea of the amount of incorrect claims made by the State of Florida on behalf of individuals that were actually Medicaid eligible in Georgia. While the ultimate goal should be no claims being paid to individuals not a current resident of the State of Georgia, the comparison information between the States would be useful for process improvement and benefit analysis.

We have several planned actions in response to the audit findings. We also have recently implemented some actions to ensure greater data integrity in the Medicaid eligibility process. The planned actions include your recommendation to work with Florida Medicaid agency to share available Medicaid eligibility information as well as other planned responses.

Beginning in March 2008 DCH introduced a data broker application for Medicaid eligibility. The Data Broker application provides an information technology solution to improve the efficiency and accuracy of the State's Medicaid eligibility determination process. The data broker provides access to public record, credit report, child support, and vital records information. Specifically in regards to residency, the data broker application provides real property searches, possible roommate matching information, as well as driver's license information. All Medicaid applications and re-determinations are systematically run through the data broker application to obtain all relevant information for view by the Medicaid Eligibility Specialists making Medicaid determinations.

Also, DCH is currently working with the Public Assistance Reporting Information System (PARIS) to provide a match of individuals dually eligible for Medicaid in Georgia as well as any other participating State. Florida is currently a participating member of the PARIS system. DCH has been in contact with Mark Graboyes at the Administration for Children and Families to enhance the current matching information. DCH is looking to incorporate the PARIS information as part of the ongoing data broker solution.

Finally, DCH will begin to do targeted reviews of eligibility determinations for residency. Currently DCH through an Administrative Services Organization reviews 850 cases monthly for eligibility accuracy. As a component of each determination starting in May 2008 will specifically review and document residency as a targeted element of review. Corrective action will be administered for those counties and workers that do not comply with residency requirements in the eligibility process.

Again, DCH appreciates the opportunity to review the draft report and respond. We have outlined areas of consideration in methodology and provided planned and implemented process improvement steps in response to the audit. If you have any questions or comments, please do not hesitation to contact Brian Dowd, Director of Member Services and Policy, at (404) 651-9981 or through email at bdowd@dch.ga.gov.

Sincerely,

Mark Trail, Chief
Medical Assistance Plans

cc: Brian Dowd
John Hankins