DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY - 8 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Two States During August 2003 (A-05-06-00057)

The attached final report provides the results of our nationwide audit of payments for services provided to beneficiaries with concurrent Medicaid eligibility in two States during August 2003.

The objective of our review was to determine whether States' Medicaid agencies (States' agencies) made payments on behalf of beneficiaries who should not have been Medicaid-eligible because of their eligibility in another State.

For August 2003, we estimate that States' agencies paid approximately $2 million on behalf of beneficiaries who should not have been eligible because of their Medicaid eligibility in another State. The Medicaid payments were made on behalf of these beneficiaries because the States' agencies did not share all available Medicaid eligibility information.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- share the results of our audit with all States to emphasize the need to ensure beneficiary eligibility changes are identified and appropriate action is taken and

- encourage States to identify opportunities to use existing eligibility data to minimize concurrent Medicaid eligibility periods.

Based on the results of this audit, we plan to select specific State pairs for detailed audits of payments for services provided to Medicaid-eligible beneficiaries.

In its comments on our draft report, CMS concurred with the recommendations.

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Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-05-06-00057 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR SERVICES PROVIDED TO BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN TWO STATES DURING AUGUST 2003

Daniel R. Levinson
Inspector General

May 2008
A-05-06-00057

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.

In accordance with the Balanced Budget Act of 1997, all Medicaid claims processed are submitted electronically through the Medicaid Statistical Information System (MSIS). The MSIS is a detailed national database of eligibility and claims data that States' Medicaid agencies (States' agencies) submit to CMS. The purpose of the MSIS is to collect, manage, analyze, and disseminate information on eligible beneficiaries, utilization, and payment for services covered by States' Medicaid programs.

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' agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The States' agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

In August 2003, we identified 131,453 payments totaling approximately $9.9 million made on behalf of 33,726 beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in two States. The States' agencies made these payments on behalf of the beneficiaries using a variety of possible payment systems, such as monthly capitation payments to managed care organizations or fee-for-service payments to providers who rendered the services.

OBJECTIVE

The objective of our review was to determine whether States' agencies made payments on behalf of beneficiaries who should not have been Medicaid-eligible because of their eligibility in another State.

SUMMARY OF FINDINGS

The States' agencies made payments on behalf of beneficiaries who should not have been eligible because of their Medicaid eligibility in another State. From a random sample of 100 payments totaling $7,425 made by the States' agencies, 28 payments totaling $1,557 were

for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits. The remaining 72 payments were for services to beneficiaries who were eligible to receive the benefit. Twenty-one of the improper payments were monthly capitation payments in both States. The remaining seven payments were monthly capitation payments in one State and fee-for-service payments in the other State. The Medicaid payments were made on behalf of these beneficiaries because the States' agencies did not share all available Medicaid eligibility information. As a result, for our 1-month audit period, we estimated that the States' agencies made approximately $2 million in payments on behalf of ineligible beneficiaries.

RECOMMENDATIONS

We recommend that CMS:

- share the results of our audit with all States to emphasize the need to ensure beneficiary eligibility changes are identified and appropriate action is taken and

- encourage States to identify opportunities to use existing eligibility data to minimize concurrent Medicaid eligibility periods.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS concurred with the recommendations. We have included CMS's comments as Appendix C.

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INTRODUCTION

BACKGROUND

Medicaid Program

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.

States' Medicaid agencies (States' agencies) make payments for medical services provided to eligible beneficiaries using a variety of possible payment systems, such as capitation payments to managed care organizations or fee-for-service payments to medical providers. A capitation payment is a specified amount of money paid to a health plan, such as a Health Maintenance Organization, contracted to provide a comprehensive set of services to a beneficiary. A fee-for-service payment is the amount paid directly to a provider for services rendered to a beneficiary. Nationally, enrollment in Medicaid managed care, whether with comprehensive or limited benefits, rose from 40 percent in 1996 to 61 percent in 2004. Capitation payments in Federal fiscal year (FY) 2005 were $50.6 billion, or approximately $1 out of every $6 spent on Medicaid.

Medicaid Statistical Information System

In accordance with the Balanced Budget Act of 1997, all Medicaid claims processed are submitted electronically through the Medicaid Statistical Information System (MSIS). The MSIS is a detailed national database of eligibility[1] and claims data that States' agencies submit to CMS. The purpose of the MSIS is to collect, manage, analyze, and disseminate information on eligible beneficiaries, utilization, and payment for services covered by States' Medicaid programs. MSIS data are supposed to be extracted from the States' Medicaid Management Information Systems (MMIS)[2] and submitted to CMS within 45 days after the end of each quarter. CMS performs quality assurance edits and other reviews on the data before releasing the data to other agencies.

Medicaid Beneficiary Eligibility and Residency Requirements

Federal regulation (42 CFR § 435.403(a)) says that a State agency must provide Medicaid services to eligible residents of that State. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should

[1]The MSIS eligibility file contains an eligibility record for each person who was Medicaid-eligible for at least 1 day during the reporting quarter and includes such data as beneficiary identification number, Social Security number, date of birth, race, sex, county code, zip code, and FY quarter.

[2]The 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.

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 Medicaid services. However, if the State agency determines that the recipient has been accepted for Medicaid services in another State, advance notice to terminate benefits is not required (42 CFR § 431.213(e)).

Pursuant to 42 CFR § 435.916, the States' agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The States' agencies must promptly redetermine eligibility when they receive information about changes in beneficiary circumstances that may affect eligibility.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether States' agencies made payments on behalf of beneficiaries who should not have been Medicaid-eligible because of their eligibility in another State.

Scope

For August 2003, we identified 131,453 payments totaling approximately $9.9 million made on behalf of 33,726 beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in two States. From this population, we selected a random sample of 100 payments totaling $7,425.

We validated the sampled MSIS eligibility and claims data but did not validate the nonsampled MSIS data.

We did not review the overall internal control structure of the States' agencies. We limited our internal control review to obtaining an understanding of the procedures used to identify Medicaid-eligible individuals who moved from one State and enrolled in another State's Medicaid program.

We performed our fieldwork at States with the sampled payments. See Appendix A for the list of the States.

Methodology

To accomplish our audit objective, we obtained eligibility and claims data from the MSIS for the 50 States and the District of Columbia for the fourth quarter of FY 2003 (July 1, 2003, through September 30, 2003). We matched Social Security numbers, dates of birth, and income codes[3]

[3]Income codes indicate eligibility for each given month.

to identify beneficiaries who were Medicaid-eligible in more than one State for all 3 months of the fourth quarter of FY 2003.

We matched the MSIS identification numbers for these beneficiaries to the MSIS claims data and extracted all claims paid for "Other" types of service[4] provided during August 2003. We limited our review to August 2003, the middle month of the quarter, to ensure the beneficiaries were concurrently eligible in both States before and after August. Therefore, we determined that the beneficiaries had established permanent residency in one of the two States in which Medicaid payments were made. We also reviewed August date-of-service payments to ensure that States' agencies had adequate time to coordinate reported residency changes affecting beneficiaries' eligibility.

We randomly selected 100 payments totaling $7,425 made on behalf of the concurrently eligible beneficiaries. The selected payments were for services provided in only one of the two States during August 2003. Although we reviewed residency status and documentation in both States, we did not review the other State agency's payment. See Appendix B for more information regarding the sampling methodology.

We used the States' MMIS data to verify that the beneficiaries were enrolled in the States' Medicaid program and that payments were made to providers, as reported in the MSIS. In addition, for each of the 100 payments, we reviewed the Medicaid application files and other supporting documentation in both States to establish in which State the beneficiary had permanent residency in August 2003. We also obtained Supplemental Security Income (SSI) eligibility data from the Social Security Administration, when necessary. Based on the sample results, we estimated the total amount of payments that States' agencies paid on behalf of beneficiaries who should not have been Medicaid-eligible for August 2003.

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 objective.

FINDINGS AND RECOMMENDATIONS

The States' agencies made payments on behalf of beneficiaries who should not have been eligible because of their Medicaid eligibility in another State. From a random sample of 100 payments totaling $7,425 made by the States' agencies, 28 payments totaling $1,557 were for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits. The remaining 72 payments were for services to beneficiaries who were eligible to receive the benefit. Twenty-one of the improper payments were monthly capitation payments in both States. The remaining seven payments were monthly capitation payments in one State and fee-for-service payments in the other State. The Medicaid payments were made on behalf of

[4]MSIS claims are grouped into four claims classifications: inpatient, long-term care, other, and prescription drugs. Based on previous Office of Inspector General reviews (A-05-06-00020 and A-05-06-00021) and analyses, we determined that "other" claims contained the most instances of beneficiaries with concurrent eligibility in two States.

these beneficiaries because the States' agencies did not share all available Medicaid eligibility information. As a result, for our 1-month audit period, we estimated that the States' agencies made approximately $2 million in payments on behalf of ineligible beneficiaries.

PAYMENTS ON BEHALF OF CONCURRENTLY ELIGIBLE BENEFICIARIES

We estimated that States' agencies paid approximately $2 million for services on behalf of beneficiaries who should not have been eligible to receive Medicaid benefits because of their eligibility in another State.

Federal and State Requirements

Federal regulation (42 CFR § 435.403(j)(3)) states "The [State] 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 beneficiary eligibility.

Each State agency has specific guidelines for determining whether an individual satisfies the Federal criteria defining eligibility and State residency. For example, the Michigan Family Independence Agency's "Program Eligibility Manual," section 220, states that a person is an eligible resident for Medicaid if he or she is not receiving assistance from another State and is living in Michigan, except for a temporary absence, and intends to remain in the State permanently or indefinitely. Similarly, the Ohio Administrative Code 5101:1-39-54 states that Medicaid eligibility can be extended only to residents of Ohio, which the Code defines as individuals living in Ohio at the time of application and not receiving assistance in another State.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the Ohio assistance application requests information on the applicant's prior State of eligibility so that Ohio can share the information with the other State. Michigan's assistance application informs beneficiaries of their responsibility to report a change of address and warns them that concealing the change can result in prosecution for fraud or perjury.

Beneficiaries With Concurrent Eligibility

Of the 100 payments made by States' agencies totaling $7,425 in our random sample, 28 payments totaling $1,557 were for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits. Twenty-one of the improper payments were monthly

capitation payments in both States. The remaining seven payments were monthly capitation payments in one State and fee-for-service payments in the other State.

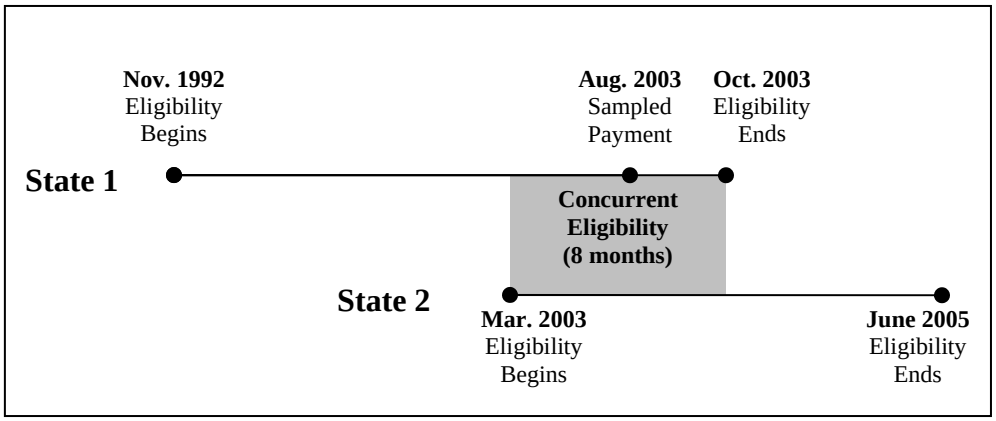
Summary of Sampled Payments

Type of Payment	Number	Amount Paid
Allowable Payments (Eligible Beneficiaries)	72	$5,868
Unallowable Payments (Beneficiaries Who Should Not Have Been Eligible)	28	1,557
Total	**100**	**$7,425**

Medicaid application files, SSI eligibility data, and other supporting documentation indicated that the 28 beneficiaries were no longer residents in the State in which the sampled Medicaid payments were paid. In some cases, beneficiaries did not comply with existing procedures to notify States' agencies of changes in residency affecting eligibility or report eligibility in another State when applying for Medicaid benefits. In other cases, although beneficiaries reported either changes in residency affecting eligibility or eligibility in another State, the States' agencies did not coordinate the changes or terminate eligibility in the State of previous residency.

In one example, the beneficiary with one of the unallowable sampled State payments (State 1) had moved and established residency in a different State (State 2). State 1's recorded eligibility period for the beneficiary was November 16, 1992, through October 31, 2003. The State 2 eligibility period was March 1, 2003, through June 30, 2005. Both States made capitation payments for this beneficiary during August 2003.

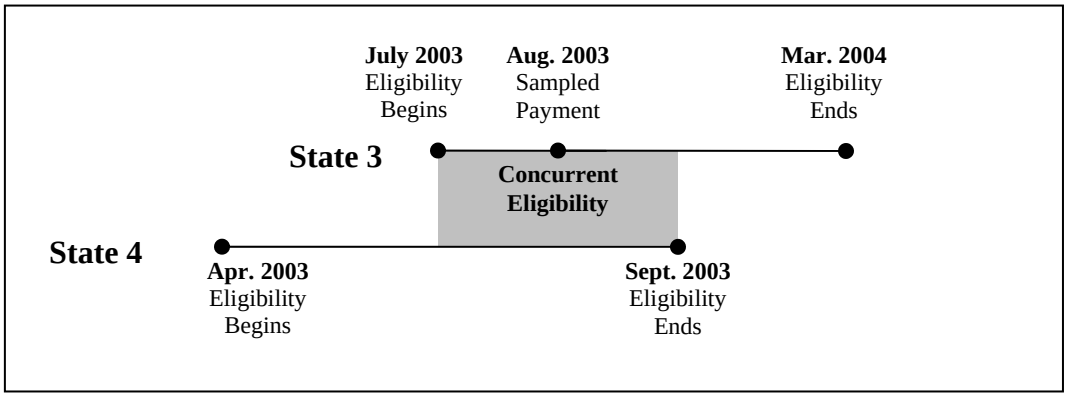
Exhibit 1: Period of Concurrent Eligibility for an Unallowable Sampled Payment States 1 and 2



State 1 Medicaid records document that the beneficiary's family moved out of the State, but the mother of the beneficiary (a minor) did not report this information. As a result of the beneficiary's move, State 1 should not have made the sampled Medicaid payment on behalf of the beneficiary for August 2003.

In contrast, a different sampled claim was allowable and appropriately paid because the beneficiary resided in the State that made the payment (State 3) after moving from the other State (State 4). The State 3 eligibility period was July 7, 2003, through March 11, 2004. The State 4 eligibility period was April 1, 2003, through September 30, 2003.

Exhibit 2: Period of Concurrent Eligibility for an Allowable Sampled Payment States 3 and 4



The applicant (and beneficiary) applied for benefits in State 3 on July 7, 2003, indicating on the application that the family had moved from State 4. The State 3 Medicaid agency notified the State 4 Medicaid agency to close the case file, effective August 1, 2003. The State 4 Medicaid case notes, dated July 17, 2003, say that the beneficiary moved to State 3. Based on available data, the State 3 sampled payment was for an eligible beneficiary.

INSUFFICIENT SHARING OF ELIGIBILITY DATA

Payments were made for services provided to beneficiaries who should not have been Medicaid-eligible because the States' agencies did not share all available Medicaid eligibility information. The States' agencies did not promptly identify all changes in beneficiary eligibility and residency. Although States' agencies sometimes coordinated beneficiary eligibility, as shown in Exhibit 2, the States' agencies did not consistently identify and coordinate changes in beneficiary eligibility and residency.

RECOMMENDATIONS

We recommend that CMS:

- share the results of our audit with all States to emphasize the need to ensure beneficiary eligibility changes are identified and appropriate action is taken and

- encourage States to identify opportunities to use existing eligibility data to minimize concurrent Medicaid eligibility periods.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS concurred with the recommendations. We have included CMS's comments as Appendix C.

APPENDIXES

APPENDIX A

STATES WITH SAMPLED PAYMENTS

Alabama
Arizona
Arkansas
California
Connecticut
District of Columbia
Florida
Georgia
Idaho
Illinois
Indiana
Louisiana
Maryland
Michigan
Minnesota
Missouri
Mississippi
Nebraska
New Jersey
New Mexico
New York
North Carolina
Ohio
Oklahoma
Pennsylvania
Rhode Island
South Carolina
Texas
Washington
Wisconsin

SAMPLING METHODOLOGY

POPULATION

The population was the 50 States and the District of Columbia's Medicaid payments for services provided to beneficiaries with concurrent eligibility in two States during August 2003. The population consisted of 131,453 Medicaid payments totaling $9,908,627 for services provided to 33,726 beneficiaries.

SAMPLE DESIGN

We used an unrestricted random sample. We used the Office of Inspector General, Office of Audit Services' statistical software RAT-STATS to generate the random numbers used to select the sample.

SAMPLE RESULTS

The results of our review are as follows:

Number of Payments	Sample Size	Value of Sample	Number of Improper Payments	Value of Improper Payments
131,453	100	$7,425	28	$1,557

ESIMATION OF SAMPLE RESULTS

Based on the sample results, the point estimate of the improper payments was $2,046,723, and the lower limit was $1,200,945. We calculated limits for the 90-percent confidence interval.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 1 4 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in Two States during August 2003" (A-05-06-00057)

Thank you for the opportunity to review and comment on the subject draft report entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in Two States during August 2003." The Centers for Medicare & Medicaid Services (CMS) has reviewed this report, and we offer the following comments.

The CMS recognizes the importance of ensuring the integrity of Medicaid eligibility information. In fact, CMS has established procedures to require timely reporting of changes in State residency which could impact eligibility. There are continuing challenges in this area given the mobility of the population and the potential uncertainty of residency at any given time. Your study provides valuable information that can be examined when addressing the issue of multiple Medicaid payments related to concurrent eligibility in two States.

OIG Recommendation

Share the results of our audit with all States to emphasize the need to ensure beneficiary eligibility changes are identified and appropriate action is taken.

CMS Response

We concur. We will share the audit results with all States to emphasize the need to ensure beneficiary eligibility changes are identified and appropriate action is taken.

OIG Recommendation

Encourage States to identify opportunities to use existing eligibility data to minimize concurrent Medicaid eligibility periods.

Page 2- Joseph E. Vengrin

CMS Response

We concur. We will encourage States to identify opportunities to use existing eligibility data to minimize concurrent Medicaid eligibility periods.

General Comment

Page 4- The fourth full paragraph, first sentence, reads: "Each State agency has specific criteria defining eligibility and residency." In fact, each State is required to apply the residency definition contained in Federal regulation and does not have flexibility to adopt different standards. As such, we recommend the sentence be revised to read as follows: "Each State agency has specific guidelines for determining whether an individual satisfies the Federal criteria defining eligibility and State residency."

We again thank you for the opportunity to provide comments on the subject draft report.