Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OHIO MADE CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS FOR MEDICAID BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN ANOTHER STATE

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Office of Inspector General

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Report in Brief
Date: November 2020
Report No. A-05-19-00023

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State

Why OIG Did This Audit

Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly paid capitation payments on behalf of beneficiaries with concurrent eligibility in another State. We conducted a similar audit of the Ohio Department of Medicaid, which administers the Medicaid program.

Our objective was to determine whether Ohio made capitation payments on behalf of Medicaid beneficiaries who were residing and enrolled in Medicaid in another State.

How OIG Did This Audit

Our audit covered 23,935 August 2018 capitation payments, totaling $12.9 million, made on behalf of beneficiaries with concurrent eligibility in another State during our audit period, July 1 through September 30, 2018. We selected the middle month of our audit period to ensure that beneficiaries were eligible in the months before and after the August 2018 capitation payments. We selected a stratified random sample of 104 capitation payments, totaling $47,807 ($34,447 Federal share), and determined whether the beneficiaries were residing and receiving Medicaid benefits in Ohio during the audit period.

What OIG Found

Ohio made an estimated $5.9 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 104 capitation payments in our stratified random sample, 57 capitation payments were associated with beneficiaries who were residing and eligible for Medicaid benefits in Ohio. However, for the remaining 47 capitation payments, totaling $24,912 ($17,620 Federal share), Ohio made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Ohio because they were concurrently eligible and residing in another State. On the basis of our sample results, we estimated that Ohio could have saved $5.9 million ($4.2 million Federal share) for August 2018 capitation payments made to managed care organizations on behalf of beneficiaries with concurrent eligibility.

What OIG Recommends and Ohio's Comments

We recommend that Ohio (1) develop or enhance current procedures to identify beneficiaries with concurrent eligibility in another State, which could have saved Ohio an estimated $5.9 million ($4.2 million Federal share) in capitation payments for the month of August 2018, and (2) ensure that procedures are in place for county caseworkers to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

In written comments on our draft report, Ohio did not agree or disagree with our findings. In its comments on our recommendations, Ohio said that it intends to continue the use of Public Assistance Reporting Information System (PARIS) files to determine concurrent eligibility. However, Ohio noted several planned enhancements to limit payments to beneficiaries with concurrent eligibility in another State.

Ohio will ensure that PARIS alerts are sent to the counties after the alerts are generated and will ensure the counties' timely processing of these alerts. Ohio will conduct training covering returned mail procedures, PARIS alerts, and steps that should be taken to properly process a PARIS alert. An additional enhancement will stop eligibility from being passively renewed if there is an unworked PARIS match. Manual eligibility renewal packets will be generated and returned if the individual has moved out of State.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Ohio Department of Medicaid (State agency) pays managed care organizations (MCOs) to make services available to eligible Medicaid beneficiaries in return for a monthly fixed payment (capitation payment) for each enrolled beneficiary. Previous Office of Inspector General (OIG) audits[1] found that State Medicaid agencies had improperly paid capitation payments on behalf of beneficiaries with concurrent eligibility in another State. We conducted a similar audit of the State agency, which administers the Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of Medicaid beneficiaries who were residing and enrolled in Medicaid in another State.[2]

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). 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.

State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid beneficiaries. States contract with an MCO to make services available to enrolled Medicaid beneficiaries, usually in return for a periodic payment, known as a capitation payment. States report capitation payments claimed by Medicaid MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

[1] See Appendix B for related OIG audits.

[2] In this report, we refer to Medicaid enrollment in more than one State as "concurrent eligibility."

During the period July 1 through September 30, 2018 (audit period), the FMAP in Ohio was 62.78 percent.[3]

Federal Requirements

States are required to provide Medicaid services to eligible residents, including residents who are absent from the State. If a resident of one State subsequently establishes residency in another State for purposes of Medicaid eligibility, the beneficiary's Medicaid eligibility in the previous State should end (42 CFR § 435.403(a) and (j)(3)).

States must generally provide notice when the State agency terminates a Medicaid beneficiary's covered benefits or eligibility at least 10 days before the date of action (42 CFR § 431.211). However, if a State establishes that the beneficiary has been accepted for Medicaid services by another State, the original State must provide notice of the termination of the beneficiary's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)).

A capitation payment is "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract…for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

Ohio's Medicaid Managed Care Program

Ohio's comprehensive risk-based Medicaid Managed Care program was introduced in 2005 and has been phased in over time to cover the entire State. The program covers all services in the Medicaid State plan, including acute, primary, and specialty services. During our audit period, approximately 90 percent of Ohio's Medicaid population received benefits through MCOs under contract with the State agency. The contracts with the MCOs covered health care services to eligible Medicaid beneficiaries in exchange for a fixed per-member, per-month capitation payment.

Ohio's State Medicaid plan requires that Medicaid be granted to eligible applicants who, among other requirements, are residents of the State, including residents who are absent from the State under certain conditions. Self-declaration is sufficient evidence of State residency, unless contradictory information is provided to or maintained by the State agency.

[3] Because of the Patient Protection and Affordable Care Act's (ACA's) Medicaid expansion, payments for "newly eligible" adults were reimbursed at a 100-percent FMAP during calendar years 2014 through 2016 and gradually declined to 90 percent by 2020. The ACA was designed to significantly reduce the number of uninsured by providing affordable health care coverage options through Medicaid and the Health Insurance Marketplaces. Coverage for most low-income adults was increased to 138 percent of the Federal poverty level for States that chose to implement the ACA expansion.

The Medicaid MCO contracts incorporate rules set forth in the Ohio Administrative Code (OAC) (State agency managed care contracts Article XIV), which requires the State agency to disenroll a beneficiary from an MCO plan when the beneficiary's permanent residence moves outside the plan's service area (OAC 5160-26-02.1(B)(1) and OAC 5160-58-02.1(A)(2)). Disenrollment must take effect on the last day of the month in which the beneficiary moves (OAC 5160-26-02.1(B)(1) and OAC 5160-58-02.1(A)(2)).

Transformed Medicaid Statistical Information System

The Transformed Medicaid Statistical Information System (T-MSIS) is a critical data and systems component maintained by CMS. The primary purpose of T-MSIS is to establish an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claim data about Medicaid recipients to be used for the administration of Medicaid at the Federal level, and assist in the detection of fraud, waste, and abuse in Medicaid.

The T-MSIS data set contains:

- enhanced information about beneficiary eligibility,
- beneficiary and provider enrollment data,
- service utilization data,
- claim and managed care data, and
- expenditure data.

Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is an information exchange system managed by the Administration for Children and Families. PARIS matches State and Federal data to provide State Public Assistance Agencies with beneficiary information that they can use to identify possible concurrent eligibility and erroneous payments. The three parts of PARIS are the Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Match (duplicate payments made to or on behalf of the same beneficiary in more than one State). The programs that use PARIS data are Medicaid, Temporary Assistance for Needy Families, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program.

Section 1903(r)(3) of the Social Security Act and 42 CFR § 435.945(d) require that all States have an eligibility determination system that conducts data matching using PARIS, which can help States detect and deter improper payments by identifying beneficiaries with concurrent eligibility in two or more States. The PARIS interstate match alerts the States that are potentially making duplicate payments for Medicaid beneficiaries with concurrent eligibility in

another State. This interstate match can be used to help determine which State is responsible for providing the beneficiaries' Medicaid benefits. States are expected to determine whether matched individuals continue to be eligible for benefits in their State and take whatever case action is appropriate.[4] However, CMS has not specified how States must verify continued eligibility when a match is identified. Some States use local benefit office staff, fraud investigators, or both, to review the matches.

Ohio's Medicaid eligibility verification plan describes the use of PARIS as a post-eligibility check for concurrent benefits received in another State while the individual is enrolled in Ohio Medicaid. The PARIS match information is added to Ohio's eligibility system and generates an electronic alert (PARIS alert) for beneficiaries who were identified as having concurrent eligibility in another State. Ohio generally relies on county caseworkers to verify concurrent eligibility for beneficiaries with a PARIS alert or other information that may affect the beneficiaries' eligibility. County caseworkers may contact the beneficiaries directly or the other State listed in the PARIS alert to obtain confirmation that the beneficiaries were not concurrently eligible in another State.

The State agency is required to contact the beneficiaries before eligibility may be terminated.[5] If the State agency receives information that may affect a beneficiary's Medicaid benefits, such as a PARIS alert, the State agency sends a PARIS Contact Notice to the beneficiary, and the beneficiary has 10 days to respond. If the beneficiary doesn't respond, a county caseworker sends out a reminder letter. If there is no response from the beneficiary[6] or if mail addressed to the beneficiary is returned from the post office with no forwarding address, the beneficiary's eligibility may be terminated.[7] If the State agency confirms that the beneficiary has been determined eligible for Medicaid in another State, the State agency is not required to provide advance notice and may send notice on the effective date of the beneficiary's eligibility termination.[8]

[4] 42 CFR § 435.952(a) and § 435.916(d)(1).

[5] Ohio's Medicaid eligibility verification plan indicates that if the State receives conflicting information regarding an individual's residency, the State will request additional information from the individual. Additionally, under 42 CFR § 435.952(d), a State Medicaid agency may not terminate a beneficiary's Medicaid eligibility based on information received through sources such as PARIS unless the State agency has sought additional information from the beneficiary.

[6] The PARIS Contact Notice states that if the beneficiary does not contact the caseworker within 10 days, the beneficiary's benefits may be terminated. Additionally, according to OAC 5160:1-2-01(I)(3)(f)(v), the State Medicaid agency must terminate the eligibility of an individual who fails to provide all necessary verifications.

[7] 42 CFR § 431.213(d).

[8] 42 CFR § 431.213(e).

HOW WE CONDUCTED THIS AUDIT

Our audit covered 23,935 August 2018 capitation payments, totaling $12,855,763, made on behalf of beneficiaries with concurrent eligibility in another State during our audit period.[9] We selected the middle month of our audit period to ensure that beneficiaries were eligible in the months before and after the August 2018 capitation payments. This helped us to identify beneficiaries who did not move to or from another State during August 2018.[10] To identify our population of beneficiaries who had concurrent eligibility during our audit period, we compared CMS's T-MSIS data for Ohio with T-MSIS data from 47 States, the District of Columbia, and Puerto Rico[11] using the beneficiaries' Social Security numbers (SSNs), dates of birth (DOB), names, and sex (personally identifiable information (PII)). We then identified all associated August 2018 capitation payments that the State agency made.

We selected a stratified random sample of 104 capitation payments, totaling $47,807 ($34,447 Federal share), and determined whether the beneficiaries were residing and receiving Medicaid benefits in Ohio during the audit period. Stratum 1 contained 74 capitation payments associated with Ohio Medicaid beneficiaries who had identical PII in the matched State. Stratum 2 contained 30 capitation payments associated with Ohio Medicaid beneficiaries who had an identical SSN in the matched State, but at least one of the other PII fields did not match. Using the results of our sample, we estimated the total value and Federal share of capitation payments that the State agency paid on behalf of beneficiaries who were also eligible for and receiving Medicaid benefits in another State.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains the details of our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal and State requirements.

[9] The audit period of July 1 through September 30, 2018, encompassed the most current data available at the time we initiated our audit.

[10] Concurrent capitation payments are allowable in the month a beneficiary moves and establishes Medicaid eligibility in another State.

[11] At the time of our request, two States (Vermont and Virginia) did not have T-MSIS Medicaid managed care eligibility data available.

FINDINGS

The State agency made an estimated $5.9 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 104 capitation payments in our stratified random sample, 57 capitation payments were associated with beneficiaries who were residing and eligible for Medicaid benefits in Ohio. However, for the remaining 47 capitation payments, totaling $24,912 ($17,620 Federal share), the State agency made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Ohio because they were concurrently eligible and residing in another State. On the basis of our sample results, we estimated that the State agency could have saved $5.9 million ($4.2 million Federal share)[12] for August 2018 capitation payments made to MCOs on behalf of beneficiaries with concurrent eligibility. The State agency made August 2018 capitation payments on behalf of concurrently eligible beneficiaries because the State agency did not always identify, review, and terminate eligibility for beneficiaries who had established Medicaid in another State.

THE STATE AGENCY MADE PAYMENTS TO MANAGED CARE ORGANIZATIONS FOR MEDICAID BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN ANOTHER STATE

Federal regulations prohibit beneficiaries from being concurrently eligible for Medicaid benefits in more than one State.[13] Contractual agreements with the MCOs require the State agency to disenroll a beneficiary from an MCO plan when the beneficiary's permanent place of residence moves outside the plan's service area. Disenrollment must take effect on the last day of the month the beneficiary moves.

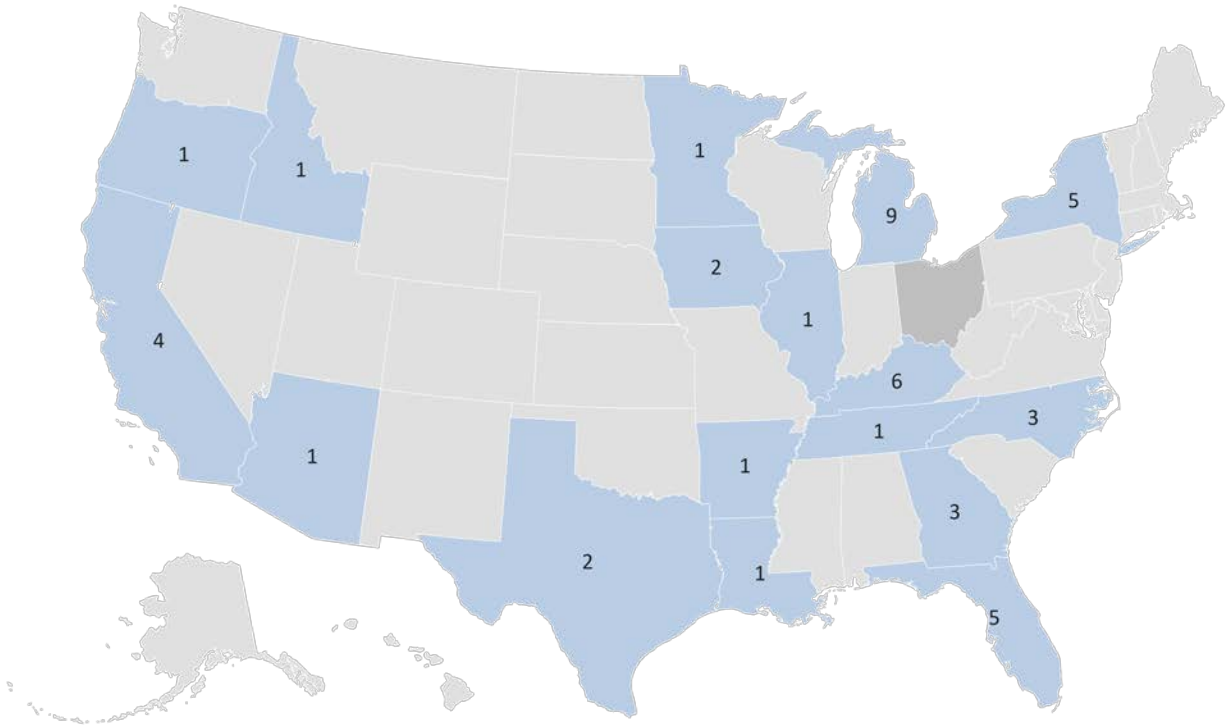
Of the 104 capitation payments in our stratified random sample, 57 capitation payments (32 in stratum 1 and 25 in stratum 2) were associated with beneficiaries who were residing in Ohio and eligible for Medicaid benefits. However, for the remaining 47 capitation payments (42 in stratum 1 and 5 in stratum 2), totaling $24,912 ($17,620 Federal share), the State agency made the payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Ohio because they were concurrently eligible and residing in another State (Figure, next page).[14]

[12] Rounding to the nearest dollar, the amounts equaled $5,859,881 and $4,152,838, respectively.

[13] 42 CFR §§ 435.403(a) and (j)(3).

[14] We confirmed the beneficiaries' status using State and county case files, PARIS alerts, and a national investigative database, and by contacting the other State's Medicaid agency when necessary. We also reviewed encounter claims that identify the date the beneficiaries had an interaction with a health care provider and the location of the beneficiaries.

Figure: Capitation Payments Made for Beneficiaries Who Were Residing and Medicaid Eligible in Another State in August 2018



On the basis of our sample results, we estimated that the State agency could have saved $5.9 million ($4.2 million Federal share) for August 2018 capitation payments made to MCOs on behalf of beneficiaries with concurrent eligibility.

The State agency did not always identify beneficiaries with concurrent eligibility. The State agency's eligibility system identified a PARIS alert for 32 of the 104 sampled capitation payments.[15] Additionally, county caseworkers did not always review and terminate eligibility for beneficiaries despite receiving other available information indicating concurrent eligibility.

The State agency reviews PARIS alerts, using information obtained from the beneficiary or information provided by another State to determine whether beneficiaries are concurrently eligible and receiving Medicaid benefits in another State.[16] However, the county caseworkers did not always terminate eligibility after reviewing the PARIS alert or for beneficiaries who failed to respond to a county caseworker's request. This occurred because the State agency did not have formal policies and procedures for reviewing PARIS alerts or other information that

[15] Of the 104 sampled beneficiaries, 32 had a PARIS match in March or June 2018 (prior to our audit period).

[16] Information may include a beneficiary notifying the State agency that he or she is moving to another State and communication from another State Medicaid agency asking whether the beneficiary's Ohio Medicaid eligibility has already been terminated.

may affect the beneficiaries' eligibility. The State agency stated that each county benefit office established its own policies and procedures for reviewing and managing PARIS alerts.[17]

The following are examples of cases for which county caseworkers did not review a PARIS alert or did not take appropriate actions after receiving information that may have affected a beneficiary's Medicaid eligibility:

- **PARIS Alert Was Not Reviewed**
  For one sampled capitation payment, the beneficiary had concurrent eligibility in Ohio and Tennessee during our audit period. The State agency's eligibility system generated PARIS alerts for June, September, and December 2018. However, the county caseworker did not review the PARIS alerts to identify the concurrent eligibility as of December 2019. The beneficiary's Medicaid eligibility in Ohio started in December 2014 and was still active as of January 2019. The beneficiary's Medicaid eligibility in Tennessee started in February 2018 and continued through January 2019. The duplicate capitation payments that occurred after the initial PARIS alert in June 2018 could have been prevented if the county caseworker had followed up on the PARIS alerts and terminated the beneficiary's eligibility.

- **PARIS Alert Was Reviewed but Eligibility Was Not Terminated**
  For one sampled capitation payment, the beneficiary had concurrent eligibility in Ohio and Arizona during our audit period. The State agency's eligibility system generated PARIS alerts for June and September 2018. The county caseworker reviewed the PARIS alerts in July and October 2018. Rather than terminating the beneficiary's Medicaid eligibility after the required PARIS Contact Notice, the caseworker closed the PARIS alerts without taking any further action. The beneficiary's Medicaid eligibility in Ohio started in December 2017 and was still active as of January 2019. The beneficiary's eligibility in Arizona started in June 2018 and was still active as of January 2019. The duplicate capitation payments that occurred after the PARIS alerts were reviewed and closed could have been prevented if the county caseworker had terminated the beneficiary's eligibility.

- **Beneficiary's Mail Returned (No Forwarding Address)**
  For one sampled capitation payment, the beneficiary had concurrent eligibility in Ohio and Idaho during our audit period. The State agency attempted to contact the beneficiary by mail in February, March, and October 2018. However, the post office returned the letters without a forwarding address. The county caseworker did not terminate the beneficiary's eligibility. The beneficiary's eligibility in Ohio started in December 2017 and continued through February 2019. The beneficiary's eligibility in Idaho started in June 2018 and continued through January 2019. The duplicate capitation payments could have been prevented if the county caseworker had

[17] The State agency established rules for reviewing and verifying PARIS matches after our audit period (OAC 5160:1-1-06, effective Jan. 2, 2020).

terminated the beneficiary's eligibility after letters to the beneficiary were returned without a forwarding address.

- **Beneficiary's Mail Returned (Out-of-State Forwarding Address)**
  For one sampled capitation payment, the beneficiary had concurrent eligibility in Ohio and New York during our audit period. The State agency attempted to contact the beneficiary by mail in August 2018. However, the post office returned the letter with a New York forwarding address. The county caseworker did not take steps to confirm that the beneficiary had moved to New York or terminate the beneficiary's eligibility. The beneficiary's eligibility in Ohio started in June 2014 and was still active as of January 2019. The beneficiary's Medicaid eligibility in New York started in March 2017 and was still active as of January 2019. The duplicate capitation payments could have been prevented if the county caseworker had taken the proper steps to confirm that the beneficiary moved to another State.

RECOMMENDATIONS

We recommend that the Ohio Department of Medicaid:

- develop or enhance current procedures to identify beneficiaries with concurrent eligibility in another State, which could have saved the State agency an estimated $5,859,881 ($4,152,838 Federal share) in capitation payments for the month of August 2018; and

- ensure that procedures are in place for county caseworkers to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not agree or disagree with our findings. In its comments on our recommendations, the State agency said that it intends to continue the use of PARIS files to determine concurrent eligibility. However, the State agency noted several planned enhancements to limit payments to beneficiaries with concurrent eligibility in another State.

The State agency stated that it will ensure that PARIS alerts are sent to the counties after the alerts are generated each quarter and will monitor the PARIS alert report to ensure the counties' timely processing of these alerts on at least a quarterly basis. The State agency also said that it will conduct training in November 2020 covering returned mail procedures, PARIS alerts, reviewing PARIS interface screens, and the steps that should be taken to properly process a PARIS alert. According to the State agency, additional enhancements have been made or are planned that will provide for timelier reviews and more efficient processing. The enhancements will make PARIS alerts more visible for the caseworkers and will stop eligibility

from being passively renewed if there is an unworked PARIS match. Specifically, manual eligibility renewal packets will be generated, and if the individual has moved out of State, the packet will be returned to the State agency and processed as returned mail.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 23,935 August 2018 capitation payments, totaling $12,855,763, made by the State agency on behalf of beneficiaries with concurrent eligibility in another State from July 1 through September 30, 2018 (audit period). We selected and reviewed a stratified random sample of 104 capitation payments, totaling $47,807 ($34,447 Federal share), to determine whether the beneficiaries were residing in Ohio and eligible for Medicaid benefits during the audit period.

We determined that a review of the State agency's internal controls was significant to accomplishing our audit objective. We assessed the design, implementation, and operating effectiveness of the State agency's internal controls related to control activities and monitoring of capitation payments made on behalf of beneficiaries with concurrent eligibility in another State. As part of our internal control review, we reviewed the State agency's policies and procedures for identifying and terminating the eligibility of Medicaid beneficiaries who were not residents of Ohio.

We conducted our audit, which included fieldwork at the State agency office in Columbus, Ohio, from August 2019 through August 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed the State agency contracts with the MCOs that were in effect during the audit period;
- reviewed Federal and State laws, regulations, and guidance;
- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments that were made on behalf of beneficiaries with concurrent eligibility in another State;
- identified sources that the State agency used to identify beneficiaries who were eligible for Medicaid in another State;
- used T-MSIS data to match Medicaid MCO eligibility information, by the beneficiaries' SSN, among 48 States, the District of Columbia, and Puerto Rico and identified 23,935 Ohio Medicaid beneficiaries who had an August 2018 capitation payment and were eligible for Medicaid in another State during the entire 3-month audit period, totaling $12,855,763;

- selected for review a stratified random sample of 104 capitation payments, totaling $47,807 ($34,447 Federal share);

- validated the T-MSIS data for each sampled capitation payment by:

    - comparing current beneficiary data from the State agency to determine whether the beneficiaries' eligibility and PII information was accurate and

    - comparing current payment data from the State agency to determine whether a capitation payment occurred for August 2018, to determine whether an adjustment to the payment was made, and to verify the accuracy of any encounter claims that were submitted;

- reviewed the following supporting documentation associated with each sampled capitation payment to help determine in which State each beneficiary resided and was eligible for Medicaid benefits during the audit period:

    - PARIS Alerts, which identified the matched State(s) and time period that the beneficiaries were concurrently eligible for Medicaid benefits;

    - encounter claims, which contained a record of Medicaid services that were provided and were used to identify the date and location that beneficiaries had an interaction with a health care provider;

    - eligibility case files, which contained detailed eligibility and residency information, such as utility bills, lease agreements, and detailed notes of interactions between the beneficiaries and county caseworkers, to help determine where the beneficiaries resided and whether they were eligible for Medicaid benefits during the audit period;

    - Accurint, which is a LexisNexis national investigative data depository that contains more than 78 billion records, e.g., addresses, utility information, and driver's license records, that we used to help determine where the beneficiaries resided during the audit period; and

    - information from other States, i.e., eligibility case file information from the matched State, to help determine whether the beneficiaries resided and received Medicaid benefits in the other State during the audit period;

- estimated, based on the sample results, the overall value and Federal share of any improper capitation payments made by the State agency on behalf of beneficiaries who were concurrently eligible and residing in another State by using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software; and

- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Issue Date
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in New York and New Jersey for July 1, 2005, Through June 30, 2006	A-02-07-01030	8/8/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in New Jersey and New York for July 1, 2005, Through June 30, 2006 - New Jersey Department of Human Services	A-02-07-01029	7/24/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Florida and Georgia for July 1, 2005, Through June 30, 2006	A-04-08-03034	6/3/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Georgia and Florida for July 1, 2005, Through June 30, 2006	A-04-07-03033	5/15/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Two States During August 2003	A-05-06-00057	5/8/2008
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	A-05-07-00057	5/5/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Maryland and the District of Columbia for July 1, 2005, Through June 30, 2006 - Maryland Department of Health and Mental Hygiene	A-03-07-00215	4/30/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in the District of Columbia and Maryland for July 1, 2005, Through June 30, 2006 - The District of Columbia Department of Health	A-03-07-00214	4/30/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in California and Arizona for July 1, 2005, Through June 30, 2006 - California Department of Health Care Services	A-05-07-00058	4/14/2008

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Missouri and Kansas for July 1, 2005, Through June 30, 2006 - Missouri Department of Social Services	A-07-07-04078	2/14/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Kansas and Missouri for July 1, 2005, Through June 30, 2006	A-07-07-04079	2/7/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Indiana and Illinois for July 1, 2005, Through June 30, 2006 - Indiana Family and Social Services Administration	A-05-06-00070	1/25/2008
Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Illinois and Indiana for July 1, 2005, Through June 30, 2006 - Illinois Department of Healthcare and Family Services	A-05-06-00069	1/17/2008
Medicaid Payments for Beneficiaries With Concurrent Eligibility in Michigan and Ohio - Michigan Department of Community Health	A-05-06-00020	8/28/2006
Medicaid Payments for Beneficiaries With Concurrent Eligibility in Ohio and Michigan, Ohio Department of Job and Family Services	A-05-06-00021	6/23/2006

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 23,935 August 2018 capitation payments made by the State agency on behalf of Ohio Medicaid beneficiaries who were concurrently eligible and enrolled in another State during our audit period, totaling $12,855,763.

SAMPLE UNIT

The sample unit was an August 2018 capitation payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 1). Stratum 1 contained capitation payments associated with Ohio Medicaid beneficiaries who had identical SSNs, DOB, first names, last names, and sex (PII) in the matched State with concurrent eligibility. Stratum 2 contained capitation payments associated with Ohio Medicaid beneficiaries who had an identical SSN in the matched State and concurrent MCO eligibility, but at least one of the other PII fields did not match.

Table 1: Sample Design Summary

Stratum	Frame Information			
	Matching Data Fields Between Ohio and Other States	**Number of August 2018 Capitation Payments**	**Amount of Payments**	**Sample Size**
1	SSN, DOB, first name, last name, and sex	17,717	$9,964,156	74
2	SSN	6,218	2,891,607	30
	Total	**23,935**	**$12,855,763**	**104**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units within strata 1 and 2. After generating the random numbers for each stratum, we selected the corresponding sample units in the sampling frame.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total value and Federal share of improper capitation payments made by the State agency on behalf of Ohio beneficiaries who were concurrently eligible and residing in another State during our audit period.[18]

[18] Due to technical issues, the State agency incorrectly coded Children's Health Insurance Program (CHIP) beneficiaries who received their benefits through Medicaid expansion (i.e., Medicaid-Expansion CHIP beneficiaries) as Medicaid-only beneficiaries when submitting the T-MSIS data to CMS. The State agency stated that this issue was corrected after our audit period. Our audit objective did not include reviewing Medicaid-Expansion CHIP beneficiaries. We addressed this issue by not including the identified improper CHIP capitation payments in our analysis.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Federal Share of Sample	No. of Improper Capitation Payments	Total Value of Improper Capitation Payments	Federal Share of Improper Capitation Payments
1	17,717	$9,964,156	74	$36,889	$26,491	42	$21,660	$15,578
2	6,218	2,891,607	30	10,918	7,956	5	3,253	2,042
Total	**23,935**	**$12,855,763**	**104**	**$47,807**	**$34,447**	**47**	**$24,912**[19]	**$17,620**

Table 3: Estimates of Improper Capitation Payments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount	Federal Share
Point estimate	$5,859,881	$4,152,838
Lower limit	4,313,632	3,091,162
Upper limit	7,406,131	5,214,514

[19] The stratum amounts do not sum to the total amount due to rounding.

APPENDIX E: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

States are required to provide Medicaid to eligible residents, including residents who are absent from the State. If a resident of one State subsequently establishes residency in another State for purposes of Medicaid eligibility, the beneficiary's Medicaid eligibility in the previous State should end (42 CFR § 435.403(a) and (j)(3)).

States must generally provide advance notice when the State agency terminates a Medicaid beneficiary's covered benefits or eligibility at least 10 days before the date of action (42 CFR § 431.211). However, if a State establishes that the beneficiary has been accepted for Medicaid services by another State, the original State must provide notice of the termination of the beneficiary's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)). Additionally, advance notice of eligibility termination is not required if the beneficiary's whereabouts are unknown and the post office returns agency mail indicating no forwarding address (42 CFR § 431.213(d)).

A capitation payment is "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract…for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income, as calculated by a defined formula (42 CFR § 433.10).

Section 1903(r)(3) of the Social Security Act and 42 CFR § 435.945(d) require that all States have an eligibility determination system that provides data matching through PARIS.

STATE REQUIREMENTS

Ohio's State Medicaid plan requires that Medicaid be granted to eligible applicants who, among other requirements, are residents of the State, including residents who are absent from the State under certain conditions. Self-declaration is sufficient verification of State residency, unless contradictory information is provided to or maintained by the State agency.

The State agency is required to disenroll a beneficiary from an MCO plan when the beneficiary's permanent residence moves outside the plan's service area. Disenrollment must take effect on the last day of the month in which the beneficiary moves (OAC 5160-26-02.1(B)(1) and OAC 5160-58-02.1(A)(2)).

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

October 15, 2020

Ms. Sheri Fulcher
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: Report Number: A-05-19-00023

Dear Ms. Fulcher:

Thank you for the opportunity to respond to the draft report issued by the OIG regarding the review of Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State.

The Ohio Department of Medicaid's (ODM) informal comments are as follows:

Recommendation 1
Develop or enhance current procedures to identify beneficiaries with concurrent eligibility in another State, which could have saved the State agency an estimated $5,859,881 ($4,152,838 Federal share) in capitation payments for the month of August 2018.

Management Response
To ensure ODM's records agree with CMS' data, we have requested our TAF. At this time, ODM intends to continue to use the PARIS files to determine concurrent eligibility and will monitor the process as indicated in our monitoring plan. If CMS directs Ohio and other states to use other state's TAF data to determine concurrent eligibility, when it is available, ODM will evaluate how to complete that process.

Recommendation 2
Ensure that procedures are in place for county caseworkers to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

Management Response
PARIS Interstate Match alerts are generated each quarter in March, June, September and December. Beginning with the September 2020 PARIS alerts, and continuing for each quarter after, ODM will ensure that a communication is sent to all Ohio Benefits users to notify every user of the date that the PARIS alerts will generate, provide general PARIS alert processing

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reminders, and inform counties that a report of the PARIS alerts will be sent to each County Department of Job and Family Services once the alerts are generated. ODM will ensure that reports of PARIS alerts are sent to the County Departments of Job and Family Services after the alerts are generated each quarter. ODM will monitor the PARIS alert report to ensure the county's timely processing of these alerts, on at least a quarterly basis.

ODM will ensure that training is provided to the County Departments of Job and Family Services on PARIS Interstate Match alert processing and returned mail processing. ODM will conduct the PARIS alert training jointly with ODJFS on November 9, 2020. This training will cover finding PARIS alerts, reviewing PARIS Interface screens, and the steps that should be taken to properly process a PARIS alert. In addition, an updated PARIS Alert Processing Guide will be published. Training on processing returned mail will be provided November 16, 2020 and will cover the steps that County Departments of Job and Family Services should take when a piece of mail is returned from the post office.

An enhancement to Ohio Benefits is planned for February 2021 which will stop cases from being passively renewed if there is an unworked PARIS match. Manual Renewal packets will be generated and if the individual has moved out of state, the packet will be returned to the agency and processed as returned mail.

Several system enhancements have been made to improve the visibility of alerts for caseworkers. In R3.6.3 (August 2020) functionality was implemented which places a modified Case Summary page (typically the first screen accessed by case workers) to include a new Alert and Task Dashboard. This dashboard will display the number of pending and overdue alerts as well as hyperlinks for caseworkers to access when processing the case.

ODM appreciates the OIG's review and recommendations. Thank you for the opportunity to provide informal comments on the draft report. Please let me know if you have questions or need additional information.

Sincerely,

Maureen M. Corcoran, Director