



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

REGION V
OFFICE OF
INSPECTOR GENERAL

January 17, 2008

Report Number: A-05-06-00069

Barry S. Maram
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Mr. Maram:

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 Illinois and Indiana for July 1, 2005, Through June 30, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to contact Mike Barton, Audit Manager, at (614) 469-2543 or through e-mail at Mike.Barton@oig.hhs.gov. Please refer to report number A-05-06-00069 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Mr. Barry Maram

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

**ILLINOIS DEPARTMENT OF
HEALTHCARE AND FAMILY SERVICES**



Daniel R. Levinson
Inspector General

January 2008
A-05-06-00069

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid eligibility in each State is based on residency. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. The States' Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' Medicaid agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The States' Medicaid agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

For the audit period July 1, 2005, through June 30, 2006, the Illinois Department of Healthcare and Family Services (State agency) paid approximately \$2.2 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Illinois and Indiana.

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 Indiana.

SUMMARY OF FINDINGS

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$408,841 (\$204,420 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible because of their Medicaid eligibility in Indiana. The Medicaid payments were made on behalf of these beneficiaries because the State agency and Indiana's Medicaid agency did not share all available Medicaid eligibility information.

RECOMMENDATIONS

We recommend that the State agency work with the Indiana 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 \$408,841 (\$204,420 Federal share), made on behalf of beneficiaries residing in Indiana.

STATE AGENCY'S COMMENTS

In written comments on our draft report, the State agency agreed that the audit identified a need for reducing the occurrence of Illinois Medicaid recipients having concurrent eligibility in Indiana. The State agency identified several steps to address the issue and reduce future errors. These steps include working with the Indiana Medicaid agency to exchange concurrent enrollment information. The State agency's comments are included as Appendix B.

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INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Illinois Department of Healthcare and Family Services (State agency) manages the Illinois Medicaid program.

Federal regulation 42 CFR § 435.403(a) states that States' agencies must provide Medicaid services to eligible residents of the State. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. Federal regulation 42 CFR § 435.930 states that a State agency must furnish Medicaid services to recipients until they are determined to be ineligible. Pursuant to 42 CFR § 431.211, if a recipient is determined to be ineligible the State agency must notify the recipient at least 10 days before the State agency takes action to terminate the Medicaid services. However, if the State agency determines that the recipient has been accepted for Medicaid services in another State, advance notice to terminate benefits is not required (42 CFR § 431.213(e)).

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

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in Indiana.¹

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

Scope

For the audit period of July 1, 2005, through June 30, 2006, the State agency paid approximately \$2.2 million for services provided to beneficiaries who were Medicaid-eligible and receiving benefits in Illinois and Indiana. From the universe of 5,241 beneficiary-months,² we selected a random sample of 100 beneficiary-months with payments totaling \$88,205.

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 Illinois and enrolled in the Indiana Medicaid program.

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

Methodology

To accomplish our audit objective, we obtained eligibility data from the Illinois and Indiana 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 Illinois' and Indiana'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 Illinois and Indiana, we combined all dates of service for a single beneficiary-month and matched the payment data files, between States, by Social Security number, date of birth, and month of service.

We used the Office of Inspector General, Office of Audit Service's statistical sample software RATS-STATS' random number generator to select 100 beneficiary-months with paid dates of services in both Illinois and Indiana. In Illinois, the statistical sample included payments totaling \$88,205. The selected beneficiary-months were for services provided to beneficiaries with Medicaid eligibility in both States during the same month. See Appendix A for more information regarding the sampling methodology.

We used the State agency's MMIS data to verify that the beneficiaries were enrolled in the Medicaid program and that payments were made to providers. In addition, for each

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

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

of the 100 beneficiary-months, we reviewed the Medicaid application files and other supporting documentation in both States to establish in which State the beneficiary had permanent residency in the sampled month. Based on the sample results, we estimated the total amount of payments that the State agency paid on behalf of beneficiaries who should not have been Medicaid-eligible.

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

FINDINGS AND RECOMMENDATIONS

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$408,841 (\$204,420 Federal share) for Medicaid services provided to beneficiaries who should not have been eligible due to their Medicaid eligibility in Indiana. From a random sample of 100 beneficiary-months with Medicaid payments totaling \$88,205, the State agency paid \$7,801 for 50 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Illinois. The remaining 50 payments were for services provided to beneficiaries who were eligible to receive the benefits. The payments were made on behalf of beneficiaries who should not have been eligible because the State agency and Indiana's Medicaid agency did not share all available Medicaid eligibility information.

PAYMENTS FOR INDIANA MEDICAID-ELIGIBLE BENEFICIARIES

We estimate that the State agency paid approximately \$408,841 (\$204,420 Federal share) for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits due to their eligibility in Indiana.

Federal and State Requirements

Federal regulation 42 CFR § 435.403(j)(3) states, "The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid." (Emphasis added.)

Federal regulation 42 CFR § 435.916 provides that the States' agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The States' agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The States' agencies must promptly redetermine eligibility

when they receive information of changes in beneficiaries' circumstances that may affect their eligibility.

Each State agency has specific criteria defining eligibility and residency. The Illinois Administrative Code Section 120.311 states that, in order to be eligible for Medicaid, an individual must be a resident of Illinois. Similarly, Indiana Code 12-15-4-4(2) states that Medicaid should be granted to eligible applicants who, among other requirements, are residents of Indiana.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the Illinois assistance application informs beneficiaries of the responsibility to inform the agency within 10 days of any change in living arrangements or address, and warns them that intentionally not disclosing information can result in criminal or civil prosecution.

Beneficiaries With Concurrent Eligibility

From a random sample of 100 beneficiary-months with Medicaid payments totaling \$88,205, the State agency paid \$7,801 for 50 beneficiary-months for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in Illinois.

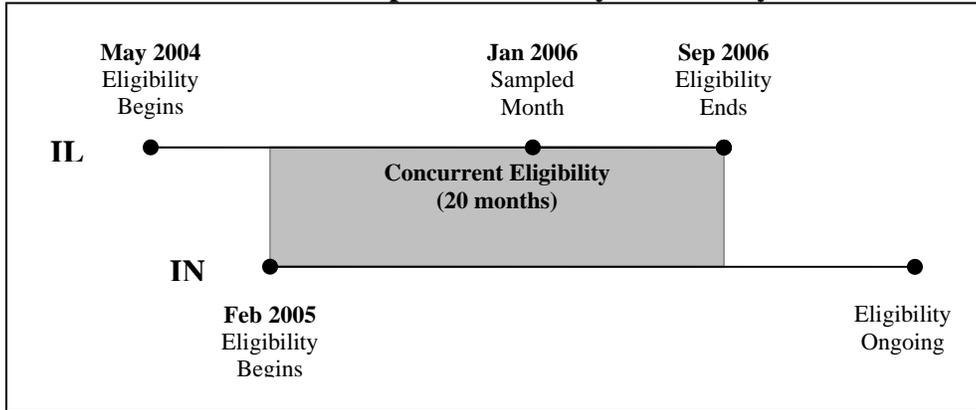
Summary of Sampled Beneficiary-Month Payments

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	50	\$80,404
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	50	7,801
Totals	100	\$88,205

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

In one example, a beneficiary, associated with a payment for one of the sampled beneficiary-months, moved from Illinois and established residency in Indiana. The Illinois eligibility period was May 1, 2004, through September 30, 2006. The Indiana eligibility period started February 1, 2005, and the beneficiary was still eligible for benefits at the end of our fieldwork.

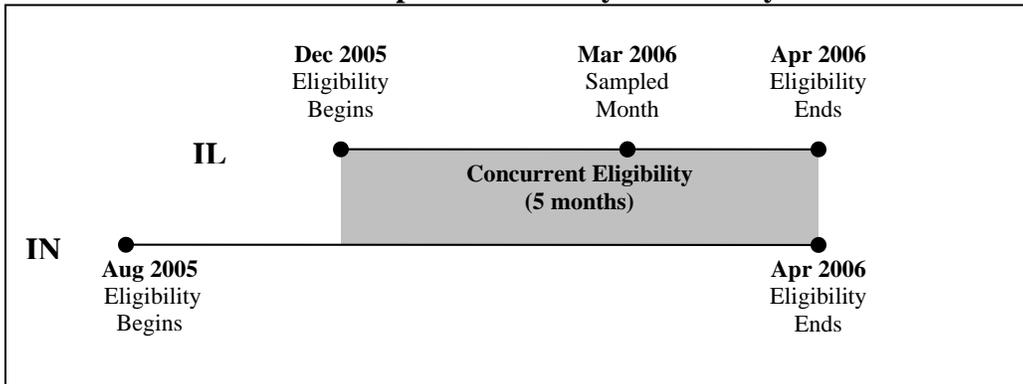
Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month Payment



Indiana Medicaid records document that the beneficiary’s family moved from Illinois and established residency in Indiana prior to the sampled beneficiary-month (January 2006). As a result, the State agency should not have made the payment for the sampled beneficiary-month (January 2006).

In contrast, a different beneficiary, associated with a payment for a sampled beneficiary-month, moved from Indiana and established residency in Illinois. The Illinois eligibility period was December 1, 2005, through April 30, 2006. The Indiana eligibility period was August 1, 2005, through April 30, 2006.

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



The Illinois Medicaid records indicated that the beneficiary moved from Indiana and established residency in Illinois in October 2005. The beneficiary provided the State agency documentation of employment and verification of residency. Because the beneficiary was an Illinois resident, the State agency appropriately made the Medicaid payments on behalf of the beneficiary for the sampled beneficiary-month (March 2006).

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 Indiana 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 Indiana 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 \$408,841 (\$204,420 Federal share), made on behalf of beneficiaries residing in Indiana.

STATE AGENCY'S COMMENTS

In written comments on our draft report, the State agency agreed that the audit identified a need for reducing the occurrence of Illinois Medicaid recipients having concurrent eligibility in Indiana. The State agency identified several steps to address the issue and reduce future errors. These steps include working with the Indiana Medicaid agency to exchange concurrent enrollment information. The State agency's comments are included as Appendix B.

APPENDIXES

SAMPLING METHODOLOGY

POPULATION

The population included beneficiary-months with services provided to Medicaid beneficiaries with concurrent eligibility in Illinois and Indiana during the audit period of July 1, 2005, through June 30, 2006. The universe consisted of 5,241 beneficiary-months with Illinois Medicaid payments totaling \$2,244,212 for services provided to beneficiaries.

SAMPLE DESIGN

We used a statistical random sample for this review. We used the Office of Inspector General, Office of Audit Services' statistical sampling software RATS-STATS to select the random sample.

RESULTS OF SAMPLE

The results of our review are as follows:

Number of Beneficiary-Months	Sample Size	Value of Sample	Number of Errors	Value of Errors
5,241	100	\$88,205	50	\$7,801

Based on the errors found in the sample data, the point estimate is \$408,841 with a lower limit at the 90% confidence level of \$175,091. The precision of the 90% confidence interval is plus or minus \$233,750 or 57.17%.

APPENDIX B



Rod R. Blagojevich, Governor
Barry S. Maram, Director

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Springfield, Illinois 62763-0002

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December 28, 2007

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

Re: Report Number A-05-06-00069

Dear Mr. Gustafson:

We have reviewed the draft report, "Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Illinois and Indiana for July 1, 2005, through June 30, 2006" and the recommendations made by your office. We appreciate having the opportunity to comment upon the draft report.

We agree that the audit has identified a need for reducing the occurrence of Illinois Medicaid recipients having concurrent eligibility in Indiana. We have identified several steps to address this issue and to reduce future errors:

- We will contact our counterparts in Indiana to review and clarify effective processes for exchange of appropriate concurrent enrollment information;
- Working with our sister state agency, the Department of Human Services, we will publish a policy memorandum clarifying the appropriate action caseworkers should take when they learn a recipient may be enrolled concurrently in another state;
- We will reemphasize to staff the importance of adjusting eligibility when a recipient appears in the quarterly *Public Assistance Reporting and Information System PARIS* report.

Efforts to implement the actions outline above are underway. If you have any questions or comments about our response to the audit, please contact Peggy Edwards, External Audit Liaison, at (217) 785-9764 or through e-mail at Peggy.Edwards@illinois.gov.

Sincerely,

A handwritten signature in black ink that reads "Barry S. Maram/kay".

Barry S. Maram
Director

E-mail: hfswebmaster@illinois.gov

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