



September 13, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Concurrently Enrolled State Children's Health Insurance Program and Medicaid Beneficiaries in Florida From April 1, 2007, Through March 31, 2008 (A-04-09-03046)

Attached, for your information, is an advance copy of our final report on concurrently enrolled Children's Health Insurance Program and Medicaid beneficiaries in Florida. We will issue this report to the Florida Agency for Health Care Administration within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services at (404) 562-7750 or through email at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-09-03046 in all correspondence.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

September 15, 2010

Report Number: A-04-09-03046

Mr. Thomas W. Arnold
Secretary
Florida Agency for Health Care Administration
2727 Mahan Drive—Mail Stop #1
Tallahassee, FL 32308

Dear Mr. Arnold:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Concurrently Enrolled State Children's Health Insurance Program and Medicaid Beneficiaries in Florida From April 1, 2007, Through March 31, 2008*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Drake, Audit Manager, at (404) 562-7755 or through email at John.Drake@oig.hhs.gov. Please refer to report number A-04-09-03046 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations (CMCHO)
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF CONCURRENTLY
ENROLLED STATE CHILDREN'S
HEALTH INSURANCE PROGRAM AND
MEDICAID BENEFICIARIES IN FLORIDA
FROM APRIL 1, 2007, THROUGH
MARCH 31, 2008**



Daniel R. Levinson
Inspector General

September 2010
A-04-09-03046

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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 Act), Medicaid pays for medical assistance for certain individuals and families with low income and resources. Pursuant to Title XXI of the Act, the State Children's Health Insurance Program (SCHIP, now known as CHIP) provides free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage.

The Federal and State Governments jointly fund and administer both Medicaid and SCHIP. The Centers for Medicare & Medicaid Services (CMS) administers both programs at the Federal level. To participate in the programs, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its programs, including program administration, eligibility criteria, service coverage, and provider reimbursement.

The Florida Agency for Health Care Administration (the State agency) operates both Medicaid and SCHIP. The Florida Department of Children and Families (DCF) determines Medicaid eligibility. The State agency contracts with other entities to provide various SCHIP services; the largest of these is the Florida Healthy Kids Corporation (FHKC), which determines SCHIP eligibility and pays most SCHIP capitation payments.

The Federal medical assistance percentages (FMAP) are used to determine the amount of Federal financial participation (FFP), or matching funds, for State expenditures in Medicaid and other certain social services. For Medicaid, section 1905(b) of the Act specifies the formula for calculating the FMAPs. The Federal Government uses enhanced FMAPs to determine the amount of FFP for State expenditures in SCHIP. The formula for calculating the enhanced FMAP is found under section 2105(b) of the Act. The State agency reports its expenditures to CMS for FFP on Forms CMS-64 (Medicaid) and CMS-21 (SCHIP). In Florida, the FMAP ranged from 56.83 percent to 58.76 percent and the enhanced FMAP ranged from 69.78 percent to 71.13 percent during our audit period. During our audit period, the State agency claimed FFP of \$7,957,995,310 and \$272,971,981 for Medicaid and SCHIP, respectively.

OBJECTIVE

Our objective was to determine whether the State agency claimed SCHIP FFP for individuals who were also enrolled in Medicaid from April 1, 2007, through March 31, 2008.

SUMMARY OF FINDINGS

The State agency claimed enhanced FFP for SCHIP enrollees who were also enrolled in Medicaid. Of the 100 concurrent enrollment-months in our sample, 93 totaling \$8,304 FFP were not allowable for Federal reimbursement under SCHIP because the beneficiaries were also enrolled in Medicaid. We found no errors in the remaining seven enrollment-months. Based on our sample results, we estimated that from April 1, 2007, through March 31, 2008, the State

agency claimed \$5,348,853 in FFP for SCHIP enrollees who were concurrently enrolled in SCHIP and Medicaid for a total 65,121 enrollment-months.

The concurrent enrollments occurred primarily because:

- Medicaid enrollment can be retroactive for up to 3 months, during which time the individual may also have been enrolled in SCHIP.
- The State agency's partners (DCF and FHKC) that administer the Medicaid and SCHIP programs did not have adequate internal controls to prevent or correct concurrent enrollments promptly.

RECOMMENDATIONS

We recommend that the State agency:

- make a financial adjustment of \$5,348,853 on Form CMS-21 for FFP claimed on behalf of SCHIP enrollees who were also enrolled concurrently in Medicaid,
- make regular financial adjustments on future Forms CMS-21 to correct FFP claimed on behalf of SCHIP enrollees who are enrolled concurrently in Medicaid, and
- develop additional policies and procedures to prevent or recoup SCHIP payments made on behalf of individuals who are enrolled concurrently in Medicaid.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our overall findings. In addition, the State agency said that four instances we cited were not errors because it made a Medicaid capitation but no SCHIP capitation payment. The State agency provided documentation to support that no SCHIP payment had been made.

The State agency said that in most cases, Medicaid claims were not paid for the audit month. The State agency further said that because it took reasonable action to comply with its approved State plan and duplicate payments were minimal, the Office of Inspector General should limit its recommended disallowance to duplicate payments rather than to improper SCHIP payments based on duplicate enrollment. Appendix C contains the State Agency's response, excluding the additional documentation it provided. We excluded the additional documentation because it contained personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

Based on our analysis of additional information the State agency provided, we reduced: (1) the number of unallowable concurrent enrollment months from 97 to 93, (2) the estimated total concurrent enrollment months from 68,982 to 65,121, and (3) the recommended overpayment recovery from \$5.6 million to \$5.3 million.

In regard to the State agency's comments that our recommended disallowance should be limited to duplicate payment rather than to improper SCHIP payments based on duplicate enrollment, Federal law prohibits SCHIP payments for expenditures for child health assistance provided for a targeted low-income child under its SCHIP State plan for which payment has been made or can reasonably be expected to be made under any other Federal health insurance program. Further, if a child does not meet the definition of a targeted low income child for SCHIP eligibility, i.e., a child who is eligible for Medicaid, he or she is ineligible for SCHIP. Therefore, no SCHIP payment is allowable for health care coverage, unless presumptive eligibility is applicable. Therefore, our findings on this issue remain unchanged.

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INTRODUCTION

BACKGROUND

Medicaid and State Children's Health Insurance Program

Pursuant to Title XIX of the Social Security Act (the Act), Medicaid pays for medical assistance for certain individuals and families with low income and resources. Pursuant to Title XXI of the Act, the State Children's Health Insurance Program (SCHIP¹) provides free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage.

The Federal and State Governments jointly fund and administer both Medicaid and SCHIP. The Centers for Medicare & Medicaid Services (CMS) administers both programs at the Federal level. To participate in the programs, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its programs, including program administration, eligibility criteria, service coverage, and provider reimbursement.

The Federal medical assistance percentages (FMAP) are used to determine the amount of Federal financial participation (FFP), or matching funds, for State expenditures in Medicaid and other certain social services. For Medicaid, section 1905(b) of the Act specifies the formula for calculating the FMAPs. The Federal Government uses enhanced FMAPs to determine the amount of FFP for State expenditures in SCHIP. The formula for calculating the enhanced FMAP is found under section 2105(b) of the Act.

Florida's Medicaid and State Children's Health Insurance Program

The Florida Agency for Health Care Administration (State agency) operates both Medicaid and SCHIP. The Florida Department of Children and Families (DCF) determined Medicaid eligibility. The State agency makes payments to providers on behalf of Medicaid-eligible individuals for fee-for-service claim or monthly capitation payments.

The State agency contracts with other entities to provide various SCHIP services; the largest of these is the Florida Healthy Kids Corporation (FHKC), which determines SCHIP eligibility and pays SCHIP monthly capitation payments.

If an individual is eligible for Medicaid, he or she is ineligible for SCHIP. Concurrent enrollment arises when an individual is enrolled in both SCHIP and Medicaid. Payment for a concurrently enrolled beneficiary could take three forms:

1. FHKC makes an SCHIP capitation payment on behalf of an enrolled individual and the State agency makes a Medicaid capitation payment on behalf of the same individual.

¹ This program was renamed the Children's Health Insurance Program as of February 4, 2009.

2. FHKC makes an SCHIP capitation payment on behalf of an enrolled individual and the State agency pays Medicaid fee-for-service claims for the same individual.
3. FHKC makes an SCHIP capitation payment on behalf of an enrolled individual who is also eligible for Medicaid but the State agency does not pay any Medicaid fee-for-service claims for that individual.

The State agency reports its expenditures to CMS for Federal reimbursement on Forms CMS-64 (Medicaid) and CMS-21 (SCHIP). In Florida, the Federal medical assistance percentage (FMAP) ranged from 56.83 percent to 58.76 percent and the enhanced FMAP ranged from 69.78 percent to 71.13 percent during our audit period. During our audit period, the State agency claimed FFP of \$7,957,995,310 and \$272,971,981 for Medicaid and SCHIP, respectively.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed SCHIP FFP for individuals who were also enrolled in Medicaid from April 1, 2007, through March 31, 2008.

Scope

From a population of 74,630 enrollment-months, we reviewed 100 during which individuals were concurrently enrolled in SCHIP and Medicaid from April 1, 2007, through March 31, 2008. We did not evaluate the State agency's eligibility determinations for our enrollment-months beyond determining whether SCHIP enrollees were concurrently enrolled in Medicaid.

We performed fieldwork at the State agency and FHKC in Tallahassee, Florida, from February through August 2009.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other guidance related to Medicaid and SCHIP enrollment;
- interviewed State agency officials to identify the State agency's policies and procedures for coordinating Medicaid and SCHIP enrollment;
- obtained Medicaid and SCHIP enrollment files from April 1, 2007, through March 31, 2008;
- matched Medicaid and SCHIP enrollment files for the same months to identify individuals who were enrolled in both programs during the same month, i.e., a concurrent enrollment-month;

- selected a sample of 100 concurrent enrollment-months from the matched enrollment file;
- for all 100 sampled enrollment-months, reviewed available Medicaid and SCHIP records—including enrollment applications, case notes, correspondence, and other supporting documentation—and verified concurrent enrollment with State agency officials;
- for all 100 sampled enrollment-months, calculated the amount of unallowable payments by subtracting the monthly family contribution from the monthly SCHIP payment and multiplying the net amount by the applicable FMAP; and
- estimated the number of concurrent enrollment-months and the total amount of unallowable payments in our sampling frame.

See Appendix A for a complete description of our sampling methodology and Appendix B for our sample results.

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.

FINDING AND RECOMMENDATIONS

The State agency claimed FFP for SCHIP enrollees who were also enrolled in Medicaid. Of the 100 concurrent enrollment-months in our sample, 93 totaling \$8,304 FFP were not allowable for Federal reimbursement under SCHIP because the beneficiaries were also enrolled in Medicaid. We found no errors in the remaining seven sampled enrollment-months. Based on our sample results, we estimated that from April 1, 2007, through March 31, 2008, the State agency claimed \$5,348,853 in FFP for SCHIP enrollees who were concurrently enrolled in SCHIP and Medicaid for a total 65,121 enrollment-months.

The concurrent enrollments occurred primarily because:

- Medicaid enrollment can be retroactive for up to 3 months, during which time the individual may have been enrolled in SCHIP.
- The State Agency’s partners (DCF and FHKC) that administer Medicaid and SCHIP did not have adequate internal controls to prevent or correct concurrent enrollments promptly.

CONCURRENTLY ENROLLED INDIVIDUALS

Federal and State Requirements

Pursuant to section 2105(a)(1)(A) of the Act, SCHIP is available to targeted low-income children. Section 2110(b)(1)(C) of the Act defines targeted low-income children as those not found to be eligible for Medicaid or covered under a group health plan or other health insurance coverage.

Section 2105(c)(6)(B) of the Act specifically prohibits SCHIP payments for which payment has been made or can reasonably be expected to be made under any other Federal health care insurance program.

Federal regulations (42 CFR § 457.350(a)(1)) require States to use screening procedures to ensure that only targeted low-income children are furnished child health assistance. If the children are potentially eligible for Medicaid, the State must facilitate application to Medicaid. Otherwise, the State screens the children for SCHIP eligibility (42 CFR § 457.350(a)(2)).

Section 4.3 of the Florida SCHIP State Plan requires, as a condition for SCHIP eligibility, that the child is uninsured and ineligible for Medicaid.

Because only targeted low-income children are eligible for coverage through SCHIP, and by definition such children are ineligible for Medicaid, there should not be concurrent enrollment in Medicaid and SCHIP.

State Children's Health Insurance Program Payments Made On Behalf of Individuals Enrolled in Medicaid

Of the 100 concurrent enrollment-months in our sample, 93 totaling \$8,304 FFP were not allowable for Federal reimbursement under SCHIP because the beneficiaries were also enrolled in Medicaid.

Of the 93 sampled enrollment-months:

- 12 were for individuals concurrently enrolled for 1 month or less;
- 42 were for individuals concurrently enrolled for 2 months;
- 35 were for individuals concurrently enrolled for 3 months; and
- 4 were for individuals concurrently enrolled for more than 3 months.

The longest period for which an individual was concurrently enrolled was 7 months. The State agency did not credit the Federal Government for FFP claimed during the individuals' months of concurrent enrollment.

Of the 93 sampled enrollment-months:

- 12 were for individuals on whose behalf the State agency also made Medicaid capitation payments, totaling \$1,248;
- 11 were for individuals on whose behalf the State agency also paid Medicaid fee-for-service claims, totaling \$2,797; and
- 70 were for individuals enrolled in Medicaid on a fee-for-service basis but on whose behalf the State agency did not pay any Medicaid claims.

Retroactive Medicaid Enrollment and Inadequate Controls Between Programs

Retroactive Medicaid Enrollment

The combination of retroactive Medicaid enrollment and prospective SCHIP coverage can result in monthly SCHIP capitation payments being made before an individual's eligibility for Medicaid is established. Florida provides Medicaid coverage for the full month if an individual is eligible at any time during the month.² In addition, Medicaid enrollment can be retroactive for up to 3 months if the individual would have been eligible during the retroactive period.³ SCHIP eligibility, however, is determined prospectively, as is its annual redetermination. Once an individual is enrolled in SCHIP, the individual is eligible for continuous coverage for 12 months. Thus, an SCHIP enrollee may apply for Medicaid coverage and be determined retroactively eligible for Medicaid while still enrolled in SCHIP.

For example:

- FHKC referred an SCHIP enrollee to Medicaid on December 12, 2007. The individual was then enrolled in Medicaid retroactively to December 1, 2007. This individual was already covered under SCHIP for the month of December, thus creating a concurrent enrollment-month.
- An individual was enrolled in SCHIP effective April 1, 2007. The individual then applied for Medicaid on May 14, 2007, and was retroactively covered for Medicaid effective March 1, 2007. The period of concurrent enrollment lasted for 3 months, from April through June.
- An individual was enrolled in SCHIP effective July 1, 2007. On August 7, 2007, the individual was referred from SCHIP to Medicaid. The individual's Medicaid coverage was retroactive to July 1, 2007. The period of concurrent enrollment lasted for 5 months, from July through November.

² 42 CFR § 435.914(b) and Attachment 2.6-A of the Florida Medicaid State Plan

³ Section 1902(a)(34) of the Act and 42 CFR § 435.914(a)

State agency officials knew of no provision in contracts with SCHIP providers to retroactively cancel SCHIP coverage when retroactive Medicaid coverage has been established. In addition, if an SCHIP enrollee appeals the determination that he or she is no longer eligible for SCHIP because of entitlement to Medicaid, the enrollee's coverage under SCHIP will continue during the appeal.

Inadequate Controls Between Programs

The State agency's partners (DCF and FHKC) that administered Medicaid and SCHIP did not have adequate internal controls to prevent or correct concurrent enrollments promptly. All new SCHIP applicants were screened to ensure they were not enrolled in Medicaid. Based on periodic screenings during redeterminations or upon inquiry from enrollees, FHKC identified enrollees that were potentially Medicaid-eligible and referred them to DCF. Also, the State matched Medicaid and SCHIP enrollment records monthly to identify concurrent enrollment.⁴ However, the results from the referrals and data matches were not always acted on promptly, allowing concurrent enrollments to continue.

Some of our concurrent enrollment-months involved individuals with multiple Medicaid and SCHIP referrals, primarily due to fluctuations in the individuals' income. For these individuals, careful program coordination and prompt followup on data matches is critical to prevent concurrent enrollments from continuing for multiple months.

For example:

- FHKC referred an SCHIP enrollee to Medicaid on December 12, 2007. The enrollee's Medicaid eligibility became effective on December 1, 2007; however, the enrollee did not receive a letter from FHKC until February 5, 2008, indicating that the individual was enrolled in Medicaid and the enrollee's SCHIP coverage would terminate at midnight on March 1, creating 3 concurrent enrollment-months.
- Another SCHIP enrollee's file indicated that both Medicaid and SCHIP coverage began in November 2007. FHKC did not identify the concurrent enrollment until January 2008. The individual was concurrently enrolled for 3 months from November 2007 through January 2008.
- One individual was enrolled in Medicaid effective January 1, 2008. FHKC sent a letter to the individual dated March 6, 2008, over 2 months after the Medicaid effective date, indicating that FHKC received information that the individual was enrolled in Medicaid and that his SCHIP coverage would terminate at midnight on April 1, 2008. Ultimately, the individual was concurrently enrolled for 3 months during our audit period.

⁴ After our audit period, FHKC increased the frequency of these data matches to daily.

Improperly Claimed Federal Financial Participation

We estimated that from April 1, 2007, through March 31, 2008, the State agency claimed \$5,348,853 in FFP, which was based on the enhanced FMAP, for individuals who were concurrently enrolled in SCHIP and Medicaid.

While these payments were ineligible for Federal reimbursement, services that were eligible for reimbursement under Medicaid may have been provided to individuals under SCHIP. Determination of the specific services provided to the individuals in our sample, and whether these services were reimbursable under Medicaid, was beyond the scope of our audit.

RECOMMENDATIONS

We recommend that the State agency:

- make a financial adjustment of \$5,348,853 on Form CMS-21 for FFP claimed on behalf of SCHIP enrollees who were enrolled concurrently in Medicaid,
- make regular financial adjustments on future Forms CMS-21 to correct FFP claimed on behalf of SCHIP enrollees who are enrolled concurrently in Medicaid, and
- develop additional policies and procedures to prevent or recoup SCHIP payments made on behalf of individuals who are enrolled concurrently in Medicaid.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our overall findings. In addition, the State agency said that four instances we cited were not errors because it made a Medicaid capitation but no SCHIP capitation payment. The State agency provided documentation to support that no SCHIP payment had been made.

The State agency said that in most cases, Medicaid claims were not paid for the audit month. The State agency further said that because it took reasonable action to comply with its approved State plan and duplicate payments were minimal, the Office of Inspector General should limit its recommended disallowance to duplicate payments rather than to improper SCHIP payments based on duplicate enrollment. Appendix C contains the State Agency's response, excluding the additional documentation it provided. We excluded the additional documentation because it contained personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

Based on our analysis of additional information the State agency provided, we reduced: (1) the number of unallowable concurrent enrollment months from 97 to 93, (2) the estimated total concurrent enrollment months from 68,982 to 65,121, and (3) the recommended overpayment recovery from \$5.6 million to \$5.3 million.

In regard to the State agency's comments that our recommended disallowance should be limited to duplicate payments rather than improper SCHIP payments based on duplicate enrollment, Federal law prohibits SCHIP payments for expenditures for child health assistance provided for a targeted low-income child under its SCHIP State plan for which payment has been made or can reasonably be expected to be made under any other Federal health insurance program. Further, if a child does not meet the definition of a targeted low income child for SCHIP eligibility, i.e., a child who is eligible for Medicaid, he or she is ineligible for SCHIP. Therefore, no SCHIP payment is allowable for health care coverage, unless presumptive eligibility is applicable. Therefore, our findings on this issue remain unchanged.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

Population

The population consisted of individuals in Florida who were concurrently enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP) for at least a portion of the same month from April 1, 2007, through March 31, 2008.

Sampling Frame

We downloaded a database of enrolled Medicaid individuals from April 1, 2007, through March 31, 2008, from the Medicaid Statistical Information System. We also obtained a database of enrolled SCHIP individuals from April 1, 2007, through March 31, 2008, from the Florida Healthy Kids Corporation. We matched the Medicaid data with the SCHIP data to create a database of concurrent enrollees. This database contained 42,217 individuals with 74,630 concurrent enrollment-months during our 1-year audit period.

Sample Unit

The sample unit was a concurrent enrollment-month.

Sample Design

We used a simple random sample.

Sample Size

We selected a sample of 100 concurrent enrollment-months.

Source of Random Numbers

The random numbers used in our sample were generated by Office of Inspector General/Office of Audit Services (OIG/OAS) statistical software.

Method of Selecting Sample Items

We consecutively numbered the sample units in the frame from 1 to 74,630. After generating 100 random numbers, we selected the corresponding frame items.

Treatment of Missing Sample Items

There were no missing sample items.

Estimation Methodology

We used the OIG/OAS statistical software to estimate the amount of Federal financial participation (FFP) related to SCHIP payments for concurrently enrolled individuals that the State agency claimed improperly.

Description of How Results Are Reported

Our estimates are reported at the lower limit for a 90-percent confidence interval. See Appendix B for the complete listing of sample results.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Frame Size	Sample Size	Value of Sample	Number of Ineligible Concurrent Enrollment-Month Payments	Value of Ineligible Payments (FFP)
74,630	100	\$14,061	93	\$8,304

Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Number of Concurrent Enrollment-Months	Estimated Dollar Value of Ineligible Payments (FFP)
Point Estimate	69,406	\$6,197,021
Lower Limit	65,121	\$5,348,853
Upper Limit	72,142	\$7,045,188

APPENDIX C: STATE AGENCY COMMENTS



CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

June 30, 2010

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General, Region IV
61 Forsyth Street, S.W., Room 3T41
Atlanta, GA 30303-8909

RE: A-04-09-03046

Dear Mr. Barbera:

Thank you for the opportunity to respond to the Office of Inspector General's draft report, *Review of Concurrently Enrolled Children's Health Insurance Program and Medicaid Beneficiaries in Florida From April 1, 2007, Through March 31, 2008*. We would like to take this opportunity respond to the findings in general and point out our findings on four individual children cited as being in error.

The following four children only had a Title XIX Medicaid capitation paid during the audit month. FMMIS screen prints are enclosed, showing capitation payments made under a Medicaid category code.

Sample #	Month Evaluated	CHIP Payment	Medicaid Payment
19	August 2007	0	\$106.85
32	June 2007	0	\$ 99.28
34	September 2007	0	\$117.55
60	August 2007	0	\$ 99.28
Total Not in Error			\$422.96

We are not in agreement with your overall findings. Title XXI policy and procedures were followed according to our approved Title XXI State Plan Amendment #17, in effect during 2007 and 2008. The following sections pertain to Medicaid referrals:

- Section 4.3 (page 49) discusses that a referral will be made to Medicaid when a decrease in the family income makes the child potentially eligible for Medicaid.



Peter J. Barbera
June 30, 2010
Page Two

- Section 4.3 (page 50) discusses the CHIP renewal process and timeframes.
- Section 4.4.1. discusses the assurances that the screening process prevents children eligible for Medicaid or other health care coverage from getting CHIP coverage.
- Section 4.4.2. discusses the assurances that the screening process identifies children potentially eligible for Medicaid and refers to Medicaid.
- Section 2.3 discusses the coordination between CHIP and other public and private health insurance plans.
- Section 8.7.1 discusses the assurances that reasonable notice is provided to families when changes are made to a child's CHIP coverage.

In almost all of the cases, on the first day of the audit month when the CHIP coverage was provided, the child was not Medicaid eligible. The Department of Children and Families (DCF), determines eligibility for Medicaid. DCF determined Medicaid eligibility after the beginning of the audit month and authorized Medicaid coverage back to the month of the Medicaid referral. DCF authorized Medicaid coverage according to 42 CFR 435.930 and 42 CFR 435.914 which requires that Medicaid coverage begins on the first day of the month of application, or in these instances, the first day of the month of the Medicaid referral.

In most cases, a CHIP capitation was paid to a CHIP health plan at the beginning of the audit month and services were provided through the CHIP plan. Then, at the later date when DCF determined Medicaid eligibility, Medicaid fee-for-service coverage was provided. In most cases, Medicaid claims were not paid for the audit month. There were only 12 cases where a Medicaid fee-for-service claim was paid and 13 cases where a Medicaid capitation was paid to a Medicaid provider.

Recognizing that our approved State Plan can result in dual enrollment, we minimize it by running a Medicaid match each month on all active CHIP enrollees, and since 2008, we also run a daily match for pending applicants. We intend to start running a second Medicaid match each month to identify individuals enrolled later in that month. This will help identify children approved for Medicaid later in the month who were not included in the earlier match process.

We are in agreement that it serves no purpose to have a child dually enrolled and is not an effective use of state and federal funds; however, CHIP funding should not be subject to recoupment when the State took reasonable action to comply with our approved State Plan and duplicate payments were minimal. As a result, we request that OIG reconsider the overpayment and refine the amount so that it is limited to duplicate payment instead of duplicate enrollment.

Peter J. Barbera
June 30, 2010
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The Agency for Health Care Administration is exploring additional methods for minimizing or avoiding dual enrollment as we go forward. With guidance from the Centers for Medicare and Medicaid Services and consultations with the Agency's legal counsel, we hope to implement a new process to avoid dual enrollment.

Thank you for the opportunity to respond to this draft audit report. Should you have any questions regarding our request, please contact Gail Hansen, Program Administrator over CHIP, at (850) 412-4195.

Sincerely,


Thomas W. Arnold
Secretary

TWA/gh
Enclosures