



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

REGION V
OFFICE OF
INSPECTOR GENERAL

August 28, 2006

Report Number: A-05-06-00020

Ms. Janet Olszewski, Director
Michigan Department of Community Health
Capitol View Building
201 Townsend, 7th Floor
Lansing, Michigan 48933-1505

Dear Ms. Olszewski:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Medicaid Payments for Beneficiaries with Concurrent Eligibility in Michigan and Ohio" for the period October 1, 2002, through September 30, 2003. A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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.

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To facilitate identification, please refer to report number A-05-06-00020 in all correspondence relating to this report.

Sincerely,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:
Associate Regional Administrator for Medicaid
Centers for Medicare & Medicaid Services, Region V
U.S. Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID PAYMENTS FOR
BENEFICIARIES WITH
CONCURRENT ELIGIBILITY IN
MICHIGAN AND OHIO**

**MICHIGAN DEPARTMENT OF
COMMUNITY HEALTH**



Daniel R. Levinson
Inspector General

August 2006
A-05-06-00020

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

The Medicaid program provides medical services to needy individuals who are determined to be eligible beneficiaries in accordance with approved State plans. The Michigan Family Independence Agency, Program Eligibility Manual, Section 220, states a person is an eligible resident if he is not receiving assistance from another State and is living in Michigan, except for a temporary absence, and intends to remain in the State permanently or indefinitely. Similarly, the Ohio Administrative Code 5101:1-39-54 states that Medicaid eligibility can be extended only to residents of Ohio. An individual is an Ohio resident if he is living in Ohio at the time of application and is not receiving assistance in another State.

Medicaid eligibility in both Michigan and Ohio is based on residency. If a Michigan resident subsequently establishes residency in Ohio, the beneficiary's Medicaid eligibility in Michigan should end and any payments on behalf of that beneficiary would be inappropriate.

Federal computer matching initiatives, such as the Public Assistance Reporting Information System (PARIS), are available to assist states in validating Medicaid beneficiary information. Residency information for individuals with eligibility in specific public assistance programs, including Medicaid, is available for use by states participating in the PARIS project. Neither Michigan nor Ohio participates in the PARIS project.

OBJECTIVE

The objective of our audit was to determine the appropriateness of Medicaid payments made by the State of Michigan for beneficiaries who were concurrently listed as Medicaid eligible in both Michigan and Ohio.

FINDINGS

We found that the Michigan Medicaid program inappropriately paid \$843,228 for 617 Medicaid beneficiaries who had established eligibility in both States but should only have been eligible in Ohio. We did not determine the allowability of an additional \$100,575 of payments made during the first month of concurrent eligibility because Michigan considers the beneficiary eligible for the entire month once eligibility is established. Since the position is contrary to the State's eligibility prohibition against receiving assistance in another State, the State needs to determine whether these payments are allowable.

We attribute the Medicaid overpayments to a lack of state to state sharing of Medicaid beneficiary eligibility data, needed to stop payments when residency changes and State eligibility ends. Since State residency is a precondition for Medicaid eligibility and

eligibility is not available to beneficiaries receiving assistance in another State, procedures to capture and share State residency changes are essential to making the proper payments. The Michigan Department of Community Health (State agency) procedures for capturing and sharing residency information did not identify, in a timely manner, beneficiaries who moved from Michigan and became Medicaid eligibles in Ohio. During fiscal year 2003, the Michigan Medicaid program overpaid 617 beneficiaries who were concurrently eligible for Medicaid in Michigan and Ohio.

The State agency relies on the beneficiaries or other State agencies to provide information regarding changes in a beneficiaries' eligibility status. Although eligibility information is available from outside computerized data matches, such as the PARIS project, Michigan did not participate in the project and did not have access to the data. Without notification of a change in residency status from the beneficiary, from the State to which the beneficiary moved, or from other resources, the State may not know that the beneficiary is no longer eligible for Medicaid.

RECOMMENDATIONS

We recommend that the State agency:

- seek recovery of inappropriate payments, estimated to be \$843,228 (\$467,317 Federal share), and refund the Federal share of recovered amounts;
- review payments made in the first month of concurrent eligibility and determine whether the payments are allowable; and
- consider additional procedures for identifying beneficiaries moving out of State, including participation in the PARIS project and increased sharing of eligibility information with other State Medicaid programs.

In a written response dated July 12, 2006, Michigan officials agreed that they should not make Medicaid payments for beneficiaries who established residency and received assistance in another State. However, they do not intend to seek recovery of the questioned costs, asserting that they do not have the authority to recover capitated payments and that recovery of fee-for-service payments would not be cost effective. The State agency does not intend to review payments made during the first month of concurrent eligibility because, as we previously recognized, its payment policy considers these payments to be allowable, if the individuals are eligible at any time during the month. The State agency will consider participation in the PARIS project and other options to identify and prevent payments that are the responsibility of another State.

We believe that the State agency can and should attempt to recover the inappropriate Medicaid payments of \$843,228 (\$467,317 Federal share). The contract between the State agency and providers established the State as the sole authority for determining individual or family eligibility and permitted the State to retroactively disenroll a person and recoup the capitated payments as soon as an enrollment error is discovered. The

State agency should attempt to recover the inappropriate capitated payments (\$823,931) and fee-for-service (\$19,297) payments.

We also believe that the State agency should reconsider the allowability of the \$100,575 (\$55,739 Federal share) of payments made during the first month of concurrent eligibility, which contradict the State's criteria precluding eligibility if the beneficiary established residency and received assistance in another State.

We support the State agency's plan to explore possible options to identify and prevent overpayments for beneficiaries no longer eligible for Medicaid in Michigan.

The response is summarized in the body of the report and is included in its entirety as an Appendix to the report.

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INTRODUCTION

BACKGROUND

The Medicaid program provides medical services to needy individuals who are determined to be Medicaid eligible beneficiaries in accordance with approved State plans. The program is jointly administered by the Federal Government through the Centers for Medicare & Medicaid Services and by the States through their designated state agency. In Michigan, the Medicaid program is administered by the Michigan Department of Community Health (State agency).

The Michigan Family Independence Agency, Program Eligibility Manual, section 220, states a person is an eligible resident for Medicaid if he is not receiving assistance from another State and is living in Michigan, except for a temporary absence, and intends to remain in the state permanently or indefinitely. Similarly, the Ohio Administrative Code 5101:1-39-54 states that Medicaid eligibility can be extended only to those individuals who are determined to be residents of Ohio. An individual is an Ohio resident if he is living in Ohio at the time of application and is not receiving assistance in another State.

Medicaid eligibility in both Michigan and Ohio is based on residency. If a Michigan resident subsequently establishes residency in Ohio, the beneficiary's Medicaid eligibility in Michigan should end and any payments on behalf of that beneficiary would be inappropriate.

States can use Federal computer matching initiatives such as the Public Assistance Reporting Information System (PARIS) to validate beneficiary information and residency for programs such as Medicaid. The U.S. Department of Health and Human Services' Administration for Children and Families designed PARIS as a means to verify public assistance client information. Although there are currently 36 State agencies participating in the PARIS project, neither Michigan nor Ohio participates.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our audit was to determine the appropriateness of Medicaid payments made by the State of Michigan for beneficiaries who were concurrently listed as Medicaid eligible in both Michigan and Ohio.

Scope

For Federal fiscal year (FY) 2003 (October 1, 2002, through September 30, 2003), we identified 4,961 beneficiaries who were concurrently listed as Medicaid eligible in Michigan and Ohio. Medicaid payments on behalf of these beneficiaries during FY 2003 by Michigan and Ohio totaled \$5,814,373 and \$4,560,645, respectfully. These Medicaid payments were either monthly capitation payments to managed care organizations or fee for service payments made to providers that provided services to the Medicaid

beneficiaries. In Michigan, most of the payments were monthly capitated payments to managed care organizations.

We did not review the overall internal control structure of the State agency's Medicaid program. Our internal control review was limited to obtaining an understanding of Michigan's procedures to identify individuals who moved out of State and enrolled in Ohio's Medicaid program.

We performed our audit work at the State agency offices in Lansing, Michigan and Columbus, Ohio. The fieldwork was conducted from December 2004, through August 2005.

Methodology

We downloaded fiscal year (FY) 2003 eligibility data from the Medicaid Statistical Information System (MSIS) and extracted selected eligibility data for all beneficiaries in the States of Michigan and Ohio. We then matched the social security numbers on the MSIS files to identify those beneficiaries who were listed as eligible in both States during FY 2003. For these beneficiaries, we extracted payments for "Other" types of claims¹ from the FY 2003 MSIS files for each State.

We then matched the payments by beneficiaries' social security numbers and dates of birth to identify beneficiaries who were eligible in and had payments made by both States during the same month. This data matching process produced a set of 1,251 beneficiaries with Medicaid payments totaling \$2,139,113 in Michigan and \$1,946,219 in Ohio.

Using monthly eligibility data from the FY 2002 and FY 2003 Medicaid Management Information System (MMIS), we then determined the State in which each of the 1,251 beneficiaries first established their Medicaid eligibility.

For the first month after concurrent eligibility, we classified Medicaid payments made by Michigan as inappropriate if beneficiaries first established eligibility in Michigan and subsequently moved to Ohio. Conversely, we accepted payments for the first month after concurrent eligibility if beneficiaries obtained Medicaid eligibility in Michigan after moving from Ohio.

We did not determine the allowability of 1009 payments (770 capitated and 239 fee-for-service payments) made in the month in which concurrent eligibility was established. Through a review of the State Plan and discussions with State agency officials, we did determine how Michigan established Medicaid eligibility during the first month of concurrent eligibility, as compared to criteria cited in this report.

Our audit was conducted in accordance with generally accepted government auditing standards.

¹ MSIS utilizes four claims files: Inpatient Claims, Long Term Care Claims, Other Claims, and Prescription Drug Claims.

FINDINGS AND RECOMMENDATIONS

We found that the Michigan Medicaid program inappropriately paid \$843,228 for 617 Medicaid beneficiaries who had established eligibility in both States but should only have been eligible in Ohio. We did not determine the appropriateness of an additional \$100,575 of payments made during the first month of concurrent eligibility because Michigan considers the beneficiary eligible for the full month once eligibility is established any time during the month. Since this seems contrary to the State’s eligibility prohibition against receiving assistance in another state, we have recommended that Michigan determine the allowability of these payments.

We attribute these inappropriate Medicaid payments to the State agency’s lack of state to state sharing of Medicaid beneficiary eligibility data. Since State residency is a precondition for Medicaid eligibility and eligibility is not available to beneficiaries receiving assistance in another State, procedures to capture and share State residency changes are essential to making correct payments. The State agency’s procedures for capturing and sharing residency information did not identify, in a timely manner, beneficiaries who moved from Michigan and became Medicaid eligible in Ohio.

The State agency relies upon beneficiaries or Medicaid agencies in other States to provide information regarding changes in a beneficiaries’ eligibility status. Although eligibility information is available from outside computerized data matches, such as PARIS, currently used by 36 State agencies, Michigan did not participate in the PARIS project. Without timely notification of a change in residency status from beneficiaries, from the State to which the beneficiary moved, or from other resources, the State may not that know the beneficiary is no longer eligible for Medicaid.

Inappropriate Payments for Concurrently Eligible Beneficiaries

The Michigan Medicaid program made inappropriate payments for 617 beneficiaries who were concurrently listed as Medicaid eligible in Michigan and Ohio during FY 2003. State Medicaid regulations stipulate that in order for beneficiaries to be Medicaid eligible, they must live in a State on a permanent or indefinite basis and cannot receive assistance from another State. Accordingly, once these beneficiaries moved to Ohio and established Medicaid eligibility, they were no longer eligible for Medicaid in Michigan.

The State agency overpaid 6,567 Medicaid claims totaling \$843,228. The following table details the inappropriate payments by type of claim. As shown, most of the inappropriate payments were for capitated payments.

Medicaid Overpayments by Type of Claim

Fee for Service	480	\$ 19,297	2%
Capitated Payments	6,087	\$ 823,931	98%

As previously indicated, we did not determine the appropriateness of \$100,575 in capitated and fee-for-service payments for 1,009 claims paid during the first month of concurrent eligibility. These included 770 claims totaling \$92,175 for capitated payments and 239 claims totaling \$8,400 for fee-for-service payments.

Although the Medicaid State plan states that coverage is available for the full month if the individuals are eligible at any time during the month, the previously cited eligibility criteria precludes eligibility if the beneficiary is receiving assistance in another State. Despite, the State's eligibility prohibition against receiving assistance concurrently in another State, the State agency still considered these capitated and fee-for-service payments to be allowable during the first month of concurrent eligibility. Capitated payments continue until an event triggers the termination of eligibility and stops the payment. Capitated payments generally terminate when a beneficiary fails to respond to the annual Medicaid eligibility determination questionnaire.

The State Agency Lacks Controls to Detect Movement Out of State

The State agency's procedures for capturing and sharing residency information did not identify, in a timely manner, beneficiaries who moved from Michigan and established Medicaid eligibility in Ohio. Procedures used to identify a change in residency depend upon notices from beneficiaries and Medicaid agencies in other States and do not include systematic matching or use of other available sources of eligibility data.

To encourage notification from beneficiaries, the Michigan Medicaid assistance application informs the beneficiaries of their responsibility to report a change of address within 10 days of moving and warns the beneficiaries that intentionally not disclosing this change can result in prosecution for fraud or perjury.

Although Ohio attempts to identify applicants for Ohio benefits that were Medicaid beneficiaries in another State and then notifies that State of conflicting eligibility, numerous beneficiaries remained eligible in Michigan after establishing eligibility in Ohio. The Ohio medical assistance application requests information on the applicant's prior State of eligibility so that the information can be shared with the previous State of residency.

In addition to individual eligibility information available from the Michigan and Ohio MMISs, eligibility data could also be obtained from computerized matches of this data or other available data from sources, such as PARIS. The PARIS cooperative initiative provides Medicaid related information for clients of participating State public assistance agencies. Participating agencies submit data that includes their clients' Medicaid status, Medicaid eligibility start and end dates, and addresses. Those States that participate can use the matched data to validate client or beneficiary information and identify possible erroneous payments. Michigan did not participate in the PARIS project and, therefore, did not have access to the data.

Without notification of a change in residency status from beneficiaries, from another State, or from other sources, the State may not know that the beneficiary is no longer eligible for Medicaid.

RECOMMENDATIONS

We recommend that the State agency:

- seek recovery of inappropriate payments, estimated to be \$843,228 (\$467,317 Federal share), and refund the Federal share of recovered amounts;
- review payments made in the first month of concurrent eligibility and determine whether the payments are allowable; and
- consider additional procedures for identifying beneficiaries moving out of State, including participation in the PARIS project and increased sharing of eligibility information with other State Medicaid programs.

STATE AGENCY COMMENTS

The State agency agreed that they should not make Medicaid payments for beneficiaries who established residency and received assistance in another State. However, they do not intend to seek recovery of the questioned costs, asserting that they do not have the authority to recover capitated payments of \$823,931 (\$456,623 Federal share) and that recovery of fee-for-service payments of \$19,297 (\$10,694 Federal share) would not be cost effective. The State agency does not intend to review payments made during the first month of concurrent eligibility because, as we previously recognized, its payment policy considers these payments to be allowable, if the individuals are eligible at any time during the month. The State agency will consider participation in the PARIS project and other options to identify and prevent payments that are the responsibility of another State.

OIG RESPONSE

We believe that the State agency can and should attempt to recover inappropriate Medicaid payments of \$843,228 (\$467,317 Federal share). The contract between the State agency and providers of Comprehensive Health Care Program Services for Medicaid Beneficiaries in Selected Michigan Counties established the State as the sole authority for determining whether individuals or families meet eligibility requirements, as specified for enrollment in the contract. The contract permitted the State to retroactively disenroll a person and recoup the capitated payments to the contractor as soon as an enrollment error is discovered. In regard to fee-for-service payments, the State agency should attempt to recover \$19,297 in inappropriate payments, of which 215 of 480 exceeded \$25.

We also believe that the State agency should reconsider the allowability of the \$100,575 (\$55,739 Federal share) of payments made during the first month of concurrent eligibility. Michigan considers the beneficiary eligible for a full month's payment once eligibility is established any time during the month but does not consider how this contradicts the State's criteria precluding eligibility if the beneficiary established residency and received assistance in another State.

We support the State agency's plan to explore possible options to identify and prevent overpayments for beneficiaries no longer eligible for Medicaid in Michigan. Because providers for 392 of the 617 concurrently eligible beneficiaries in our audit were inappropriately paid for three or more additional months of service, an increased emphasis on controls to identify beneficiary movement out of State and to stop inappropriate payments is warranted.

APPENDIX



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

July 12, 2006

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: Report Number (A-05-06-00020)

Dear Mr. Swanson:

Enclosed is the Michigan Department of Community Health's response to the draft report entitled "Medicaid Payments for Beneficiaries with Concurrent Eligibility in Michigan and Ohio" that covered the period October 1, 2002 through September 30, 2003.

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Jim Hennessey at (517) 335-5323.

Sincerely,


Janet Olszewski
Director

JO:kk

Enclosure

cc: Dave McLaury
Sue Moran
Nick Lyon
Jim Hennessey

MICHIGAN DEPT. OF COMMUNITY HEALTH'S RESPONSE TO HHS OIG AUDIT
REPORT A-05-06-00020 REGARDING CONCURRENT MEDICAID ELIGIBILITY
IN MICHIGAN AND OHIO

HHS OIG Recommendations

We recommend that the State agency:

- a. seek recovery of inappropriate payments, estimated to be \$843,228 (\$467,317 Federal share), and refund the Federal share of recovered amounts;
- b. review payments made in the first month of concurrent eligibility and determine whether the payments are allowable;
- c. consider additional procedures for identifying beneficiaries moving out of State, including participation in the PARIS project and increased sharing of eligibility information with other State Medicaid programs.

DCH (Dept. of Community Health) Response

DCH agrees that it should not be making Medicaid payments for beneficiaries who have established residency in another state. However, DCH does not intend to seek recovery of the payments discussed in the first recommendation because it lacks the necessary legal standing to recover capitated payments made to a managed health care plan on a beneficiary's behalf. Managed care plans in Michigan are paid a capitated payment based on a per member, per month methodology. Each managed care plan receives a monthly enrollment file and is not required to bill the Department in order to be reimbursed. The managed care plans have a contractual legal obligation to provide services to any of these individuals at any time during the applicable month as long as the individual had eligibility in Michigan, was enrolled in the health plan, and the plan received a payment for the individual for the applicable month. As discussed in the response to the third recommendation, DCH intends to explore possible options in an effort to identify and prevent payments for beneficiaries that should be the responsibility of another state. In addition, DCH certainly agrees that the payments made for beneficiaries that had fee-for-service coverage were inappropriate; however, since the amount identified is relatively insignificant it doesn't appear that it would be cost effective to seek recovery of these payments.

DCH also does not necessarily agree with the conclusion that it did not have procedures in place that would identify, on a timely basis, residency information that could be captured and shared for beneficiaries that moved from Michigan and became residents in another state.

Michigan does not have access to eligibility information from computerized data matches outside the State of Michigan. Access to such information and systems would also only be beneficial if the neighboring states participate and share information on these systems. In this case, the subject neighboring state, Ohio, does not participate. DCH has consistently and timely identified and disenrolled beneficiaries using the tools

MICHIGAN DEPT. OF COMMUNITY HEALTH'S RESPONSE TO HHS OIG AUDIT
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available for such determinations. Under Michigan's program, it is the beneficiaries' responsibility to inform the State of their departure from Michigan (change in circumstances) within 10 days. A beneficiary's eligibility is terminated promptly as a change in state residency is reported.

DCH disagrees with the second recommendation. DCH does not need to review payments made during the first month of concurrent eligibility because coverage is available for the full month if an individual is eligible at any time during the month under Michigan's program.

DCH agrees with the third recommendation. The Michigan Department of Human Services (DHS), through an interagency agreement with DCH, is responsible for determining Medicaid eligibility. DHS is currently exploring participation in the PARIS project as it develops a new Client Eligibility System, and has applied for a PARIS State Partnership Grant to assist with the implementation. However, any formal decision on whether to participate will need to recognize that the system's effectiveness is contingent upon whether neighboring states also decide to participate.