

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

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

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February 2021  
A-05-19-00031

# *Office of Inspector General*

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matters.

## Report in Brief

Date: February 2021

Report No. A-05-19-00031

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



### Why OIG Did This Audit

A previous Office of Inspector General (OIG) audit found that a State Medicaid agency had improperly paid capitation payments on behalf of beneficiaries with concurrent eligibility in another State. We conducted a similar audit of Illinois' Medicaid program.

Our objective was to determine whether Illinois 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 31,679 August 2018 capitation payments, totaling \$10.4 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 100 capitation payments, totaling \$33,515 (\$20,295 Federal share), and determined whether the beneficiaries were residing and receiving Medicaid benefits in Illinois during the audit period.

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

### What OIG Found

Illinois made an estimated \$3.8 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 100 capitation payments in our stratified random sample, 66 capitation payments were associated with beneficiaries who were residing and eligible for Medicaid benefits in Illinois. However, for the remaining 34 capitation payments, totaling \$11,867 (\$6,562 Federal share), Illinois made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Illinois because they were concurrently eligible and residing in another State. On the basis of our sample results, we estimated that Illinois could have saved \$3.8 million (\$2.1 million Federal share) for August 2018 capitation payments made to managed care organizations on behalf of beneficiaries with concurrent eligibility.

### What OIG Recommends and Illinois' Comments

We recommend that Illinois (1) develop or enhance current procedures to identify beneficiaries with concurrent eligibility in another State, which could have saved Illinois an estimated \$3.8 million (\$2.1 million Federal share) in capitation payments for the month of August 2018, and (2) ensure that procedures are in place for 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, Illinois accepted our recommendations. Illinois said that it has implemented Public Assistance Reporting Information System (PARIS) matching improvements for all medical beneficiaries and prioritized PARIS match work with eligibility staff. In addition, Illinois said that it will work to identify and implement strategies to improve the eligibility system's ability to better single out reported address changes to improve processing timeliness. Illinois will also research and pursue use of other States' enrollment data to check applicants for benefits and regularly check enrolled individuals for benefits in other States.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Illinois Department of Healthcare and Family Services (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. A previous Office of Inspector General (OIG) audit<sup>1</sup> found that a State Medicaid agency 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.<sup>2</sup>

### 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).

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<sup>1</sup> *Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State* (A-05-19-00023).

<sup>2</sup> 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 Illinois was 50.74 percent.<sup>3</sup>

## **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).

## **Illinois' Medicaid Managed Care Program**

Illinois began providing managed care to Medicaid beneficiaries in 1976 with the introduction of its Voluntary Managed Care program, which covered primary, acute, and specialty care, and behavioral health services on a voluntary basis to low-income children and families, pregnant women, and American Indians who live in certain counties. Over time, Illinois has expanded its managed care program to include a number of other populations and services. As of January 1, 2019, approximately 76 percent of Illinois Medicaid beneficiaries were enrolled in comprehensive, risk-based MCOs. The program covers almost all services offered under Illinois Medicaid, and plans can also provide services beyond those covered under Medicaid at their own expense. The contracts with the MCOs cover health care services for eligible Medicaid beneficiaries in exchange for a fixed per member, per month capitation payment, regardless of whether the member received covered services in that month.

Illinois' 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

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<sup>3</sup> 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 State under certain conditions unless another State has determined the individual is a resident of that State for the purposes of Medicaid. If electronic verification of residency is not available, Illinois requests a reasonable explanation or documents to verify residency if the inconsistency would impact the individual's eligibility.<sup>4</sup>

The Medicaid MCO contracts are made pursuant to section 5-11 of the Illinois Public Aid Code (305 ILCS 5/5-11) and are between the State agency and the MCO. Under section 4.14.1 of the Medicaid MCO contract, which addresses termination of coverage, the State shall terminate an enrollee's coverage when the enrollee becomes ineligible for the State's Medicaid program or upon the occurrence of certain conditions, including when an enrollee no longer resides in the plan's contracting area under section 4.14.1.3. Under section 4.14.1.3 of the Medicaid MCO contract, termination of coverage under the plan takes effect at 11:59 p.m. on the last day of the month prior to the month in which the State agency determines that the enrollee no longer resides in the contracting area.

### **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 to 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

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<sup>4</sup> Illinois' Medicaid eligibility verification plan.

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 inter-State match alerts the States that are potentially making duplicate payments for Medicaid beneficiaries with concurrent eligibility in another State. This inter-State 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.<sup>5</sup> 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.

Illinois' 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 Illinois Medicaid. The PARIS match information is added to Illinois' eligibility system and generates an electronic alert (PARIS alert) for beneficiaries who were identified as having concurrent eligibility in another State. Illinois generally relies on caseworkers at State or county offices to verify the accuracy of PARIS alerts. Caseworkers should make contact by mail with the beneficiary to determine the current Illinois address or whether the beneficiary resides in a different State.

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 31,679 August 2018 capitation payments, totaling \$10,446,336, made on behalf of beneficiaries with concurrent eligibility in another State during our audit period.<sup>6</sup> 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.<sup>7</sup> To identify our population of beneficiaries who had concurrent eligibility during our audit period, we compared CMS's T-MSIS data for Illinois with T-MSIS data from 48 States, the District of Columbia, and

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<sup>5</sup> 42 CFR §§ 435.952(a) and 435.916(d)(1).

<sup>6</sup> The audit period of July 1 through September 30, 2018, encompassed the most current data available at the time we initiated our audit.

<sup>7</sup> Concurrent capitation payments are allowable in the month a beneficiary moves and establishes Medicaid eligibility in another State.

Puerto Rico<sup>8</sup> 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 100 capitation payments, totaling \$33,515 (\$20,295 Federal share), and determined whether the beneficiaries were residing and receiving Medicaid benefits in Illinois during the audit period. Stratum 1 contained 60 capitation payments associated with Illinois Medicaid beneficiaries who had identical PII in the matched State. Stratum 2 contained 40 capitation payments associated with Illinois 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 B contains the details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the Federal and State requirements.

## FINDINGS

The State agency made an estimated \$3.8 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 100 capitation payments in our stratified random sample, 66 capitation payments were associated with beneficiaries who were residing and eligible for Medicaid benefits in Illinois. However, for the remaining 34 capitation payments, totaling \$11,867 (\$6,562 Federal share), the State agency made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Illinois 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 \$3.8 million (\$2.1 million Federal share)<sup>9</sup> 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.

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<sup>8</sup> At the time of our request, Vermont did not have T-MSIS Medicaid managed care eligibility data available.

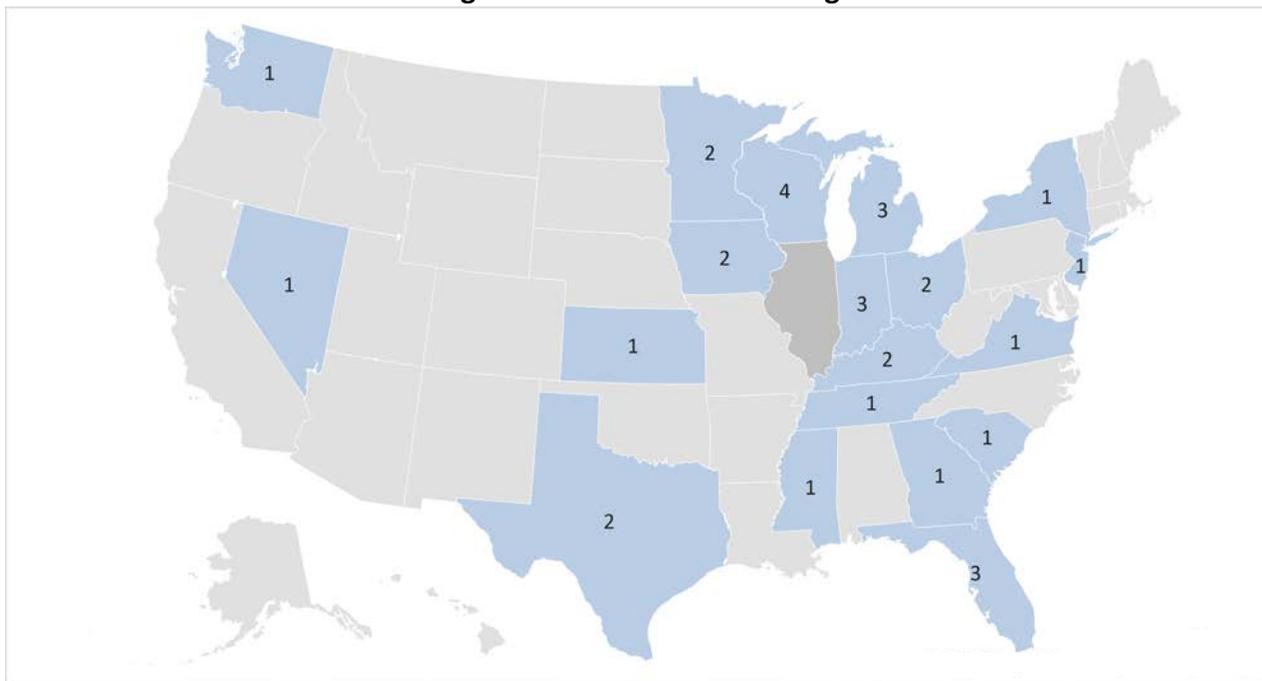
<sup>9</sup> Rounded to the nearest dollar, the amounts equaled \$3,790,896 and \$2,094,545, respectively.

## 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.<sup>10</sup> Under contractual agreements with the MCOs, the State agency shall disenroll a beneficiary from an MCO plan when the beneficiary no longer resides in the plan's contracting area. Disenrollment takes effect at 11:59 p.m. on the last day of the month prior to the month in which the State agency determines that the enrollee no longer resides in the contracting area.

Of the 100 capitation payments in our stratified random sample, 66 capitation payments (39 in Stratum 1 and 27 in Stratum 2) were associated with beneficiaries who were residing in Illinois and eligible for Medicaid benefits. However, for the remaining 34 capitation payments (21 in Stratum 1 and 13 in Stratum 2), totaling \$11,867 (\$6,562 Federal share), the State agency made the payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Illinois because they were concurrently eligible and residing in another State (Figure, below).<sup>11</sup>

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



*Not pictured: Puerto Rico had one match.*

<sup>10</sup> 42 CFR §§ 435.403(a) and (j)(3).

<sup>11</sup> We confirmed the beneficiaries' status using information from the beneficiaries' case files, PARIS alerts, and a national investigative database. 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.

On the basis of our sample results, we estimated that the State agency could have saved \$3.8 million (\$2.1 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 4 of the 100 sampled capitation payments.<sup>12</sup> Additionally, caseworkers did not always review and terminate eligibility for beneficiaries despite receiving other available information indicating concurrent eligibility.

The State agency reviewed PARIS alerts and used information either obtained from the beneficiary or provided by another State to determine whether beneficiaries were concurrently eligible and receiving Medicaid benefits in another State.<sup>13</sup> However, caseworkers did not always terminate eligibility after reviewing the PARIS alert or when beneficiaries provided information about moving out of Illinois. This occurred because the State agency did not have formal policies and procedures to ensure that PARIS alerts and other notifications of potential out-of-State residency were reviewed and processed by caseworkers on a timely basis. Although some of the concurrently eligible beneficiaries were identified, caseworkers did not always follow up on the information and properly review the beneficiaries' eligibility status.

The following are examples of cases for which 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:

- **No Evidence PARIS Alert Was Reviewed**

For one sampled capitation payment, the beneficiary had concurrent eligibility in Illinois and Indiana during our audit period. The State agency's eligibility system generated PARIS alerts for December 2017 and June 2018. The beneficiary's electronic case file contained no evidence that a caseworker reviewed and followed up on the PARIS alert. The case file contained no documentation of any application or annual redetermination establishing Illinois residency. There were no caseworker notes in the case file. The beneficiary's Medicaid eligibility in Illinois started in June 2014 and was still active as of April 2019. The beneficiary's Medicaid eligibility in Indiana started in June 2018 and was still active as of April 2019. The duplicate capitation payments that occurred after the PARIS alert in June 2018 could have been prevented if the caseworker had followed up on the PARIS alerts and terminated the beneficiary's eligibility.

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<sup>12</sup> Of the 100 sampled beneficiaries, 4 had a PARIS match in December 2017 or June 2018 (prior to our audit period).

<sup>13</sup> 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 Illinois Medicaid eligibility has already been terminated.

- **Paris Alert Was Not Reviewed in a Timely Manner**

For one sampled capitation payment, the beneficiary had concurrent eligibility in Illinois and Michigan during our audit period. The State agency's eligibility system generated PARIS alerts for December 2017 and June 2018; however, a caseworker did not follow up on the alert until August 20, 2018. At that time, a caseworker noted that the beneficiary's residency was not verified by a State system operated by the Illinois Secretary of State. The caseworker sent an email to a caseworker in Michigan to determine whether the beneficiary was receiving Medicaid in Michigan. The beneficiary's Illinois Medicaid eligibility began in November 2017 and was not terminated until September 2018. The beneficiary's Medicaid eligibility in Michigan started in May 2017 and was still active as of April 2019. The duplicate capitation payments that occurred after the initial PARIS alert in December 2017 could have been prevented if the caseworker had followed up on the PARIS alerts at an earlier time and terminated the beneficiary's eligibility.

- **Caseworker Did Not Terminate Eligibility After Beneficiary Reported Out-of-State Residence**

For one sampled capitation payment, the beneficiary had concurrent eligibility in Illinois and Iowa during our audit period. On May 14, 2018, the beneficiary reported that she lived in Iowa; however, her Medicaid eligibility was not terminated until June 2019. Case notes from August 15, 2018, indicated that the client no longer met residency requirements. In a separate note from May 20, 2019, a caseworker noted that the case was not previously closed properly. The beneficiary's Illinois Medicaid eligibility began in April 2018 and was not terminated until June 2019, more than a year after the beneficiary reported her out-of-State residence. The beneficiary's Medicaid eligibility in Iowa started in June 2018 and ended in April 2019. The duplicate capitation payments that occurred after May 2018, when the beneficiary reported her move to Iowa, could have been prevented if the caseworker had terminated the beneficiary's eligibility at that time.

For another sampled capitation payment, the beneficiary had concurrent eligibility in Illinois and Indiana during our audit period. On February 17, 2018, the beneficiary sent a letter to her county office reporting that she was moving to Indiana to live with her daughter and would be applying for assistance in Indiana. The letter was stamped by the county office as being received on February 26, 2018. However, it was not until September 7, 2018, when a caseworker noted in the eligibility file that the client submitted a letter in February stating that she was moving out of State and that the case would now be closed. The beneficiary's Illinois Medicaid eligibility began in June 2014 and was not terminated until September 2018, more than 6 months after the county office received the letter saying the beneficiary was moving out of State. The beneficiary's Medicaid eligibility in Indiana started in June 2018 and was still active as of April 2019. The duplicate capitation payments that occurred after February 2018, when the beneficiary reported her move to Indiana, could have been prevented if the caseworker terminated the beneficiary's eligibility at that time.

## RECOMMENDATIONS

We recommend that the Illinois Department of Healthcare and Family Services:

- develop or enhance current procedures to identify beneficiaries with concurrent eligibility in another State, which could have saved the State agency an estimated \$3,790,896 (\$2,094,545 Federal share) in capitation payments for the month of August 2018, and
- ensure that procedures are in place for 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 accepted our recommendations. The State agency said that it has implemented PARIS matching improvements for all medical beneficiaries and prioritized PARIS match work with eligibility staff. In addition, the State agency said that it will work to identify and implement strategies to improve the eligibility system's ability to better single out reported address changes to improve processing timeliness. The State agency will also research and pursue use of other States' enrollment data to check applicants for benefits and regularly check enrolled individuals for benefits in other States. The State agency's comments are included in their entirety as Appendix E.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 31,679 August 2018 capitation payments, totaling \$10,446,336, 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 100 capitation payments, totaling \$33,515 (\$20,295 Federal share), to determine whether the beneficiaries were residing in Illinois 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 Illinois.

We conducted our audit, which included fieldwork at the State agency office in Springfield, Illinois, from September 2019 through November 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 49 States, the District of Columbia, and Puerto Rico and identified 31,679 Illinois 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 \$10,446,336;

- selected for review a stratified random sample of 100 capitation payments, totaling \$33,515 (\$20,295 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 was 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 caseworkers to help determine where the beneficiaries resided and whether they were eligible for Medicaid benefits during the audit period;
  - Accurant, 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: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

Our sampling frame consisted of 31,679 August 2018 capitation payments made by the State agency on behalf of Illinois Medicaid beneficiaries who were concurrently eligible and enrolled in another State during our audit period, totaling \$10,446,336.

### 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 Illinois 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 Illinois 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			Sample Size
	Matching Data Fields Between Illinois and Other States	Number of August 2018 Capitation Payments	Amount of Payments	
1	SSN, DOB, first name, last name, and sex	19,301	\$6,980,595	60
2	SSN	12,378	3,465,742	40
	<b>Total</b>	<b>31,679</b>	<b>\$10,446,336<sup>14</sup></b>	<b>100</b>

### SOURCE OF RANDOM NUMBERS

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

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<sup>14</sup> The individual stratum capitation payment totals do not add due to rounding. The actual total rounds to \$10,446,336.

## **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 Illinois beneficiaries who were concurrently eligible and residing in another State during our audit period.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Total Value of Sample</b>	<b>Federal Share of Sample</b>	<b>No. of Improper Capitation Payments</b>	<b>Total Value of Improper Capitation Payments</b>	<b>Federal Share of Improper Capitation Payments</b>
1	19,301	\$6,980,595	60	\$21,851	\$13,180	21	\$9,712	\$5,236
2	12,378	3,465,742	40	11,664	7,115	13	2,155	1,326
<b>Total</b>	<b>31,679</b>	<b>\$10,446,336<sup>15</sup></b>	<b>100</b>	<b>\$33,515</b>	<b>\$20,295</b>	<b>34</b>	<b>\$11,867</b>	<b>\$6,562</b>

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

	<b>Total Amount</b>	<b>Federal Share</b>
Point estimate	\$3,790,896	\$2,094,545
Lower limit	2,332,390	1,316,802
Upper limit	5,249,403	2,872,288

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<sup>15</sup> The individual stratum capitation payment totals do not add due to rounding. The actual total rounds to \$10,446,336.

## **APPENDIX D: 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**

Illinois' 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 unless another State has determined the individual is a resident of that State for the purposes of Medicaid. Illinois' Medicaid eligibility verification plan states that if electronic verification of residency is not available, Illinois requests a reasonable explanation or documents to verify residency if the inconsistency would impact the individual's eligibility.

Under the MCO contract between the State agency and the MCO, the State agency shall terminate an enrollee's Medicaid coverage when the enrollee becomes ineligible for the State's Medicaid program or upon the occurrence of certain conditions, including when an enrollee no longer resides in the plan's contracting area under section 4.14.1.3 of the contract. Further,

under section 4.14.1.3 of the Medicaid MCO contract, termination of coverage under the plan shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the State agency determines that the enrollee no longer resides in the contracting area.

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December 17, 2020

Department of Health and Human Services  
Office of Audit Services, Region V  
Attn: Sheri L. Fulcher, Regional Inspector General for Audit Services  
223 North Michigan Avenue, Suite 1360  
Chicago, IL 60601

Re: Draft Audit Report A-05-19-00031

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled “*Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State*”.

The Department accepts the recommendations. We have implemented PARIS matching improvements for all medical beneficiaries and prioritized PARIS match work with eligibility staff. In addition, we will work to identify and implement strategies to improve the eligibility system’s ability to better single out reported address changes to improve processing timeliness. We will also research and pursue use of other states’ enrollment data from new clearinghouse sources to check applicants for benefits in other states and to regularly check enrolled individuals for benefits in other states.

We appreciate the work completed by your audit team and the open lines of communication with HFS staff throughout this audit. If you have any questions or comments about our response to the audit, please contact Amy Lyons, External Audit Liaison, and (217) 558-4347 or through email at [amy.lyons@illinois.gov](mailto:amy.lyons@illinois.gov).

Sincerely,

Theresa Eagleson  
Director