

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**FLORIDA MADE ALMOST \$4 MILLION  
IN UNALLOWABLE CAPITATION  
PAYMENTS FOR BENEFICIARIES  
ASSIGNED MULTIPLE MEDICAID ID  
NUMBERS**

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**Amy J. Frontz**  
Deputy Inspector General  
for Audit Services

March 2020  
A-04-18-07080

# *Office of Inspector General*

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## Report in Brief

Date: March 2020

Report No. A-04-18-07080

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



### Why OIG Did This Audit

Previous Office of Inspector General audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries.

Our objective was to determine whether the Agency for Health Care Administration (Florida) made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers.

### How OIG Did This Audit

Our audit covered approximately \$43.2 billion in Medicaid capitation payments made to MCOs on behalf of Medicaid beneficiaries in Florida from July 1, 2014, through June 30, 2017. From the 2,603 beneficiary matches (multiple Medicaid ID numbers assigned to what appears to be a single individual) that we identified as being associated with payments totaling approximately \$16.8 million (\$10.2 million Federal share) for which Florida claimed Federal reimbursement, we selected and reviewed a stratified random sample of 100.

## Florida Made Almost \$4 Million in Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers

### What OIG Found

Florida made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers. Of the 100 beneficiary matches in our sample, Florida correctly made capitation payments on behalf of 1. However, it incorrectly made capitation payments that totaled \$383,487 (\$232,520 Federal share) on behalf of the remaining 99.

According to Florida, the unallowable capitation payments made on behalf of beneficiaries who were assigned multiple Medicaid ID numbers occurred because it needed a significantly more complex matching algorithm than the one that it already had in place to identify beneficiary matches that existed in its system. For example, the name matching criteria were not strong enough to detect or prevent the additional Medicaid ID numbers for those beneficiaries with existing Medicaid ID numbers. Furthermore, Florida stated that newborn Medicaid ID numbers were duplicated when the demographic information used to update Department of Children and Families' FLORIDA system for newborns was different from the demographic information (supplied by a provider or an MCO). Florida used this information to initially activate the newborns' records in the Florida Medicaid Management Information System.

On the basis of our sample results, we estimated that Florida made unallowable capitation payments totaling at least \$6.5 million (\$3.9 million Federal share) on behalf of beneficiaries with multiple Medicaid ID numbers during our audit period.

### What OIG Recommends and Florida Comments

We recommend that Florida: (1) refund to the Federal Government approximately \$3.9 million (Federal share) in unallowable payments, (2) review capitation payments that fell outside of our audit period and refund any unallowable payments, and (3) modify its current methodology to identify beneficiaries with multiple Medicaid ID numbers.

Florida agreed with our findings and recommendations and outlined the corrective actions that it was taking.

**TABLE OF CONTENTS**

INTRODUCTION.....1

    Why We Did This Audit .....1

    Objective .....1

    Background .....1

        The Medicaid Program .....1

        Florida’s Medicaid Managed Care Program .....1

    How We Conducted This Audit .....4

FINDINGS.....5

    Beneficiaries Had Multiple Medicaid Identification Numbers .....6

    Estimate of Unallowable Capitation Payments. ....6

RECOMMENDATIONS .....6

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION COMMENTS .....7

APPENDICES

    A: Audit Scope and Methodology .....8

    B: Related Office of Inspector General Reports .....10

    C: Statistical Sampling Methodology.....11

    D: Sample Results and Estimates .....13

    E: Federal and State Requirements.....14

    F: Florida Agency for Health Care Administration Comments .....15

## INTRODUCTION

### WHY WE DID THIS AUDIT

Previous Office of Inspector General (OIG) audits<sup>1</sup> identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries.

### OBJECTIVE

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers.

### 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. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

#### Florida's Medicaid Managed Care Program

The State agency is responsible for the administration of the Florida Medicaid program. It implemented the Statewide Medicaid Managed Care program in 2014. Under that program, most Medicaid beneficiaries are enrolled in a managed care health plan. Nationally accredited health plans were selected through a competitive procurement for participation in the program.

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<sup>1</sup> See Appendix B for related OIG reports.

### *Capitation Payments*

The State agency pays MCOs a monthly fee, known as a capitation payment, to ensure that an enrolled beneficiary has access to a comprehensive range of medical services. A capitation payment is “a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment” (42 CFR § 438.2). The State agency may adjust funds previously paid to an MCO, as required (Core Contract Provisions, section IX, B2b).

### *Medicaid Eligibility Information and Assignment of Medicaid ID Numbers*

The Florida Department of Children and Families (DCF) determines Medicaid eligibility for low-income individuals and families. Medicaid eligibility information is transmitted to the Florida Medicaid Management Information System (FMMIS) from various external sources (e.g., DCF, Florida Healthy Kids Corporation (Healthy Kids), the Social Security Administration (SSA), and manual data entries). These sources provide data to add or update Medicaid beneficiaries to the FMMIS. The FMMIS is the repository for the State Agency’s Medicaid beneficiary information.

#### *Department of Children and Families*

DCF assigns each applicant a Florida personal ID number that becomes the Medicaid ID number in the Florida Online Recipient Integrated Data Access (FLORIDA) system.<sup>2</sup> The FLORIDA system then interfaces with the FMMIS and provides FMMIS with the Medicaid ID numbers for the beneficiaries.

#### *Florida Healthy Kids Corporation*

Healthy Kids, which administers Florida’s Children’s Health Insurance Program, has a third-party vendor that performs application and enrollment processing. The vendor assigns a “MediKids ID,” which is used in the FMMIS as the Medicaid ID number.

#### *Social Security Administration*

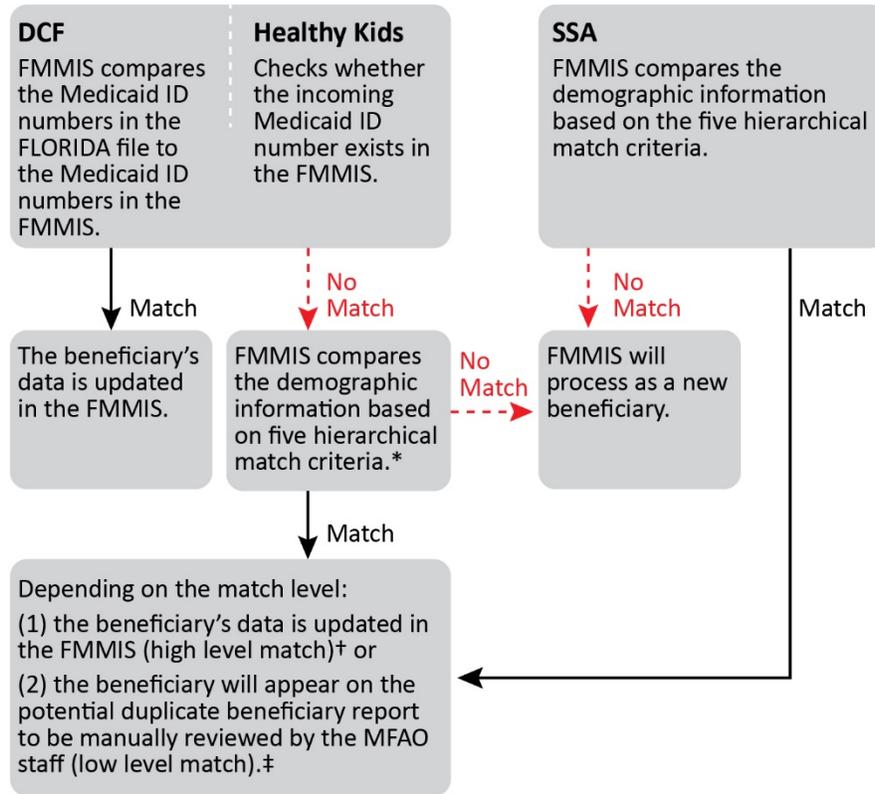
The SSA sends a beneficiary information file to the FMMIS via DCF using the State Data Exchange and the FMMIS then reviews for duplicates, as discussed below, prior to assigning a Medicaid ID number.

The FMMIS processes each type of transaction file in a specific way to try to prevent creating multiple Medicaid ID numbers in the system and treating different individuals as if they were the same person (figure).

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<sup>2</sup> The FLORIDA system is the public assistance eligibility mainframe system.

**Figure: Florida’s Processes for Detecting and Preventing Duplicate Medicaid ID Numbers**



\* First and last names, DOB, SSN, and gender.

† First match criteria scenario is first and last names, SSN, and DOB. This match is considered a high level match, because the confidence level of this match is sufficient to identify a positive match.

‡ Second through fifth match criteria consist of matches based on various combinations of first and last names, gender, SSN, and DOB. These matches are considered low level matches, because the confidence level of these matches is not sufficient to identify a positive match.

*Detection and Prevention of Duplicate Medicaid ID Numbers*

*Department of Children and Families*

The State agency has a process for detecting and preventing potential duplicate Medicaid ID numbers coming into the FMMIS from the FLORIDA records. First, the State agency compares the Medicaid ID number in the FLORIDA file to the Medicaid ID numbers in the FMMIS. If a match is identified, then the beneficiary’s data is updated in the FMMIS. If there are no matches, then the FMMIS compares the demographic information based on five hierarchical

match criteria.<sup>3</sup> If there is a match, depending on the match level,<sup>4</sup> either the beneficiary's data is updated in the FMMIS or the beneficiary will appear on the potential Duplicate Beneficiary Report to be manually reviewed by the Medicaid Fiscal Agent Operations (MFAO) staff. If there are no matches based on these criteria, then the FMMIS will process the individual as a new beneficiary.

#### *Florida Healthy Kids Corporation*

While processing MediKids files, the State agency has a process for checking incoming Medicaid ID numbers to see whether it exists in the FMMIS. This is the same as DCF's process.

#### *Social Security Administration*

The State agency has a process for detecting and preventing potential duplicate Medicaid ID numbers from occurring as the FMMIS receives the files from SSA. Before a new Medicaid ID number is assigned in the FMMIS, the FMMIS compares the demographic information in the SSA files based on five hierarchical match criteria to determine whether a record exists in the FMMIS. From this point, the process is the same as DCF and Florida Healthy Kids.

#### *Manual Duplicate Detection Process*

The State agency also has manual processes to detect whether duplicate Medicaid ID numbers exist. For example, some of the MFAO staff have access to update and add records to the FMMIS. When beneficiaries appear on the potential Duplicate Beneficiary Reports, these staff members manually determine whether a duplicate ID exists. If they find a duplicate ID, then they link the duplicate Medicaid ID number to the primary ID.

Additionally, when an MCO, provider, or beneficiary notifies the State agency of a possible duplicate Medicaid ID number, the information is routed to the MFAO to process an adjustment.

### **HOW WE CONDUCTED THIS AUDIT**

Our audit covered approximately \$43.2 billion<sup>5</sup> in Medicaid capitation payments made to MCOs on behalf of Medicaid beneficiaries in Florida from July 1, 2014, through June 30, 2017 (audit period). From a detailed list of all capitation payments to MCOs during our audit period, we

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<sup>3</sup> The five hierarchical match criteria use various combinations of first and last names, gender, SSN, and date of birth (DOB).

<sup>4</sup> The first match criterion is based on first and last names, SSN, and DOB. This match is considered a high-level match because the confidence level of this match is sufficient to identify a positive match. The second through fifth matches are based on various combinations of first and last names, gender, SSN, and DOB. These matches are considered low level matches, because the confidence level is not sufficient to identify a positive match.

<sup>5</sup> Total paid was \$43,229,284,225.

identified 2,603 instances in which more than one Medicaid ID number could be matched to a single beneficiary.<sup>6</sup> From the 2,603 beneficiary matches that we identified,<sup>7</sup> which were associated with approximately \$16.8 million (\$10.2 million Federal share) in capitation payments, we selected and reviewed a stratified random sample of 100.

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

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

## FINDINGS

The State agency made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers. Of the 100 beneficiary matches in our sample, the State agency correctly made capitation payments on behalf of 1; however, the State agency incorrectly made capitation payments on behalf of the remaining 99, which totaled \$383,487 (\$232,520 Federal share).

According to the State agency, the unallowable capitation payments made on behalf of beneficiaries who were assigned multiple Medicaid ID numbers occurred because it needed a significantly more complex matching algorithm than the one that it already had in place to identify beneficiary matches that existed in its system. For example, the name-matching criteria were not strong enough to detect or prevent the additional Medicaid ID numbers for those beneficiaries with existing Medicaid ID numbers. Furthermore, the State agency said that newborn Medicaid ID numbers were duplicated when the demographic information used to update DCF's FLORIDA system for newborns was different from the demographic information (supplied by a provider or an MCO) used to initially activate the newborns' records in the FMMIS.

On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least \$6,451,820 (\$3,909,840 Federal share) on behalf of beneficiaries with multiple Medicaid ID numbers during our audit period.

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<sup>6</sup> Throughout this report, we will refer to multiple Medicaid ID numbers assigned to what appears to be a single individual as "beneficiary matches." We define a beneficiary match as more than one Medicaid ID number associated with a beneficiary that has both (1) the same or similar first and last names or the inverse of the exact or similar first and last names and (2) the same date of birth.

<sup>7</sup> We performed data analytics to identify these 2,603 beneficiary matches.

## **BENEFICIARIES HAD MULTIPLE MEDICAID IDENTIFICATION NUMBERS**

States generally must refund the Federal share of Medicaid overpayments to CMS (§ 1903(d)(2)(A) of the Act; 42 CFR § 433.312). Overpayments are amounts paid in excess of allowable amounts and would include unallowable capitation payments made on behalf of the same beneficiary for the same coverage of services.

Of the 100 beneficiary matches that we sampled, the State agency correctly made capitation payments on behalf of 1. However, the State agency incorrectly claimed Federal Medicaid reimbursement for managed care payments totaling \$383,487 (\$232,520 Federal share) made on behalf of 99 beneficiaries to whom it had issued multiple Medicaid ID numbers. Specifically, the State agency made multiple managed care payments for each of these 99 beneficiaries under different Medicaid ID numbers for the same capitation month.

The State agency had some controls in place to try to detect and prevent payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers, such as the hierarchical match criteria. In addition, potential duplicate beneficiary Medicaid ID numbers appeared on multiple FMMIS reports and were reviewed by the MFAO staff. However, the State agency's controls were not sufficient to detect or prevent multiple Medicaid ID numbers from being assigned to the same beneficiary because it needed a significantly more complex matching algorithm than the one that it already had in place to identify beneficiary matches that existed in its system.

## **ESTIMATE OF UNALLOWABLE CAPITATION PAYMENTS**

On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least \$6,451,820 (\$3,909,840 Federal share) on behalf of beneficiaries with multiple Medicaid ID numbers during our audit period.

## **RECOMMENDATIONS**

We recommend that the Florida Agency for Health Care Administration:

- refund to the Federal Government \$3,909,840 (Federal share) in unallowable payments,
- review capitation payments that fell outside of our audit period and refund any unallowable payments, and
- modify its current methodology to identify beneficiaries with multiple Medicaid ID numbers.

## **FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION COMMENTS**

In written comments on our draft report, the State agency agreed with our findings and recommendations and outlined the corrective actions that it was taking.

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

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$43,229,284,225 in Medicaid capitation payments made to MCOs on behalf of Medicaid beneficiaries in Florida from July 1, 2014, through June 30, 2017 (audit period). From the 2,603 beneficiary matches that we identified<sup>8</sup> and that the State agency claimed, with payments totaling \$16,836,494 (\$10,206,087 Federal Share), we selected and reviewed a stratified random sample of 100.

We did not review the overall internal control structure of the State agency's Medicaid program. Rather, we reviewed only those controls related to our objective. We limited our audit to determining whether MCOs in Florida received capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers, thus causing unallowable capitation payments.

We conducted this audit from August 2018 to January 2020.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and State guidance;
- met with State agency officials to gain an understanding of the procedures for assigning Medicaid ID numbers and preventing the assignment of multiple Medicaid ID numbers to the same beneficiary;
- requested that the State agency provide a detailed list of all capitation payments to MCOs from July 1, 2014, through June 30, 2017;
- performed data analytics on the list of all capitation payments to identify beneficiary matches;
- selected a stratified random sample of 100 beneficiary matches from the sampling frame;
- reviewed computer records for each sample item to determine whether a beneficiary was issued multiple Medicaid ID numbers; and

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<sup>8</sup> We performed data analytics to identify these 2,603 beneficiary matches.

- estimated the total amount of unallowable Medicaid capitation payments that the State agency made during our audit period.

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

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Tennessee Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<a href="#"><u>A-04-18-07079</u></a>	10/29/2019
<i>Georgia Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<a href="#"><u>A-04-16-07061</u></a>	12/27/2017
<i>Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned More Than One Medicaid Identification Number</i>	<a href="#"><u>A-06-15-00024</u></a>	3/01/2017
<i>New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<a href="#"><u>A-02-11-01006</u></a>	4/15/2013

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

We obtained from the State agency a detailed list of the capitation payments that it made to MCOs on behalf of Florida Medicaid beneficiaries from July 1, 2014, through June 30, 2017. We analyzed these payments to identify beneficiary matches.<sup>9</sup> After we identified the beneficiary matches, we created an Excel file containing 20,716 capitation rows totaling \$16,836,494 for 2,603 beneficiary matches.

### SAMPLE UNIT

The sample unit was a beneficiary match.

### SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We divided the sampling frame into three strata as shown in Table 1:

**Table 1: Details of Sampling Frame**

<b>Stratum</b>	<b>Number of Sample Units</b>	<b>Sample Size</b>	<b>Net Payment Amounts</b>	<b>Description of Stratum</b>
1	1,690	40	\$5,371,241	Net Capitation Totals are > \$100 and < \$6,831
2	784	40	7,191,941	Net Capitation Totals are ≥ \$6,831 and <\$15,008
3	129	20	4,273,312	Net Capitation Totals are ≥ \$15,008
<b>Total</b>	<b>2,603</b>	<b>100</b>	<b>\$16,836,494</b>	

### SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

### METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items for review.

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<sup>9</sup> We define a beneficiary match as more than one Medicaid ID number associated with a beneficiary that has both (1) the same or similar first and last names or the inverse of the exact or similar first and last names and (2) the same date of birth. We removed all matches less than \$100.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of unallowable Medicaid capitation payments that the State agency made during our audit period.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

<b>Stratum</b>	<b>Beneficiary Matches in Sample Frame</b>	<b>Value</b>	<b>Sample Size</b>	<b>Value of the Sample</b>	<b>Number of Beneficiary Matches With Overpayments</b>	<b>Value of the Overpayments</b>	<b>Federal Share Value Per Stratum</b>
1	1,690	\$5,371,241	40	\$127,031	39	\$62,839	\$37,984
2	784	7,191,941	40	347,803	40	175,757	106,742
3	129	4,273,312	20	596,945	20	144,891	87,794
<b>Total</b>	<b>2,603</b>	<b>\$16,836,494</b>	<b>100</b>	<b>\$1,071,779</b>	<b>99</b>	<b>\$383,487</b>	<b>\$232,520</b>

**Table 3: Estimated Value of Overpayments  
(Limits Calculated for a 90-Percent Confidence Interval)**

	<b>Total Amount</b>	<b>Federal Share</b>
<b>Point estimate</b>	\$7,034,353	\$4,263,235
<b>Lower limit</b>	6,451,820	3,909,840
<b>Upper limit</b>	7,616, 887	4,616,630

## **APPENDIX E: FEDERAL AND STATE REQUIREMENTS**

### **FEDERAL REQUIREMENTS**

Section 1903(d)(2)(A) of the Act requires Federal Medicaid payments to a State to be reduced to make adjustment for prior overpayments.

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

The Federal Government reimburses the State for its share (Federal share) of State medical assistance expenditures according to a defined formula (42 CFR § 433.10(a)). States are responsible for refunding the Federal share of overpayments to CMS (42 CFR § 433.312(a)).

In connection with the Medicaid managed care program, the providers are defined as "any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services" (42 CFR § 400.203).

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

### **STATE REQUIREMENTS**

The State agency may adjust funds previously paid to an MCO, as required (Core Contract Provisions, section IX, B2b).

APPENDIX F: FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION COMMENTS



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

February 27, 2020

Ms. Lori S. Pilcher  
Regional Inspector General for Audit Services  
Department of Health & Human Services  
Office of Inspector General  
Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta, GA 30303

Dear Ms. Pilcher:

Thank you for your letter of January 28, 2020, requesting us to provide comments on the draft report number A-04-18-07080 entitled *Florida Made Almost \$4 Million in Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers*. In accordance with your request, we have sent you an electronic copy of our comments.

If you have any questions regarding our response, please contact Pilar Zaki, Audit Director, at 850-412-3986.

Sincerely,

Mary C. Mayhew  
Secretary

MCM/sgb

Enclosure: Response to Draft Report #A-04-18-07080

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**Agency for Health Care Administration**  
**Florida Made Almost \$4 Million in Unallowable Capitation Payments**  
**for Beneficiaries Assigned Multiple Medicaid ID Numbers**  
**Response to HHS/OIG Draft Report A-04-18-07080 dated January 28, 2020**

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**Summary of Findings**

The State agency made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers. Of the 100 beneficiary matches in our sample, the State agency correctly made capitation payments on behalf of 1; however, the State agency incorrectly claimed capitation payments on behalf of the remaining 99, which totaled \$383,487 (\$232,520 federal share).

On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least \$6,451,820 (\$3,909,840 Federal share) on behalf of beneficiaries with multiple Medicaid ID numbers during our audit period.

**Recommendation #1**

Refund to the Federal Government \$3,909,840 (Federal share) in unallowable payments.

**Agency Response and Corrective Action Plan:**

The Agency concurs.

The Agency agrees to refund the federal share for unallowable capitation payments paid on behalf of beneficiaries who were assigned multiple Medicaid ID numbers. The Agency will refund the federal share (\$3,909,840) of the \$6,451,820 estimated overpayment.

**Anticipated Completion Date:**

The federal share of \$3,909,840 will be posted as an adjustment on the July 2020 Quarterly CMS-64 report.

**Recommendation #2**

Review capitation payments that fell outside of our audit period and refund any unallowable payments.

**Agency Response and Corrective Action Plan:**

The Agency concurs.

When a systematic or manual correction of a Duplicate ID case is performed, the Florida Medicaid Management Information System (FMMIS) automatically reevaluates the beneficiary's managed care assignments and capitation payments. If there is an overlap, an automatic recoupment of capitation funds from the managed care providers and the automatic refund of the federal share occurs.

The FMMIS is being modified to generate new reports to assist in identifying possible duplicate beneficiary IDs. Experienced Agency staff will review each case identified on the new reports to determine which Medicaid ID is the primary ID and which one(s) is the duplicate (non-primary ID). The FMMIS is designed to generate a recoupment of funds for any duplicate IDs.

Per Change Request CSR #3360 Duplicate Capitation Reports, two new reports are being created.

Change Order # 172475 Potential Duplicate Managed Care Span Report:

This is a new monthly report displaying information of potential duplicate beneficiary IDs with overlapping managed care spans. The reporting logic for identifying potential duplicates is based on the revised "name match methodology" described in Recommendation #3 below.

Change Order # 172478 Duplicate ID Capitation Report:

This is a new monthly report used to identify capitation payments made for beneficiaries with multiple Medicaid IDs with capitation payments that have not been recouped. This report will identify older capitation payments processed incorrectly and requires manual intervention to correct.

**Anticipated Completion Date:**

The reports are expected to be implemented by April 30, 2020.

**Recommendation #3**

Modify its current methodology to identify beneficiaries with multiple Medicaid ID numbers.

**Agency Response and Corrective Action Plan:**

The Agency concurs.

The Florida Medicaid Management Information System (FMMIS) receives beneficiary demographic information from multiple sources. Medicaid eligibility and demographic information comes from the Florida Department of Children and Families, the State Data Exchange, and the Florida Healthy Kids Corporation. Duplicate Medicaid IDs result when source systems transmit multiple Medicaid IDs for the same beneficiary or when demographic updates are received from multiple inputs for the same beneficiary. Currently, the FMMIS “name match logic” does not identify like or similar names; it requires a strong name match.

The Agency is modifying the “name match logic” methodology used to identify duplicate beneficiaries. Per Change Request CSR #3350 Identify Duplicate IDs, the methodology used to perform the name match function is being modified to use the Jaro-Winkler Similarity Function. This function identifies like and similar names and allows the Agency to set confidence levels of identifying a match. A confidence level of 97 will result in a name match. A confidence level of 85 – 96 will be flagged as a possible duplicate and will be reported on existing possible duplicate reports for manually review. A confidence score of 84 or lower will be considered a distinct name.

**Anticipated Completion Date:**

The new “name match methodology” is expected to be implemented by March 5, 2020.