

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FLORIDA MADE CAPITATION PAYMENTS
FOR ENROLLEES WHO WERE
CONCURRENTLY ENROLLED IN A
MEDICAID MANAGED CARE PROGRAM IN
ANOTHER STATE**

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Office of Inspector General

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Report in Brief

Date: February 2023
Report No. A-05-21-00028

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



Why OIG Did This Audit

Florida pays managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee. Previous OIG audits found that State Medicaid agencies had improperly made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State. We are concerned that the concurrent Medicaid enrollment identified in our previous audits could be an issue that negatively impacts Florida's Medicaid program.

Our objective was to determine whether Florida made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

How OIG Did This Audit

Our audit covered \$15.8 million in Medicaid managed care capitation payments for August 2020 made by Florida on behalf of 55,164 Florida enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2020 (audit period).

To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's Transformed Medicaid Statistical Information System (T-MSIS) data from 47 States, the District of Columbia, and Puerto Rico. We then identified all associated August 2020 capitation payments that Florida made.

Florida Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

What OIG Found

Florida made August 2020 Medicaid managed care capitation payments totaling \$15.8 million on behalf of 55,164 enrollees who were concurrently enrolled for Medicaid benefits in another State. Of the 100 enrollees in our stratified random sample, we determined that 56 enrollees were residing and enrolled for Medicaid benefits in Florida. However, Florida made August 2020 capitation payments totaling \$22,624 (\$15,336 Federal share) on behalf of 44 Florida Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of our sample results, we estimated that Florida incurred costs of \$6.9 million (\$4.7 million Federal share) for August 2020 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

What OIG Recommends and Florida Comments

We recommend that Florida resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding plan to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State when the PHE ends, and work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

In written comments on our draft report, Florida concurred with our recommendations and described the actions that it plans to take to address them. Florida's actions include: (1) resuming procedures to identify individuals with Medicaid coverage in other States and closing benefits as appropriate and (2) meeting with CMS to determine whether there is a plan of action that CMS and Florida can take to use T-MSIS data to identify potential cases of concurrent enrollment.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Florida Agency for Health Care Administration (State agency) pays managed care organizations (MCOs) to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee.¹ Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State.² We determined that these States did not always identify and terminate enrollment for enrollees with concurrent Medicaid enrollment. We are concerned that the concurrent Medicaid enrollment identified in our previous audits could be an issue that negatively impacts Florida's Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

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 each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both.³ Under the FFS model, the State pays providers directly for each covered service received by a Medicaid enrollee. Under managed care, the State pays a fee to a managed care plan for each person enrolled in the plan. State Medicaid managed care programs are intended

¹ 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).

² These audits were conducted in Illinois, Minnesota, and Ohio. See Appendix B for related report information.

³ We limited our audit to managed care capitation payments.

to increase access to and improve the quality of health care for Medicaid enrollees. Approximately two-thirds of Medicaid enrollees are enrolled in managed care nationally.

States contract with MCOs to make services available to Medicaid enrollees, usually in return for a periodic payment, known as a capitation payment. In turn, the MCO pays providers for all the Medicaid services an enrollee may require that are included in the MCO's contract with the State. States make the capitation payments regardless of whether the enrollees receive services during the period covered by the payment. If an enrollee's enrollment is not terminated when appropriate, capitation payments may continue automatically. States report these capitation payments 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 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).

Federal Requirements

States are required to provide Medicaid services to eligible residents, including residents who are absent from the State, unless another State determines that an enrollee has established residency there for purposes of Medicaid eligibility (42 CFR §§ 435.403(a) and (j)(3)).

Ordinarily, States must redetermine the eligibility of Medicaid enrollees whose eligibility is determined using methodologies based on modified adjusted gross income (MAGI), a measure of income based on Internal Revenue Service rules, once every 12 months and no more frequently than once every 12 months (42 CFR § 435.916(a)). For Medicaid enrollees whose eligibility is not determined using MAGI-based financial methodologies, States must redetermine eligibility at least once every 12 months (42 CFR § 435.916(b)).⁴ States must also have procedures designed to ensure that enrollees make timely and accurate reports of any change in circumstances that may affect their eligibility. States must promptly redetermine eligibility when they receive information about changes in enrollee circumstances that may affect eligibility (42 CFR §§ 435.916(c) and (d)). States may not deny or terminate eligibility or reduce benefits for any individual based on information received unless the State has sought additional information from the individual and provided the individual a reasonable period to respond and proper notice and hearing rights (42 CFR §§ 435.952(c) and (d)). Receiving Medicaid in another State typically represents a potential change in an enrollee's circumstances, which requires the State to contact the enrollee and attempt to verify State residency prior to termination.

However, during the Public Health Emergency (PHE) for coronavirus disease 2019 (COVID-19), which is when our audit took place, States made changes to their eligibility and enrollment operations to comply with the Families First Coronavirus Response Act (FFCRA), as amended by

⁴ For example, MAGI-based methods do not apply to individuals receiving Supplemental Security Income (42 CFR § 435.603(j)).

the Coronavirus Aid, Relief, and Economic Security (CARES) Act. To qualify for the temporary 6.2-percentage-point FMAP increase provided under the FFCRA during the PHE, States must satisfy certain conditions, such as maintaining eligibility standards, methodologies, or procedures that are no more restrictive than what the State had in place as of January 1, 2020, and ensuring that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, are continuously enrolled through the end of the month in which the PHE ends. However, the FFCRA has exceptions that allow States that receive the temporary FMAP increase to still disenroll individuals who request a voluntary termination of eligibility or cease to be a resident of the State (§ 6008 of the FFCRA). Federal regulations also provide an exception in meeting the States' timeliness standards for processing Medicaid eligibility redeterminations and changes in an enrollee's circumstances for Medicaid eligibility during an emergency, such as the PHE (42 CFR § 435.912(e)(2)). During the period July 1 through September 30, 2020 (audit period), the FMAP in Florida was 67.67 percent, which includes the 6.2-percentage-point increase provided under the FFCRA.

Once the FFCRA's continuous enrollment requirement ends, States will have up to 12 months to resume their normal eligibility and enrollment operations. States must also develop unwinding plans that address how they will restore normal operations in their Medicaid programs following the end of the PHE.

States must generally provide advance notice when the State agency terminates a Medicaid enrollee'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 enrollee has been accepted for Medicaid services by another State, the original State may send notice of the termination of the enrollee's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)).

State Requirements

The State agency revised its Medicaid verification plan and implemented temporary policies and procedures to satisfy the provisions of the FFCRA. Specifically, the State agency suspended the closing of Medicaid coverage for enrollees who failed to renew their eligibility during annual redeterminations, extended all Medicaid recertifications, and generally suspended the closure of enrollees' Medicaid coverage. However, under the State's temporary policies and procedures, Medicaid coverage may be closed if the enrollee requests a voluntary termination of eligibility, ceases to be a State resident, or dies.

Florida's Medicaid Managed Care Program

The State agency is the single State agency responsible for administering Medicaid. The State agency is responsible for handling Medicaid payment claims, enrolling Medicaid providers, maintaining Medicaid State plan and amendments, and coordinating with the Department of Children and Families (DCF) to develop and implement Medicaid policies, rules, and regulations. DCF coordinates with the State agency and is responsible for Medicaid eligibility determinations in Florida, which includes utilizing eligibility data from other sources such as the Social Security

Administration State Data Exchange files and the Public Assistance Reporting Information System (PARIS) to assist in making appropriate updates to an enrollee's information, including terminating ineligible enrollees from Florida Medicaid. Throughout this report, we use the term "State agency" to include DCF's responsibilities and coordination with the State agency.

In 2020, approximately 3 million people were enrolled in Florida's Statewide Medicaid Managed Care program. The program consists of three parts: Managed Medical Assistance, Long-Term Care, and Dental. Persons eligible for Medicaid will receive services using one or more of these plan types. During our audit period, approximately 82 percent of Florida's Medicaid population received benefits through MCOs under contract with the State agency. The contracts with the MCOs covered health care services to eligible Medicaid enrollees in exchange for a fixed per member, per month capitation payment. In fiscal year 2020, Florida's total Medicaid MCO expenditures were approximately \$17 billion.

Florida's State Medicaid plan requires that Medicaid be granted to eligible applicants who, among other requirements, are residents of the State, including those who are temporarily absent from the State under certain conditions, unless another State has determined the individual is a resident there for purposes of Medicaid. According to Florida's Medicaid eligibility verification plan (effective March 20, 2020), self-declaration is sufficient evidence of State residency, unless the State becomes aware of information that is questionable or inconsistent with other information that the State has obtained for other verifications.

Under section III.C.1.b of Florida's Medicaid managed care contract provisions, the managed care plan will provide services to enrollees who meet eligibility requirements and are living in a region with authorized Managed Care Plans.

Transformed Medicaid Statistical Information System

CMS maintains the Transformed Medicaid Statistical Information System (T-MSIS). Its primary purpose is to establish an accurate, current, and comprehensive database of standardized enrollment, eligibility, and paid claim data about Medicaid recipients that is used for administering Medicaid federally and to assist in detecting fraud, waste, and abuse in Medicaid. States submit their T-MSIS data to CMS monthly.

T-MSIS contains enhanced information about enrollee eligibility, enrollee and provider enrollment data, service utilization data, claim and managed care data, and expenditure data. OIG has full access to T-MSIS data for all States. However, CMS limits States' access to other States' T-MSIS data, with the exception of the T-MSIS Analytic Files (TAF).⁵

⁵ The TAF is available to all States upon request and approval from CMS but does not contain personally identifiable information that is needed to identify enrollees with concurrent Medicaid enrollment. The TAF is a research-optimized version of T-MSIS data and serves as a data source tailored to meet the broad research needs of the Medicaid and Children's Health Insurance Program (CHIP) data user community. These files include data on Medicaid and CHIP enrollment, demographics, service utilization, and payments.

Public Assistance Reporting Information System

The PARIS, managed by the Administration for Children and Families (ACF),⁶ matches State and Federal public assistance eligibility data, including Medicaid data, quarterly to provide States with enrollee information that they can use to identify possible concurrent enrollment and erroneous payments. The Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Match are the three parts of PARIS. The programs that use PARIS include Medicaid, Temporary Assistance for Needy Families, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program.

As a condition of receiving Medicaid funding for their automated data systems, States are required to have an eligibility determination system that provides for data matching through PARIS (Social Security Act § 1903(r)(3) and 42 CFR § 435.945(d)). The PARIS Interstate Match alerts States when they may be making payments on behalf of Medicaid enrollees with concurrent enrollment in another State. States are ordinarily expected to determine whether such enrollees should continue to be eligible for benefits in their State and take whatever case action is appropriate.⁷ States may use local benefit office staff, fraud investigators, or both to review PARIS Interstate Match alerts. However, PARIS data are only collected and matched on a quarterly basis by a non-Medicaid agency, data are only available for the current quarter and are not maintained by ACF,⁸ and data matching agreements do not prescribe which of the three PARIS matches State Medicaid agencies must conduct, nor the frequency with which any match must be conducted.

The State agency is required to contact the enrollees before eligibility may be terminated.⁹ If the State agency receives information that may affect an enrollee's Medicaid benefits, such as a PARIS alert, the State agency typically sends a PARIS Contact Notice to the enrollee, and the enrollee has 10 days to respond.

However, in accordance with the flexibilities that were available to States during the PHE, the State agency suspended the use of the PARIS Interstate Match data for the quarter prior to our audit period due to a shift of priorities during the PHE.

⁶ ACF is a division of HHS that promotes the economic and social well-being of families, children, youth, individuals and communities with funding, strategic partnerships, guidance, training, and technical assistance.

⁷ 42 CFR §§ 435.952(a) and 435.916(d)(1).

⁸ The State agency maintains the PARIS matches for six rolling quarters.

⁹ According to 42 CFR § 435.952(d), a State Medicaid agency may not terminate an enrollee's Medicaid eligibility based on information received through sources such as PARIS unless the State agency has sought additional information from the enrollee.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$15.8 million in Medicaid managed care capitation payments for August 2020 made by the State agency on behalf of 55,164 Florida enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2020 (audit period). We selected the middle month of our audit period to ensure that enrollees were eligible in the month before, during, and after the August 2020 capitation payments. This helped to identify enrollees who did not move to or from another State during August 2020. To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's T-MSIS data from 47 States, the District of Columbia, and Puerto Rico¹⁰ using the enrollees' Social Security numbers (SSNs), dates of birth (DOB), names, and sex (personally identifiable information (PII)). We then identified all associated August 2020 capitation payments that the State agency made.

We selected a stratified random sample of 100 Florida Medicaid managed care enrollees with August 2020 capitation payments, totaling \$83,909 (\$56,834 Federal share), to determine whether the enrollees were residing and receiving Medicaid benefits in Florida during the audit period. 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 enrollees who were residing and enrolled for 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 audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency made August 2020 Medicaid managed care capitation payments totaling \$15.8 million on behalf of 55,164 enrollees who were concurrently enrolled for Medicaid benefits in another State. Of the 100 enrollees in our stratified random sample, we determined that 56 enrollees were residing and enrolled for Medicaid benefits in Florida. However, the State agency made August 2020 capitation payments totaling \$22,624 (\$15,336 Federal share) on behalf of 44 Florida Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of our sample results, we estimated that

¹⁰ At the time of our request, three States (Alaska, Connecticut, and Vermont) did not have complete T-MSIS Medicaid managed care enrollment and payment data available.

the State agency incurred costs of \$6.9 million (\$4.7 million Federal share)¹¹ for August 2020 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

The State agency made August 2020 capitation payments on behalf of Medicaid enrollees who established residency and Medicaid enrollment in another State but remained enrolled in Florida's Medicaid managed care program. We determined that the State agency did not always receive notification when enrollees in our sample had moved and enrolled in Medicaid in another State. When the State agency received notification from some of the sampled enrollees that they were no longer residing in Florida, the State agency did not terminate enrollees' Medicaid enrollment, as permitted under the FFCRA and its policies and procedures.

THE STATE AGENCY MADE PAYMENTS TO MANAGED CARE ORGANIZATIONS FOR MEDICAID ENROLLEES WITH CONCURRENT ENROLLMENT IN ANOTHER STATE

Under Federal regulations, State agencies must provide Medicaid to eligible residents of the State, including those who are temporarily absent, unless a person has established residency and enrolled in Medicaid in another State.¹²

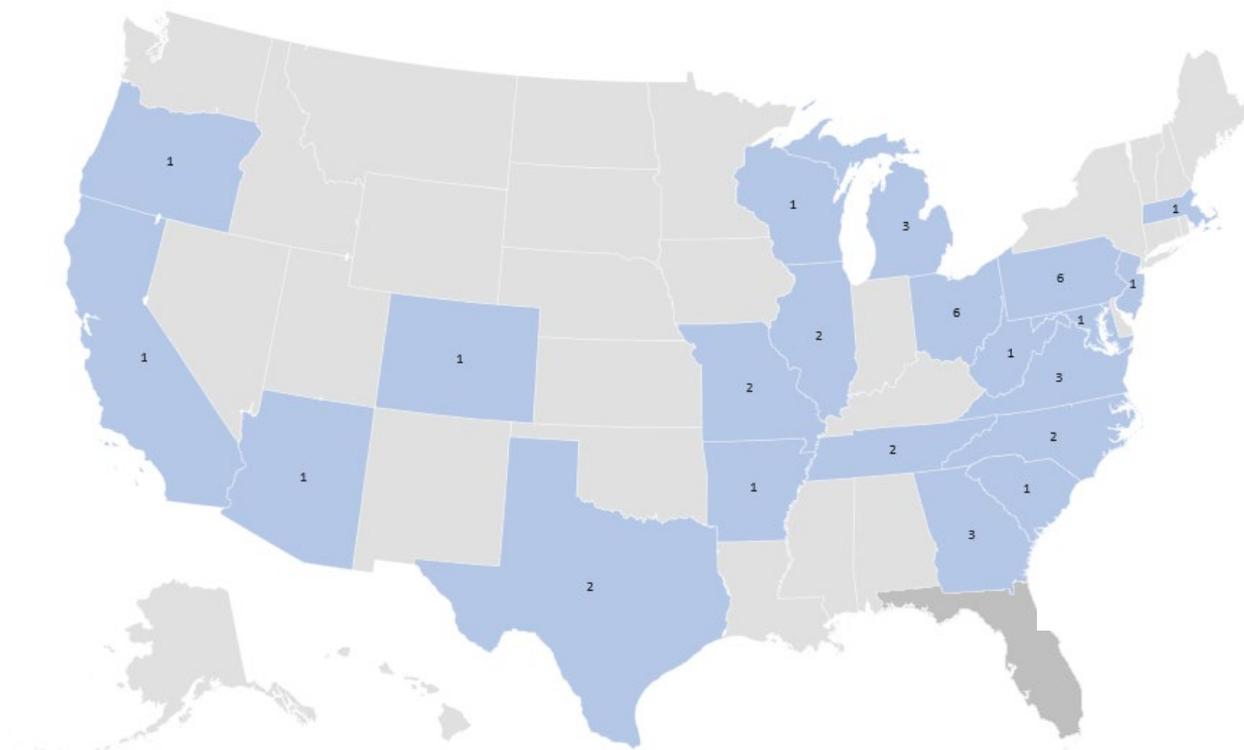
For our sample, we found that the State agency made August 2020 capitation payments totaling \$22,624 (\$15,336 Federal share) on behalf of 44 Florida Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid managed care in another State (Figure on the next page).¹³

¹¹ Rounding to the nearest dollar, the amounts equaled \$6,924,962 and \$4,712,084, respectively.

¹² 42 CFR §§ 435.403(a) and (j)(3).

¹³ We confirmed the enrollees' Medicaid enrollment status using State and county case files, PARIS alerts, Supplemental Nutrition Assistance Program transactions (SNAP), a national investigative database, and by contacting the other States' Medicaid agency when necessary. We also reviewed encounter claims that identify the date and location the enrollees had an interaction with a health care provider.

Figure: August 2020 Capitation Payments Made for Enrollees Who Were Residing and Concurrently Enrolled for Medicaid Managed Care in Another State



Not pictured: Puerto Rico had two matches.

On the basis of our sample results, we estimated that the State agency incurred costs of \$6.9 million (\$4.7 million Federal share) for August 2020 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in Medicaid in another State.

The State Agency Did Not Receive Notification That Enrollees Moved Out of State or Did Not Terminate Enrollees Who Provided Notification They Moved Out of State

The State agency made the August 2020 capitation payments on behalf of 44 concurrently enrolled Medicaid enrollees for two reasons. The State agency did not receive notification that 30 of the 44 enrollees were no longer residing in Florida during our audit period. For the remaining 14 enrollees, the State agency received notification from the enrollees that they were no longer residing in Florida, but the State agency did not terminate these enrollees' Medicaid enrollment.

The State agency did not receive notification that the 30 sampled enrollees were residing and had concurrent enrollment in another State. While annual eligibility redeterminations and the use of PARIS data may have identified enrollees who established residency and Medicaid enrollment in another State, in accordance with the flexibilities provided to States during the

PHE and the State's approved eligibility verification plan, the State agency was not processing annual eligibility redeterminations during the PHE and suspended the use of the PARIS Interstate Match data for the quarter prior to our audit period.

The FFCRA allows the State agency to terminate Medicaid enrollment when the enrollee ceases to be a resident of the State or requests a voluntary termination of enrollment. However, the State agency did not terminate Medicaid enrollment for 14 enrollees when the enrollee informed the State agency of a change in residency to another State. The State agency revised its Medicaid verification plan and implemented temporary policies and procedures that included these exceptions under the FFCRA, but the State agency did not always choose to use these exceptions under these policies and procedures.

The following examples describe some of the issues we found:

- **Florida Was Not Notified That the Enrollee Resided and Received Medicaid in Another State**

One sampled enrollee had concurrent Medicaid enrollment in Florida and Michigan during our audit period. The enrollee's managed care in Florida started in January 2019 and was still active during our fieldwork. The enrollee's Medicaid enrollment in Michigan started in July 2019 and was still active during our fieldwork. Florida and Michigan made an August 2020 capitation payment to a managed care organization in their State on behalf of the same enrollee, totaling \$548 and \$274, respectively. OIG contacted Michigan's Medicaid agency and received confirmation that the enrollee resided and received Medicaid in Michigan during our audit period. Florida did not receive notification that the enrollee resided and was enrolled for Medicaid in Michigan during our audit period. While annual eligibility redeterminations may have identified enrollees who established residency and Medicaid enrollment in another State, in accordance with the flexibilities provided to States during the PHE and the State's approved eligibility verification plan, the State agency was not processing annual eligibility redeterminations during the PHE.

- **The Enrollee Notified Florida of Moving to Another State**

One sampled enrollee had concurrent Medicaid enrollment in Florida and Oregon during our audit period. The enrollee notified the State agency that they moved to Oregon in March 2020. However, the enrollee's enrollment was not terminated. The enrollee's managed care in Florida started in March 2020 and continued until December 2021. The enrollee's Medicaid enrollment in Oregon started in June 2020 and was still active during our fieldwork. Florida and Oregon made an August 2020 capitation payment to a managed care organization in their State on behalf of the same enrollee, totaling \$114 and \$216, respectively. The capitation payments that occurred after the enrollee moved to Oregon could have been prevented if the State agency terminated the enrollee's enrollment for ceasing to be a resident of Florida, as permitted under its own policies and procedures.

CONCLUSION

We estimated that the State agency incurred costs of \$6.9 million (\$4.7 million Federal share) for August 2020 capitation payments made on behalf of enrollees who were residing and concurrently enrolled for Medicaid in another State. This amount represents potential monthly savings to Florida's Medicaid program that, if annualized, would amount to approximately \$82.8 million (\$56.4 million Federal share) in program savings.

For Florida and other States that accepted the temporary 6.2-percent FMAP increase during the PHE, section 6008 of the FFCRA added new restrictions for States related to Medicaid eligibility. In addition to other requirements, States are restricted from terminating an enrollee's Medicaid eligibility during the PHE for most situations unless the enrollee requests a voluntary termination of eligibility or ceases to be a State resident.¹⁴ Federal regulations also provide an exception in meeting the States' timeliness standards for processing Medicaid redeterminations and changes in an enrollee's circumstances for Medicaid eligibility during an emergency, such as the PHE.

Although the FFCRA restrictions may have increased concurrent enrollment across two States during the PHE, previous audits have shown that concurrent Medicaid enrollment was an issue in Florida prior to the PHE.¹⁵ Going forward, we believe that the number of capitation payments made on behalf of enrollees with concurrent Medicaid enrollment in another State can be reduced with the use of timelier T-MSIS data, and improved policies and procedures to confirm the concurrent enrollment and disenroll these enrollees.

¹⁴ Following our audit period, on November 2, 2020, 42 CFR § 433.400(d)(3)(ii) went into effect. This regulation states that an enrollee may be treated as not being a State resident under § 6008(b)(3) of the FFCRA when there is a PARIS match indicating concurrent enrollment in two or more States, and the enrollee fails to respond to a request to verify State residency, provided that the State takes all reasonably available measures to attempt to verify the enrollee's residency, and the State's alternative efforts cannot verify the enrollee's continued residency in the State through other sources. However, since 42 CFR § 433.400(d)(3)(ii) was not in effect during our audit period, States claiming the temporary FMAP increase were unable to treat an enrollee as not being a State resident without the enrollee verifying a change in residency.

¹⁵ In our previous audit, we identified 25,698 Florida Medicaid enrollees with concurrent Medicaid managed care enrollment in another State during July – September 2019. See Appendix B, OIG report number A-05-20-00025.

RECOMMENDATIONS

We recommend that the Florida Agency for Health Care Administration:

- resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding plan to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State when the PHE ends and
- work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described the actions that it plans to take to address them. The State agency's actions include: (1) resuming procedures to identify individuals with Medicaid coverage in other States and closing benefits as appropriate and (2) meeting with CMS to determine whether there is a plan of action that CMS and the State agency can take to use T-MSIS data to identify potential cases of concurrent enrollment. The State agency's comments are included in their entirety as Appendix E.

We recognize the corrective actions the State agency plans to implement to address our recommendations. These corrective actions should assist the State agency with identifying and correcting concurrent enrollment.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$15.8 million in Medicaid managed care capitation payments for August 2020 made by the State agency on behalf of 55,164 Florida enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2020 (audit period). We selected and reviewed a stratified random sample of 100 enrollees with capitation payments totaling \$83,909 (\$56,834 Federal share), to determine whether the enrollees were residing and enrolled for Medicaid benefits in Florida during the audit period.

To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's T-MSIS data from 47 States, the District of Columbia, and Puerto Rico using the enrollees' PII. We then identified all associated August 2020 capitation payments that the State agency made.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, 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 enrollees with concurrent enrollment in a Medicaid managed care program in another State. As part of our internal control review, we reviewed the State agency's policies and procedures for identifying and terminating the enrollment of Medicaid enrollees who were not residents of Florida. However, because our review was limited to these aspects of internal control, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We conducted our audit work from August 2021 through November 2022.

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 enrollees with concurrent enrollment in another State;

- identified sources that the State agency used to identify enrollees who were receiving Medicaid in another State;
- obtained T-MSIS data that identified 55,164 Florida enrollees with concurrent Medicaid managed care enrollment in another State during our audit period July through September 2020 and obtained August 2020 capitation payment data associated with these enrollees that were made by the State agency, totaling \$15,818,639;
- selected for review a stratified random sample of 100 enrollees with August 2020 capitation payments, totaling \$83,909 (\$56,834 Federal share);
- validated the T-MSIS data for each sampled enrollee and capitation payment by:
 - comparing current enrollee data from the State agency to determine whether the enrollees' Medicaid managed care enrollment and PII information was accurate and
 - comparing current payment data from the State agency to determine whether a capitation payment occurred for August 2020, 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 for each sampled enrollee to help determine in which State the enrollee resided and was receiving Medicaid benefits during the audit period:
 - PARIS Alerts, which identified the matched State(s) and time period that the enrollees were concurrently eligible for Medicaid benefits;
 - SNAP transactions, which contained a record of the dates and locations the enrollees used their food assistance benefits (i.e. – grocery store and gas station purchases, etc.);
 - encounter claims, which contained a record of Medicaid services that were provided and were used to identify the date and location that enrollees 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 enrollees and county caseworkers, to help determine where the enrollees 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 enrollees 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 enrollees resided and received Medicaid benefits in the other State during the audit period;
- estimated, based on the sample results, the total value and Federal share of capitation payments made that the State agency paid on behalf of enrollees who were residing and enrolled for Medicaid benefits 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Issue Date
<i>Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States</i>	<u>A-05-20-00025</u>	9/19/2022
<i>Minnesota Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State</i>	<u>A-05-19-00032</u>	5/6/2021
<i>Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State</i>	<u>A-05-19-00031</u>	2/3/2021
<i>Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State</i>	<u>A-05-19-00023</u>	11/12/2020

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame was an Access database containing 55,164 Florida Medicaid enrollees with August 2020 capitation payments and concurrent Medicaid managed care enrollment in another State during the period of July 1 through September 30, 2020, totaling \$15,818,639.

SAMPLE UNIT

The sample unit was a Florida Medicaid managed care enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample outlined in Table 1.

Table 1: Sample Design Summary

Stratum	Frame Information			Sample Size
	Stratum Dollar Boundaries	Number of Enrollees	Dollar Amount of August 2020 Capitation Payments	
1	\$1.49 - \$562.99	49,381	\$8,691,100	50
2	\$565.32 - \$27,509.53	5,783	7,127,539	50
	Totals	55,164	\$15,818,639	100

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted each stratum using the enrollees' Social Security number and consecutively numbered the items in each stratum in the sampling frame. A statistical specialist generated random numbers for each stratum, and we selected the corresponding sample frame items for review given the sample sizes defined.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total value and Federal share of capitation payments that the State agency paid on behalf of Florida Medicaid enrollees who were residing and enrolled for Medicaid benefits in another State during our audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Federal Share of Sample	Florida Medicaid Enrollees Who Were Residing and Enrolled for Medicaid Benefits in Another State		
						Number in Sample	Total Value of August 2020 Capitation Payments	Federal Share of August 2020 Capitation Payments
1	49,381	\$8,691,100	50	\$8,553	\$5,840	28	\$4,941	\$3,370
2	5,783	7,127,539	50	75,357	50,994	16	17,683	11,966
Total	55,164	\$15,818,639	100	\$83,909¹⁶	\$56,834	44	\$22,624	\$15,336

**Table 3: Estimated August 2020 Capitation Payments in the Sampling Frame That the State Agency Paid on Behalf of Florida Medicaid Enrollees Who Were Residing and Enrolled for Medicaid Benefits in Another State
(Limits Calculated at the 90-Percent Confidence Level)**

	Total Amount	Federal Share
Point estimate	\$6,924,962	\$4,712,084
Lower limit	5,450,686	3,712,323
Upper limit	8,399,238	5,711,846

¹⁶ The stratum amounts do not sum to the total amount due to rounding.

APPENDIX E: STATE AGENCY COMMENTS



RON DESANTIS
GOVERNOR

JASON WEIDA
INTERIM SECRETARY

January 20, 2023

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Dear Ms. Fulcher:

Thank you for your letter dated December 7, 2022, requesting us to provide comments on the draft report number A-05-21-00028 entitled *Florida Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State*.

In accordance with your request, we have sent you an electronic copy of our comments.

I feel obligated to point out that, for the better part of two years, our Agency has been waiting for the continuous coverage requirements as part of the Public Health Emergency to be lifted. Unfortunately, those requirements prevented the Department of Children and Families from being able to properly identify individuals with Medicaid coverage in other states, review, and close benefits as appropriate, and transmit closures to the Agency for beneficiary disenrollment.

If you have any questions regarding our response, please contact Karen Preacher, Audit Director, at [REDACTED].

Sincerely,

Jason Weida
Interim Secretary

JW/sgb

Enclosure: Response to Draft Report No. A-05-21-00028

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Twitter.com/AHCA_FL

Agency for Health Care Administration
Florida Made Capitation Payments for Beneficiaries Who Were Concurrently
Enrolled in a Medicaid Managed Care Program in Another State
Response to HHS/OIG Draft Report A-05-21-00028 dated December 7, 2022

Finding#1

The State agency made payments to managed care organizations for Medicaid beneficiaries with concurrent enrollment in another state.

Finding#2

The State agency did not receive notification that beneficiaries moved out of state or did not terminate beneficiaries who provided notification they moved out of state.

Recommendation #1

Resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding plan to identify and disenroll beneficiaries who are residing and enrolled in Medicaid managed care in another State when the PHE ends.

Agency for Health Care Administration (AHCA) Response and Corrective Action Plan:

The Agency concurs with the finding. With the end of the continuous coverage requirement, the Agency will resume procedures on April 1, 2023, to close recipients when new out-of-state codes are received from the Department of Children and Families and the Social Security Administration.

AHCA Anticipated Completion Date:

Twelve months after starting the process to end continuous coverage requirements, which currently is determined to be March 31, 2024.

Department of Children and Families (DCF) Response and Corrective Action Plan:

DCF concurs with the finding/recommendation. Upon starting the process to end continuous coverage, DCF, working closely with the Agency for Healthcare Administration (AHCA), will resume procedures to identify individuals with Medicaid coverage in other states, review and close benefits as appropriate, and transmit closures to AHCA for beneficiary disenrollment.

DCF Anticipated Completion Date:

Twelve months after starting the process to end continuous coverage requirements, which currently is determined to be March 31, 2024.

AHCA Contact:

Elizabeth Wade
[REDACTED]

Recommendation #2

Work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

AHCA Response and Corrective Action Plan:

The Agency concurs with the finding. The Agency will work with CMS to consider the potential use of Transformed Medicaid Statistical Information System (T-MSIS) data. The Agency will set up a meeting with their CMS representative to discuss and determine if there is a plan of action

Agency for Health Care Administration
Florida Made Capitation Payments for Beneficiaries Who Were Concurrently
Enrolled in a Medicaid Managed Care Program in Another State
Response to HHS/OIG Draft Report A-05-21-00028 dated December 7, 2022

that CMS and the Agency can take to use T-MSIS data to identify potential cases of concurrent enrollment.

AHCA Anticipated Completion Date:

The Agency anticipates the meeting with CMS to occur by the end of March 2023.

DCF Response and Corrective Action Plan:

DCF concurs with the finding/recommendation. DCF will partner with AHCA in its effort to work with CMS to consider the potential use of T-MSIS data.

DCF Anticipated Completion Date:

March 31, 2023

AHCA Contact:

Elizabeth Wade

