

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEARLY ALL STATES MADE CAPITATION
PAYMENTS FOR BENEFICIARIES WHO
WERE CONCURRENTLY ENROLLED IN A
MEDICAID MANAGED CARE PROGRAM IN
TWO STATES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Christi A. Grimm
Inspector General**

**September 2022
A-05-20-00025**

Office of Inspector General

<https://oig.hhs.gov>

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

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

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

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a
recommendation for the disallowance of costs incurred or claimed, and
any other conclusions and recommendations in this report represent the
findings and opinions of OAS. Authorized officials of the HHS operating
divisions will make final determination on these matters.

Report in Brief

Date: September 2022

Report No. A-05-20-00025

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



Why OIG Did This Audit

Most State Medicaid agencies pay managed care organizations to make services available to eligible Medicaid beneficiaries in return for a monthly fixed payment (capitation payment) for each enrolled beneficiary. Previous OIG audits found that States had improperly made capitation payments on behalf of beneficiaries 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 the Medicaid program nationwide.

Our objective was to determine whether States made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.

How OIG Did This Audit

Our audit covered \$145.7 million and \$234.2 million in Medicaid managed care capitation payments for August 2019 and August 2020, respectively, made by States on behalf of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States during the periods of July through September 2019 and July through September 2020.

To identify our population of concurrently enrolled beneficiaries, we compared CMS's Transformed Medicaid Statistical Information System (T-MSIS) data from 45 States, the District of Columbia, and Puerto Rico (together referred to as "47 States"). We then identified all associated August 2019 and August 2020 capitation payments that were made by two States for the same beneficiary.

Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States

What OIG Found

All 47 States reviewed made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in two States. Specifically, capitation payments were made on behalf of 208,254 concurrently enrolled beneficiaries in August 2019 and 327,497 concurrently enrolled beneficiaries in August 2020. The Medicaid program incurred costs of approximately \$72.9 million in August 2019 and \$117.1 million in August 2020 for capitation payments associated with beneficiaries in one of the two concurrently enrolled States. The significant increase in these payments from August 2019 to August 2020 coincided with an overall increase in Medicaid enrollment during that time, and new Federal requirements and flexibilities that were available to States during the COVID-19 public health emergency.

CMS does not actively monitor beneficiaries' concurrent Medicaid managed care enrollments; instead, it relies on the individual States to identify concurrent enrollments and potential erroneous payments. CMS does not provide States with T-MSIS national enrollment data that would assist them in identifying beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States. Two States often made capitation payments for the same Medicaid beneficiary in part because States did not have full access to data they needed to identify beneficiaries who were concurrently enrolled in another State. Therefore, CMS does not take all available steps, either directly or through the States, to identify and prevent State capitation payments for non-resident beneficiaries.

What OIG Recommends and CMS Comments

We recommend that CMS provide States with matched T-MSIS enrollment data that identify Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States, and assist States with utilizing the data as needed to reduce future capitation payments made on behalf of beneficiaries concurrently enrolled in two States.

CMS did not concur with our recommendations. CMS stated the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to States, and CMS will continue to provide guidance and technical assistance to States as needed. We maintain that our recommendations are valid and plan to continue our work with States to identify opportunities to reduce the number and amount of concurrent Medicaid capitation payments.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Audit.	1
Objective	1
Background	1
The Medicaid Program.....	1
Federal Requirements.....	2
Transformed Medicaid Statistical Information System	3
Public Assistance Reporting Information System	4
How We Conducted This Audit	4
FINDING.....	5
States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States	6
RECOMMENDATIONS	8
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	8
APPENDICES	
A: Audit Scope and Methodology	11
B: Related Office of Inspector General Reports.....	13
C: States With Concurrently Enrolled Medicaid Beneficiaries and Capitation Payments for August 2019 and August 2020	14
D: Centers for Medicare & Medicaid Services Comments	16

INTRODUCTION

WHY WE DID THIS AUDIT

Most State Medicaid agencies pay 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.¹ Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly made capitation payments on behalf of beneficiaries who were residing and enrolled in Medicaid in another State.² We determined that these States did not always identify and terminate enrollment for beneficiaries with concurrent Medicaid enrollment. We are concerned that the concurrent Medicaid enrollment identified in our previous audits could be an issue that negatively impacts the Medicaid program nationwide.

OBJECTIVE

Our objective was to determine whether States made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.³

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.

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 These payments occur when two different States made Medicaid managed care capitation payments covering the same month of service on behalf of the same Medicaid beneficiary. The capitation payments are not necessarily identical or improper. They may cover different types of benefits in each State, and the payment amounts may vary.

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both.⁴ Under the FFS model, the State pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the State pays a fee to a managed care plan for each person enrolled in the plan. Approximately two-thirds of Medicaid beneficiaries are enrolled in managed care nationally.

States contract with MCOs to make services available to enrolled Medicaid beneficiaries, usually in return for a periodic payment, known as a capitation payment. In turn, the MCO pays providers for Medicaid services a beneficiary receives that are included in the MCO's contract with the State. States make the capitation payments regardless of whether the beneficiaries receive services during the period covered by the payment. If a beneficiary'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).

To qualify for the temporary 6.2-percentage-point FMAP increase provided under the Families First Coronavirus Response Act (FFCRA) during the public health emergency (PHE) for coronavirus disease 2019 (COVID-19), States must satisfy certain conditions, including maintaining Medicaid eligibility standards, methodologies, or procedures that are no more restrictive than what they had in place as of January 1, 2020. In addition to other requirements, States must also ensure that beneficiaries who were determined eligible for Medicaid benefits as of or after March 18, 2020, are treated as eligible through the end of the month in which the PHE ends, unless the individual requests a voluntary termination of eligibility or ceases to be a resident of the State (§ 6008 of the FFCRA).

Federal Requirements

States are required to provide Medicaid services to eligible residents, including residents who are absent from the State. However, if one State determines that a beneficiary has established 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 redetermine the eligibility of Medicaid beneficiaries 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 beneficiaries whose eligibility is not determined using MAGI-based financial methodologies, States must redetermine eligibility at

⁴ Our audit was limited to managed care capitation payments.

least once every 12 months (42 CFR § 435.916(b)).⁵ States must also have procedures designed to ensure that beneficiaries 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 beneficiary 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 represents a potential change in a beneficiary's circumstances, which requires the State to contact the beneficiary and attempt to verify State residency prior to termination.

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 may send notice of the termination of the beneficiary's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)).

Generally, States must determine eligibility, including Medicaid renewals and changes in circumstances for Medicaid eligibility, within their timeliness standards, except in unusual circumstances, such as during an administrative or other emergency beyond the State's control (42 CFR § 435.912(e)(2)).

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 beneficiary eligibility, beneficiary 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).⁶

⁵ For example, MAGI-based methods do not apply to individuals receiving Supplemental Security Income (42 CFR § 435.603(j)).

⁶ 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 beneficiaries 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 Public Assistance Reporting Information System (PARIS), managed by the Administration for Children and Families (ACF),⁷ matches State and Federal public assistance eligibility data, including Medicaid data, quarterly to provide States with beneficiary 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 beneficiaries with concurrent enrollment in another State. States are expected to determine whether such beneficiaries should continue to be eligible for benefits in their State and take whatever case action is appropriate.⁸ 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 in a database, 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.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$145.7 million and \$234.2 million in Medicaid managed care capitation payments for August 2019 and August 2020, respectively, made by States on behalf of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States during the periods of July through September 2019 and July through September 2020 (audit periods). We selected the middle month of our 3-month audit periods to ensure that beneficiaries were enrolled in the months before, during, and after the August capitation payments. This helped us to identify beneficiaries who did not move to or from another State during August 2019 and August 2020.

To identify the population of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States during our audit periods, we compared CMS's T-MSIS data from 45 States, the District of Columbia, and Puerto Rico (together referred to as "47 States")

⁷ 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.

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

using the beneficiaries' Social Security numbers (SSNs), dates of birth, names, and sex.⁹ We then identified all associated August 2019 and August 2020 capitation payments that were made by two States for the same beneficiary. We calculated the amount of the capitation payments made by the two States for the same beneficiary for August 2019 and August 2020.

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.

FINDING

All 47 States reviewed made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in two States. Specifically, capitation payments were made on behalf of 208,254 concurrently enrolled beneficiaries in August 2019 and 327,497 concurrently enrolled beneficiaries in August 2020. The Medicaid program incurred costs of approximately \$72.9 million in August 2019 and \$117.1 million in August 2020 for capitation payments associated with beneficiaries in one of the two concurrently enrolled States.¹⁰ The significant increase in these payments from August 2019 to August 2020 coincided with an overall increase in Medicaid enrollment during that time, and new Federal requirements and flexibilities that were available to States during the COVID-19 PHE.

CMS does not actively monitor beneficiaries' concurrent Medicaid managed care enrollments; instead, it relies on the individual States to identify concurrent enrollments and potential erroneous payments. CMS does not provide States with T-MSIS national enrollment data that would assist them in identifying beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States. Two States often made capitation payments for the same Medicaid beneficiary in part because States did not have full access to data they needed to identify beneficiaries who were concurrently enrolled in another State. Therefore, CMS does not take all available steps, either directly or through the States, to identify and prevent State capitation payments for non-resident beneficiaries.

⁹ At the time of our requests, three States (Alaska, Connecticut, and Vermont) did not have complete T-MSIS Medicaid managed care enrollment data available, and two States (Tennessee and Texas) did not have complete T-MSIS Medicaid managed care capitation payment data available.

¹⁰ We did not perform a detailed review of each beneficiary and capitation payment to identify which of the two payments should have been made. These amounts represent potential savings in one of the two States in which beneficiaries were concurrently enrolled.

STATES MADE CAPITATION PAYMENTS FOR BENEFICIARIES WHO WERE CONCURRENTLY ENROLLED IN A MEDICAID MANAGED CARE PROGRAM IN TWO STATES

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.¹¹ Capitation payments were made for 208,254 beneficiaries in August 2019 and 327,497 beneficiaries in August 2020 who were concurrently enrolled in a Medicaid managed care program in two States. The Medicaid program incurred costs of approximately \$72.9 million in August 2019 and \$117.1 million in August 2020 for capitation payments associated with beneficiaries in one of the two concurrently enrolled States. For this audit, we did not identify the residency status of each beneficiary to determine which State was responsible for providing the beneficiaries' Medicaid benefits during the months of concurrent enrollment.¹² As a result, we do not know which of the two States should have made the capitation payment.

Table 1 below provides an example of a beneficiary who, according to T-MSIS data, was enrolled in Medicaid managed care in Illinois and concurrently enrolled in Ohio during our audit period. Illinois made a \$378 capitation payment and Ohio made a \$534 capitation payment in August 2020 for the same beneficiary. For this example, we determined that \$456 was the average of the two capitation payments for this beneficiary in August 2020.

Table 1: Example of a Concurrently Enrolled Medicaid Beneficiary and Capitation Payments for August 2020

Concurrent States	Medicaid Managed Care Enrollment	Value of August Capitation Payments	Value of Lower Payment	Value of Average Payment	Value of Higher Payment
Illinois	January 2019–Current ¹³	\$378	\$378	\$456	\$534
Ohio	August 2019–Current	\$534			

To estimate the impact of our findings, we made three calculations related to the August 2019 and August 2020 capitation payments. First, for each beneficiary we identified as being enrolled in two States' Medicaid managed care programs, we calculated the average payment

¹¹ 42 CFR §§ 435.403(a) and (j)(3).

¹² This audit did not use statistical sampling. Due to the large number of beneficiaries included in our audit, we could not identify the residency status and the State that was responsible for providing Medicaid benefits for each beneficiary.

¹³ "Current" represents that the beneficiary was actively enrolled as of the date the T-MSIS data was obtained (May 2021).

made by the two States and summed those averages.¹⁴ Second, we identified the lower of the two payments made on behalf of the concurrently enrolled beneficiaries and added those payments together. Third, we identified the higher of the two payments made on behalf of the concurrently enrolled beneficiaries and added those payments together. Table 2 shows the results of these calculations and provides details on the number of beneficiaries and payments associated with beneficiaries concurrently enrolled in two States. (Appendix C provides the details for each State.)

Table 2: Concurrently Enrolled Medicaid Beneficiaries and Capitation Payments for August 2019 and 2020

Description	August 2019	August 2020
Number of beneficiaries concurrently enrolled	208,254	327,497
Total number of capitation payments	416,508	654,994
Total value of capitation payments	\$145,722,169	\$234,165,639
Total value of lower payments	\$43,125,346	\$71,816,610
Total value of average payments	\$72,861,085	\$117,082,819
Total value of higher payments	\$102,596,824	\$162,349,029

The significant increase in payments from August 2019 to August 2020 coincided with an overall increase in Medicaid enrollment during that time, as well as new Federal requirements and flexibilities that were available to States during the COVID-19 PHE. For 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 a beneficiary's Medicaid eligibility during the PHE for most situations unless the beneficiary requests a voluntary termination of eligibility or ceases to be a State resident.¹⁵ Federal regulations also provide an exception in meeting the States' timeliness

¹⁴ Every beneficiary had capitation payments in two different States. We identified the average capitation payment amount of the two State payments made on behalf of each beneficiary and summed those amounts for all beneficiaries.

¹⁵ Following our audit period, on November 2, 2020, 42 CFR § 433.400(d)(3)(ii) went into effect. This regulation states that a beneficiary 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 beneficiary fails to respond to a request to verify State residency, provided that the State takes all reasonably available measures to attempt to verify the beneficiary's residency, and the State's alternative efforts cannot verify the beneficiary'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 a beneficiary as not being a State resident without the beneficiary verifying a change in residency.

standards for processing Medicaid renewals and changes in a beneficiary's circumstances for Medicaid eligibility during an emergency, such as the PHE.¹⁶

Two States often made capitation payments for the same Medicaid beneficiary in part because States did not have access to timely data needed to identify beneficiaries who were concurrently enrolled in another State. Full access to the T-MSIS data would provide an excellent tool to identify beneficiaries with concurrent Medicaid enrollment and to capture capitation payments made by each State. Once concurrent enrollment is identified, States would need to determine which State was responsible for providing the beneficiaries' Medicaid benefits before enrollment can be terminated.¹⁷

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- provide States with matched T-MSIS enrollment data that identify Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States and
- assist States with utilizing the data as needed to reduce future capitation payments made on behalf of beneficiaries concurrently enrolled in two States.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS COMMENTS

In written comments, CMS stated that it did not concur with our recommendations. Regarding our first recommendation, CMS stated that the PARIS Interstate Match already allows States to compare eligibility with other State Medicaid programs to identify concurrently enrolled beneficiaries, and the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to States, especially considering the existing statutory and regulatory framework underlying State monitoring of concurrent enrollments through PARIS. CMS also indicated that the timelag associated with T-MSIS file submission presents potential challenges for the utilization of T-MSIS data to identify concurrently enrolled beneficiaries in a timely manner, because data for a given month is typically not complete until 3 months following the end of the month. CMS stated that in OIG's previous audits of Illinois, Minnesota, and Ohio, OIG identified issues resulting from human error and a lack of internal State processes and procedures to ensure PARIS alerts were reviewed and processed in a timely manner. CMS

¹⁶ 42 CFR § 435.912(e)(2).

¹⁷ States may not deny or terminate enrollment based on information received in an electronic data match (i.e., PARIS and T-MSIS) 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. If the beneficiary cannot be located, the State can also contact the other matching State for additional residency information.

stated that these issues would be unlikely to be addressed by providing States with a new data source.

Regarding our second recommendation, CMS stated it is committed to working with States to ensure the accuracy of Medicaid eligibility determinations and will continue to provide guidance and technical assistance to States as needed, but it stated that the PARIS Interstate Match already allows States to compare eligibility with other State Medicaid programs. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding technical comments, are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we maintain that our recommendations are valid. We disagree with CMS's statement that providing States with matched T-MSIS enrollment data would be redundant, inefficient, and confusing to States. CMS and the States have devoted a significant amount of time and resources to establish, improve, and maintain T-MSIS data. In its comments, CMS acknowledged PARIS' limitations, including that data are only collected and matched on a quarterly basis by a non-Medicaid agency, and data are only available for the current quarter and not maintained in a database. In addition, CMS does not prescribe which of the three PARIS matches State Medicaid agencies must conduct, nor the frequency with which any match must be conducted. Our previous audits did identify issues with the timely processing of PARIS alerts. However, the majority of our reported beneficiaries were not identified by the State as concurrently eligible through the use of PARIS data. Instead, this audit identified the concurrently eligible beneficiaries through the analysis of T-MSIS data maintained by CMS and available to OIG. Through our analysis using T-MSIS data, we estimated that the Medicaid program incurred costs of approximately \$72.9 million in August 2019 and \$117.1 million in August 2020 for capitation payments associated with beneficiaries in one of the two concurrently enrolled States. These amounts represent potential monthly savings to the Medicaid program that, if annualized, would amount to approximately \$1 billion in program savings. Using T-MSIS data and appropriate reconciliation could assist CMS and States to prevent these potential payments and ensure Medicaid MCOs are not paid for beneficiaries for which they are no longer at risk for covering.

States submit their Medicaid data to CMS monthly for T-MSIS processing. State Public Assistance Agencies and other Federal agencies may submit public assistance eligibility and beneficiary data, including Medicaid data, to a data center quarterly for PARIS processing. The T-MSIS data provide information specific to the Medicaid program, and the data should be more complete and more current than PARIS data. Thus, providing States with access to T-MSIS data can significantly enhance the ability to identify beneficiaries with concurrent Medicaid enrollment and reduce the number and amount of concurrent capitation payments.

We acknowledge CMS's commitment to work with States to ensure the accuracy of Medicaid eligibility determinations and provide technical assistance as needed. We also plan to continue

our work with States to identify opportunities to reduce the number and amount of concurrent Medicaid capitation payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$145.7 million and \$234.2 million in Medicaid managed care capitation payments for August 2019 and August 2020, respectively, made by States on behalf of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States during our audit periods. We selected the middle month of our 3-month audit periods to ensure that beneficiaries were enrolled in the months before, during, and after the August capitation payments. This helped us to identify beneficiaries who did not move to or from another State during August 2019 and August 2020.

To identify the population of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States during our audit periods, we compared CMS's T-MSIS data from 47 States using the beneficiaries' SSNs, dates of birth, names, and sex.¹⁸

Our audit objective did not require an understanding or assessment of CMS's complete internal control structure. We limited our review of internal controls to obtaining an understanding of the controls that CMS had in place related to payments made on behalf of beneficiaries concurrently enrolled in a Medicaid managed care program in two States. We assessed the design, implementation, and operating effectiveness of CMS's internal controls for preventing or detecting capitation payments made on behalf of Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.

We conducted our audit work from May 2020 through April 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of ways States can prevent and identify capitation payments made on behalf of beneficiaries concurrently enrolled in a Medicaid managed care program in two States;
- obtained T-MSIS data that identified beneficiaries with concurrent Medicaid managed care enrollment in more than one State during July through September 2019 (1,436,806 records) or during July through September 2020 (2,464,984 records);

¹⁸ At the time of our requests, three States (Alaska, Connecticut, and Vermont) did not have complete T-MSIS Medicaid managed care enrollment data available, and two States (Tennessee and Texas) did not have complete T-MSIS Medicaid managed care capitation payment data available.

- analyzed the T-MSIS data to identify the number of unique SSNs associated with beneficiaries with concurrent Medicaid managed care enrollment for July through September 2019 (282,317 records) and July through September 2020 (445,753 records);
- obtained from T-MSIS all August 2019 and August 2020 capitation payment data associated with the unique SSNs of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States;
- analyzed the capitation payment data for August 2019 and August 2020 to identify capitation payments that occurred in the State pairs that we identified in our initial concurrent Medicaid managed care enrollment match;
- summarized the capitation payments for 208,254 beneficiaries in August 2019 and 327,497 beneficiaries in August 2020 who were concurrently enrolled in a managed care program in two States:
 - calculated the average payment made to the two States and summed those averages;
 - identified the lower of the two payments made on behalf of the concurrently enrolled beneficiaries and added those payments together;
 - identified the higher of the two payments made on behalf of the concurrently enrolled beneficiaries and added those payments together; and
- discussed the results of our audit with CMS 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>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: STATES WITH CONCURRENTLY ENROLLED MEDICAID BENEFICIARIES AND
CAPITATION PAYMENTS FOR AUGUST 2019 AND AUGUST 2020¹⁹**

State	Number of Beneficiaries Concurrently Enrolled— August 2019	Total Value of August 2019 Capitation Payments	Number of Beneficiaries Concurrently Enrolled— August 2020	Total Value of August 2020 Capitation Payments
AL	3,145	\$12,985	12,772	\$26,988
AR	5,904	\$848,240	8,624	\$808,246
AZ	22,226	\$11,440,834	28,174	\$14,892,901
CA	44,481	\$13,185,783	65,395	\$21,990,820
CO	24,423	\$2,452,419	26,341	\$2,674,421
DC	5,754	\$1,791,718	6,688	\$2,210,540
DE	3,007	\$1,798,288	4,776	\$3,016,703
FL	25,698	\$7,752,691	48,184	\$13,811,143
GA	19,826	\$4,052,740	34,672	\$7,105,032
HI	2,840	\$1,290,291	4,436	\$2,148,307
IA	5,773	\$2,849,632	8,364	\$4,059,083
ID	2,619	\$226,939	3,307	\$320,222
IL	16,662	\$6,291,184	29,373	\$11,900,410
IN	12,779	\$4,830,661	23,763	\$9,361,704
KS	4,311	\$2,735,737	5,807	\$3,342,754
KY	10,387	\$5,705,729	15,196	\$8,394,303
LA	12,457	\$5,783,291	17,785	\$8,960,836
MA	8,499	\$2,796,238	11,993	\$4,467,279
MD	9,147	\$3,617,530	15,877	\$6,316,093
ME	388	\$1,358	1,030	\$3,605
MI	11,587	\$3,988,237	19,221	\$5,400,375
MN	4,717	\$2,548,662	7,621	\$4,089,300
MO	8,163	\$1,386,728	12,904	\$2,696,183
MS	2,881	\$1,690,601	4,989	\$2,688,799
MT	3,145	\$24,824	2,723	\$20,923
NC	18,489	\$1,932,324	25,448	\$3,003,577
ND	215	\$430	565	\$1,130
NE	2,167	\$1,167,867	2,404	\$1,253,787
NH	77	\$32,662	2,076	\$1,029,798

¹⁹ At the time of our requests, three States (Alaska, Connecticut, and Vermont) did not have complete T-MSIS Medicaid managed care enrollment data available, and two States (Tennessee and Texas) did not have complete T-MSIS Medicaid managed care capitation payment data available.

State	Number of Beneficiaries Concurrently Enrolled— August 2019	Total Value of August 2019 Capitation Payments	Number of Beneficiaries Concurrently Enrolled— August 2020	Total Value of August 2020 Capitation Payments
NJ	8,313	\$3,656,236	14,078	\$6,281,097
NM	6,404	\$3,320,563	8,177	\$4,584,939
NV	7,251	\$1,973,951	19,799	\$5,534,725
NY	20,745	\$11,311,512	29,763	\$15,271,207
OH	12,927	\$8,137,601	19,299	\$12,823,694
OK	3,420	\$18,822	5,585	\$33,836
OR	5,722	\$3,224,602	7,345	\$3,860,442
PA	11,099	\$6,762,493	19,412	\$12,436,571
PR	3,627	\$526,403	6,462	\$1,083,872
RI	2,586	\$1,058,286	3,324	\$1,537,802
SC	12,196	\$3,209,170	17,917	\$4,933,029
SD	251	\$753	518	\$1,554
UT	2,438	\$757,150	4,384	\$1,697,529
VA	8,084	\$4,679,629	19,359	\$10,610,921
WA	9,339	\$2,429,391	11,304	\$3,212,669
WI	6,259	\$1,498,263	11,294	\$2,598,330
WV	4,079	\$913,931	6,465	\$1,665,615
WY	1	\$6,792	1	\$2,544
Total	416,508	\$145,722,169*	654,994	\$234,165,639*

* Due to rounding, the individual State capitation payment amounts do not sum to the total amount.

APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: July 1, 2022

TO: Gregory E. Demske
Acting Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Nearly All States Made
Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a
Medicaid Managed Care Program in Two States (A-05-20-00025)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of the Medicaid program. Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities.

The federal-state partnership central to the success of the Medicaid program depends on clear lines of responsibility and shared expectations. States are responsible for accurately determining eligibility for all individuals applying for or receiving benefits in accordance with federal regulations, and CMS provides states with guidance and technical assistance to ensure states comply with federal requirements.¹ For example, CMS provides technical assistance to states in the development and review of their eligibility verification plans to ensure that their verification practices are in accordance with regulations. As noted in a 2019 Information Bulletin, and described in regulations at 42 CFR § 435.945(j), each state's Modified Adjusted Gross Income eligibility verification plan must be maintained in accordance with federal verification requirements and is required to be submitted to CMS upon request or when changes are made.² As part of verification plan reviews, CMS discusses the states' verification policies, available options, implementation plan, and provides technical assistance to ensure the state is following all applicable federal requirements.

In accordance with Section 1903(r) of the Social Security Act (the Act) and the regulations at 42 CFR § 435.945(d), states are required to have eligibility determination systems that provide for data matching through the Public Assistance Reporting Information System (PARIS), which is a system for matching data from certain public assistance programs including state Medicaid programs, with selected federal and state data for purposes of facilitating appropriate enrollment and retention in public programs. PARIS currently consists of three types of data matches: the

¹ 42 CFR § Part 435 and, if applicable, 42 CFR § 435.119

² CMS, Oversight of State Medicaid Claiming and Program Integrity Expectations, 2019, Accessed at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf>

Federal Match, the Veterans Affairs (VA) Match, and the Interstate Match. While all states are required to sign an agreement to participate in PARIS as a condition of receiving Medicaid funding for automated data systems (including the Medicaid Management Information System), CMS does not prescribe which of the three PARIS matches state Medicaid agencies must conduct, nor the frequency with which any match must be conducted. In their eligibility verification plans, states must detail what they use PARIS to verify, such as whether they participate in the Interstate Match to compare beneficiary enrollment in other state public assistance programs, including Medicaid, or the VA Match for identifying veteran's benefits.

Outside of the current Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), which has had a substantial effect on states' eligibility and enrollment operations, there are several steps states are obligated to take when receiving information that may impact a beneficiary's eligibility, before taking adverse action. When a state receives information that may impact a beneficiary's eligibility, such as information identified through PARIS, they must provide the individual an opportunity to reasonably explain the change in circumstance or provide other documentation to refute the state's evidence.^{3,4} Additionally, a state cannot terminate a beneficiary's benefits unless it has first sought this information.⁵ If the beneficiary either does not respond to this request or provides an insufficient response, and the state does not have sufficient information to make a determination of continued eligibility, then the state can determine that the individual is no longer eligible. It is only at this time that the beneficiary's Medicaid eligibility can be terminated, and the state must provide notice of the termination of the beneficiary's eligibility no later than the date of the termination.⁶ If a beneficiary is identified as receiving Medicaid benefits in another state, such as the concurrently enrolled beneficiaries identified in the OIG's report, this represents a potential change in circumstance and requires the state to conduct outreach and follow-up to verify the beneficiary's residency prior to terminating coverage. CMS expects that states are operating their Medicaid programs in compliance with these requirements. However, given the OIG's findings in this report, states may be experiencing challenges in this area. CMS takes these findings seriously and appreciates the OIG's review in this area, as they indicate that further review by CMS may be warranted.

In general, the COVID-19 PHE has significantly disrupted routine Medicaid eligibility and enrollment operations, and states have made numerous policy, programmatic, and systems changes to respond effectively to COVID-19. For example, for states to qualify for the temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127), states need to satisfy a continuous enrollment condition; meaning that states must maintain enrollment for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. States claiming the temporary FMAP increase authorized by section 6008 of the FFCRA have been required to suppress terminations and other adverse actions for Medicaid beneficiaries that would violate the continuous enrollment condition. This means that while states may terminate coverage for individuals who are confirmed to no longer be residents of the state, they may not terminate beneficiaries' coverage based on their failure to return a renewal form or to respond to a request

³ 42 CFR § 435.916(d)

⁴ 42 CFR § 435.952(c)(2)

⁵ 42 CFR § 435.952(d)

⁶ 42 CFR § 431.213(e)

for additional information from the state Medicaid agency. Finally, many states may have made changes to their use of PARIS and/or have experienced a decreased capacity to conduct outreach and follow-up as a result of the ongoing COVID-19 PHE.

Many of the changes that were implemented by states to satisfy the section 6008 FFCRA continuous enrollment condition directly impacted their ability to disenroll beneficiaries who were enrolled in a Medicaid managed care plan in more than one state in August 2020, the time of the OIG's review. Effective November 2, 2020, following the time period under OIG's review, CMS's Interim Final Rule with Comment (CMS-9912 IFC), established that states may terminate coverage if the beneficiary is no longer a resident of the state, as described in section 6008(b)(3) of the FFCRA and at 42 CFR § 433.400(d)(1)(ii).⁷ Further, the regulation at 42 CFR § 433.400(d)(3)(ii), created an exception to a state's ability to terminate eligibility based on a PARIS Interstate Match. Effective November 2, 2020, states may, but are not required to, terminate coverage if: the beneficiary is identified through the Interstate Match with PARIS, the state takes all available reasonable measures to determine state residency prior to termination, and the beneficiary fails to respond to a request for information to verify their residency. This exception is narrow, limited to beneficiaries identified through the PARIS Interstate Match, and was not in effect during the months of July to August 2020. As such, it is not possible for CMS to draw conclusions from the number of concurrently enrolled beneficiaries identified in the OIG's report from August 2020.

The expiration of the continuous enrollment condition authorized by the FFCRA presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act. In an effort to support states as they transition back to normal operations, CMS has worked closely with states to prepare for the return to normal operations through regular workgroups, bi-weekly and individual calls with states, and through the development of guidance, tools, and resources for states to use in their planning efforts.⁸ As discussed in State Health Official letters released in August 2021 and March 2022, CMS is providing states 12-months to initiate renewals of eligibility and other pending eligibility and enrollment actions for all individuals enrolled in Medicaid when the PHE ends.^{9,10} States may take an additional two months, or up to 14 months total, to complete outstanding eligibility and enrollment actions work initiated during the 12-month unwinding period. States are encouraged to use the entire 12-month unwinding period in order to prevent inappropriate terminations of coverage for individuals still eligible for Medicaid, facilitate seamless coverage transitions, and achieve a

⁷ Federal Register: "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (CMS-9912-IFC) (November 6, 2020) <https://www.govinfo.gov/content/pkg/FR-2020-11-06/pdf/2020-24332.pdf>

⁸ CMS, Unwinding and Returning to Regular Operations after COVID-19, Accessed at: <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html>

⁹ CMS, Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency, 2021, Accessed at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>

¹⁰ CMS, Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency, 2022, Accessed at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>

sustainable renewal schedule. CMS has released additional guidance, as well as planning and communications tools, that offer states a roadmap to restore routine eligibility and enrollment operations when the PHE ends.⁸ CMS encourages states to consider strategies to streamline enrollment, establish procedures to update contact information, engage stakeholders in planning efforts, update systems, and train eligibility and enrollment staff.

CMS is committed to working with states to ensure the accuracy of Medicaid eligibility determinations and appreciates the opportunity to comment on the OIG's report. OIG's recommendations and CMS's responses are below.

OIG Recommendation

We recommend that the Centers for Medicare & Medicaid Services provide States with matched T-MSIS enrollment data that identifies Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.

CMS Response

CMS does not concur with this recommendation. CMS appreciates the information provided in the OIG's report and understands the intent behind the recommendation. Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities. States, as the direct administrators of their programs, are responsible for conducting accurate and timely eligibility determinations, and following up with beneficiaries regarding potential changes in circumstance, if needed.

The PARIS Interstate Match already allows states to compare eligibility with other state Medicaid programs to identify beneficiaries that may be concurrently enrolled in more than one state. Most states are already relying on this system and investing resources to use it, and the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to states, especially considering the existing statutory and regulatory framework underlying state monitoring of concurrent enrollments through PARIS. CMS recognizes the limitations described in the OIG's report that states may face when utilizing PARIS, however, the time lag associated with T-MSIS file submission also presents potential challenges for the utilization of T-MSIS data to identify concurrently enrolled beneficiaries in a timely manner. While as of May 2022 all 50 states, the District of Columbia, the Virgin Islands and Puerto Rico are producing and submitting T-MSIS data to CMS monthly, the data for a given month is typically not complete until three months following the end the given month.

Further, in OIG's previous reviews of three individual states—Ohio, Minnesota, and Illinois—looking at capitation payments made in August 2018, OIG identified issues resulting from human error and a lack of internal state processes and procedures to ensure that PARIS alerts and other notifications were reviewed and processed on a timely basis. These issues would unlikely be addressed by providing states with a new data source.

OIG Recommendation

We recommend that the Centers for Medicare & Medicaid Services assist States with utilizing the data as needed to reduce future capitation payments made on behalf of beneficiaries concurrently enrolled in two States.

CMS Response

CMS does not concur with this recommendation. CMS is committed to working with states to ensure the accuracy of Medicaid eligibility determinations and will continue to provide guidance and technical assistance to states as needed. However, as noted above, CMS does not concur with the OIG's first recommendation to provide states with matched T-MSIS enrollment data, as the PARIS Interstate Match already allows states to compare eligibility with other state Medicaid programs to identify beneficiaries that may be concurrently enrolled in more than one state.