

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA MADE ALMOST
\$16 MILLION IN UNALLOWABLE
CAPITATION PAYMENTS FOR
BENEFICIARIES WITH MULTIPLE
CLIENT INDEX NUMBERS**

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

**October 2022
A-04-21-07097**

Office of Inspector General

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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: October 2022

Report No. A-04-21-07097

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



Why OIG Did This Audit

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

Our objective was to determine whether the California Department of Health Care Services (California) made unallowable capitation payments on behalf of beneficiaries with multiple Client Index Numbers (CINs).

How OIG Did This Audit

Our audit covered approximately \$112.1 million (\$56.1 million Federal share) in Medicaid capitation payments California made to MCOs from July 1, 2015, through June 30, 2019, for the 12,686 beneficiary matches that we identified. We selected and reviewed a stratified random sample of 100 of these beneficiary matches.

California Made Almost \$16 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Client Index Numbers

What OIG Found

California made unallowable capitation payments on behalf of beneficiaries with multiple CINs. Of the 100 beneficiary matches in our sample, California correctly made capitation payments on behalf of individuals associated with 24 beneficiary matches. However, it incorrectly made capitation payments that totaled \$657,057 (\$328,529 Federal share) on behalf of individuals associated with the remaining 76 beneficiary matches.

The unallowable capitation payments occurred because the associated beneficiaries had multiple CINs. According to California, human error caused it to assign multiple CINs to these beneficiaries. Specifically, during the file clearance process, California county staff made data entry errors that included misspelling beneficiaries' names. Also, staff transposed Social Security numbers, failed to identify and link multiple records, and did not always identify and resolve variations in beneficiaries' names. In addition, the algorithm that California used to create the Beneficiary Name and Date of Birth (DOB) Match Report was too broad and, thus, not effective. Further, California did not require county staff to review training materials.

On the basis of our sample results, we estimated that California made unallowable capitation payments totaling approximately \$31.4 million (\$15.7 million Federal share) on behalf of beneficiaries with multiple CINs during our audit period.

What OIG Recommends and California Comments

We recommend that California: (1) refund to the Federal Government approximately \$15.7 million in unallowable payments, (2) review capitation payments that fell outside of our audit period and refund any unallowable payments, (3) ensure that the algorithm used to create its revised Beneficiary Name and DOB Match Reports is effective at detecting individuals with multiple records, (4) require county staff to review training materials on the prevention of issuing multiple CINs, and (5) enhance its controls to ensure that no beneficiary is issued multiple CINs.

In written comments on our draft report, California concurred with our recommendations and described the corrective actions that it has taken or plans to take to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

Previous Office of Inspector General (OIG) audits¹ identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries.

OBJECTIVE

Our objective was to determine whether the California Department of Health Care Services (State agency) made unallowable capitation payments on behalf of beneficiaries with multiple Client Index Numbers (CINs).²

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

California's Medicaid Managed Care Program

The State agency is responsible for the administration of California's Medicaid managed care program, known as Medi-Cal Managed Care. The purpose of the program is to provide high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventative care.

¹ See Appendix B for related OIG reports.

² The State agency used CINs to process payments as opposed to Medicaid ID numbers similar to those used by other Medicaid State agencies that we have reviewed.

Capitation Payments

The State agency pays MCOs a monthly fee, known as a capitation payment, to ensure that an enrolled beneficiary has access to a comprehensive range of medical services. A capitation payment is “a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract . . . for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment” (42 CFR § 438.2). The State agency has the right to recover from the MCO amounts paid to the MCO if it determines that it made an improper payment to the MCO for reasons including, but not limited to, errors, omissions, delays, or neglect on the part of the State agency or other entity or person (Medicaid Managed Care Contract, County Organized Health Systems Coordinated Care Initiative Boilerplate Contract, exhibit B, item 12 C: “Recovery of Capitation Payments”).³

File Clearance Process and Establishing a CIN

California county staff must clear all applicants prior to processing their Medicaid application. This is done through a file clearance process that determines whether the individual exists in the Medi-Cal Eligibility Data System (MEDS)⁴ or Statewide Client Index (SCI) database and has a current or previous record of eligibility. The file clearance process also involves checking the SCI database and MEDS against certain identifying information that the applicant provided. Additionally, to allow the county agencies to identify beneficiaries with multiple records and remove any duplicate CINs, the State agency sends California county agencies a Beneficiary Name and Date of Birth (DOB) Match Report on a quarterly basis.

Through MEDS, county staff use the applicant’s name (including “scored” name and “fuzzy” name searches),⁵ DOB, gender, address, Social Security number, CIN, mother’s name, birthplace, and citizenship status to select the correct case record, if one exists.

Through SCI, via the county’s local automated system, county staff use the information from the application form (e.g., applicant’s name, DOB, and gender) to perform a broad-based search on the county’s local automated system to determine whether the individual already exists in the SCI.

If the file clearance process identifies the applicant through existing information on MEDS or SCI, county staff link the information for that individual to their existing CIN. If the individual is not already in the MEDS or SCI, a new CIN is established.

³ We have confirmed that this language was included in the applicable MCO contracts during our audit period.

⁴ MEDS stores eligibility information for individuals who have been approved for Medi-Cal benefits. SCI identifies if a client is already known on local or State databases or whether multiple records exist in the State databases.

⁵ “Scored” name search uses the applicant’s name, exact DOB, and gender. MEDS will provide results up to 25 possible records, in order of which record has the highest percent of matching information. “Fuzzy” name search uses the applicant’s name and a range (e.g., an entire year) for their DOB.

The file clearance process should prevent the State agency from issuing multiple CINs and prevent errors such as: (1) duplication of benefits, (2) creation of multiple SCI or MEDS records, and (3) assumption of someone else's MEDS records.

HOW WE CONDUCTED THIS AUDIT

We limited our audit to Medicaid capitation payments that the State agency made to MCOs on behalf of Medicaid beneficiaries in California from July 1, 2015, through June 30, 2019 (audit period).⁶ From a detailed list of capitation payments to MCOs during our audit period, we identified 12,686 instances of individual beneficiaries that we could match to more than one CIN.⁷ From these beneficiary matches,⁸ for which the State agency made capitation payments totaling \$112,109,129 (\$56,054,565 Federal share), we selected and reviewed a stratified random sample of 100 beneficiary matches.

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

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

FINDINGS

The State agency made unallowable capitation payments on behalf of beneficiaries with multiple CINs. Of the 100 beneficiary matches in our sample, the State agency correctly made capitation payments on behalf of individuals associated with 24 beneficiary matches; however, the State agency incorrectly made capitation payments on behalf of individuals associated with the remaining 76 beneficiary matches, totaling \$657,057 (\$328,529 Federal share).

The unallowable capitation payments occurred because the associated beneficiaries had multiple CINs. According to the State agency, human error caused it to assign multiple CINs to these beneficiaries. Specifically, during the file clearance process, California county staff made data entry errors that included misspelling beneficiaries' names. Also, staff transposed Social Security numbers, failed to identify and link multiple records, and did not always identify and resolve variations in beneficiaries' names (e.g., nicknames and hyphenated names). In addition,

⁶ The audit period encompassed the most current data available at the time we initiated our audit.

⁷ Throughout this report, we will refer to multiple CINs assigned to what appears to be an individual as "beneficiary matches." We define a beneficiary match as more than one CIN associated with a beneficiary that has both: (1) the same or similar first and last names or the inverse of the exact or similar first and last names and (2) the same DOB.

⁸ We performed data analytics to identify these 12,686 beneficiary matches.

the algorithm that the State agency used to create the Beneficiary Name and DOB Match Report was too broad and, thus, not effective. Further, the State agency did not require county staff to review training materials.

On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least \$31,445,148 (\$15,722,587 Federal share) on behalf of beneficiaries with multiple CINs during our audit period.

BENEFICIARIES HAD MULTIPLE CLIENT IDENTIFICATION NUMBERS

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

Of the 100 sampled beneficiary matches, the State agency correctly made capitation payments on behalf of beneficiaries associated with 24 beneficiary matches. However, the State agency incorrectly claimed Federal Medicaid reimbursement for managed care payments totaling \$657,057 (\$328,529 Federal share) made on behalf of 76 beneficiaries under multiple CINs for the same month.

The State agency had some controls in place to detect and prevent payments on behalf of beneficiaries assigned multiple CINs, such as sending its Beneficiary Name and DOB Match Report to California county agencies on a quarterly basis. One of the main purposes of this report is to allow county agencies to identify beneficiaries with multiple records and remove any duplicate CINs. The report groups CINs by individual, and county staff research the State agency eligibility systems to determine whether the records belong to the same individual. If an individual has multiple CINs, county staff merge them into one record and CIN. In addition, the State agency had training materials for county staff who process Medicaid applications to reduce the creation of multiple records in eligibility systems and explain how to link records when a beneficiary is found to have multiple records.

However, the State agency's controls were not sufficient to detect or prevent multiple CINs from being assigned to the same beneficiary. For example, it did not consider the potential for human error. In addition, the algorithm that the State agency used to create the Beneficiary Name and DOB Match Report was too broad and, thus, not effective. Further, the State agency did not require county staff to review the training materials.

According to the State agency, human error caused it to assign multiple CINs to beneficiaries. Specifically, during the file clearance process, California county staff made data entry errors (e.g., misspelling beneficiaries' names and transposed Social Security numbers), failed to identify and link multiple records, and did not always identify and resolve variations in beneficiaries' names (e.g., nicknames and hyphenated names). As a result, county staff created multiple records for beneficiaries. The State agency also stated that the algorithm it used to create the Beneficiary Name and DOB Match Report was too broad in scope. As a result,

county staff may not have efficiently or consistently used these reports to detect individuals with multiple records because doing so required the county staff to conduct labor intensive research to determine whether a beneficiary had multiple records.⁹ Lastly, county staff had access to MEDS training materials that included topics such as reducing the creation of multiple records in eligibility systems and how to link records when an individual is found to have multiple records. However, the State agency did not require county staff to review these training materials and did not have a mechanism in place to determine whether staff reviewed and understood the training materials.

ESTIMATE OF UNALLOWABLE CAPITATION PAYMENTS

On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least \$31,445,148 (\$15,722,587 Federal share) on behalf of beneficiaries with multiple CINs during our audit period.

RECOMMENDATIONS

We recommend that the California Department of Health Care Services:

- refund to the Federal Government \$15,722,587 in unallowable payments,
- review capitation payments that fell outside of our audit period and refund any unallowable payments,
- ensure that the algorithm used to create its revised Beneficiary Name and DOB Match Reports is effective at detecting individuals with multiple records,
- require county staff to review training materials on the prevention of issuing multiple CINs, and
- enhance its controls to ensure that no beneficiary is issued multiple CINs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the corrective actions that it has taken or plans to take to address them.

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

⁹ After our audit period, the State agency revised the report to include pseudo IDs (MEDS assigns a pseudo ID to an individual who does not have a valid SSN) and similar names associated with the same address and DOB. The State agency stated that it plans to closely monitor counties' progress in resolving the records on the report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$112,109,129 (\$56,054,565 Federal share) in Medicaid capitation payments that the State agency made to MCOs from July 1, 2015, through June 30, 2019 (audit period) for 12,686 beneficiary matches.¹⁰

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

We conducted this audit from December 2021, through September 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and State guidance;
- reviewed the State agency's policies and procedures on how it assigns CINs and prevents the assignment of multiple CINs to the same beneficiary;
- performed data analytics to identify beneficiary matches;
- requested that the State agency provide a detailed list of capitation payments to MCOs from July 1, 2015, through June 30, 2019, for these beneficiary matches;
- selected a stratified random sample of 100 beneficiary matches from the sampling frame;
- reviewed computer records for each sample item to determine whether a beneficiary was issued multiple CINs; and
- estimated the total amount of unallowable Medicaid capitation payments that the State agency made during our audit period.

¹⁰ We performed data analytics to identify these 12,686 beneficiary matches.

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	Date Issued
<i>Kentucky Made Almost \$2 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Medicaid ID Numbers</i>	<u>A-04-20-07094</u>	12/02/2021
<i>New York Made Unallowable Payments Totaling More Than \$9 Million to the Same Managed Care Organization for Beneficiaries Assigned More Than One Medicaid Identification Number</i>	<u>A-02-20-01007</u>	05/11/2021
<i>Florida Made Almost \$4 Million in Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers</i>	<u>A-04-18-07080</u>	03/23/2020
<i>New York Made Unallowable Payments Totaling More Than \$10 Million for Managed Care Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<u>A-02-18-01020</u>	02/20/2020
<i>Tennessee Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<u>A-04-18-07079</u>	10/29/2019
<i>Georgia Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<u>A-04-16-07061</u>	12/27/2017
<i>Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned More Than One Medicaid Identification Number</i>	<u>A-06-15-00024</u>	3/01/2017
<i>New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers</i>	<u>A-02-11-01006</u>	4/15/2013

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of an Excel file containing 535,206 capitation rows totaling \$112,109,129 for 12,686 beneficiary matches¹¹ having total net capitation payments greater than \$100.

SAMPLE UNIT

The sample unit was a beneficiary match.

SAMPLE DESIGN AND SAMPLE SIZE

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

Table 1: Details of Sampling Frame

Stratum	Number of Sample Units	Sample Size	Net Payment Amounts	Description of Stratum
1	9,026	34	\$36,263,798	Net capitation total >\$107.32 and <\$9,174.05
2	3,005	33	43,888,943	Net capitation total ≥\$9174.05 and <\$28,508.95
3	655	33	31,956,388	Net capitation total ≥\$28,508.95
Total	12,686	100	\$112,109,129	

SOURCE OF THE RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sampling frame for each beneficiary match from lowest to highest total net capitation payments and then by the lowest CIN for each match. Then each beneficiary match associated with these payments was consecutively assigned a number. After generating the random numbers for each stratum, we selected the corresponding frame items for review.

¹¹ We define a beneficiary match as more than one CIN associated with a beneficiary that has both: (1) the same or similar first and last names or the inverse of the exact or similar first and last names and (2) the same DOB.

ESTIMATION METHODOLOGY

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

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Beneficiary Matches in the Sampling Frame	Frame Value	Sample Size	Sample Value	Number of Beneficiary Matches with Overpayments in the Sample	Value of the Overpayments in the Sample (Total)	Value of the Overpayments in the Sample (Federal Share)
1	9,026	\$36,263,798	34	\$123,849	24	\$34,999	\$17,499
2	3,005	43,888,943	33	520,223	28	219,461	109,731
3	655	31,956,388	33	1,806,466	24	402,597	201,299
Total	12,686	\$112,109,129	100	\$2,450,538	76	\$657,057	\$328,529

**Table 3: Estimated Value of Overpayments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)**

	Total Amount	Federal Share
Point estimate	\$37,266,319	\$18,633,173
Lower limit	31,445,148	15,722,587
Upper limit	43,087,490	21,543,760

APPENDIX E: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Section 1903(d)(2)(A) of the Act requires Federal Medicaid payments to a State to be reduced to make adjustment for prior overpayments. In addition, States are responsible for refunding the Federal share of overpayments to CMS (42 CFR § 433.312(a)).

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

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

A capitation payment is "a payment the State 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).

STATE REQUIREMENTS

The State agency has the right to recover from the MCO amounts paid to the MCO if it determines that it made an improper payment to the MCO for reasons including, but not limited to, errors, omissions, delays, or neglect on the part of the State agency or other entity or person (Medicaid Managed Care Contract, County Organized Health Systems Coordinated Care Initiative Boilerplate Contract, exhibit B, item 12 C: "Recovery of Capitation Payments").¹²

¹² We have confirmed that this language was included in the applicable MCO contracts during our audit period.

APPENDIX F: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

October 7, 2022

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
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RE: RESPONSE TO DRAFT AUDIT REPORT A-04-21-07097

Dear Ms. Pilcher:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the Office of Inspector General (OIG) draft audit report number A-04-21-07097, titled, "California Made Almost \$16 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Client Index Numbers."

In the above draft audit report, OIG issued five recommendations for DHCS. DHCS concurs with all of OIG's recommendations and has prepared corrective action plans for implementation.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any questions, please contact the DHCS Office of Compliance, Internal Audits at (916) 445-0759.

Sincerely,

Michelle Baass
Director

Enclosure

cc: See Next Page

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Department of Health Care Services

Audit: “California Made Almost \$16 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Client Index Numbers”

Audit Entity: Office of Inspector General

Report Number: A-04-21-07097 (22-07) (Capitation Payments Audit)

Response Type: Draft Audit Report Response

Finding 1 Beneficiaries had multiple client identification numbers (CIN).

Recommendation 3

Department of Health Care Services (DHCS) should ensure that the algorithm used to create its revised Beneficiary Name and Date of Birth (DOB) Match Reports is effective at detecting individuals with multiple records.

What is DHCS’ Response to the Recommendation? Concurrence

DHCS Response:

In March of 2021, DHCS modified the multiple CIN report, to improve detection/identification of beneficiaries with multiple CINs in the Medi-Cal Eligibility System (MEDS), and improved the report’s readability. The Beneficiary Name/DOB Match Report is an older report, which counties may not have used efficiently to detect individuals with multiple records. DHCS revised the reports to increase the detection of multiple records by expanding the report to include Pseudo Identifications, and similar names with the same case address and/or DOB. DHCS will implement a monitoring process by March 31, 2023. The process will ensure that counties are working the reports timely. In addition, DHCS will issue updated guidance on DHCS’ expectations on working the reports, and instructions on how to merge these types of records successfully.

Recommendation 4

DHCS should require county staff to review training materials on the prevention of issuing multiple CINs.

What is DHCS’ Response to the Recommendation? Concurrence

DHCS Response:

DHCS will issue updated guidance about DHCS’ expectations on working the new Beneficiary Name/DOB Match Report. Guidance will be issued by March 31, 2023; the guidance will notify counties the staff is required to review training materials on the prevention of issuing multiple CINs on a regular basis.

Recommendation 5

DHCS should enhance its controls to ensure that no beneficiary is issued multiple CINs.

What is DHCS' Response to the Recommendation? Concurrence

DHCS Response:

DHCS will implement a process to monitor counties' progress on resolving the records on the new Beneficiary Name/DOB Match Report, and work with counties to identify the factors that contribute to the issuance of multiple CINs. Upon isolating the factors that contribute to the issue, DHCS will work with counties to add additional controls to mitigate the issuance of multiple CINs. In addition, DHCS will issue updated guidance about DHCS' expectations on working the new Beneficiary Name/DOB Match Report, and will ensure all appropriate staff review training materials on the prevention of issuing multiple CINs on a regular basis. DHCS' county monitoring process will commence by March 31, 2023.

Finding 2 Estimate of unallowable capitation payments.

Recommendation 1

DHCS should refund to the Federal Government \$15,722,587 in unallowable payments.

What is DHCS' Response to the Recommendation? Concurrence

DHCS Response:

DHCS will use the usual and customary process to refund unallowable payments to the federal government as soon as feasible. DHCS Managed Care Operations Division will draft a memo for Accounting to report the recoupment on the appropriate line item for funds returned due to an audit (Line 10A), which is part of the CMS-64 – Medicaid Budget and Expenditure System.

Recommendation 2

DHCS should review capitation payments that fell outside of our audit period and refund any unallowable payments.

What is DHCS' Response to the Recommendation? Concurrence

DHCS Response:

DHCS will review capitation payments that fell outside of the audit period and refund any unallowable payments identified. DHCS will report on calculated refund amounts by October 2023.