Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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

Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief
Date: May 2021
Report No. A-05-19-00032

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

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

Why OIG Did This Audit

Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly paid capitation payments on behalf of beneficiaries with concurrent eligibility in another State. We conducted a similar audit of Minnesota's Medicaid program.

Our objective was to determine whether Minnesota made capitation payments on behalf of Medicaid beneficiaries who were residing and enrolled in Medicaid in another State.

How OIG Did This Audit

Our audit covered 7,706 August 2018 capitation payments, totaling $4.0 million, made on behalf of beneficiaries with concurrent eligibility in another State during our audit period, July 1 through September 30, 2018. We selected the middle month of our audit period to ensure that beneficiaries were eligible in the months before and after the August 2018 capitation payments. We selected a stratified random sample of 106 capitation payments, totaling $45,919 ($29,458 Federal share), and determined whether the beneficiaries were residing and receiving Medicaid benefits in Minnesota during the audit period.

What OIG Found

Minnesota made an estimated $1.1 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 106 capitation payments in our stratified random sample, 71 were associated with beneficiaries who were residing and eligible for Medicaid benefits in Minnesota. However, for the remaining 35 capitation payments, totaling $15,084 ($9,167 Federal share), Minnesota made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Minnesota because they were concurrently eligible and residing in another State. On the basis of our sample results, we estimated that Minnesota could have saved $1.1 million ($665,000 Federal share) for August 2018 capitation payments made to managed care organizations on behalf of beneficiaries with concurrent eligibility.

What OIG Recommends and Minnesota's comments

We recommend that Minnesota: (1) develop new procedures or enhance current ones to identify beneficiaries with concurrent eligibility in another State, which could have saved Minnesota an estimated $1.1 million ($665,000 Federal share) in capitation payments for the month of August 2018; and (2) ensure that county caseworkers follow procedures to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

In written comments on our draft report, Minnesota accepted our recommendations and described actions it has taken or plans to take to address them. Specifically, Minnesota said that it will continue to use the Public Assistance Reporting Information System (PARIS) files to determine concurrent eligibility until a successor system is available, but it will review and revise, as necessary, procedures related to recording and acting on changes of address. Minnesota said that it will remind county and State workers of their responsibilities related to processing PARIS matches and their responsibility to coordinate changes of address across the State's two eligibility systems. Minnesota also noted our use of the Transformed Medicaid Statistical Information System (T-MSIS) database to perform the audit, a system not currently available to States, and said that it looks forward to the day T-MSIS is made available to States for their use.

The full report can be found at https://oig.hhs.gov/oas/reports/region5/51900032.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Minnesota Department of Human Services (State agency) pays managed care organizations (MCOs) to make services available to eligible Medicaid beneficiaries in return for a monthly fixed payment (capitation payment) for each enrolled beneficiary. Previous Office of Inspector General (OIG) audits[1] found that State Medicaid agencies had improperly paid capitation payments on behalf of beneficiaries with concurrent eligibility in another State. We conducted a similar audit of the State agency, which administers the Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of Medicaid beneficiaries who were residing and enrolled in Medicaid in another State.[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. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid beneficiaries. States contract with an MCO to make services available to enrolled Medicaid beneficiaries, usually in return for a periodic payment, known as a capitation payment. States report capitation payments claimed by Medicaid MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

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[1] *Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State* (A-05-19-00023) and *Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State* (A-05-19-00031).

[2] In this report, we refer to Medicaid enrollment in more than one State as "concurrent eligibility."

During the period July 1 through September 30, 2018 (audit period), the FMAP in Minnesota was 50 percent.[3]

Federal Requirements

States are required to provide Medicaid services to eligible residents, including residents who are absent from the State. If a resident of one State subsequently establishes residency in another State for purposes of Medicaid eligibility, the beneficiary's Medicaid eligibility in the previous State should end (42 CFR §§ 435.403(a) and (j)(3)).

States must generally provide notice when the State agency terminates a Medicaid beneficiary's covered benefits or eligibility at least 10 days before the date of action (42 CFR § 431.211). However, if a State establishes that the beneficiary has been accepted for Medicaid services by another State, the original State must provide notice of the termination of the beneficiary's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)).

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

Minnesota's Medicaid Managed Care Program

Minnesota began providing managed care to Medicaid beneficiaries in 1985, with a federally authorized demonstration program called the Prepaid Medical Assistance Program allowing mandatory enrollment for some beneficiaries into HMOs in the Minneapolis area. Over time, Minnesota has expanded managed care to include several other populations and services. The programs are operational in all 87 counties of the State. Enrollees are served by eight managed care organizations (MCOs). Average monthly enrollment in Minnesota's Medicaid program has remained relatively consistent since 2015, with about 1.1 million people covered. Roughly two-thirds of those covered in 2018 were parents, children, and pregnant women. The managed care program covered almost all services offered under Minnesota Medicaid, and plans can also provide services beyond those covered under Medicaid at their own expense. The contracts with the MCOs covered health care services to eligible Medicaid beneficiaries in exchange for a fixed per-member, per-month capitation payment, regardless of whether the member received covered services in that month.

[3] Because of the Patient Protection and Affordable Care Act's (ACA's) Medicaid expansion, payments for "newly eligible" adults were reimbursed at a 100-percent FMAP during calendar years 2014 through 2016 and gradually declined to 90 percent by 2020. The ACA was designed to significantly reduce the number of uninsured by providing affordable health care coverage options through Medicaid and the Health Insurance Marketplaces. Coverage for most low-income adults was increased to 138 percent of the Federal poverty level for States that chose to implement the ACA expansion.

Minnesota's State Medicaid plan requires that Medicaid be granted in accordance with 42 CFR § 435.403 to eligible applicants who, among other requirements, are residents of the State, including residents who are absent from the State under certain conditions unless another State has determined the individual is a resident there for the purposes of Medicaid.

Under section 3.2 of the Medicaid MCO contracts, which addresses termination of enrollee coverage, the State may terminate an enrollee's coverage when the enrollee becomes ineligible for the State's Medicaid program or upon the occurrence of certain conditions, including when an enrollee moves out of an MCO's service area. Generally, termination of coverage takes effect at midnight on the first day of the month following the month when the termination was entered in the State's Medicaid Management Information System (MMIS), or on the first day of the second month following the month during which termination was entered, depending on whether the entry occurred before or after the State's MMIS cutoff date.

Transformed Medicaid Statistical Information System

The Transformed Medicaid Statistical Information System (T-MSIS) is a critical data and systems component maintained by CMS. The primary purpose of T-MSIS is to establish an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claim data about Medicaid recipients to be used for the administration of Medicaid at the Federal level and to assist in the detection of fraud, waste, and abuse in Medicaid.

The T-MSIS data set contains:

- enhanced information about beneficiary eligibility,
- beneficiary and provider enrollment data,
- service utilization data,
- claim and managed care data, and
- expenditure data.

Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is an information exchange system managed by the Administration for Children and Families. PARIS matches State and Federal data to provide State Public Assistance Agencies with beneficiary information that they can use to identify possible concurrent eligibility and erroneous payments. The three parts of PARIS are the Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Match (duplicate payments made to or on behalf of the same beneficiary in more than one State). The programs that use PARIS data are Medicaid,

Temporary Assistance for Needy Families, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program (SNAP).[4]

Section 1903(r)(3) of the Social Security Act and 42 CFR § 435.945(d) require that all States have an eligibility determination system that conducts data matching using PARIS, which can help States detect and deter improper payments by identifying beneficiaries with concurrent eligibility in two or more States. The PARIS inter-State match alerts the States that are potentially making duplicate payments for Medicaid beneficiaries with concurrent eligibility in another State. This inter-State match can be used to help determine which State is responsible for providing the beneficiaries' Medicaid benefits. States are expected to determine whether matched individuals continue to be eligible for benefits in their State and take whatever case action is appropriate.[5] However, CMS has not specified how States must verify continued eligibility when a match is identified. Some States use local benefit office staff, fraud investigators, or both to review the matches.

Minnesota's Medicaid eligibility verification plan describes the use of PARIS as a post-enrollment check for concurrent benefits received in other States' public programs while the individual is enrolled in Minnesota Medicaid. The PARIS match information is added to Minnesota's MAXIS eligibility system and generates an electronic alert (PARIS alert) for beneficiaries who were identified as having concurrent eligibility in another State. The PARIS match information is issued via a report in the Minnesota Eligibility Technology System (METS). Minnesota generally relies on caseworkers at county offices to verify the accuracy of PARIS alerts. Caseworkers should make contact by mail with the beneficiary to determine the current Minnesota address or whether the beneficiary resides in a different State.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 7,706 August 2018 capitation payments, totaling $3,987,584, made on behalf of beneficiaries with concurrent eligibility in another State during our audit period.[6] We selected the middle month of our audit period to ensure that beneficiaries were eligible in the months before and after the August 2018 capitation payments. This helped us to identify beneficiaries who did not move to or from another State during August 2018.[7] To identify our population of beneficiaries who had concurrent eligibility during our audit period, we compared CMS's T-MSIS data for Minnesota with T-MSIS data from 48 States, the District of Columbia, and

[4] Minnesota SNAP helps Minnesotans with low incomes get the food they need for nutritious and well-balanced meals. The program provides support to help beneficiaries stretch their household food budget.

[5] 42 CFR § 435.952(a) and § 435.916(d)(1).

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

[7] Concurrent capitation payments are allowable in the month a beneficiary moves and establishes Medicaid eligibility in another State.

Puerto Rico[8] using the beneficiaries' Social Security numbers (SSNs), dates of birth (DOB), names, and sex (personally identifiable information (PII)). We then identified all associated August 2018 capitation payments that the State agency made.

We selected a stratified random sample of 106 capitation payments, totaling $45,919 ($29,458 Federal share), and determined whether the beneficiaries were residing and receiving Medicaid benefits in Minnesota during the audit period. Stratum 1 contained 76 capitation payments associated with Minnesota Medicaid beneficiaries who had identical PII in the matched State. Stratum 2 contained 30 capitation payments associated with Minnesota Medicaid beneficiaries who had an identical SSN in the matched State, but at least 1 of the other PII fields did not match. Using the results of our sample, we estimated the total value and Federal share of capitation payments that the State agency paid on behalf of beneficiaries who were also eligible for and receiving Medicaid benefits in another State.

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

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

FINDINGS

The State agency made an estimated $1.1 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 106 capitation payments in our stratified random sample, 71 were associated with beneficiaries who were residing and eligible for Medicaid benefits in Minnesota. However, for the remaining 35 capitation payments, totaling $15,084 ($9,167 Federal share), the State agency made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Minnesota because they were concurrently eligible and residing in another State. On the basis of our sample results, we estimated that the State agency could have saved $1.1 million ($665,000 Federal share)[9] for August 2018 capitation payments made to MCOs on behalf of beneficiaries with concurrent eligibility. The State agency made August 2018 capitation payments on behalf of concurrently eligible beneficiaries because the State agency did not always identify, review, and terminate eligibility for beneficiaries who had established Medicaid in another State.

[8] At the time of our request, Vermont did not have T-MSIS Medicaid managed care eligibility data available.

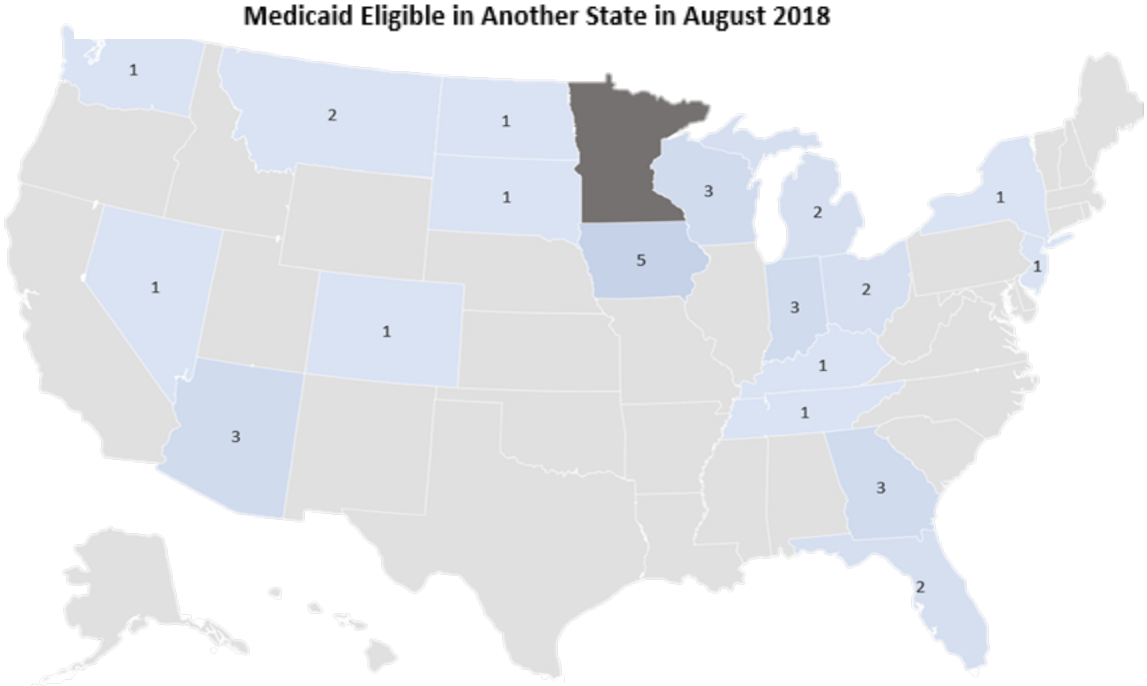
[9] Rounding to the nearest dollar, the amounts equaled $1,100,008 and $665,440, respectively.

THE STATE AGENCY MADE PAYMENTS TO MANAGED CARE ORGANIZATIONS FOR MEDICAID BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN ANOTHER STATE

Federal regulations prohibit beneficiaries from being concurrently eligible for Medicaid benefits in more than one State.[10] Under contractual agreements with the MCOs, the State agency may disenroll a beneficiary from an MCO plan when the beneficiary moves outside the plan's service area. Generally, section 3.2 indicates that termination will become effective on either the first day of the month following the month in which termination was entered on the State MMIS or on the first day of the second month following the month in which termination was entered on the State MMIS, depending on whether the termination is entered on the State MMIS before or after the cutoff date.

Of the 106 capitation payments in our stratified random sample, 71 (50 in stratum 1 and 21 in stratum 2) were associated with beneficiaries who were residing in Minnesota and eligible for Medicaid benefits. However, for the remaining 35 capitation payments (26 in stratum 1 and 9 in stratum 2), totaling $15,084 ($9,167 Federal share), the State agency made the payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Minnesota because they were concurrently eligible and residing in another State (Figure, below).[11]

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



Not pictured: One beneficiary resided out of country and was not eligible in either State.

[10] 42 CFR §§ 435.403(a) and (j)(3).

[11] We confirmed the beneficiaries' status using information from the beneficiaries' case files and PARIS alerts. We also reviewed encounter claims that identified the date the beneficiaries had an interaction with a health care provider and the location of the beneficiaries.

On the basis of our sample results, we estimated that the State agency could have saved $1.1 million ($665,000 Federal share) for August 2018 capitation payments made to MCOs on behalf of beneficiaries with concurrent eligibility.

The State agency did not always identify beneficiaries with concurrent eligibility. The State agency's eligibility system identified a PARIS alert for 6 of the 106 sampled capitation payments.[12]

The State agency reviews PARIS alerts, uses information obtained from the beneficiary, or uses information provided by another State to determine whether beneficiaries are concurrently eligible and receiving Medicaid benefits in another State.[13] However, beneficiaries remained eligible despite caseworkers' review of PARIS alerts or beneficiary-provided information about moving out of Minnesota. This occurred because the State agency's procedures did not ensure that PARIS alerts and other notifications of potential out-of-State residency were reviewed and processed by caseworkers on a timely basis. Although some of the concurrently eligible beneficiaries were identified, caseworkers did not always follow up on the information and properly review the beneficiaries' eligibility status.

Additionally, in some cases, while the caseworkers terminated eligibility for SNAP assistance due to notifications of out-of-State residency, Medicaid eligibility and managed care enrollment was not terminated.[14] The disparity in treatment may have resulted from State systems that were not effectively transferring data. A Minnesota Office of Legislative Auditor report from April 2020 entitled *Minnesota Eligibility Technology System – Internal Controls and Compliance Audit*[15] states that the METS internal control mechanisms required more than one-third of eligibility cases to undergo further review by caseworkers to help complete the determination process, citing the inaccurate transfer of data between METS and MMIS was due to an MMIS defect.

The following are examples of cases for which county caseworkers did not review a PARIS alert or did not take appropriate actions after receiving information that may have affected a beneficiary's Medicaid eligibility:

[12] Of the 106 sampled beneficiaries, 3 had a PARIS match in 2017, and 3 had a PARIS match in March or June 2018 (prior to our audit period).

[13] Information may include a beneficiary notifying the State agency that he or she is moving to another State, and communication from another State Medicaid agency asking whether the beneficiary's Minnesota Medicaid eligibility has already been terminated.

[14] Minnesota county caseworkers use the MAXIS eligibility system to enter eligibility data for cash, food, and certain health care populations, and the METS eligibility system for other health care populations. However, a separate payment system is used to close health care cases and stop payments.

[15] https://www.auditor.leg.state.mn.us/fad/pdf/fad20-04.pdf.

PARIS Alert Was Reviewed But Eligibility Was Not Timely Terminated: For one sampled capitation payment, the beneficiary was reported on the April 2018 PARIS report as having Medicaid eligibility in another State. County staff sent an initial inquiry to determine whether the beneficiary was residing in Minnesota. The beneficiary did not respond. The county staff did not follow up with the beneficiary, and the case remained open. The beneficiary continued to receive benefits in Minnesota until the county closed the case in May 2019 due to the case having a failure for auto-renewal.

No Evidence PARIS Alert Was Reviewed: For one sampled capitation payment, the county received a PARIS alert in September 2017. There was no evidence in the case files that the beneficiary was contacted regarding the PARIS alert. In October 2018, the county sent a request for the family to verify the residential address. After not receiving a response to the request, the county closed the Medicaid case in November 2018.

Beneficiary Reported Out-of-State Residence: For one sampled capitation payment, the beneficiary reported to the county in December 2017 that she moved to Wisconsin. The county failed to close the Medicaid case based on the beneficiary's notification of the move. The county processed a PARIS alert on September 2018 and closed the Medicaid case as of November 2018 when the beneficiary did not respond.

RECOMMENDATIONS

We recommend that the Minnesota Department of Human Services:

- develop new procedures or enhance current ones to identify beneficiaries with concurrent eligibility in another State, which could have saved the State agency an estimated $1,100,008 ($665,440 Federal share) in capitation payments for the month of August 2018; and

- ensure that county caseworkers follow procedures to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency accepted our recommendations and described actions it has taken or plans to take to address them. Specifically, the State agency said that it will continue to use the PARIS files to determine concurrent eligibility until a successor system is available, but it will review and revise, as necessary, procedures related to recording and acting on changes of address. The State agency said that it will remind county and State workers of their responsibilities related to processing PARIS matches and their responsibility to coordinate changes of address across the State's two eligibility systems. The State agency also noted our use of the T-MSIS database to perform the audit, a system not

currently available to States, and said that it looks forward to the day T-MSIS is made available to States for their use. The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 7,706 August 2018 capitation payments, totaling $3,987,584, made by the State agency on behalf of beneficiaries with concurrent eligibility in another State from July 1 through September 30, 2018 (audit period). We selected and reviewed a stratified random sample of 106 capitation payments, totaling $45,919 ($29,458 Federal share), to determine whether the beneficiaries were residing in Minnesota and eligible for Medicaid benefits during the audit period.

We determined that the State agency's control activities and monitoring were significant to our audit objective. We assessed the design, implementation, and operating effectiveness of the State agency's internal controls related to capitation payments made on behalf of beneficiaries with concurrent eligibility in another State. We also reviewed the State agency's policies and procedures for identifying and terminating the eligibility of Medicaid beneficiaries who were not residents of Minnesota.

We conducted our audit, which included fieldwork at the State agency office in St. Paul, Minnesota, from September 2019 through January 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed the State agency contracts with the MCOs that were in effect during the audit period;

- reviewed Federal and State laws, regulations, and guidance;

- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments that were made on behalf of beneficiaries with concurrent eligibility in another State;

- identified sources that the State agency used to identify beneficiaries who were eligible for Medicaid in another State;

- used T-MSIS data to match Medicaid MCO eligibility information, by the beneficiaries' SSN, among 49 States, the District of Columbia, and Puerto Rico and identified 7,706 Minnesota Medicaid beneficiaries who had an August 2018 capitation payment and were eligible for Medicaid in another State during the entire 3-month audit period, totaling $3,987,584;

- selected for review a stratified random sample of 106 capitation payments, totaling $45,919 ($29,458 Federal share);

- validated the T-MSIS data for each sampled capitation payment by:

    - comparing current beneficiary data from the State agency to determine whether the beneficiaries' eligibility and PII information was accurate and

    - comparing current payment data from the State agency to determine whether a capitation payment occurred for August 2018, to determine whether an adjustment to the payment was made, and to verify the accuracy of any encounter claims that were submitted;

- reviewed the following supporting documentation associated with each sampled capitation payment to help determine in which State each beneficiary resided and was eligible for Medicaid benefits during the audit period:

    - PARIS Alerts, which identified the matched State(s) and time period that the beneficiaries were concurrently eligible for Medicaid benefits;

    - encounter claims, which contained a record of Medicaid services that were provided and were used to identify the date and location that beneficiaries had an interaction with a health care provider; and

    - eligibility case files, which contained detailed eligibility and residency information, such as utility bills and lease agreements, to help determine where the beneficiaries resided and whether they were eligible for Medicaid benefits during the audit period;

- estimated, based on the sample results, the overall value and Federal share of improper capitation payments made by the State agency on behalf of beneficiaries who were concurrently eligible and residing in another State by using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software; and

- discussed the results of our audit with State agency officials.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 7,706 August 2018 capitation payments made by the State agency on behalf of Minnesota Medicaid beneficiaries who were concurrently eligible and enrolled in another State during our audit period, totaling $3,987,584.

SAMPLE UNIT

The sample unit was an August 2018 capitation payment.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 1). Stratum 1 contained capitation payments associated with Minnesota Medicaid beneficiaries who had identical SSNs, DOB, first names, last names, and sex (PII) in the matched State with concurrent eligibility. Stratum 2 contained capitation payments associated with Minnesota Medicaid beneficiaries who had an identical SSN in the matched State and concurrent MCO eligibility, but at least one of the other PII fields did not match.

Table 1: Sample Design Summary

Stratum	Frame Information			
	Matching Data Fields Between Minnesota and Other States	**Number of August 2018 Capitation Payments**	**Amount of Payments**	**Sample Size**
1	SSN, DOB, first name, last name, and sex	5,867	$3,131,715	76
2	SSN	1,839	855,869	30
	Total	**7,706**	**$3,987,584**	**106**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted the frame by SSN and then consecutively numbered the sample units within strata 1 and 2. After generating the random numbers for each stratum, we selected the corresponding sample units in the sampling frame.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total value and Federal share of improper capitation payments made by the State agency on behalf of Minnesota beneficiaries who were concurrently eligible and residing in another State during our audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Federal Share of Sample	No. of Improper Capitation Payments	Total Value of Improper Capitation Payments	Federal Share of Improper Capitation Payments
1	5,867	$ 3,131,715	76	$33,351	$21,711	26	$11,031	$6,512
2	1,839	855,869	30	12,568	7,747	9	4,053	2,655
Total	**7,706**	**$3,987,584**	**106**	**$45,919**	**$29,458**	**35**	**$15,084**	**$9,167**

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

	Total Amount	Federal Share
Point estimate	$1,100,008	$665,440
Lower limit	739,486	434,977
Upper limit	1,460,531	895,904

APPENDIX D: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

States are required to provide Medicaid to eligible residents, including residents who are absent from the State. If a resident of one State subsequently establishes residency in another State for purposes of Medicaid eligibility, the beneficiary's Medicaid eligibility in the previous State should end (42 CFR §§ 435.403(a) and (j)(3)).

States must generally provide advance notice when the State agency terminates a Medicaid beneficiary's covered benefits or eligibility at least 10 days before the date of action (42 CFR § 431.211). However, if a State establishes that the beneficiary has been accepted for Medicaid services by another State, the original State must provide notice of the termination of the beneficiary's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)). Additionally, advance notice of eligibility termination is not required if the beneficiary's whereabouts are unknown and the post office returns agency mail indicating no forwarding address (42 CFR § 431.213(d)).

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

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

Section 1903(r)(3) of the Social Security Act and 42 CFR § 435.945(d) require that all States have an eligibility determination system that provides data matching through PARIS.

STATE REQUIREMENTS

Minnesota's State Medicaid plan requires that Medicaid be granted to eligible applicants who, among other requirements, are residents of the State, including residents who are absent from the State under certain conditions in accordance with 42 CFR § 435.403. Minnesota Administrative Code Minn. R. 9505.0030 states that Medicaid eligibility is limited to Minnesota residents who are not eligible for or receiving medical assistance from another State.

Under section 3.2 of the Medicaid MCO contracts, which addresses termination of enrollee coverage, the State may terminate an enrollee's coverage when the enrollee becomes ineligible for the State's Medicaid program, or upon the occurrence of certain conditions, including when an enrollee moves out of an MCO's service area. Generally, termination of coverage takes effect at midnight on the first day of the month following the month when the termination was entered in the State's Medicaid Management Information System (MMIS), or on the first day of

the second month following the month during which termination was entered, depending on whether the entry occurred before or after the State's MMIS cutoff date.

APPENDIX E: STATE AGENCY COMMENTS

Minnesota Department of Human Services
Elmer L. Andersen Building
Commissioner Jodi Harpstead
Post Office Box 64998
St. Paul, Minnesota 55164-0998

April 14, 2021

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

Dear Ms. Fulcher:

Thank you for providing an opportunity to comment on draft audit report A-05-19-00032 entitled *Minnesota Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State.* We note that in conducting this audit, your auditors used a database, Transformed Medicaid Statistical Information System (T-MSIS), that is not available to states conducting this very important work. We look forward to the day when this resource is made available to all states, including Minnesota.

The Department accepts the recommendations and our response to each recommendation is detailed below.

Recommendation #1: We recommend that the Minnesota Department of Human Services develop new procedures or enhance current ones to identify beneficiaries with concurrent eligibility in another State, which could have saved the State agency an estimated $1,100,008 ($665,440 Federal share) in capitation payments for the month of August 2018.

Response to Recommendation #1: Minnesota will continue to use data matching through the Public Assistance Reporting Information System (PARIS) as required under section 1903(r)(3) of the Social Security Act until data matching is available to States through a successor system.

On December 15, 2020, we issued Bulletin #20-21-13 announcing changes to processing PARIS interstate matches during the COVID-19 emergency as required by the Centers for Medicare & Medicaid Services (CMS) interim final rule that was effective November 2, 2020. The rule requires closing Medicaid coverage for beneficiaries who do not respond to a request for information about

their state residency after a reasonable attempt by the State to verify that information. When the emergency ends we will return to our standard procedures.

We will also review and revise, as necessary, our procedures related to recording and acting on changes of address.

Recommendation #2: We recommend that the Minnesota Department of Human Services ensure that county caseworkers follow procedures to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

Response to Recommendation #2: Minnesota will remind county and state workers of their responsibilities related to processing PARIS matches and their responsibility to coordinate changes of address across our two eligibility systems. Worker announcements are issued after each quarterly PARIS interstate match alerting them to these matches and reminding them of the processing timeline and procedures. We will further reinforce this information with workers at Health Care Eligibility Partner Information Exchange meetings and assess the need for additional training.

If you have any questions, comments or concerns about our response, please contact Gary L. Johnson, Director of Internal Audits, at 651 431-3623 or through e-mail at Gary.L.Johnson@state.mn.us.

Sincerely,

/Jodi Harpstead/
Jodi Harpstead
Commissioner