Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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REPORT HIGHLIGHTS

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

Why OIG Did This Audit

- California pays managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee.
- Previous OIG audits found that State Medicaid agencies made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State.
- This audit assessed whether California made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

What OIG Found

On the basis of our sample results, we estimated that California incurred costs of approximately $19.9 million ($15.5 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in a Medicaid managed care program in another State.

- Our audit covered August 2021 Medicaid managed care capitation payments totaling $36.4 million made by California on behalf of 108,800 enrollees who were concurrently enrolled for Medicaid benefits in California and another State during the period of July 1 through September 30, 2021.
- Of the 100 enrollees in our stratified random sample, we determined that 54 enrollees were residing and enrolled for Medicaid benefits in California, but 46 enrollees were residing and concurrently enrolled for Medicaid in another State.

What OIG Recommends

We recommend that California:

1. resume and enhance procedures that are in accordance with current Federal requirements to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State and
2. work with CMS to consider the potential use of Transformed Medicaid Statistical Information System data to identify potential cases of concurrent enrollment.

California concurred with our recommendations and described actions that it has taken or plans to take in response to our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

OBJECTIVE

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

BACKGROUND

The Medicaid Program

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

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

[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 Florida, Illinois, Minnesota, Ohio, and Texas. See Appendix B for related report information.

[3] We limited our audit to managed care capitation payments.

plan for each person enrolled in the plan. State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid enrollees. More than two-thirds of Medicaid enrollees are enrolled in managed care nationally.

States contract with MCOs to make services available to Medicaid enrollees, usually in return for a periodic payment, known as a capitation payment. In turn, the MCO pays providers for all the Medicaid services an enrollee may require that are included in the MCO's contract with the State. States make the capitation payments regardless of whether the enrollees receive services during the period covered by the payment. If an enrollee's enrollment is not terminated when appropriate, capitation payments may continue automatically. States report these capitation payments on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

Federal Requirements

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

Prior to the public health emergency (PHE) for coronavirus disease 2019 (COVID-19), States must redetermine the eligibility of Medicaid enrollees whose eligibility is determined using methodologies based on modified adjusted gross income (MAGI), a measure of income based on Internal Revenue Service rules, once every 12 months and no more frequently than once every 12 months (42 CFR § 435.916(a)).[4] For Medicaid enrollees whose eligibility is not determined using MAGI-based financial methodologies, States must redetermine eligibility at least once every 12 months (42 CFR § 435.916(b)).[5] States must also have procedures designed to ensure that enrollees make timely and accurate reports of any change in circumstances that may affect their eligibility. States must promptly redetermine eligibility when they receive information about changes in enrollee circumstances that may affect eligibility (42 CFR §§ 435.916(c) and (d)). States may not deny or terminate eligibility or reduce benefits for any individual based on information received unless the State has sought additional information from the individual and provided the individual a reasonable period to respond and proper notice and hearing rights (42 CFR §§ 435.952(c) and (d)). Receiving Medicaid in another State typically represents a potential change in an enrollee's circumstances, which requires the State to contact the enrollee and attempt to verify State residency prior to termination.

[4] Following our audit period, CMS published a final rule addressing Medicaid eligibility determination, enrollment, and renewal processes (89 Fed. Reg. 22780 (April 2, 2024)). Any references to Federal requirements in this report reflect requirements that were in place prior to this final rule.

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

However, during the PHE, which occurred during our audit period of July 1 through September 30, 2021, States made changes to their eligibility and enrollment operations to comply with the Families First Coronavirus Response Act (FFCRA). To qualify for the temporary 6.2-percentage-point FMAP increase provided under the FFCRA during the PHE, States had to satisfy certain conditions, such as maintaining eligibility standards, methodologies, or procedures that were no more restrictive than what the State had in place as of January 1, 2020, and ensuring that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ends. However, the FFCRA has exceptions that allowed States that received the temporary 6.2-percentage-point FMAP increase to still disenroll individuals who requested a voluntary termination of eligibility or ceased to be a resident of the State (§ 6008 of the FFCRA). Federal regulations also provide an exception in meeting the States' timeliness standards for processing Medicaid eligibility redeterminations and changes in an enrollee's circumstances for Medicaid eligibility during an emergency, such as the PHE (42 CFR § 435.912(e)(2)). During our audit period, the FMAP in California was 56.20 percent, which includes the 6.2-percentage-point increase provided under the FFCRA.[6]

On December 29, 2022, the Consolidated Appropriations Act, 2023 (CAA) was enacted. This law included various Medicaid provisions, including significant changes to the FFCRA's continuous enrollment condition. States have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid following the end of the continuous enrollment condition (this process has commonly been referred to as "unwinding"). The CAA does not address the end date of the PHE; however, it does address the end of the continuous enrollment condition, the temporary FMAP increase, and the unwinding process. Under the CAA, expiration of the continuous enrollment condition and receipt of the temporary FMAP increase is no longer linked to the end of the PHE.[7] The continuous enrollment condition ended on March 31, 2023, and the FFCRA's temporary FMAP increase was gradually phased down beginning April 1, 2023, and ending on December 31, 2023. Beginning April 1, 2023, States were able to terminate Medicaid enrollment for all individuals who are no longer eligible.

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

[6] Because of the Patient Protection and Affordable Care Act's Medicaid expansion, payments for "newly eligible" adults were reimbursed at a 100-percent FMAP beginning 2014 through 2016, gradually declined to 90 percent by 2020, and continued at 90 percent thereafter (Social Security Act § 1905(y)).

[7] The COVID-19 PHE ended on May 11, 2023.

State Requirements

During our audit period, the State agency implemented temporary policies and procedures that incorporated the continuous enrollment provisions of the FFCRA. Specifically, the State agency stopped processing Medicaid annual redeterminations and delayed discontinuances and negative actions because of renewals or reported changes in circumstances to ensure enrollees remained eligible for Medicaid during the PHE. Under the State's temporary policies and procedures, Medicaid coverage could not be denied to most enrollees receiving Medicaid as of March 16, 2020. However, while not required, the State agency staff could deny coverage if the enrollee requested a voluntary discontinuance from Medicaid, was no longer a resident of the State, or died.

California's Medicaid Managed Care Program

The State agency is the single State agency responsible for administering Medicaid in California. The State agency provides California individuals access to affordable integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. The State agency's responsibilities include performing Medicaid eligibility determinations for individuals.

Under California's Medicaid managed care contract provisions, the State agency generally establishes and determines the Medicaid covered benefits and eligibility to participate in the MCO programs. If the MCO receives information about a change in an enrollee's residence, the MCO should promptly notify the State agency. The State agency can approve the MCO to disenroll individuals who move outside the service area. During our audit period, approximately 89 percent of California's Medicaid population (13 million individuals) received benefits through MCOs under contract with the State agency.

California's State Medicaid plan requires that Medicaid be granted to eligible applicants who, among other requirements, are residents of the State, whether or not the individuals maintain their residency at a fixed address. An individual may be temporarily absent from the State and maintain California residency if the individual intends to return when the purpose of the absence has been accomplished, unless another State has determined that the individual is a resident there for purposes of Medicaid.

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 assisting in detecting fraud, waste, and abuse in Medicaid.

T-MSIS contains enhanced information about enrollee eligibility, enrollee and provider enrollment data, service utilization data, claim and managed care data, and expenditure data. Timeliness issues have prompted CMS to move towards a streamlined data submission process, along with an enhanced data repository. The T-MSIS data is expected to further CMS's goals with improved timeliness, reliability, and robustness, with an increase in the amount of data requested. States submit their T-MSIS data to CMS monthly.

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).[8]

Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS), managed by the Administration for Children and Families (ACF),[9] matches State and Federal public assistance eligibility data, including Medicaid data, quarterly to provide States with enrollee information that they can use to identify possible concurrent enrollment and erroneous payments. The Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Match are the three parts of PARIS. The programs that use PARIS include Medicaid, Temporary Assistance for Needy Families, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program (SNAP).

As a condition of receiving Medicaid funding for their automated data systems, States are required to have an eligibility determination system that provides for data matching through PARIS (Social Security Act § 1903(r)(3) and 42 CFR § 435.945(d)). The PARIS Interstate Match alerts States when they may be making payments on behalf of Medicaid enrollees with concurrent enrollment in another State. States are ordinarily expected to determine whether such enrollees should continue to be eligible for benefits in their State and take whatever case action is appropriate.[10] 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, 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.

California utilizes the PARIS data to avoid improper payments for individuals who are no longer California residents. According to California's Medicaid eligibility verification plan, California

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

[9] 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.

[10] 42 CFR §§ 435.952(a) and 435.916(d)(1).

receives approximately 60,000 PARIS matches per quarter and does not have the staffing resources to process all the matches. California filters the quarterly data based on certain risk factors. The State agency places highest priority on individuals who potentially moved out of the State and recently signed up for public assistance in another State. The State agency sends residency verification letters to the individuals with the highest risk factors based on the PARIS matches. The State agency is required to contact the enrollees before eligibility may be terminated.[11]

On November 2, 2020, 42 CFR § 433.400(d)(3)(ii) went into effect. This regulation states that an enrollee may be treated as not being a State resident under § 6008(b)(3) of the FFCRA when there is a PARIS match indicating concurrent enrollment in two or more States, and the enrollee fails to respond to a request to verify State residency, provided that the State takes all reasonably available measures to attempt to verify the enrollee's State residency, and the State's alternative efforts cannot verify the enrollee's continued residency in the State through other sources.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $36.4 million in Medicaid managed care capitation payments for August 2021 made by the State agency on behalf of 108,800 California enrollees who were concurrently enrolled in a managed care program in another State during our audit period. We selected the middle month of our audit period to ensure that enrollees were eligible in the month before, during, and after the August 2021 capitation payments. This helped to identify enrollees who did not move to or from another State during August 2021. To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's T-MSIS data from 48 States, the District of Columbia, and Puerto Rico[12] using the enrollees' Social Security numbers (SSNs), dates of birth (DOB), names, and sex (personally identifiable information (PII)). We then identified all associated August 2021 capitation payments that the State agency made.

We selected a stratified random sample of 100 California Medicaid managed care enrollees with August 2021 capitation payments, totaling $48,767 ($35,253 Federal share), to determine whether the enrollees were residing and receiving Medicaid benefits in California during the audit period. Using the results of our sample, we estimated the total value and Federal share of capitation payments that the State agency paid on behalf of enrollees who were residing and enrolled for Medicaid benefits in another State.

[11] According to 42 CFR § 435.952(d), a State Medicaid agency may not terminate an enrollee's Medicaid eligibility based on information received through sources such as PARIS unless the State agency has sought additional information from the enrollee and provided proper notice and hearing rights.

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

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

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

FINDINGS

The State agency made August 2021 Medicaid managed care capitation payments totaling $36.4 million on behalf of 108,800 enrollees who were concurrently enrolled for Medicaid benefits in California and another State. Of the 100 enrollees in our stratified random sample, we determined that 54 enrollees were residing and enrolled for Medicaid benefits in California. However, the State agency made August 2021 capitation payments totaling $25,999 ($18,576 Federal share) on behalf of 46 California Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of our sample results, we estimated that the State agency incurred costs of $19.9 million ($15.5 million Federal share)[13] for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

The State agency made August 2021 capitation payments on behalf of Medicaid enrollees who established residency and Medicaid enrollment in another State but remained enrolled in California's Medicaid managed care program. We determined that the State agency did not always receive notification when enrollees in our sample had moved and enrolled in Medicaid in another State. When the State agency received notification from two of the sampled enrollees that they were no longer residing in California, the State agency did not terminate their Medicaid enrollment, as permitted under the FFCRA and its policies and procedures.

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

Under Federal regulations, State agencies must provide Medicaid to eligible residents of the State, including those who are temporarily absent, unless a person has established residency and enrolled in Medicaid in another State.[14]

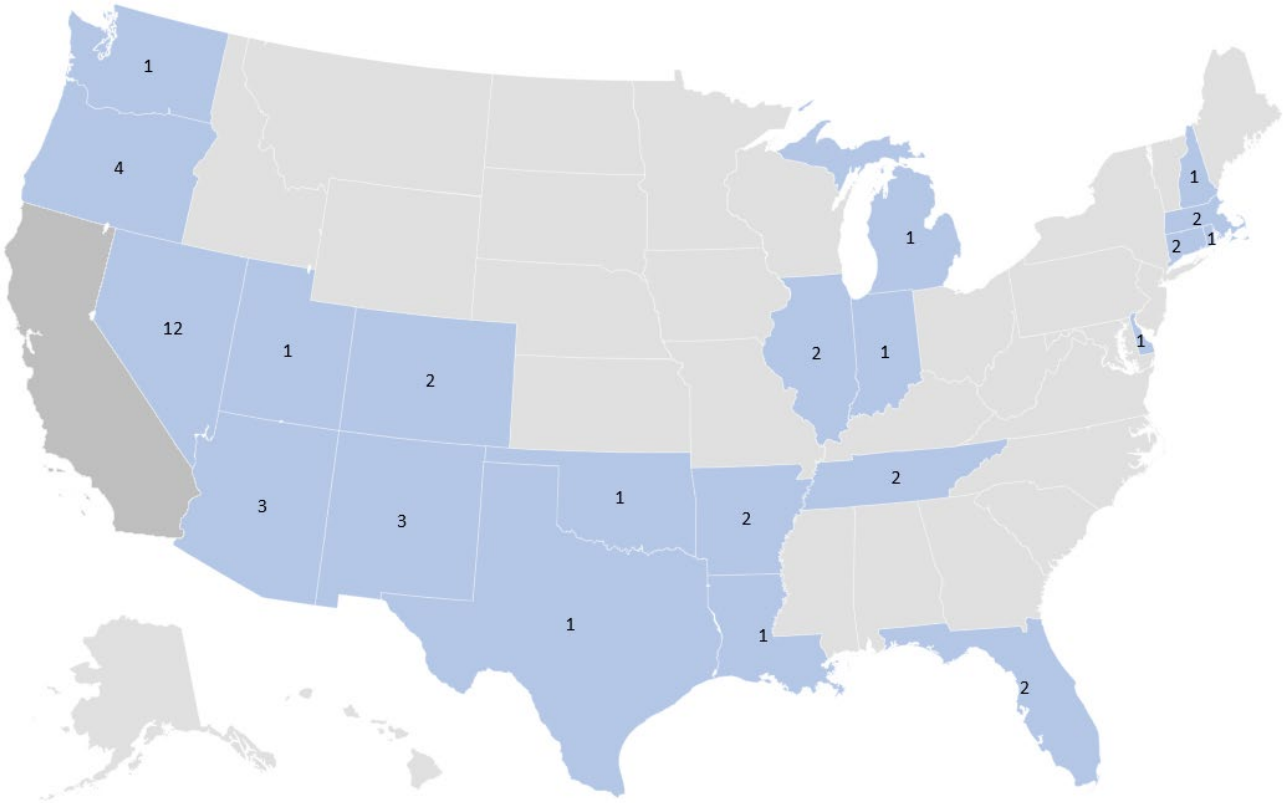
For our sample, we found that the State agency made August 2021 capitation payments totaling $25,999 ($18,576 Federal share) on behalf of 46 California Medicaid managed care

[13] Rounding to the nearest dollar, the amounts equaled $19,938,602 and $15,518,152, respectively.

[14] 42 CFR §§ 435.403(a) and (j)(3).

enrollees who were residing and concurrently enrolled for Medicaid managed care in another State (Figure below).[15]

Figure: August 2021 Capitation Payments Made for Enrollees Who Were Residing and Concurrently Enrolled for Medicaid Managed Care in Another State



On the basis of our sample results, we estimated that the State agency incurred costs of approximately $19.9 million ($15.5 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in Medicaid in another State.

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

The State agency made the August 2021 capitation payments on behalf of 46 concurrently enrolled Medicaid enrollees for two reasons. The State agency did not receive notification that 44 of the 46 enrollees were no longer residing in California during our audit period. For the

[15] We confirmed the enrollees' Medicaid enrollment status using State and county case files, SNAP transactions, a national investigative database, and by contacting the other State Medicaid agencies when necessary. We also reviewed encounter claims that identify the date and location the enrollees had an interaction with a health care provider.

remaining two enrollees the State agency received notification from the enrollees that they were no longer residing in California, but the State agency did not terminate their Medicaid enrollment.

The State agency did not receive notification that 44 sampled enrollees were residing and had concurrent enrollment in another State. During our audit period, the State agency processed Medicaid renewals in accordance with the flexibilities provided to States during the PHE, which included automatically extending Medicaid benefits for enrollees who failed to return requested information and for those who would otherwise be ineligible.

The State agency sent residency verification letters to 13 sampled enrollees who had the highest risk factors based on a PARIS match before, during, or after the quarter of our audit period.[16] Specifically, the State agency: terminated enrollment for seven enrollees who failed to respond to the letter or confirmed they were no longer a California resident, confirmed California residency for three enrollees, and continued enrollment for three enrollees whose letters were returned to the State agency as undeliverable.

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

The following examples describe some of the issues we found:

- **California Was Not Notified That the Enrollee Resided and Received Medicaid in Another State**
  One sampled enrollee had concurrent Medicaid enrollment in California and Oregon during our audit period. The enrollee's managed care in California and Oregon started in October 2019 and September 2020, respectively, and was still active as of February 2022 in both States. California and Oregon made August 2021 capitation payments to a managed care organization in their State on behalf of the same enrollee, totaling $557 and $394, respectively. OIG contacted Oregon's Medicaid agency and received confirmation that the enrollee resided and received Medicaid in Oregon during our audit period. However, the State agency did not receive notification that the enrollee resided and was enrolled for Medicaid in Oregon during our audit period. The State agency sent the enrollee several correspondence letters prior to our audit period but received multiple pieces of returned mail and was unable to locate the enrollee. Prior to the PHE, the State agency may have terminated enrollment when the enrollee could not be located. However, in accordance with the FFCRA's continuous enrollment

[16] Of the 100 sampled enrollees, 54 had a PARIS match in August 2021.

requirement as a condition of receiving the temporary FMAP increase, the State agency was unable to terminate the individual's enrollment during the PHE.

- **The Enrollee Notified California of Moving to Another State**
  One sampled enrollee had concurrent Medicaid enrollment in California and Tennessee during our audit period. In February 2021, the enrollee called to notify the State agency that they moved to another State. However, the enrollee's enrollment was not terminated. The enrollee's managed care in California and Tennessee started in January 2014 and September 2020, respectively, and was still active as of February 2022 in both States. California and Tennessee made August 2021 capitation payments to a managed care organization in their State on behalf of the same enrollee, totaling $966 and $150, respectively. The capitation payments that occurred after the enrollee informed the State agency of the move to Tennessee could have been prevented if the State agency terminated the enrollee's enrollment for ceasing to be a resident of California, as permitted under its own policies and procedures.

CONCLUSION

We estimated that the State agency incurred costs of approximately $19.9 million ($15.5 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled for Medicaid in another State. This amount represents potential monthly savings to California's Medicaid program that, if annualized, would amount to approximately $239 million ($186 million Federal share) in program savings.

For California and other States that accepted the temporary 6.2-percent FMAP increase during the PHE, section 6008 of the FFCRA added new restrictions for States related to Medicaid eligibility. In addition to other requirements, States were restricted from terminating an enrollee's Medicaid eligibility during the PHE for most situations unless the enrollee requests a voluntary termination of eligibility or ceases to be a State resident. However, on March 31, 2023, the continuous enrollment condition ended under the CAA, and States must return to normal eligibility and enrollment operations over time. States have up to 12 months to initiate, and 14 months to complete, a renewal for all Medicaid enrollees. Beginning April 1, 2023, States were able to terminate Medicaid enrollment for all enrollees who are no longer eligible.

Although the FFCRA restrictions may have increased concurrent enrollment across two States during the PHE, previous audits have shown that concurrent Medicaid enrollment was an issue in most States prior to the PHE.[17] Going forward, we maintain that the number of capitation payments made on behalf of enrollees with concurrent Medicaid enrollment in another State can be reduced with the use of timelier T-MSIS data and improved policies and procedures to confirm the concurrent enrollment and disenroll these enrollees.

[17] See Appendix B, OIG report number A-05-20-00025.

RECOMMENDATIONS

We recommend that the California Department of Health Care Services:

- resume and enhance procedures that are in accordance with current Federal requirements to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State and

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described the actions that it has taken or plans to take to address them. The State agency's actions include: (1) working with its business partners and expanding outreach efforts to identify enrollees who potentially left the State; (2) resuming focused reviews to ensure counties promptly terminate eligibility for individuals that self-report leaving the State; and (3) plans to request permission from CMS to utilize T-MSIS data to identify enrollees with concurrent enrollment. The State agency's comments are included in their entirety as Appendix E.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $36.4 million in Medicaid managed care capitation payments for August 2021 made by the State agency on behalf of 108,800 California enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2021 (audit period). We selected and reviewed a stratified random sample of 100 enrollees with capitation payments totaling $48,767 ($35,253 Federal share) to determine whether the enrollees were residing and enrolled for Medicaid benefits in California during the audit period.

To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's T-MSIS data from 48 States, the District of Columbia, and Puerto Rico[18] using the enrollees' PII. We then identified all associated August 2021 capitation payments that the State agency made.

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

We conducted our audit work from January 2023 through May 2024.

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;

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

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

- identified sources that the State agency used to identify enrollees who were receiving Medicaid in another State;

- obtained T-MSIS data that identified 108,800 California enrollees with concurrent Medicaid managed care enrollment in another State during our audit period July through September 2021 and obtained August 2021 capitation payment data associated with these enrollees that were made by the State agency, totaling $36,352,587;

- selected for review a stratified random sample of 100 enrollees with August 2021 capitation payments, totaling $48,767 ($35,253 Federal share);

- validated the T-MSIS data for each sampled enrollee by:

    - comparing current enrollee data from the State agency to determine whether the enrollees' Medicaid managed care enrollment information was accurate and

    - comparing current payment data from the State agency to determine whether a capitation payment occurred for August 2021, to determine whether an adjustment to the payment was made;

- reviewed the following supporting documentation to determine in which State the enrollee resided and was receiving Medicaid benefits during the audit period:

    - PARIS Interstate Matches, used to determine whether the State agency was made aware of an enrollee's potential concurrent enrollment in another State;

    - SNAP transactions, which contained a record of the dates and locations the enrollees used their food assistance benefits (i.e., grocery store and gas station purchases, etc.);

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

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

- Accurint, which is a LexisNexis national investigative data depository that contains more than 80 billion records, e.g., addresses, motor vehicle records, and driver's license records, that we used to help determine where the enrollees resided during the audit period; and

- information from other States, i.e., eligibility case file information from the matched State, to help determine whether the enrollees resided and received Medicaid benefits in the other State during the audit period;

- estimated, based on the sample results, the total value and Federal share of capitation payments made that the State agency paid on behalf of enrollees who were residing and enrolled for Medicaid benefits in another State by using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software; and

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

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Issue Date
Texas Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State	A-05-22-00018	9/11/2023
Florida Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State	A-05-21-00028	2/16/2023
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	9/19/2022
Minnesota Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State	A-05-19-00032	5/6/2021
Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State	A-05-19-00031	2/3/2021
Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State	A-05-19-00023	11/12/2020

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame was an Access database containing 108,800 California Medicaid enrollees with August 2021 capitation payments and concurrent Medicaid managed care enrollment in another State during the period of July 1 through September 30, 2021, totaling $36,352,587.

SAMPLE UNIT

The sample unit was a California Medicaid managed care enrollee.[19]

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample outlined in Table 1.

Table 1: Sample Design Summary

Stratum	Frame Information			
	Stratum Dollar Boundaries	Number of Enrollees	Dollar Amount of August 2021 Capitation Payments	Sample Size
1	$1.53 – $441.53	90,641	$23,116,458	50
2	$444.62 – $15,507.17	18,159	13,236,129	50
	Totals	**108,800**	**$36,352,587**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted each stratum using the enrollees' SSN and consecutively numbered the items in each stratum in the sampling frame. A statistical specialist generated random numbers for each stratum, and we selected the corresponding sample frame items for review given the sample sizes defined in Table 1.

[19] California made more than one August 2021 capitation payment for some enrollees. We grouped those payments into one August 2021 capitation payment record.

ESTIMATION METHODOLOGY

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

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

						California Medicaid Enrollees in the Sample Who Were Residing and Enrolled for Medicaid Benefits in Another State		
Stratum	**Frame Size**	**Total Value of Frame**	**Sample Size**	**Total Value of Sample**	**Federal Share of Sample**	**Number in Sample**	**Total Value of August 2021 Capitation Payments**	**Federal Share of August 2021 Capitation Payments**
1	90,641	$23,116,458	50	$14,545	$11,309	22	$7,241	$6,051
2	18,159	13,236,129	50	34,223	23,944	24	18,758	12,525
Total	**108,800**	**$36,352,587**	**100**	**$48,767**[20]	**$35,253**	**46**	**$25,999**	**$18,576**

Table 3: Estimated August 2021 Capitation Payments in the Sampling Frame That the State Agency Paid on Behalf of California Medicaid Enrollees Who Were Residing and Enrolled for Medicaid Benefits in Another State

(Limits Calculated at the 90-Percent Confidence Level)

	Total Amount	**Federal Share**
Point estimate	$19,938,602	$15,518,152
Lower limit	15,378,219	11,624,829
Upper limit	24,498,985	19,411,475

[20] The stratum amounts do not sum to the total amount due to rounding.

APPENDIX E: STATE AGENCY COMMENTS

June 28, 2024

THIS LETTER SENT VIA EMAIL

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 802
Chicago, IL 60601

RESPONSE TO DRAFT AUDIT REPORT A-05-23-00008

Dear Ms. Fulcher:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the Office of Inspector General (OIG) draft audit report number A-05-23-00008, titled, "California Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State."

In the above draft audit report, OIG estimated California incurred capitation payments made on behalf of Medicaid members who were residing out of state and concurrently enrolled in a managed care program in that state. DHCS agrees with the two recommendations issued by OIG and will embark on responsive corrective action plans, including working with DHCS' business partners. DHCS expanded outreach efforts to identify enrollees who have potentially left the state and will resume focus reviews to ensure counties promptly terminate eligibility for those who self-report leaving the state. DHCS plans to request permission from the Centers for Medicaid and Medicaid Services to utilize the Transformed Medicaid Statistical Information System data to identify enrollees with dual enrollment.

DHCS appreciates OIG's work 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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Audit: California Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

Audit Entity: Office of Inspector General
Report Number: A-05-23-00008 (23-09) (CA Medicaid Capitation Audit)
Response Type: DHCS' Response to OIG's Draft Audit Report

Finding 1: The State Agency Made Payments To Managed Care Organizations For Medicaid Enrollees With Concurrent Enrollment In Another State

Recommendation 1
Department of Health Care Services (DHCS) [should] resume and enhance procedures that are in accordance with current Federal requirements to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
The Centers for Medicare and Medicaid Services (CMS) allowed disenrollment of individuals from the Medicaid program when individuals report moving out of state during the Coronavirus Public Health Emergency (PHE); therefore, the PHE did not impact Public Assistance Reporting Information System (PARIS) activities. DHCS plans to automate most PARIS-related activities to significantly increase the processing volume of PARIS matches and substantially increase the discontinuance rate for individuals identified as receiving Medicaid in more than one state. In addition, the automation process will assist DHCS to expedite communication with members and other states to efficiently detect and disenroll individuals who have Medicaid coverage in another state.

DHCS contracted with a new vendor to increase the mail volume and gather responses from the letters. DHCS also automated outreach activities for individuals who appear to have left the state, which increased the volume of mailers sent and responses received to reaffirm state residency, discontinue eligibility due to no response, and confirm out-of-state residency.

Effective June 2024, DHCS will begin the process of resuming the oversight of county health and human services agencies. DHCS performs focus reviews to ensure the accuracy of eligibility determinations statewide. These reviews allow DHCS to identify counties who do not disenroll individuals who self-report leaving the state, timely.

Finding 2: The State Agency Did Not Receive Notification That Enrollees Moved Out Of State Or Did Not Terminate Enrollees Who Provided Notification They Moved Out Of State

Recommendation 2
DHCS [should] work with CMS to consider the potential use of Transformed Medicaid Statistical Information System (T-MSIS) data to identify potential cases of concurrent enrollment.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS agrees to contact CMS for permission to leverage T-MSIS data to identify California members with concurrent enrollment in another state.