DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR - 5 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson Daniel R. Levinson
Inspector General

SUBJECT: Review of Medicaid Eligibility in Florida (A-04-06-00020)

Attached is an advance copy of our final report on Medicaid eligibility in Florida. The Florida Department of Children and Families (DCF) determines the eligibility of applicants for Medicaid benefits. We will issue this report to DCF within 5 business days.

The Centers for Medicare & Medicaid Services and the Office of Management and Budget requested this audit.

The Medicaid program, which the Federal and State Governments jointly fund and administer, pays for medical assistance for certain individuals and families with low income and resources. Federal and State laws, regulations, and other requirements establish Medicaid eligibility. Generally, an individual must, among other things, not exceed income and resource thresholds established by the State, meet citizenship requirements, submit a written application for Medicaid benefits, furnish his or her Social Security number, meet beneficiary liability requirements, and be eligible for the specific services received. In addition, the State must include in each applicant's case file facts to support the State's eligibility determination.

Our objective was to determine the extent to which the State made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Our audit period covered January 1 through June 30, 2005, when the State made more than 26 million payments totaling $3.4 billion ($2 billion Federal share) on behalf of Medicaid beneficiaries.

The State generally made Medicaid payments on behalf of beneficiaries who met Federal and State eligibility requirements and provided adequate documentation of eligibility determinations. Of the 200 payments in our statistical sample, 3 payments totaling $50 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, three payments totaling $36 (Federal share) had case files that did not contain adequate documentation to support eligibility determinations. We attribute the low number of eligibility and documentation errors to the effectiveness of DCF's policies and procedures.

We recommend that DCF use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, DCF should continue to verify eligibility information and maintain appropriate documentation in all case files.

In written comments on our draft report, DCF stated that it was committed to program integrity and would continue to emphasize the importance of accurate and timely information as well as appropriate documentation. We considered all information provided by DCF, including information discussed during postaudit meetings referenced in DCF's comments, and revised our final report where appropriate.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Peter Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-06-00020.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

MAR - 6 2007

Report Number: A-04-06-00020

Ms. Lucy Hadi
Secretary
Florida Department of Children and Families
Building 1
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

Dear Ms. Hadi:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Eligibility in Florida." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-04-06-00020 in all correspondence.

Sincerely,

Peter J Barbera

Peter Barbera
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Roger Perez
Regional Administrator
Centers for Medicare & Medicaid Services, Region IV
Department of Health and Human Services
61 Forsyth Street SW., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ELIGIBILITY IN FLORIDA

Daniel R. Levinson
Inspector General

March 2007
A-04-06-00020

Office of Inspector General

http://oig.hhs.gov

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. The Federal and State Governments jointly fund and administer the program. The Centers for Medicare & Medicaid Services administers the program at the Federal level.

Federal and State laws, regulations, and other requirements establish Medicaid eligibility. Generally, an individual must, among other things, not exceed income and resource thresholds established by the State, meet citizenship requirements, submit a written application for Medicaid benefits, furnish his or her Social Security number, meet beneficiary liability requirements, and be eligible for the specific services received. The State must include in each applicant's case file facts to support the State's eligibility determination. In addition, the State must have a Medicaid eligibility quality control program designed to reduce erroneous expenditures by monitoring eligibility decisions.

The Florida Department of Children and Families (DCF) determines the eligibility of applicants for Medicaid benefits. From January 1 through June 30, 2005, the State made more than 26 million Medicaid payments totaling $3.4 billion ($2 billion Federal share) on behalf of Medicaid beneficiaries.

The Centers for Medicare & Medicaid Services and the Office of Management and Budget requested this audit.

OBJECTIVE

Our objective was to determine the extent to which the State made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

SUMMARY OF FINDINGS

For the period January 1 through June 30, 2005, the State generally made Medicaid payments on behalf of beneficiaries who met Federal and State eligibility requirements and provided adequate documentation of eligibility determinations.

Of the 200 payments in our statistical sample, 3 payments totaling $50 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, for three sampled payments totaling $36 (Federal share), the case files did not contain adequate documentation to support eligibility determinations. We attribute the low number of eligibility and documentation errors to the effectiveness of DCF's policies and procedures.

RECOMMENDATION

We recommend that DCF use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, DCF should continue to verify eligibility information and maintain appropriate documentation in all case files.

DEPARTMENT OF CHILDREN AND FAMILIES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DCF stated that it was committed to program integrity and would continue to emphasize the importance of accurate and timely information as well as appropriate documentation.

We considered all information provided by DCF, including information discussed during postaudit meetings referenced in DCF's comments, and revised our final report where appropriate.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) and the Office of Management and Budget requested this audit.

The Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. The Federal and State Governments jointly fund and administer the program. CMS administers the program at the Federal level.

Within broad national guidelines established by Federal statutes, regulations, and other requirements, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the payment rates for services; and (4) administers its own program. To participate in the Medicaid program, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its Medicaid program, including program administration, eligibility criteria, service coverage, and provider reimbursement.

Florida's Medicaid Program

In Florida, the Agency for Health Care Administration (AHCA) is responsible for operating the Medicaid program and uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims. From January 1 through June 30, 2005, the State made more than 26 million payments totaling $3.4 billion ($2 billion Federal share) on behalf of Medicaid beneficiaries.[1]

AHCA relies on the Florida Department of Children and Families (DCF), a separate State agency, to determine the eligibility of applicants for Medicaid benefits. To carry out its eligibility determination responsibilities, DCF requires individuals to submit written or electronic applications for Medicaid benefits. The DCF district offices review the applications and determine whether the individuals meet Medicaid eligibility requirements. For each applicant determined eligible, the district office sends a letter informing the individual of his or her responsibility to notify the district office of any changes that might affect eligibility status. In addition, the DCF district office periodically contacts beneficiaries in person or by telephone throughout each 12-month eligibility period to verify whether any changes in status have occurred. Each year thereafter, the district office must verify any updated information and redetermine the beneficiary's eligibility.

[1]The numbers exclude payments for Medicaid beneficiaries who were automatically eligible for Medicaid because of their eligibility category and payments for the State Children's Health Insurance Program Medicaid expansion.

DCF uses the Florida On-Line Recipient Integrated Data Access system (the Florida System) to organize applicants' applications, maintain data, and determine eligibility. The Florida System enables statewide monitoring of eligibility determinations and records.

DCF district office employees use the Florida System to evaluate beneficiary applications and determine Medicaid eligibility. During the application process, DCF district office employees contact the following outside sources to verify application data:

- Florida's Income and Eligibility Verification System (IEVS), the Internal Revenue Service, Florida's Workers' Compensation Data, and the Florida Retirement System (for income verification);

- the U. S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlement system (for citizenship and alien registration);

- Florida Vital Statistics (for birthdate, birthplace, and residency verification);

- the Social Security Administration (for Social Security number and citizenship verification); and

- student databases (for student status verification).

Following its eligibility determinations, DCF provides AHCA with a computerized file identifying eligible recipients, which ACHA then uses during its claims processing operations.

For beneficiaries in certain eligibility categories, if changes in eligibility information cause the beneficiary to become ineligible for Medicaid, the beneficiary may be eligible for transitional or extended Medicaid if he or she meets specified requirements. Transitional Medicaid benefits may extend for up to 12 months.

Federal Requirements Related to Medicaid Eligibility

Federal laws, regulations, and other requirements establish Medicaid eligibility requirements that a State plan must contain, the mandatory and optional groups of individuals to whom Medicaid is available under a State plan, and the eligibility procedures that the State must use in determining and redetermining eligibility.

Under Title XIX of the Act, Medicaid payments are allowable only for eligible beneficiaries. Generally, Federal regulations (42 CFR §§ 431.800–431.865) require the State to have a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility decisions. In addition, the regulations contain procedures for disallowing Federal payments for erroneous Medicaid payments that result from eligibility and recipient liability errors above a certain level, as detected through the MEQC program. Federal regulations (42 CFR § 431.804) define an eligibility error as an instance in which Medicaid coverage was authorized or payment was made for a beneficiary who (1) was ineligible for Medicaid when authorized or when he or she received services, (2) was eligible for Medicaid but

was ineligible for certain services received, or (3) had not met beneficiary liability requirements (e.g., beneficiary had not incurred medical expenses in an amount necessary to lower his/her countable income to the threshold limit).

A Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits and a citizen or national of the United States or a qualified alien.[2] Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, as codified, in part, at 8 U.S.C. §§ 1601–1646, provides that legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.

Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.[3] The income and resource thresholds, which are subject to yearly adjustments, vary based on eligibility category and the number of family members in the household.[4] For beneficiaries in the "medically needy" category, unlike those in most other eligibility categories, regulations (42 CFR § 435.831(d)) require the State to deduct certain incurred medical expenses from income when determining financial eligibility. This process is often referred to as "beneficiary liability" or "spenddown." In addition to having income and resource thresholds, some eligibility categories have other requirements. For example, for beneficiaries not receiving Supplemental Security Income (SSI) who apply for Medicaid under the eligibility category for blind or disabled persons, 42 CFR §§ 435.531 and 435.541 require that the determination of blindness or disability be based on a physician's report of examination.

Regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. The State must contact the Social Security Administration to verify that the number furnished was the correct number and the only number issued to the individual. If the applicant was not issued a Social Security number or cannot recall the number, the State must assist the individual in obtaining a number or identifying his or her existing number. The State may not deny or delay Medicaid services to an otherwise eligible individual pending issuance or verification of his or her Social Security number by the Social Security Administration. If an individual refuses to obtain a Social Security number for "well established religious objections," as defined in 42 CFR § 435.910(h)(2), the State may obtain a Social Security number on the individual's behalf or use another unique identifier. In redetermining eligibility (as required by 42 CFR § 435.916(a)), 42 CFR § 435.920(a) provides that the State must determine whether the case records contain the

[2]Undocumented aliens are eligible only for Medicaid pregnancy and emergency services.

[3]Children and pregnant women may qualify at higher income levels than other types of applicants.

[4]One eligibility criterion for the optional category for women in need of treatment for breast or cervical cancer is that the woman must have been screened for breast or cervical cancer through the Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program, which is aimed at low-income, uninsured, and underserved women. However, pursuant to sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act, once screened through the early detection program, a woman is eligible for Medicaid under this optional category, regardless of her income or resources, if the woman needs treatment for breast or cervical cancer, is not otherwise eligible for Medicaid, is under the age of 65, and is uninsured.

beneficiary's Social Security number. Generally, pursuant to 42 CFR § 435.920(b), if the records do not contain the required Social Security number, the State must require the beneficiary to furnish it.

Pursuant to 42 CFR § 435.916(b), the State must have procedures designed to ensure that beneficiaries promptly and accurately report any changes in circumstances that may affect eligibility. The State must promptly redetermine eligibility when beneficiaries report such changes or when the State anticipates a change in circumstances. Also, pursuant to 42 CFR § 435.916(a), the State must redetermine Medicaid eligibility at least every 12 months. Pursuant to 42 CFR § 435.945, the State must query appropriate Federal and State agencies to verify applicants' information when determining and redetermining eligibility.

State Requirements Related to Medicaid Eligibility

DCF assigns individuals who are eligible for Medicaid to one of five coverage categories: (1) low-income families with children; (2) poverty-level children and pregnant women; (3) the aged, blind, and disabled; (4) the medically needy; or (5) State-specific eligibility groups.

The State plan incorporates the Federal requirements pertaining to residency, citizenship, blindness and/or disability, Social Security numbers, and beneficiary liability. The State plan also establishes income and resource levels. Chapter 65A-1.204(1) of the Florida Administrative Code requires beneficiaries to inform DCF of any changes in circumstances affecting eligibility.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the extent to which the State made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

Scope

Our audit period covered January 1 through June 30, 2005. We did not review the overall internal control structure of the State Medicaid program. Rather, we reviewed DCF's procedures relevant to the objective of the audit.

We performed fieldwork from November 2005 to January 2006 at DCF's offices in Tampa and Tallahassee, Florida.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements related to Medicaid eligibility;

- held discussions with CMS regional officials and State officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;

- obtained a computer file of paid claims from the Medicaid Management Information System fiscal agent, which identified 42,602,025 Medicaid fee-for-service and managed care payments totaling approximately $6.3 billion (approximately $3.7 billion Federal share) for services rendered in Florida for the period January 1 through June 30, 2005;

- eliminated from the total number of Medicaid payments 15,896,386 Medicaid payments totaling approximately $2.3 billion (approximately $1.6 billion Federal share) made on behalf of SSI recipients and 495,706 payments totaling approximately $54.2 million (approximately $38.6 million Federal share) made on behalf of recipients of Title IV-E adoption assistance and foster care because beneficiaries in these categories are automatically eligible for Medicaid services;

- eliminated from the total number of Medicaid payments 181,950 State Children's Health Insurance Program Medicaid expansion payments totaling approximately $11.6 million (approximately $8.3 million Federal share) because we included these payments in another, ongoing review (report number A-04-06-00021);

- identified a universe of 26,027,983 payments totaling approximately $3.4 billion (approximately $2 billion Federal share) for services rendered to Medicaid beneficiaries in Florida during the 6-month period that ended June 30, 2005; and

- selected a simple random sample of 200 payments from the universe of 26,027,983 payments, as detailed in Appendix A.

For each of the 200 sampled items, we determined whether the case file contained sufficient information for the DCF district office to have made a Medicaid eligibility determination on the date of initial determination or redetermination. We also attempted to obtain sufficient independent information to determine whether the beneficiary was eligible for Medicaid on the date of service. Specifically, we determined whether:

- the case file contained an application signed by the beneficiary either in writing or electronically;

- the beneficiary was assigned to the correct eligibility category;

- the case file contained the beneficiary's Social Security number and, if so, whether the Social Security Administration issued the number to the applicant;

- the beneficiary resided in Florida by checking driver's licenses, rental agreements, utility bills, or Federal, State, or local government correspondence;

- the beneficiary's identity, including name, age, and citizenship status, in the case file matched the information on file with the Florida Bureau of Vital Statistics, the Florida

Department of Motor Vehicles, and the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlement system;

- the beneficiary's income was at or below the income threshold required to be eligible for Medicaid by reviewing information from the Florida Agency for Workforce Innovation and IEVS;

- the beneficiary's resources were at or below the resource threshold required to be eligible for Medicaid by checking IEVS and the DCF district offices' eligibility support information;

- the case file for blind and/or disabled beneficiaries not receiving SSI contained a physician's report of examination to support a determination of blindness and/or disability;

- the beneficiary met all applicable liability requirements; and

- the beneficiary was eligible for both Medicaid and the service received.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATION

For the period January 1 through June 30, 2005, the State generally made Medicaid payments on behalf of beneficiaries who met Federal and State eligibility requirements and provided adequate documentation of eligibility determinations.

Of the 200 payments in our statistical sample, 3 payments totaling $50 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, for three payments totaling $36 (Federal share), the case files did not contain adequate documentation to support eligibility determinations. We attribute the low number of eligibility and documentation errors to the effectiveness of DCF's policies and procedures.

ELIGIBILITY ERRORS

The table below summarizes the three eligibility errors noted in the sampled payments.

Eligibility Errors and Associated Unallowable Payments

Eligibility Error	Number of Unallowable Payments	Unallowable Federal Payments
Beneficiary did not meet income requirements on the date of service	1	$2
Beneficiaries had not met liability requirements	2	48
Total	**3**	**$50**

We attribute the low number of eligibility errors to the effectiveness of DCF's policies and procedures for determining eligibility. DCF makes interim contacts with beneficiaries to determine whether the beneficiaries' eligibility status has changed. In addition, even if a beneficiary is found to be ineligible for Medicaid, the beneficiary may be eligible for transitional or extended Medicaid. Transitional Medicaid benefits may extend for up to 12 months.

Beneficiary Did Not Meet Income Requirements

Pursuant to 42 CFR part 435, income and resource thresholds are established by the State and must be included in the State plan. Generally, the thresholds vary based on eligibility category and the number of family members in the household. Federal regulations (42 CFR § 435.916(b)) require the State to have procedures designed to ensure that beneficiaries promptly and accurately report any changes in circumstances that may affect eligibility.

One sampled payment totaling $2 (Federal share) was made on behalf of a beneficiary who did not meet eligibility requirements under Federal law and regulations. Specifically, the beneficiary's household income exceeded the Medicaid income threshold on the date of service.

Beneficiaries Had Not Met Liability Requirements

For the "medically needy" category, Federal regulations (42 CFR § 435.831(d)) require the State to deduct medical expenses incurred by the individual or family from income if countable income exceeds the income threshold. This is called beneficiary liability or spenddown. For example, if the monthly income threshold in the State is $1,000 and the beneficiary is earning $1,200, the beneficiary must have medical expenses equal to or greater than $200 to qualify for Medicaid. A Medicaid payment is unallowable when these beneficiary liability requirements have not been met, and such payments should be identified as eligibility errors under the State's MEQC program.

For two sampled payments totaling $48 (Federal share), the State paid for services rendered to beneficiaries who had countable income above the income threshold on the dates of service and who had not met the beneficiary liability requirements.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

Federal regulations (42 CFR § 435.907(a)) require a written application from each applicant. The regulations (42 CFR §§ 435.911(a) and 435.916(a)) also require the State to (1) determine Medicaid eligibility within 90 days for applicants who apply based on disability and within 45 days for all other applicants and (2) redetermine eligibility at least every 12 months. In addition, the State must include in each applicant's case file facts to support the State's decision on the application (42 CFR § 435.913(a)).

For three sampled payments totaling $36 (Federal share), the case files did not contain adequate documentation to support eligibility determinations. Each case file was missing a signed application covering the period in which the services were provided. We attribute the low number of documentation errors to the effectiveness of DCF's policies and procedures for maintaining case file documentation.

CONCLUSION

Of the 200 Medicaid payments in our statistical sample, only 3 were made on behalf of beneficiaries who did not meet Federal and State eligibility requirements. In addition, the State made only three payments on behalf of beneficiaries whose case files did not contain all federally required documentation supporting eligibility determinations. These results indicate that the State generally ensured that Federal and State eligibility requirements were met and that eligibility determinations were appropriately documented.

We are not recommending recovery primarily because under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program.

RECOMMENDATION

We recommend that DCF use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, DCF should continue to verify eligibility information and maintain appropriate documentation in all case files.

DEPARTMENT OF CHILDREN AND FAMILIES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DCF stated that it was committed to program integrity and would continue to emphasize the importance of accurate and timely information as well as appropriate documentation.

We considered all information provided by DCF, including information discussed during postaudit meetings referenced in DCF's comments, and revised our final report where appropriate.

APPENDIXES

SAMPLING DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine the extent to which Florida made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

POPULATION

The population was all payments for services rendered to Medicaid beneficiaries in Florida during the 6-month period that ended June 30, 2005, excluding payments for Supplemental Security Income beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance programs, and payments for the State Children's Health Insurance Program Medicaid expansion.

SAMPLING FRAME

The sampling frame was a computer file containing 26,027,983 payments for services rendered to Medicaid beneficiaries in Florida during the 6-month period that ended June 30, 2005. The 26,027,983 payments excluded payments made for Supplemental Security Income beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance programs, and payments for the State Children's Health Insurance Program Medicaid expansion. The total Medicaid reimbursement for the 26,027,983 payments was $3,444,927,983 ($2,028,820,103 Federal share).

SAMPLE UNIT

The sample unit was an individual payment for service rendered to a Medicaid beneficiary during the audit period.

SAMPLE DESIGN

We used a simple random sample to evaluate Medicaid eligibility.

SAMPLE SIZE

We selected a sample size of 200 Medicaid payments.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services (OAS) statistical sampling software dated June 2005. We used the random number generator for our simple random sample.

CHARACTERISTICS TO BE MEASURED

We based our determination as to whether each sampled payment was unallowable on Federal and State laws, regulations, and other requirements. Specifically, if at least one of the following characteristics was met, we considered the payment under review unallowable:

- The beneficiary did not meet one or more eligibility requirements.
- The beneficiary had not met liability requirements when authorized for participation in the program.
- The beneficiary was eligible for Medicaid but ineligible for the service rendered.

In addition, we determined whether the case file contained sufficient documentation to support the eligibility determination as required by Federal regulations.

ESTIMATION METHODOLOGY

Our sampling and estimation policy requires at least six errors for the sample results to be projected. Because neither category had more than five errors, we did not estimate the total amount of Federal payments made for ineligible Medicaid beneficiaries or the total amount of Federal payments for which documentation did not support eligibility determinations.

Florida Department of Children & Families

State of Florida
Department of Children and Families

Jeb Bush
Governor

Lucy D. Hadi
Secretary

August 25, 2006

RECEIVED
SEP 0 7 2006
Office of Audit Svcs.

Mr. Peter J. Barbera
Regional Inspector General,
Audit Services, Region IV
61 Forsyth Street S.W., Suite 3T41
Atlanta, GA 30303

Dear Mr. Barbera:

Thank you for your August 8 letter that provided the OIG's draft report entitled "Review of Medicaid Eligibility-Florida," Report number A-04-06-00020.

The department is pleased to note that out of 200 cases reviewed only three were considered to be in error, with the total federal expenditures in error of only $50. During the last two years, the department has implemented a variety of measures intended to improve both customer access to services as well as a higher level of Quality Assurance.

I was concerned with your observations related to the 60 cases you felt were missing either a signed application or facts supporting residence or citizenship status. As was discussed during a meeting with members of your staff and mine in February, Florida has a web based public assistance application and accepts electronic signatures. Following that meeting it was confirmed that each of the cases in question had either a manual or electronic signature.

During the February meeting my staff also explained that as proof of citizenship and residency were not required, most cases were approved based on the client's self-declaration. On July 1, 2006 the department implemented the citizenship verification component of the Deficit Reduction Act. In the future, cases reviewed will have documentation consistent with this provision.

We are committed to program integrity and will continue to emphasize the importance of accurate and timely information as well as appropriate documentation.

Mr. Peter J. Barbera
Page 2
August 25, 2006

If you have any questions, please feel free to contact Florence Love, Program Administrator, at (850) 413-6790.

Sincerely,

Lucy D. Hadi
Secretary