



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

JUL 19 2007

Washington, D.C. 20201

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

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

SUBJECT: Review of State Children's Health Insurance Program Eligibility in Florida
(A-04-06-00021)

Attached is an advance copy of our final report on State Children's Health Insurance Program (SCHIP) eligibility in Florida. The Florida Healthy Kids Corporation (FHKC) determines the eligibility of applicants for SCHIP benefits. The Florida Agency for Health Care Administration (State agency) operates both the Medicaid and SCHIP programs. We will issue this report to FHKC and the State agency within 5 business days.

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

The SCHIP program, which the Federal and State Governments jointly fund and administer, provides free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage. Federal and State laws, regulations, and other requirements establish both SCHIP and Medicaid eligibility.

States have three options when designing an SCHIP: (1) use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program, (2) design a children's health insurance program entirely separate from Medicaid, or (3) combine both the expanded Medicaid and separate program options. If a State elects to establish an expanded Medicaid program using SCHIP funds, Medicaid eligibility rules apply. Florida designed its SCHIP, called Florida KidCare, as a combination of the expanded Medicaid and separate programs.

Our objective was to determine the extent to which the State agency made SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Our audit period covered January 1 through June 30, 2005, during which the State made more than 2.7 million SCHIP payments totaling \$162 million (\$115 million Federal share).

From January 1 through June 30, 2005, the State agency (1) made some SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations.

Of the 200 payments in our statistical sample, 49 payments totaling \$1,934 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. These errors occurred because individuals who would have otherwise been deemed ineligible for enrollment on the basis of income were not properly screened as required by Florida Statute 409.814(9). In addition, for 22 sampled payments totaling \$591 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required. This occurred because the State agency did not ensure that FHKC employees maintained all required documentation.

As a result, for our 6-month audit period, we estimate that the State agency made between 519,508 and 797,411 payments totaling between \$18,776,786 and \$32,583,603 (Federal share) on behalf of ineligible beneficiaries. The midpoint amounted to 650,815 payments totaling \$25,680,194. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 200,967 to 407,319 payments totaling between \$4,130,356 and \$11,568,962 (Federal share). The midpoint amounted to 292,203 payments totaling \$7,849,659.

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State SCHIP eligibility requirements by:

- reemphasizing to FHKC employees the need to adequately verify eligibility information,
- minimizing the time period between determination of Medicaid eligibility and disenrollment of the applicant from SCHIP, and
- reemphasizing to FHKC employees the need to maintain appropriate documentation in all case files.

We also recommend that the State agency work with CMS to resolve the estimated improper payments of at least \$18,776,786 identified in our review.

In written comments on our draft report, both FHKC and the State agency said that the State dealt with a confluence of extraordinary issues that contributed to our findings. These issues included four major hurricanes, significant changes in State law, Executive Orders from the Governor's office to postpone account cancellations, and the first open-enrollment period for the Florida SCHIP program in 18 months. FHKC further stated that, after our audit period, it undertook a profusion of remediation efforts to sharply reduce the error rates in eligibility determinations. Additionally, the State agency emphasized its oversight responsibilities with respect to FHKC and indicated that it had identified significantly fewer errors during several recent monitoring reviews.

We acknowledge that the State was dealing with several extraordinary events that could have affected FHKC's ability to make accurate eligibility determinations. We commend FHKC and the State agency for taking steps to improve the accuracy of their eligibility determinations.

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-04-06-00021.

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

JUL 20 2007

Report Number: A-04-06-00021

Ms. Rose M. Naff
Executive Director
Florida Healthy Kids Corporation
Post Office Box 980
Tallahassee, Florida 32302

Dear Ms. Naff:

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 State Children's Health Insurance Program Eligibility in Florida." A copy of this report will be forwarded to the action official noted on the following 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 members of the public to the extent the information contained therein 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-04-06-00021 in all correspondence.

Sincerely,

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Mr. Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid & Children's Health
Centers for Medicare & Medicaid Services
U.S. 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
Office of Audit Services



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

JUL 20 2007

Report Number: A-04-06-00021

Ms. Gail Hansen
Program Administrator
Florida Agency for Health Care Administration
2727 Mahan Drive
Building 3, Mail Stop 20
Tallahassee, Florida 32308

Dear Ms. Hansen:

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 State Children's Health Insurance Program Eligibility in Florida." A copy of this report will be forwarded to the action official noted on the following page for review and any action deemed necessary.

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Please refer to report number A-04-06-00021 in all correspondence.

Sincerely,

A handwritten signature in cursive script, reading "Peter J. Barbera", is written above the typed name.

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Mr. Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid & Children's Health
Centers for Medicare & Medicaid Services
U.S. 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 STATE CHILDREN'S
HEALTH INSURANCE PROGRAM
ELIGIBILITY IN FLORIDA**



**Daniel R. Levinson
Inspector General**

**JULY 2007
A-04-06-00021**

Office of Inspector General

<http://oig.hhs.gov>

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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 XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP) provides free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage. The Federal and State Governments jointly fund and administer the program. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level.

States have three options when designing an SCHIP: (1) use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program, (2) design a children's health insurance program entirely separate from Medicaid, or (3) combine both the expanded Medicaid and separate program options.

Federal and State laws, regulations, and other requirements establish both SCHIP and Medicaid eligibility. If a State elects to establish an expanded Medicaid program using SCHIP funds, Medicaid eligibility rules apply. Florida designed its SCHIP, called Florida KidCare, as a combination of the expanded Medicaid and separate programs.

The Florida Agency for Health Care Administration (the State agency) operates both the Medicaid and SCHIP programs. The Florida Department of Children and Families determines Medicaid eligibility. The State agency contracts with other entities to provide various SCHIP services; the largest of these is the Florida Healthy Kids Corporation (FHKC), which determines SCHIP eligibility. From January 1 through June 30, 2005, the State agency made approximately 2.7 million SCHIP payments totaling \$162 million (\$115 million Federal share).

CMS and the Office of Management and Budget requested this audit.

OBJECTIVE

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

SUMMARY OF FINDINGS

From January 1 through June 30, 2005, the State agency (1) made some SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations.

Of the 200 payments in our statistical sample, 49 payments totaling \$1,934 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. Specifically, the State agency made:

- 47 payments on behalf of beneficiaries whose family incomes exceeded the SCHIP income threshold on the dates of service or who were enrolled in Medicaid at the time of the SCHIP payment and
- 2 payments on behalf of beneficiaries who were eligible for Medicaid and thus improperly enrolled in SCHIP.

These conditions occurred because individuals who would have otherwise been deemed ineligible for enrollment on the basis of income were not properly screened as required by Florida Statute 409.814(9). In addition, the State agency did not have procedures for promptly disenrolling individuals from SCHIP once they became eligible for Medicaid. Also, a computer system error in late 2004 prevented the State agency from canceling SCHIP coverage for anyone, including those who voluntarily attempted to cancel their SCHIP coverage when they became eligible for Medicaid. The error allowed people who should have been adjudicated as ineligible for SCHIP to remain on the program until their eligibility was redetermined in 2005. The error was corrected when FHKC made those eligibility redeterminations.

In addition, for 22 sampled payments totaling \$591 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required. The missing documentation included at least one of the following: an application covering the date of service, a signature on the application, and facts supporting income level. This condition occurred because the State agency did not ensure that FHKC employees maintained all required documentation.

As a result, for our 6-month audit period, we estimate that the State agency made between 519,508 and 797,411 payments totaling between \$18,776,786 and \$32,583,603 (Federal share) on behalf of ineligible beneficiaries. The midpoint amounted to 650,815 payments totaling \$25,680,194.

We also estimate that case file documentation did not adequately support eligibility determinations for an additional 200,967 to 407,319 payments totaling between \$4,130,356 and \$11,568,962 (Federal share). The midpoint amounted to 292,203 payments totaling \$7,849,659.

RECOMMENDATIONS

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State SCHIP eligibility requirements by:

- reemphasizing to FHKC employees the need to adequately verify eligibility information,
- minimizing the time period between determination of Medicaid eligibility and disenrollment of the applicant from SCHIP, and
- reemphasizing to FHKC employees the need to maintain appropriate documentation in all case files.

We also recommend that the State agency work with CMS to resolve the estimated improper payments of at least \$18,776,786 identified in our review.

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

We received comments to our draft report from both FHKC and the State agency. Neither agency specifically addressed our recommendations. However, neither agency disagreed with our findings. Both agencies emphasized the extraordinary issues in Florida during the audit period and described steps they had taken to improve the accuracy of their eligibility determinations. The State agency said that “[a] subsequent mid-year internal audit recently showed a 99% compliance rate, so improvements have been made.”

FHKC further noted that it was proactively pursuing data matches with as many partners as possible. We consider these actions to be one positive response to our first recommendation and a step that will likely lead to a reduction in payments to ineligible beneficiaries in the future. For example, FHKC will be able to perform a data match with the State Income and Employment Verification System to identify ineligible individuals as we did in our audit.

Neither agency presented any information that would cause us to change our recommendations. The complete text of both agencies’ comments is included as Appendix D.

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INTRODUCTION

BACKGROUND

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

State Children's Health Insurance and Medicaid Programs

The Federal and State Governments jointly fund and administer both the State Children's Health Insurance Program (SCHIP) and the Medicaid program. CMS administers the programs at the Federal level. To participate in the SCHIP and Medicaid programs, 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 programs, including program administration, eligibility criteria, service coverage, and provider reimbursement.

Pursuant to Title XXI of the Social Security Act (the Act), SCHIP provides free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage. States have three options when designing an SCHIP program: (1) use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program, (2) design a children's health insurance program entirely separate from Medicaid, or (3) combine both the expanded Medicaid and separate program options. Each State generally sets its own guidelines regarding eligibility and services. However, if a State elects to establish an expanded Medicaid program using SCHIP funds, the Federal and State Medicaid eligibility rules apply. Pursuant to 42 CFR § 457.70(c)(2), the expanded program must be consistent with the State's Medicaid plan.

Pursuant to Title XIX of the Act, the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. 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; and (3) sets the payment rates for services.

Florida's State Children's Health Insurance and Medicaid Programs

Florida designed its SCHIP, called Florida KidCare, as a combination of the expanded Medicaid and separate programs. Florida KidCare is designed to meet the health insurance needs of children under the age of 19 through three components: (1) MediKids, which covers children age 1 through 4 with family incomes between 133 percent and 200 percent of the Federal poverty level (FPL); (2) Healthy Kids, which covers children age 5 with family incomes between 133 percent and 200 percent of the FPL and age 6 through 18 with family incomes between 100 percent and 200 percent of the FPL¹; and (3) a Medicaid expansion component, which covers children under the age of 1 with family incomes between 185 percent and 200 percent of the FPL. Florida KidCare also has

¹Healthy Kids with family incomes above 200 percent of the FPL may be eligible for the full-pay premium category for which no Federal funds are used.

provisions for children with special medical and behavioral needs within each of these components. (See Appendix A for a graphic representation of the Florida KidCare component structure.)

The State entities involved with Florida KidCare are as follows:

- The Agency for Health Care Administration (the State agency) operates both the Medicaid and SCHIP programs. The State agency contracts with a fiscal agent to process Medicaid claims. In addition, the State agency contracts with other entities, the largest of which is the Florida Healthy Kids Corporation (FHKC), to administer SCHIP.
- The Department of Children and Families (DCF) determines Medicaid eligibility at its district offices.
- FHKC determines SCHIP eligibility, enrolls those who are eligible, collects premiums, contracts with authorized insurers, develops the SCHIP benefit packages, and disenrolls those who are no longer eligible.
- The Department of Health determines the medical appropriateness of including SCHIP beneficiaries in a provider network for children with special medical and behavioral needs.

FHKC and DCF require that individuals submit completed applications for SCHIP and Medicaid benefits, respectively. They cross-refer applicants when appropriate.

Individuals may submit applications directly to FHKC during open enrollment. They may also submit a Florida KidCare application at DCF district offices. DCF then electronically transmits the application to FHKC for adjudication. In addition, effective July 1, 2004, DCF transfers to FHKC a weekly file listing children who are no longer eligible for Medicaid either because their family incomes exceed the maximum or because the children are over the maximum age. These families are mailed an “Expedited Application Services for You (EASY)” KidCare application. Families who returned the EASY application along with the required documentation were processed for SCHIP coverage outside of open enrollment periods.²

Each applicant is required to sign a “Certification and Authorization” section of the application attesting that “. . . the information provided on this application is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud.” Each year thereafter, FHKC sends a renewal application 2 months before the end of the eligibility period. Applicants must complete and return the application, along with supporting documentation, to continue eligibility.

The Federal Government pays 71.23 percent of Florida’s SCHIP costs and 58.90 percent of its Medicaid costs.

²After our audit period, the State plan was amended to replace open enrollment periods with year-round continuous enrollment.

Federal and State Requirements Related to Eligibility for the Separate State Children's Health Insurance Program

Federal laws and regulations establish the SCHIP eligibility requirements, standards, procedures, and conditions for obtaining Federal funding that a State plan must contain.

Federal regulations (42 CFR § 457.350(a)(1)) require States to use screening procedures to ensure that only targeted low-income children are furnished child health assistance. If the children are potentially eligible for Medicaid, the State must facilitate application to Medicaid. Otherwise, the State screens the children for SCHIP eligibility (42 CFR § 457.350(a)(2)).

Pursuant to 42 CFR part 457 and the State plan, an SCHIP beneficiary must be a child under the age of 19, a resident of the State from which the beneficiary receives benefits, and a citizen or national of the United States or a qualified alien. 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 Federal public benefit programs for the first 5 years after entry. This ban applies to the Medicaid and SCHIP programs.³

Florida KidCare's general program eligibility criteria, as provided in the State plan, require that a child (1) be uninsured, (2) be ineligible for Medicaid, (3) not be covered by group health insurance, (4) not have access to affordable employer-sponsored dependent coverage, (5) not have voluntarily canceled employer-sponsored dependent coverage, (6) not be the dependant of a State employee, (7) have family income at or below 200 percent of the FPL, (8) be a U.S. citizen or qualified alien, (9) not be an inmate in a public institution or a patient in an institution for mental diseases, (10) be a Florida resident, and (11) be age-eligible. The State plan also requires monthly cost-sharing payments (premiums) for all KidCare components except the Medicaid component. If a monthly premium is not paid, coverage will be canceled for the next month and cannot be reinstated for 60 days.

Federal regulations (42 CFR § 457.320(e)(2)) require that eligibility be redetermined at least every 12 months. In addition, 42 CFR § 457.965 requires the State to include in each applicant's record facts to support the State's determination of eligibility for the program.

Federal and State Requirements Related to Eligibility for Expanded Medicaid Under the State Children's Health Insurance Program

If a State elects to establish an expanded Medicaid program using SCHIP funds, Medicaid eligibility rules apply. 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. The only individuals in Florida currently covered under the SCHIP Medicaid expansion program are children under the age of 1

³Notwithstanding the ban, undocumented aliens are eligible for emergency Medicaid services, including emergency labor and delivery, if they are otherwise eligible for the State's Medicaid program.

with family incomes between 185 and 200 percent of the FPL. The remaining eligible children are covered under Florida's separate SCHIP program. (See Appendix A.)

Pursuant to Title XIX of the Act, Medicaid payments are allowable only for eligible beneficiaries. 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., the beneficiary had not incurred enough medical expenses to lower countable income to the threshold limit).

Pursuant to 42 CFR § 435.229, the State may provide Medicaid coverage to all individuals under age 19 who are optional targeted low-income children or reasonable categories of these individuals. Regulations (42 CFR part 435, subpart E) provide residency and citizenship requirements for Medicaid. 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. 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.⁴

Pursuant to 42 CFR §§ 435.600–435.845, Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.⁵ The income and resource thresholds vary based on eligibility category and the number of family members in the household and are subject to yearly adjustments. For beneficiaries in the “medically needy” category, unlike beneficiaries in most other eligibility categories, 42 CFR § 435.831(d) requires the State to deduct certain incurred medical expenses from income when determining financial eligibility. This process is often referred to as “spenddown.” Some eligibility categories have other requirements.

Regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number (SSN) 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 cannot recall his or her SSN or was not issued an SSN, the State must assist the individual in obtaining one or identifying his or her existing SSN. The State may not deny or delay Medicaid services to an otherwise eligible individual pending issuance or verification of his or her SSN by the Social Security Administration. If an individual refuses to obtain an SSN for “well established religious objections,” as defined in 42 CFR § 435.910(h)(2), the State may obtain an SSN on the individual's behalf or use another unique identifier. In redetermining eligibility, as required by 42 CFR § 435.916(a), regulations (42 CFR § 435.920(a)) provide that the State must determine whether the case records contain the recipient's SSN. Generally, pursuant to 42 CFR § 435.920(b), if the records do not contain the required SSN, the State must require the Medicaid recipient to furnish it.

⁴Undocumented aliens are eligible only for emergency Medicaid services, including emergency labor and delivery.

⁵Children and pregnant women may qualify at higher income levels than other types of applicants.

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. 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)).

Florida's SCHIP State plan explicitly states that no resource tests are required in determining eligibility for enrollees in the Medicaid expansion program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the extent to which the State agency made SCHIP 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 Florida's SCHIP. Rather, we reviewed the State agency's procedures relevant to the objectives of the audit.

We performed fieldwork from November 2005 to February 2006 in Tallahassee, Florida, at the State agency, the State Medicaid fiscal agent, FHKC, the Department of Health, and DCF.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements related to SCHIP and Medicaid eligibility;
- held discussions with State officials and personnel from FHKC and the State Medicaid fiscal agent to obtain an understanding of policies, procedures, and guidance for determining SCHIP and Medicaid eligibility;
- obtained an extract of 2,424,967 Healthy Kids managed care payments totaling \$123,383,666 (\$87,886,185 Federal share) for services rendered in Florida for the period January 1 through June 30, 2005;

- obtained an extract of MediKids and Medicaid expansion payments from the State agency's Medicaid Management Information System containing 181,950 payments totaling \$11,621,124 (\$8,277,727 Federal share) for services rendered in Florida for the period January 1 through June 30, 2005;
- obtained an extract of 49,471 managed care payments for children with special medical and behavioral needs totaling \$26,730,291 (\$19,039,986 Federal share) for services rendered in Florida for the period January 1 through June 30, 2005;
- identified a combined universe of 2,656,388 SCHIP payments totaling \$161,735,081 (approximately \$115 million Federal share) for services rendered in Florida for the period January 1 through June 30, 2005; and
- selected a simple random sample of 200 payments totaling \$12,582 (\$8,962 Federal share) from the universe of 2,656,388 payments, as detailed in Appendix B.

For each of the 200 sampled SCHIP payments, we determined whether the case file contained sufficient information for FHKC (199 separate SCHIP payments) or the DCF district office (1 Medicaid expansion program payment) to have made an 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 SCHIP on the date of service. Specifically, we determined whether:

- the case file contained a completed application on behalf of the beneficiary;
- the beneficiary resided in Florida by checking driver's licenses, Federal, State, or local government correspondence, or other appropriate documentation;
- the beneficiary's identity, including name, age, and citizenship in the claims processing system matched the information on the birth certificate in the case file, the Social Security Administration's records via electronic verification, or the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlement program;
- the case file contained the beneficiary's SSN and, if so, whether the Social Security Administration had issued the number to the applicant; and
- the beneficiary's family income was at or below the SCHIP threshold by reviewing information from the State Income and Employment Verification System (IEVS).

For the 199 separate SCHIP payments, we determined whether:

- the beneficiary had access to other health insurance (i.e., the beneficiary was eligible or potentially eligible for Medicaid or covered under a group health plan or other health insurance) and
- the beneficiary met all applicable liability (e.g., enrollee premium) requirements.

For the one⁶ Medicaid expansion SCHIP payment, we also determined whether:

- the case file contained a signed application on behalf of the beneficiary (who was under the age of 1) and
- the beneficiary was eligible for both the Medicaid expansion program and the service received.

For the total population of 2,656,388 SCHIP payments for services rendered to beneficiaries, we used an attribute appraisal program to estimate (1) the total number of payments for ineligible beneficiaries and (2) the total number of payments for which documentation did not support eligibility determinations. In addition, we used a variable appraisal program to estimate (1) the dollar impact of the improper Federal funding for ineligible beneficiaries and (2) the dollar impact of the payments for which documentation did not support eligibility determinations.

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

FINDINGS AND RECOMMENDATIONS

The State agency (1) made some SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations. Of the 200 payments in our statistical sample, 49 payments totaling \$1,934 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. These conditions occurred because individuals who would have otherwise been deemed ineligible for enrollment on the basis of income were not properly screened as required by Florida Statute 409.814(9). In addition, the State agency did not have procedures for promptly disenrolling individuals from SCHIP once they became eligible for Medicaid. Also, a computer system error in late 2004 prevented the State agency from canceling SCHIP coverage for anyone, including those who voluntarily attempted to cancel their SCHIP coverage when they became eligible for Medicaid. The error allowed people who should have been adjudicated as ineligible for SCHIP to remain on the program until their eligibility was redetermined in 2005. The error was corrected when FHKC made those eligibility redeterminations.

In addition, for 22 sampled payments totaling \$591 (Federal share), the case files did not contain all required documentation supporting eligibility determinations. This condition occurred because the State agency did not ensure that FHKC employees maintained all required documentation.

As a result, for our 6-month audit period, we estimate that the State agency made between 519,508 and 797,411 payments totaling between \$18,776,786 and \$32,583,603 (Federal share) on behalf of ineligible beneficiaries. The midpoint estimate is 650,815 payments totaling \$25,680,194.

We also estimate that case file documentation did not adequately support eligibility determinations for an additional 200,967 to 407,319 payments totaling between \$4,130,356 and \$11,568,962 (Federal share). The midpoint estimate is 292,203 payments totaling \$7,849,659.

⁶Payments made on behalf of the one Medicaid expansion beneficiary met Federal and State requirements.

ELIGIBILITY ERRORS

The following table summarizes the 49 eligibility errors noted in the sampled payments.

Eligibility Errors and Associated Unallowable Payments		
Eligibility Error	Number of Unallowable Payments	Amount of Unallowable Federal Payments
Beneficiaries were ineligible for SCHIP:		
Did not meet income requirements on dates of service	39	\$1,567
Were enrolled in Medicaid at time of SCHIP payment	8	\$351
Subtotal	47	\$1,918
Beneficiaries were eligible for Medicaid	2	\$16
Total	49	\$1,934

Beneficiaries Ineligible for the State Children's Health Insurance Program

Pursuant to 42 CFR § 457.320(a), income eligibility standards are established by the State and must be included in the State plan. Generally, the income thresholds vary based on eligibility category and the number of family members in the household. The Florida SCHIP plan states that a child residing in a household having a family income at or below 200 percent of the FPL is eligible for Florida KidCare.

Federal regulations (42 CFR § 435.907(a)) for Medicaid require a written application from each applicant. 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. The State must include in each applicant's case file facts to support the State's decision (42 CFR § 435.913(a)). Federal SCHIP regulations (42 CFR § 457.35(a)) and the State plan require the State to use screening procedures to ensure that only targeted low-income children are furnished health assistance. If the children are potentially eligible for Medicaid, the State must facilitate application to Medicaid. Otherwise, the State must screen the children for SCHIP eligibility.

Of the 200 sampled payments, 47 payments totaling \$1,918 (Federal share) were made on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations.

For 39 payments totaling \$1,567 (Federal share), the beneficiaries' family incomes exceeded the SCHIP income threshold on the dates of service. We made this determination through reviews of case file documentation and independent verification by data matching with the State IEVS.

For the remaining eight payments totaling \$351 (Federal share), the beneficiaries were enrolled in Medicaid at the time of the SCHIP payment. The State agency made these erroneous payments because it did not have procedures for promptly disenrolling individuals from SCHIP once they became Medicaid-eligible. After our audit period, FHKC took steps to minimize the incidence of duplicate enrollment.

Beneficiaries Eligible for Medicaid

Federal regulations (42 CFR § 457.350(a)(2)) require the State to ensure that all SCHIP applicants are screened for Medicaid eligibility and to facilitate Medicaid enrollment for those found potentially eligible. The State plan requires that Florida KidCare applicants be ineligible for Medicaid.

Of the 200 sampled payments, 2 payments totaling \$16 (Federal share) were made on behalf of beneficiaries who were eligible for Medicaid and thus improperly enrolled in SCHIP. The State agency made these erroneous payments because a computer system error in late 2004 prevented the State agency from canceling SCHIP coverage for anyone, including those who voluntarily attempted to cancel their SCHIP coverage when they became eligible for Medicaid. The error allowed people who should have been adjudicated as ineligible for SCHIP to remain on the program until their eligibility was redetermined in 2005. The error was corrected when FHKC made those eligibility redeterminations.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

Federal regulations (42 CFR § 457.340(a)) require a completed application from each SCHIP applicant. The State plan requires the family to submit an application to Florida KidCare, along with documentation of income. Pursuant to 42 CFR § 457.965, the State must include in each SCHIP applicant's record facts to support the State's determination of eligibility for the program. In addition, 42 CFR § 457.320(e) requires that eligibility be redetermined at least every 12 months.

The case files for 22 sampled payments totaling \$591 (Federal share) were missing or did not contain all documentation needed to support eligibility determinations. The missing documentation included at least one of the following: an application covering the date of service, a signature on the application, and facts supporting income level. We were not able to make a definitive determination with respect to the eligibility of these individuals.

CONCLUSION

Of the 200 SCHIP payments in our statistical sample, 49 payments did not comply with Federal and State eligibility requirements. In addition, the State agency made 22 payments on behalf of beneficiaries whose case files did not contain all documentation supporting eligibility determinations as required by Federal or State requirements.

For our 6-month audit period, we estimate that the State agency made between 519,508 and 797,411 payments totaling between \$18,776,786 and \$32,583,603 (Federal share) on behalf of ineligible beneficiaries. The midpoint amounted to 650,815 payments totaling \$25,680,194.

We also estimate that case file documentation did not adequately support eligibility determinations for an additional 200,967 to 407,319 payments totaling between \$4,130,356 and \$11,568,962 (Federal share). The midpoint amounted to 292,203 payments totaling \$7,849,659. (See Appendix C for the details of our sample results and projections.)

RECOMMENDATIONS

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State SCHIP eligibility requirements by:

- reemphasizing to FHKC employees the need to adequately verify eligibility information,
- minimizing the time period between determination of Medicaid eligibility and disenrollment of the applicant from SCHIP, and
- reemphasizing to FHKC employees the need to maintain appropriate documentation in all case files.

We also recommend that the State agency work with CMS to resolve the estimated improper payments of at least \$18,776,786 identified in our review.

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

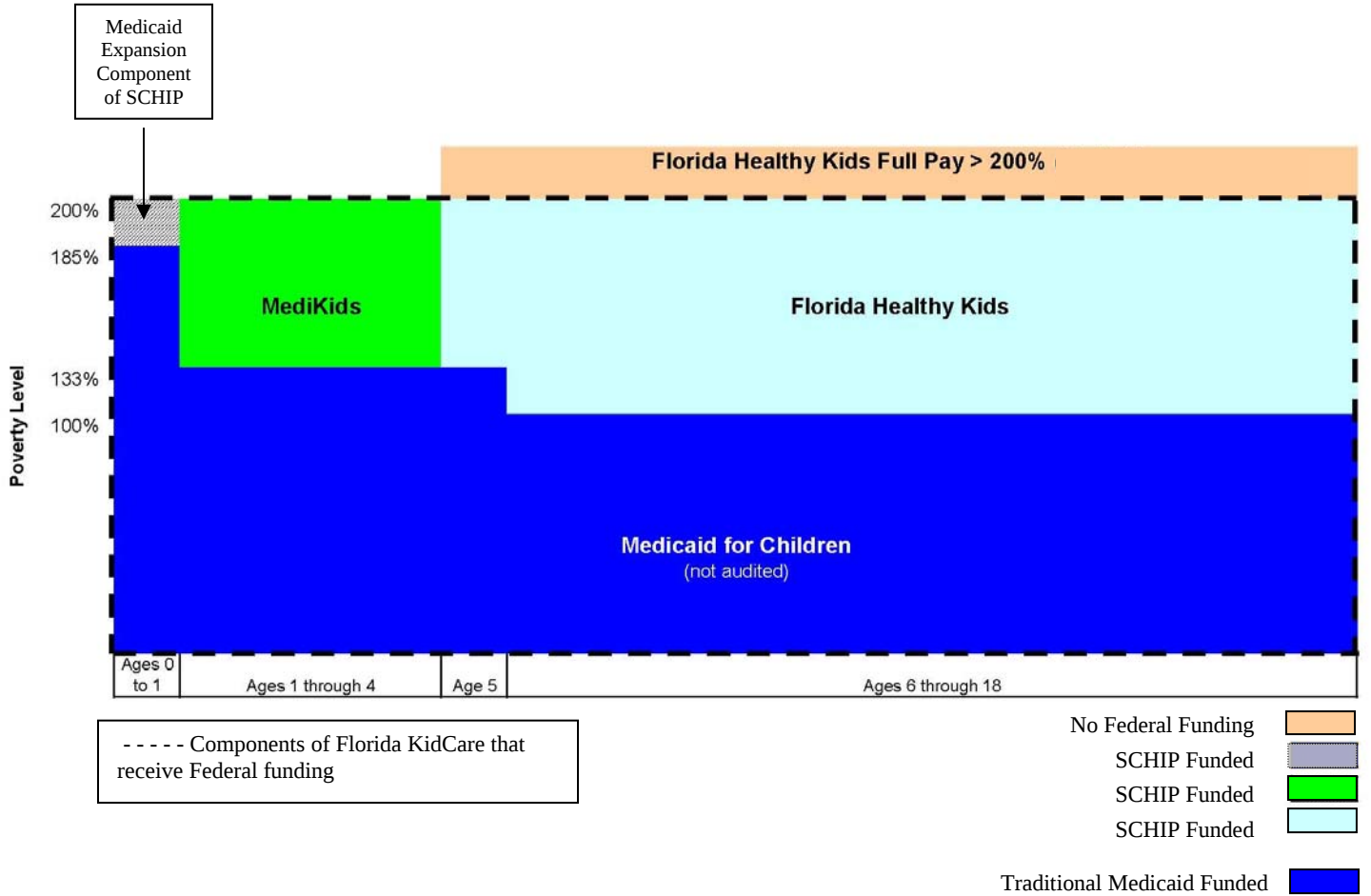
We received comments to our draft report from both FHKC and the State agency. Neither agency specifically addressed our recommendations. However, neither agency disagreed with our findings. The State agency noted its concern with our findings and stated that it will closely monitor FHKC. Both agencies emphasized the extraordinary issues in Florida during the audit period and described steps they have taken to improve the accuracy of their eligibility determinations. The State agency said that “[a] subsequent mid-year internal audit recently showed a 99% compliance rate, so improvements have been made.”

FHKC further noted that it was proactively pursuing data matches with as many partners as possible. We consider these actions to be one positive response to our first recommendation and a step that will likely lead to a reduction in payments to ineligible beneficiaries in the future. For example, FHKC will be able to perform a data match with the IEVS to identify ineligible individuals as we did in our audit.

Neither agency presented any information that would cause us to change our recommendations. The complete text of the State agency’s and FHKC’s comments is included as Appendix D.

APPENDIXES

COMPONENTS OF FLORIDA KIDCARE



SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine the extent to which the Florida Agency for Health Care Administration made State Children's Health Insurance Program (SCHIP) payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

POPULATION

The population was all payments for services rendered to SCHIP beneficiaries in Florida during the 6-month period that ended June 30, 2005.

SAMPLING FRAME

The sampling frame was a computer file containing 2,656,388 payments for services rendered to SCHIP beneficiaries in Florida during the 6-month period that ended June 30, 2005. The total SCHIP reimbursement for the 2,656,388 payments was \$161,735,081. The SCHIP payments were extracted from three sources: the Florida Department of Health payment system, the Medicaid Management Information System fiscal agent, and the Florida Healthy Kids Corporation. These payments included adjustments made to claims as of September 30, 2005.

SAMPLE UNIT

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

SAMPLE DESIGN

We used a simple random sample to evaluate SCHIP eligibility.

SAMPLE SIZE

We selected a sample size of 200 SCHIP payments.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services Statistical Sampling software dated June 2005. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame and selected the random numbers that correlated to the sequential numbers assigned to the claims in the sampling frame. We then created a list of 200 sampled items.

CHARACTERISTICS TO BE MEASURED

We based our determination regarding the allowability of each sample payment on Federal and State laws, Federal 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 SCHIP.
- The beneficiary was enrolled in SCHIP but was eligible for Medicaid.

We also determined whether case files contained sufficient documentation to support the eligibility determination as required by Federal regulations.

ESTIMATION METHODOLOGY

We used both the Office of Audit Services attribute and variable appraisal programs in RAT-STATS to appraise the sample results.

We used the attribute appraisal program to estimate the total number of payments made for SCHIP beneficiaries who did not meet eligibility requirements and the total number of payments for which documentation did not support eligibility determinations. We also used the variable appraisal program to estimate the total amount of Federal payments made for ineligible SCHIP beneficiaries and the total amount of Federal payments for which documentation did not support eligibility determinations.

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SAMPLE RESULTS AND PROJECTIONS

ELIGIBILITY ERRORS

The results of our review of the 200 Federal SCHIP payments were as follows:

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Payments	Value of Improper Payments (Federal Share)
2,656,388	\$161,735,081	200	\$8,962	49	\$1,934

Projection of Sample Results
Precision at the 90-Percent Confidence Level

	Attribute Appraisal	Variable Appraisal (Federal Share)
Midpoint	650,815	\$25,680,194
Lower limit	519,508	18,776,786
Upper limit	797,411	32,583,603

INSUFFICIENT DOCUMENTATION

The results of our review of the 200 Federal SCHIP payments were as follows:

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Payments with Insufficient Documentation	Value of Payments with Insufficient Documentation (Federal Share)
2,656,388	\$161,735,081	200	\$8,962	22	\$591

Projection of Sample Results
Precision at the 90-Percent Confidence Level

	Attribute <u>Appraisal</u>	Variable Appraisal <u>(Federal Share)</u>
Midpoint	292,203	\$7,849,659
Lower limit	200,967	4,130,356
Upper limit	407,319	11,568,962



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April 11, 2007

Pete Barbera
Regional Inspector General
61 Forsyth Street SW
Suite 3T41
Atlanta, Georgia 30303-8909

RE: Review of State Children's Health Insurance Program Eligibility in Florida

Dear Mr. Barbera:

Thank you for sending the Florida Healthy Kids Corporation (FHKC) a copy of the draft report of the Office of the Inspector General's (OIG) Review of State Children's Health Insurance Program Eligibility in Florida.

We appreciate this opportunity to elaborate on the issues that FHKC faced during the period that was chosen to be audited. These issues, which included four major hurricanes, significant changes in state law, Executive Orders from the Governor's office to postpone account cancellations, and the first open enrollment period in eighteen months, were in no way "routine" or "normal." This rare combination of natural disasters, legislative mandates, and program demand is likely to have led to a disproportionate number of conditions that contributed to the OIG's findings.

It is regrettable that Florida was selected to be part of the sample for this review, in light of the challenges that we faced. We have provided explanatory information regarding three of the major contributors to the OIG's findings.

The primary factor leading to your finding of "Beneficiaries Ineligible for SCHIP" was the fact that FHKC had limited time and resources available to respond to a December 2004 change in state law. At that time, the legislature revised the quantity of documents that families were required to submit as part of the income verification process. Whereas families were previously required to submit three documents (paystubs, W2 forms, and tax returns), the legislative change reduced the documentation requirement to one form. FHKC had an extremely compressed time frame within which to design, test and implement changes to the eligibility determination process to accommodate the new law. The resource strain on FHKC included Florida's continued recovery efforts from four major hurricanes and the need to ramp up for a demanding thirty day open enrollment period in January 2005. In response, FHKC decided to accept documentation

presented by families without our customary scrutiny, pending a thorough review at the families' next review period in six months.

Another situation cited as contributing to the finding of "Beneficiaries Ineligible for SCHIP" involved the fact that four applicants whose renewal dates were August 1, 2004, did not have redeterminations at the required six month interval. We understand that enrollees with August 1, 2004, renewal dates were subject to the new law. However, the law was signed in May 2004, resulting in an extremely contracted period of development time to implement the renewal process. As a result of this abbreviated time frame, there was not sufficient advance notice to send these enrollees their renewal notices, which must be mailed at least 60 days prior to the renewal date. By beginning with the September 1 renewal cycle, notices could be generated on July 1, 2004, providing the enrollees the prescribed amount of time to obtain and submit the necessary documentation.

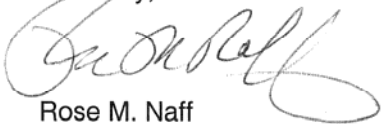
For four other accounts, the eligibility decision made by FHKC corresponded to the documentation that had been presented. However, the OIG had access to data matching information that was contradictory. Although data matching is not required in Florida's state plan, FHKC is proactively pursuing data matches with as many partners as possible. Until data matching can be incorporated into our business processes, we request that the OIG accept determinations that were made based on the documentation presented by families.

We are extremely pleased that the profusion of remediation efforts we have made has paid off in a sharply reduced error rate over the past two years. In the most recent audit, 99% of participants were noted to have the right program and the right premium. In addition, we scrupulously reviewed all of our policies and procedures, and we conducted a procurement process that led to the selection of a new Third Party Administrator. The procurement process focused on the TPA's quality assurance measures, controls, and previous experience with SCHIP programs.

Thank you again for the opportunity to comment.

If you have any questions or need additional information, please feel free to contact Fred Knapp at 850-701-6113.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rose M. Naff", written in black ink.

Rose M. Naff
Executive Director

RMN/fjk



CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

April 18, 2007

Peter Barbera
Regional Inspector General
61 Forsyth Street SW
Suite 3T41
Atlanta, Georgia 30303-8909

Dear Mr. Barbera:

Thank you for the opportunity to respond to the draft report by the Florida Office of Inspector General, Review of State Children's Health Insurance Program Eligibility. We are also in receipt of Florida Healthy Kids Corporation's response to this report.

Florida Healthy Kids Corporation is the entity designated by state statute as responsible for eligibility determinations for Florida's State Children's Health Insurance Program. The Agency for Health Care Administration is the lead agency for compliance with state and federal regulations; therefore we are acutely concerned with the findings of this report.

We concur with Florida Healthy Kids Corporation's response that the period of this review, January 1, 2005, through June 30, 2005, was not normal and does not represent normal eligibility processing. As Florida Healthy Kids Corporation described, this period of time reflects the consequences of a combination of natural disasters, significant changes in state law and the first open enrollment period in 18 months. Open enrollment occurred January 1, 2005, through January 30, 2005, and a record number of applicants applied during this time. All of these changes required significant programming, and as described by Florida Healthy Kids Corporation, there was not sufficient advance notice to implement the legislatively mandated documentation and redetermination changes within the prescribed time-frame.

Additional eligibility determination monitoring reviews have been conducted during the past year. The Agency conducted three eligibility monitoring reviews during 2006, focusing on eligibility determinations for active accounts, rejected accounts and the MediKids Full Pay component. Florida Healthy Kids Corporation also had an eligibility determination review conducted as part of their annual internal audit. Their findings showed a 10% error rate for fiscal year 2005/2006. A subsequent mid-year internal audit recently showed a 99% compliance rate, so improvements have been made.

The Agency is concerned about the Inspector General's reported findings and will continue to closely monitor Florida Healthy Kids Corporation and the monitoring of their third party administrator.

Peter Barbera
April 18, 2007
Page Two

Again, thank you for the opportunity to respond to your review.

Sincerely,

Thomas W. Arnold
Deputy Secretary for Medicaid

TWA/gh