

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**AUDIT OF MEDICAID CLAIMS AT THE
DEPARTMENT OF
HEALTH CARE FINANCE**



**CHARLES J. WILLOUGHBY
INSPECTOR GENERAL**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



February 16, 2012

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D.C. Department of Health Care Finance
899 North Capital Street, N.E., Suite 500
Washington, D.C. 20001

David A. Berns, M.P.A.
Director
Department of Human Services
64 New York Avenue, N.E., 6th Floor
Washington, D.C. 20002

Dear Mr. Turnage and Mr. Berns:

Enclosed is the final report summarizing the results of the Office of the Inspector General's (OIG) *Audit of Medicaid Claims at the Department of Health Care Finance* (OIG No. 09-2-29HF). The audit was included in the OIG's Fiscal Year 2009 Audit and Inspection Plan.

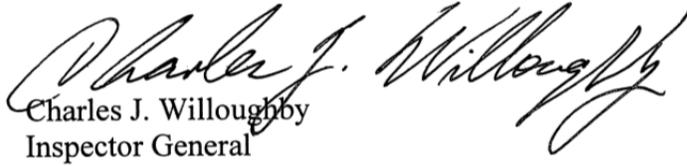
As a result of our audit, we directed four recommendations to the Department of Health Care Finance (DHCF) and one recommendation to the Department of Human Services, Income Maintenance Administration (DHS IMA) for action we consider necessary to correct identified deficiencies. The DHCF provided a written response to a draft of this report on November 30, 2011, and DHS IMA provided a written response to a draft of this report on November 4, 2011.

We reviewed the responses and determined actions planned and taken meet the intent of our recommendations. In addition, auditors will provide files to DHCF to determine whether a portion of claims identified during this audit and discussed in this report can be recouped. Also, we will provide DHS IMA a file of recipients with questionable SSNs to determine legitimacy of eligibility. Accordingly, we request that DHS IMA provide us a status report of recoupment and eligibility determinations within 60 days of the date of this report. The full text of the DHCF response is included at Exhibit B and DHS IMA's response is at Exhibit C.

Mr. Turnage and Mr. Berns
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We appreciate the cooperation and courtesies extended to our staff by DHCF and DHS IMA personnel. If you have any questions, please contact me or Ron King, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,


Charles J. Willoughby
Inspector General

Enclosure

CJW/wg

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AUDIT OF MEDICAID CLAIMS AT THE DEPARTMENT OF HEALTH CARE FINANCE

ACRONYMS

ACEDS	Automated Client Eligibility Determination System
ACS	Affiliated Computer Services
CFO	Chief Financial Officer
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
DHCF	Department of Health Care Finance
District	District of Columbia
DOD	Date of Death
DOH	Department of Health
DHS	Department of Human Services
DOS	Date of Service
FFP	Federal Financial Participation
FMAP	Federal Medicaid Assistance Percentage
FY	Fiscal Year
HCOA	Health Care Operation Administration
HHS OIG	Department of Health and Human Services Office of Inspector General
IMA	Income Maintenance Administration
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
MMIS II	Medicaid Management Information System/aka Omnicaid
OCFO	Office of the Chief Financial Officer
OIG	Office of the Inspector General
SSA	Social Security Administration
SSN	Social Security Number
State Plan	Medicaid State Plan

**AUDIT OF MEDICAID CLAIMS AT THE
DEPARTMENT OF HEALTH CARE FINANCE**

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EXECUTIVE DIGEST

OVERVIEW

Enclosed is the final report summarizing the results of the Office of the Inspector General's (OIG) Audit of Medicaid Claims at the Department of Health Care Finance (DHCF). The audit was included in the OIG's Fiscal Year 2009 Audit and Inspection Plan.

The objective of the audit was to determine the effectiveness of the DHCF process for approving Medicaid claims for payment. This audit is one of several Medicaid Program audits that we will perform on an ongoing basis, due in part to Management Reports issued in conjunction with the Comprehensive Annual Financial Report, which identified Medicaid as a major risk area.

CONCLUSIONS

During the course of the audit, we identified about \$3.8 million in potentially erroneous Medicaid payments during fiscal year (FY) 2009. These payments may have been issued erroneously because the corresponding claims: cited service dates after a Medicaid recipient's date of death; were paid for recipients who had questionable social security numbers (SSNs); or were paid at amounts higher than those billed.

These conditions occurred because DHCF: (1) did not use edits within the Medicaid Management Information System to deny claims where the service date occurred after the recipient's death; (2) relied on the Department of Human Services Income Maintenance Administration (DHS IMA) to ensure that applicants for Medicaid coverage met Medicaid enrollment and update requirements; and (3) did not have procedures in place to require supervisory reviews for Medicaid claims that required manual intervention for payment.

As a result, DHCF could not be assured that Medicaid claims paid under these conditions were valid and should have been paid. Additionally, the District may be liable to repay the federal share of invalid payments because the payments were made with both federal and District funds.

SUMMARY OF RECOMMENDATIONS

We directed four recommendations to DHCF. The recommendations focused on:

- Ensuring controls are established to prevent payment of claims to Medicaid recipients with service dates after the recipient's date of death.
- Establishing procedures to ensure that DHCF staff reviews Medicaid payments before payments are distributed to healthcare providers.

EXECUTIVE DIGEST

- Recouping \$662,934 paid after the recipients' dates of death and \$47,324 paid in excess of the amount billed as identified in this report.
- Assessing the claims associated with our listing of \$22.6 million in low-dollar claims paid in excess of amounts billed, determining whether there is a cost-effective process to identify invalid claims, and, if so, recoup excess payments.

We directed one recommendation to the DHS IMA. The recommendation focused on:

- Ensuring that controls are established to verify SSNs with the Social Security Administration during the eligibility and recertification process to improve the likelihood that Medicaid services are provided to only bonafide residents of the District.

MANAGEMENT RESPONSE

The Director of DHCF and the Director of the DHS's IMA provided written responses to the draft of this report dated November 30 and November 4, 2011, respectively. According to the responses, DHCF officials generally agreed with the report's findings and will review the claims our report identified as reimbursement for services paid after patients' date of death and paid in excess of the billed amounts to determine the appropriateness of those payments. DHS IMA officials also indicated that they would have to review the cases we identified as claims not containing SSNs to comment on whether they met allowable exceptions. Both DHCF and DHS's IMA also believe current operating procedures should prevent many of the issues we identified from occurring in the future. Specifically, DHCF cited controls contained in the new MMIS system Omnicaid and DHS's IMA issued a series of memorandums between April 2010 and July 2011 to improve the process for certifying citizenship and specifying the appropriate time period allowable for SSNs to be acquired and presented after Medicaid coverage has commenced. The full text of the DHCF response is included at Exhibit B and that of DHS IMA at Exhibit C.

OIG COMMENT

We consider actions taken and planned by DHCF and DHS IMA to meet the intent of the recommendations. With this final report, we will provide DHCF and DHS IMA the excel files containing the exceptions identified in the report for their recoupment review. We request that each agency provide a response with the outcome of these reviews within 60 days of the date of this report.

A summary of the potential benefits resulting from the audit is shown at Exhibit A.

INTRODUCTION

BACKGROUND

The Department of Health Care Finance (DHCF),¹ a newly created agency in fiscal year (FY) 2009, provides healthcare services to low-income children, adults, the elderly, and persons with disabilities. DHCF is also the District of Columbia's designated state Medicaid agency. The mission of DHCF is to improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia.

Over 192,000 District of Columbia residents receive healthcare services through DHCF's Medicaid and Alliance programs. DHCF processed more than 10 million claims in FY 2009 for reimbursement of services rendered by Medicaid providers. In FY 2009, DHCF payments for these claims represented more than \$2 billion.

Under DHCF, the Health Care Operation Administration (HCOA) is responsible for administering programs relating to claims payment, managed care organizations (MCOs), the fiscal agent contract, administrative contracts, and systems and provider enrollment requirements. HCOA also manages the Medicaid Management Information System (MMIS), recipient out-of-pocket reimbursement, Consolidated Omnibus Reconciliation Act (COBRA)² insurance payments, and financial transactions.

DHCF's FY 2010 performance plan included two program improvement initiatives related to improving claims processing including: (1) focusing on prevention efforts related to provider fraud and abuse through a number of changes to its provider enrollment process and claims payment system, which will deny payments up front and prevent the occurrence of fraud; and (2) increasing the timeliness and accuracy of payments to providers through implementation of the new MMIS.

Relationship Between State and Federal Medicaid. Title XIX of the Social Security Act, codified as amended at 42 U.S.C.S. §§ 1396 – 1396w-5 (Westlaw) (the Act), authorizes federal funding to states with federally approved state plans, to provide medical assistance to needy and disabled persons. This program is called Medicaid and, at the federal level, is administered by the Department of Health and Human Services through the Centers for Medicare and Medicaid Services (CMS). Through a designated State agency, each state administers its Medicaid program in accordance with a state plan approved by CMS.

¹ DHCF was formerly the Medical Assistance Administration within the Department of Health.

² This legislation included a provision to allow terminated employees to purchase their own health insurance at group rates.

INTRODUCTION

According to Section 1901 of the Act, states may receive approval to receive federal reimbursement or Federal Financial Participation (FFP) and participate in furnishing medical assistance to families with dependent children and aged, blind, or disabled individuals with low incomes. Also, rehabilitation and other services are authorized to help such families and individuals attain or retain capability for independence. The rate of FFP that a state receives for medical assistance expenditures is called the Federal Medical Assistance Percentage (FMAP), and generally ranges from 50 to 83 percent of the cost of medical assistance, depending on the state's per capita income and other factors. Generally, the FMAP for the District of Columbia is 70 percent.

Medicaid Management Information System. DHCF contracted with Affiliated Computer Services (ACS), which operated the MMIS to process Medicaid claims. Effective December 21, 2009, DHCF began using an upgraded MMIS, Omnicaid. Omnicaid was included in a new MMIS web portal and a stand-alone website for DHCF, apart from its MMIS legacy system located within the Department of Health (DOH). Phase One of the web portal went live in August 2008 and focused on posting general D.C. Medicaid information such as provider bulletins, billing tips, and usage policy. Commencing in January 2010, Phase Two focused on provider enrollment to allow a nearly paperless alternative for providers to re-enroll in the Medicaid program.

OIG Medicaid Audits. The District of Columbia's Office of the Inspector General (OIG) is committed to evaluating Medicaid controls and testing transactions to assure compliance with Medicaid provisions and identify ways to minimize program costs for the District. In the last two years, the OIG performed a comprehensive Medicaid research project to gain a thorough understanding of the various aspects of this program.

During the last few years, the District's Medicaid Program has undergone major changes such as establishing the newly created DHCF, upgrading the MMIS system, and responding to changes in personnel and outside audits. These changes have created both opportunities and challenges. This report recognizes those changes and is one step toward establishing a framework for future audit work in the Medicaid area.

Our analysis of controls and testing of transactions for this audit was based on the MMIS legacy system existing in FY 2009. However, we believe the issues discussed in this report are relevant to the new MMIS-Omnicaid system and that DHCF should consider this report in that light. The intention of the OIG is to test controls in the new Medicaid-Omnicaid system during future audit cycles.

Other Reviews. Various audits in the District and other jurisdictions have been performed in recent years identifying issues with processing Medicaid claims where automated systems edits and manual claims payment adjustments resulted in overpaid or improperly paid claims.

INTRODUCTION

For example, the Department of Health and Human Services Office of Inspector General (HHS OIG) issued report number A-03-08-00208, *Review of Medicaid Management Information System Prepayment Edit in the District of Columbia* in June 2010. The audit found that the State agency's MMIS edit 103 did not properly identify "claims with possible conflicts and flag[] them for one of the three general dispositions: pay the claim, suspend the claim for further review, or deny the claim."³ The audit reviewed 116 matches with possible conflicts and identified 60 claims resulting in overpayments of \$742,856. The overpayments occurred because the MMIS was set to automatically pay the flagged claims without supervisory review.

In another audit of Medicaid claims processing, the Maryland Office of Legislative Audits in November 2009 found that four employees were able to deactivate or reactivate the Maryland MMIS II automated edit setting without supervisory review. There were no written justifications or approvals to document the changes. The Maryland audit determined that 532 employees had the ability to force payment of claim-failed edits through MMIS. These employees had "inquiry only" access, but were still allowed to pay suspended claims in MMIS II. The audit determined that these users were provided with updated access, which allowed them to force payment of claims that failed edits.

OBJECTIVES, SCOPE, AND METHODOLOGY

The OIG conducted this audit of non-public⁴ Medicaid claims at DHCF, as part of our continuous coverage of the District's Medicaid Program. The objective of the audit was to determine whether the DHCF process for approving Medicaid claims for payment was effective. The audit was conducted under OIG Project No. 09-2-29HF.

To accomplish our objectives, we obtained an understanding of DHCF's payment process by reviewing Medicaid documents as well as documented policies and procedures, and holding discussions with responsible staff at HCOA, the Income Management Administration (IMA), and Affiliated Computer Services (ACS). We reviewed the MMIS claims recipient profiles, claims, and data files. In order to obtain certain delivery records, we requested and received files from ACS.

We performed tests to determine the validity of paid claims and asked DHCF staff about claims we identified as questionable. Finally, we tested claims processed under the new MMIS system during a 1 month period to see whether the issues we identified under the old system recurred under the new MMIS system.

³ *Id.* at 1.

⁴ Non-public providers are healthcare providers from the private sector such as hospitals, physicians, and non-public nursing homes. Public providers are employees of the District who perform services that are covered and reimbursable through Medicaid.

INTRODUCTION

The scope of the audit covered Medicaid claims paid during FY 2009 for non-public providers only. In FY 2009, DHCF processed approximately \$2 billion in paid claims. Non-public claims approved for payment accounted for \$1.1 billion based on a data file requested from ACS. Non-public providers include entities such as dentists, hospitals, physicians, nursing homes, and durable medical equipment (DME) suppliers.

Our universe did not include public providers, MCOs, and pharmacies with claims for prescriptions. Public providers such as D.C. Public Schools and the Child and Family Services Agency have been reviewed in the past by DHCF, CMS, and the HHS OIG. MCO claims consisted of monthly premium payments to the MCOs. MCOs are responsible for approving and paying their providers' Medicaid claims. We omitted pharmacy claims because of pending changes concerning pricing, processing, and replacement of the pharmaceutical point-of-sales contractor. Pharmacy claims will be reviewed during a future audit.

We performed our audit on computer-processed data from the MMIS, from which we extracted claims that met predetermined criteria. Although we did not perform reliability assessments of the claims universe, we assessed the reliability of the extracted paid claims by verifying a portion of the claims with the Office of the Chief Financial Officer (OCFO) to ensure payments identified in MMIS were actually made, and with the IMA to ensure the accuracy of our findings with respect to SSNs and other eligibility data. We also used MMIS data for presenting background about the program but did not verify the accuracy of the data as a whole.

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

FINDINGS AND RECOMMENDATIONS

FINDING: REVIEWING INVALID CLAIMS
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SYNOPSIS

DHCF processed approximately \$3.8 million in potentially erroneous Medicaid payments to providers in FY 2009. These claims appeared erroneous because of the following issues: (1) service dates followed a Medicaid recipient's date of death; (2) services paid for recipients with questionable SSNs; or (3) claims paid at amounts greater than those billed. DHCF did not detect these issues because DHCF: (1) did not use available controls to prevent payment of provider claims for services performed after a Medicaid recipient's date of death; (2) relied on information from IMA for the acquisition and maintenance of SSN information; and (3) did not recognize that other selected claims were erroneously paid more than the amount billed.

These conditions occurred because DHCF did not use MMIS edits to deny claims for services occurring after a recipient's date of death; failed to recognize that missing or erroneous SSNs may be an indication that recipients supplied and IMA accepted invalid data to support applications for Medicaid eligibility; and lacked procedures to perform supervisory reviews of Medicaid claims that required manual intervention for payment. As a result, DHCF could not assure that claims paid under these conditions were valid submissions that warranted payment.

DISCUSSION

During our fieldwork, we requested HCOA to provide a file of Medicaid claims paid in FY 2009. From this population, we isolated non-public provider claims and performed analyses on various claim data elements. The population included doctors, hospitals, DME suppliers, nursing homes, and other private providers.

We tested five conditions in the population by matching data elements that should not occur simultaneously in a valid claim. For example, we analyzed the timely filing of claims. Medicaid State Plan regulations require a claim to be made within 180 days⁵ of the performance of the service or be denied. For in-state providers, a claim paid after 180 days of the service would be a potentially invalid claim.

Results from these matches identified potentially erroneous payments in three areas: (1) claims paid for recipients with service dates after the recipient's death; (2) claims paid without SSNs; and (3) claims paid for amounts in excess of the amount billed. The following section summarizes the results of our analysis of the three claims issues identified.

⁵ 365 days for out of state providers

FINDINGS AND RECOMMENDATIONS

Payments for Service After Recipient’s Date of Death. For 129 recipients, DHCF paid claims where the service dates occurred after the recipient’s date of death, totaling \$662,934. Table 1, below, shows a breakdown of the claims, amounts paid, and the time between the date of death and the date of service.

Table 1. FY 2009 Medicaid Payments Made for Recipients After Date of Death

Range of Payments	Number of Recipients	Total \$ of Payments	Average Payment	Claims Paid < 30 Days After Death	Claims Paid 31-180 Days After Death	Claims Paid 181-365 Days After Death	Claims Paid > 365 Days After Death (days)
>\$50,000	3	\$287,627	\$95,875	2	0	0	1 (3,237)
>\$10,001 <=\$50,000	14	\$246,179	\$17,584	13	0	0	1 (691)
>\$1,001 <=\$10,000	29	\$120,698	\$4,162	26	3	0	0
\$1-1,000	83	\$8,430	\$127	67	15	0	1 (2109)
TOTAL	129	\$662,934	N/A	108	18	0	3

We provided DHCF with a judgmental sample of 17 claims valued at \$304,374 to research and determine the reason for payment. DHCF provided responses indicating that 6 of the 17 claims (totaling \$220,022) were invalid and required recoupment. DHCF staff indicated that the remaining sampled claims required additional research to determine whether recoupment actions should be initiated; however, DHCF staff indicated that the remaining 11 sampled claims were questionable because dates of death may have been incorrect; the claims were capitation claims where services constitute daily charges for recipient maintenance but were not discontinued timely; and others were yet to be explained. In summary, if the dates of death are accurate, DHCF should recoup the full \$662,934.

MMIS receives date of death information (DOD) from the IMA Automated Client Eligibility Determination System (ACEDS). The ACEDS collects DOD information from various sources such as the Social Security Administration, hospitals, and health departments. MMIS had a “recipient date of death before last day of service” edit number 244 to automatically deny a claim submitted after a recipient’s date of death. Our review noted that DHCF did not use DOD information to test or verify Medicaid claims. According to DHCF officials, they did not consider reviewing or creating a periodic report comparing DOD information to paid claims because DHCF did not believe it was a high priority in validating claim information.

DHCF officials stated that claims paid after the date of death may be the result of data entry errors or untimely receipt of death notification. However, claims payment months or in some

FINDINGS AND RECOMMENDATIONS

cases, years after the date of death is an indicator of potential fraud. In our review, we found that one claim was processed as late as 8 years after the death.

Validity of Social Security Numbers. In FY 2009, DHCF paid \$2,459,657 in Medicaid claims for Medicaid recipients who had no SSN in the claim record and were not recipients whose eligibility did not require SSNs. Also, DHCF paid another \$659,168 in FY 2009 for Medicaid claims for 279 recipients who had invalid SSNs recorded in their Medicaid claim record. IMA provided DHCF with incorrect enrollment information and had no guidelines for providing SSNs after initial eligibility was granted. In addition, DHCF failed to conduct in-house reviews to determine the accuracy of SSN information. As a result, DHCF paid approximately \$3,118,825 in Medicaid claims for recipients with questionable Medicaid eligibility.

DHS IMA was the District entity responsible for collecting and reviewing identification, residency, and other supporting data to process District residents' applications for Medicaid eligibility. IMA staff keyed this information into ACEDS terminals, which in turn processed eligibility decisions and provided those decisions to MMIS, which mailed Medicaid identification cards to recipients and processed Medicaid payments. One part of the identification process was to obtain and record the applicant's SSN.

According to 42 CFR § 435.910(a), "[t]he agency [DHCF] must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs)." Further, 42 CFR § 435.910(e) states:

If an applicant cannot recall his SSN or has not been issued a SSN the agency must--

- (1) Assist the applicant in completing an application for a SSN;
- (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
- (3) Either send the application to SSA or if there is evidence that the applicant has previously been issued a SSN, request the SSA to furnish the number.

The agency also has a responsibility to check for SSNs during periodic redetermination of Medicaid eligibility. Title 42 CFR § 435.916(a) states, "The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months"

Title 42 CFR § 435.920(a) states that "[i]n re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families,

FINDINGS AND RECOMMENDATIONS

each family member's SSN.” Further, as provided at 42 CFR § 435.920(b), “[i]f the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of § 435.910.”

In addition, IMA’s Policy Manual Part IV: Non-Financial Eligibility Requirements states that: “applications must be accompanied by proof of each applicant’s SSN or proof that an SSN has been applied for.” SSNs are needed to verify the age, citizenship or alien status, and the true identity⁶ of the applicant.

We extracted a report, from our FY 2009 paid claims database, of paid claims with SSNs that were never issued according to the Social Security Administration and paid claims where the SSN data field was filled with zeros. We found that 55,441 claims in our non-public provider population valued at \$43,349,234 were paid for 4,569 recipients. Table 2, below, summarizes the results of that report.

Table 2. FY 2009 Medicaid Payments Made for Recipients With Absent or Invalid Social Security Number

SSN Range	Number of Claims	Claims Paid to This SSN Range	Average Value of Claim
000-00-0000	51,672	\$42,690,066	\$826
650 - 699-##-####	3,419	\$548,634	\$160
734 - 799-##-####	350	\$110,534	\$316
Total	55,441	\$43,349,234	N/A

The greatest portion of potentially erroneous paid claims resulted from claims where the SSN data element was populated with zeros. According to HCOA personnel, there are valid reasons why a recipient would not have an SSN, as in the case of small children whose guardians have not yet applied for SSNs; services provided to recipients described as a good cause;⁷ services delivered in life threatening emergencies; and care provided after an SSN application was submitted. We found that DHCF paid \$26,550,295 for children younger than 1 year of age; \$13,753,055 for emergency services or good cause services; and the balance of \$2,459,657 for others over 1 year-old. IMA had not established criteria as to when an SSN is required; however, a year after a child is born is sufficient time to obtain and report an SSN to secure full eligibility after previously receiving conditional Medicaid eligibility.

⁶ Identity, D.C. residency, income limit, and child/child caretaker/pregnancy/elderly eligibility are criteria measured to determine applicants’ qualification for Medicaid.

⁷ IMA policy allows Medicaid coverage where an applicant is having procedural issues such as securing an out-of-state birth certificate.

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We conducted further testing on the \$548,634 of FY 2009 claims paid with invalid SSNs to determine from the source documentation whether there were transcriptions or other data transfer errors that supported those numbers. We found no indication in the applications or other source documentation that the SSNs were incorrectly transcribed or erroneously recorded.

Even though the MMIS data files contained the recipient's SSN, ACS relies on the Medicaid number to pay the providers' claims for services. However, SSNs are used to verify an individual's identification and an incorrect SSN could indicate that an applicant intentionally provided the incorrect SSN to IMA intake personnel and, as a result, is not eligible for Medicaid coverage.

Provider Claims Paid in Excess of Billing. DHCF did not implement procedures to consistently review claims prior to making payments in excess of the billed amount. DHCF paid \$124 million during FY 2009 for Medicaid claims at amounts that exceeded billings by \$22.6 million. DHCF made these payments for 78,361 claims with the payments exceeding provider billings by amounts ranging between \$1 and \$139,739. We prepared a stratification of the universe of 78,361 FY 2009 claims paid more than billed to show the range of payment amounts that exceeded claim billings. See Table 3, below for the results of that stratification.

Table 3. FY 2009 Medicaid Claims Paid in Excess of the Original Amount Billed

Adjusted Payment	Claim Count	Payments in Excess of Billing	Average Adjustment Per Claim
>\$50,000	10	\$6,263,071	\$70,751*
\$30,001 - \$50,000	19	\$744,585	\$39,188
\$15,001 - \$30,000	38	\$785, 933	\$20,682
\$1,001 - \$15,000	3,913	\$11,035,381	\$2,820
\$1-\$1,000	74,381	\$9,351,889	\$125
TOTAL	78,361	\$28,180,859	N/A

*Excludes the check printed but not paid for \$5,555,555.

Sixty-seven of these payments exceeded billings by at least \$15,000 each. DHCF indicated that claims are paid at a value higher than billed for several reasons, such as a change in rates for claims paid between billing and rate-change periods. For example one claim was billed as a daily rate for Intermediate Care Facility services at \$132 per day for 15 days. By the time the bill was submitted the rate had risen to \$167.27 per day. The bill was paid at the higher rate for a total of \$2509.05 for the 15 day period.

Through a manual scan of these 67 payments, we identified two claims with significant variances for a more detailed review. One claim was billed at \$100 but paid at \$5.6 million and

FINDINGS AND RECOMMENDATIONS

the other billed at \$225 but paid at \$47,549. We asked HCOA to research these claims and they provided the following explanations. HCOA reported that the \$5.6 million payment was an error that passed through all but a final DHCF management check where it was identified and cancelled due to its unusually high dollar value. The other reviewed claim was erroneously paid at \$47,234. DHCF said recoupment efforts would be initiated to recover the overpayment. The errors were both caused by a keying error of a data resolution clerk.

We expanded our review by requesting research of 6 additional claims from the entire universe of claims paid more than billed. HCOA researched the 6 claims and found that 4 of the claims were properly adjusted based on billing data submitted with erroneous rate information. The two remaining claims were identified as having been properly paid. However, one claim's resolution was annotated as "hospice services"; and the other with the annotation ICF services. We don't know how those reasons justify the payments.

Table 4, below, details the results of DHCF's research into the underlying causes of a sample of payments in amounts greater than the provider billings.

Table 4. Sample of FY 2009 Medicaid Claims Paid in Excess of the Original Amount Billed

Claim Number	Billed Claim Amount	Paid Claim Amount	Result of HCOA Review
20914100804000212	\$157	\$173	Proper Adjustment
20907800807000932	\$89,893	\$165,658	Proper Adjustment
40914000901200099	\$1,980	\$2,509	Proper Adjustment
20921500806000179	\$13,404	\$14,385	Not Determined (ICF Services)
40915200914200093	\$1,119	\$27,169	Not Determined (Hospice Services)
20912500806000085	\$9,750	\$10,396	Proper Adjustment
00924300121000100	\$225	\$47,549	To Be Recouped
00829800809004300	\$100	\$5,555,555	Not Paid

With regard to the \$5.6 million check, HCOA explained that the provider initially submitted the claim for \$100, which was denied because the claim exceeded a filing deadline date. According to HCOA officials, the claim was sent to a clerk for manual resolution and the clerk inadvertently held down the "5" key long enough to create a \$5.6 million payment entry. After

FINDINGS AND RECOMMENDATIONS

this claim went through the data resolution process, a check was cut for \$5.6 million. However, the error was detected only when the DHCF Deputy Chief of Program Operations noticed a check with an unusually large payment amount in a batch of checks ready for distribution. This particular claim was not subjected to an ACS supervisory review and continued through the payment process until caught by the DHCF official.

Claims processing requires supervisory review when human intervention is needed to pay claims previously rejected. One resolution of a rejected claim is to have a claims resolution clerk force pay the claim. Supervision occurs when claims forced for payment are scrutinized by a quality control review. DHCF requested revisions to its processing oversight after the \$5.6 million payment was discovered. An exception report, called the “409 report,” was added which directed pending claims to a supervisor for review when the payment amount exceeded thresholds of \$100,000 per inpatient claim and \$200,000 per outpatient claim. This procedure was an effective first step toward addressing necessary supervisory reviews, but we believe the dollar thresholds that trigger reviews are too high.

Our review showed that \$20 million in claims paid in excess of the amounts billed were overpaid by amounts between \$1 and \$15,000 per claim. Those claims would not be reviewed under DHCF’s current thresholds. The review of every claim paid in excess of the amount billed might not be cost effective, but a periodic or other criteria-generated intermittent review should be conducted to ensure the validity of these claims and payments.

Internal Controls. During this audit and the Medicaid Research Project performed prior to this audit, we obtained extensive information from DHCF and ACS related to their systems of preventive and detective controls employed to ensure proper payment of District Medicaid claims. Preventive controls consisted of computer system edits to ensure correct payments to providers for claims submitted to MMIS both manually and electronically. Detection controls included exception reports provided to management for review to ensure claims are paid in compliance with federal and District laws and regulations.

In this report, we identified weaknesses in those controls to the extent of our test parameters. These weaknesses included the system’s ability to make payments for services performed after recipients have died, payments for recipients who have questionable eligibility, and payments in excess of amounts billed. The last of these three issues is of special concern because it occurs after manual adjustment of claims, which increases the possibility of human error. Future audits will focus on other aspects of the claims process and we will include a review of applicable internal controls.

Generally Accepted Government Auditing Standards (GAGAS) establish that internal control “comprises the plans, policies, methods, and procedures used to meet the organization’s mission, goals, and objectives. Internal control includes the processes and procedures for planning, organizing, directing, and controlling program operations, and management’s system

FINDINGS AND RECOMMENDATIONS

for measuring, reporting, and monitoring program performance.”⁸ Management is responsible for developing, implementing, and monitoring internal controls. Ultimately, internal controls provide reasonable, but not absolute assurance, that the organization’s goals will be achieved.

DHCF needs to improve oversight of the claims payment process to ensure that only valid claims are paid. Specifically, we noted that indicators, such as claims paid without SSNs (although not always a requirement of eligibility), should be reviewed, in conjunction with IMA, to ensure that recipients are otherwise eligible for coverage.

RECOMMENDATIONS

We recommend that the Director of DHCF:

1. Establish review procedures and employ automated edits within MMIS to prevent payment of claims with dates of service after recipients’ date of death.

DHCF RESPONSE

DHCF stated that DHCF implemented a new MMIS system Omnicaid in December 2010. Omnicaid contains edits that prevents the payment of claims for services rendered after a beneficiary’s date of death.

OIG COMMENTS

The actions taken with the implementation of the new Omnicaid claims processing system meet the intent of our recommendation. Controls in the new MMIS system will be tested during future audits.

We recommend that the Director of DHCF:

2. Recoup \$662,934 paid for services dated after the recipients’ dates of death and \$47,324 paid in excess of the amount billed as identified in this report.

DHCF RESPONSE

DHCF stated that they will review the sampled claims to determine if recoupment is appropriate. The auditors will provide a file of the \$662,934 in claims paid after recipients’ date of death for possible recoupment.

⁸ U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GOVERNMENT AUDITING STANDARDS 20, § 1.30, GAO-07-731G (2007 Rev.).

FINDINGS AND RECOMMENDATIONS

OIG COMMENTS

We consider the planned action to meet the intent of our recommendation.

We recommend that the Director of DHCF:

3. Establish procedures to ensure Medicaid payments are reviewed by DHCF staff before payments are distributed to healthcare providers for those claims that do not meet current thresholds of \$100,000 and \$200,000 for inpatient and outpatient claims, respectively.

DHCF RESPONSE

DHCF stated that the number of claims is so large that a prepayment review on all claims is not possible. DHCF currently targets specific areas for review that focus on situations that represent the greatest potential for improper payment, such as high volumes of service and high cost areas. DHCF also discussed post-payment screening tools to review provider billing and reimbursement patterns in an effort to identify the top billed procedure codes on a rolling 12 month basis. In addition, the new Omnicaid has a series of edits in place that serves as an electronic review of claims before payment. These actions inform the department's auditing schedule throughout the year.

OIG COMMENTS

We consider the added controls detailed by DHCF in the new Omnicaid sufficient to meet the intent of our recommendations.

We recommend that the Director of DHCF:

4. Assess the claims associated with our listing of \$22.6 million of claims paid in excess of billings that do not reach the current DHCF review threshold and implement a cost effective process to identify and recoup invalid claims payments within this grouping.

DHCF RESPONSE

DHCF officials indicated that until they had the opportunity to review the claims in question, they could not determine why the claims we found were paid more than the amount billed. They agreed to review the claims and determine whether there were overpayments.

FINDINGS AND RECOMMENDATIONS

OIG COMMENTS

We consider the planned action sufficient to meet the intent of our recommendation. The auditors will provide to DHCF a file of the \$22.6 million in claims paid in excess of billings for review and possible recoupment.

We recommend that the Director of DHS IMA:

5. Establish controls to ensure eligibility intake and recertification procedures include verification of SSNs with the SSA to prevent the acceptance of applications with invalid SSNs.

DHS's IMA RESPONSE

DHS's IMA stated that Medicaid rules prohibit denial of eligibility and delay in processing applications solely due to the absence of an SSN. Depending on when the SSN was submitted and reviewed, the absence of an SSN could be valid due to the 90-day "reasonable opportunity period" allowed for the applicant to provide a valid SSN. However, they agreed that a year is sufficient time to obtain a valid SSN. This issue is addressed in memoranda to DHS IMA staff dated September 3, 2010 and July 20, 2011, respectively. DHS's IMA also stated that with respect to SSNs, established criteria dictates that SSNs are not required at the time of application if good cause is shown. DHS IMA could not comment on the specific cases we identified because they did not have our file.

OIG COMMENTS

The action planned and taken by DHS's IMA meets the intent of our recommendation. The OIG commends the agency's increased efforts to establish Medicaid recipients' citizenship and obtain SSNs. The 90-day grace period afforded applicable recipients to obtain SSNs seems appropriate and should be made a part of the IMA Policy Manual. The memoranda cited are recent and drafted during our fieldwork. We will provide our analysis listings to DHS IMA for follow-up on the eligibility of those without SSNs.

OTHER MATTERS OF INTEREST

OTHER MATTERS OF INTEREST

During the period of this audit, we were informed of an unrelated issue within the responsibility of both DHCF and OCFO. This audit report provided us an opportunity to raise the issue of check receipt management at DHCF. In September 2010, the OIG's Medicaid Fraud Control Unit (MFCU) apprised the OIG Audit Division that the District had not negotiated three nationwide litigation settlement checks remitted to DHCF from providers, such as insurance companies, drug companies, and other types of providers.

The New York State MFCU (NY MFCU) is tasked with processing nationwide litigation settlements. The NY MFCU receives the proceeds, retains the federal share, and makes proportional distributions of states' shares to the respective state MFCUs, which in turn, forward the checks to the state Medicaid agencies. The NY MFCU informed the District MFCU that the District had not cashed two checks totaling \$1,996 in July 2010 and were concerned about the status of those checks.

After communication between the District MFCU, DHCF, and OCFO, the District MFCU asked the OIG Audit Division to review the issue.

OIG auditors met with OCFO officials, discussed management of checks at DHCF, and noted the following:

- DHCF receives numerous checks⁹ from not only MFCU but also third-party liability or estate checks and drug rebates from drug companies monthly.
- DHCF is aware of pending checks and can monitor the arrival of checks from lawsuit settlements and third-party liability/estate checks, but drug rebates are the responsibility of ACS because ACS is the source of information quantifying drug prescriptions filled and, as such, ACS provides usage data to the drug companies, which in turn, price the rebate and remit the checks. Although DHCF expects periodic drug rebates, DHCF is not involved in the process until the checks are received.
- OCFO staff stated that the checks in question totaling \$1,996 were slow in being deposited but were not misplaced. Further, OCFO staff stated that checks received from the MFCU are placed off-site and the checks in question were deposited in the bank on September 29, 2010. OCFO staff said the checks were deposited slowly because of end-of-the-year financial reports closing priorities.
- OCFO staff, however, has no written policies and procedures for check-receipt handling and DHCF has not performed monitoring at check-receipt locations.

⁹ We did not audit to determine the quantity or value of those checks.

OTHER MATTERS OF INTEREST

- We asked an OCFO official whether he considered the key internal controls needed to ensure that checks processed by OFCO on behalf of DHCF are safe and accounted for, and he said he had not identified key controls for check processing. He committed to providing us that information; however, as of the date of this report, we have not received documentation regarding this issue.

The OCFO needs to document and implement written policies and procedures with respect to check receipt processing and oversight for DHCF check receipts. Although the value of the MFCU checks was small, OCFO officials described check amounts received from other sources as significant and deserve management attention to ensure that these funds are protected and promptly placed under District financial control.

**EXHIBIT A: SUMMARY OF POTENTIAL BENEFITS
RESULTING FROM AUDIT**

Recommendations	Description of Benefit	Amount and Type of Benefit	Status¹⁰
1	Internal Controls and Economy and Efficiency. Requires DHCF to establish procedures to prevent payments of claims with service dates subsequent to recipients' date of death.	Non-Monetary	Closed
2	Economy and Efficiency. Requires DHCF to recoup invalid payments made after recipients' dates of death and those identified by review of claims paid in excess of the amount billed.	Monetary \$662,934 \$47,324	Open
3	Internal Controls. Establish procedures to ensure Medicaid payments are reviewed by DHCF staff before payments are distributed to healthcare providers.	Non-Monetary	Closed

¹⁰ This column provides the status of a recommendation as of the report date. For final reports, "**Open**" means management and the OIG are in agreement on the action to be taken, but action is not complete. "**Closed**" means management has advised that the action necessary to correct the condition is complete. If a completion date was not provided, the date of management's response is used. "**Unresolved**" means that management has neither agreed to take the recommended action nor proposed satisfactory alternative actions to correct the condition.

**EXHIBIT A: SUMMARY OF POTENTIAL BENEFITS
 RESULTING FROM AUDIT**

Recommendations	Description of Benefit	Amount and Type of Benefit	Status¹⁰
4	Economy and Efficiency. Requires DHCF to assess \$22.6 million in low-dollar claims paid with amounts in excess of billings and implement a cost-effective process to locate invalid claims for recoupment.	Monetary Up to \$22.6 million	Open
5	Internal Controls. Requires IMA to develop controls to ensure that eligibility intake and recertification include verification of SSNs with SSA.	Non-Monetary	Open

EXHIBIT B:
DHCF MANAGEMENT RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Director

November 30, 2011

Charles J. Willoughby
Inspector General
717 14th Street, N.W.
Fifth Floor
Washington, D.C. 20005

RE: OIG No. 09-2-29HF

Dear Mr. Willoughby:

This letter is in response to the draft report summarizing the District of Columbia Office of Inspector General's report *Audit of Medicaid Claims at the Department of Health Care Finance* (OIG No. 09-2-29HF). The recommendations are addressed in detail below:

1. Establish review of procedures and employ automated edits within MMIS to prevent payment of claims with dates of service after the recipients' date of death.

Response: DHCF implemented a new MMIS system, Omnicaid, in December 2010. Omnicaid contains edits that prevents the payment of claims for services rendered after a beneficiary's date of death.

2. Recoup \$622,934 paid for services dated after the recipients' dates of death and \$47,234 paid in excess of the amount billed as identified in this report.

Response: DHCF will review the sampled claims to determine if recoupment is appropriate.

3. Establish procedures to ensure Medicaid payments are reviewed by DHCF staff before payments are distributed to healthcare providers for those claims that do not meet current thresholds of \$100,000 and \$200,000 for inpatient and outpatient claims.

Response: As noted in the draft report, approximately \$1.1 billion in non-public provider claims were made in fiscal year 2009. Given the claims volume, it is not possible to conduct a pre-payment review on all claims. DHCF currently targets specific areas for review that focus on situations that represent the greatest potential for improper payment, such as

**EXHIBIT B:
DHCF MANAGEMENT RESPONSE**

Charles J. Willoughby
OIG 09-2-29HF
November 30, 2011
Page 2

high volume of services; high cost services (below established threshold levels); dramatic change in frequency of use; high risk problem-prone areas; and/or, areas where outside entities have alerted the department of issues or concern regarding questionable business practices and/or problematic delivery of care to recipients.

Post-payment screening tools are also used to review provider billing and reimbursement patterns in an effort to identify the top billed procedure codes on a rolling twelve months, top billing providers by type, specialty, and dollars billed, as well as looking at providers on a peer to peer basis to determine outliers that may warrant closer claims review prior to payment processing. In addition, the new MMIS has a series of edits in place that serve as an electronic review of claims before payment. These actions inform the department's auditing schedule throughout the year.

4. Assess the claims associated with our listing of \$22.6 million of claims paid in excess of billings that do not reach the current DHCF review threshold and implement a cost effective process to identify and recoup invalid claims payment within this grouping.

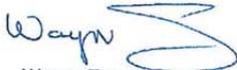
Response: It is not intuitively obvious why the MMIS would generate payments that exceeded the billed amount. DHCF will review claims in question to determine whether there was an overpayment. In the cases where an overpayment is confirmed, DHCF will recoup the payment.

Finally, I will reach out to the DHCF agency fiscal officer regarding the policies and procedures governing check processing.

DHCF is committed to ensuring that the District of Columbia Medicaid program is administered with quality and attention to program integrity. Thank you for the opportunity to respond to the draft report. Additionally, I apologize for the delayed response and I appreciate your willingness to allow for the extended response period.

If you have any questions regarding this letter, please do not hesitate to contact me or _____, Deputy Director – Finance, at 202-442-

Sincerely,


Wayne Turnage

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Income Maintenance Administration



November 4, 2011

Charles Willoughby
Inspector General
Office of the Inspector General

RE: DHS' Response to the Draft Report of OIG Audit of Medicaid Claims at the Department of Health Care Finance

Dear Inspector Willoughby:

Thank you for the opportunity to review and comment on the Draft Report of the OIG Audit of Medicaid Claims at the Department of Healthcare Finance. Outlined below are the agency's comments and recommendations relating to the report. As you will see in the response, DHS has addressed many of the concerns outlined in the report, as indicated in the enclosed Memoranda dated, September 3, 2010 and July 20, 2011. Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Deborah A. Carroll".

Deborah A. Carroll
Administrator

Enclosures

cc: David A. Berns, Director, Department of Human Services
Sakina Thompson, Interim Deputy Director, Department of Human Services
Wayne Turnage, Director, Department of Health Care Finance

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

DHS' Response to the Report of *OIG Audit of Medicaid Claims at the Department of Health Care Finance*

Page i-

OIG Report: "(2) relied on the Department of Health's Income Maintenance Administration..."

DHS Response: Should say, "(2) relied on the Department of Human Services' Income Maintenance Administration". ✓

Page ii -

OIG Report: "We directed one recommendation to the DOH's IMA."

DHS Response: Should say, "We directed one recommendation to the DHS' IMA." ✓

Page 6 –

OIG Report: "The ACEDS collects DOD information from various sources..., the Internal Revenue Service..."

DHS Response: Remove "Internal Revenue Service" from the above statement. ACEDS does ✓ not collect DOD information from the Internal Revenue Service.

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OIG Report: "Also, DHCF paid another \$659,168 in FY 2009 for Medicaid claims for 279 recipients who had invalid SSNs recorded in their Medicaid claim record. IMA provided DHCF incorrect enrollment information and had no guidelines for timely providing SSNs after initial eligibility was granted."

DHS Response: Medicaid rules prohibit denial of eligibility and delay of processing the application solely due to the absence of a social security number. Depending on when the application was submitted and was reviewed, the absence of an SSN could be valid due the 90-day reasonable opportunity period allowed for the applicant to provide a valid SSN (see, attached memorandum, dated July 20, 2011). However, we agree that one year is sufficient time to determine the valid social security number. This is addressed in the memoranda to staff, dated September 30, 2010 and July 20, 2011.

Additionally, IMA is subject to the Social Security Administration (SSA) timelines when providing SSNs to DHCF after initial eligibility is granted. This constraint is also recognized in IMA policy as indicated in Part IV, Chapter 3.1 of the IMA Policy Manual, wherein:

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

DHS' Response to the Report of *OIG Audit of Medicaid Claims at the Department of Health Care Finance*

“Applicants/recipients must:

- apply for a number (either because a number has not been issued or is not known) and furnish the number when it is received from SSA...”

Page 7-

OIG Report: DHS' IMA was the District entity responsible for collecting and reviewing identification, residency, and other supporting data to process District residents' applications for Medicaid eligibility. “IMA clerks keyed this information into ACEDS terminals...”

DHS Response: Should say, “IMA staff keyed this information into ACEDS terminals...”

While IMA does employ “clerks”, and there may be some clerks who can enter information into ACEDS, as a rule, information keyed into ACEDS relative to resident's applications for Medicaid eligibility is done by SSRs, Supervisors, etc. Clerk's responsibilities do not generally include the above stated function.

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OIG Report: “IMA had not established criteria as to when an SSN is required...”

DHS Response: IMA does have established criteria as to when an SSN is required. In accordance with IMA policy SSNs are required at the time of application unless good cause for not doing so is determined (see IMA Policy Manual Part IV, Chapter 3.1 at http://dhs.dc.gov/dhs/cwp/view,a,1345,q,604418,dhsNav_GID,1728,.asp).

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OIG Report: “Specifically, we noted that indicators, such as claims paid without SSNs..., should be reviewed, in conjunction with IMA, to ensure that recipients are otherwise eligible for coverage.”

DHS Response: DHS, IMA will respond to DHCF's invitation to collaborate on the development of a joint process that will facilitate a decrease in the claims paid for persons without SSNs.

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

**DHS' Response to the Report of *OIG Audit of Medicaid Claims at the Department of Health
Care Finance***

Page 12

OIG Report: RECOMMENDATIONS

"We recommend that the Director of IMA:

5. Establish controls to ensure eligibility intake and recertification procedures include verification of SSNs with the SSA to prevent the acceptance of applications with invalid SSNs"

DHS Response: IMA has existing eligibility intake and recertification controls and procedures that include verification of SSNs with SSA as indicated in the IMA Policy Manual Part IV, Chapter 3 (see excerpt below). If SSA does not verify citizenship and if after IMA finds no discrepancy or corrects a discrepancy with SSA, IMA sends the applicant a notice giving the applicant 90 days to provide documentation of ID and US citizenship. The applicant remains eligible for Medicaid during this period. If the applicant does not provide timely documentation, he/she is not eligible for Medicaid until they provide the necessary documentation (see, attached memorandum dated July 20, 2011). Moreover, without knowing which specific cases are being referenced, IMA has no way of knowing if the absence of the SSN in a particular case is valid due the 90 day reasonable opportunity period allowed for the applicant to provide a valid SSN. Further, it is a violation of IMA Policy "to prevent the acceptance of applications with invalid SSNs". As stated in Part IV, Chapter 3.4, of the IMA Policy Manual, *The SSR should not delay the issuance of benefits pending receipt of a number when application for an SSN has been verified.* However, as stated previously IMA has established system controls to address SSN verification.

VERIFICATION 3.4

All SSNs must be verified unless the person is exempt from the requirement. Once an applicant/recipient has furnished an SSN, the primary means of verification is by submission of the SSN to SSA for verification through the ACEDS system.

The SSR should not delay the issuance of benefits pending receipt of a number when application for an SSN has been verified.

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES



Income Maintenance Administration

MEMORANDUM

TO: All IMA Staff

FROM: Deborah A. Carroll 
Administrator

DATE: September 3, 2010

SUBJECT: New Citizenship Verification Procedures for Medicaid

This memorandum provides information and instructions regarding the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). **As a result of this law, IMA staff should stop requesting proof of citizenship at the point of application for Medicaid.**

CHIPRA authorized the Social Security Administration (SSA) to verify citizenship for Medicaid applicants and recipients who are recertifying for Medicaid. This makes it easier for many applicants and recipients to meet the requirement to verify citizenship in order to receive Medicaid. This memorandum supplements information provided in the April 8, 2010 memorandum regarding the changes made to ACEDS to allow IMA to obtain this information through computer matches.

VERIFYING CITIZENSHIP OF MEDICAID APPLICANTS

CHIPRA requires states to provide temporary Medicaid eligibility to U.S. citizens or nationals, who need time to obtain proof of their citizenship status.

- Act on applications for Medicaid without requesting or waiting for verification of U.S. citizenship. At the time the customer declares that he or she is a U.S. citizen or national and provides all other required information, IMA must make a decision on the applicant's eligibility.
- IMA will accept proof of citizenship if the applicant provides it.
- IMA will allow the applicant to declare citizenship and submit the applicant's identifying information to Social Security to verify his/her citizenship.
- IMA must follow-up to ensure that citizenship is verified within a reasonable opportunity period (see "Follow-up on Unmatched Cases" below.)

EXHIBIT C: DHS IMA MANAGEMENT RESPONSE

Memo to Staff Regarding New Citizenship Verification Procedures for Medicaid
September 3, 2010
Page 2

Example:

Ms. Lopez goes into her neighborhood service center to apply for Medical Assistance for herself and three children. She declares that she is a U.S National and her three children were born in New Jersey. She does not present a passport or birth certificates for herself or children at the time of application. IMA will use the demographic data match with SSA to confirm citizenship. Since Ms. Lopez provided all other verification needed to determine Medicaid eligibility, IMA will approve her case while waiting for the response from SSA regarding citizenship. IMA will not request proof of citizenship from the customer at the time of application as a condition of eligibility. IMA will not request the birth certificates using Form 1049.

VERIFYING CITIZENSHIP AT RECERTIFICATIONS

At recertification, ACEDS will submit demographic data to SSA for all recipients needing citizenship verification. IMA must follow-up, if the SSA data match does not confirm citizenship (see "Follow-up on Unmatched Cases" below.)

ELIGIBILITY OF DEEMED NEWBORNS

Under the new rules, children who are born in the U.S. to mothers who are receiving AR or AX benefits are known as "deemed newborns." They are "deemed" to have provided satisfactory proof of citizenship and identity (by just being born in the United States) and do not need to provide additional proof of citizenship at any subsequent Medicaid or CHIP eligibility determination or redetermination. This changes the previous rule, which said they did have to provide verification at the first recertification after they turned one year old.

Example:

Mrs. Woldemarian gets DC Medicaid for her 3-year-old son and herself. She now also has a 2-month-old daughter who was born at Howard University Hospital. She goes to her neighborhood service center to add her daughter to her Medicaid benefits. Mrs. Woldemarian does not have a birth certificate for her daughter yet. However, she did provide all other verifications to establish eligibility. The child is considered a "deemed newborn." She does not need to provide verification of her daughter's citizenship to add her to Medicaid, nor does she need to provide proof of citizenship at any future Medicaid or CHIP eligibility determination or redetermination.

EXHIBIT C: DHS IMA MANAGEMENT RESPONSE

Memo to Staff Regarding New Citizenship Verification Procedures for Medicaid
September 3, 2010
Page 3

RETROACTIVE MEDICAID

IMA is required to give retroactive benefits to any individual who was denied Medicaid or CHIP eligibility because of the requirement to document citizenship or nationality. Benefits may be given back to July 1, 2006, the effective date of the Medicaid citizenship verification requirements. If the individual is eligible, IMA must grant or restore eligibility back to the month of the original application or the month that the Medicaid was terminated because of the requirement. Please note that because IMA approved Medicaid while attempting to get citizenship verification from vital records, it is unlikely that IMA will need to provide retroactive benefits. Contact the IMA Policy Office if you find a case that may be entitled to retroactive benefits.

NEW VERIFICATION CODES FOR ETRC AND VIRE

There are two new verification codes for the citizenship field on the ETRC screen in ACEDS:

- “V6” is displayed by ACEDS when SSA has verified that an individual is a U.S. Citizen or National. This code is entered by ACEDS and cannot be deleted or changed by IMA staff.
- “V7” is entered by IMA staff to indicate that an applicant/recipient was requested to provide citizenship verification but the client failed to do so during the reasonable opportunity period. (See “Follow-Up on Unmatched Cases” below.)

The Vital Records (VIRE) screen now displays a VR code of “Z” to show that an individual is a U.S. citizen or national and that SSA has verified that information. This new code is entered by ACEDS only, and cannot be deleted or changed by IMA staff. Please refer to the attached memorandum of April 8, 2010 for examples.

THE SSA MATCHING PROCESS

- IMA submits a demographic record to SSA that includes each applicant’s name, Social Security Number, and Date of Birth (DOB). This occurs at the time an application is approved and when a recertification is registered.
- SSA will compare IMA’s record to SSA’s record and provide a response to every record submitted by IMA identifying whether citizenship is verified.
- If SSA verifies citizenship, ACEDS will update the ETRC and VIRE screen to display the appropriate verification codes.
- If there are data inconsistencies, SSA will report that they were unable to process the match due to missing or invalid data.

EXHIBIT C: DHS IMA MANAGEMENT RESPONSE

Memo to Staff Regarding New Citizenship Verification Procedures for Medicaid
September 3, 2010
Page 4

- IMA will review the SSA report, and the demographic data in ACEDS to detect the data that was submitted, make corrections as needed and resubmit the file to SSA if the ACEDS demographic record was changed.
- If the ACEDS demographic record appears to be correct and IMA did not get a match, ACEDS will generate a report listing the recipients whose citizenship was not verified.
- The report will be sent to the Division of Program Operations (DPO) for follow-up.

FOLLOW-UP ON UNMATCHED CASES

When the CHIPRA match does not result in citizenship verification, IMA will do follow-up according to these procedures:

- IMA must contact the recipient and give them a reasonable opportunity to provide the documentation of citizenship or nationality to IMA, which is 90 days from the date the recipient receives the request. To measure this 90-day period, three business days will be added from the date the notice is printed in ACEDS.
- At the time of request, the caseworker should enter "V7" as the citizenship verification code on the ETRC screen.
- If the customer does supply acceptable verification, staff will change the citizenship verification code to V1, V2, V3, or V4, as appropriate.
- If the verification is not received, IMA shall send a reminder notice to the recipient on the 45th day of the reasonable opportunity period.
- If the customer contacts the agency and is making a good-faith effort to obtain documentation, the reasonable opportunity period shall be extended for an additional 90 days.
- If the inconsistency has not been resolved or documentation of citizenship has not been provided after the reasonable opportunity period, IMA must terminate the individual's Medicaid after issuing timely and adequate notice.
- If IMA terminates a recipient's Medicaid eligibility for failure to provide citizenship verification, the agency must test the recipient's eligibility for Healthcare Alliance or the Immigrant Children Program (ICP) benefits.
- If documentation of citizenship is not received, enter "V7" on the ETRC screen.

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

Memo to Staff Regarding New Citizenship Verification Procedures for Medicaid
September 3, 2010
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IMPORTANCE OF ACCURATE IDENTIFYING INFORMATION IN ACEDS

IMA must report when it is unable to match over 3% of names submitted to SSA for citizenship confirmation. If IMA does not meet the required match rate, IMA may be penalized. For this reason, it is very important that we ensure we are submitting accurate information about the applicant's name, Social Security Number (SSN), and date of birth (DOB).

If you have any questions about these changes, you may contact _____
in the Policy Office by telephone at 698-_____ or by email at _____@dc.gov.

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES



Income Maintenance Administration

MEMORANDUM

TO: All IMA Staff

FROM: Deborah A. Cartoll
Administrator

DATE: April 8, 2010

SUBJECT: Changes in ACEDS Screens Verifying Citizenship

Due to recent changes in the law, the Social Security Administration (SSA) has joined us in helping to verify citizenship of persons eligible for Medicaid. The Income Maintenance Administration (IMA) has begun submitting records to SSA to confirm citizenship. If the citizenship is verified, ACEDS will be updated on the Vital Records (VIRE) and Race/Residency/Citizenship/Identity (ETRC) screens using new codes. The use of the new codes will take effect immediately.

The VIRE screen will now display a VR code of "Z" to show that an individual is a U.S. citizen or national and that SSA has verified that information. On the ETRC screen, a new verification (VR) code of "V6" will be displayed by ACEDS when SSA has verified that an individual is a U.S. citizen or national. The new codes will be entered by ACEDS only, and cannot be deleted or changed by IMA staff. Below are examples of both screens showing the new codes.

VIRE		VITAL RECORDS			033010 09:28	JODIE S
NAME	REL	BIRTH CERTIFICATE NO	PLACE OF BIRTH	MOTHER'S MAIDEN NAME	VR SENT	DATE OF DEATH
		FATHER'S NAME	MOTHER'S NAME		CLAIM NUMBER	
01 LISA J	PI	000-01-000010	DC	JUNE JOHNSON		Z
		JOHN JOHNSON				
02 NICOL J	CH	000-02-000009	DC	LISA JOHNSON		Z
		NOT LISTED				
03 GIANN J	CH	000-03-000008	DC	LISA JOHNSON		Z
		NOT LISTED				

645 H Street, N.E., 5th Floor, Washington, D.C. 20002 (202) 698-3900

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Memorandum on ACEDS Screen Changes
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ETRC RACE / RESIDENCY / CITIZENSHIP / IDENTITY 033010 09:28 JODIE S

CASE NAME: JOHNSON, LISA

CASE NUMBER: 0123450

NAME	REL	ETH	RACE	RES	VR	PEND	CIT	VR	PEND	ID	VR	PEND
01 JOHNS P	PI	NH	BL	Y	VR		US	V6		Y	VR	
02 JOHNS N	CH	NH	BL	Y	VR		US	V6		Y	VR	
03 JOHNS G	CH	NH	BL	Y	VR		US	V6		Y	VR	

You will receive a detailed memorandum later about how these changes will affect our process for verifying the citizenship of Medicaid applicants and recipients. If you have any questions about these codes, you may contact the ACEDS Help Desk at 698-4188.

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Income Maintenance Administration

MEMORANDUM



*copy
All*

TO: All IMA Staff
FROM: Deborah A. Carroll *DA*
Administrator
DATE: July 20, 2011
SUBJECT: ACEDS Changes Regarding Medicaid Citizenship Documentation Requirement

Effective immediately, ACEDS has added new codes to the Medicaid eligibility determination screens for persons who state they are US citizens but fail to provide needed documentation within ninety days.

Background

A person who applies for Medicaid and states that he/she is a US citizen simply has to provide a valid SSN at the point of application as documentation of citizenship. ACEDS sends the identifying information to the Social Security Administration. If SSA sends a return message that US citizenship has been confirmed, the citizenship documentation requirement has been satisfied. In these cases, ACEDS will update the verification code on the ETRC screen to "V6".

If SSA does not verify US citizenship, IMA first looks to see if there are discrepancies in the identifying information between IMA and SSA that might explain the failure. If discrepancies are found and corrected, the computer match with SSA is run again.

If no discrepancy is found, or a corrected discrepancy still does not result in SSA verifying citizenship, IMA staff must send a notice to the customer giving the recipient 90 days to provide documentation of ID and US citizenship. The recipient remains eligible for Medicaid during this period. If the recipient does not provide timely documentation, staff must enter the code "V7" on the ETRC screen. Such individuals are not eligible for Medicaid until they provide needed documentation of citizenship.

The new ACEDS coding on the eligibility determination screens ARED, AXED, and SRED will show that persons with code V7 on ETRC fail Medicaid eligibility.

**EXHIBIT C:
DHS IMA MANAGEMENT RESPONSE**

Memo to Staff Regarding ACEDS Changes Regarding Medicaid Citizenship Documentation
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New ACEDS Codes

- (1.) If an adult is coded 'IN' an AR or AX program and has a citizenship type of US and a V7 verification code the Citizenship Eligibility and Med Eligibility fields on ARED and AXED for that person will show '**FAIL**'. This means the individual is not eligible for Medicaid.
- (2.) If an adult is coded 'IN' an AR or AX program and does not have a V7 verification code and the only child in the case has a citizenship type of US and a V7 verification code the Med Eligibility field will display '**FCV7**' for the adult and '**P420**' for the child. The 'FCV7' code means the adult fails Medicaid eligibility because the only child is not Medicaid eligible. The 'P420' code means the child passes eligibility for the Immigrant Children Program only.
- (3.) If an adult is coded 'IN' the SR program and has a citizenship type of US and a V7 verification code the Citizenship Eligibility and Med Eligibility fields on SRED will display '**FAIL**'. If the customer is under age 65, an additional message will display at the bottom of the screen saying '**FAILED - CHECK FOR ALLIANCE ELIGIBILITY**'.

These new codes will assist staff in properly applying policy regarding citizenship. If you have questions regarding the citizenship verification policy for Medicaid, contact _____ in the Policy Unit at (202) 698-_____ or by e-mail at _____@dc.gov. If you have questions regarding the ACEDS codes, contact the ACEDS Help Desk at (202) 698-4188.