



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT - 5 2006

**TO:** Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Review of Medicaid Eligibility in New York State (A-02-05-01028)

Attached is an advance copy of our final report on Medicaid eligibility in New York State. We will issue this report to the New York State Department of Health (the State agency) within 5 business days.

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

Our objective was to determine the extent to which the State agency made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Our audit period covered January 1 through June 30, 2005, when the State agency made more than 52.7 million payments totaling \$10.7 billion (\$5.4 billion Federal share) on behalf of Medicaid beneficiaries.

The State agency (1) made some Medicaid 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, 16 payments totaling \$874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. Specifically, the State agency made:

- 12 payments on behalf of beneficiaries whose household incomes exceeded the Medicaid income threshold on the dates of service, who had not met the waiting period for certain qualified aliens, who had not reapplied for continued coverage, or who had not furnished their Social Security number;
- 2 payments on behalf of beneficiaries who had not met liability requirements; and

- 2 payments on behalf of beneficiaries who were eligible for Medicaid but not eligible for the specific services received.

In addition, for 58 sampled payments totaling \$10,699 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required. Each case file was missing at least one of the following: an application covering the date of service; a signature on the application; and facts supporting income level, fulfillment of beneficiary liability requirements, residence, date of birth, and citizenship status.

As a result, for the 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling \$230,375,748 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling \$2,820,569,979 (Federal share). We are not recommending recovery primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid eligibility quality control program.

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, the State agency should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require its district office employees to verify eligibility information and maintain appropriate documentation in all case files.

In its comments on our draft report, the State agency described some actions being taken to help ensure compliance with Federal and State Medicaid eligibility requirements. However, the State agency stated that we had equated the requirement to have "facts" in the file to support an eligibility determination with having independent documents that are not required by the Centers for Medicare & Medicaid Services (CMS). The State agency cited CMS guidance specifying that State agencies are not to redocument information already in agency files.

We agree that the State agency does not need to redocument existing eligibility information. However, for some sampled payments, we could not make eligibility determinations based on the information made available to us, despite our attempts to obtain information through other systems and sources. When we could not locate the necessary records, we categorized the cases as "insufficient documentation to support eligibility determinations," not as "eligibility errors."

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](mailto:George.Reeb@oig.hhs.gov) or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through e-mail at [James.Edert@oig.hhs.gov](mailto:James.Edert@oig.hhs.gov). Please refer to report number A-02-05-01028.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

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OCT 10 2006

Report number: A-02-05-01028

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
Commissioner  
New York State Department of Health  
Empire State Plaza  
Corning Tower, 14<sup>th</sup> Floor, Room 1408  
Albany, New York 12237

Dear Dr. Novello:

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

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

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

Please refer to report number A-02-05-01028 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "James P. Edert".

James P. Edert  
Regional Inspector General  
for Audit Services

Enclosures

**Direct Reply to HHS Action Official:**

Ms. Sue Kelly  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
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Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF  
MEDICAID ELIGIBILITY  
IN NEW YORK STATE**



Daniel R. Levinson  
Inspector General

October 2006  
A-02-05-01028

# ***Office of Inspector General***

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

## **OAS FINDINGS AND OPINIONS**

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



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

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

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

In New York State, the Department of Health (the State agency) administers the Medicaid program. The State agency's district offices determine the eligibility of applicants for Medicaid benefits. From January 1 through June 30, 2005, the State agency made more than 52.7 million payments totaling \$10.7 billion (\$5.4 billion Federal share) on behalf of Medicaid beneficiaries.<sup>1</sup>

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 Medicaid 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 Medicaid 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, 16 payments totaling \$874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. Specifically, the State agency made:

- 12 payments on behalf of beneficiaries whose household incomes exceeded the Medicaid income threshold on the dates of service, who had not met the waiting period for certain qualified aliens, who had not reapplied for continued coverage, or who had not furnished their Social Security number;

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<sup>1</sup>These numbers exclude payments for Medicaid beneficiaries who were automatically eligible for Medicaid because of their eligibility category and payments for the State Children's Health Insurance Program Medicaid expansion.



- 2 payments on behalf of beneficiaries who had not met liability requirements; and
- 2 payments on behalf of beneficiaries who were eligible for Medicaid but not eligible for the specific services received.

In addition, for 58 sampled payments totaling \$10,699 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required. Each case file was missing at least one of the following: an application covering the date of service; a signature on the application; and facts supporting income level, fulfillment of beneficiary liability requirements, residence, date of birth, and citizenship status.

As a result, for the 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling \$230,375,748 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling \$2,820,569,979 (Federal share). We are not recommending recovery primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program.

## **RECOMMENDATION**

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, the State agency should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require its district office employees to verify eligibility information and maintain appropriate documentation in all case files.

## **STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE**

In its comments on our draft report (Appendix C), the State agency described some actions being taken to help ensure compliance with Federal and State Medicaid eligibility requirements. However, the State agency stated that we had equated the requirement to have "facts" in the file to support an eligibility determination with having independent documents that are not required by CMS. The State agency cited CMS guidance specifying that State agencies are not to redocument information already in agency files.

We agree that the State agency does not need to redocument existing eligibility information. However, for some sampled payments, we could not make eligibility determinations based on the information made available to us, despite our attempts to obtain information through other systems and sources. When we could not locate the necessary records, we categorized the cases as "insufficient documentation to support eligibility determinations," not as "eligibility errors."

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## **INTRODUCTION**

### **BACKGROUND**

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

#### **The Medicaid Program**

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

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

#### **New York's Medicaid Program**

In New York State, the Department of Health (the State agency) is responsible for operating the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The State agency requires that individuals submit written applications for Medicaid benefits. The State agency district offices review the applications and determine whether the individuals meet Medicaid eligibility requirements. For each applicant determined eligible, the district office sends a letter informing the individual of his or her responsibility to notify the district office of any changes that might affect eligibility status. Each year thereafter, the district office must verify any updated information and redetermine the individual's eligibility.

#### **Federal Requirements Related to Medicaid Eligibility**

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

Under Title XIX of the Act, Medicaid payments are allowable only for eligible beneficiaries. Generally, Federal regulations (42 CFR §§ 431.800–431.865) require the State to have a

Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility decisions. In addition, the regulations contain procedures for disallowing Federal payments for erroneous Medicaid payments that result from eligibility and beneficiary liability errors above a certain level, as detected through the MEQC program. Federal regulations (42 CFR § 431.804) define an eligibility error as an instance in which Medicaid coverage was authorized or payment was made for a beneficiary who (1) was ineligible for Medicaid when authorized or when he/she received services, (2) was eligible for Medicaid but ineligible for certain services received, or (3) had not met beneficiary liability requirements (e.g., the beneficiary had not incurred medical expenses in an amount necessary to lower countable income to the threshold limit).

A Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits and a citizen or national of the United States or a qualified alien.<sup>1</sup> Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, as codified, in part, at 8 U.S.C. §§ 1601–1646, provides that legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.

Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.<sup>2</sup> The income and resource thresholds, which are subject to yearly adjustments, vary based on eligibility category and the number of family members in the household.<sup>3</sup> For beneficiaries in the “medically needy” category, unlike those 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 “beneficiary liability” or “spenddown.” In addition to having income and resource thresholds, some eligibility categories have other requirements. For example, for beneficiaries not receiving Supplemental Security Income (SSI) who apply for Medicaid under the eligibility category for blind or disabled persons, 42 CFR §§ 435.531 and 435.541 require that the determination of blindness or disability be based on a physician’s report of examination.

Regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. The State must contact the Social Security Administration to verify that the number furnished was the correct number and the only number issued to the individual. If the applicant was not issued a Social Security number or cannot recall the number, the State must assist the individual in

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<sup>1</sup>Undocumented aliens are eligible only for Medicaid pregnancy and emergency services.

<sup>2</sup>Children and pregnant women may qualify at higher income levels than other types of applicants.

<sup>3</sup>One eligibility criterion for the optional category for women in need of treatment for breast or cervical cancer is that the woman must have been screened for breast or cervical cancer through the Centers for Disease Control and Prevention breast and cervical cancer early detection program, which is aimed at low-income, uninsured, and underserved women. However, pursuant to sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act, once screened through the early detection program, a woman is eligible for Medicaid under this optional category, regardless of her income or resources, if the woman needs treatment for breast or cervical cancer, is not otherwise eligible for Medicaid, is under age 65, and is uninsured.

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

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

### **State Requirements Related to Medicaid Eligibility**

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

FHPlus provides comprehensive health insurance to low-income adults aged 19 through 64 who are not pregnant, who have income or resources above the thresholds for the other Medicaid categories, and who do not have other health insurance coverage.

The State plan incorporates the Federal requirements pertaining to residency, citizenship, blindness and/or disability, Social Security number, and beneficiary liability. The State plan also establishes income and resource levels. Section 366-a(4) of the New York State Social Services Law requires beneficiaries to inform the State agency district office of any changes in financial situation or any other changes affecting eligibility.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

## Scope

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

We performed fieldwork from October 2005 to January 2006 at the State agency's offices in Albany and New York, New York; the New York City Human Resource Administration (a State agency district office) in New York, New York; and the State MMIS fiscal agent in Rensselaer, New York.

## Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements related to Medicaid eligibility;
- held discussions with CMS headquarters and regional office officials and with State officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
- ran computer programming applications at the MMIS fiscal agent, which identified a total of 100,365,212 Medicaid fee-for-service and managed care payments amounting to approximately \$18.1 billion (approximately \$9.1 billion Federal share) for services rendered in New York from January 1 through June 30, 2005;
- eliminated from the total number of Medicaid payments 46,093,239 payments totaling approximately \$7.1 billion (approximately \$3.6 billion Federal share) made on behalf of SSI recipients and 625,352 payments totaling approximately \$130.4 million (approximately \$65.3 million Federal share) made on behalf of Title IV-E adoption assistance and foster care recipients because beneficiaries in these categories are automatically eligible for Medicaid services;
- eliminated from the total number of Medicaid payments 923,026 State Children's Health Insurance Program Medicaid expansion payments totaling approximately \$87.7 million (approximately \$56.3 million Federal share) because we included these payments in a separate ongoing review (report number A-02-06-01003);
- identified a universe of 52,723,595 payments totaling approximately \$10.7 billion (approximately \$5.4 billion Federal share) for services rendered to Medicaid beneficiaries in New York during the 6-month period ended June 30, 2005; and
- selected a simple random sample of 200 payments from the universe of 52,723,595 payments, as detailed in Appendix A.

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

- the case file contained a signed application from the beneficiary;
- the beneficiary was assigned to the correct eligibility category;
- the case file contained the beneficiary's Social Security number and, if so, whether the Social Security Administration issued the number to the beneficiary;
- the beneficiary resided in New York State by checking driver's licenses, rental agreements, or Federal, State, or local government correspondence;
- the beneficiary's identity, including name, age, and citizenship status, in the case file matched the information on file with the New York Bureau of Vital Statistics and the U.S. Citizenship and Immigration Services's Systematic Alien Verification for Entitlement program;
- the beneficiary's income was at or below the income threshold required to be eligible for Medicaid by reviewing information from the State Wage Information Collection Agency;
- the beneficiary's resources were at or below the resource threshold required to be eligible for Medicaid by checking the State Welfare Management System's Resource File Integration system;<sup>4</sup>
- the case file for blind and/or disabled beneficiaries not receiving SSI contained a physician's report of examination to support a determination of blindness and/or disability;
- the beneficiary met all applicable liability requirements; and
- the beneficiary was eligible for both Medicaid and the service received.

We used an attributes appraisal program to estimate, for the total population of 52,723,595 payments for services rendered to Medicaid beneficiaries, (1) the total number of payments for ineligible beneficiaries and (2) the total number of payments for which documentation did not support eligibility determinations.

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<sup>4</sup>The Resource File Integration system, a subsystem of the Welfare Management System, uses Social Security numbers to compare individuals in the Welfare Management System against individuals on the resource files of various State and Federal agencies, including the State Department of Taxation and Finance, the State Department of Labor, and the Social Security Administration.

We used a variables appraisal program to estimate, for the total population of 52,723,595 payments for services rendered to Medicaid beneficiaries, (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 RECOMMENDATION

The State agency (1) made some Medicaid 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, 16 payments totaling \$874 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, for 58 payments totaling \$10,699 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required.

As a result, for the 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling \$230,375,748 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling \$2,820,569,979 (Federal share).

### ELIGIBILITY ERRORS

The table below summarizes the 16 eligibility errors noted in the sampled payments.

**Eligibility Errors and Associated Unallowable Payments**

| Eligibility Error  | Number of Unallowable Payments | Unallowable Federal Payments |
|--|--------------------------------|------------------------------|
| Beneficiaries were ineligible:                               |                                |                              |
| Did not meet income requirements on dates of service         | 6                              | \$378                        |
| Did not meet the waiting period for certain qualified aliens | 3                              | 154                          |
| Did not reapply for continued coverage                       | 2                              | 63                           |
| Did not furnish a Social Security number                     | <u>1</u>                       | <u>87</u>                    |
| <b>Subtotal</b>  | <b>12</b>                      | <b>\$682</b>                 |
| Beneficiaries had not met liability requirements             | 2                              | \$131                        |
| Beneficiaries were ineligible for certain services           | <u>2</u>                       | <u>61</u>                    |
| <b>Total</b>   | <b>16</b>                      | <b>\$874</b>                 |



## **Beneficiaries Were Ineligible**

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

Pursuant to Federal laws restricting welfare and public benefits for aliens (8 U.S.C. §§ 1601–1646), 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.

Pursuant to 42 CFR § 435.916(a), the State must redetermine Medicaid eligibility at least every 12 months. The State agency’s “Medicaid Reference Guide” requires that the beneficiary “submit a written renewal (recertification) to continue Medicaid.”

Regulations (42 CFR § 435.910(a)) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. If the individual cannot recall or was not issued a Social Security number, the State must assist the individual in obtaining or identifying his or her Social Security number. If an individual refuses to get a Social Security number for “well established religious objections,” as defined in 42 CFR § 435.910(h)(2), the State may obtain a Social Security number for the individual or use another unique identifier.

Of the 200 sampled payments, 12 payments totaling \$682 (Federal share) were made on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations:

- For six payments totaling \$378 (Federal share), the beneficiaries’ household incomes exceeded the Medicaid income threshold on the dates of service.
- For three payments totaling \$154 (Federal share), the beneficiaries had not satisfied the 5-year waiting period applicable to certain qualified aliens.
- For two payments totaling \$63 (Federal share), the case files documented that the beneficiaries had not reapplied for continued coverage.
- For one payment totaling \$87 (Federal share), the beneficiary had not furnished his or her Social Security number. The case file confirmed that the beneficiary had never applied for a Social Security number, and there was no evidence of any religious objections to obtaining a Social Security number.

## **Beneficiaries Had Not Met Liability Requirements**

For the “medically needy” category, Federal regulations (42 CFR § 435.831(d)) require the State to deduct medical expenses incurred by the individual or family from income if countable income exceeds the income threshold. This is called beneficiary liability or spenddown. For example, if

the monthly income threshold in the State is \$1,000 and the beneficiary is earning \$1,200, the beneficiary must have medical expenses equal to or greater than \$200 to qualify for Medicaid. A Medicaid payment is unallowable when these beneficiary liability requirements have not been met, and such payments should be identified as eligibility errors under the State's MEQC program.

For two sampled payments totaling \$131 (Federal share), the State agency paid for services rendered to beneficiaries who had countable income above the income threshold on the dates of service and who had not met the beneficiary liability requirements.

### **Beneficiaries Were Ineligible for Certain Services**

Federal regulations (42 CFR § 431.804) define one type of eligibility error as "Medicaid coverage has been authorized or payment has been made for a recipient . . . [who] was eligible for Medicaid but was ineligible for certain services he received . . . ."

Section 369-ee of the New York State Social Services Law provides eligibility and coverage criteria for the FHPlus program. Pursuant to section 369-ee, FHPlus provides comprehensive health insurance to low-income adults aged 19 through 64 who are not pregnant, who have income or resources above the thresholds for the other Medicaid categories, and who do not have other health insurance coverage. Section 369-ee provides that the FHPlus benefit package includes primary, preventive, specialty, and inpatient care provided through managed care plans. Thus, beneficiaries who are eligible only for FHPlus are not eligible for services provided on a fee-for-service basis.

For two sampled payments totaling \$61 (Federal share), the State agency paid for specific services not covered under two beneficiaries' eligibility categories. The two payments were fee-for-service payments for beneficiaries whose incomes on the dates of service were within the requirements for FHPlus but above the thresholds for the other Medicaid categories. Thus, although the beneficiaries were eligible only for FHPlus, the State agency district office had classified the beneficiaries in other coverage categories. Under FHPlus, all health care services are provided through the managed care plan and are not separately billable.

### **INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS**

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

For 58 sampled payments totaling \$10,699 (Federal share), the case files did not contain adequate documentation to support eligibility determinations. Each case file was missing at least one of the following: an application covering the date of service; a signature on the application; and facts supporting income level, fulfillment of beneficiary liability requirements, residence, date of birth, and citizenship status.

## **CONCLUSION**

Of the 200 Medicaid payments sampled, 16 payments were made on behalf of beneficiaries who did not meet Federal and State eligibility requirements. In addition, the State agency made 58 payments on behalf of beneficiaries whose case files did not contain all federally required documentation supporting eligibility determinations.

For the sampled payments, (1) beneficiaries did not always fully disclose information at the time of application or eligibility redetermination and did not always notify the State agency district offices of changes in financial situation or other changes affecting eligibility, (2) the district offices did not verify all information provided to support beneficiaries' applications, and (3) the district offices did not always maintain appropriate documentation to support eligibility determinations.

Extrapolating the results of our statistical sample to the 6-month audit period, we estimate that the State agency made 4,217,888 payments totaling \$230,375,748 (Federal share) on behalf of ineligible beneficiaries. Further, we estimate that case file documentation did not adequately support eligibility determinations for an additional 15,289,843 payments totaling \$2,820,569,979 (Federal share). (See Appendix B for the details of our sample results and projections.)

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

## **RECOMMENDATION**

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, the State agency should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require its district office employees to verify eligibility information and maintain appropriate documentation in all case files.

## **STATE AGENCY'S COMMENTS**

In its May 29, 2006, comments on our draft report, the State agency described some actions being taken to help ensure compliance with Federal and State Medicaid eligibility requirements.

However, the State agency commented that we "may have relied on interpretations of federal regulations that are not consistent with instructions the State has received from CMS." The State agency's specific comments follow:

- The State agency referred to the provision in CMS Medicaid Director Letter 01-015 that specifies that States are to streamline and simplify the Medicaid application process and to rely on information gathered from other programs. Specifically, Medicaid agencies are not to redocument information that is not subject to change already in agency files. The State agency stated that we had repeatedly cited the requirement to have “facts” in the file to support an eligibility determination but seemed to equate “facts” in the file with independent documents that are not required by CMS.
- The State agency stated that we had refused to accept the logic of the Welfare Management System (which contains Medicaid eligibility data) or to recognize the validity of client-specific vital records data in the system, including Medicaid liability data. Instead, according to the State agency, we had insisted on seeing paper.
- The State agency commented that we had questioned whether the State was providing benefits to individuals who did not reside in the State for such allowable exceptions as out-of-State representative payees and beneficiaries placed in out-of-State facilities for medical reasons.

The State agency also requested that we provide workpapers to assess the findings.

Appendix C contains the full text of the State agency’s comments.

## **OFFICE OF INSPECTOR GENERAL’S RESPONSE**

After reviewing applicable Federal and State laws, regulations, and other requirements, and the State agency’s comments on our draft report, we continue to believe that our findings are valid. Our responses to the State agency’s specific comments follow:

- We agree that the State agency does not need to redocument existing eligibility information. However, for some sampled payments, we could not make an eligibility determination based on the information available to us in the case files. Throughout the audit, we provided the State agency with lists of the sampled cases and the missing documentation. In many cases, the State agency could not provide the supporting source documents. We also attempted to independently verify needed information through other systems and sources, such as verifying birth records through State vital records. When we were successful in locating the records, we did not count the cases as documentation errors. When neither State personnel nor we could locate the records, we categorized the cases as “insufficient documentation to support eligibility determinations,” not as “eligibility errors.”
- Government Auditing Standards require that auditors obtain sufficient, competent, and relevant evidence that computer-processed data are valid and reliable when these data are significant to the audit findings. Accordingly, we looked behind the computerized data by reviewing supporting documentation in the case files.

- We did not identify any payments as "eligibility errors" because of the beneficiary's residency status. However, for some cases, we were unable to verify residency information, and we categorized those cases as "insufficient documentation to support eligibility determinations," not as "eligibility errors."

We provided written documentation supporting our findings to State officials during the audit and at the exit conference. Upon specific request, we will provide any additional relevant data.

# **APPENDIXES**

## **SAMPLE DESIGN AND METHODOLOGY**

### **AUDIT OBJECTIVE**

Our objective was to determine the extent to which the New York State Department of Health (the State agency) made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

### **POPULATION**

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

### **SAMPLING FRAME**

The sampling frame was a computer file containing 52,723,595 payments for services rendered to Medicaid beneficiaries in New York during the 6-month period ended June 30, 2005. The 52,723,595 payments excluded payments for SSI beneficiaries and beneficiaries under the Title IV-E foster care and adoption assistance programs, as well as payments for the SCHIP Medicaid expansion. Total Medicaid reimbursement for the 52,723,595 payments was \$10,715,127,315 (\$5,377,058,250 Federal share).

### **SAMPLE UNIT**

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

### **SAMPLE DESIGN**

We used a simple random sample to evaluate Medicaid eligibility.

### **SAMPLE SIZE**

We selected a sample size of 200 Medicaid payments.

### **SOURCE OF THE RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE ITEMS**

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

## **CHARACTERISTICS TO BE MEASURED**

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

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

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

## **ESTIMATION METHODOLOGY**

We used both the OAS attributes and variables appraisal programs in RAT-STATS to appraise the sample results.

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



## SAMPLE RESULTS AND PROJECTIONS

## ELIGIBILITY ERRORS

The results of our review of the 200 Federal Medicaid 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) |
|----------------------|-----------------------------------|-------------|---------------------------------|-------------------|--|
| 52,723,595           | \$5,377,058,250                   | 200         | \$26,706                        | 16                | \$874                                      |

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

|             | <u>Attributes</u><br><u>Appraisal</u> | <u>Variables</u><br><u>Appraisal</u> |
|-------------|---------------------------------------|--------------------------------------|
| Midpoint    | 4,217,888                             | \$230,375,748                        |
| Lower limit | 2,679,507                             | 116,355,444                          |
| Upper limit | 6,272,615                             | 344,396,053                          |

## INSUFFICIENT DOCUMENTATION

The results of our review of the 200 Federal Medicaid 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) |
|----------------------|-----------------------------------|-------------|---------------------------------|--|---|
| 52,723,595           | \$5,377,058,250                   | 200         | \$26,706                        | 58                                       | \$10,699  |

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

|             | <u>Attributes</u><br><u>Appraisal</u> | <u>Variables</u><br><u>Appraisal</u> |
|-------------|---------------------------------------|--------------------------------------|
| Midpoint    | 15,289,843                            | \$2,820,569,979                      |
| Lower Limit | 12,512,778                            | 1,545,965,763                        |
| Upper Limit | 18,316,064                            | 4,095,174,195                        |

**DOH** STATE OF NEW YORK  
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
*Commissioner*

Dennis P. Whalen  
*Executive Deputy Commissioner*

May 29, 2006

James P. Edert  
Regional Inspector General for  
Audit Services  
DHHS OIG Office of Audit Services  
26 Federal Plaza  
Room 3900A  
New York, New York 10278

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS – OIG's Draft Audit Report (A-02-05-01028) on "Review of Medicaid Eligibility in New York State."

Thank you for the opportunity to comment.

Sincerely,



Dennis P. Whalen  
Executive Deputy Commissioner

Enclosure

cc: Mr. Charbonneau  
Mr. Griffin  
Mr. Howe  
Ms. Kelly  
Ms. Napoli  
Ms. O'Connor  
Mr. Reed  
Ms. Rice  
Mr. Seward  
Mr. Wing

**Department of Health  
Comments on the  
Department of Health and Human Services  
Office of Inspector General  
Draft Audit Report A-02-05-01028 on  
“Review of Medicaid Eligibility in New York State”**

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The following are the Department of Health’s (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-05-01028) on “Review of Medicaid Eligibility in New York State.”

**Recommendation #1:**

The Department should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require district office employees to verify eligibility information and maintain appropriate documentation in all case files.

**Response #1:**

Staff has a number of comments and observations regarding both the draft report and the audit process on which the findings and recommendations are based.

Through numerous eligibility categories, the New York State Medicaid program provides comprehensive, high quality health care coverage and services to more than four million low income residents of New York State who would otherwise lack access to medical care.

The New York State Medicaid program is centrally supervised by the New York State Department of Health, and administered by the State’s 58 local departments of social services (LDSS). Trained staff take applications and determine Medicaid eligibility by evaluating information from a combination of sources: face-to face interviews with applicants, documents required from and supplied by applicants, and behind-the-scenes interfaces and verification with a number of data sources to resolve or clarify any discrepancies found.

Data sources include the agencies’ own files, such as the Welfare Management System (WMS). As directed by the Centers for Medicare and Medicaid Services (CMS) and OIG in State Medicaid Director Letter #01-015, states are to streamline and simplify the Medicaid application process, as well as to rely on information gathered from other programs. Specifically, Medicaid agencies are not to redocument information already in agency files that is not subject to change. This would include applicant information such as proof of citizenship, date of birth and copies of social security cards. Verification of these types of information is imbedded in other routinely accessible reports or through one or more of the State data systems.

The Medicaid program, and particularly one as diverse as New York's, is challenging for persons unfamiliar with its complexities and nuances to interpret. It was our observation that, for the most part, OIG audit staff were unfamiliar with all but the most general aspects of the systems and components of the New York State Medicaid program. Department staff spent months explaining Medicaid policy, procedures and systems to OIG auditors. Despite their extensive efforts, we are not able to determine from the information contained in the draft report how the auditors applied what they were told or how they arrived at their conclusions. The Department will need actual work papers to assess their findings.

From the report, it appears that audit staff may have relied on interpretations of federal regulations that are not consistent with instructions the State has received from CMS. For example, auditors repeatedly cite the requirement to have "facts" in the file to support an eligibility determination, but seem to equate "facts" with independent documents that are not required by CMS. Until the passage of the Deficit Reduction Act, which requires documentation of citizenship, the only specific documents required were those pertaining to immigration status, a point made by CMS numerous times as states attempted to improve access to health care.

Other examples of the differences between Medicaid rules and guidance, and the audit approach, include the following:

- Refusal to accept the WMS systems logic and to recognize the validity of client-specific vital records data contained within WMS. The lack of understanding in this area was evidenced by the insistence on "seeing" client documentation known to WMS but related to earlier cases. Many clients had been associated with other cases as children, and moved to new cases as they aged and/or their family units changed. However, the "paper" proving basic, unchanging client demographics such as date of birth, although verifiable through WMS, remained with the original case record. For an individual known to the system for 10 to 15 years or longer, as are many of our Office of Mental Retardation and Developmental Disabilities (OMRDD) recipients, much of the individual's original case files would be difficult to locate or retrieve from archives.
- Questions about whether New York State was providing Medicaid benefits to individuals who did not reside in the State. Many elderly recipients have a representative payee, frequently a son or daughter, whose residence would be listed in the case record for purposes of notification. That residence may be outside of New York State. In other instances, a recipient may have been placed by New York State in an out-of-state facility for medical reasons.
- Findings that recipients did not meet their Medicaid liability. Satisfaction of recipient liability can be achieved in many ways: use of unpaid bills, some of which can be carried forward for several months; use of bills paid by other programs such as New York's Elderly Pharmaceutical Insurance Coverage (EPIC) program;

payments entered into district-administered recipient pay-in accounts – which are all part of WMS – or principal provider payment deductions incorporated into eMedNY (MMIS). OIG audit staff was unfamiliar with these generally accepted methods and did not accept the logic of WMS's principal provider subsystem and its ability to systematically reduce provider payments by the appropriate recipient liability amount.

- References to use of Medicaid Eligibility Quality Control (MEQC) procedures that fail to recognize the State's federal waiver for targeted MEQC reviews.

Finally, as program experts and not statisticians, the Department does not have any way to evaluate the auditors' methods of extrapolating from findings, accurate or not, to the full spectrum of Medicaid payments. Therefore, we are requesting a layperson's explanation of the "attributes appraisal" and "variables appraisal" programs – in particular, the underlying assumptions, the way these programs use data, and the contexts in which they are normally used.

The report does contain findings that can be acted upon, and we are taking immediate steps to do so. For example, ensuring that applications contain applicant signatures is certainly something that will be reinforced for our LDSS. The Department's Office of Medicaid Management (OMM) has also increased its monitoring of eligibility processes and outcomes in local districts, an activity made possible by the addition of staff to OMM's Local District Support Unit over the past several months. Districts are being reminded to impress upon applicants their responsibilities and their rights when they apply. Despite our best efforts, however, some applicants may conceal or fail to report information that would be vital to maintaining their eligibility.

This audit, which we understand was intended to help inform Payment Error Rate Measurement (PERM) regulations regarding Medicaid eligibility, appears to establish a standard for supporting eligibility determinations that is far more stringent than anything upon which the federal Medicaid program has operated to date. We cannot assess whether this derives from a perspective unfamiliar with program operations, or from a change in federal policy that has not yet been articulated to states through regular communication channels.

We look forward to receiving the requested materials, and would welcome a dialogue on this very important review as you move forward in establishing audit protocols that will be used in PERM.

# ACKNOWLEDGMENTS

This report was prepared under the direction of James P. Edert, Regional Inspector General for Audit Services, Region II. Other principal Office of Audit Services staff who contributed include:

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