



JUL 19 2007

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

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

SUBJECT: Review of State Children's Health Insurance Program Eligibility in New York State (A-02-06-01003)

Attached is an advance copy of our final report on the review of State Children's Health Insurance Program (SCHIP) 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 Centers for Medicare & Medicaid Services and the Office of Management and Budget requested this audit.

The SCHIP program, which the Federal and State Governments jointly fund and administer, provides free or affordable health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage. States have three options when designing an SCHIP: (1) use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program, (2) design a children's health insurance program entirely separate from Medicaid, or (3) combine both the expanded Medicaid and separate program options. Federal and State laws, regulations, and other requirements establish both SCHIP and Medicaid eligibility. If a State elects to establish an expanded Medicaid program using SCHIP funds, Medicaid eligibility rules apply.

New York State operated both a separate children's health program (Child Health Plus B) and an expanded Medicaid program until March 31, 2005. Beginning April 1, 2005, the State transitioned to the Child Health Plus B program only.

Our objective was to determine the extent to which the State agency made SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Our audit period covered January 1 through June 30, 2005, when the State agency made more than 2.3 million payments totaling \$267.2 million (approximately \$173 million Federal share) on behalf of SCHIP beneficiaries.

The State agency (1) made some SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations. Of the 200 payments in our statistical sample, 39 payments (27 Child Health Plus B and 12 expanded Medicaid) totaling \$2,928 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. Specifically, the State agency made:

- 13 payments on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations,
- 15 payments on behalf of beneficiaries who had not met liability requirements, and
- 11 payments on behalf of beneficiaries who were eligible for Medicaid but were improperly enrolled in SCHIP.

In addition, for 22 sampled payments totaling \$1,294 (Federal share), the case files were missing or did not contain all documentation supporting eligibility determinations as required. The missing documentation included at least one of the following: an application covering the date of service; a signature on the application; and facts supporting income level, household size, residence, date of birth, and citizenship.

As a result, for our 6-month audit period, we estimate that the State agency made between 222,788 and 416,346 Child Health Plus B payments totaling between \$17,682,343 and \$32,892,050 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 309,970 payments totaling \$25,287,197.

In addition, for our 6-month audit period, we estimate that the State agency made between 80,324 and 219,045 expanded Medicaid payments totaling between \$3,122,651 and \$13,528,708 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 137,764 payments totaling \$8,325,679. We are not recommending recovery related to Medicaid eligibility errors primarily because a disallowance of Federal payments, including for expanded Medicaid, can occur only if the errors are detected through a State's Medicaid eligibility quality control program.

We also estimate that case file documentation did not adequately support eligibility determinations for an additional 173,708 to 352,069 payments totaling between \$9,529,453 and \$20,176,073 (Federal share). The midpoint of the confidence interval amounted to 252,568 payments totaling \$14,852,763.

We recommend that the State agency use the results of this review to help ensure compliance with Federal and State SCHIP eligibility requirements by (1) reemphasizing to beneficiaries the need to provide accurate and timely information and (2) requiring employees of managed care organizations to verify eligibility information and maintain appropriate documentation in all case files. We also recommend that the State agency work with the Centers for Medicare & Medicaid Services to resolve the estimated improper Child Health Plus B payments of at least \$17,682,343 identified in our review.

In its comments on our draft report, the State agency commented that New York’s SCHIP is in compliance with all Federal and State eligibility requirements. The State agency also stated that we applied standards for supporting eligibility determinations that are beyond current Federal and State eligibility requirements.

After reviewing applicable Federal and State laws, regulations, and other requirements and the State agency’s comments on our draft report, we continue to support our findings.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or 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. Please refer to report number A-02-06-01003.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
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JUL 24 2007

Report Number: A-02-06-01003

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
Empire State Plaza
Fourteenth Floor, Room 1408
Corning Tower
Albany, New York 12237

Dear Dr. Daines:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of State Children's Health Insurance Program Eligibility in 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-02-06-01003 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "James P. Edert".

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

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Associate Regional Administrator
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF STATE CHILDREN'S
HEALTH INSURANCE PROGRAM
ELIGIBILITY IN NEW YORK STATE**



Daniel R. Levinson
Inspector General

July 2007
A-02-06-01003

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

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

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

Federal and State laws, regulations, and other requirements establish both SCHIP and Medicaid eligibility. If a State elects to establish an expanded Medicaid program using SCHIP funds, Medicaid eligibility rules apply. New York State operated both a separate children's health program (Child Health Plus B) and an expanded Medicaid program until March 31, 2005. Beginning April 1, 2005, the State transitioned to the Child Health Plus B program only.

In New York State, the Department of Health (the State agency) operates both the SCHIP and Medicaid programs. The State agency administers the Child Health Plus B program by contracting with managed care organizations to provide services to qualified beneficiaries. The managed care organizations determine the eligibility of applicants for Child Health Plus B benefits, whereas 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 approximately 2.3 million Child Health Plus B and expanded Medicaid payments totaling \$267.2 million (\$173 million Federal share) on behalf of SCHIP beneficiaries.

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

OBJECTIVE

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

SUMMARY OF FINDINGS

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

Of the 200 payments in our statistical sample, 39 payments (27 Child Health Plus B and 12 expanded Medicaid) totaling \$2,928 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. Specifically, the State agency made:

- 13 payments on behalf of beneficiaries who were ineligible because their household incomes exceeded the SCHIP income threshold on the dates of service, they did not meet the waiting period for certain qualified aliens, or they were enrolled in Medicaid at the time of the SCHIP payment;
- 15 payments on behalf of beneficiaries who had not met liability requirements; and
- 11 payments on behalf of beneficiaries who were eligible for Medicaid but were improperly enrolled in SCHIP.

In addition, for 22 sampled payments totaling \$1,294 (Federal share), the case files were missing or did not contain all documentation supporting eligibility determinations as required. The missing documentation included at least one of the following: an application covering the date of service; a signature on the application; and facts supporting income level, household size, residence, date of birth, and citizenship.

As a result, for our 6-month audit period, we estimate that the State agency made between 222,788 and 416,346 Child Health Plus B payments totaling between \$17,682,343 and \$32,892,050 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 309,970 payments totaling \$25,287,197.

In addition, for our 6-month audit period, we estimate that the State agency made between 80,324 and 219,045 expanded Medicaid payments totaling between \$3,122,651 and \$13,528,708 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 137,764 payments totaling \$8,325,679. We are not recommending recovery related to Medicaid eligibility errors primarily because a disallowance of Federal payments, including for expanded Medicaid, can occur only if the errors are detected through a State's Medicaid eligibility quality control program.

We also estimate that case file documentation did not adequately support eligibility determinations for an additional 173,708 to 352,069 payments totaling between \$9,529,453 and \$20,176,073 (Federal share). The midpoint of the confidence interval amounted to 252,568 payments totaling \$14,852,763.

RECOMMENDATIONS

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

- reemphasizing to beneficiaries the need to provide accurate and timely information and
- requiring employees of managed care organizations to verify eligibility information and maintain appropriate documentation in all case files.

We also recommend that the State agency work with CMS to resolve the estimated improper Child Health Plus B payments of at least \$17,682,343 identified in our review.

STATE AGENCY’S COMMENTS AND OFFICE OF INSPECTOR GENERAL’S RESPONSE

In its comments on our draft report (Appendix C), the State agency commented that New York’s SCHIP is in compliance with all Federal and State eligibility requirements. The State agency also stated that we applied standards for supporting eligibility determinations that are beyond current Federal and State eligibility requirements. In addition, the State agency opposed the extrapolation procedures used to estimate the total improper payments for the audit period.

After reviewing applicable Federal and State laws, regulations, and other requirements and the State agency’s comments on our draft report, we revised the estimate to remove expanded Medicaid errors. We continue to support our findings. 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.” In addition, the sampling methodology used in the audit is a valid statistical methodology.

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INTRODUCTION

BACKGROUND

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

State Children's Health Insurance and Medicaid Programs

The Federal and State Governments jointly fund and administer both the State Children's Health Insurance Program (SCHIP) and the Medicaid program. CMS administers the programs at the Federal level. To participate in the SCHIP and Medicaid programs, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its programs, including program administration, eligibility criteria, service coverage, and provider reimbursement.

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

Pursuant to Title XIX of the Act, the Medicaid program pays for medical assistance for certain individuals and families with low income and resources. Within broad national guidelines established by Federal statutes, regulations, and other requirements, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; and (3) sets the payment rates for services.

New York's State Children's Health Insurance and Medicaid Programs

New York State operated both a separate children's health program (Child Health Plus B) and an expanded Medicaid program until March 31, 2005. Beginning April 1, 2005, the State transitioned to the Child Health Plus B program only.¹

The Department of Health (the State agency) is responsible for operating both the SCHIP and Medicaid programs. The State agency administers the Child Health Plus B program by contracting with managed care organizations to provide services to qualified beneficiaries. The State agency administers the Medicaid program through its district offices.

¹The State screened new SCHIP applicants for eligibility for the Child Health Plus B program beginning April 1, 2005. The State transitioned children enrolled in the expanded Medicaid program to the Child Health Plus B program upon redetermination of eligibility.

The State agency uses the Knowledge, Information, and Data System to process and pay Child Health Plus B premiums and the Medicaid Management Information System (MMIS) to process and pay Medicaid claims.

The State agency requires that individuals submit completed applications for SCHIP and Medicaid benefits. The contracted managed care organizations or the State agency district offices review the applications and determine whether the individuals meet eligibility requirements. Each Child Health Plus B applicant is required to sign a “Terms, Rights and Responsibilities” section of the application, agreeing to immediately report any changes in the information provided on the application. For each applicant determined eligible for the expanded Medicaid benefit, 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 managed care organization or district office must verify any updated information and redetermine the individual’s eligibility.

The Federal Government pays 65 percent of New York’s SCHIP costs and 50 to 90 percent of its Medicaid costs (depending on the type of service received).

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

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

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

Pursuant to 42 CFR part 457 and the State plan, an SCHIP beneficiary must be a child under the age of 19, a resident of the State from which the beneficiary receives benefits, and a citizen or national of the United States or a qualified alien. Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, as codified, in part, at 8 U.S.C. §§ 1601–1646, provides that legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Federal public benefit programs for the first 5 years after entry. This ban applies to the Medicaid and SCHIP programs.²

Pursuant to the New York State plan, a child residing in a household having a gross household income at or below 250 percent of the Federal poverty level (as defined and annually revised by the Office of Management and Budget) is eligible for Child Health Plus B. In addition, Federal regulations (42 CFR § 457.310(b)(2)) provide that to be eligible for SCHIP, a child must not have access to other health coverage. A child is not eligible for SCHIP if the child is eligible for Medicaid, an inmate of a public institution or a patient in an institution for mental diseases, or a

²Notwithstanding the ban, undocumented aliens are eligible for emergency Medicaid services, including emergency labor and delivery, if they are otherwise eligible for the State’s Medicaid program.

member of a family that is eligible for health benefits under a State group health plan on the basis of a family member's employment with a public agency in the State.

The State plan also requires monthly cost-sharing payments (premiums) for beneficiaries whose family income exceeds certain income levels. If a monthly premium is not paid, the child is ineligible for SCHIP for that month.

Pursuant to the State plan, families are required to inform the managed care organization of any changes in circumstances that may affect SCHIP eligibility and/or the family contribution. Federal regulations (42 CFR § 457.320(e)(2)) require that eligibility be redetermined at least every 12 months. In addition, 42 CFR § 457.965 requires the State to include in each applicant's record facts to support the State's determination of eligibility for the program.

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

If a State elects to establish an expanded Medicaid program using SCHIP funds, Medicaid eligibility rules apply. Federal laws, regulations, and other requirements establish Medicaid eligibility requirements that a State plan must contain, the mandatory and optional groups of individuals to whom Medicaid is available under a State plan, and the eligibility procedures that the State agency must use in determining and redetermining eligibility.

Pursuant to 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 was 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).

Pursuant to 42 CFR § 435.229, the State may provide Medicaid coverage to all individuals under age 19 who are optional targeted low-income children or reasonable categories of these individuals. New York State Social Services Law section 366(4)(s) states that a child under the age of 19 who is determined eligible for medical assistance remains eligible for such assistance until the earlier of (1) the last day of the month that is 12 months following the determination or redetermination of eligibility for such assistance or (2) the last day of the month in which the child reaches the age of 19.

Regulations at 42 CFR part 435, subpart E provide residency and citizenship requirements for Medicaid. A Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits and a citizen or national of the United States or a qualified alien.

Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, as codified, in part, at 8 U.S.C. §§ 1601–1646, provides that legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.³

Pursuant to 42 CFR §§ 435.600–435.845, Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.⁴ The income and resource thresholds vary based on eligibility category and the number of family members in the household and are subject to yearly adjustments. For beneficiaries in the “medically needy” category, unlike beneficiaries in most other eligibility categories, 42 CFR § 435.831(d) requires the State to deduct certain incurred medical expenses from income when determining financial eligibility. This process is often referred to as “spenddown.” In addition to the income and resource thresholds, some eligibility categories have other requirements.

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

Pursuant to 42 CFR § 435.916(b), the State must have procedures designed to ensure that beneficiaries promptly and accurately report any changes in circumstances that may affect eligibility. The State must promptly redetermine eligibility when beneficiaries report such changes or when the State anticipates a change in circumstances. Also, pursuant to 42 CFR § 435.916(a), the State must redetermine Medicaid eligibility at least every 12 months. Pursuant to 42 CFR § 435.945, the State must query appropriate Federal and State agencies to verify applicants’ information when determining and redetermining eligibility. In addition, the State must include in each applicant’s case file facts to support the State’s decision on the application (42 CFR § 435.913(a)).

The State plan incorporates the Federal requirements pertaining to residency, citizenship, blindness and/or disability, SSN, and beneficiary liability. The State plan also establishes income and resource levels. Under expanded Medicaid for Title XXI, children aged 6 to 18

³See footnote 2 on p. 2.

⁴Children and pregnant women may qualify at higher income levels than other types of applicants.

whose net family income is between 100 and 133 percent of the Federal poverty level are eligible for the program. 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 SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

Scope

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

We performed fieldwork from November 2005 to February 2006 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 SCHIP and 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 SCHIP and Medicaid eligibility;
- obtained an extract of SCHIP Child Health Plus B payments from the State agency's Knowledge, Information, and Data System containing 1,373,048 managed care payments totaling \$179,464,979 (\$116,652,236 Federal share) for services rendered in New York for the period January 1 through June 30, 2005;
- ran computer programming applications at the MMIS fiscal agent that identified 923,026 SCHIP expanded Medicaid payments totaling \$87,686,284 (\$56,320,449 Federal share) for services rendered in New York for the period January 1 through June 30, 2005;
- identified a combined universe of 2,296,074 SCHIP payments (Child Health Plus B and expanded Medicaid) totaling \$267,151,263 (\$172,972,685 Federal share) for services

rendered to beneficiaries in New York during the 6-month period that ended June 30, 2005; and

- selected a simple random sample of 200 payments from the universe of 2,296,074 payments, as detailed in Appendix A.

For each of the 200 sampled SCHIP payments (117 Child Health Plus B and 83 expanded Medicaid payments), we determined whether the case file contained sufficient information for the managed care organization or State agency district office to have made an eligibility determination on the date of initial determination or redetermination. We also attempted to obtain sufficient independent information to determine whether the beneficiary was eligible for SCHIP on the date of service. Specifically, for the 117 Child Health Plus B payments, we determined whether:

- the case file contained a completed application on behalf of the beneficiary;
- the beneficiary resided in New York State by checking driver's licenses, household rental agreements, or Federal, State, or local government correspondence;
- the beneficiary's identity, including name, age, and citizenship status, in the claims-processing system matched the information on the birth certificate in the case file and the U.S. Citizenship and Immigration Services's Systematic Alien Verification for Entitlement program;
- the beneficiary's household income was at or below the income threshold required to be eligible for Child Health Plus B by reviewing information from the New York State Department of Taxation and Finance and the case file;
- the beneficiary did not have access to other health insurance, i.e., the beneficiary was not eligible or potentially eligible for Medicaid or covered under a group health plan or other health insurance; and
- the beneficiary met all applicable liability requirements.

For the 83 expanded Medicaid payments, we determined whether:

- the case file contained a signed application on behalf of the beneficiary;
- the case file contained the beneficiary's SSN and, if so, whether the Social Security Administration had issued the number to the applicant;
- the beneficiary resided in New York State by checking driver's licenses, household rental agreements, or Federal, State, or local government correspondence;
- the beneficiary's identity, including name, age, and citizenship status, in the claims-processing system matched the information on the birth certificate in the case file and the

U.S. Citizenship and Immigration Services's Systematic Alien Verification for Entitlement program;

- the beneficiary's household income was at or below the income threshold required to be eligible for the expanded Medicaid program by reviewing information from the New York State Department of Taxation and Finance and the case file;
- the beneficiary met all applicable liability requirements; and
- the beneficiary was eligible for both expanded Medicaid and the service received.

We used an attribute appraisal program to estimate, for the total population of 2,296,074 SCHIP payments for services rendered to beneficiaries, (1) the total number of Child Health Plus B payments for ineligible beneficiaries, (2) the total number of expanded Medicaid payments for ineligible beneficiaries and (3) the total number of payments for which documentation did not support eligibility determinations.

We used a variable appraisal program to estimate, for the total population of 2,296,074 SCHIP payments for services rendered to beneficiaries, (1) the dollar impact of the improper Federal funding for ineligible Child Health Plus B beneficiaries, (2) the dollar impact of the improper Federal funding for ineligible expanded Medicaid beneficiaries, and (3) the dollar impact of the payments for which documentation did not support eligibility determinations.

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

FINDINGS AND RECOMMENDATIONS

The State agency (1) made some SCHIP payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not always adequately document eligibility determinations. Of the 200 payments in our statistical sample, 39 payments (27 Child Health Plus B and 12 expanded Medicaid) totaling \$2,928 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. In addition, for 22 payments totaling \$1,294 (Federal share), the case files did not contain all documentation supporting eligibility determinations as required.

As a result, for our 6-month audit period, we estimate that the State agency made between 222,788 and 416,346 Child Health Plus B payments totaling between \$17,682,343 and \$32,892,050 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 309,970 payments totaling \$25,287,197.

In addition, for our 6-month audit period, we estimate that the State agency made between 80,324 and 219,045 expanded Medicaid payments totaling between \$3,122,651 and \$13,528,708 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 137,764 payments totaling \$8,325,679.

We also estimate that case file documentation did not adequately support eligibility determinations for an additional 173,708 to 352,069 payments totaling between \$9,529,453 and \$20,176,073 (Federal share). The midpoint of the confidence interval amounted to 252,568 payments totaling \$14,852,763.

ELIGIBILITY ERRORS

The table below summarizes the 39 eligibility errors noted in the sampled payments.

Eligibility Errors and Associated Unallowable Payments		
Eligibility Error	Number of Unallowable Payments	Amount of Unallowable Federal Payments
Beneficiaries were ineligible:		
Did not meet income requirements on dates of service (Child Health Plus B)	9	\$741
Did not meet the waiting period for certain qualified aliens	3	286
Were enrolled in Medicaid at time of SCHIP payment	<u>1</u>	<u>76</u>
Subtotal	13	\$1,103
Beneficiaries had not met liability requirements	15	\$927
Beneficiaries were eligible for Medicaid	<u>11</u>	<u>898</u>
Total	39	\$2,928

Beneficiaries Were Ineligible

Pursuant to 42 CFR § 457.320(a), income eligibility standards are established by the State and must be included in the State plan. Generally, the income thresholds vary based on eligibility category and the number of family members in the household. Pursuant to the State plan, a child residing in a household having a gross income at or below 250 percent of the Federal poverty level is eligible for Child Health Plus B. The State plan requires families to inform the managed care organization of any changes in circumstances that may affect SCHIP eligibility and/or the family contribution.

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.

Section 2511 of the New York State Public Health Law provides that a child is eligible for SCHIP (Child Health Plus B) only if the child is not eligible for medical assistance (Medicaid) and meets other SCHIP eligibility criteria. Federal regulations (42 CFR § 457.350(a)) require States to use screening procedures to ensure that only targeted low-income children are furnished child health assistance. If the children are potentially eligible for Medicaid, the State must

facilitate application to Medicaid. Otherwise, the State must screen the children for SCHIP eligibility.

Of the 200 sampled payments, 13 payments totaling \$1,103 (Federal share) were made on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations:

- For nine payments totaling \$741 (Federal share) made on behalf of beneficiaries enrolled in Child Health Plus B, the beneficiaries' household incomes exceeded the SCHIP income threshold on the dates of service.
- For three payments totaling \$286 (Federal share), the beneficiaries did not satisfy the 5-year waiting period applicable to certain qualified aliens.
- For one payment totaling \$76 (Federal share), the beneficiary was also enrolled in Medicaid at the time of the Child Health Plus B payment.

Beneficiaries Had Not Met Liability Requirements

The State plan requires cost-sharing payments (premiums) for Child Health Plus B beneficiaries whose household incomes exceed certain levels. During our audit period, a \$9 monthly premium was required if family income was between 160 and 222 percent of the Federal poverty level, and a \$15 monthly premium was required if income was between 223 and 250 percent of the Federal poverty level. If a monthly premium (i.e., the beneficiary liability) is not paid, the child is ineligible for SCHIP for that month.

In addition, for expanded Medicaid, 42 CFR § 435.831(d) requires the State to deduct medical expenses incurred by the individual or family from income if countable income exceeds the income threshold for the "medically needy" category. This is called beneficiary liability or spenddown. For example, if the monthly income threshold in the State is \$1,000 and the family income is \$1,200, the beneficiary must have medical expenses equal to or greater than \$200 to qualify for Medicaid. A payment is unallowable when these beneficiary liability requirements have not been met.

For 15 sampled payments totaling \$927 (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. Specifically, 10 payments totaling \$744 were for Child Health Plus B beneficiaries whose families had not paid the required \$9 or \$15 premium based on income at the date of service, and 5 payments totaling \$183 were for expanded Medicaid beneficiaries who had not met the beneficiary liability for income exceeding the threshold at the date of service.

Beneficiaries Eligible for Medicaid Were Improperly Enrolled in the State Children's Health Insurance Program

Section 2511 of the New York State Public Health Law provides that a child is eligible for SCHIP only if the child is not eligible for medical assistance (Medicaid) and meets other SCHIP

eligibility criteria. Federal regulations (42 CFR § 457.350(b)) require the State to use screening procedures to identify any applicant or enrollee who is potentially eligible for Medicaid. Also, 42 CFR § 457.350(a)(2) requires the State to initiate the Medicaid application and enrollment process for children found to be potentially eligible for Medicaid.

Pursuant to 42 CFR § 457.350(f), if the screening process reveals that the child is potentially eligible for Medicaid, the State must establish procedures to facilitate enrollment in Medicaid. The State plan provides that any child under the age of 19 whose household income does not exceed 250 percent of the Federal poverty level and who appears to be Medicaid eligible must be presumed temporarily eligible for Child Health Plus B coverage. The eligibility period for temporary enrollment continues until the earlier of the date a Medicaid eligibility determination is made or 2 months after the temporary eligibility period begins.⁵

Federal regulations (42 CFR § 435.229(a)) permit the State to provide Medicaid coverage to all individuals under the age of 19 who are optional targeted low-income children. Pursuant to section 366(4)(s) of the New York State Social Services Law, a child under the age of 19 who is determined eligible for medical assistance remains eligible for such assistance until the earlier of (1) the last day of the month that is 12 months following the determination or redetermination of eligibility for such assistance or (2) the last day of the month in which the child reaches the age of 19.

For 11 sampled payments totaling \$898 (Federal share), the State agency provided coverage to beneficiaries who were eligible for Medicaid and, thus, were improperly enrolled in SCHIP. Specifically, for seven payments totaling \$625, the beneficiaries had family incomes below the minimum qualifying Child Health Plus B income levels and were, therefore, eligible for Medicaid benefits. For the remaining four payments totaling \$273, the expanded Medicaid beneficiaries reached the age of 19 before the dates of service.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

Federal regulations (42 CFR § 457.340(a)) require a completed application from each SCHIP applicant. The State plan requires the family to submit an application together with any required documentation needed to support the information in the application, including proof of age, residency, and income. Pursuant to 42 CFR § 457.965, the State must include in each SCHIP applicant's record facts to support the State's determination of eligibility for the program. In addition, 42 CFR § 457.320(e)(2) requires that eligibility be redetermined at least every 12 months.

Federal regulations (42 CFR § 435.907(a)) require a written application from each Medicaid applicant. Regulations (42 CFR §§ 435.911(a) and 435.916(a)) also require the State to (1) determine Medicaid eligibility within 90 days for applicants who apply based on disability and within 45 days for all other applicants and (2) redetermine eligibility at least every

⁵The temporary enrollment eligibility may be extended in the event a Medicaid eligibility determination has not been made within the 2-month period through no fault of the applicant and all the required documentation has been submitted within the 2-month period.

12 months. In addition, the State must include in each Medicaid applicant's case file facts to support the State's decision on the application (42 CFR § 435.913(a)).

For 22 sampled payments totaling \$1,294 (Federal share), the case files were missing or did not contain all documentation needed to support eligibility determinations. The missing documentation included at least one of the following: an application covering the date of service; a signature on the application; and facts supporting income level, household size, residence, date of birth, and citizenship.

CONCLUSION

Of the 200 SCHIP payments in our statistical sample, 39 payments (27 Child Health Plus B and 12 expanded Medicaid) made on behalf of beneficiaries did not comply with Federal and State eligibility requirements. In addition, the State agency made 22 payments on behalf of beneficiaries whose case files did not contain all documentation supporting eligibility determinations as required by Federal or State requirements.

For 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 office of changes in financial situation or other changes affecting eligibility, (2) managed care organizations and district offices did not verify all information provided to support beneficiaries' applications, and (3) managed care organizations and district offices did not always maintain appropriate documentation to support eligibility determinations.

Extrapolating the results of our sample to the 6-month audit period, we estimate that the State agency made between 222,788 and 416,346 Child Health Plus B payments totaling between \$17,682,343 and \$32,892,050 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 309,970 payments totaling \$25,287,197.

In addition, for our 6-month audit period, we estimate that the State agency made between 80,324 and 219,045 expanded Medicaid payments totaling between \$3,122,651 and \$13,528,708 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 137,764 payments totaling \$8,325,679. We are not recommending recovery related to Medicaid eligibility errors primarily because a disallowance of Federal payments, including for expanded Medicaid, can occur only if the errors are detected through a State's MEQC program.

Further, we estimate that case file documentation did not adequately support eligibility determinations for an additional 173,708 to 352,069 payments totaling between \$9,529,453 and \$20,176,073 (Federal share). The midpoint of the confidence interval amounted to 252,568 payments totaling \$14,852,763. (See Appendix B for the details of our sample results and projections.)

RECOMMENDATIONS

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

- reemphasizing to beneficiaries the need to provide accurate and timely information and
- requiring employees of managed care organizations to verify eligibility information and maintain appropriate documentation in all case files.

We also recommend that the State agency work with CMS to resolve the estimated improper Child Health Plus B payments of at least \$17,682,343 identified in our review.

STATE AGENCY'S COMMENTS

In its August 25, 2006, comments on our draft report, the State agency commented that New York's SCHIP is in compliance with all Federal and State eligibility requirements. The State agency also stated that we applied standards for supporting eligibility determinations that are beyond current Federal and State eligibility requirements. The State agency's specific comments follow:

- The State agency stated that CMS, in State Medicaid Director Letter #01-015, directs States to streamline and simplify the Medicaid application process and to rely on information gathered from other programs. Specifically, Medicaid agencies are not to reverify information already in agency files that is not subject to change.
- The State agency stated that we 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. Instead, according to the State agency, we insisted on obtaining a copy of the "paper" documentation.
- The State agency commented that we used data from the New York State Department of Taxation and Finance's wage-reporting system as the only source of income verification. The State agency stated that this system is unreliable and insufficient to render eligibility decisions because it does not include other sources of income (e.g., self-employment, nonwage income). According to the State agency, we considered any record that did not match data in the wage-reporting system to be an eligibility error.
- The State agency stated that Medicaid has 12-month continuous eligibility for children, which allows a child to remain covered regardless of a change in the family's financial circumstances. The State agency also stated that we examined income for a particular date of service within the eligibility period and that any Medicaid expansion income finding would therefore be irrelevant.
- The State agency stated that we failed to recognize fluctuations in income of the low-income population and cited sample cases where the family's income fluctuated from

month to month. According to the State agency, CMS has directed States to average unusual income over a year so a single month of higher income does not render a child ineligible.

- The State agency commented that presumptive eligibility cases should not have been considered errors because New York’s State plan permits temporary enrollment in Child Health Plus B when a child appears to be eligible for Medicaid.
- The State agency commented that without appropriate followup, errors in family contributions should not have been disallowed. Even if the contributions were considered errors, the State agency stated it was unreasonable to disallow the entire premium paid if the parent may have been required to pay more toward coverage than he or she actually paid for the child in the month examined.
- The State agency stated “medically needy” financial liability requirements (42 CFR § 435.831(d)) are not applicable to the Medicaid expansion children—children between the ages of 6 and 19 whose family incomes are above the “medically needy” level and less than or equal to 133 percent of the Federal poverty level. Such children, according to the State agency, have no financial liability toward their cost of care.
- The State agency strongly opposed the extrapolation procedures used to estimate the total improper payments for the audit period.

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 revised the estimate to remove expanded Medicaid errors. We continue to support our findings. Our responses to the State agency’s specific comments follow:

- The State Medicaid Director Letter #01-015 does not direct States to streamline and simplify the Medicaid application process but addresses States’ concerns about the possible impact of simplification strategies on error rates. 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 use data from the wage-reporting system as the only source of income verification. We also verified other reported income contained in the case files (e.g., pay statements, tax returns, letters from employers). We considered payments to be eligibility errors only after we identified and reviewed all sources of income and determined that eligibility requirements were not met.
- We agree that the New York Medicaid program has 12-month continuous eligibility for children. While the sample items for the Medicaid expansion cases with excess income would not have been eligible for Medicaid based on the income at the date of service, we revised our initial findings before issuing the draft report because the State regulations deem children eligible for 12 continuous months regardless of changes in financial circumstances. The draft report did not include these sample items as eligibility errors.
- After it sent us its written comments, the State agency provided additional references (42 CFR § 435.711 and 45 CFR § 233.31) to support its statement that CMS has instructed States to average unusual income over a year so a single month of higher income does not render a child ineligible. These sections⁶ discuss the requirements for determining financial eligibility; however, there is no indication in either section that unusual income should be averaged over a year.

We did recognize fluctuations in income of the low-income population by following the same methodology that contracted managed care organizations use when making eligibility determinations. Specifically, we converted weekly, biweekly, or yearly income to a monthly amount for the month of our sample payment by using the same instructions provided to the contracted managed care organizations.

- We agree that the State may presumptively enroll a child who appears to be eligible for Medicaid in Child Health Plus B for 2 months⁷ or longer. Pursuant to 42 CFR § 457.350(a)(2), the State must initiate the Medicaid application and enrollment process for children found to be potentially eligible for Medicaid. We considered sample payments for a child enrolled in Child Health Plus B an eligibility error only when the State did not identify the child as Medicaid eligible as of the service date and, therefore, did not initiate the Medicaid application and enrollment process.
- We did not disallow the entire family contribution payment if the parent was required to pay an additional premium amount for the child in the month examined. We considered payments to be eligibility errors only when a premium was required based on the income

⁶42 CFR § 435.711 has been removed from 42 CFR part 435 and is no longer applicable.

⁷The eligibility period of temporary enrollment can be less than 2 months if a Medicaid eligibility determination is made before the 2-month period ends.

at the date of service selected but no premium was paid. Pursuant to State requirements, the monthly premium must be paid for the child to be eligible for SCHIP benefits.

- We agree that the financial liability requirements for children apply only when income is above 133 percent of the Federal poverty level. We considered payments to be eligibility errors only when the State agency paid for services rendered to beneficiaries who had countable income above the 133-percent income threshold on the dates of service and who had not met the beneficiary liability requirements.
- The audit was conducted in accordance with the Office of Inspector General, Office of Audit Services policy on sampling and estimation, “Sampling and Estimation Techniques in Auditing.” The sampling methodology used in the audit is a valid statistical methodology.

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 State Children's Health Insurance Program (SCHIP) payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

POPULATION

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

SAMPLING FRAME

The sampling frame was a computer file containing 2,296,074 payments for services rendered to SCHIP beneficiaries in New York during the 6-month period that ended June 30, 2005. The payments represented services provided under both the separate children's health program, Child Health Plus B, and the expanded Medicaid program. The total SCHIP reimbursement for the 2,296,074 payments was \$267,151,263 (\$172,972,685 Federal share). The SCHIP separate program payments were extracted from the Knowledge, Information, and Data System paid claims files, and the SCHIP payments under the expanded Medicaid program were extracted from the Medicaid Management Information System paid claims files.

SAMPLE UNIT

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

SAMPLE DESIGN

We used a simple random sample to evaluate SCHIP eligibility.

SAMPLE SIZE

We selected a sample size of 200 SCHIP payments.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services (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 claims in our sampling frame and selected the random numbers that correlated to the sequential numbers assigned to the claims in the sampling frame. We then created a list of 200 sampled items.

CHARACTERISTICS TO BE MEASURED

We based our determination 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 was enrolled in SCHIP.

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

ESTIMATION METHODOLOGY

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

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

SAMPLE RESULTS AND PROJECTIONS

ELIGIBILITY ERRORS

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

Sample Results – Child Health Plus B

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Payments	Value of Improper Payments (Federal Share)
2,296,074	\$172,972,685	200	\$14,194	27	\$2,203

Projection of Sample Results – Child Health Plus B
Precision at the 90-Percent Confidence Level

	<u>Attribute Appraisal</u>	<u>Variable Appraisal</u>
Midpoint	309,970	\$25,287,197
Lower limit	222,788	17,682,343
Upper limit	416,346	32,892,050

Sample Results – Expanded Medicaid

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Payments	Value of Improper Payments (Federal Share)
2,296,074	\$172,972,685	200	\$14,194	12	\$725

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

	<u>Attribute Appraisal</u>	<u>Variable Appraisal</u>
Midpoint	137,764	\$8,325,679
Lower limit	80,324	3,122,651
Upper limit	219,045	13,528,708

INSUFFICIENT DOCUMENTATION

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

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Payments With Insufficient Documentation	Value of Payments With Insufficient Documentation (Federal Share)
2,296,074	\$172,972,685	200	\$14,194	22	\$1,294

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

	<u>Attribute Appraisal</u>	<u>Variable Appraisal</u>
Midpoint	252,568	\$14,852,763
Lower limit	173,708	9,529,453
Upper limit	352,069	20,176,073

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

August 25, 2006

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

Report Number: A-02-06-01003

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS - OIG's Draft Audit (A-02-06-01003) on "Review of State Children's Health Insurance Program Eligibility in New York State."

Thank you for the opportunity to comment.

Sincerely,



Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Ms. Arnold
Ms. Farrell
Mr. Griffin
Mr. Howe
Mr. Reed
Ms. Stackman

**Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-06-01003 on
“Review of State Children’s Health Insurance Program
Eligibility in New York State”**

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-02-06-01003) on “Review of State Children’s Health Insurance Program Eligibility in New York State.”

Recommendation #1:

The State agency should use the results of this review to help ensure compliance with Federal and State SCHIP eligibility requirements. Specifically, the State agency should (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require employees of managed care organizations to verify eligibility information and maintain appropriate documentation in all case files.

Response #1:

New York’s State Children’s Health Insurance Program (SCHIP) is in compliance with all Federal and State eligibility requirements. Beneficiaries are required to provide accurate and timely information upon enrollment. Managed care organizations are also currently required, as part of the Child Health Plus B (CHPlus B) contract, to verify eligibility information and maintain appropriate documentation in all case files. This information is verified and audited on a sample of over 3,000 SCHIP enrollments per year. The results of these audits show less than a two percent eligibility error rate.

The OIG audit methodology applied standards for supporting eligibility determinations that are beyond current Federal and State eligibility requirements in either statute or regulations. Moreover, they were not consistent with the program’s policies and procedures which have been approved by the Centers for Medicare and Medicaid Services (CMS) in the SCHIP State Plan.

The audit found 22 cases of missing documentation, but only three of those cases were from the records of managed care plans for children enrolled in CHPlus B. The Department concurs with the three errors. The remaining 19 errors were found on SCHIP Medicaid cases from reviews performed at the Human Resources Administration in New York City. The Department disagrees that these are errors because OIG applied criteria inconsistent with program policy and procedures. As directed by 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 re-verify 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. OIG refused to accept the Welfare Management Systems (WMS) logic and to recognize the validity of client-specific vital records data contained within WMS. Instead, they insisted on obtaining a copy of the "paper" documentation, and if available electronically, but not on paper, the audit identified it as an error. The Department disagrees with all such errors.

Recommendation #2:

The State agency should work with CMS to resolve the estimated improper payments of at least \$24,717,515 identified in our review.

Response #2:

The Department strongly disagrees that the errors identified by OIG can be classified as improper payments. The State's SCHIP program is held to the standards for determining eligibility established in the State Plan. Payments should only be considered improper if they fall outside the criteria for eligibility determinations agreed upon in the approved State Plan. Moreover, the methodology OIG employed for identifying improper payments was flawed. OIG never definitively proved that the majority of the cases labeled "improper" were actually ineligible. The remainder of our response describes the flaws in the methodology that invalidate these findings.

1. *Using the wage reporting system as the only source of income verification.*

The SCHIP program, both CHPlus B and the Medicaid expansion, verifies eligibility upon enrollment using documents provided by the applicant and third-party data sources. Federal regulations do not require periodic verification of eligibility prior to the annual redeterminations. Medicaid has twelve-month continuous eligibility for children, which allows a child to remain covered regardless of a change in the family's financial circumstances. CHPlus B implemented twelve-month continuous eligibility in August 2005, subsequent to the audit period.

OIG examined income for a particular date of service within the eligibility period instead of reviewing the information provided upon enrollment. For Medicaid, any finding would be irrelevant given twelve-month continuous eligibility. We disagree with the ten Medicaid errors identified on this premise.

OIG identified 18 errors¹ in CHPlus B based on a comparison with the data in the Department's Knowledge Information and Data System (KIDS) to data from the New York State Department of Taxation and Finance wage reporting system. The wage

¹ These include all the improper program enrollment errors, six out of ten liability errors, and six out of nine income errors as classified by OIG.

reporting system is a useful tool for identifying cases requiring further investigation, but it is unreliable and insufficient to render eligibility decisions. Yet, this is how OIG used it. Despite the Department's warnings of the limitations of the data base and how to use it properly, the auditors merely cited any record that didn't match as an eligibility error.

The wage reporting system reports on all New Yorkers who receive wages. It does not include other sources of income (e.g., self employment, non-wage income). It is also not always accurate. The CHPlus B program relies on the data to review income information at renewal. However, every case that is identified as "potentially ineligible" is followed up to obtain current documentation of income prior to any decision to disenroll the family. In our experience, only a quarter of those appearing ineligible from the tax match are ineligible at the level enrolled once follow-up income information is provided.

OIG failed to recognize the fluctuations in income of the low-income population. Typically, wage earners are paid by the hour, work multiple jobs, and/or supplement their income with seasonal employment. For example, the mother from sample number 193 works as a substitute teacher. Her income fluctuates from month to month, but over the course of the year, her children are eligible for CHPlus B. It would be extremely burdensome for the family and the State to review her income on a monthly basis and move her in and out of different subsidy levels. Monthly eligibility reviews would result in unnecessary and unwarranted churning of children in and out of health insurance.

In another case, sample number 130, the father works for a Chinese importing company. He is paid by the hour and his wages average \$1,200 every two weeks. In December and January, during the Chinese New Year, he works overtime. OIG examined the wage reporting system for the month of his unusual income. CMS has directed states to average unusual income over a year so a single month of higher income does not render a child ineligible.

As stated above, the wage reporting system does not include all income earned by a family. Many low income families work multiple jobs and some of those jobs do not pay them wages. Had OIG followed up with actual income documentation from the families, they would have found some of the families that appear eligible for Medicaid actually have another job that does not appear in the wage reporting system. For example, the father from sample number 127 operates a cabinet making business in addition to his regular wages. His business return was submitted along with his weekly salary to document the household income. By only relying on the wage reporting system, OIG erroneously identified this household as Medicaid eligible and identified the payment as improper.

Without appropriate follow-up on cases identified from the wage reporting system, they cannot be considered definitive errors or improper payments. In addition, if continuous coverage had been in effect during the review, the finding of additional income in a month subsequent to enrollment would be irrelevant. The Department disagrees with all 18 of these cases.

2. *Including presumptive cases in the sample.*

New York's approved SCHIP State Plan permits us to presumptively enroll a child who appears Medicaid eligible in CHPlus B for two months or longer. It may be longer than two months if the application was submitted to Medicaid within the two month presumptive period, but eligibility has not yet been determined. OIG found four of these presumptive cases to be ineligible. The Department disagrees with these errors because Medicaid renders eligibility decisions based on information provided on the date the application is signed and has twelve month continuous eligibility for children under age 19. If the income appeared higher at a point in time during this 12 month period, it would not affect their eligibility for Medicaid. All four cases were correctly enrolled on a presumptive basis and should not be considered errors.

3. *Disallowing the full amount of the premium for errors in family contribution.*

Using the wage reporting system, OIG found 10 errors in family contribution for CHPlus B. In these cases families may have been required to pay more toward their coverage than they actually paid. As stated above, without appropriate follow up to collect current documentation of income, we cannot accept that these are errors. Even if some of them are errors, it is unreasonable to disallow the entire premium paid on behalf of an eligible child if the parent was required to pay an additional \$6 for that child in the month examined.

4. *Applying "medically needy" financial liability requirements to the expanded Medicaid population.*

OIG found five cases of children enrolled in Medicaid who did not meet their financial liability. OIG cites 42 CFR 435.831(d) as requiring the State to "deduct medical expenses incurred by the individual or family from income if countable income exceeds the income threshold for the 'medically needy' category" when determining eligibility for expanded children. This regulation is not applicable to the Medicaid expansion children. These are, by definition, children between the ages of six and 19 whose family incomes are above the medically needy level and less than or equal to 133 percent of the federal poverty level. Such children have no financial liability toward their cost of care. Only if the child's income was above 133 percent of the federal poverty level would the child be required to spend down to the medically needy income threshold, or the child could enroll in the CHPlus B program. Further, as stated above, reliance on the wage reporting system alone without documentation of income would render any conclusions about these five cases suspect.

In conclusion, the Department concurs with four out of the 27 CHPlus B eligibility errors. Of these four errors, only two children (cases 89 and 133) were ineligible at the time of application, while the other two were eligible, but at a different subsidy level (cases 117 and 191). Of the two eligibility errors, one involved a calculation error and the other an immigration status error. The Department has adjusted the federal claim to remove payment for these cases.

While the Department concurs that the State is responsible for reimbursing CMS for the Federal portion of all improper payments definitively identified by OIG, we strongly oppose OIG's extrapolation procedures across all program costs. The reason for this is that OIG failed, for the reasons cited above, to prove the payments were improper. Further, CMS has not issued guidance on extrapolation procedures. Even the Payment Error Rate Methodology (PERM) regulations define the State's obligation as the repayment of actual errors found through the methodology, not an extrapolation of those errors over all program payments.