



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General  
Office Of Audit Services

August 6, 2008

Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278

Report Number: A-02-07-01030

Richard F. Daines, M.D.  
Commissioner  
New York State Department of Health  
14<sup>th</sup> Floor, Corning Tower  
Empire State Plaza  
Albany, New York 12237

Dear Mr. Daines:

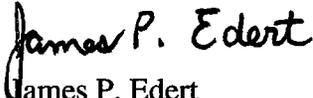
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in New York and New Jersey for July 1, 2005 Through June 30, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jeffrey I. Jacobs, Audit Manager, at (212) 264-1321 or through e-mail at [Jeffrey.Jacobs@oig.hhs.gov](mailto:Jeffrey.Jacobs@oig.hhs.gov). Please refer to report number A-02-07-01030 in all correspondence.

Sincerely,

  
James P. Edert  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Jackie Garner, Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID PAYMENTS FOR  
SERVICES PROVIDED TO  
BENEFICIARIES WITH  
CONCURRENT ELIGIBILITY IN  
NEW YORK AND NEW JERSEY  
FOR JULY 1, 2005, THROUGH  
JUNE 30, 2006**



**Daniel R. Levinson  
Inspector General**

**August 2008  
A-02-07-01030**

# ***Office of Inspector General***

<http://oig.hhs.gov>

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

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Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID PAYMENTS FOR  
SERVICES PROVIDED TO  
BENEFICIARIES WITH  
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Daniel R. Levinson  
Inspector General

August 2008  
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# *Notices*

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

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Department of Health (the State agency) manages the New York Medicaid program.

Medicaid eligibility in each State is based on residency. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. The State Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State Medicaid agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The State Medicaid agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

For the audit period July 1, 2005, through June 30, 2006, the State agency paid approximately \$4.9 million on behalf of beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in New York and New Jersey.

### **OBJECTIVE**

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in New Jersey.

### **SUMMARY OF FINDINGS**

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$680,576 (\$344,540 Federal share) on behalf of beneficiaries who should not have been eligible due to their Medicaid eligibility in New Jersey. From a statistical sample of 100 beneficiary-months, totaling \$30,739 in Medicaid services, the State agency made payments for 51 beneficiary-months, totaling \$6,299, for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in New York. The remaining 49 payments were for services to beneficiaries who were eligible to receive the benefit. We attribute the Medicaid payments made on behalf of beneficiaries who were not eligible in New York to the insufficient sharing of eligibility data between the State agency and New Jersey's Medicaid agency.

## **RECOMMENDATIONS**

We recommend that the State agency work with the New Jersey Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status and
- reducing the amount of payments, estimated to be \$680,576 (\$344,540 Federal share), made on behalf of beneficiaries residing in New Jersey.

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

In its comments on our draft report, the State agency indicated that it did not dispute our findings but did not indicate its agreement or disagreement with our recommendations. The State agency indicated that performing verifications of several million case openings and renewals annually would be administratively burdensome and costly. The State agency's comments are included in their entirety as Appendix B.

While we acknowledge the State agency's administrative and cost concerns, we continue to maintain our recommendation that the State agency work with the New Jersey Medicaid agency to share available Medicaid eligibility information for use in determining accurate beneficiary eligibility status.

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## INTRODUCTION

### BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Department of Health (the State agency) manages the New York Medicaid program.

Medicaid eligibility in each State is based on residency. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. The State Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State Medicaid agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The State Medicaid agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

### OBJECTIVE, SCOPE AND METHODOLOGY

#### Objective

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in New Jersey.<sup>1</sup>

#### Scope

For the audit period of July 1, 2005, through June 30, 2006, we identified 10,804 beneficiary-months,<sup>2</sup> with payments totaling approximately \$4.9 million made by the State agency on behalf of beneficiaries who were Medicaid-eligible and receiving benefits in New York and New Jersey. From this universe, we selected a statistical sample of 100 beneficiary-months with payments totaling \$30,739.

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the procedures used to identify

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<sup>1</sup>A separate report will be issued to the State of New Jersey Department of Human Services to address payments made on behalf of beneficiaries who should not have been Medicaid-eligible in New Jersey due to their eligibility in New York.

<sup>2</sup>A beneficiary-month included all payments for Medicaid services provided to one beneficiary during one month.

Medicaid-eligible individuals who moved from New York and enrolled in the New Jersey Medicaid program.

We performed our fieldwork at the State agency's offices in Albany and New York, New York, as well as at New Jersey's Medicaid agency in Mercerville, New Jersey, from June 2007, through January 2008.

## **Methodology**

To accomplish our audit objective, we obtained eligibility data from the New York and New Jersey Medicaid Management Information Systems (MMIS)<sup>3</sup> for the period of July 1, 2005, through June 30, 2006. We matched Social Security numbers and dates of birth from New York's and New Jersey's MMIS data to identify 6,405 beneficiaries who were Medicaid-eligible in the two states.

The State agency provided the MMIS payment data files for the beneficiaries with concurrent Medicaid eligibility and payments with dates of services that occurred during the 12-month period. For each beneficiary who was Medicaid-eligible and receiving Medicaid benefits in New York and New Jersey, we combined all dates of service for a single beneficiary-month and matched the payment data files, between States, by Social Security number, date of birth, and month of service.

We selected a simple random sample of 100 beneficiary-months with paid dates of services in both New York and New Jersey. In New York, the statistical sample included payments totaling \$30,739. The selected beneficiary-months were for services provided on behalf of beneficiaries with Medicaid eligibility in both States during the same month. See the Appendix for more information regarding the sampling methodology.

We used the State agency's MMIS data to verify that the beneficiaries were enrolled in the Medicaid program and that payments were made to providers. In addition, for each of the 100 beneficiary-months, we reviewed the Medicaid application files and/or other supporting documentation in both States to determine which State agency had established the appropriate Medicaid eligibility based on permanent residency for the sampled month. Based on the sample results, we estimated the total amount of payments that the State agency paid on behalf of beneficiaries who should not have been Medicaid-eligible.

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

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<sup>3</sup>MMIS is a mechanized claims processing and information retrieval system that States are required to use to record Title XIX program and administrative costs, report services to recipients, and report selected data to CMS.

## FINDINGS AND RECOMMENDATIONS

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid \$680,576 (\$344,540 Federal share) on behalf of beneficiaries who should not have been eligible due to their Medicaid eligibility in New Jersey. From a statistical sample of 100 beneficiary-months, totaling \$30,739 in Medicaid services, the State agency made payments for 51 beneficiary-months, totaling \$6,299, for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in New York. The remaining 49 payments were for services provided to beneficiaries who were eligible to receive the benefit. We attribute the Medicaid payments made on behalf of beneficiaries who were not eligible in New York to the insufficient sharing of eligibility data between the State agency and New Jersey's Medicaid agency.

### PAYMENTS ON BEHALF OF CONCURRENTLY ELIGIBLE BENEFICIARIES

We estimate that the State agency paid approximately \$680,576 (\$344,540 Federal share) for services on behalf of beneficiaries who should not have been eligible to receive Medicaid benefits due to their eligibility in New Jersey.

#### Federal and State Requirements

Federal regulation 42 CFR § 435.403(j)(3) states, "The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid." (Emphasis added.)

Federal regulation 42 CFR § 435.916 provides that the State agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The State agencies must promptly redetermine eligibility when they receive information of changes in beneficiaries' circumstances that may affect their eligibility.

Each State agency has specific criteria defining eligibility and residency. The New York Social Services Law § 117.3(a) states that no public assistance benefits shall be paid to or for any person who is not a resident of the State. Similarly, New Jersey Administrative Code, section 10:71-3.4 states that an applicant for or beneficiary of Medicaid only shall be a resident of New Jersey.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the New York assistance application informs beneficiaries of their responsibility to immediately report any changes to the information on the application, and warns them that anyone who knowingly lies or hides the truth in order to receive services is committing a crime and subject to federal and state penalties.

## Beneficiaries With Concurrent Eligibility

From a statistical sample of 100 beneficiary-months, totaling \$30,739 in Medicaid services, the State agency made payments for 51 beneficiary-months, totaling \$6,299 for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in New York.

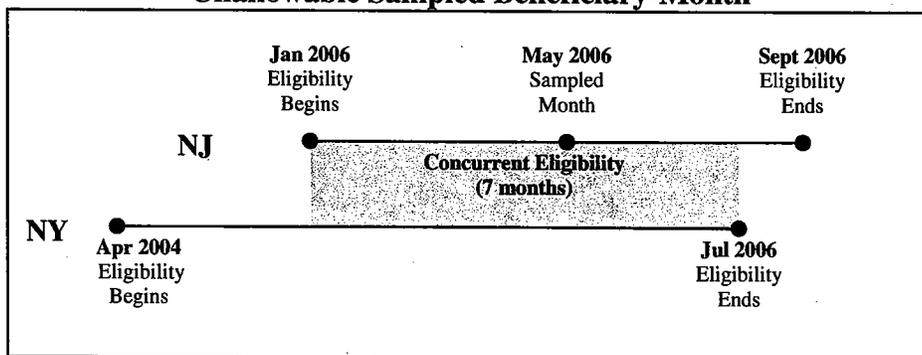
**Summary of Sampled Beneficiary-Month Payments**

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	49	\$24,440
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	51	\$6,299
<b>Totals</b>	<b>100</b>	<b>\$30,739</b>

Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer New York residents during the 51 beneficiary-months.<sup>4</sup>

In one example, a beneficiary, associated with a payment for one of the unallowable sampled beneficiary-months, moved from New York and established residency in New Jersey. The New York eligibility period was April 1, 2004, through July 19, 2006. The New Jersey eligibility period was January 1, 2006, through September 30, 2006.

**Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month**



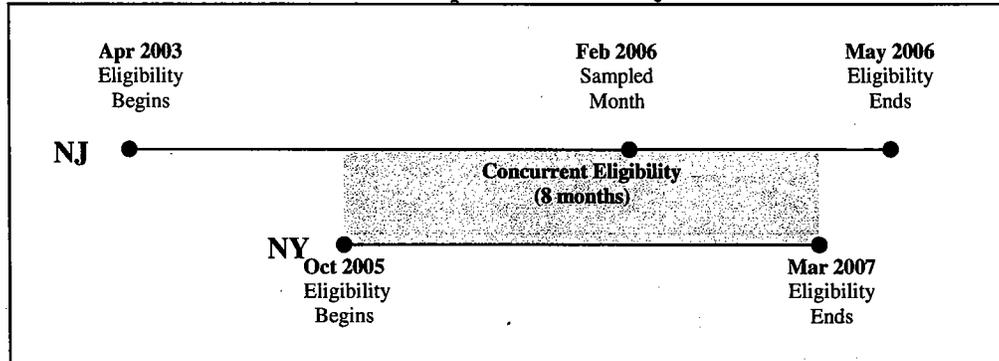
New Jersey Medicaid records document that the beneficiary moved from New York and established residency in New Jersey prior to the sampled beneficiary-month (May 2006). As a

<sup>4</sup>Two of the 51 beneficiary-months were for Supplemental Security Income beneficiaries who were categorically eligible for Medicaid. The State agency was not responsible for determining Medicaid eligibility for these beneficiaries, but was responsible for ensuring that they resided within the State.

result, the Medicaid payment made by the State agency on behalf of the beneficiary for the sampled beneficiary-month (May 2006) was unallowable.

In contrast, a different beneficiary, associated with a payment for an allowable sampled beneficiary-month, moved from New Jersey and established residency in New York. The New Jersey eligibility period was April 1, 2003, through May 31, 2006. The New York eligibility period was October 1, 2005, through March 31, 2007.

**Exhibit 2. Period of Concurrent Eligibility for an Allowable Sampled Beneficiary-Month**



The New York Medicaid records indicated that the beneficiary moved from New Jersey and established residency in New York in September 2005. The State agency provided the beneficiary's application for medical assistance as documentation of residency. Because the beneficiary was a New York resident, the State agency appropriately made the Medicaid payment on behalf of the sampled beneficiary-month (February 2006).

### **INSUFFICIENT SHARING OF ELIGIBILITY DATA**

We attribute the payments made for services provided to beneficiaries who should not have been Medicaid-eligible to insufficient sharing of eligibility data between the State agency and the New Jersey Medicaid agency. Although the State agency sometimes coordinated beneficiary eligibility with the New Jersey Medicaid agency, the State agency did not promptly and systematically identify all changes in beneficiary eligibility and residency.

### **RECOMMENDATIONS**

We recommend that the State agency work with the New Jersey Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status and
- reducing the amount of payments, estimated to be \$680,576 (\$344,540 Federal share), made on behalf of beneficiaries residing in New Jersey.

## **STATE AGENCY COMMENTS**

In its comments on our draft report, the State agency indicated that it did not dispute our findings but did not indicate agreement or disagreement with our recommendations. The State agency indicated that performing verifications of several million case openings and renewals annually would be administratively burdensome and costly. The State agency also indicated that performing such verifications would result in case processing delays. The State agency further indicated that it would continue to utilize the Public Assistance Reporting System (PARIS) to identify individuals residing in other states. The State agency's written comments are included in their entirety as Appendix B.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

While we acknowledge the State agency's administrative and cost concerns, we continue to maintain our recommendation that the State agency work with the New Jersey Medicaid agency to share available Medicaid eligibility information for use in determining accurate beneficiary eligibility status.

# **APPENDIXES**

## SAMPLING METHODOLOGY AND RESULTS

### UNIVERSE

The universe included beneficiary-months for services provided on behalf of Medicaid beneficiaries with concurrent eligibility in New York and New Jersey during the audit period of July 1, 2005 through June 30, 2006. The universe consisted of 10,804 beneficiary-months totaling \$4,881,476 in Medicaid payments for services provided to beneficiaries in New York.

### SAMPLE DESIGN

We used a simple random sample for this review. We used the Office of Inspector General, Office of Audit Services' statistical sampling software RAT-STATS to select the random sample.

### RESULTS OF SAMPLE

The results of our review are as follows:

<b>Number of Beneficiary-Months</b>	<b>Value of Universe</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Errors</b>	<b>Value of Errors</b>
10,804	\$4,881,476	100	\$30,739	51	\$6,299

Based on the errors found in the sample data, the point estimate is \$680,576 with a lower and upper limit at the 90% confidence level of \$550,210 and \$810,943, respectively. The precision of the 90% confidence interval is plus or minus \$130,366 or 19.16%.



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

Richard F. Daines, M.D.  
*Commissioner*

Wendy E. Saunders  
*Chief of Staff*

July 24, 2008

James P. Edert  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Region II  
Jacob Javitz Federal Building  
26 Federal Plaza  
New York, New York 10278

Ref. No. A-02-07-01030

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-07-01030 on "Medicaid Payments for Services Provided to Beneficiaries in New York and New Jersey for July 1, 2005 through June 30, 2006."

Thank you for the opportunity to comment.

Sincerely,



Wendy E. Saunders  
Chief of Staff

Enclosure

cc: Stephen Abbott  
Deborah Bachrach  
Homer Charbonneau  
Ronald Farrell  
Gail Kerker  
Sandra Pettinato  
Robert W. Reed

**New York State Department of Health  
Comments on the  
Department of Health and Human Services  
Office of Inspector General  
Draft Audit Report A-02-07-01030 on  
"Medicaid Payments for Services Provided to Beneficiaries  
with Concurrent Eligibility in New York and New Jersey for  
July 1, 2005 through June 30, 2006"**

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The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) draft audit report A-02-07-01030 on "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in New York and New Jersey for July 1, 2005 through June 30, 2006."

**OIG Recommendation:**

OIG recommends that the State agency work with the New Jersey Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status, and
- reducing the amount of payments, estimated to be \$680,576 (\$344,540 Federal share), made on behalf of beneficiaries residing in New Jersey.

**Department Response:**

All New York State beneficiaries are instructed that they must report residency changes to the local department of social services, although it is the Department's experience that this requirement is nearly impossible to enforce. As such, the Department does not dispute that the OIG review may have uncovered evidence that more clearly indicates New Jersey residency for the cases associated with the audit findings. However, performing verifications of several million case openings and renewals annually would be administratively burdensome and costly, with the associated administrative costs likely to exceed any New York State benefit savings. It would inevitably result in case processing delays, as it regularly takes some time to obtain information from another state, and would also take staff away from processing their own work to perform verifications for other states. The consequences of such delays include inability to comply with federal timeliness standards, and unwarranted postponement of health coverage for individuals requiring care through Medicaid and Family Health Plus. The Department and the local departments of social services will continue to utilize the PARIS match to identify individuals residing in other states, and to close cases accordingly.