



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V  
233 North Michigan Avenue  
Suite 1360  
Chicago, IL 60601

December 15, 2009

Report Number: A-05-08-00091

Mr. Barry S. Maram  
Director  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East  
Springfield, Illinois 62763-0001

Dear Mr. Maram:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG) final report entitled "Review of Eligibility Redeterminations for Medicaid Beneficiaries in Cook County, Illinois." 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mike Barton, Audit Manager, at (614) 469-2543 or through email at [Mike.Barton@oig.hhs.gov](mailto:Mike.Barton@oig.hhs.gov). Please refer to report number A-05-08-00091 in all correspondence.

Sincerely,

/Stephen Slamar/  
Acting Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Jackie Garner, Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
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Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF ELIGIBILITY  
REDETERMINATIONS FOR  
MEDICAID BENEFICIARIES IN  
COOK COUNTY, ILLINOIS**

**JULY 1, 2006, THROUGH  
JUNE 30, 2007**



Daniel R. Levinson  
Inspector General

December 2009  
A-05-08-00091

# *Office of Inspector General*

<http://oig.hhs.gov>

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The designation of financial or management practices as questionable,  
a recommendation for the disallowance of costs incurred or claimed,  
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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 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.

Pursuant to Federal and Illinois requirements, Medicaid-eligibility redeterminations are required at least every 12 months and when a beneficiary's circumstances affecting eligibility may have changed. The State Medicaid agency must have procedures designed to ensure that required annual eligibility redeterminations are performed and beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. Redeterminations are required to ensure that a beneficiary continues to meet the Medicaid-eligibility requirements.

Under Title XIX of the Act, Medicaid payments are allowable only for eligible beneficiaries. Generally, Federal regulations (42 CFR §§ 431.800–431.865) require the State to have a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility decisions. In addition, these 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.

The Illinois Department of Healthcare and Family Services (State Medicaid agency) administered the State medical assistance (Medicaid) program and was responsible for ensuring that eligibility redeterminations were performed. The State Medicaid agency delegated to the Illinois Department of Human Services (State human services agency) the administration of the Medicaid application and eligibility process, including the performance of initial eligibility determinations and redeterminations. Staff within the State human services agency's local Family Community Resource Centers conducted the reviews. During our audit period, 22 Family Community Resource Centers were located in Cook County (Cook County centers).

For the audit period July 1, 2006, through June 30, 2007, the State Medicaid agency paid approximately \$5 billion for services on behalf of 1.1 million Cook County beneficiaries. During this time, the State Medicaid agency paid \$2.5 billion for services provided to 578,974 Cook County beneficiaries who were continuously Medicaid-enrolled for the 3-year period July 1, 2005, through June 30, 2008. The remaining \$2.5 billion was paid for beneficiaries who were enrolled for some portion of the 3-year period.

## **OBJECTIVE**

Our objective was to determine whether the State Medicaid agency, through its agent, the State human services agency, made timely redeterminations for Medicaid beneficiaries who were continuously enrolled during our audit period.

## **SUMMARY OF FINDING**

Generally, the State Medicaid agency made timely redeterminations for Medicaid beneficiaries who were continuously enrolled during our audit period. From a random sample of 200 Medicaid beneficiaries with payments for services totaling \$916,658, the State Medicaid agency paid \$911,396 to providers on behalf of 191 beneficiaries whose redeterminations were performed by the Cook County centers within the required 12-month period. However, the State Medicaid agency paid \$5,262 to providers on behalf of nine beneficiaries whose eligibility redeterminations were not performed by the Cook County centers within the required 12-month period. The Medicaid payments were made on behalf of the nine beneficiaries because the State agency was unaware that the Cook County centers did not always comply with Federal and State requirements. Although the Cook County centers were provided with a monthly list of the cases that were due for redetermination, the centers did not complete all of the redeterminations pursuant to the Federal and State requirements. For the period July 1, 2006, through June 30, 2007, we estimated that the State Medicaid agency claimed \$15,232,024 (\$7,616,012 Federal share) for Medicaid services provided to 26,054 beneficiaries whose eligibility redeterminations were not performed by the Cook County centers within the required 12-month period.

We are not recommending recovery of the Federal share of payment made on behalf of beneficiaries whose eligibility redeterminations were not completed in a timely fashion because a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program.

## **RECOMMENDATION**

We recommend that the State Medicaid agency require the State human services agency to develop a corrective action plan to help ensure Cook County centers perform Medicaid beneficiary eligibility redeterminations at least every 12 months pursuant to Federal and State requirements.

## **STATE MEDICAID AGENCY COMMENTS**

In written comments on our draft report, the State Medicaid agency stated that they are working closely with the State human services agency to develop a corrective action plan to complete redeterminations timely. The State Medicaid agency comments are included in their entirety as Appendix C.

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## INTRODUCTION

### BACKGROUND

Pursuant to Title XIX of the Social Security Act (the 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.

#### **Federal and State Requirements**

Pursuant to Federal and Illinois requirements, Medicaid-eligibility redeterminations are required at least every 12 months and when a beneficiary's circumstances affecting eligibility may have changed. The State Medicaid agency must have procedures designed to ensure that required annual eligibility redeterminations are performed and beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. Redeterminations are required to ensure that a beneficiary continues to meet the Medicaid-eligibility requirements.

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.

#### **Illinois Medicaid Eligibility Quality Control Review**

The Illinois Department of Healthcare and Family Services (State Medicaid agency) operated the MEQC program as a pilot program that conducted focused reviews and special studies. The purpose of the fiscal year (FY) 2007 review was to determine the accuracy and thoroughness of Medicaid eligibility redeterminations that were completed. The universe of this review included statewide redeterminations for three categories of assistance: Medical Assistance No Grant; Aid to the Aged, Blind, and Disabled; and Medicaid cases that did not receive a Temporary Assistance for Needy Families (TANF) grant. Sampled redetermination case files were reviewed to determine the accuracy and thoroughness of the most recent redetermination completed. After completing all eligibility reviews, the State Medicaid agency calculated a case error rate.

The FY 2007 MEQC program selected and reviewed 1,198 redetermination case files.<sup>1</sup> The MEQC program identified 246 files (21 percent) with eligibility errors and of those, 144 were identified with payment errors.

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<sup>1</sup>The sample frame of our audit included 264 of the case files reviewed under the MEQC program (264 of 1,198). However, none of the case files were selected in our audit sample of 200 cases.

The State Medicaid agency reported to CMS the results of the FY 2007 MEQC program review on April 3, 2009. CMS responded to the report on May 21, 2009, and requested a copy of corrective action plans to address the deficiencies noted in the summary of findings report. The State Medicaid agency is currently developing recommendations for improvement.

## **Illinois Department of Healthcare and Family Services**

The State Medicaid agency administered the State Medicaid program and was responsible for ensuring that eligibility redeterminations were performed. The State Medicaid agency delegated to the Illinois Department of Human Services (State human services agency) the administration of the Medicaid application and eligibility process, including the performance of initial eligibility determinations and redeterminations. Staff within the State human services agency's local Family Community Resource Centers conducted the reviews. During our audit period, 22 Family Community Resource Centers were located in Cook County (Cook County centers).

For the audit period July 1, 2006, through June 30, 2007, the State Medicaid agency paid approximately \$5 billion for services on behalf of 1.1 million Cook County beneficiaries. During this time, the State Medicaid agency paid \$2.5 billion for services provided to 578,974 Cook County beneficiaries who were continuously Medicaid-enrolled for the 3-year period July 1, 2005, through June 30, 2008. The remaining \$2.5 billion was paid for beneficiaries who were enrolled for some portion of the 3-year period.

## **OBJECTIVE, SCOPE AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State Medicaid agency, through its agent, the State human services agency, made timely redeterminations for Medicaid beneficiaries who were continuously enrolled during our audit period.

### **Scope**

The scope of our audit included State Medicaid agency payments made for services provided to Cook County beneficiaries during the period July 1, 2006, through June 30, 2007. For this period, the State Medicaid agency paid approximately \$2.5 billion for services provided to 578,974 Cook County beneficiaries who were continuously Medicaid-enrolled for the 3-year period July 1, 2005, through June 30, 2008. We selected this 3-year period to ensure that the sampled beneficiaries were enrolled before and after our 1-year audit period, ensuring that Medicaid-eligibility redeterminations were required during our audit period.

From the population of 578,974 beneficiaries, we selected and reviewed Medicaid-eligibility redetermination documentation for a random sample of 200 beneficiaries for which the State Medicaid agency made Medicaid payments totaling \$916,658 during our audit period.

We did not review the overall internal control structure of the State Medicaid agency or Cook County centers. We limited our internal control review to obtaining an understanding of the procedures used to perform Medicaid-eligibility redeterminations for Cook County beneficiaries.

We performed our fieldwork at the Humboldt Park Cook County Center in Chicago, Illinois, during December 2008.

## **Methodology**

To accomplish our audit objective, we:

- obtained eligibility data from the State Medicaid agency's Medicaid Management Information System (MMIS)<sup>2</sup> to identify 578,974 Cook County beneficiaries who were continuously enrolled in Medicaid during the 3-year period July 1, 2005, through June 30, 2008;
- used the State Medicaid agency's MMIS data to obtain payment data on behalf of the beneficiaries continuously enrolled during our audit period;
- selected a random sample of 200 of the 578,974 beneficiaries and reviewed the Medicaid case files and other supporting documentation to
  - determine the month and year of the last Medicaid-eligibility redetermination before our audit period and
  - determine whether a Medicaid-eligibility redetermination was performed within 12 months of the last redetermination and during the audit period;
- identified beneficiaries whose required Medicaid-eligibility redeterminations were not performed and quantified the Medicaid payments that were made on their behalf during the audit period;
- estimated, based on the sample results,
  - the number of beneficiaries whose Medicaid-eligibility redeterminations were not performed within the required 12-month period and
  - the total Medicaid payments that the State Medicaid agency made on behalf of those beneficiaries; and
- reviewed the Illinois MEQC Summary of Information report for Federal fiscal year 2007 and the CMS response, dated May 21, 2009, to the State Medicaid agency.

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<sup>2</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.

See Appendixes A and B for details regarding the sampling methodology and estimates.

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 finding and conclusions based on our audit objective.

### **FINDING AND RECOMMENDATION**

Generally, the State Medicaid agency made timely redeterminations for Medicaid beneficiaries who were continuously enrolled during our audit period. From a random sample of 200 Medicaid beneficiaries with payments for services totaling \$916,658, the State Medicaid agency paid \$911,396 to providers on behalf of 191 beneficiaries whose redeterminations were performed by the Cook County centers within the required 12-month period. However, the State Medicaid agency paid \$5,262 to providers on behalf of nine beneficiaries whose eligibility redeterminations were not performed by the Cook County centers within the required 12-month period. The Medicaid payments were made on behalf of the nine beneficiaries because the State agency was unaware that the Cook County centers did not always comply with Federal and State requirements. Although the Cook County centers were provided with a monthly list of the cases that were due for redetermination, the centers did not complete all redeterminations pursuant to Federal and State requirements. For the period July 1, 2006, through June 30, 2007, we estimated that the State Medicaid agency claimed \$15,232,024 (\$7,616,012 Federal share) for Medicaid services provided to 26,054 beneficiaries whose eligibility redeterminations were not performed by the Cook County centers within the required 12-month period.

### **FEDERAL AND STATE REQUIREMENTS**

Federal regulations (42 CFR § 435.1002(b)) state that Federal financial participation is available in expenditures for services provided to recipients who were Medicaid-eligible in the month in which the medical care or services were provided. Pursuant to 42 CFR § 435.916, the State agency must perform eligibility redeterminations for Medicaid beneficiaries at least every 12 months.

Pursuant to Illinois Administrative Code 89, section 120.399, a redetermination of eligibility shall be conducted at least every 12 months and when a beneficiary's circumstances affecting eligibility may have changed.

### **PAYMENTS FOR BENEFICIARIES WITHOUT MEDICAID-ELIGIBILITY REDETERMINATIONS**

From a random sample of 200 Medicaid beneficiaries with payments totaling \$916,658, the State Medicaid agency made payments totaling \$5,262 on behalf of 9 beneficiaries whose eligibility redeterminations were not performed within the required 12-month period.

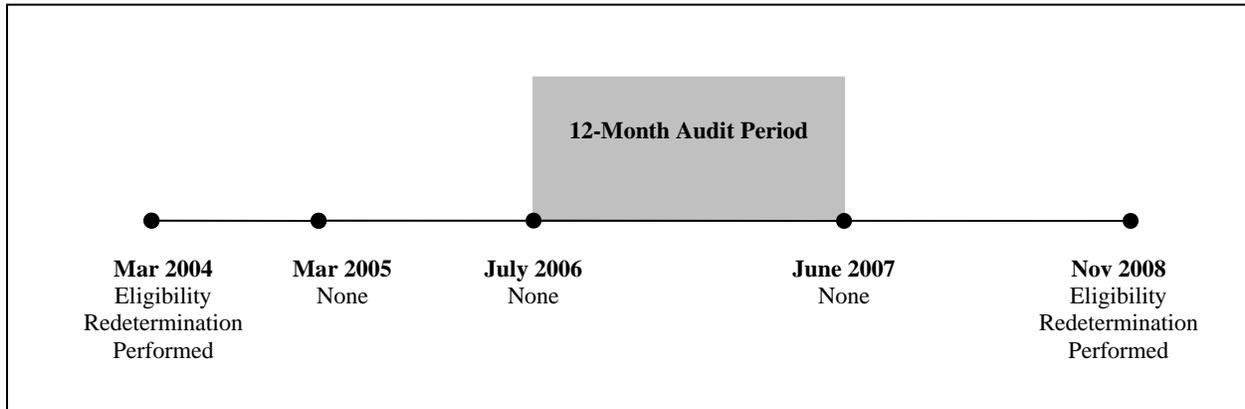
**Summary of Sampled Beneficiaries and Associated Payments**

	<b>Sampled Beneficiaries</b>	<b>Payments</b>
Beneficiaries with eligibility redeterminations performed within 12-month period	191	\$911,396
Beneficiaries without eligibility redeterminations performed within 12-month period	9	5,262
<b>Total</b>	<b>200</b>	<b>\$916,658</b>

Medicaid application files and other supporting documentation indicated that the Medicaid-eligibility redeterminations for the nine beneficiaries were not performed by the Cook County centers within the required 12-month period. However, the nine beneficiaries were determined to be Medicaid eligible when the Cook County centers performed the past-due redeterminations. For the period July 1, 2006, through June 30, 2007, we estimated that the State Medicaid agency claimed approximately \$15,232,024 (\$7,616,012 Federal share) for Medicaid services provided to 26,054 beneficiaries whose eligibility redeterminations were not performed by the Cook County centers within the required 12-month period (Appendix B).

In the following example, the State Medicaid agency made payments for services on behalf of a beneficiary whose Medicaid-eligibility redetermination had not been performed during the 12-month audit period.

**Exhibit 1. Period of Time Without Redetermination Performed (Sample Beneficiary)**



The Cook County centers performed the beneficiary’s last Medicaid-eligibility redetermination in March 2004, before our audit period. However, Cook County centers did not complete the required eligibility redetermination by March 2005 or during our audit period but completed it in November 2008. The State Medicaid agency considered the beneficiary Medicaid-eligible from March 2004 through November 2008 without performing any eligibility redeterminations during this time. The State Medicaid agency made payments on behalf of the beneficiary during the

audit period July 1, 2006, through June 30, 2007. During the November 2008 redeterminations, the individual was found to be eligible for Medicaid.

## **COOK COUNTY CENTERS COMPLIANCE WITH REQUIREMENTS**

The State Medicaid agency personnel informed us that they were unaware that the State human services agency's Cook County centers did not consistently comply with the Federal and State Medicaid requirements to ensure that eligibility redeterminations were performed in a timely manner. A Priority Action List report was provided monthly to local offices of the State human services agency. The list identified cases which had an error, had a high probability of error, or were due for a redetermination. Local office managers determined the priority order for reviewing the cases that appeared on the Priority Action List and each case listed was assigned to the appropriate caseworker. Although the Cook County centers were provided with a monthly list of the cases that were due for redetermination, the centers did not complete all eligibility redeterminations.

We are not recommending recovery of the Federal share of payments made on behalf of beneficiaries whose eligibility redeterminations were not completed primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's MEQC program.

## **RECOMMENDATION**

We recommend that the State Medicaid agency require the State human services agency to develop a corrective action plan to help ensure Cook County centers perform Medicaid beneficiary eligibility redeterminations at least every 12 months pursuant to Federal and State requirements.

## **STATE MEDICAID AGENCY COMMENTS**

In written comments on our draft report, the State Medicaid agency stated that they are working closely with the State human services agency to develop a corrective action plan to complete redeterminations timely. The State Medicaid agency comments are included in their entirety as Appendix C.

# **APPENDIXES**

## **APPENDIX A: SAMPLING METHODOLOGY**

### **POPULATION**

The population was beneficiaries with 3 years of continuous Medicaid enrollment in Cook County during July 1, 2005, through June 30, 2008, and with Medicaid payments for services provided to those beneficiaries during the 12-month audit period, July 1, 2006, through June 30, 2007.

### **SAMPLE FRAME**

The sampling frame was 578,974 beneficiaries that were continuously enrolled in Medicaid for the 3-year period, July 1, 2005, through June 30, 2008.

### **SAMPLE UNIT**

The sample unit was a beneficiary.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a random sample of 200 beneficiaries.

### **SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

### **METHOD OF SELECTING SAMPLE ITEMS**

The sample frame was consecutively numbered from 1 to 578,974. After generating 200 random numbers, we selected the corresponding sample frame items to create a list of sample items.

## **ESTIMATION METHODOLOGY**

We used the Office of Inspector General, Office of Audit Services, statistical software to calculate our estimates. We estimated the total number of beneficiaries whose Medicaid-eligibility redeterminations were not performed and the State Medicaid agency payments made to providers for services provided to those beneficiaries during our audit period.

## APPENDIX B: SAMPLE RESULTS AND ESTIMATES

### Sample Results

<b>Number of Beneficiaries in Sample Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Beneficiaries Without Eligibility Redeterminations During Audit Period</b>	<b>Value of Payments</b>
578,974	200	\$916,658	9	\$5,262

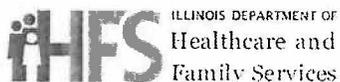
### Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

	<b>Estimated Number of Beneficiaries Without Eligibility Redeterminations During Audit Period</b>	<b>Estimated Payments</b>
Point Estimate	26,054	\$15,232,024
Lower Limit	13,709	\$5,918,088
Upper Limit	44,699	\$24,545,961

Based on the sample results, we estimated that the State Medicaid agency claimed \$15,232,024 (\$7,616,012 Federal share) for Medicaid services provided to 26,054 beneficiaries whose Medicaid-eligibility redeterminations were not performed in a timely fashion.

## APPENDIX C: STATE MEDICAID AGENCY COMMENTS



Pat Quinn, Governor  
Barry S. Maram, Director

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Springfield, Illinois 62763-0002

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November 17, 2009

Mr. Mark Gustafson  
Regional Inspector General for Audit Services  
Office of Audit Services, Region V  
Office of Inspector General  
U.S. Department of Health and Human Services  
233 North Michigan Avenue, Suite 1360  
Chicago, Illinois 60601

Report Number: A-05-08-00091

Dear Mr. Gustafson:

We have reviewed the draft audit report entitled "Review of Eligibility Redeterminations for Medicaid Beneficiaries in Cook County, Illinois." The report states that nine out of 200 randomly sampled Medicaid beneficiaries did not have their eligibility redeterminations performed within the required 12-month time period. HFS will work closely with the Department of Human Services to develop a corrective action plan to complete redeterminations timely.

We appreciate the opportunity to comment on this draft report. Should you have questions regarding our response, or need any additional information, please contact Peggy Edwards of my staff. She may be reached by telephone at (217) 785-9764 or by e-mail at [Peggy.Edwards@illinois.gov](mailto:Peggy.Edwards@illinois.gov).

Sincerely,

A handwritten signature in black ink, appearing to read 'Theresa A. Eagleson', is written over a faint, illegible typed name.

Theresa A. Eagleson, Medicaid Director  
Division of Medical Programs