



JUL 25 2007

TO: Herb Kuhn
Acting Deputy 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 California
(A-09-06-00022)

Attached is an advance copy of our final report on State Children's Health Insurance Program (SCHIP) eligibility in California. We will issue this report to the California Department of Health Services and the Managed Risk Medical Insurance Board (referred to collectively as the State agencies) within 5 business days. This report is part of a multistate review requested by the Centers for Medicare & Medicaid Services and the Office of Management and Budget.

SCHIP, 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. Federal and State laws, regulations, and other requirements establish both SCHIP and Medicaid eligibility.

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.

California operates two separate children's health insurance programs (Healthy Families and Access for Infants and Mothers) and an expanded Medicaid program using SCHIP funds. The Managed Risk Medical Insurance Board (the Board) administers the two separate children's health insurance programs by contracting with managed care organizations to provide services to qualified beneficiaries. A separate contractor, MAXIMUS, Inc., determines eligibility for these programs. The California Department of Health Services (DHS) administers the Medicaid program, which includes expanded Medicaid.

Our objective was to determine the extent to which the State agencies 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 approximately 6 million payments totaling approximately \$504 million (approximately \$318 million Federal share) on behalf of SCHIP beneficiaries.

The State agencies (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 191 payments in our statistical sample, 7 payments totaling \$259 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. Specifically, the State agencies made four payments on behalf of beneficiaries whose family incomes exceeded the SCHIP income threshold and three payments on behalf of beneficiaries who were enrolled in Medicaid at the time of the SCHIP payment. In addition, for 12 sampled payments totaling \$410 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing or inadequate documentation included preenrollment applications and facts supporting income level and other health care coverage.

As a result, for the 6-month audit period, we estimate that the State agency made between 104,162 and 407,226 payments totaling between \$2,081,901 and \$14,248,148 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 220,345 payments totaling \$8,165,024. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 220,344 to 600,063 payments totaling between \$4,996,337 and \$20,829,931 (Federal share). The midpoint of the confidence interval amounted to 377,733 payments totaling \$12,913,134.

We recommend that the State agencies 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 MAXIMUS and the county offices to verify eligibility information and maintain appropriate documentation in all case files.

In their comments on our draft report (Appendixes C and D), the State agencies agreed with our recommendation. DHS also agreed that three payments were made on behalf of beneficiaries who were enrolled in Medicaid at the time of the SCHIP payment. However, the Board did not agree with all our findings regarding eligibility errors. Specifically, the Board disagreed with one eligibility error because of our annualization of overtime wages when calculating household income and disagreed with two eligibility errors because of “difference and inconsistency” between the Board’s and our income verification standards. Further, both DHS and the Board disagreed with our fiscal extrapolation of the Federal share associated with the estimated improper payments because they believe that the errors identified do not represent a sufficient sample size for extrapolating to the SCHIP population.

Regarding the eligibility error due to the inclusion of overtime wages, we agree that the beneficiary’s gross family income did not exceed the SCHIP income threshold when taking into consideration the exemption for irregular or infrequent income. We adjusted the report accordingly. To determine whether the two beneficiaries’ gross family incomes were at or below

the income threshold required to be eligible for SCHIP, we used the State's Income Eligibility Verification System. Regarding our fiscal extrapolation, we used a valid statistical sample, which we selected randomly.

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 Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through e-mail at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-06-00022.

Attachment



Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

JUL 27 2007

Report Number: A-09-06-00022

Ms. Lesley Cummings
Executive Director
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, California 95814

Dear Ms. Cummings:

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 California.” A copy of this report will be forwarded 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 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 information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

I will also provide this response to Ms. Sandra Shewry. Please refer to report number A-09-06-00022 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services, Region IX
U.S. Department of Health and Human Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, California 94103



Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

JUL 27 2007

Report Number: A-09-06-00022

Ms. Sandra Shewry
Director
California Department of Health Services
1501 Capitol Avenue, Suite 6001
MS 0000
Sacramento, California 95899

Dear Ms. Shewry:

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 California.” A copy of this report will be forwarded 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 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.

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I will also provide this response to Ms. Lesley Cummings. Please refer to report number A-09-06-0022 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services, Region IX
U.S. Department of Health and Human Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, California 94103

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



Daniel R. Levinson
Inspector General

July 2007
A-09-06-00022

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.

California operates (1) two separate children's health insurance programs (Healthy Families and Access for Infants and Mothers) and (2) an expanded Medicaid program.

- The Managed Risk Medical Insurance Board (the Board) administers the two separate children's health insurance programs by contracting with managed care organizations to provide services to qualified beneficiaries. In addition, a separate contractor, MAXIMUS, Inc., determines eligibility for these programs.
- The California Department of Health Services (DHS) administers the Medicaid program, which includes expanded Medicaid. The California county government offices determine eligibility for the Medicaid program.

From January 1 through June 30, 2005, the Board and DHS (referred to collectively in this report as the State agencies) made approximately 6 million payments for the children's health insurance and expanded Medicaid programs on behalf of SCHIP beneficiaries. These payments totaled approximately \$504 million (approximately \$318 million Federal share).

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

OBJECTIVE

Our objective was to determine the extent to which the State agencies 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 agencies (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 191 payments in our statistical sample, 7 payments totaling \$259 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. Specifically, the State agencies made:

- four payments on behalf of beneficiaries whose family incomes exceeded the SCHIP income threshold and
- three payments on behalf of beneficiaries who were enrolled in Medicaid at the time of the SCHIP payment.

In addition, for 12 sampled payments totaling \$410 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing or inadequate documentation included preenrollment applications and facts supporting income level and other health care coverage.

As a result, for our 6-month audit period, we estimate that the State agencies made between 104,162 and 407,226 payments totaling between \$2,081,901 and \$14,248,148 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 220,345 payments totaling \$8,165,024.

For the same 6-month period, we estimate that case file documentation did not adequately support eligibility determinations for an additional 220,344 to 600,063 payments totaling between \$4,996,337 and \$20,829,931 (Federal share). The midpoint of the confidence interval amounted to 377,733 payments totaling \$12,913,134.

RECOMMENDATION

We recommend that the State agencies 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 MAXIMUS and the California county government offices to verify eligibility information and maintain appropriate documentation in all case files.

STATE AGENCIES' COMMENTS

In their comments on our draft report (Appendixes C and D), the State agencies agreed with our recommendation. DHS also agreed that three payments were made on behalf of beneficiaries who were enrolled in Medicaid at the time of the SCHIP payment. However, the Board did not agree with all our findings regarding eligibility errors. Specifically, the Board disagreed with one eligibility error because of our annualization of overtime wages when calculating household

income and disagreed with two eligibility errors because of “difference and inconsistency” between the Board’s and our income verification standards. Further, both DHS and the Board disagreed with our fiscal extrapolation of the Federal share associated with the estimated improper payments because they believe that the errors identified do not represent a sufficient sample size for extrapolating to the SCHIP population.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

Regarding the eligibility error due to the inclusion of overtime wages, we agree that the beneficiary’s gross family income did not exceed the SCHIP income threshold when taking into consideration the exemption for irregular or infrequent income. We adjusted the report accordingly. To determine whether the two beneficiaries’ gross family incomes were at or below the income threshold required to be eligible for SCHIP, we used the State’s Income Eligibility Verification System. Regarding our fiscal extrapolation, we used a valid statistical sample, which we selected randomly.

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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 its State plan. A 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 program: (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.

California's State Children's Health Insurance and Medicaid Programs

California operates two separate children's health insurance programs (Healthy Families and Access for Infants and Mothers) and an expanded Medicaid program using SCHIP funds. The Managed Risk Medical Insurance Board (the Board) administers the two separate children's health insurance programs by contracting with managed care organizations to provide services to qualified beneficiaries. The California Department of Health Services (DHS) administers the Medicaid program, which includes expanded Medicaid.¹ (In this report, the Board and DHS are referred to collectively as the State agencies.)

The Board uses a database system to process capitation payments for the children's health insurance programs. DHS uses the Medicaid Management Information System to process expanded Medicaid claims.

¹In California, Medicaid is referred to as the Medi-Cal program.

The State agencies require that applicants submit completed applications for SCHIP and Medicaid benefits. MAXIMUS, Inc., an independent contractor for the Board, determines eligibility for Healthy Families and Access for Infants and Mothers. The California county government offices (county offices) determine eligibility for the Medicaid program.

For each beneficiary determined eligible for Healthy Families,² eligibility is granted for a continuous 12 months. Each year thereafter, MAXIMUS must redetermine the beneficiary's eligibility. For each beneficiary determined eligible for expanded Medicaid, the county office must redetermine the beneficiary's eligibility at least annually. In addition, the instructions accompanying the Medicaid application notify applicants of their responsibility to report to the county office any changes that may affect eligibility status.

The Federal Government pays 65 percent of California's costs for the separate children's health insurance programs and 50 to 65 percent of its costs for expanded Medicaid, depending on the type of service received.

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

Federal law 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 California 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 Medicaid and SCHIP programs.³

Pursuant to the California State plan, a child who resides in a family that has gross 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 Healthy Families.⁴ In addition, Federal regulations

²Our discussion is limited to Federal and State criteria for Healthy Families and expanded Medicaid because the results of our random sample did not contain payments from Access for Infants and Mothers.

³Notwithstanding 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.

⁴For children through the age of 2 who were born to mothers in Access for Infants and Mothers, the gross family income to be eligible for Healthy Families is at or below 300 percent of the Federal poverty level.

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

The California State plan also requires monthly cost-sharing payments (premiums) for beneficiaries, which vary according to income levels, type of health plan, and family size. If the applicant fails to pay the required premium for 2 consecutive calendar months, the beneficiary is disenrolled from participation in SCHIP (Title 10, sections 2699.6611(a)(4) and (d), of the California Code of Regulations).

Pursuant to Title 10, section 2699.6625, of the California Code of Regulations, eligibility for Healthy Families is continuous for 12 months unless a child is otherwise made ineligible. A beneficiary may be disenrolled from Healthy Families for a number of reasons, including the following: (1) the beneficiary attains the age of 19, (2) the beneficiary is determined not to be a citizen or national of the United States or a qualified alien, (3) the applicant fails to pay the monthly premium on behalf of the beneficiary for 2 consecutive calendar months, (4) the applicant intentionally makes false statements to establish eligibility, or (5) the beneficiary dies (Title 10, section 2699.6611, of the California Code of Regulations).

Federal regulations (42 CFR § 457.320(e)(2)) require that eligibility for SCHIP 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 or 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 enough medical expenses to lower countable income to the threshold limit).

Pursuant to 42 CFR § 435.229, the State may provide Medicaid coverage to all individuals under the age of 19 who are optional targeted low-income children or reasonable categories of these individuals. Regulations (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.⁵

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.⁶ 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.” 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 an SSN, the State must assist the individual in obtaining a number or identifying his or her existing number. The State may not deny or delay Medicaid services to an otherwise eligible individual pending issuance or verification of his or her 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 beneficiary’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 beneficiary to furnish it.

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

⁵See footnote 3 on p. 2.

⁶Children and pregnant women may qualify at higher income levels than other types of applicants.

Pursuant to 42 CFR § 435.1100, the State may provide services to children under the age of 19 during a period of presumptive eligibility before a formal determination of Medicaid eligibility. The State may provide these services following a determination by a qualified entity that the child's estimated gross family income does not exceed applicable income standards (42 CFR § 435.1102). Pursuant to the California State plan, each beneficiary must complete a preenrollment application for an initial 2-month period of coverage. A child does not qualify for presumptive eligibility if the child is (1) already enrolled in Medicaid or Healthy Families or (2) known to have a confirmed ineligible immigration status.

The California State plan incorporates the Federal requirements pertaining to residency, citizenship, blindness and/or disability, SSN, and beneficiary liability. The California State plan also establishes income and resource levels. Under California's expanded Medicaid for Title XXI, children aged 1 to 5 whose gross family income is less than 133 percent of the Federal poverty level and children aged 6 to 18 whose gross family income is less than 100 percent of the Federal poverty level are eligible for the program. Title 22, section 50185(a)(4), of the California Code of Regulations requires beneficiaries to inform the county office of any changes in financial situation or any other changes affecting eligibility within 10 calendar days following the date the change occurred.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the extent to which the State agencies 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 California's SCHIP. Rather, we reviewed the State agencies' procedures relevant to the objective of the audit.

We performed fieldwork from September 2005 to February 2006 at the State agencies' offices in Sacramento, California, and at the Los Angeles County Department of Public Social Services (a county office) in Los Angeles, California.

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 regional officials and with the Board and DHS officials to obtain an understanding of policies, procedures, and guidance for determining eligibility for the children's health insurance programs and expanded Medicaid;

- obtained an extract of the Board’s Healthy Families and Access for Infants and Mothers payments containing 4,193,882 managed care payments totaling approximately \$385.9 million (approximately \$250.8 million Federal share) for services rendered in California for the period January 1 through June 30, 2005;
- obtained an extract of the DHS payments from the Medicaid Management Information System that included 1,818,376 expanded Medicaid payments totaling approximately \$118.5 million (approximately \$67.5 million Federal share) for services rendered in California for the period January 1 through June 30, 2005;
- identified a combined universe of 6,012,258 SCHIP payments (Healthy Families, Access for Infants and Mothers, and expanded Medicaid) totaling approximately \$504.4 million (approximately \$318.3 million Federal share) for services rendered to beneficiaries in California for the period January 1 through June 30, 2005; and
- selected a simple random sample of 191 payments from the universe of 6,012,258 payments, as detailed in Appendix A.

For each of the 191 sampled SCHIP payments (134 Healthy Families payments and 57 expanded Medicaid payments), we determined whether the case file contained sufficient information for MAXIMUS or the county 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 134 Healthy Families payments, we determined whether:

- the case file contained a completed application on behalf of the beneficiary;
- the beneficiary resided in California by checking driver’s licenses, household rental receipts, or State 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, the State’s Income Eligibility Verification System (IEVS), and the U.S. Citizenship and Immigration Services’ Systematic Alien Verification for Entitlement program;
- the beneficiary’s gross family income was at or below the income threshold required to be eligible for Healthy Families by reviewing information from the IEVS and case file documentation (applicable to both the date of the most recent application and the period covered by the capitation payment);⁷
- the beneficiary did not have access to other health insurance, i.e., the beneficiary was not eligible or potentially eligible for Medicaid or other health coverage;

⁷We reviewed income information applicable to both periods because eligibility for Healthy Families is granted for a continuous 12 months.

- the beneficiary was deceased by reviewing information from California’s Bureau of Vital Statistics; and
- the beneficiary had paid the required premiums.

For the 57 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 California by checking driver’s licenses, rental receipts, utility bills, or 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, the IEVS, and the Systematic Alien Verification for Entitlement program;
- the beneficiary’s gross family income was at or below the income threshold required to be eligible for expanded Medicaid by reviewing information from the IEVS and case file documentation;
- the beneficiary was deceased by reviewing information from California’s Bureau of Vital Statistics; and
- the beneficiary was eligible for both expanded Medicaid and the service received.

For the total population of 6,012,258 SCHIP payments, we used an attribute appraisal program to estimate (1) the total number of payments for ineligible beneficiaries and (2) the total number of payments for which case file documentation did not adequately support eligibility determinations. In addition, we used a variable appraisal program to estimate (1) the dollar impact of the improper Federal funding for ineligible beneficiaries and (2) the dollar impact of the payments for which case file documentation did not adequately support eligibility determinations.

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

FINDINGS AND RECOMMENDATION

The State agencies (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 191 payments in our statistical sample, 7 payments totaling \$259 (Federal share) were unallowable because the beneficiaries were ineligible for SCHIP. Specifically, the State agencies made:

- four payments on behalf of beneficiaries whose family incomes exceeded the SCHIP income threshold and
- three payments on behalf of beneficiaries who were enrolled in Medicaid at the time of the SCHIP payment.

In addition, for 12 sampled payments totaling \$410 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing or inadequate documentation included preenrollment applications and facts supporting income level and other health care coverage.

As a result, for our 6-month audit period, we estimate that the State agencies made between 104,162 and 407,226 payments totaling between \$2,081,901 and \$14,248,148 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 220,345 payments totaling \$8,165,024.

For the same 6-month period, we estimate that case file documentation did not adequately support eligibility determinations for an additional 220,344 to 600,063 payments totaling between \$4,996,337 and \$20,829,931 (Federal share). The midpoint of the confidence interval amounted to 377,733 payments totaling \$12,913,134.

ELIGIBILITY ERRORS

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

Eligibility Errors and Associated Unallowable Payments		
Eligibility Error	Number of Unallowable Payments	Amount of Unallowable Federal Payments
Beneficiary did not meet income requirements	4	\$233
Beneficiary was enrolled in Medicaid at time of SCHIP payment	<u>3</u>	<u>26</u>
Total	7	\$259

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 California State plan, a child who resides in a family that has gross income at or below 250 percent of the Federal poverty level is eligible for Healthy Families. For Healthy Families, pursuant to the California State plan, eligibility is continuous for 12 months unless a child is otherwise made ineligible.

Pursuant to the California State plan, a child does not qualify for presumptive eligibility if the child is (1) already enrolled in Medicaid or Healthy Families or (2) known to have a confirmed ineligible immigration status.

Of the 191 sampled payments, 7 payments totaling \$259 (Federal share) were made on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations:

- For four Healthy Families payments totaling \$233 (Federal share), the beneficiaries' gross family incomes exceeded the SCHIP income threshold on the date of the most recent application and for the period covered by the capitation payment.
- For three expanded Medicaid payments totaling \$26 (Federal share), the beneficiaries did not qualify for presumptive eligibility because they had existing Medicaid coverage.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

The California 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.

Federal regulations (42 CFR § 435.907(a)) require a written application from each Medicaid applicant. 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)). Pursuant to the California State plan, for presumptive eligibility, each beneficiary must have a completed preenrollment application for an initial 2-month period of coverage.

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.

For 12 sampled payments totaling \$410 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing or inadequate documentation included preenrollment applications and facts supporting income level and other health coverage.⁸

⁸For one case, the application indicated that the child had other health coverage, but MAXIMUS did not determine whether the other health coverage disqualified the child for Healthy Families.

CONCLUSION

Of the 191 SCHIP payments in our statistical sample, 7 payments made on behalf of beneficiaries did not comply with Federal and State eligibility requirements. In addition, we were unable to make eligibility determinations for 12 payments because the case files were missing or did not contain adequate documentation supporting eligibility determinations.

For the sampled payments, (1) beneficiaries did not always fully disclose information at the time of application or eligibility redetermination, (2) MAXIMUS and the county offices did not verify all information provided to support beneficiaries' applications, and (3) MAXIMUS and the county offices did not always maintain appropriate documentation to support eligibility determinations.

Extrapolating the results of our sample, we estimate that the State agencies made between 104,162 and 407,226 payments totaling between \$2,081,901 and \$14,248,148 (Federal share) on behalf of ineligible beneficiaries. The midpoint of the confidence interval amounted to 220,345 payments totaling \$8,165,024.

Further, we estimate that case file documentation did not adequately support eligibility determinations for an additional 220,344 to 600,063 payments totaling between \$4,996,337 and \$20,829,931 (Federal share). The midpoint of the confidence interval amounted to 377,733 payments totaling \$12,913,134. (See Appendix B for the details of our sample results and projections.)

RECOMMENDATION

We recommend that the State agencies 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 MAXIMUS and the county offices to verify eligibility information and maintain appropriate documentation in all case files.

STATE AGENCIES' COMMENTS

In their comments on our draft report, the State agencies agreed with our recommendation. DHS also agreed that three payments were made on behalf of beneficiaries who were enrolled in Medicaid at the time of the SCHIP payment. However, the State agencies did not agree with all our findings regarding eligibility errors:

- The Board disagreed with one eligibility error because of our annualization of overtime wages when calculating household income. It stated that overtime wages are irregular.
- The Board disagreed with two eligibility errors because of "difference and inconsistency" between the Board's and our income verification standards.

- Both DHS and the Board disagreed with our fiscal extrapolation of the Federal share associated with the estimated improper payments because they believe that the errors identified do not represent a sufficient sample size for extrapolating to the SCHIP population.

Appendixes C and D contain the full text of the Board's and DHS's comments.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Our responses to the State agencies' specific comments follow:

- Regarding overtime wages, we agree that the beneficiary's gross family income did not exceed the SCHIP income threshold when taking into consideration the exemption for irregular or infrequent income (Title 10, section 50542, of the California Code of Regulations). We adjusted the report accordingly.
- Regarding the income verification standards, we used the State's IEVS to determine whether the two beneficiaries' gross family incomes were at or below the income threshold required to be eligible for Healthy Families. The SCHIP State plan requires MAXIMUS to use the IEVS to verify income information when conducting a random sample audit of applications.
- Regarding our fiscal extrapolation, we used a valid statistical sample of 191 payments, which we selected randomly from a universe of 6,012,258 SCHIP payments. Of the 191 sampled payments, we identified 7 unallowable payments and extrapolated the results of our sample to the universe of payments. However, we are no longer recommending that the State agencies work with CMS to resolve the estimated improper payments primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors, including expanded Medicaid, can occur only if the errors are detected through a State's MEQC program. After excluding the expanded Medicaid cases, we did not have a sufficient number of errors from the Healthy Families cases to recommend recovery of funds. We continue to recommend that the State agencies ensure compliance with Federal and State requirements.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine the extent to which California's Managed Risk Medical Insurance Board (the Board) and California's Department of Health Services (DHS) 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 California during the 6-month period that ended June 30, 2005.

SAMPLING FRAME

The sampling frame for the Board's managed care payments contained 4,193,882 capitation payments totaling \$385,869,465 (\$250,817,983 Federal share), the sampling frame for DHS's fee-for-service payments contained 1,022,990 payments totaling \$85,108,281 (\$46,494,448 Federal share), and the sampling frame for DHS's managed care payments contained 795,386 capitation payments totaling \$33,388,081 (\$21,034,933 Federal share). The total SCHIP sampling frame contained 6,012,258 payments totaling \$504,365,827 (\$318,347,364 Federal share).

SAMPLE UNIT

The sample unit was an individual payment for services rendered to a SCHIP beneficiary during the audit period. An individual payment for services was either a (1) fee-for-service paid claim or (2) monthly capitation payment. Because a beneficiary could be enrolled in multiple health plans (e.g., medical, dental, and vision) during a month, we considered all capitation payments for the beneficiary for the same month as one capitation payment.

SAMPLE DESIGN

We used a simple random sample to evaluate SCHIP eligibility.

SAMPLE SIZE

We selected a sample size of 191 SCHIP payments.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the payments in our sampling frame and selected the random numbers that correlated to the sequential numbers assigned to the payments in the sampling frame. We then created a list of 191 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 enrolled in SCHIP but was eligible for Medicaid.

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

ESTIMATION METHODOLOGY

We used both the OAS 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 case file documentation did not adequately support eligibility determinations. We also 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 case file documentation did not adequately support eligibility determinations.

SAMPLE RESULTS AND PROJECTIONS

ELIGIBILITY ERRORS

The results of our review of the 191 Federal SCHIP payments were as follows:

Sample Results

Payments in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Payments	Value of Improper Payments (Federal Share)
6,012,258	\$318,347,364	191	\$9,327	7	\$259

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

	Attribute Appraisal	Variable Appraisal
Midpoint	220,345	\$8,165,024
Lower limit	104,162	2,081,901
Upper limit	407,226	14,248,148

INSUFFICIENT DOCUMENTATION

The results of our review of the 191 Federal SCHIP payments were as follows:

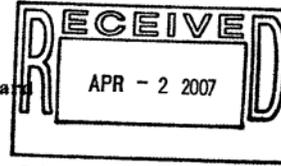
Sample Results

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)
6,012,258	\$318,347,364	191	\$9,327	12	\$410

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

	Attribute Appraisal	Variable Appraisal
Midpoint	377,733	\$12,913,134
Lower limit	220,344	4,996,337
Upper limit	600,063	20,829,931

**California Managed Risk Medical Insurance Board
Response to the OIG Draft Report**



Review of State Children's Health Insurance Program Eligibility in California

Recommendation: We recommend that the State agencies 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 MAXIMUS and the county offices to verify eligibility information and maintain appropriate documentation in all case files.

Response: We agree with the recommendation and will work with MAXIMUS and the Certified Applicant Assistants (CAA) to review requirements for eligibility verification and documentation, and enhance both MAXIMUS staff and CAA training.

Recommendation: We recommend that the State agencies work with CMS to resolve the estimated improper payments of at least \$3,310,095.¹

Response: We agree with five of the nine findings regarding eligibility and insufficient documentation errors. However, MRMIB disagrees with four of the nine findings, as follows: a) income calculation exclusions, specifically, because overtime wages are irregular, these payments cannot be annualized to calculate annual income, and b) difference and inconsistency between MRMIB and OIG's income verification standards.²

Overall, MRMIB does not believe that these nine cases represent a sufficient sample that should be used to extrapolate over the SCHIP population at large, resulting in the estimated improper payments.

¹OIG Note: This recommendation has been removed from the report.

²OIG Note: In its comments, the Board stated that it disagreed with "four of the nine findings . . ." However, in a discussion with the Board, we clarified that the Board disagreed with only three eligibility errors. We also clarified that the Board disagreed with our use of the Income Eligibility Verification System for income verification.

We recommend that CMS defer action on payment recovery until after the CMS-mandated Payment Error Rate Measurement (PERM) review is up and running. The PERM requirements and sampling methodology for program eligibility and payments cover the full fiscal year of the audit period and will provide a more detailed and comprehensive representation of the SCHIP case population and error rate.

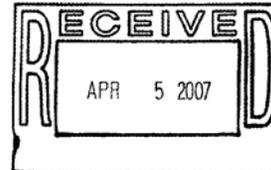
State of California—Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

APR 02 2007

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
50 United Nations Plaza, Room 171
San Francisco, CA 94102



Dear Ms. Ahlstrand:

The California Department of Health Services (CDHS) has prepared its response to the Office of Inspector General's (OIG) draft report entitled "Review of State Children's Health Insurance Program Eligibility in California" for the period January 1 through June 30, 2005 (Report Number A-09-06-00022). The CDHS appreciates the work performed by the OIG and the opportunity to respond to the draft report.

Please contact Stan Rosenstein, Deputy Director, Medical Care Services, at (916) 440-7800 if you have any questions.

Sincerely,

Sandra Shewry
Director

cc: See next page

Lori A. Ahlstrand
Page 2

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**California Department of Health Services
Response to the OIG Draft Report**

***Review of State Children's Health Insurance
Program Eligibility in California***

Recommendation: We recommend that the State agencies 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 MAXIMUS and the county offices to verify eligibility information and maintain appropriate documentation in all case files.

Response: We agree with the recommendation and will work with MAXIMUS and the County Welfare Departments to review requirements for eligibility verification and documentation. We will also review processes for seeking clarification from beneficiaries when inaccurate or inconsistent information is identified on applications.

Applications for beneficiaries at issue were completed through the mail-in or electronic process rather than face-to-face contact. We will review these processes and consider reemphasis of beneficiary responsibilities in the application process.

Recommendation: We recommend that the State agencies work with CMS to resolve the estimated improper payments of at least \$3,310,095.¹

Response: We agree with the findings that three payments were made on behalf of beneficiaries who were enrolled in Medicaid at the time of SCHIP payment. Two of the beneficiaries had been approved for Medi-Cal through a County Welfare Department process when the child accessed benefits through the Child Health and Disability Prevention Gateway. In the third situation, an application had previously been submitted and approved under the Presumptive Medicaid eligibility through the Single Point of Entry process. Because of conflicting information, provided by the caretaker relative, the CHDP provider was unable to verify eligibility to the established Medi-Cal programs for the child and duplicate benefits were issued. We do not believe that these three cases represent a

¹OIG Note: This recommendation has been removed from the report.

sufficient sample that should be used to extrapolate over the SCHIP population at large to a proposed recovery.

The Department will work with CMS to assess the need for recovery of these payments taking into account that Federal laws and regulations dictate that a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a state's Medicaid eligibility quality control program.