DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 26 2007

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

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

SUBJECT: Review of Medicaid Eligibility in California for the Period January 1 Through June 30, 2005 (A-09-06-00028)

Attached is an advance copy of our final report on Medicaid eligibility in California. We will issue this report to the California Department of Health Services (the State agency) 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.

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

In California, the State agency administers the Medicaid program. However, the county government offices of the 58 California counties (the county offices) determine the eligibility of applicants for Medicaid benefits.

Our objective was to determine the extent to which the State agency made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Our audit period covered January 1 through June 30, 2005, when the State agency made an estimated 54.8 million payments totaling $5.3 billion ($2.7 billion Federal share) on behalf of Medicaid beneficiaries.

The State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not ensure that the county offices always

adequately documented eligibility determinations. Of the 199 payments in our statistical sample, 17 payments totaling $480 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. Specifically, the State agency made:

- 12 payments on behalf of beneficiaries who had not met the waiting period for certain qualified aliens, who did not meet the Federal requirement that the household include a child deprived of parental support or care, whose household incomes exceeded the Medicaid income threshold on the dates of service, who were not residents of California, or who were deceased;

- 4 payments on behalf of beneficiaries who had not met liability requirements; and

- 1 payment on behalf of a beneficiary who was eligible for Medicaid but not eligible for the specific service received.

In addition, for nine sampled payments totaling $423 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing documentation included at least one of the following: an application covering the date of service and facts supporting resources.

As a result, for the 6-month audit period, we estimate that the State agency made 4,705,170 payments totaling $132,727,302 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 2,490,972 payments totaling $117,020,338 (Federal share). We are not recommending recovery primarily because, under Federal laws and regulations, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through a State's Medicaid eligibility quality control program.

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

In its comments on our draft report, the State agency agreed with our recommendation. In an enclosure that provided beneficiary-specific comments, the State agency commented that it had refunded the Federal share for the beneficiaries who had not met the waiting period for certain qualified aliens. The State agency disagreed with our findings that one beneficiary was ineligible for the specific service received and that certain cases lacked adequate documentation to support eligibility determinations. Finally, the State agency disagreed with the fiscal projection of the Federal share associated with the findings because it believed that the statistical sample size was small and the confidence level was low.

The State agency did not provide supporting documentation to substantiate its statement that the Federal share was refunded for the beneficiaries who had not met the waiting period. Also, the

State agency was unable to provide adequate support for its statement that the beneficiary was eligible for the specific Medicaid service. For the cases that lacked adequate documentation to support eligibility determinations, the State agency acknowledged that supporting documentation was missing from certain case files. Regarding our fiscal projection, we used a statistically valid sample size and a commonly used confidence level.

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-09-06-00028.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

FEB 28 2007

Report Number: A-09-06-00028

Ms. Sandra Shewry
Director
California Department of Health Services
P.O. Box 997413, 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 Medicaid Eligibility in California for the Period January 1 Through June 30, 2005." 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 the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-09-06-00028 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services, Region IX
U.S. Department of Health and Human Services
75 Hawthorne Street, Suite 408
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ELIGIBILITY IN CALIFORNIA FOR THE PERIOD JANUARY 1 THROUGH JUNE 30, 2005

Daniel R. Levinson
Inspector General

February 2007
A-09-06-00028

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

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

In California, the Department of Health Services (the State agency) administers the Medicaid program. However, the county government offices of the 58 California counties (the county offices) determine the eligibility of applicants for Medicaid benefits. From January 1 through June 30, 2005, the State agency made an estimated 54.8 million payments totaling $5.3 billion ($2.7 billion Federal share) on behalf of Medicaid beneficiaries.

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

OBJECTIVE

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

SUMMARY OF FINDINGS

From January 1 through June 30, 2005, the State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not ensure that the county offices always adequately documented eligibility determinations. Of the 199 payments in our statistical sample, 17 payments totaling $480 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. Specifically, the State agency made:

- 12 payments on behalf of beneficiaries who had not met the waiting period for certain qualified aliens, who did not meet the Federal requirement that the household include a child deprived of parental support or care, whose household incomes exceeded the Medicaid income threshold on the dates of service, who were not residents of California, or who were deceased;

- 4 payments on behalf of beneficiaries who had not met liability requirements; and

- 1 payment on behalf of a beneficiary who was eligible for Medicaid but not eligible for the specific service received.

In addition, for nine sampled payments totaling $423 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing documentation included at least one of the following: an application covering the date of service and facts supporting resources.

As a result, for the 6-month audit period, we estimate that the State agency made 4,705,170 payments totaling $132,727,302 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 2,490,972 payments totaling $117,020,338 (Federal share).

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

RECOMMENDATION

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

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

In its comments on our draft report (Appendix C), the State agency agreed with our recommendation. In a spreadsheet that provided beneficiary-specific comments, the State agency commented that it had refunded the Federal share for the beneficiaries who had not met the waiting period for certain qualified aliens. The State agency disagreed with our findings that one beneficiary was ineligible for the specific service received and that certain cases lacked adequate documentation to support eligibility determinations. Finally, the State agency disagreed with the fiscal projection of the Federal share associated with the findings because it believed that the statistical sample size was small and the confidence level was low.

The State agency did not provide supporting documentation to substantiate its statement that the Federal share was refunded for the beneficiaries who had not met the waiting period. Also, the State agency was unable to provide adequate support for its statement that the beneficiary was eligible for the specific Medicaid service. For the cases that lacked adequate documentation to support eligibility determinations, the State agency acknowledged that supporting documentation was missing from certain case files.

Regarding our fiscal projection, we used a statistically valid sample size and a commonly used confidence level. We considered all information provided by the State agency and made changes to the final report as appropriate.

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INTRODUCTION

BACKGROUND

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

The Medicaid Program

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

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

California's Medicaid Program

In California, the Department of Health Services (the State agency) is responsible for operating the Medicaid program.[1] However, the county government offices of the 58 California counties (the county offices) determine the eligibility of applicants for Medicaid benefits. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims.

The State agency requires that individuals submit written applications for Medicaid benefits. The county offices review the applications and determine whether the individuals meet Medicaid eligibility requirements. The instructions accompanying the Medicaid application notify the applicant of his or her responsibility to report to the county office any changes that may affect eligibility status. Each year thereafter, the county office must verify certain information and redetermine the individual's eligibility.

Federal Requirements Related to Medicaid Eligibility

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

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

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 medical expenses in an amount necessary to lower countable income to the threshold limit).

A Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits and a citizen or national of the United States or a qualified alien. 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. However, Federal Medicaid funds are available for emergency services provided to undocumented aliens and to qualified aliens who have not satisfied the 5-year waiting period.

Medicaid income and resource thresholds are established by the State, subject to certain restrictions, and must be included in the State plan.[2] The income and resource thresholds, which are subject to yearly adjustments, vary based on eligibility category and the number of family members in the household.[3] For beneficiaries in the "medically needy" category, unlike those in most other eligibility categories, 42 CFR § 435.831(d) requires the State to deduct certain incurred medical expenses from income when determining financial eligibility. This process is often referred to as "beneficiary liability" or "spenddown."

In addition to having income and resource thresholds, some eligibility categories have other requirements. For example, for beneficiaries not receiving Supplemental Security Income (SSI) who apply for Medicaid under the eligibility category for blind or disabled persons, 42 CFR §§ 435.531 and 435.541 require that the determination of blindness or disability be based on a physician's report of examination. Also, for the optional category of specified relatives that care for a dependent child, Federal regulations (42 CFR §§ 435.201, 435.310, and 435.510) require the State agency to base eligibility on a determination of the child's

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

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

dependency. Regulations (42 CFR § 435.510) provide that a determination of dependency be made when a child is deprived of parental support or care as defined by the State's Aid to Families with Dependent Children (AFDC) plan. Regulations (42 CFR § 435.4 and 45 CFR § 233.90) further state that a State's AFDC plan must find a child to be deprived of parental support or care by reason of (1) death, continued absence from the home, or physical or mental incapacity of a parent or (2) unemployment of the parent who is the principal earner.

Regulations (42 CFR § 435.910) require, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her Social Security number to the State. The State must contact the Social Security Administration to verify that the number furnished was the correct number and the only number issued to the individual. If the applicant was not issued a Social Security number or cannot recall the number, the State must assist the individual in obtaining a number or identifying his or her existing number. The State may not deny or delay Medicaid services to an otherwise eligible individual pending issuance or verification of his or her Social Security number by the Social Security Administration. If an individual refuses to obtain a Social Security number for "well established religious objections," as defined in 42 CFR § 435.910(h)(2), the State may obtain a Social Security number on the individual's behalf or use another unique identifier. In redetermining eligibility (as required by 42 CFR § 435.916(a)), 42 CFR § 435.920(a) provides that the State must determine whether the case records contain the beneficiary's Social Security number. Generally, pursuant to 42 CFR § 435.920(b), if the records do not contain the required Social Security number, the State must require the 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 (42 CFR § 435.916(c)). Also, pursuant to 42 CFR § 435.916(a), the State must redetermine Medicaid eligibility at least every 12 months. Pursuant to 42 CFR § 435.945, the State must query appropriate Federal and State agencies to verify applicants' information when determining and redetermining eligibility.

State Requirements Related to Medicaid Eligibility

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

The State plan incorporates the Federal requirements pertaining to residency, citizenship, blindness and/or disability, Social Security number, and beneficiary liability. The State plan also establishes income and resource levels. Pursuant to the California State plan, undocumented aliens are provided Medicaid benefits only for care and services necessary for the treatment of an emergency medical condition, including emergency labor and delivery. Title 22, section 50185, 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

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

We performed fieldwork from September 2005 to February 2006 at the State agency's 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 Medicaid eligibility;
- held discussions with CMS regional office officials and with State officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
- obtained computer files from the State agency consisting of 55,078,163 payments for Medicaid fee-for-service and managed care totaling approximately $6.7 billion for services rendered in California from January 1 through June 30, 2005;[4] and
- selected a simple random sample of 199 payments from the 55,078,163 payments, as detailed in Appendix A.

The State agency's data included payments that were not federally funded because the State agency could not identify and exclude them in a timely manner for the purposes of our review. As a result, we estimated that the State agency made 54.8 million payments totaling $5.3 billion ($2.7 billion Federal share) on behalf of Medicaid beneficiaries. (See Appendix A for our sample design and methodology and Appendix B for the details of our sample results and projections.)

In the random sample of 199 payments, we identified one payment that was not federally funded, so we did not review it. For each of the sampled items reviewed, we determined whether the case file contained sufficient information for the county office to have made a Medicaid

[4]The data provided by the State agency excluded payments made for SSI beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance programs, and beneficiaries of the State Children's Health Insurance Program Medicaid expansion.

eligibility determination on the date of initial determination or redetermination. We also attempted to obtain sufficient independent information to determine whether the beneficiary was eligible for Medicaid on the date of service. Specifically, we determined whether:

- the case file contained a signed application from the beneficiary;
- the beneficiary was assigned to the correct eligibility category;
- the case file contained the beneficiary's Social Security number and, if so, whether the Social Security Administration issued the number to the applicant;
- the beneficiary resided in California by checking driver's licenses, rental agreements, utility bills, or Federal, State, or local government correspondence;
- the beneficiary's identity, including name, age, and citizenship status, in the case file matched the information on file with the State agency's Income Eligibility Verification System and the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlement program;
- the beneficiary's income was at or below the income threshold required to be eligible for Medicaid by reviewing information from the Income Eligibility Verification System;
- the beneficiary met all applicable resource requirements;
- the beneficiary was deceased by reviewing information from California's Bureau of Vital Statistics;
- the case file for blind and/or disabled beneficiaries not receiving SSI contained a physician's report of examination to support a determination of blindness and/or disability;
- the beneficiary met all applicable liability requirements; and
- the beneficiary was eligible for both Medicaid and the service received.

We used an attribute appraisal program to estimate (1) the total number of Medicaid payments claimed for Federal funding, (2) the total number of Medicaid payments made for ineligible beneficiaries, and (3) the total number of Medicaid payments for which documentation did not support eligibility determinations.

We used a variable appraisal program to estimate (1) the total dollar amount of Medicaid payments claimed for Federal funding and the Federal share of these payments, (2) the dollar impact of the improper Federal funding for ineligible beneficiaries, and (3) the dollar impact of the payments for which documentation did not support eligibility determinations.

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

FINDINGS AND RECOMMENDATION

The State agency (1) made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and (2) did not ensure that the county offices always adequately documented eligibility determinations. Of the 199 payments in our statistical sample, 17 payments totaling $480 (Federal share) were unallowable because the beneficiaries were ineligible for Medicaid. In addition, for nine sampled payments totaling $423 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations.

As a result, for the 6-month audit period, we estimate that the State agency made 4,705,170 payments totaling $132,727,302 (Federal share) on behalf of ineligible beneficiaries. We also estimate that case file documentation did not adequately support eligibility determinations for an additional 2,490,972 payments totaling $117,020,338 (Federal share).

ELIGIBILITY ERRORS

The table below summarizes the 17 eligibility errors noted in the sampled payments.

Eligibility Errors and Associated Unallowable Payments

Eligibility Error	Number of Unallowable Payments	Amount of Unallowable Federal Payments
Beneficiaries were ineligible:		
Had not met the waiting period for certain qualified aliens	7	$213
Did not meet dependent child requirement	2	95
Did not meet income requirements on dates of service	1	46
Did not meet residency requirement	1	5
Were deceased	1	5
Subtotal	**12**	**$364**
Beneficiaries had not met liability requirements	4	$64
Beneficiary was ineligible for the service received	1	52
Total	**17**	**$480**

Beneficiaries Were Ineligible

Pursuant to Federal laws restricting welfare and public benefits for aliens (8 U.S.C. §§ 1601–1646), legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for the first 5 years after entry.

Pursuant to 42 CFR part 435, Medicaid benefits will be granted to certain families who meet categorical requirements. For example, for the optional category of specified relatives who care for a dependent child, Federal regulations (42 CFR §§ 435.201, 435.310, and 435.510) require the State agency to base eligibility on a determination of the child's dependency. Regulations (42 CFR § 435.510) provide that a determination of dependency be made when a child is deprived of parental support or care as defined by the State's AFDC plan. Regulations (42 CFR § 435.4 and 45 CFR § 233.90) further state that a State's AFDC plan must find a child to be deprived of parental support or care by reason of (1) death, continued absence from the home, or physical or mental incapacity of a parent or (2) unemployment of the parent who is the principal earner.

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

Pursuant to 42 CFR § 435.403(a), the State agency must provide Medicaid benefits to eligible residents of the State.

Of the 199 sampled payments, 12 payments totaling $364 (Federal share) were made on behalf of beneficiaries who did not meet eligibility requirements under Federal law and regulations:

- For seven payments totaling $213 (Federal share), the beneficiaries had not satisfied the 5-year waiting period applicable to certain qualified aliens.

- For two payments totaling $95 (Federal share), the beneficiaries did not meet the requirement that the household include a child deprived of parental support or care.

- For one payment totaling $46 (Federal share), the beneficiary's household income exceeded the Medicaid income threshold on the date of service.

- For one payment totaling $5 (Federal share), the beneficiary was not a resident of California.

- For one payment totaling $5 (Federal share), the beneficiary was deceased before the period covered by the capitation payment.

Beneficiaries Had Not Met Liability Requirements

For beneficiaries in the "medically needy" category, Federal regulations (42 CFR § 435.831(d)) require the State to deduct medical expenses incurred by the individual or family from income if countable income exceeds the income threshold. This is called "beneficiary liability" or "spenddown." For example, if the monthly income threshold in the State is $1,000 and the beneficiary is earning $1,200, the beneficiary must have medical expenses equal to or greater than $200 to qualify for Medicaid. A Medicaid payment is unallowable when these beneficiary

liability requirements have not been met, and such payments should be identified as eligibility errors under the State's MEQC program.

For four sampled payments totaling $64 (Federal share), the State agency paid for services rendered to beneficiaries who had countable income above the income threshold on the dates of service and who had not met the beneficiary liability requirements.

Beneficiary Was Ineligible for the Service Received

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

Pursuant to 42 CFR §§ 435.406(c) and 440.255(c), undocumented aliens are provided Medicaid benefits only for emergency care and services. Pursuant to the California State plan, undocumented aliens are provided Medicaid benefits only for care and services necessary for the treatment of an emergency medical condition, including emergency labor and delivery.

For one sampled payment totaling $52 (Federal share), the State agency provided Medicaid coverage to a beneficiary for a specific service not covered under the beneficiary's eligibility category. The beneficiary was assigned to the eligibility category for undocumented aliens and, thus, was eligible only for Medicaid emergency services. However, the fee-for-service payment was for a medication that was not related to an emergency service.

INSUFFICIENT DOCUMENTATION TO SUPPORT ELIGIBILITY DETERMINATIONS

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

For nine sampled payments totaling $423 (Federal share), the case files were missing or did not contain adequate documentation supporting eligibility determinations. The missing documentation included at least one of the following: an application covering the date of service and facts supporting resources.

CONCLUSION

Of the 199 Medicaid payments sampled, 17 payments were made on behalf of beneficiaries who did not meet Federal and State eligibility requirements. In addition, the State agency made nine payments on behalf of beneficiaries whose 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 and did not always notify the county offices of changes in financial situation or other changes affecting eligibility; (2) the county offices did not verify all information provided to support beneficiaries' applications; and (3) the county offices did not always maintain adequate documentation to support eligibility determinations.

Extrapolating the results of our sample to the 6-month audit period, we estimate that the State agency made 4,705,170 payments totaling $132,727,302 (Federal share) on behalf of ineligible beneficiaries. Further, we estimate that case file documentation did not adequately support eligibility determinations for an additional 2,490,972 payments totaling $117,020,338 (Federal share). (See Appendix B for the details of our sample results and projections.)

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

RECOMMENDATION

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

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

In its comments on our draft report, the State agency agreed to implement our recommendation to use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. The State agency disagreed with certain (1) identified eligibility errors and (2) cases in which documentation did not support eligibility determinations. The State agency also disagreed with the fiscal projection of the Federal share associated with the findings. We included the text of the State agency's comments as Appendix C but did not include the spreadsheet because of its volume. We considered all information provided by the State agency and made changes to the report as appropriate.

Eligibility Errors

State Agency's Comments

For the seven beneficiaries who had not satisfied the 5-year waiting period applicable to certain qualified aliens, the State agency commented that it had provided services and then refunded the Federal share to the Federal Government.

For one beneficiary who had not met the liability requirements, the State agency commented that the beneficiary was eligible for another category without a beneficiary liability requirement.

For the one beneficiary who was eligible for only emergency services, the State agency commented that the undocumented beneficiary appropriately received birth control pills as a pregnancy-related service.

Office of Inspector General's Response

The State agency did not provide documentation substantiating its claim that the Federal share was refunded for the seven beneficiaries who had not satisfied the 5-year waiting period applicable to certain qualified aliens.

We agree with the State agency that the beneficiary who had not met the liability requirements was eligible for another category that did not have a beneficiary liability requirement; therefore, we revised the report accordingly.

Regarding the beneficiary who was ineligible for the service received, the beneficiary was assigned to the eligibility category for undocumented aliens and, thus, was eligible only for Medicaid emergency services pursuant to Federal regulations and the California State plan. However, the fee-for-service payment was for a medication that was not related to an emergency service.

Insufficient Documentation To Support Eligibility Determinations

State Agency's Comments

Of the sampled payments in which the case files were missing or did not contain adequate supporting documentation, the State agency commented that 4 cases should be classified as "procedural errors" and that 18 cases had adequate documentation of citizenship because self-declaration is allowed under California regulations.

In addition, the State agency commented that (1) the high mobility of the Medicaid population would make it difficult to verify required eligibility documentation with the increased passage of time and (2) missing documentation would not necessarily lead to total ineligibility.

Office of Inspector General's Response

Regarding the four cases that the State agency recommended categorizing as "procedural errors," the State agency acknowledged that documentation supporting the eligibility determinations was missing from the case files. Therefore, we continue to maintain that these case files had insufficient documentation to support eligibility determinations. Regarding the 18 cases of self-declaration of citizenship, we revised the report to reflect that these cases complied with existing requirements.

Regarding the State agency's comment about the mobility of the Medicaid population, the State agency was required to make timely eligibility determinations based on review of applications and supporting documentation. In addition, Federal regulations (42 CFR § 435.913(a)) require

States to include in each applicant's case file facts to support eligibility determinations. Where we were unable to make eligibility determinations, we categorized these cases as "insufficient documentation to support eligibility determinations," not as "eligibility errors."

Fiscal Projection

State Agency's Comments

The State agency disagreed with the fiscal projection of the Federal share associated with the findings because it believed that the statistical sample size was small and the confidence level was low.

Office of Inspector General's Response

Our sample was a valid statistical sample selected randomly. The size of the sample does not have an impact on the validity of the statistical estimate, which we calculated using an unbiased estimator. The lower and upper limits of the confidence interval take into account the sample size; we fully disclosed these limits in Appendix B. The 90-percent confidence level we used is one of the most commonly used levels of confidence for calculating confidence intervals and is used consistently in our reports.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

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

POPULATION

The population was all payments for services rendered to Medicaid beneficiaries in California during the 6-month period that ended June 30, 2005, excluding payments made for Supplemental Security Income (SSI) beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance programs, and beneficiaries of the State Children's Health Insurance Program (SCHIP) Medicaid expansion. Payments that were not federally funded were also excluded.

SAMPLING FRAME

The sampling frame consisted of computer files obtained from the State agency that contained 55,078,163 payments for services rendered to Medicaid beneficiaries in California during the 6-month period that ended June 30, 2005. The 55,078,163 payments excluded payments made for SSI beneficiaries, beneficiaries under the Title IV-E foster care and adoption assistance cases, and the SCHIP Medicaid expansion. However, the sampling frame included some payments that were not federally funded because the State agency was not able to identify and exclude these payments in a timely manner for the purposes of our review. As a result, the sampling frame was larger than the target population because the sampling frame included an unknown number of payments that were not federally funded. The total number of payments and amount for the population was estimated from the sampling frame. The total Medicaid payments for the 55,078,163 payments were $6,660,971,265.

SAMPLE UNIT

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

SAMPLE DESIGN

We used a simple random sample to evaluate Medicaid eligibility.

SAMPLE SIZE

We selected a sample size of 199 Medicaid payments from the sampling frame of 55,078,163 payments.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services 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 199 sampled items.

CHARACTERISTICS TO BE MEASURED

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

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

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

If the sampled payment was not federally funded, the payment was not reviewed.

ESTIMATION METHODOLOGY

We used both the Office of Audit Services attribute and variable appraisal programs in RAT-STATS to appraise the sample results.

We used the attribute appraisal program to estimate from the sampling frame the total number of payments claimed for Federal funds, the total number of payments made for Medicaid beneficiaries who did not meet eligibility requirements, and the total number of payments for which documentation did not support eligibility determinations. We used the variable appraisal program to estimate from the sampling frame the total amount of payments claimed for Federal funds, the total amount of Federal payments made for ineligible Medicaid beneficiaries, and the total amount of Federal payments for which documentation did not support eligibility determinations.

SAMPLE RESULTS AND PROJECTIONS

ELIGIBILITY ERRORS

The results of our review of the 199 sample payments were as follows:

Sample Results

Payments in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample (Federal Share)	Improper Payments	Value of Improper Payments (Federal Share)
55,078,163	$6,660,971,265	199	$9,754	17	$480

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

	Attribute Appraisal	Variable Appraisal
Midpoint	4,705,170	$132,727,302
Lower Limit	3,038,271	67,491,633
Upper Limit	6,905,931	197,962,971

INSUFFICIENT DOCUMENTATION

The results of our review of the 199 sample payments were as follows:

Sample Results

Payments in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample (Federal Share)	Payments With Insufficient Documentation	Value of Payments With Insufficient Documentation (Federal Share)
55,078,163	$6,660,971,265	199	$9,754	9	$423

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

	Attribute Appraisal	Variable Appraisal
Midpoint	2,490,972	$117,020,338
Lower Limit	1,310,507	32,236,678
Upper Limit	4,273,640	201,803,999

TOTAL PAYMENTS

The results of our review of the 199 sample payments were as follows:

Sample Results

Payments in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample	Payments Claimed for Federal Funding	Value of Payments Claimed for Federal Funding
55,078,163	$6,660,971,265	199	$19,392	198	$19,240

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

	Attribute Appraisal	Variable Appraisal
Midpoint	54,801,388	$5,325,100,722
Lower Limit	53,777,470	3,753,622,495
Upper Limit	55,063,968	6,896,578,948

FEDERAL SHARE OF TOTAL PAYMENTS

The results of our review of the 199 sample payments were as follows:

Sample Results

Payments in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample	Payments Claimed for Federal Funding	Value of Payments Claimed for Federal Funding (Federal Share)
55,078,163	$6,660,971,265	199	$19,392	198	$9,754

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

	Attribute Appraisal	Variable Appraisal
Midpoint	54,801,388	$2,699,715,666
Lower Limit	53,777,470	1,914,317,728
Upper Limit	55,063,968	3,485,113,604

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

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

SEP 21 2006

Ms. Lori A. Ahlstrand
Centers for Medicare and Medicaid Services
Regional Inspector General For Audit Services
Office of Inspector General
50 United Nations Plaza
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 Medicaid Eligibility in California For The Period January 1, 2005 through June 30, 2005," report Number A-09-06-00028. CDHS appreciates the work performed by the OIG and the opportunity to respond to the draft report.

The purposes of the letter are to document CDHS' general and specific responses to the OIG's draft audit findings. The audit report evaluates the appropriateness of eligibility determinations associated with 199 claims during this period.

Generally, CDHS agrees with the OIG recommendation to "use the results of this review to help ensure compliance with federal and state Medicaid eligibility requirements." The State of California and its counties are committed to ensuring that appropriate benefits are available to appropriate beneficiaries and that these transactions are adequately documented on a timely basis. There is also a clear expectation that county eligibility workers will verify eligibility information and maintain appropriate documentation in all case eligibility files.

The CDHS will use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. CDHS will (1) reemphasize to beneficiaries the need to provide accurate and timely information and (2) require county eligibility workers to verify eligibility information, and maintain appropriate case file documentation.

Specifically, CDHS disagrees with several of the OIG audit findings. Specific CDHS responses to each of the case audit findings and recommended resolutions are documented in the attached spreadsheet.[1] Of the 18 beneficiary eligibility issues, CDHS agrees with ten.[2] Of the 27 missing case documentation issues, CDHS agrees with five. Thus, the draft OIG report documented a total of 45 audit issues. CDHS agrees with 15 of the audit issues.

CDHS also disagrees with the OIG's fiscal projection of the federal dollars associated with these audit issues. From the State perspective, there are several problems with this. These problems are:

1. The draft OIG audit report documents 45 audit issues, or 22.6 percent of all sampled cases. CDHS' responses yield only 15 audit issues, or 7.5 percent of all sampled cases.
2. In addition, some of the missing documentation would not necessarily lead to total ineligibility. This factor would further lower the potential error rate and associated dollar impact.
3. The sample of 199 cases is very small in relationship to the State's Medicaid population of 6.6 million.
4. The draft OIG audit report projects these audit findings over the entire population with a 90 percent confidence level. A 90 percent confidence level is a fairly low level. We understand that higher confidence levels are normally sought and expected. We would use a 95 percent confidence level.
5. Using CDHS' estimate of error (7.5 percent) and a 95 percent confidence level, the lower bound estimate of the error rate would be only 0.55 percent.

In addition, the delayed sample interval would have likely had an adverse impact on case findings, therefore overstating the number of cases in error. Normally, CDHS staff conducts its Medi-Cal Eligibility Quality Control (MEQC) and focused review work within two to three months of the sample period. OIG staff studied payments and underlying eligibility determinations for the January 2005 through June 2005 interval during November 2005 through March 2006. Since the State's Medi-Cal population is highly mobile, it would be much more difficult to establish client contact and verify required eligibility documentation with the increased passage of time.

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[1]Office of Inspector General (OIG) Note: We did not include the State agency's spreadsheet with detailed responses to each of the sample items because of its volume. A copy of the spreadsheet is available from the OIG by request.

[2]OIG Note: Based on a review of the State agency's spreadsheet, we determined that the State agency agreed with nine of the eligibility errors.

In summary, CDHS appreciates the OIG audit efforts and many of the specific findings. CDHS has documented its disagreement with certain specific findings with supportive documentation (enclosed). CDHS will use this audit report to enhance county eligibility determination efforts and supportive documentation.

If you have any questions, please contact Mr. Stan Rosenstein, Deputy Director of Medical Care Services, at (916) 440-7800.

Sincerely,

Sandra Shewry
Director

Enclosure

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