NEW YORK STATE
OFFICE OF THE STATE COMPTROLLER

H. Carl McCall
STATE COMPTROLLER

DEPARTMENT OF HEALTH AND OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

MEDICAID ELIGIBILITY UNDER TANF ASSISTANCE

2000-S-22

DIVISION OF MANAGEMENT AUDIT AND
STATE FINANCIAL SERVICES

H. Carl McCall
STATE COMPTROLLER

Report 2000-S-22

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Commissioner
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Mr. Brian J. Wing
Commissioner
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Dear Dr. Novello and Mr. Wing:

The following is our report on the processes used by the Department of Health and the Office of Temporary and Disability Assistance to ensure that local social services districts conduct Medicaid eligibility reviews when necessary for TANF applicants and TANF recipients who become ineligible for such assistance.

We performed this audit according to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. We list major contributors to this report in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

April 10, 2001

Executive Summary

Department of Health and Office of Temporary and Disability Assistance
Medicaid Eligibility Under TANF Assistance

Scope of Audit

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act replaced the Aid to Families with Dependent Children program with a new state-run Temporary Assistance for Needy Families (TANF) program and ended the link between eligibility for public assistance and Medicaid. As a result, Medicaid eligibility is not based on TANF eligibility. A separate Medicaid eligibility review is required for TANF applicants who are determined not to be TANF eligible or for TANF recipients who are no longer eligible for TANF assistance. The joint application for TANF and Medicaid is processed by local social services districts (districts) under the direction of the Office of Temporary and Disability Assistance (OTDA). OTDA consults with the Department of Health (DOH) on Medicaid issues; DOH provides direction regarding Medicaid eligibility. Districts outside of New York City use the Welfare Management System (WMS) to record case information for applicants and recipients of assistance. New York City uses its own WMS system to record case information.

Our audit addressed the following question relating to Medicaid eligibility for TANF applicants and recipients for the period January 1, 1999 through October 31, 2000:

- Have DOH and OTDA ensured that districts conduct required Medicaid eligibility reviews when applicants were denied TANF benefits and for TANF recipients who were determined no longer eligible for such assistance?

Audit Observations and Conclusions

The responsible agencies need to improve their efforts to ensure that Medicaid eligibility reviews are performed as required. We noted numerous instances where separate Medicaid eligibility reviews were not conducted for TANF applicants who were determined at the time of their application to be ineligible for TANF. Although we noted a few exceptions, districts generally did an effective job of conducting a separate Medicaid eligibility review when a TANF case was closed. However, in both cases, some of the people who did not get separate Medicaid eligibility review were in fact eligible for Medicaid coverage.

For TANF applicants who were determined to be ineligible for TANF, we reviewed case files and information available on WMS for nine selected districts to determine if separate Medicaid eligibility reviews were conducted. We identified 32 cases, of 320 cases reviewed (10 percent), in which seven of the nine districts did not conduct a separate Medicaid eligibility review when the applicant was denied TANF. These 32 cases involved 103 individuals. At our request, the districts determined that at least 23 of these individuals were eligible for Medicaid at the time of their TANF denial, and as a result, these individuals did not receive, or were delayed in receiving, Medicaid coverage. For many of the other individuals in our review, sufficient documentation was not on file for the districts to determine their Medicaid eligibility. The exceptions we noted can be attributed to a lack of procedures in the districts for ensuring separate Medicaid eligibility reviews are performed for TANF applicants who are denied benefits. A basic goal of welfare reform is self-sufficiency. However, if individuals are not provided with the assistance to which they are entitled, such as Medicaid coverage, their efforts to attain self-sufficiency could be jeopardized. (See pp. 5-8)

In addition, individuals can lose their TANF eligibility and still be eligible for Medicaid. Therefore, it is important for districts to have procedures in place to prevent inappropriate Medicaid terminations. In general, we found that districts did an effective job of conducting a separate Medicaid eligibility review when a TANF case was closed. We identified three cases in three of the nine districts visited in which districts did not conduct a separate Medicaid eligibility review when the TANF case was closed. At our request, in these three cases, the districts determined that 3 individuals were eligible for Medicaid, but were unable to determine the eligibility of 5 additional individuals because of an absence of documentation. (See pp. 8-10)

We recommend that DOH and OTDA work collectively to ensure districts have adequate procedures in place and perform the required Medicaid reviews.

Comments of Officials

DOH officials generally agree with our recommendations and indicated the steps they have taken or will take to implement them. OTDA officials stated they have and will continue to work with DOH to improve Medicaid participation by individuals who are denied temporary assistance or whose cases are closed. A complete copy of the DOH and OTDA responses are included as Appendix B and Appendix C, respectively.

Contents

Introduction

Background

Prior to 1996, many low-income families received their health insurance coverage through their eligibility for cash assistance. Under the Aid to Families with Dependent Children (AFDC) program, low-income families automatically received Medicaid coverage when they qualified for cash assistance. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act replaced AFDC with a new state-run Temporary Assistance for Needy Families (TANF) program and ended the link between eligibility for public assistance and Medicaid. As a result, Medicaid eligibility is not based on TANF eligibility. States may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF because of employment, time limits or sanctions.

In New York, as well as in many other states, a joint application is used for both TANF and Medicaid. However, because Medicaid eligibility is to be determined separately from TANF under the de-linked programs, in most instances, a separate Medicaid eligibility review is required for TANF applicants who are determined not to be TANF eligible.

The application for TANF and Medicaid is processed by local social services districts (districts) under the direction of the Office of Temporary and Disability Assistance (OTDA). OTDA consults with the Department of Health (DOH) on Medicaid issues. DOH is the agency responsible for the administration of Medicaid and providing direction regarding Medicaid eligibility in New York State. DOH and OTDA work jointly to disseminate information regarding Medicaid policy and eligibility to the districts.

There are 58 districts in New York State, including the New York City district. Districts outside of New York City use the Welfare Management System (WMS) to record case information for applicants and recipients of assistance. WMS is a management information system designed to assist districts in carrying out client eligibility determinations and processing functions. New York City uses its own WMS system to record case information.

In July 1998, the New York Regional Office of the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) began receiving complaints that applicants were encountering barriers when applying for Medicaid. In June 1999, HCFA conducted site visits in the New York City, Nassau and Suffolk districts to determine whether applicants were being deterred from applying for Medicaid. HCFA officials informed us that a draft report was issued to DOH in September 2000, while

our audit was in process. Because HCFA's report had not been finalized, we were not able to obtain a copy of the report during our audit.

Additionally, in December 1998, a Federal lawsuit was filed against the City of New York (City) and New York State (DOH and OTDA) alleging the City systematically prevented eligible individuals from obtaining food stamps, Medicaid and cash assistance by imposing unreasonable requirements upon individuals in the application process. The lawsuit also asserted that the State failed to adequately monitor the City's administration of these programs. As of October 31, 2000 this case was still pending.

HCFA officials issued a letter to all state Medicaid directors in April 2000. Among the actions states were directed to take was to determine whether individuals and families have lost Medicaid coverage when their TANF case closed. Further, if improper terminations were identified, HCFA called for the development of a timetable for reinstating coverage and conducting follow-up eligibility reviews. The HCFA letter also pointed out that in some states, eligible individuals applying for both Medicaid and TANF may have been denied Medicaid improperly because eligibility determinations continue to be linked. While HCFA did not require states to identify and enroll these applicants at this time, the officials encouraged states to take the actions necessary to do so. HCFA officials required states to submit a plan to their regional HCFA office indicating the actions that would be taken to address the issues included in the April 2000 letter. DOH officials established a workgroup to develop a plan to address the issues included in the HCFA letter. DOH officials submitted the plan to HCFA in August 2000.

Audit Scope, Objectives and Methodology

We audited the processes used by DOH and OTDA to ensure that districts conducted required Medicaid eligibility reviews for the period January 1, 1999 through October 31, 2000. The objectives of our performance audit were to determine whether: (1) applicants who were denied TANF benefits but who also applied for Medicaid benefits had separate reviews to determine their Medicaid eligibility and (2) TANF recipients who were determined to be no longer eligible for such assistance received a separate determination regarding whether their Medicaid benefits should continue. To accomplish our objectives, we interviewed appropriate DOH, OTDA and selected district staff. We also conducted site visits at nine districts (Broome, Erie, Monroe, Montgomery, Oneida, Onondaga, Orange, Saratoga and Westchester). Our audit did not include the New York City district because of the HCFA review and the pending lawsuit.

At each district, we analyzed case files for a sample of TANF applicants who were denied TANF benefits and TANF recipients who had been deemed ineligible for such assistance to determine if a separate Medicaid eligibility review was done as required. The scope of this audit did not include an assessment of whether TANF eligibility determinations were made properly by the districts or an analysis of the timeliness of the determinations. At both the Saratoga and Montgomery districts, we reviewed samples of 10 TANF cases. At Monroe, we reviewed 18 TANF cases. As a result of our preliminary analysis at these districts, we conducted site visits at six additional districts (Broome, Erie, Oneida, Onondaga, Orange and Westchester). These districts were selected after analyzing data obtained from DOH on the number TANF/Medicaid cases in each district, and data supplied by OTDA on TANF case closings and denials.

In conducting our review at each of these six districts, we reviewed random samples of 100 TANF cases (50 closed and 50 denied) selected from populations of cases closed and denied in the months of January 1999, July 1999 and April 2000. Our sample was selected from those cases that were closed and/or denied for reasons that should have resulted in either Medicaid being continued and/or a separate Medicaid eligibility determination. Exhibit A shows each of the districts selected, the number of denied and closed cases sampled, and the populations from which these samples were selected. We have no reason to believe that the cases we selected from these months would be any different from those in any other month.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of DOH and OTDA that are within our audit scope. Further, these standards require that we understand DOH's and OTDA's internal control structure and their compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that we have identified through a preliminary survey as having the greatest probability of

needing improvement. Consequently, by design, we use our finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." While this report highlights those areas needing improvement and generally does not address activities that may be functioning properly, we note examples of effective practices by certain districts.

Response of Officials to Audit

We provided draft copies of this report to DOH and OTDA officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B and Appendix C, respectively.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health and the Commissioner of the Office of Temporary and Disability Assistance shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Medicaid Eligibility Review Process

New York State utilizes a joint application for public assistance, Medicaid, food stamps and other public assistance. If a low-income family applies for both TANF assistance and Medicaid, the application is first reviewed for TANF eligibility. If the applicant is determined to be TANF eligible, the family will receive Medicaid through their TANF eligibility. In those instances where a family is determined to be ineligible for TANF, in most instances, a separate Medicaid eligibility determination is required.

For individuals who lose their TANF eligibility, Transitional Medicaid Assistance (TMA) is available. TMA is available for a maximum of 12 months if all eligibility requirements are met. To be TMA eligible, the following requirements need to be met: the family becomes ineligible for TANF due to excess earnings from new employment of the caretaker relative, the family has a dependent child under 21 living in the household, and the family received Medicaid in three of the six months prior to the termination of TANF eligibility.

In April 1999, OTDA issued a directive (99-INF-6) to all districts which required the districts to make separate Medicaid eligibility determinations when a TANF case is denied or closed. As part of this process, district officials enter a reason code into the WMS when closing a case and/or when denying an application. For closed cases, if the proper reason code is entered, Medicaid coverage will not be terminated. WMS has been programmed to ensure separate Medicaid eligibility reviews are conducted for individuals whose TANF cases were closed. However, WMS has not been programmed to ensure such reviews are performed for those cases where TANF benefits were denied at application. In such cases, it is the responsibility of district officials to forward these applications to their Medicaid units for a separate review. Our audit work at DOH, OTDA and several districts disclosed that oversight efforts need improvement to ensure that Medicaid eligibility reviews are performed as required.

Medicaid Eligibility for Applicants Who Were Denied TANF Benefits

For TANF applicants who were determined to be ineligible for TANF, we reviewed case files and information available on WMS for nine selected districts to determine if separate Medicaid eligibility reviews were conducted when required. As shown in the following table, we identified a total of 32 cases, out of 320 cases reviewed (10 percent), in which seven of the nine districts did not conduct a separate Medicaid eligibility review as required when the applicant was denied TANF.

District	Number of Sampled Cases Reviewed	Number of Denied Cases Not Receiving Separate Medicaid Eligibility Review
Oneida	50	13
Westchester	50	7
Onondaga	50	3
Orange	50	3
Monroe	10	3
Erie	50	2
Montgomery	5	1
Broome	50	0
Saratoga	5	0
Total	320	32

For example, in the Oneida district, for 13 of the 50 cases reviewed (26 percent) a TANF/Medicaid applicant was denied TANF and a separate review to determine Medicaid eligibility was not conducted as required. We asked district officials to review all 32 cases and determine whether the individuals included in each of these cases were eligible for Medicaid at the time their TANF case was denied. The following chart shows the number of individuals in each district who did not receive a separate Medicaid eligibility review as required and the number of these individuals whom district officials subsequently determined were eligible for Medicaid at the time of the TANF denial.

District	Number of Denied Cases Not Receiving Separate Medicaid Eligibility Review	Number of Individuals in Case	Number Medicaid Eligible	Number Not Medicaid Eligible	Number for Whom the District Was Unable to Determine Medicaid Eligibility	Number for Whom the District Did Not Indicate Clients' Medicaid Eligibility
Oneida	13	44	16	1	27	0
Westchester	7	19	3	5	11	0
Onondaga	3	11	0	0	0	11
Orange	3	11	1	2	8	0
Monroe	3	12	3	5	4	0
Erie	2	4	0	0	0	4
Montgomery	1	2	0	0	0	2
Total	32	103	23	13	50	17

As summarized in the table, officials in four districts (Oneida, Westchester, Orange and Monroe) determined that 23 individuals who were denied TANF were in fact eligible for Medicaid at the time of their TANF denial. Further, officials in these four districts determined that 13 individuals who were denied TANF benefits were not eligible for Medicaid at the time of their TANF denial. For 50 individuals in these four districts, the case files did not contain sufficient information to allow district officials to determine whether these individuals were eligible for Medicaid. Officials stated they would contact these individuals to obtain information needed to make a Medicaid eligibility determination. In addition, in three districts (Onondaga, Erie and Montgomery), officials did not inform us whether the 17 individuals identified were eligible for Medicaid at the time of the TANF denial. The Onondaga district accounted for 11 of these 17 instances. Onondaga officials stated that 8 of the 11 individuals were determined to be eligible for Medicaid as a result of their re-applying for such assistance at a later date.

DOH and OTDA delegated responsibility to the districts for establishing controls and procedures to ensure separate Medicaid eligibility reviews are conducted. However, the exceptions we noted can be attributed to a general

lack of procedures for ensuring separate Medicaid eligibility reviews are performed for TANF applicants who were denied benefits. We also found that neither DOH nor OTDA officials have conducted periodic reviews or audits at the districts to ensure required Medicaid eligibility reviews are done. Most districts we visited relied on supervisory review to ensure such reviews were done. Officials in the Broome and Saratoga districts have procedures in place whereby all denied TANF cases receive a separate Medicaid eligibility review, which contributed to the lack of exceptions in these counties. The other districts have not established effective procedures to ensure denied TANF applications requiring a separate Medicaid eligibility review are referred to their Medicaid units for such review. In addition, while DOH has programmed WMS to take proper action when a TANF case is closed, no such control exists within WMS when a TANF application is denied. As a result, cases are not referred for a separate determination in all instances as required, and some Medicaid applicants did not receive benefits for which they were eligible.

A basic goal of welfare reform is self-sufficiency. However, if individuals are not provided with the assistance to which they are entitled, such as Medicaid coverage, their efforts to attain self-sufficiency could be jeopardized.

In addition, we noted that certain procedures and policies adopted by Broome and Erie officials may be beneficial to other districts in tracking cases and ensuring proper action is taken with respect to Medicaid eligibility reviews. Broome officials have developed intake summary forms and eligibility summary forms which promote a more thorough eligibility review by intake workers. Erie utilizes a Document Imaging System which is very efficient for locating and maintaining case files and documents. In addition, the Erie Medicaid unit developed procedures for logging and tracking cases, which is also useful for case management, report writing and statistical analysis. DOH and OTDA officials should assess these practices and determine whether they would be beneficial for use by other districts.

Medicaid Eligibility for TANF Recipients Whose Cases Were Closed

Individuals can lose their TANF eligibility and still be eligible for Medicaid. Therefore, it is important for districts to have procedures in place to prevent inappropriate Medicaid terminations. In general, we found that districts did an effective job of conducting a separate Medicaid eligibility review when a TANF case was closed. We identified a total of three cases in three of the nine districts visited in which districts did not conduct a separate Medicaid eligibility review as required when the TANF case was closed. The following table shows the results of our testing in each district.

District	Number of Sampled Cases Reviewed	Number of Closed Cases Not Receiving Separate Medicaid Eligibility Review
Westchester	50	1
Montgomery	5	1
Monroe	5	1
Broome	50	0
Erie	50	0
Oneida	50	0
Onondaga	50	0
Orange	50	0
Saratoga	5	0
Totals	315	3

DOH has programmed WMS to help ensure that when TANF cases are closed and Medicaid eligibility is to be continued, Medicaid coverage is not lost. To be effective, the system requires district workers to use the proper case closing (reason) codes on WMS. In addition, the system allows for the use of manual closing codes. When the manual codes are used, the automatic extension of Medicaid coverage will not occur and as such, district officials must ensure the case files receive a separate Medicaid review. However, for each of the three cases that did not receive a separate Medicaid eligibility determination, we found that the case was closed using an improper closing code and/or the case was closed manually and not directed to the district's Medicaid unit for a separate review.

We also attempted to determine whether or not the individuals included in the closed cases were eligible for Medicaid at the time the TANF case closing took place. The following table shows the number of individuals included in each of the cases and the number that district officials determined to be Medicaid eligible at the time of the case closing.

District	Number of Closed Cases Not Receiving Separate Medicaid Eligibility Review	Number of Individuals in Case	Number Medicaid Eligible	Number Not Medicaid Eligible	Number for Whom the District Was Unable to Determine Medicaid Eligibility
Westchester	1	4	3	1	0
Montgomery	1	1	0	0	1
Monroe	1	4	0	0	4
Total	3	9	3	1	5

As summarized in the table, officials in the Westchester district determined that three individuals who lost their TANF eligibility were eligible for continued Medicaid coverage at the time their TANF benefits ended. Westchester officials also determined that one other individual who lost TANF eligibility was not eligible for continued Medicaid coverage at the time TANF benefits ended. Further, for five individuals (one in the Montgomery district and four in the Monroe district), the case files did not contain sufficient information for officials to determine whether Medicaid coverage should have been continued and they were unable to locate the applicants.

Although DOH has established controls within WMS to help ensure that closed TANF cases requiring separate Medicaid reviews receive such a review, our findings indicate that controls need to be strengthened.

Recommendations

To DOH and OTDA

1. DOH and OTDA should work collectively to ensure:

   - districts develop and implement a system of procedures/controls to ensure that TANF applicants determined not to be TANF eligible and TANF recipients who are deemed ineligible for TANF receive a separate Medicaid determination when required;

   - districts comply with 99-INF-6 and other guidance issued by OTDA and DOH; and

   - information on best practices utilized by districts is communicated to other districts for their consideration.

To DOH

2. Ensure that the districts make timely determinations of the eligibility for Medicaid of the 72 persons in our samples for whom sufficient information was not available.

Summary of Sample Sizes and Populations From Which Sampled Cases Were Selected for Each District

Denied Cases

District	Sample Size	Population from Which Sample was Selected
Saratoga	5	22
Montgomery	5	16
Monroe	10	1,347
Erie	50	178
Broome	50	240
Onondaga	50	449
Westchester	50	254
Orange	50	157
Oneida	50	151

Closed Cases

District	Sample Size	Population from Which Sample was Selected
Saratoga	5	14
Montgomery	5	19
Monroe	5	1,981
Erie	50	1,159
Broome	50	312
Onondaga	50	1,367
Westchester	50	1,054
Orange	50	332
Oneida	50	429

Exhibit A

Major Contributors to This Report

Kevin McClune
Rick Sturm
Edward Durocher
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Appendix A

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Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

January 29, 2001

Kevin M. McClune
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Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2000-S-22, entitled "Medicaid Eligibility Under TANF Assistance".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Appendix B

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2000-S-22 Entitled
"Medicaid Eligibility Under TANF Assistance"

The following are the Department of Health's (DOH) comments in response to Draft Audit Report 2000-S-22 entitled "Medicaid Eligibility Under TANF Assistance".

The following are general comments on observations made in the draft audit report.

Executive Summary

The Scope of Audit statement that the joint application for Medicaid and TANF is processed under the direction of OTDA should reflect that while OTDA processes the eligibility determination for the TANF application, and such eligibility nearly always enables eligibility for Medicaid, the Department of Health provides direction regarding Medicaid eligibility. Correction is also needed to the statement that New York City does not use WMS; New York City does, in fact, also use WMS to record case information. Both inaccuracies are repeated in the "Introduction, Background" section.

* Note 1

Introduction and Description of Medicaid Eligibility Review Process

In both of these sections it is stated that a separate Medicaid eligibility determination is required whenever a TANF case is denied or closed. The Introduction says that "[s]tates may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF because of employment, time limit sanctions, *or for any other reason"* (emphasis added). This overstates the requirements. While it is true that most TANF denials or closures require separate determinations, not all do. If the person files a joint application for TANF and Medicaid, it is sometimes possible that the person would be ineligible for TANF and Medicaid for a reason that applies to both programs, such as failure to demonstrate that he or she is a New York State resident. In such a situation, TANF and Medicaid could properly be denied at the same time, and no separate Medicaid determination would be necessary.

* Note 1

The section entitled "Medicaid Eligibility for Applicants Who Were Denied TANF Benefits" on page 8, says that neither DOH nor OTDA have conducted periodic reviews or audits at the districts to ensure required Medicaid eligibility reviews are done. Annual audits are regularly performed by Medicaid Eligibility Quality Control staff through a memorandum of understanding with OTDA.

* Note 2

*See State Comptroller's Notes, Appendix D

The section entitled 'Medicaid Eligibility for TANF Recipients Whose Cases Were Closed" on page 9, describes the use of manual closing codes when staff are not certain of the proper reason code to use. We disagree that staff use manual notices when they are not able to determine a correct code. The language generated by the Client Notices System (CNS) for each of approximately 125 reason codes is available for worker review in the Electronic Library (ELIB) if questions arose regarding the language for any code. CNS trainers are also available to assist. We must include the ability to issue a manual notice when unusual case situations occur. For example, continuous Medicaid coverage is authorized for children when eligibility under Low Income Families is lost less than 12 months after the family was determined eligible. On very rare occasions, continuous coverage would be terminated if fraud were involved in the initial eligibility determination. A manual notice would be used to include the appropriate language for the closing.

* Note 1

Recommendation #1:

The report includes a joint recommendation to DOH and OTDA, that the agencies work collectively to ensure:

- "districts develop and implement a system of procedures/controls to ensure that TANF applicants determined not to be TANF eligible and TANF recipients who are deemed ineligible for TANF receive a separate Medicaid determination when required;"

Response:

The Department, in conjunction with the Office of Temporary and Disability Assistance (OTDA), has taken various opportunities to ensure that persons who are found ineligible for Temporary Assistance (formerly PA) receive a separate Medicaid determination. Directives, training and teleconferences are but some of the methods employed.

In addition, the Office of Medicaid Management (OMM) has utilized the Medicaid Eligibility Quality Control (MEQC) process to identify problems in the past and will continue to do so in the future. (A copy of the MEQC plan was provided to OSC with a letter.) These activities will be supplemented by activities described in the workplan provided to HCFA.

* Note 2

Lastly, with federal Welfare Reform monies, we will be conducting process reviews in local districts to identify ways to strengthen and enhance such controls.

- "districts comply with 99-INF-6 and other guidance issued by OTDA and DOH; and

*See State Comptroller's Notes, Appendix D

Response:

The Department of Health will be addressing these issues through the workplan referenced above and our reviews of local district processes.

- "information on best practices utilized by districts is communicated to other districts for their consideration."

Response:

The Department recognizes that some counties have implemented exemplary procedures to assure that separate Medicaid determinations are performed as necessary. Two counties, Broome and Clinton, participated in a November 21, 2000 teleconference, "Separate Determinations and Access to Medicaid: A Collaborative Approach". These counties shared their somewhat different but successful practices and forms used to assure that separate determinations are performed. These materials and practices are now available to other districts for their consideration.

Identification of successful practices is one objective of our process reviews and other district contacts. As reviews indicate the need for additional enhancements to the separate determination process, other best practices will be shared.

Recommendation #2:

The following recommendation is addressed to the Department of Health:

- "Ensure that the districts make timely determinations of the eligibility for Medicaid of the 72 persons in our samples for whom sufficient information was not available."

Response:

The 72 individuals referenced include 50 individuals on denied cases for whom the district was unable to determine Medicaid eligibility, 17 denied for whom the district did not indicate the client's Medicaid eligibility, and 5 individuals on closed cases for whom the district was unable to determine Medicaid eligibility.

Eligibility of many of the affected individuals was addressed subsequent to OSC's notice of findings letters sent to each district. For example, in a September 27, 2000 letter to audit staff, Oneida County described its corrective actions to determine eligibility for the 27 individuals denied for whom they were unable to determine eligibility.

To assure that an eligibility determination is attempted for all such individuals, the Department will request each district, if it has not already done so, to:

- ✓ send a letter to the most currently available address for the head of household to request information needed to determine eligibility at the point of denial or closing;
- ✓ determine eligibility for that period using information provided; and
- ✓ notify the Department of the outcome of the attempt to contact the individual and of eligibility determination.

Regarding findings and examples cited by OSC, we note that the Monroe County sample included 40 public assistance cases that were denied and 10 cases closed. The report now mentions 10 denials and 5 closings. We recognize that OSC corrected the size of the universe from which the sample was drawn to include only Family Assistance cases rather than all public assistance case types. However, we cannot determine whether that change would affect the number of cases included in the sample. Actual figures need to be confirmed, especially since the larger sample size would reduce the percentage of cases found in error.

* Note 3

*See State Comptroller's Notes, Appendix D

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Brian J. Wing
Commissioner

January 8, 2001

Dear Mr. McClune:

The Office of Temporary and Disability Assistance (OTDA) has reviewed the draft audit report (2000-S-22) on the processes used by the Department of Health and OTDA to ensure that local social services districts conduct medicaid separate determinations.

OTDA has, and will continue to work with DOH to continually improve medicaid participation by individuals who are denied temporary assistance or whose cases are closed. Such cooperative activities include training, teleconferences, and sharing draft directives to insure that medicaid implications associated with temporary assistance policy are included as appropriate.

OTDA is committed to providing the supports to DOH and local districts that are needed to provide appropriate medicaid continuations and separate determinations.

Sincerely,

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Appendix C

State Comptroller's Notes

1. Based on DOH's comments, we modified our report accordingly.

2. We acknowledge that audits are conducted on a regular basis by Medicaid Eligibility and Quality Control staff. However, as stated in our report, we found that neither DOH nor OTDA conducted periodic reviews or audits at the districts to ensure required Medicaid eligibility reviews were done. The audits that have been conducted focused on particular issues and would not have disclosed the type of problems we identified in our district visits. Hence, we recommended that DOH and OTDA work collectively to ensure that districts develop and implement a system of procedures/controls to ensure that Medicaid determinations are conducted when required.

3. DOH is correct in its response that we adjusted our Exhibit A figures for the Monroe district to reflect only Family Assistance cases as the universe from which our sample was selected. This adjustment also affected our sample size for the Monroe district. The findings we report for the Monroe district relate only to those Family Assistance cases that were included in our sample.