

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK INCORRECTLY CLAIMED
ENHANCED FEDERAL MEDICAID
REIMBURSEMENT FOR SOME
BENEFICIARIES**

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Office of Inspector General

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Report in Brief

Date: August 2019

Report No. A-02-15-01023

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

The Patient Protection and Affordable Care Act (ACA) gave States the option to expand Medicaid coverage to low-income adults without dependent children and established enhanced Federal reimbursement rates (Federal Medical Assistance Percentage, or FMAP) for services provided to beneficiaries enrolled through this group, known as the new adult group. Enhanced Federal reimbursement is defined as a payment made at a higher percentage than the State's standard FMAP rate. These higher FMAP rates raised concerns about States improperly enrolling individuals in the new adult group and the potential for improper payments.

Our objective was to determine whether New York correctly claimed an enhanced FMAP rate for Medicaid services provided to beneficiaries enrolled in the new adult group.

How OIG Did This Review

Our review covered almost 1.4 million beneficiaries enrolled in the new adult group and for whom New York received enhanced Federal Medicaid reimbursement totaling \$3.2 billion (Federal share) for services paid during the period October 1, 2014, through March 31, 2015 (audit period). We reviewed a stratified random sample of 130 of these beneficiaries and determined whether New York properly enrolled beneficiaries in the new adult group.

New York Incorrectly Claimed Enhanced Federal Medicaid Reimbursement for Some Beneficiaries

What OIG Found

From our sample of 130 beneficiaries, New York correctly claimed enhanced Medicaid reimbursement for 111 beneficiaries. However, for the remaining 19 beneficiaries, New York incorrectly claimed enhanced reimbursement for 18 beneficiaries and did not provide sufficient documentation to verify that the remaining 2 beneficiaries were eligible for enhanced Medicaid reimbursement. The total exceeds 130 because 2 beneficiaries had multiple deficiencies. New York incorrectly enrolled beneficiaries in eligibility categories for which services were reimbursed at an enhanced FMAP rate despite case file documentation indicating that the beneficiaries should have been enrolled in a group for which services qualified under the standard FMAP or were not eligible for reimbursement. For these beneficiaries, New York failed to correctly apply Federal and State requirements or consider all available, relevant information when enrolling beneficiaries in the new adult group. In addition, staff did not comply with New York's approved verification plan when verifying Medicaid eligibility. Lastly, New York did not maintain documentation to support its determinations that beneficiaries were eligible for enhanced Medicaid reimbursement.

On the basis of our sample results, we estimated that New York incorrectly claimed enhanced Federal Medicaid reimbursement of \$116.9 million on behalf of 184,590 Medicaid beneficiaries enrolled in the new adult group during our 6-month audit period.

What OIG Recommends and New York's Comments

We recommend that New York (1) redetermine, as appropriate, the current Medicaid coverage group of the sampled beneficiaries for whom services were incorrectly reimbursed at an enhanced FMAP rate; (2) ensure that it claims Medicaid reimbursement at the correct FMAP rate by taking the necessary steps to ensure that its staff considers all relevant documentation and Federal and State requirements during the enrollment process, which could have reduced or eliminated an estimated \$116.9 million in overpayments caused by eligibility errors over the 6-month audit period; and (3) maintain the necessary documentation to determine whether it enrolled individuals who did not meet Federal and State Medicaid eligibility requirements in the new adult group.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations but stated that it disagreed with our determinations related to four beneficiaries and provided, under separate cover, additional information related to these beneficiaries. After reviewing New York's comments and additional documentation, we revised our findings and a related recommendation. We maintain that our findings and recommendations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2010, Congress passed the Patient Protection and Affordable Care Act (P.L. No. 111-148) and the Health Care and Education Reconciliation Act (P.L. No. 111-152), collectively known as the Affordable Care Act (ACA). The ACA gave States the option to expand Medicaid coverage to cover nondisabled, low-income adults without dependent children, commonly referred to as the “new adult group.” The ACA also established enhanced Federal reimbursement rates (Federal Medical Assistance Percentage, or FMAP) for services provided to these beneficiaries.¹ These higher FMAP rates raised concerns about the possibility of States improperly enrolling individuals in the new adult group and the potential for improper payments.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) correctly claimed an enhanced FMAP rate for Medicaid services provided to beneficiaries enrolled in the new adult group.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, Federal law requires States to cover certain population groups. The ACA required the establishment in each State of a health insurance exchange (marketplace), which is designed to serve as a “one-stop shop” where individuals review their health insurance options and are evaluated for Medicaid eligibility. Generally, individual eligibility criteria are met by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of United States citizenship. For many eligibility groups, income requirements are tied to the Federal Poverty Level (FPL).

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures, called the FMAP, which is developed from criteria such as the State’s per capita income.² The “standard” FMAP varies by State and ranges from

¹ Enhanced Federal reimbursement is defined as a payment made at a higher percentage than the State’s standard FMAP rate.

² Social Security Act (the Act) § 1905(b).

50 to 75 percent.^{3, 4} Federal Medicaid reimbursement is not available for expenditures on behalf of certain individuals, including those who have not been a qualified alien for at least 5 years or are an inmate of a public institution.

Medicaid Expansion to the New Adult Group Under the Affordable Care Act

Prior to the ACA, only certain groups of individuals who met income and asset thresholds were eligible for Medicaid. Historically, these groups included parents with children, pregnant women, people with disabilities, and the elderly. Beginning in 2014, the ACA provided States with the option to expand their Medicaid programs to cover low-income, nondisabled adults without dependent children (the new adult group).^{5, 6}

As of February 13, 2019, 36 States and the District of Columbia had elected to expand Medicaid coverage to the new adult group. To be eligible for Medicaid under this group, individuals must meet citizenship requirements, State residency requirements, and the following criteria:⁷

- be between ages 19 and 64;
- not be pregnant;
- not be eligible for or enrolled in Medicare;
- not be otherwise eligible for a mandatory Medicaid eligibility group;⁸

³ 79 Fed. Reg. 3385 (Jan. 21, 2014).

⁴ U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, “FY2015 Federal Medical Assistance Percentages.” Available online at: <https://aspe.hhs.gov/pdf-report/fy2015-federal-medical-assistance-percentages>. Accessed on October 25, 2018.

⁵ ACA § 2001(a)(1)(C).

⁶ The ACA required States to expand their Medicaid programs for certain categories of individuals. However, the U.S. Supreme Court found that this expansion violated the Constitution “by threatening existing Medicaid funding” (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)). The decision allowed each State the option to refuse to expand its Medicaid program and not face any reduction in current Medicaid funding.

⁷ The Act § 1902(a)(10)(A)(i)(VIII).

⁸ The Act § 1902(a)(10)(A)(i), subclauses I through VII and IX, list the other Medicaid eligibility groups for which beneficiaries in the new adult category may not be eligible.

- have income that does not exceed 133 percent of the FPL;⁹ and
- not be living with a dependent, uninsured child.¹⁰

New York Medicaid Expansion and Enhanced Federal Medicaid Reimbursement Rates for the New Adult Group

A Medicaid expansion State is defined as one that previously offered health benefits statewide to parents and non-pregnant, childless adults whose income is at least 100 percent of the FPL.¹¹ New York met CMS’s definition of an expansion State when it expanded its Medicaid program as of January 1, 2014.¹² Therefore, it was entitled to receive an enhanced FMAP reimbursement rate for Medicaid services provided to individuals that it enrolled under its new adult group category, including individuals previously eligible for the category and for whom the State agency was eligible for a standard FMAP reimbursement rate.¹³ Table 1 on the next page details the FMAP rates in effect during the period October 1, 2014, through March 31, 2015 (audit period), for New York’s new adult group.

Table 1: Reimbursement Rates for Medicaid Beneficiaries Enrolled in New Adult Group

Individual Household Income	Pre-Expansion	Post-Expansion	
	Standard FMAP	Enhanced FMAP	
	Pre-2014	2014	2015
Up to 100% FPL	50%	75%	80%
Between 100% and 138% FPL	Not eligible	100%	100%

⁹ 42 CFR § 435.119(b)(5). The Act § 1902 established the FPL threshold at 133 percent but allows for a 5-percent income disregard (a standard deduction applied to calculate income for Medicaid), making the effective threshold 138 percent of the FPL.

¹⁰ 42 CFR § 435.119(c).

¹¹ The Act § 1905(z)(3).

¹² Not all beneficiaries enrolled through the new adult category are eligible for the post-expansion enhanced FMAP of 100 percent. For beneficiaries in the new adult category who would have been eligible for Medicaid benefits in their State under an existing category as of December 1, 2009, the post-expansion FMAP rates of 75 percent or 80 percent apply because the State already covered those adults. See CMS, “Medicaid and CHIP FAQs: Newly Eligible and Expansion State FMAP.” Available online at: <http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Expansion-State-FMAP-2013.pdf>. Accessed on October 25, 2018.

¹³ The enhanced FMAP rate for individuals who were not previously eligible for Medicaid was set to remain at 100 percent through 2016 and gradually decrease to 90 percent by 2020 (42 CFR § 433.10(c)(6)).

New York’s Process for Determining Medicaid Eligibility

In New York, individuals can apply for Medicaid in person, at local department of social services offices overseen by the State agency (local districts), or online through New York’s State-based marketplace, known as New York State of Health. To determine whether applicants are eligible for Medicaid, local district and marketplace staff review applicant-provided documentation and query multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub). The data sources available through the Data Hub are provided by HHS, the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the Internal Revenue Service (IRS), among others. Data sources maintained by New York, such as the State Wage Information Collection Agency (SWICA), are also used. The State agency’s CMS-approved “verification plan” details its procedures for verifying each eligibility factor as well as available electronic data sources.

HOW WE CONDUCTED THIS REVIEW

Our review covered almost 1.4 million Medicaid beneficiaries enrolled in the new adult group and for whom the State agency received enhanced Medicaid reimbursement totaling \$4 billion (\$3.17 billion Federal share) for services paid during the audit period. We reviewed Medicaid eligibility determinations made by the State agency’s local districts and marketplace for a stratified random sample of 130 beneficiaries. We also reviewed the internal controls in place at the State agency (i.e., its local districts and marketplace).

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

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency incorrectly claimed an enhanced FMAP rate for Medicaid services provided to some Medicaid beneficiaries enrolled in its new adult group. For our sample of 130 beneficiaries, the State agency correctly claimed enhanced Medicaid reimbursement for 111 beneficiaries. However, for the remaining 19 beneficiaries, the State agency incorrectly claimed enhanced reimbursement for 18 beneficiaries and did not provide sufficient supporting

documentation to verify that 2 beneficiaries were eligible for enhanced Medicaid reimbursement.¹⁴

The State agency claimed enhanced Medicaid reimbursement for these beneficiaries as a result of human or system errors. Specifically, State agency staff (i.e., local district and marketplace staff) incorrectly enrolled beneficiaries in eligibility categories for which services were reimbursed at an enhanced FMAP rate despite case file documentation indicating that the beneficiaries should have been enrolled in an eligibility group for which services qualified under the standard FMAP or were not eligible for reimbursement.¹⁵ For these beneficiaries, State agency staff either failed to correctly apply Federal and State requirements or failed to consider all available, relevant information when they enrolled the individuals into the new adult group. In addition, staff did not always comply with the State agency's CMS-approved verification plan when verifying Medicaid eligibility. Lastly, the State agency did not always maintain documentation to support its determinations that beneficiaries were eligible for enhanced Medicaid reimbursement.

On the basis of our sample results, we estimated that the State agency incorrectly claimed enhanced Federal Medicaid reimbursement of \$116.9 million on behalf of 184,000 Medicaid beneficiaries enrolled in the new adult group during our 6-month audit period.^{16, 17}

NEW YORK INCORRECTLY CLAIMED ENHANCED MEDICAID REIMBURSEMENT FOR SERVICES PROVIDED TO SOME MEDICAID BENEFICIARIES

Beneficiaries Did Not Meet Income Requirements

Individuals whose household incomes are at or below 138 percent of the applicable FPL may be eligible for Medicaid under the new adult group.¹⁸ To ensure that individuals meet income requirements, the State agency verifies Medicaid applicants' reported financial information

¹⁴ We identified multiple deficiencies for payments for services associated with two beneficiaries. This includes one beneficiary who was found to be both ineligible and potentially ineligible.

¹⁵ We questioned all Medicaid reimbursement made for beneficiaries who we determined were not eligible for Medicaid. We also questioned the difference between the enhanced FMAP rate and the FMAP rate at which the State agency should have claimed Medicaid reimbursement.

¹⁶ Our actual estimate is \$116,926,176 on behalf of 184,590 newly eligible Medicaid beneficiaries. The 90-percent confidence interval for the enhanced Federal Medicaid reimbursement estimate ranges from \$38,325,617 to \$195,526,736. The 90-percent confidence interval for the beneficiaries estimate ranges from 102,157 to 267,023.

¹⁷ We are not recommending recovery of the overpayments made to the State agency because, under Federal law, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through the State's Medicaid Eligibility Quality Control or Payment Error Rate Measurement reviews.

¹⁸ 42 CFR § 435.119(b)(5).

through the Data Hub and State resources.¹⁹ The State agency must request additional information or documentation from an applicant if their attested income is not reasonably compatible²⁰ with the income identified in the State agency's electronic sources.²¹

As Table 1 shows, during our audit period, services provided to beneficiaries enrolled in the new adult group were eligible for Federal reimbursement at an enhanced FMAP rate that varied based on individuals' income. Specifically, for services provided to individuals whose household income was below 100 percent of the FPL, the enhanced FMAP rate was 75 percent in 2014 and 80 percent in 2015.²² For services provided to beneficiaries whose household income was between 100 and 138 percent of the FPL, the enhanced FMAP rate was 100 percent.^{23, 24}

For 6 of the 130 sampled beneficiaries, the State agency incorrectly claimed enhanced Medicaid reimbursement for services provided to beneficiaries enrolled in the new adult group whose household income did not meet income requirements for either income range described above. Specifically:

- For three beneficiaries, the State agency incorrectly enrolled individuals in the new adult group for whom services were reimbursed at the 100-percent FMAP rate when services should have been reimbursed at an FMAP rate of 75 percent (2014) or 80 percent (2015). The beneficiaries' case files indicated that their household income was below 100 percent of the FPL.
- For two beneficiaries, the State agency incorrectly enrolled individuals in the new adult group for whom services were reimbursed at the 100-percent FMAP rate when they should not have been enrolled in any Medicaid group. The beneficiaries' case files indicated that their household income exceeded the maximum allowable level (138 percent of the FPL). Therefore, services provided to these individuals were not eligible for Federal Medicaid reimbursement.

¹⁹ 42 CFR § 435.948(a)-(b).

²⁰ New York's verification plan defines "reasonably compatible" as when the applicant's attested income and verified income are both at or below the 138-percent FPL standard or when the applicant's verified income is above 138 percent of the FPL but within 10 percent of their attested income, which is at or below 138 percent of the FPL.

²¹ 42 CFR § 435.952(c)(2).

²² NYS Health Foundation, *Implementing Federal Health Care Reform: A Roadmap for New York State* (August 2010). Available online at https://info.nystateofhealth.ny.gov/sites/default/files/roadmap_for_nys.pdf. Accessed on November 6, 2018.

²³ The Act § 1905(y)(1).

²⁴ New York did not have any eligibility groups that would cover this population under a non-newly eligible category.

- For one beneficiary, the State agency correctly enrolled the individual in the new adult group; however, a defect in the marketplace’s enrollment system assigned an incorrect data element known as an “aid category code” for the beneficiary that resulted in some services being incorrectly claimed at the 80-percent FMAP rate. The beneficiary’s case file indicated that his household income was between 100 and 138 percent of the FPL. Therefore, services for the beneficiary were eligible for reimbursement at the 100-percent FMAP rate.²⁵

Beneficiaries Had Dependent Children

Individuals between 19 and 64 years of age who are not living with children under 21 years of age and do not meet the requirements for any other category of assistance may be enrolled in New York’s Medicaid program under the new adult group.²⁶ During our audit period, the enhanced FMAP rate for beneficiaries enrolled in this eligibility group ranged from 75 to 100 percent.²⁷ (See Table 1.)

For 5 of the 130 sampled beneficiaries, the State agency incorrectly claimed enhanced Medicaid reimbursement for services provided to beneficiaries enrolled under the new adult group despite their applications demonstrating that dependent children were in the household and that the requirements of another category of assistance were met.²⁸ As a result, services provided to these beneficiaries were reimbursed at enhanced FMAP rates of 75 or 80 percent but should have been reimbursed at the State agency’s standard FMAP rate of 50 percent.

Beneficiaries Were Disabled

Individuals may not be enrolled in the new adult category if they are otherwise eligible for Medicaid through a mandatory category.²⁹

For 3 of the 130 sampled beneficiaries, the State agency incorrectly enrolled the individuals in the new adult group despite their case files demonstrating that they were certified as disabled and receiving Social Security disability benefits—a mandatory coverage group for which the standard FMAP rate applied. For these beneficiaries, the State agency claimed Medicaid

²⁵ For this beneficiary, we allowed Federal reimbursement at the 100-percent FMAP rate for 2 months for which reimbursement was made at the 80-percent rate.

²⁶ The Act § 1902(a)(10)(A)(i)(VIII) and 42 CFR § 435.119.

²⁷ ACA section 2001.

²⁸ These five beneficiaries met the requirements of a mandatory coverage group—Low-Income Family, for which the FMAP rate is 50 percent.

²⁹ The Act § 1902(a)(10)(A)(i).

reimbursement for services at enhanced FMAP rates of 75 or 80 percent instead of the standard FMAP rate of 50 percent.

Beneficiaries Were Enrolled in Medicare

For an individual to be enrolled in the new adult group, he or she must not be enrolled in or entitled to Medicare Part A or Part B benefits.³⁰ States are required to have an eligibility verification system to verify whether an individual has or is eligible for Medicare.³¹

For 2 of the 130 sampled beneficiaries, the State agency incorrectly enrolled the beneficiary in the new adult group despite their enrollment in Medicare. Specifically, the State agency incorrectly enrolled beneficiaries in the new adult group even though their case files indicated that they were receiving Medicare benefits. The State agency's verification plan requires that SSA data be used to verify that applicants are not receiving Medicare benefits. However, for these two beneficiaries, there was no evidence in their associated case files that local district staff complied with the verification plan and considered available SSA data. Services provided to these beneficiaries were reimbursed at enhanced FMAP rates of 75 and 100 percent. To be conservative, we allowed the standard FMAP rate of 50 percent for these beneficiaries, as they may have been eligible for a different coverage group.

Beneficiaries Did Not Meet Citizenship Requirements

Individuals who are U.S. citizens or qualified aliens³² are eligible to receive Medicaid.³³ State Medicaid agencies are required to verify citizenship status at the time of application.³⁴ States may verify citizenship or nationality by electronically verifying citizenship status with SSA.³⁵ If a State is unable to verify citizenship or nationality, there is a 90-day inconsistency period to resolve a discrepancy during which the beneficiary is presumed eligible.³⁶

³⁰ ACA § 2001(a)(1)(C).

³¹ The Act § 1137(b)(2).

³² Examples of a "qualified alien" include individuals who are lawfully permitted permanent residency, individuals granted asylum, refugees admitted to the United States, and individuals granted conditional entry.

³³ 8 USC § 1613(a). Qualified aliens are not eligible for Medicaid benefits until 5 years from the date they enter the United States with qualified alien status.

³⁴ The Act § 1903(x).

³⁵ 42 CFR §§ 435.406 and 435.949.

³⁶ The Act § 1902(ee).

For 2 of the 130 sampled beneficiaries, the State agency could not confirm the individuals' citizenship status and, therefore, enrolled them in the new adult group to allow them to resolve this discrepancy. However, the State agency's marketplace enrollment system did not disenroll them from Medicaid after the discrepancy was not resolved before the 90-day inconsistency period lapsed.³⁷ Services for these beneficiaries after the 90-day period lapsed were reimbursed at enhanced FMAP rates of 75 and 80 percent when they were not eligible for any Federal Medicaid reimbursement.

Beneficiary Was Incarcerated

Federal Medicaid reimbursement is not available for services provided to inmates of a public institution except when the inmate becomes an inpatient in a medical institution.³⁸ New York State law requires the State agency to suspend Medicaid benefits of incarcerated beneficiaries during their incarceration.³⁹ To facilitate this process, the New York State Office of Temporary and Disability Assistance (OTDA), on behalf of the State agency, receives monthly notifications of incarcerations. OTDA uses this information to identify incarcerated Medicaid beneficiaries and provides reports of these matches to the State agency for appropriate action.⁴⁰

For 1 of the 130 sampled beneficiaries, the State agency did not suspend Medicaid benefits for the beneficiary after he had been incarcerated. The beneficiary was correctly enrolled in the new adult group; however, services provided to the beneficiary during his incarceration (not while an inpatient in a medical institution) were reimbursed at an 80-percent enhanced FMAP rate when they were not eligible for any Federal Medicaid reimbursement.

NEW YORK DID NOT PROVIDE DOCUMENTATION TO VERIFY THAT BENEFICIARIES WERE ELIGIBLE FOR THE NEW ADULT GROUP

The State agency must maintain or supervise the maintenance of the records necessary to properly and efficiently operate the Medicaid program.⁴¹ The State agency must also include in each applicant's case record facts to support its decision on a beneficiary's application.⁴²

³⁷ There was no information to show that these individuals made a good-faith effort to obtain the necessary documentation to support their citizenship and were provided additional time to resolve the discrepancy in accordance with 42 CFR § 435.956(b)(2)(ii)(B).

³⁸ 42 U.S.C. § 1396d(a)(29)(A) and the Act § 1905(a)(29)(A).

³⁹ New York State Social Services Law § 366 (1-a).

⁴⁰ 08 Office of Health Insurance Programs/ADM-3 § III.B.1.

⁴¹ 42 CFR § 431.17.

⁴² 42 CFR § 435.914.

For 2 of 130 sampled beneficiaries, the State agency did not provide sufficient documentation to verify that the beneficiaries were eligible for the new adult group. Individuals with dependent children in their household are eligible for the new adult group if the children are receiving benefits under Medicaid or the Children's Health Insurance Program or are otherwise enrolled in minimum essential coverage.⁴³ However, the case files for these beneficiaries did not contain such information, and therefore, we were unable to determine whether this requirement was met.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- redetermine, as appropriate, the current Medicaid coverage group of the sampled beneficiaries for whom services were incorrectly reimbursed at an enhanced FMAP rate;
- ensure that it claims Medicaid reimbursement at the correct FMAP rate by taking the necessary steps to ensure that local district and marketplace staff consider all relevant documentation and Federal and State requirements during the enrollment process, which could have reduced or eliminated an estimated \$116,926,176 in overpayments caused by eligibility errors over the 6-month audit period; and
- maintain the necessary documentation to determine whether it enrolled individuals who did not meet Federal and State Medicaid eligibility requirements in the new adult group.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not specifically indicate concurrence or nonconcurrence with our recommendations. However, it stated that it disagreed with our determinations related to four sampled beneficiaries identified in our draft report as ineligible for enhanced Medicaid reimbursement or as having received Medicaid reimbursement at the incorrect enhanced FMAP rate. Specifically, the State agency disagreed with our determinations for two beneficiaries who did not meet income requirements for the FMAP rate that was claimed and two others who were disabled. Under separate cover, the State agency provided additional information related to these four beneficiaries.

For one of the two beneficiaries who were identified in our draft report as not meeting income requirements, the State agency stated that the household income was below 100 percent of the FPL—not above 138 percent, as we described. According to the State agency, services provided to this individual should have been reimbursed at an FMAP rate of 75 or 80 percent, depending on the date of service. For the other beneficiary, the State agency indicated that our determination was incorrect because the individual's income was below 100 percent of the FPL

⁴³ 42 CFR 435.119(c).

for a portion the audit period. According to the State agency, services during this period were reimbursed at the correct (i.e., lower) FMAP rate.

For the two beneficiaries who were identified in our draft report as not eligible for enhanced Medicaid reimbursement because they were disabled, the State agency contended that the associated claims were correctly paid. According to the State agency, the beneficiaries were eligible for the new adult group at the time the claims were paid because they had not yet been determined disabled by SSA. The State agency indicated that it is not required to re-adjudicate claims paid prior to the date of an SSA disability determination.

Lastly, the State agency described steps it has taken after our audit period, including issuing guidance to local districts and modifying its marketplace system, to ensure that its Medicaid determination and enrollment policies are followed and that it claims Medicaid reimbursement at the correct FMAP rate.

The State agency's comments appear in their entirety as Appendix D.⁴⁴

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and the additional information provided, we amended our determinations related to the four beneficiaries and revised our report and a related recommendation accordingly. Although we acknowledge the State agency's efforts to improve its determination and enrollment processes, we did not assess these efforts.⁴⁵ Further, although more than 4 years have passed since our audit period, the State agency continues to rely on local district staff and its marketplace system to process more than 3 million eligibility determinations or enrollments per year.⁴⁶ Accordingly, we maintain that our findings and recommendations, as revised, are valid.

⁴⁴ We did not include the additional information provided under separate cover because it contained personally identifiable information.

⁴⁵ We note that in some cases (e.g., guidance to district offices in 2015 and 2019 regarding adherence to eligibility and administrative rules), we were not made aware of the State agency's efforts until we received its comments on our draft report.

⁴⁶ *Medicaid Administration: Annual Report to the Governor and Legislature*, New York Department of Health (December 2018). Available online at: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2018_annual_report_governor_and_legislature.pdf. Accessed on July 30, 2019.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 1,357,665 Medicaid beneficiaries in New York for whom the State agency received enhanced Medicaid payments totaling \$4,057,321,629 (\$3,167,249,653 Federal share) for services paid during the period October 1, 2014, through March 31, 2015.

We limited our review of internal controls to those applicable to our objective. Our testing of controls included a review of supporting documentation at New York State of Health or the State agency's local districts to evaluate whether beneficiaries enrolled under the new adult group and receiving enhanced Medicaid reimbursement met the requirements described in the ACA. We also gained an understanding of the marketplace's and local district's policies and procedures for determining which enrollment group Medicaid applicants were eligible for.

We performed fieldwork at the State agency and the New York marketplace in Albany, New York, and local districts throughout the State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, guidance, and other requirements related to Medicaid eligibility;
- assessed internal controls by:
 - interviewing officials from the New York marketplace to obtain an understanding on how the marketplace (1) processes an applicant's information, (2) verifies an applicant's eligibility for enrollment in Medicaid, and (3) transmits enrollment data to the State agency;
 - holding discussions with State agency and local district officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
 - performing a walkthrough of the applicant information and determination of eligibility verification processes for enrollment in Medicaid; and
 - determining how the system documents that the verification and determination of eligibility processes occurred;

- obtained a database of New York Medicaid claims paid during the 6-month audit period that were reimbursed at an enhanced FMAP rate, excluding American Indians and Alaska Natives claims;⁴⁷
- created a sampling frame of 1,357,665 Medicaid beneficiaries for whom the State agency received enhanced Medicaid payments totaling \$4,057,321,629 (\$3,167,249,653 Federal share);
- selected a stratified random sample of 130 Medicaid beneficiaries;
- obtained application data and documentation, for each sample item (where possible), to support the eligibility determination to determine:
 - which organization or agency made the eligibility determination (i.e., New York marketplace or local district);
 - whether the agency making eligibility determinations followed implemented verification procedures; and
 - whether beneficiaries who were determined to be eligible for the new adult group under provisions described in the ACA met Federal and State eligibility requirements (e.g., income level, residency, immigration status).
- obtained sufficient independent information (where possible) to determine whether the State agency properly enrolled beneficiaries in the new adult group and were therefore eligible for enhanced Medicaid reimbursement;
- estimated the total number of beneficiaries for whom the State agency incorrectly claimed enhanced Federal Medicaid reimbursement;
- estimated the total amount of enhanced Federal Medicaid reimbursement that the State agency incorrectly claimed; and
- discussed the results of our review with State agency officials.

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

⁴⁷ American Indians and Alaska Natives are subject to different eligibility requirements and were not part of this review.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of Medicaid beneficiaries, excluding American Indians and Alaska Natives, for whom the State agency received enhanced Federal Medicaid reimbursement for services paid during the 6-month audit period.

SAMPLING FRAME

The sampling frame consisted of Access databases containing data about Medicaid beneficiaries in New York for whom the State agency received enhanced Medicaid payments during the audit period. Specifically, the sampling frame consisted of 1,357,665 Medicaid beneficiaries, with enhanced Medicaid payments totaling \$4,057,321,629 (\$3,167,249,653 Federal share). We obtained the data from New York's Medicaid Management Information System.⁴⁸

SAMPLE UNIT

The sample unit was a Medicaid beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as described in Table 2 below:

Table 2: Sample Design and Sample Size

Stratum Number	Stratum Dollar Bounds	Frame Paid Amount	Frame Federal Share	Number of Beneficiaries	Sample Size
1	Beneficiaries with total payments <\$1,900	\$869,568,788	\$663,224,797	592,773	30
2	Beneficiaries with total payments ≥\$1,900 and <\$2,500	1,355,695,527	1,067,379,330	503,833	35
3	Beneficiaries with total payments ≥\$2,500 and <\$7,500	939,000,973	759,651,094	223,210	30
4	Beneficiaries with total payments ≥\$7,500	893,056,341	676,994,432	37,849	35
	Total	\$4,057,321,629	\$3,167,249,653	1,357,665	130

⁴⁸ The State agency is responsible for operating New York's Medicaid program and uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the Medicaid beneficiaries within strata 1, 2, 3, and 4. After generating the random numbers for each of these strata, we selected the corresponding Medicaid beneficiaries in the sampling frame for our sample.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total number of Medicaid beneficiaries for whom the State agency incorrectly claimed enhanced Federal Medicaid reimbursement. We also estimated the total amount of enhanced Federal Medicaid reimbursement that the State agency incorrectly claimed for these beneficiaries. We used this software to calculate the lower and upper limits of the 90-percent confidence intervals associated with these estimates.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES⁴⁹

Table 3: Sample Detail and Results for Beneficiaries for Whom Incorrect Enhanced Medicaid Payments Were Made

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Beneficiaries for Whom Incorrect Enhanced Medicaid Payments Were Made	Value of Incorrect Enhanced Medicaid Payments
1	592,773	\$663,224,797	30	\$36,817	5	\$1,671
2	503,833	1,067,379,330	35	74,326	3	4,691
3	223,210	759,651,094	30	83,126	5	1,597
4	37,849	676,994,432	35	674,766	5	4,156
Totals	1,357,665	\$3,167,249,653	130	\$869,035	18	\$12,115

Table 4: Sample Detail and Results for Beneficiaries Potentially Ineligible for Enhanced Medicaid Payments

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	592,773	\$663,224,797	30	\$36,817	1	\$474
2	503,833	1,067,379,330	35	74,326	1	2,290
3	223,210	759,651,094	30	83,126	0	0
4	37,849	676,994,432	35	674,766	0	0
Totals	1,357,665	\$3,167,249,653	130	\$869,035	2	\$2,764

⁴⁹ The values included in this appendix are Federal share amounts of the payments associated with the beneficiaries.

ESTIMATES

**Table 5: Estimated Number of Beneficiaries for Whom Incorrect
Enhanced Medicaid Payments Were Made and the Value of the Associated Payments**
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Beneficiaries	Total Value of Payments
Point estimate	184,590	\$116,926,176
Lower limit	102,157	38,325,617
Upper limit	267,023	195,526,736

APPENDIX D: STATE AGENCY COMMENTS



ANDREW M. CUOMO
Governor

Department
of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 24, 2019

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-15-01023

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-15-01023 entitled, "New York Incorrectly Claimed Enhanced Federal Medicaid Reimbursement for Some Beneficiaries."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
Erin Ives
Brian Kiernan
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James Cataldo
Jessica Lynch

**New York State Department of Health
Comments on the Department of Health and
Human Services Office of Inspector General
Draft Audit Report A-02-15-01023 entitled,
“New York Incorrectly Claimed Enhanced Federal Medicaid
Reimbursement for Some Beneficiaries”**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-15-01023 entitled, “New York Incorrectly Claimed Enhanced Federal Medicaid Reimbursement for Some Beneficiaries.”

General Comments:

The Department reviewed the draft report and supporting information provided by OIG and disagrees with the total federal payments identified by OIG as not correct (i.e., incorrect and potentially incorrect). The Department properly claimed almost 50 percent of those payments. After adjusting for these properly claimed payments, the net federal payment error rate for the entire audit sample was less than 1.5 percent.

The following comments address specific findings discussed in various sections of the report.

- *Beneficiaries Did Not Meet Income Requirements* section, page 6, first bullet:
The Department disagrees with OIG's findings for one of the three cases in this section (S3-21). The sampled individual's household income was below 100 percent of the federal poverty level (FPL), not above 138 percent of the FPL as cited by OIG. Therefore, services provided to this individual were eligible for a 75 or 80 percent Federal Medical Assistance Percentage (FMAP) rate depending on the date of service, not zero percent as cited by OIG.

As a result, OIG erroneously counted more than \$2,097 of proper claims as incorrect. This negates over 8 percent of the total payments identified by OIG as not correctly claimed.

- *Beneficiaries Did Not Meet Income Requirements* section, page 7, third bullet:
The Department disagrees with the description OIG provided for this case (S3-22). When the review determination was made, eligibility was correctly determined based on verified income and the correct aid code was assigned by the system. The system also assigned a correct, but different, aid code at the subsequent administrative renewal when income changed. However, the subsequent aid code was also retroactively applied by the system to the prior eligibility period, which resulted in some incorrect claiming adjustments being processed. This system defect was internally identified and remediated on April 11, 2015, prior to commencement of the audit.
- *Beneficiaries Were Disabled*, page 7:
The Department disagrees with OIG's findings for two of the five cases in this section (S4-02 and S4-28). The claims identified as inappropriate by OIG were correctly paid at the higher FMAP rate. At the time the claims were paid, the consumers were eligible for the new adult group because they had not yet been determined eligible by the Social Security Administration (SSA) for Supplemental Security Income (SSI). Regardless of the effective date of the SSI determination made by SSA (i.e., an SSI payment was awarded by SSA for a retroactive period), the Department is not required to re-adjudicate previously paid claims for the period prior to the date the SSI determination was provided to the Department.

As a result, OIG erroneously identified more than \$10,265 of proper claims as incorrect. This negates over 41 percent of the total payments identified by OIG as not correctly claimed.

Recommendation #1:

Redetermine, as appropriate, the current Medicaid coverage group of the sampled beneficiaries for which services were incorrectly reimbursed at an enhanced FMAP rate.

Response #1:

More than four years have passed since the last coverage month reviewed by OIG, which means that all the beneficiaries reviewed by OIG, if they are still enrolled, had their eligibility redetermined at least four times.

Recommendation #2:

Ensure that it claims Medicaid reimbursement at the correct FMAP rate by taking the necessary steps to ensure that local district and marketplace staff consider all relevant documentation and Federal and State requirements during the enrollment process, which could have reduced or eliminated an estimated \$142,920,939 in overpayments caused by eligibility errors over the 6-month audit period.

Response #2:

Most of the valid OIG findings were caused by caseworker errors. The Department issued letters to local district offices in 2015 and 2019 reminding them that they need to adhere to all eligibility and administrative rules and employ adequate internal control procedures to ensure that Medicaid policies are followed during the determination and enrollment process.

In addition, appropriate system modifications were made more than four years ago to limit future occurrences related to the valid non-caseworker findings. Furthermore, the Department continuously monitors its eligibility and enrollment systems via various quality assurance activities and, as needed, takes steps to make improvements to ensure that the systems are operating effectively.

Recommendation #3:

Maintain the necessary documentation to determine whether it enrolled individuals who did not meet Federal and State Medicaid eligibility requirements in the new adult group.

Response #3:

The Department issued letters to local district offices in 2015 and 2019 reminding them of their obligation to maintain and make available upon request all evidence necessary to validate every eligibility decision.