

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK DID NOT CORRECTLY
DETERMINE MEDICAID ELIGIBILITY
FOR SOME NON-NEWLY ELIGIBLE
BENEFICIARIES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Joanne M. Chiedi
Acting Inspector General**

July 2019
A-02-16-01005

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: July 2019

Report No. A-02-16-01005

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



Why **OIG** Did This Review

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid (traditional coverage groups). After the passage of the Patient Protection and Affordable Care Act (ACA), some beneficiaries remained eligible under these traditional coverage groups. We refer to these beneficiaries as “non-newly eligible beneficiaries.” This review is part of an ongoing series of **OIG** reviews of States’ Medicaid eligibility determinations. We conducted these reviews to address the concern that States might have difficulty accurately determining eligibility for Medicaid beneficiaries.

Our objective was to determine whether New York determined Medicaid eligibility for non-newly eligible beneficiaries in accordance with Federal and State eligibility requirements.

How **OIG** Did This Review

Our review covered 3,351,560 non-newly eligible beneficiaries for whom Medicaid payments totaling \$24.6 billion (\$13.2 billion Federal share) were made for services provided from October 2014 through March 2015. We reviewed supporting documentation for a stratified random sample of 130 of these beneficiaries to evaluate whether New York determined the individuals’ Medicaid eligibility in accordance with Federal and State eligibility requirements (e.g., income and citizenship requirements).

New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries

What **OIG** Found

For our sample of 130 beneficiaries, New York correctly determined Medicaid eligibility for 110 beneficiaries but incorrectly determined Medicaid eligibility for 6 beneficiaries. New York did not provide supporting documentation to verify that the remaining 14 beneficiaries were Medicaid-eligible. For these beneficiaries, New York did not consider all available, relevant information or failed to comply with its Medicaid State plan or verification plan when determining Medicaid eligibility. Additionally, New York’s enrollment system did not always query all electronic data sources to ensure individuals were reporting all sources of countable income when applying for Medicaid. Lastly, New York did not always maintain documentation to support eligibility determinations.

On the basis of our sample results, we estimated that New York made Federal Medicaid payments of \$520.3 million on behalf of 383,893 ineligible beneficiaries and \$1.3 billion on behalf of 618,057 potentially ineligible beneficiaries 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 eligibility status of the sampled beneficiaries who did not meet Federal and State eligibility requirements; (2) take the necessary steps to ensure local district and marketplace staff consider all available, relevant information and data sources, as well as all Federal and State requirements when determining Medicaid eligibility, which could have reduced or eliminated an estimated \$520.3 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, which could have resulted in up to \$1.3 billion in potentially improper Federal Medicaid payments over the 6-month audit period.

New York did not specifically indicate concurrence or nonconcurrence with our recommendations. However, it stated that it disagreed with our determinations for six sampled beneficiaries and provided, under separate cover, additional information related to these beneficiaries. New York also described steps it has taken after our audit period to ensure that Medicaid determination and enrollment policies are adhered to. After reviewing New York’s comments and the additional information provided, we maintain our findings and recommendations are valid.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Review	1
Objective	1
Background	2
The Medicaid Program.....	2
Medicaid Coverage and Changes to Medicaid Eligibility Rules Under the Affordable Care Act.....	2
Medicaid Eligibility Verification Requirements.....	3
New York’s Process for Determining Medicaid Eligibility.....	3
How We Conducted This Review	4
FINDINGS.....	4
New York Incorrectly Determined Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries	5
Beneficiaries Did Not Meet Income Requirements	5
Beneficiaries Did Not Meet Medically Needy Coverage Group Requirements.....	7
Beneficiary Did Not Meet Citizenship Requirements	7
New York Did Not Provide Documentation To Verify That Beneficiaries Were Eligible for Medicaid.....	8
RECOMMENDATIONS	9
STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	9
Beneficiaries Did Not Meet Income Requirements	10
State Agency Comments.....	10
Office of Inspector General Response	10
New York Did Not Provide Documentation To Verify That Beneficiaries Were Eligible for Medicaid.....	10
State Agency Comments.....	10
Office of Inspector General Response	11

APPENDICES

A: Audit Scope and Methodology 12

B: Related Office of Inspector General Reports..... 14

C: Statistical Sampling Methodology 15

D: Sample Results and Estimates 17

E: State Agency Comments 19

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 mandated changes to Medicaid eligibility rules, such as calculating income based on Modified Adjusted Gross Income (MAGI), a measure of income that is based on Internal Revenue Service (IRS) rules.¹ The ACA also provided States with the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these newly eligible beneficiaries. These changes led to significantly increased applications for Medicaid coverage.

Although many individuals applied for Medicaid coverage for the first time after the passage of the ACA, some of them were part of a population that had traditionally been eligible for Medicaid on the basis of one of the existing eligibility categories. We refer to these individuals as “non-newly eligible beneficiaries.”

This review is part of an ongoing series of Office of Inspector General (OIG) reviews of States’ Medicaid eligibility determinations.² We conducted these reviews to address the concern that State agencies might have difficulty accurately determining eligibility for Medicaid beneficiaries. We selected New York to ensure that our reviews covered States in different parts of the country and because New York’s pre-ACA eligibility guidelines were so broad, more than 90 percent of its post-ACA Medicaid beneficiaries are non-newly eligible.³

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) determined Medicaid eligibility for non-newly eligible beneficiaries in accordance with Federal and State eligibility requirements.

¹ 26 U.S.C. § 36B(d)(2)(B).

² See Appendix B for a list of related OIG reports on Medicaid eligibility.

³ We excluded newly eligible beneficiaries from this review because they were included in another OIG report, *New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (A-02-15-01015), issued January 5, 2018.

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 groups of individuals (coverage groups), including parents with children, pregnant women, and individuals who are aged, blind, or disabled.

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 Federal medical assistance percentage (FMAP), which is developed from criteria such as the State's per capita income.⁴ The standard FMAP varies by State and generally ranges from 50 to 75 percent.^{5, 6} In addition, 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. For example, States have the option to establish a "medically needy" coverage group for individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other coverage groups.

When making a Medicaid eligibility determination, a State must follow Federal requirements as well as the process outlined in its State plan and State eligibility verification plan.⁷ CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control and Payment Error Rate Measurement programs, which are designed to reduce improper payments.

Medicaid Coverage and Changes to Medicaid Eligibility Rules Under the Affordable Care Act

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These traditional coverage groups included low-income parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly.

⁴ Social Security Act (the Act) § 1905(b).

⁵ 79 Fed. Reg. 3385 (Jan. 21, 2014).

⁶ The U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation. "FY 2017 Federal Medical Assistance Percentages." Accessed at <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages> on January 22, 2019.

⁷ Each State is required to develop a Medicaid verification plan describing its eligibility verification policies and procedures (42 CFR § 435.945(j)).

Beginning in 2014, the ACA provided States with the option to expand their Medicaid programs to cover more low-income people, including nondisabled adults without dependent children, commonly referred to as the “new adult group.” The ACA also required the establishment in each State of a health insurance exchange (marketplace), which is designed to serve as a “one-stop shop” where individuals can review their health insurance options and are evaluated for Medicaid eligibility. Further, States were required to make a number of changes to their Medicaid application and enrollment processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual’s eligibility for all potential health coverage options, such as Medicaid, the Children’s Health Insurance Program, and qualified health plans available through the health insurance marketplaces.⁸ Finally, in most cases, the ACA required States to use MAGI to determine a person’s income.⁹

Medicaid Eligibility Verification Requirements

Generally, individuals meet eligibility criteria by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of U.S. citizenship. For many coverage groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL).

States are required to have an income and eligibility verification system for determining Medicaid eligibility, and upon CMS’s request, a verification plan describing the State agency’s policies and procedures for implementing the eligibility verification requirements.¹⁰ States must verify individuals’ eligibility information, such as citizenship or lawful presence, and entitlement to or enrollment in Medicare, through electronic sources.¹¹ States may accept an individual’s attestation for certain information, such as pregnancy status and household composition (e.g., household size and family relationships), without further verification.¹²

New York’s Process for Determining Medicaid Eligibility

In New York, individuals can apply for Medicaid in person, at local departments of social services (local districts) overseen by the State agency, or online through New York’s State-based marketplace, known as New York State of Health. To determine whether individuals are eligible for Medicaid, local district and marketplace staff review documentation provided by individuals and query multiple electronic data sources, including sources available through the Federal

⁸ ACA § 1413(b).

⁹ The Act §§ 1902(e)(14)(A)-(D). Certain individuals, such as seniors aged 65 and older and medically needy individuals, are exempt from the use of this methodology.

¹⁰ The Act §§ 1137(a) and (b); 42 CFR § 435.945(j).

¹¹ 42 CFR §§ 435.945(a) and (b) and 435.949.

¹² 42 CFR §§ 435.945(a) and 435.956.

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 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 and available electronic data sources.

If determined eligible, an individual may receive Medicaid coverage for 12 months. The State agency is not required to redetermine Medicaid eligibility before the end of this period unless it is notified of updated information that would affect the individual's eligibility status.

HOW WE CONDUCTED THIS REVIEW

Our review covered 5,351,560 non-newly eligible Medicaid beneficiaries for whom Medicaid payments totaling \$24.6 billion (\$13.2 billion Federal share) were made for services provided during the period October 1, 2014, through March 31, 2015 (audit period). We reviewed the Medicaid eligibility determinations (including re-determinations) made by the State agency's local districts and the New York marketplace for a stratified random sample of 130 beneficiaries. We also reviewed the internal controls in place at the State agency, local districts, and the New York 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 C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency did not correctly determine Medicaid eligibility for some non-newly eligible beneficiaries in accordance with Federal and State requirements. Specifically, New York correctly determined Medicaid eligibility for 110 of the 130 beneficiaries in our sample. However, it incorrectly determined Medicaid eligibility for 6 sampled beneficiaries¹³ and did not provide supporting documentation to verify that individuals were Medicaid-eligible for the remaining 14 sampled beneficiaries, who were potentially ineligible.

¹³ None of these six sampled beneficiaries were found to be eligible for Medicaid.

On the basis of our sample results, we estimated that during our 6-month audit period, the State agency made Federal Medicaid payments of \$520.3 million on behalf of 384,000 ineligible beneficiaries,^{14, 15} and \$1.3 billion on behalf of 618,000 potentially ineligible beneficiaries.¹⁶

The deficiencies we identified occurred because of human or system errors. Specifically, State agency staff (i.e., local district and marketplace staff) did not consider all available, relevant information or failed to comply with New York's State plan or its CMS-approved verification plan when determining Medicaid eligibility. Additionally, the State agency's enrollment system did not always query all electronic data sources to ensure individuals were reporting all sources of countable income when applying for Medicaid. Lastly, the State agency did not always maintain documentation to support its eligibility determinations.

NEW YORK INCORRECTLY DETERMINED MEDICAID ELIGIBILITY FOR SOME NON-NEWLY ELIGIBLE BENEFICIARIES

The State agency incorrectly determined Medicaid eligibility for six beneficiaries who did not meet (1) income requirements, (2) the requirements for its medically needy coverage group, or (3) citizenship requirements.

Beneficiaries Did Not Meet Income Requirements

The ACA expanded Medicaid coverage to individuals who have household income at or below 133 percent of the FPL for the applicable family size.¹⁷ A 5-percent income "disregard" is allowed, making the effective threshold 138 percent of the FPL.¹⁸ The State agency must verify financial information related to wages, net earnings from self-employment, unearned income, and resources from SWICA, IRS, SSA, and State unemployment insurance.¹⁹ The State agency

¹⁴ Our actual estimates are \$520,295,792 on behalf of 383,893 ineligible Medicaid beneficiaries. The 90-percent confidence interval for the Federal Medicaid payments estimate ranges from \$80,414,611 to \$960,176,973. The 90-percent confidence interval for the ineligible beneficiaries estimate ranges from 114,266 to 653,520.

¹⁵ We are not recommending recovery 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.

¹⁶ Our actual estimates are \$1,297,308,200 on behalf of 618,057 potentially ineligible Medicaid beneficiaries. The 90-percent confidence interval for the Federal Medicaid payments estimate ranges from \$726,192,069 to \$1,868,424,330. The 90-percent confidence interval for the potentially ineligible beneficiaries estimate ranges from 299,478 to 936,636.

¹⁷ 42 CFR § 435.119(b)(5).

¹⁸ The Act § 1902(e)(14)(I)(i).

¹⁹ 42 CFR §§ 435.948(a)-(b).

must request additional information or documentation from individuals whose attested income is not reasonably compatible²⁰ with the State's electronic sources.²¹

For 3 of the 130 sampled beneficiaries, the State agency incorrectly determined individuals to be eligible for the new adult group even though information in their case files demonstrated that their household income exceeded 138 percent of the FPL.²² Specifically:

- One individual's case file indicated that his Medicaid eligibility was redetermined in August 2014. That redetermination found that the individual's income exceeded 138 percent of the FPL and therefore he should have been disenrolled from Medicaid as of August 2014, before the start of our audit period. Local district staff could not explain why the individual remained enrolled in Medicaid during our audit period.
- One individual attested to income that was below the applicable income limit (138 percent of the FPL). The marketplace verified that attested amount by querying IRS data (i.e., Federal tax returns). Because the attested amount was compatible with IRS data, the enrollment system did not query any other electronic data sources to ensure all countable sources of income for determining Medicaid eligibility were identified. However, the individual's spouse had Social Security disability income that was not included in the attested amount, and because no other electronic data sources were queried, that income was never identified by the marketplace. Such income should have been included in the MAGI calculation, and had it been, the individual would have been found to have income in excess of the 138 percent of the FPL and therefore to not have been eligible for Medicaid.²³
- One individual attested to income in excess of the maximum allowable amount; however, her case file contained other information from an electronic data source that indicated her income was below the threshold. According to the State agency's verification plan, attested income above the applicable standard (138 percent of the FPL) should be used when verifying Medicaid eligibility, even if data sources indicate

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

²¹ 42 CFR § 435.952(c)(2).

²² These three individuals were included in our review because they were determined eligible by the State agency prior to ACA under an existing coverage group, which had a maximum income threshold of 100 percent of the FPL. As a result, they are categorized as "non-newly eligible" for the new adult group.

²³ 26 U.S. Code § 36B(d)(2)(B).

that the individual's income is below the standard. Nevertheless, local district staff incorrectly continued this individual's Medicaid coverage.

Beneficiaries Did Not Meet Medically Needy Coverage Group Requirements

To qualify for Medicaid under the medically needy coverage group, an individual must incur medical expenses so that their income and resources are below the State agency's income limits for the coverage group.²⁴

For 2 of the 130 sampled beneficiaries, the State agency incorrectly determined individuals to be eligible under the medically needy category when information in their case files indicated that their income or resources exceeded the State agency's limits for the coverage group. Specifically:

- One individual's household income exceeded the State agency's limits for the coverage group. Specifically, the individual's case file indicated his income was \$1,092 per month, which exceeded the State agency's applicable income limit for the medically needy coverage group by almost \$200.²⁵ There was no information to show that this individual incurred medical expenses to lower his income below that limit. Nevertheless, the individual was determined eligible for Medicaid under the medically needy coverage group.
- One individual's resources exceeded the maximum allowable amount for the coverage group. Specifically, the individual's case file contained a bank statement showing a balance of approximately \$16,000, which exceeded the State agency's applicable resources limit for the medically needy coverage group by more than \$1,000.²⁶ There was no information to show that this individual incurred medical expenses to reduce her resources below that limit. Nevertheless, the individual was determined eligible for Medicaid under the medically needy coverage group.

Beneficiary Did Not Meet Citizenship Requirements

For an individual to receive full-scope Medicaid benefits, he or she must be a citizen or national of the United States or a qualified alien.²⁷ However, a qualified alien is not eligible for full

²⁴ 42 CFR §§ 435.301 and 435.320.

²⁵ Maximum allowed monthly income for a household of one was \$809 in 2014 and \$825 in 2015 (New York State Medicaid Plan Amendment Numbers 14-06 and 15-06).

²⁶ Maximum allowed resources for a household of one were \$14,550 in 2014 and \$14,850 in 2015 (New York State Medicaid Plan, attachment 2.6A, supplement 2).

²⁷ 42 CFR § 435.406.

Medicaid benefits until 5 years from the date he or she enters the United States with qualified alien status, often referred to as “the 5-year bar.”²⁸ Medicaid eligibility for an individual subject to the 5-year bar is limited to emergency and pregnancy-related services only.²⁹

For 1 of the 130 sampled beneficiaries, local district staff incorrectly determined the individual to be eligible for full-scope Medicaid benefits even though the individual had not been in the United States for 5 years. Specifically, the individual applied for Medicaid in May 2014. Documentation in her case file indicated that she arrived in the United States in 2012 and, therefore, was not eligible for full-scope Medicaid benefits under the 5-year bar. The individual was eligible for only emergency and pregnancy-related services but received other services.

NEW YORK DID NOT PROVIDE DOCUMENTATION TO VERIFY THAT BENEFICIARIES WERE ELIGIBLE FOR MEDICAID

The State agency must maintain or supervise the maintenance of the records necessary to properly and efficiently operate the Medicaid program.³⁰ The State agency must also include in each individual’s case record facts to support its decision on the individual’s application.³¹

For 14 of the 130 sampled beneficiaries, the State agency did not provide the necessary documentation to verify that the individuals were eligible for Medicaid. Specifically:

- For seven individuals determined eligible under the medically needy coverage group, the State agency did not provide documentation that it verified the individuals’ resources, as required.
- For six individuals redetermined as Medicaid-eligible, the State agency did not provide documentation that it verified their income, as required. These six individuals provided attestations of their income. According to State agency officials, such attestations do not have to be verified. However, an administrative directive issued by the State agency clearly requires that income information provided by an individual be verified for accuracy to redetermine eligibility.³²
- For one individual, the income verification information supplied through the Data Hub indicated the individual’s income was not reasonably compatible with other data

²⁸ Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1613(a).

²⁹ 42 CFR § 435.406(a)(2)(ii).

³⁰ 42 CFR § 431.17.

³¹ 42 CFR § 435.914.

³² 42 CFR 435.948; New York State Department of Health’s Office of Health Insurance Programs (OHIP) Administrative Directive 11 OHIP/ADM-1, section IV A.2.

sources. The State agency did not provide any additional documentation to resolve the discrepancy.

Without the necessary documentation, we could not determine whether the State agency enrolled potentially ineligible individuals who did not meet Medicaid eligibility requirements, resulting in potential improper Federal expenditures.

RECOMMENDATIONS

We recommend that the State agency:

- redetermine, as appropriate, the current Medicaid eligibility status of the sampled beneficiaries who did not meet Federal and State eligibility requirements;
- take the necessary steps to ensure local district and marketplace staff consider all available, relevant information and data sources, as well as all Federal and State requirements when determining Medicaid eligibility, which could have reduced or eliminated an estimated \$520,295,792 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, which could have resulted in up to \$1,297,308,200 in potentially improper Federal Medicaid payments over the 6-month audit period.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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 for 6 of the 20 sampled beneficiaries identified in our draft report as ineligible or potentially ineligible. Under separate cover, the State agency provided additional information related to the six sampled beneficiaries. The State agency also described steps it has taken after our audit period to ensure that local district and marketplace staff adhere to Medicaid determination and enrollment policies. The State agency's comments appear in their entirety as Appendix E.

After reviewing the State agency's comments and the additional information provided, we maintain our findings and recommendations are valid.

BENEFICIARIES DID NOT MEET INCOME REQUIREMENTS

State Agency Comments

The State agency disagreed with our determination for one of the three beneficiaries identified in our draft report as having been incorrectly found to be Medicaid-eligible because they did not meet income requirements. Specifically, the State agency indicated that the individual had attested to anticipated annual income that was below the Medicaid level (138 percent of the FPL). The attested income was compatible with IRS data (i.e., Federal tax returns) that showed an income that was also below the Medicaid level. Therefore, the State agency contended that its determination was correct and in accordance with its verification plan.

Office of Inspector General Response

We maintain that the sampled beneficiary was not eligible for Medicaid (as described in the second bullet on page 6) because her income exceeded 138 percent of the FPL. This individual's spouse had Social Security disability income that was not included in the attested amount but was disclosed on a system-generated report that was in the individual's case file at the time the Medicaid eligibility determination was made. We acknowledge that the marketplace followed procedures for verifying income; however, Federal regulations³³ require the State agency to query additional data sources to determine whether the individual or her spouse had other sources of countable income. Social Security disability is income that should be included in the MAGI calculation, and had it been, the individual would have been found to have had income that exceeded 138 percent of the FPL and therefore to have not been eligible for Medicaid.

NEW YORK DID NOT PROVIDE DOCUMENTATION TO VERIFY THAT BENEFICIARIES WERE ELIGIBLE FOR MEDICAID

State Agency Comments

The State agency disagreed with our determinations for 5 of the 14 beneficiaries identified in our draft report as potentially ineligible. This included four beneficiaries for whom the State agency did not provide documentation that it verified the individuals' resources and one beneficiary for whom the State agency did not provide documentation that it verified the beneficiary's income.

According to the State agency, two of the four beneficiaries attested to not having any resources, which was supported by data in the State agency's Resource File Integration (RFI) system. As such, the State agency contended that no additional documentation was required. For two other beneficiaries, the State agency stated that case records included documentation

³³ 42 CFR § 435.948.

of the resources the beneficiaries attested to, as well as RFI data indicating that the beneficiaries had no resources beyond what they reported. For the remaining beneficiary, the State agency contended that the associated case file contained RFI data indicating that the beneficiary had no income.

Office of Inspector General Response

We maintain that the State agency did not provide the necessary documentation that it verified resources or income for these five individuals at the time of application, as required. For four of the five individuals,³⁴ the State agency provided RFI system print-outs dated up to 5 years after the individuals applied for Medicaid to support its contention that no additional documentation was required. These print-outs may not accurately reflect the individual's resources or income from years earlier and therefore could not be relied on as a source of verification. Without contemporaneous documentation, we could not determine whether the State agency enrolled potentially ineligible individuals.

³⁴ Although the State agency contended that it provided RFI data to support that it verified resources for the remaining beneficiary, the State agency never provided this information despite multiple requests for it.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered non-newly eligible Medicaid beneficiaries who received services 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 the State agency's local districts or the New York marketplace to evaluate whether Medicaid eligibility was determined in accordance with Federal and State requirements. In addition, we gained an understanding of the local districts' and marketplace's policies and procedures for determining whether an individual met Medicaid eligibility requirements.

We performed our 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, and other requirements related to Medicaid eligibility;
- obtained and reviewed New York's verification plan, which details how its marketplace meets all legal and operational requirements to execute marketplace activities;
- assessed internal controls by:
 - holding discussions with State agency and local district officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
 - interviewing officials from the New York marketplace who also demonstrated how the marketplace (1) processes an individual's information, (2) verifies an individual's eligibility for enrollment in Medicaid, and (3) transmits enrollment data to the State agency; and
 - determining how the system documents that the process of verifying and determining Medicaid eligibility has occurred;

- obtained a database of all Medicaid paid claims data in New York with service dates during the audit period (excluding claims for services provided to American Indians and Alaska Natives);³⁵
- created a sampling frame of 5,351,560 non-newly eligible Medicaid beneficiaries for which the State agency made Medicaid payments totaling \$24,568,360,392 (\$13,239,935,181 Federal share);
- selected a stratified random sample of 130 Medicaid beneficiaries;
- for each sample item, where possible, obtained application data and documentation to support the eligibility determination and determined:
 - the organization or agency that made the eligibility determination (i.e., the local district or marketplace);
 - whether the agency making eligibility determinations followed implemented verification procedures; and
 - whether individuals met Federal and State eligibility requirements, such as income level, residency, immigration status, disability, and resources amount;
- where possible, obtained sufficient independent information to determine whether each individual was eligible for Medicaid during the audit period;
- estimated the total number of ineligible and potentially ineligible beneficiaries;
- estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible and potentially ineligible beneficiaries; 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.

³⁵ American Indians and Alaskan Natives are subject to different eligibility requirements that were not a part of this review.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<u>A-09-17-02002</u>	12/11/2018
<i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<u>A-09-16-02023</u>	2/20/2018
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-02-15-01015</u>	1/5/2018
<i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements</i>	<u>A-04-16-08047</u>	8/17/2017
<i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-04-15-08044</u>	5/10/2017

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of all beneficiaries for whom the State agency made Medicaid payments for services provided during the audit period, excluding those newly eligible for Medicaid under the ACA and American Indians and Alaskan Natives.

SAMPLING FRAME

The sampling frame consisted of Access databases containing 5,351,560 non-newly eligible Medicaid beneficiaries who received services during the audit period. The State agency made Medicaid payments totaling \$24,568,360,392 (\$13,239,935,181 Federal share) for these beneficiaries. We obtained the data for these Medicaid beneficiaries from New York's Medicaid Management Information System.

SAMPLE UNIT

The sample unit was a non-newly eligible Medicaid beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows:

Stratum Number	Stratum Dollar Bounds	Frame Medicaid Paid	Frame Federal Share Paid	Number of Beneficiaries	Sample Size
1	Beneficiaries with total payments <\$3,000	\$7,852,035,222	\$4,558,898,365	4,554,007	60
2	Beneficiaries with total payments ≥\$3,000 and <\$15,000	\$8,332,899,170	\$4,344,783,927	643,816	35
3	Beneficiaries with total payments ≥\$15,000	\$8,383,426,000	\$4,336,252,889	153,737	35
Totals		\$24,568,360,392	\$13,239,935,181	5,351,560	130

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total number of ineligible and potentially ineligible Medicaid beneficiaries. We also estimated the total amount of Medicaid payments made on behalf of ineligible and potentially ineligible beneficiaries. We used this software to calculate point estimates and the lower and upper limits of the 90-percent confidence intervals associated with these estimates.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES³⁶

Table 1: Sample Detail and Results for Ineligible Beneficiaries

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	4,554,007	\$4,558,898,365	60	\$58,600	5	\$5,508
2	643,816	4,344,783,927	35	231,432	0	0
3	153,737	4,336,252,889	35	955,528	1	23,271
Totals	5,351,560	\$13,239,935,181	130	\$1,245,560	6	\$28,780³⁷

Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries

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	4,554,007	\$4,558,898,365	60	\$58,600	7	\$7,438
2	643,816	4,344,783,927	35	231,432	4	25,806
3	153,737	4,336,252,889	35	955,528	3	58,749
Totals	5,351,560	\$13,239,935,181	130	\$1,245,560	14	\$91,993

³⁶ The values included in this appendix are Federal share amounts of the payments associated with the ineligible or potentially ineligible beneficiaries.

³⁷ The individual stratum values do not add to the total value due to rounding.

ESTIMATES

Table 3: Estimated Number of Ineligible Beneficiaries and the Value of Associated Payments
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments Associated With Ineligible Beneficiaries
Point estimate	383,893	\$520,295,792
Lower limit	114,266	\$80,414,611
Upper limit	653,520	\$960,176,973

Table 4: Estimated Number of Potentially Ineligible Beneficiaries and the Value of Associated Payments
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Potentially Ineligible Beneficiaries	Total Value of Payments Associated With Potentially Ineligible Beneficiaries
Point estimate	618,057	\$1,297,308,200
Lower limit	299,478	\$726,192,069
Upper limit	936,636	\$1,868,424,330

APPENDIX E: STATE AGENCY COMMENTS



Department
of Health

ANDREW M. CUOMO
Governor

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

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

April 30, 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-02-16-01005

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-02-16-01005 entitled, "New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible 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
Timothy Brown
Amber Rohan
Elizabeth Misa
Geza Hrazdina
Daniel Duffy
Jeffrey Hammond
Jill Montag
Ryan Cox
James Dematteo

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

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-02-16-01005 entitled,
“New York Did Not Correctly Determine Medicaid Eligibility for Some
Non-Newly Eligible 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-02-16-01005 entitled, “New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries.”

General Comments:

The Department disagrees with OIG’s findings for six cases, which account for more than 40 percent of the payments OIG identified as incorrect. Separate from this response, the Department will work with OIG to securely identify the individual cases and claims that were incorrectly identified as improper. The Department will also provide copies of the supporting information that appears to have been disregarded during the audit.

The following identifies the sections of the report that included OIG’s erroneous findings.

- *Beneficiaries Did Not Meet Income Requirements* section, second bullet (page 6):
The Department does not agree with OIG’s findings with one of the three cases in this section. The case was handled appropriately and in accordance with New York State’s verification plan.
- *New York Did Not Provide Documentation to Verify That Beneficiaries Were Eligible for Medicaid* section, bullet 1 (page 8):
The Department does not agree with OIG’s findings for four of the seven cases in this section. For two of the cases, the consumer attested at renewal that they did not have any resources, which was supported by the available Resource File Integration (RFI) data. Since the available RFI data source matches the consumer’s attestation of no resources, no additional documentation was required.

For the other two cases, the case record included documentation of the consumer’s attested resources. Additionally, the record included RFI data which verified no additional resources beyond what the consumer reported.

- *New York Did Not Provide Documentation to Verify That Beneficiaries Were Eligible for Medicaid* section, bullet 2 (page 8):
The Department does not agree with OIG’s findings for one of the six cases in this section. The consumer attested to no income at renewal and this was supported by the RFI data available in the case record as required by 11 OHIP/ADM-1, which states on page 6:

... The local district must verify the accuracy of the income information provided by the recipient in order to re-determine eligibility. This is done by using third party database information, such as RFI...

Similar guidance was also issued in 08 OHIP/ADM-4 on page 4.

Recommendation #1:

Redetermine, as appropriate, the current Medicaid eligibility status of the sampled beneficiaries who did not meet Federal and State eligibility requirements.

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 had their eligibility redetermined at least four times if they are still enrolled.

Recommendation #2:

Take the necessary steps to ensure local district and marketplace staff consider all available, relevant information and data sources, as well as all Federal and State requirements when determining Medicaid eligibility, which could have reduced or eliminated an estimated \$520,295,792 in overpayments caused by eligibility errors over the 6-month audit period.

Response #2

All but one of the valid OIG findings were caused by caseworker errors. The Department issued letters to local district offices in 2017 and 2018 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 finding. 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, which could have resulted in up to \$1,297,308,200 in potentially improper Federal Medicaid payments over the 6-month audit period.

Response #3

As indicated herein, the Department disagrees that necessary documentation was not available for 5 out of the 14 cases identified by OIG.

Furthermore, 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. The Department also issued letters in 2017 and 2018 reminding local districts of their responsibility to check all data sources to support attested income at renewal, including the need to document in the case record when there are no data sources available.