

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**KENTUCKY DID NOT CORRECTLY
DETERMINE MEDICAID ELIGIBILITY FOR
SOME NEWLY ENROLLED
BENEFICIARIES**

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Office of Inspector General

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Report in Brief

Date: May 2017

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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 a higher Federal reimbursement rate (Federal Medical Assistance Percentage or FMAP) for services provided to these newly eligible beneficiaries. As of December 2016, Kentucky was 1 of 32 States that had chosen to expand Medicaid to include the newly eligible beneficiaries.

Our objective was to verify whether Kentucky met Federal and State requirements when determining Medicaid eligibility for services provided from October 2014 through March 2015 to newly eligible beneficiaries.

How OIG Did This Review

We reviewed a stratified random sample of 120 newly eligible beneficiaries who received Medicaid-covered services from October 2014 through March 2015. We reviewed supporting documentation to evaluate whether Kentucky determined the applicants' eligibility in accordance with Federal and State requirements. We refer to beneficiaries for whom eligibility was not determined in accordance with requirements as "potentially ineligible."

Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

What OIG Found

Kentucky did not always determine Medicaid eligibility in accordance with Federal and State requirements. Of our sample of 120 beneficiaries, Kentucky correctly determined eligibility for 111 beneficiaries, but it did not determine eligibility for the remaining 9 beneficiaries in accordance with Federal and State requirements. Specifically, Kentucky did not always electronically or manually verify income and citizenship. In addition, although it did not violate an eligibility requirement, Kentucky did not perform, or maintain documentation of, identity-proofing for 40 beneficiaries in accordance with Federal requirements. The Federal identity-proofing requirements are intended to reduce the potential for identity theft.

Kentucky did not always meet Federal and State requirements when making eligibility determinations because of human and system errors. As a result, we estimated that Kentucky made Federal Medicaid payments on behalf of 34,593 potentially ineligible beneficiaries totaling \$105 million out of 464,814 total beneficiaries with payments of \$1.49 billion. We did not include the identity-proofing errors in our estimate of potentially ineligible beneficiaries and payments, but we are highlighting the potential for identity theft if the State agency does not correct these errors.

What OIG Recommends and Kentucky's Comments

We recommend that Kentucky redetermine, if necessary, the current Medicaid eligibility status of the sample beneficiaries for whom income or citizenship verifications did not meet Federal and State requirements; ensure that the enrollment system used to determine eligibility verifies income and citizenship data using available electronic data sources; and ensure that the enrollment system used verifies applicants' identity and maintains identity-proofing documentation for applicant filers.

In its written comments on our draft report, the State agency agreed with our recommendations and described actions it had taken to address them.

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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 low-income adults without dependent children and established a higher Federal reimbursement rate (Federal Medical Assistance Percentage or FMAP) for services provided to these newly eligible beneficiaries.¹ The higher FMAP for these newly eligible beneficiaries raised concerns about enrollment of ineligible individuals at the higher FMAP and the potential for improper payments. The ACA also mandated changes to Medicaid eligibility rules, such as calculating income based on Modified Adjusted Gross Income (MAGI) and increasing the Federal Poverty Level (FPL) to 133 percent, raising the concern that State agencies might have difficulty accurately determining eligibility for this new group of Medicaid beneficiaries.

OBJECTIVE

Our objective was to verify whether the Kentucky Department for Medicaid Services (State agency) met Federal and State requirements when determining Medicaid eligibility for services provided for the 6-month period from October 1, 2014, through March 31, 2015, to newly eligible beneficiaries.

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. Generally, individual eligibility criteria are met by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of U.S. citizenship. For many eligibility groups, income is calculated in relation to a percentage of the 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

¹ We will refer to these low-income adults without dependent children that receive a higher FMAP as “newly eligible” beneficiaries. These beneficiaries can also be referred to as the “New Adult Group” or “Group VIII.”

the State's per capita income.^{2,3} The "standard" FMAP varies by State and ranges from 50 to 75 percent.^{4,5}

CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs. In June 2016, CMS issued a notice of proposed rulemaking that modified its MEQC and PERM requirements to incorporate changes mandated by the ACA.⁶

Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act

Medicaid is the Nation's primary health insurance program for low-income individuals and families, providing coverage to approximately 69 million people in 2015. Historically, only certain groups of individuals who met income and asset thresholds were eligible for Medicaid. 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 more low-income people, including nondisabled adults without dependent children.^{7,8} In States that elected to implement this option, individuals were eligible for Medicaid in the new adult group if they met all of the following criteria, in addition to citizenship and State residency requirements:⁹

- not younger than 19 or older than 64 years of age;
- not pregnant;

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

³ CMS, "Financing & Reimbursement." Accessed at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html> on July 6, 2016.

⁴ 77 Fed. Reg. 71420, 71422 (Nov. 30, 2012).

⁵ Office of the Assistant Secretary for Planning and Evaluation. "FY2017 Federal Medical Assistance Percentages." Accessed at <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages> on July 6, 2016.

⁶ 81 Fed. Reg. 40596 (June 22, 2016).

⁷ P.L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), § 2001(a)(1)(C).

⁸ 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." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012). The decision allowed States the option to refuse to expand its Medicaid program and not face any reduction in current Medicaid funding.

⁹ SSA § 1902(a)(10)(A)(i)(VIII).

- not eligible for or enrolled in Medicare;
- not eligible for Medicaid through any mandatory category other than the new adult group;¹⁰
- not having an income exceeding 133 percent of the FPL;¹¹ and
- not living with a dependent, uninsured child.¹²

The ACA § 2001 authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled through the new adult category.^{13,14} This “newly eligible FMAP” was set to remain at 100 percent through 2016, gradually decreasing to 90 percent by 2020.¹⁵

The ACA required States to make a number of changes to their Medicaid application and enrollment processes. Changes included requiring States to develop a single, streamlined enrollment application that facilitates screening applicant eligibility for all potential health coverage options, including Medicaid, the Children’s Health Insurance Program (CHIP), and qualified health plans available through the health insurance marketplaces.¹⁶ In most cases, the ACA required States to use MAGI, a measure of income that is based on Internal Revenue Service (IRS) rules, to determine a person’s income. As of December 31, 2016, 32 States including Kentucky had elected to expand Medicaid coverage.

¹⁰ SSA § 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.

¹¹ 42 CFR § 435.119(b)(5). ACA § 1902 established the FPL threshold at 133 percent but allows for a 5-percent income disregard, making the effective threshold 138 percent of FPL.

¹² 42 CFR 435.119(c).

¹³ SSA § 1905(y)(2)(A) defines “newly eligible” as “an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the ACA, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage.”

¹⁴ Not all beneficiaries enrolled through the new category are eligible for the higher FMAP. For beneficiaries in the new adult category who would have been eligible for Medicaid benefits in their State under an existing category on the date of the ACA’s enactment (December 1, 2009), the standard FMAP applies because the State already covered such adults. See “Medicaid and CHIP FAQs: Newly Eligible and Expansion State FMAP.” Accessed 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> on July 6, 2016.

¹⁵ 42 CFR § 433.10(c)(6).

¹⁶ ACA § 1413(b).

Health Insurance Marketplace Requirements and Identity-Proofing

The ACA requires the establishment in each State of a health insurance exchange (marketplace) designed to serve as a “one-stop shop” where individuals review their health insurance options and are evaluated for Medicaid eligibility. As of December 2016, Kentucky was 1 of 13 States that had established a State-based marketplace (State marketplace). An applicant begins the Medicaid enrollment process through the State marketplace by providing basic personal information, such as name, birth date, and Social Security number.¹⁷

Before an applicant can submit an online or phone application, the marketplace must verify the applicant’s identity through identity-proofing. The purpose of identity-proofing is to (1) prevent an unauthorized individual from creating an account for another individual and applying for health coverage without the individual’s knowledge and (2) safeguard personally identifiable information created, collected, and used by the marketplace. When completing any type of application, the applicant attests that answers to all questions are true and that the applicant is subject to the penalty of perjury.¹⁸ For paper applications, the marketplace further requires the applicant’s signature before the State agency processes the application.¹⁹

Kentucky Medicaid

The State agency is responsible for operating the Medicaid program and uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. From October 1, 2014, through March 31, 2015, the State agency made Federal Medicaid payments totaling \$1.49 billion on behalf of 464,814 newly eligible Medicaid beneficiaries.

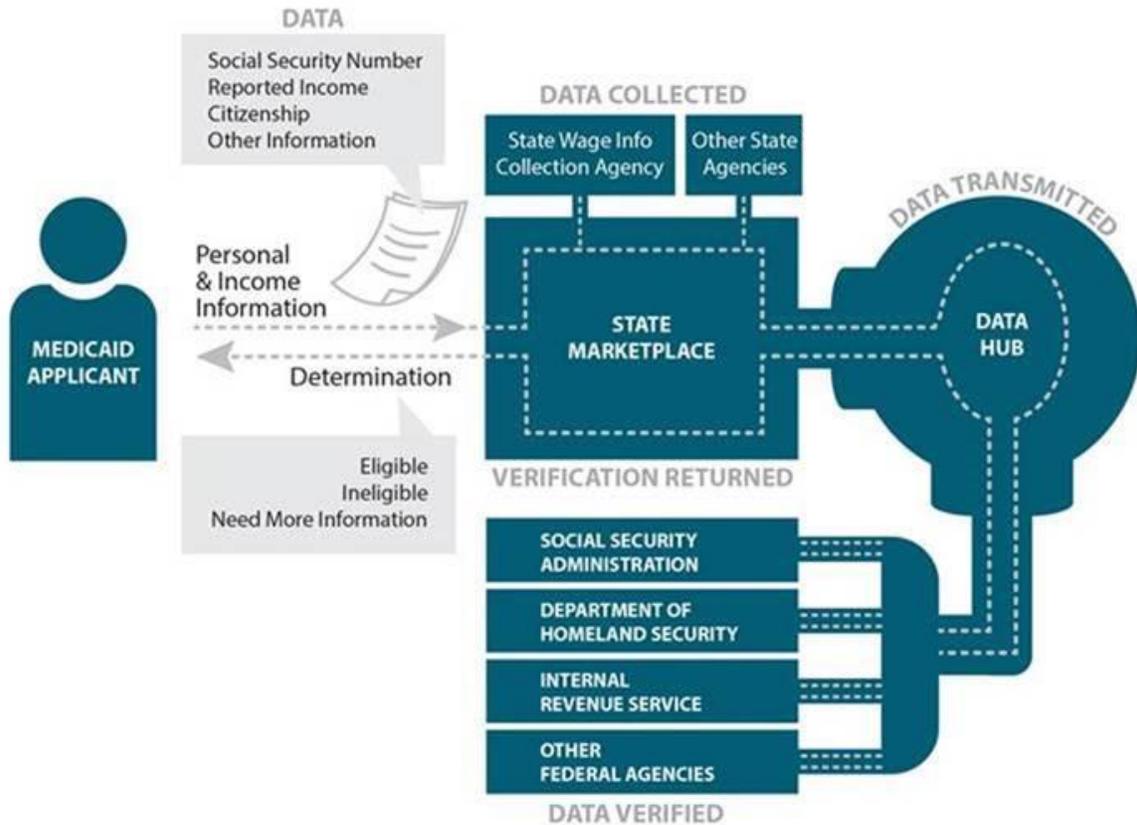
Kentucky’s State marketplace was known as Kynect. To verify eligibility during our audit period, Kynect used multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub). The data sources available through the Data Hub are provided by the U.S. Department of Health and Human Services (HHS), the Social Security Administration, the U.S. Department of Homeland Security, and IRS, among others. (See the figure on the next page.)

¹⁷ As of February 29, 2016, Kentucky’s State marketplace was replaced with a new system, named Benefind, for determining Medicaid eligibility. Benefind also replaced Kentucky’s legacy Medicaid system. Eligibility determinations under Kentucky’s legacy system will be addressed in a subsequent report. Kentucky will rely on the Federal marketplace to determine eligibility for private health insurance coverage.

¹⁸ Any person who fails to provide correct information may be subject to a civil monetary penalty (ACA § 1411(h)).

¹⁹ CMS’s *Guidance Regarding Identity Proofing for Marketplace, Medicaid and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub* (Identity-Proofing Guidance), June 11, 2013.

Figure: Medicaid Eligibility Process



Federal rules require Kentucky to have a verification plan to ensure the accuracy of Medicaid eligibility determinations. Kentucky’s verification plan states that it will rely on the Data Hub and other State sources, such as the State Wage Information Collection Agency (SWICA), to verify the accuracy of eligibility information provided by an applicant.

HOW WE CONDUCTED THIS REVIEW

Our audit covered Medicaid beneficiaries in the newly eligible adult group who received services from October 1, 2014, through March 31, 2015 (audit period). We reviewed a stratified random sample of 120 Medicaid beneficiaries who were determined or redetermined²⁰ to be eligible after Kentucky expanded its Medicaid coverage. We reviewed the supporting documentation to evaluate whether the State agency determined the applicants’ eligibility in accordance with Federal and State requirements. We also reviewed the internal controls in place at the State agency and Kynect.

²⁰ Medicaid eligibility redeterminations are required at least every 12 months with respect to circumstances that may change or when the State agency has information about anticipated changes in a beneficiary’s circumstances that may affect eligibility (42 CFR § 435.916).

Beneficiaries enrolled on the basis of determinations that did not meet Federal and State requirements may not be eligible for Medicaid coverage. We did not assess beneficiaries for Medicaid eligibility categories other than the newly eligible category.²¹ As a result of these limitations, we could not conclusively determine whether beneficiaries were eligible or ineligible for Medicaid, but instead we refer to these beneficiaries for whom eligibility was not determined in accordance with requirements as “potentially ineligible.”

We limited our review of internal controls to those related to verifying applicant identity and determining applicant eligibility for Medicaid enrollment. In addition, we gained an understanding of the State agency’s and the marketplace’s policies and procedures for determining whether beneficiaries enrolled under the expanded Medicaid coverage met the eligibility requirements described in the ACA.

We performed fieldwork from September 2015 through July 2016 at the Kentucky Medicaid office in Frankfort, Kentucky.

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 did not always determine Medicaid eligibility in accordance with Federal and State requirements. Of our sample of 120 beneficiaries, the State agency correctly determined eligibility for 111 beneficiaries, but it did not correctly determine eligibility for 9 beneficiaries in accordance with Federal and State requirements. Specifically, it did not always electronically or manually verify income or citizenship. In addition, although it did not violate an eligibility requirement, the State agency either did not perform, or did not maintain documentation that it had performed, identity-proofing for 40 sampled beneficiaries in accordance with Federal requirements. The Federal identity-proofing requirements are intended to reduce the potential for identity theft.

The State agency did not always meet Federal and State requirements when making eligibility determinations because of human or system errors. The State agency did not always perform, or maintain documentation that it had performed, identity-proofing because of human or

²¹ We also did not contact beneficiaries directly to request additional documentation, which is another step States are required to perform before determining whether an applicant is eligible for Medicaid.

system errors related to new eligibility determination processes implemented in response to the ACA.

On the basis of our sample, we estimated that the State agency made Federal Medicaid payments on behalf of 34,593 potentially ineligible beneficiaries totaling \$105,075,377. Identity-proofing deficiencies are not considered eligibility determination errors and therefore were not included in our estimate of potentially ineligible beneficiaries and payments.

KENTUCKY DID NOT CORRECTLY DETERMINE MEDICAID ELIGIBILITY FOR SOME NEWLY ENROLLED BENEFICIARIES

Kentucky Enrolled Beneficiaries Who May Not Have Met Income Requirements

The State agency must provide Medicaid to individuals who have household income that is at or below 138 percent FPL for the applicable family size (42 CFR § 435.119(b)(5)). The State agency must verify financial information related to wages, net earnings from self-employment, unearned income, and resources such as from SWICA, IRS, and SSA, to the extent the State determines such information is useful to verifying the financial eligibility of an individual (§ 435.948(a)(1)).²²

The State agency must request additional information or documentation from the beneficiary if attested income is not reasonably compatible²³ with electronic sources (§ 435.952(c)(2)). In addition, States must maintain records that include facts essential to determination of initial and continuing eligibility (§ 431.17).

For 5 of 120 sampled beneficiaries, the State agency did not electronically verify income or request additional documentation from the beneficiary. Specifically:

- For four beneficiaries, the State agency did not request additional documentation to support income after it attempted to verify attested income with electronic sources. These beneficiaries attested to no income, and the State agency received a response

²² Kentucky's eligibility verification plan determined it would request information from IRS, SSA, SWICA, and State unemployment compensation to verify an applicant's financial information on the application.

²³ Kentucky's eligibility verification plan defines "reasonably compatible" as a 10-percent threshold. Additionally, the verification plan explains that if the individual attests to income below the income standard of 138 percent, and data sources indicate income above the standard, and the difference between the two is greater than 10 percent, a reasonable explanation and/or paper documentation will be requested from the applicant.

from the electronic sources that the income match failed.^{24,25} The State agency indicated that, because of a system error, it never created a request for additional information, and it approved the beneficiaries for Medicaid coverage on the basis of their attested income.

- For one beneficiary, the State agency could not provide any documentation supporting that the attested income was electronically or manually verified. The State agency indicated that it had no additional documentation to prove that it verified the income.

Without verifying income, the State agency may have enrolled beneficiaries into the new adult category for Medicaid who did not actually meet the requirements to be considered newly eligible, resulting in improper Federal expenditures.

Kentucky Enrolled Beneficiaries Who May Not Have Met Citizenship Requirements

To properly verify citizenship or nationality status of beneficiaries enrolled in Medicaid, States must ensure that those individuals declaring to be citizens or nationals of the United States have presented satisfactory documentary evidence of citizenship or nationality (SSA § 1903(x)). In addition, to satisfy the documentation requirements, States may verify citizenship by electronically verifying citizenship status with SSA (42 CFR §§ 435.406 and .949). States must maintain records that include facts essential to determination of initial and continuing eligibility (§ 431.17).

For 4 of 120 beneficiaries,²⁶ the State agency determined these beneficiaries eligible for Medicaid without verifying citizenship in accordance with Federal requirements. For these beneficiaries, the State agency submitted their citizenship status through the Data Hub for verification with SSA. However, the State agency could not provide documentation that it had received a citizenship verification response. The State agency indicated that, because of a human error and system errors, no supporting documentation could be found. The human error occurred because a caseworker did not properly convert a beneficiary's verification sources from the old system to Kynect, which resulted in citizenship never being verified. The system errors occurred because Kynect indicated that it verified the citizenship status of

²⁴ A failed income match indicates that the beneficiaries' attested income was not within 10 percent of the verified income provided by the electronic sources, and the electronic sources provided an income amount over 138 percent of the FPL.

²⁵ A Data Hub response of income over 138 percent does not necessarily mean that the applicant has current income over 138 percent. A Data Hub income match relies on historic income data, and applicants are provided the opportunity to resolve an inconsistency by providing documentation of attested income.

²⁶ During our fieldwork, we asked the State agency to attempt to verify the four beneficiaries' citizenship using the Data Hub. Although the State subsequently provided evidence that these beneficiaries were citizens as of August 25, 2016, we have included them in our overall estimate of potentially ineligible beneficiaries because, at the time of their eligibility determination, the State did not maintain documentation that it had verified citizenship in accordance with Federal requirements.

potential beneficiaries with the Data Hub but did not retain the Data Hub confirmation that the beneficiaries were citizens.

Because the State agency did not maintain documentation that it had verified citizenship, we could not determine whether the State agency was enrolling into Medicaid beneficiaries who met requirements to be considered newly eligible.

KENTUCKY DID NOT ALWAYS VERIFY IDENTITY OR MAINTAIN IDENTITY-PROOFING DOCUMENTATION

Marketplaces must maintain, and ensure that their contractors, subcontractors, and agents maintain for 10 years, documents and records that are sufficient to enable HHS or its designees to evaluate the marketplaces' compliance with Federal requirements (45 CFR § 155.1210(a)). The records must include information related to the marketplaces' eligibility verifications and determinations and enrollment transactions (§ 155.1210(b)(4)).

Marketplaces must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that they create, collect, use, or disclose and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it (§ 155.260(a)(4)).

According to CMS's identity-proofing guidance for State marketplaces, before a marketplace accepts an online or a telephone application for enrollment in Medicaid, it must conduct identity-proofing sufficient to provide assurance that only the appropriate individual has access to restricted data. The guidance explains that identity-proofing involves the (1) collection of core attributes, including the applicant's name, birth date, Social Security number (optional), address, phone number, and email address; (2) validation of core attributes with a trusted data source; and (3) collection and validation, for some applicants, of responses to questions about the applicant's personal history, e.g., the names of current and past employers.

The State agency did not always verify identity or maintain documentation from identity-proofing of beneficiaries. For 40 of 120 beneficiaries, the State agency did not verify identity during the application process or document that it had performed identity-proofing in accordance with Federal requirements.²⁷ Specifically:

- For 27 beneficiaries, State agency personnel completed the application either online or over the phone and did not verify identity. The State agency was unable to provide any documentation indicating that personnel followed Federal requirements to verify identity for these online or phone applications.

²⁷ Marketplaces perform identity-proofing of application filers. If a sample applicant was not the application filer, we reviewed supporting documentation for identity-proofing of the application filer. For example, the application filer may be a parent seeking coverage for a child who is the applicant.

- For 13 beneficiaries, the State agency either did not verify identity or did not maintain documentation of the verification because of Kynect system errors. For nine of these beneficiaries, Kynect rendered the application source as unknown, meaning that the State agency could not identify whether the applicant applied online, over the phone, or by mail and thus could not provide the beneficiaries' identity-proofing documentation. For four of these beneficiaries, the State agency performed identity-proofing through the Data Hub but did not have a control in place to maintain the Data Hub responses.

The State agency's failure to verify applicants' identity or to maintain identity-proofing documentation increase the risks of undetected identity theft and ineligible applicant filers.

ESTIMATED PAYMENTS TO POTENTIALLY INELIGIBLE BENEFICIARIES

On the basis of our sample, we estimated that during our 6-month audit period the overall percent of potentially ineligible beneficiaries was 7.44, and the overall percent of Federal payments associated with those beneficiaries was 7.05. As a result, we estimated that the State agency made Federal Medicaid payments on behalf of 34,593 potentially ineligible beneficiaries totaling \$105,075,377. We did not include the identity-proofing errors in our estimate of potentially ineligible beneficiaries and payments, but we are highlighting the potential for identity theft if the State agency does not correct these errors.

RECOMMENDATIONS

We recommend that the State agency:

- redetermine, if necessary, the current Medicaid eligibility status of the sample beneficiaries for whom income or citizenship verifications did not meet Federal and State requirements;
- ensure that the enrollment system used to determine eligibility verifies income and citizenship data using available electronic data sources, as appropriate; and
- ensure that the enrollment system used verifies applicants' identity and maintains identity-proofing documentation for applicant filers.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency agreed with our recommendations and described actions it had taken to address them. The State agency's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered newly eligible Medicaid beneficiaries who received services from October 1, 2014, through March 31, 2015 (audit period).

We limited our review of internal controls to those related to verifying applicant identity and determining applicant eligibility for Medicaid enrollment. Our testing of controls included a review of supporting documentation at the State agency to evaluate whether the State determined the applicant's eligibility in accordance with Federal and State requirements. In addition, we gained an understanding of the marketplace's policies and procedures for determining whether newly enrolled beneficiaries enrolled under the enhanced Medicaid coverage met the eligibility requirements described in the ACA. We did not assess newly eligible beneficiaries' eligibility for alternative Medicaid eligibility categories or contact beneficiaries to obtain additional supporting documentation.

We performed fieldwork from September 2015 through July 2016 at the State agency in Frankfort, Kentucky.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements, regulations, and CMS guidance regarding the implementation of ACA changes related to the enrollment of newly eligible beneficiaries;
- interviewed State agency officials to obtain an understanding of internal controls regarding how the marketplace processes an applicant's information and verifies an applicant's eligibility for enrollment in Medicaid;
- selected a stratified random sample of 120 beneficiaries from a total of 464,814 beneficiaries who were determined or redetermined to be newly eligible during the audit period;
- obtained application data and documentation to verify the Medicaid eligibility of each sampled beneficiary;
- analyzed the State agency's documentation supporting beneficiaries' Medicaid eligibility;
- estimated the total number of payments made during the audit period on behalf of potentially ineligible beneficiaries and the dollars associated with those payments;

- calculated an overall eligibility error rate for both the number of payments and the dollar amounts; 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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of beneficiaries determined newly eligible for Medicaid under the ACA, excluding American Indians and Alaskan Natives,²⁸ for whom the State agency made Medicaid payments for services provided from October 1, 2014, through March 31, 2015.

SAMPLING FRAME

The sampling frame consisted of an Access database containing 464,814 newly eligible Medicaid beneficiaries under the ACA in Kentucky for whom the State agency made Medicaid payments totaling \$1,506,972,991 (\$1,490,398,213 Federal share) for services provided during the audit period. We obtained the data for the Medicaid beneficiaries from Kentucky's MMIS. We excluded American Indian and Alaskan Native beneficiaries from our sampling frame.

SAMPLE UNIT

The sample unit was a newly eligible Medicaid beneficiary.

SAMPLE DESIGN

We used a stratified random sample.

- Stratum 1: Medicaid beneficiaries who were categorized as being newly eligible for Medicaid under the ACA with total Federal Medicaid payments less than \$3,384 per beneficiary. This stratum consisted of 276,875 Medicaid beneficiaries with payments totaling \$667,960,872 (\$662,342,370 Federal share).
- Stratum 2: Medicaid beneficiaries who were categorized as being newly eligible for Medicaid under the ACA with total Federal Medicaid payments greater than or equal to \$3,384 per beneficiary. This stratum consisted of 187,939 Medicaid beneficiaries with payments totaling \$839,012,119 (\$828,055,843 Federal share).

SAMPLE SIZE

We selected 120 Medicaid beneficiaries: 55 from stratum 1 and 65 from stratum 2.

²⁸ American Indians and Alaskan Natives are subject to different eligibility requirements that were not a part of this review.

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 and 2. After generating the random numbers for each of these strata, we selected the corresponding Medicaid beneficiary in the sample frame for our sample.

ESTIMATION METHODOLOGY

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

In addition, we determined the percentage of potentially ineligible beneficiaries by dividing the estimated number of potentially ineligible beneficiaries by the total number of beneficiaries in the sampling frame. We also determined the percentage of Federal dollars expended for potentially ineligible beneficiaries by dividing the estimated amount of Federal dollars expended by the total amount of Federal dollars in the sampling frame.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Detail and Results

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Federal Share of Payments Associated With Sampled Beneficiaries)	Potentially Ineligible Beneficiaries	Value of Potentially Improper Payments (Federal Share)
1	276,875	55	\$129,367	4	\$9,936
2	187,939	65	289,340	5	19,042
Totals	464,814	120	\$418,707	9	\$28,978

ESTIMATES

Table 2: Estimated Number of Potentially Ineligible Beneficiaries and Value of Overpayments
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Potentially Ineligible Beneficiaries	Total Value of Potentially Improper Payments (Federal Share)
Point estimate	34,593	\$105,075,377
Lower limit	15,489	47,151,981
Upper limit	53,697	162,998,772

Table 3: Calculation of Overall Rate of Potentially Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Potentially Ineligible Beneficiaries	34,593	7.44%
	Total Number of Beneficiaries in Sample Frame	464,814	
Dollar Value of Payments	Estimated Federal Dollars Associated With Potentially Ineligible Beneficiaries	\$105,075,377	7.05%
	Total Federal Dollars in Sample Frame	\$1,490,398,213	

APPENDIX D: STATE AGENCY COMMENTS



CABINET FOR HEALTH AND FAMILY SERVICES DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Vickie Yates Brown Glisson
Secretary

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Frankfort, KY 40621
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Stephen P. Miller
Commissioner

April 7, 2017

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Audit Services Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: Report Number A-04-15-08044

Dear Ms. Pilcher:

Pursuant to your request, please find the Department for Medicaid Services (DMS) comments to the recommendations contained in the above referenced draft report. The recommendations revolve around the finding that DMS through kynect did not correctly determine Medicaid eligibility for some newly enrolled beneficiaries. The recommendations and responsive comments are set out below.

Recommendation:

Re-determine if necessary, the current Medicaid eligibility status of the sample beneficiaries for whom income or citizenship verifications did not meet Federal and State requirements.

State Comment:

Kentucky DMS agrees that during the audit timeframe, October 2014 through March 2015, kynect experienced a coding problem that resulted in a failure to request additional information when electronic verification returned income above the correct federal poverty level (FPL). On 7/8/16, kynect implemented a coding change that corrected the problem.

Kentucky DMS also agrees that due to system and human error citizenship or qualified alien status verification was not properly maintained. During the audit timeframe noted above, the OIG identified this as a problem previously unknown by the state. When informed of the issue, DMS utilized staff communications and training to re-inforce correct procedures. Additionally, the state added this verification item to our quality reviews. Finally, kynect technical staff conducted reviews during the OIG visit and found no evidence the error continued beyond the audit period. There is no present evidence of this error.

As all of the reviewed cases have undergone at least one recertification cycle between the OIG review and today, the state believes there is no need to re-run eligibility for that period.

Recommendation:

Kentucky must ensure that its eligibility system verifies applicants' identity and maintains identity-proofing documentation for the applicants.

Comments:

Kentucky DMS agrees. During the audit timeframe of October 2014 through March 2015, the system did not enforce Remote Identify Proofing (RIDP) for phone applications when completed. This allowed human error when state employees or contract employees did not complete RIDP as policy required. A coding change, promoted on 12/9/15, no longer allows a user to complete a phone application for Financial Assistance programs without completing RIDP.

The state appreciates the opportunity to comment on your recommendations. We believe the issues identified have been successfully corrected. Thank you again for this opportunity.

Very Sincerely,

/Stephen P. Miller/

Stephen P. Miller, Commissioner
Department for Medicaid Services