

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PRIOR AUDITS OF MEDICAID
ELIGIBILITY DETERMINATIONS
IN FOUR STATES IDENTIFIED
MILLIONS OF BENEFICIARIES
WHO DID NOT OR MAY NOT
HAVE MET ELIGIBILITY
REQUIREMENTS**

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Office of Inspector General

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Report in Brief

Date: February 2022

Report No. A-02-20-01018

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



Why OIG Did This Audit

The Affordable Care Act provided States with the authority to expand Medicaid coverage to low-income adults without dependent children (newly eligible beneficiaries). It also mandated changes to Medicaid eligibility rules. These two factors led to a significant increase in applications for Medicaid coverage. Prior OIG audits of New York, California, Colorado, and Kentucky found that these States did not always determine Medicaid eligibility for newly eligible beneficiaries and individuals eligible under traditional Medicaid coverage groups (referred to as non-newly eligible beneficiaries) in accordance with Federal and State requirements.

The objective of this audit was to summarize the results of our prior audits in order to assist the Centers for Medicare & Medicaid Services (CMS) in achieving greater efficiencies in its operation of the Medicaid program.

How OIG Did This Audit

Our prior audits covered Federal Medicaid payments totaling \$33.6 billion on behalf of almost 17.5 million beneficiaries. Using statistical sampling, we reviewed the four States' Medicaid eligibility determinations.

Prior Audits of Medicaid Eligibility Determinations in Four States Identified Millions of Beneficiaries Who Did Not or May Not Have Met Eligibility Requirements

What OIG Found

Our previous audits of 4 States' Medicaid eligibility determinations found that during 2014 and 2015 Medicaid payments were made on behalf of 109 of 460 sampled newly eligible beneficiaries and 98 of 515 sampled non-newly eligible beneficiaries who did not meet or may not have met Medicaid eligibility requirements. We determined that both human and system errors, as well as a lack of policies and procedures, contributed to these improper or potentially improper payments. Although the States concurred with all 31 recommendations from our prior audits to address these deficiencies, 15 of these recommendations remain unimplemented.

On the basis of our sample results, we estimated that the 4 States made Federal Medicaid payments on behalf of newly eligible beneficiaries totaling almost \$1.4 billion for more than 700,000 ineligible or potentially ineligible beneficiaries. We also estimated that the 4 States made Federal Medicaid payments on behalf of non-newly eligible totaling more than \$5 billion for almost 5 million ineligible or potentially ineligible beneficiaries.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) work with States to implement all of the recommendations made in OIG's prior audits; (2) maintain its efforts to provide training, technical advice, and guidance to States to address the causes identified in OIG's prior audits; and (3) use all available remedies to prevent and reduce the amount of improper payments made on behalf of ineligible beneficiaries.

Although CMS stated that it will continue to work with States to implement OIG's prior recommendations, it requested that we remove our first recommendation. CMS concurred with our second and third recommendations. We maintain that our recommendations are appropriate because prioritizing them can help improve States' eligibility determinations and reduce eligibility improper payment rates.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	2
Background.....	2
Medicaid Program.....	2
Medicaid Coverage and Changes to Medicaid Eligibility Rules Under the Affordable Care Act.....	2
Medicaid Eligibility Verification Requirements.....	3
CMS Programs to Review States’ Medicaid Eligibility Determinations.....	4
CMS Actions to Improve Medicaid Program Integrity.....	5
How We Conducted This Audit.....	6
FINDINGS.....	6
States Made Medicaid Payments on Behalf of Newly and Non-Newly Eligible Beneficiaries Who Did Not Meet Medicaid Eligibility Requirements.....	7
States Made Medicaid Payments on Behalf of Newly and Non-Newly Eligible Beneficiaries Who May Not Have Met Medicaid Eligibility Requirements.....	8
CONCLUSION.....	9
RECOMMENDATIONS.....	10
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	11
CMS Comments.....	11
Office of Inspector General Response.....	12
APPENDICES	
A: Audit Scope and Methodology.....	14
B: Prior Office of Inspector General Reports.....	16
C: Federal and State Requirements for Medicaid Eligibility.....	17

D: Statistical Sampling Methodology.....	21
E: Newly Eligible Sample Results and Estimates.....	23
F: Non-Newly Eligible Sample Results and Estimates.....	26
G: CMS Comments	28

INTRODUCTION

WHY WE DID THIS AUDIT

Medicaid spending and enrollment continue to grow. In 2019, Medicaid spending totaled more than \$613 billion and, as of March 2021, 81.7 million individuals were enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). These spending and enrollment levels are the highest in the history of the Medicaid program. Part of that growth was due to Medicaid eligibility changes promulgated by the Patient Protection and Affordable Care Act (P.L. No. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. No. 111-152), collectively known as the Affordable Care Act (ACA). Beginning in 2014, the ACA provided States with the authority to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these beneficiaries. The ACA also mandated changes to Medicaid eligibility rules, such as how income is calculated for most eligibility categories. The combination of expanded coverage and new eligibility rules led to a significant increase in applications for Medicaid coverage.

The Office of Inspector General (OIG) conducted eight audits of four States’ Medicaid eligibility determinations made under the modified Medicaid eligibility rules during 2014 and 2015. The OIG audits of Medicaid eligibility determinations by New York, California, Colorado, and Kentucky found that these States did not always determine Medicaid eligibility for low-income adults without dependent children (referred to as “newly eligible beneficiaries”) and individuals eligible under traditional Medicaid coverage groups (referred to as “non-newly eligible beneficiaries”) in accordance with Federal and State requirements. OIG made a total of 31 recommendations to the States to address these deficiencies. The States concurred with all of the recommendations.

In addition, the Centers for Medicare & Medicaid Services (CMS) revised its procedures for assessing eligibility improper payment rates included in CMS’s Payment Error Rate Measure (PERM) program. In 2019 and 2020—the first 2 years that CMS relied on its revised procedures—the PERM Medicaid eligibility improper payment rates were 20.60 percent and 22.32 percent, respectively. This led to an increase in the rolling national Medicaid PERM improper payment rate from 9.79 percent in 2018 to 21.36 percent in 2020. Although its revised procedures for calculating eligibility improper payment rates in 2019 and 2020 may have factored into high improper payment rates for these years, the rates also indicate that States may still face challenges in making eligibility determinations—an indication that is similar to what OIG identified in its audits.

To assist CMS's efforts to address high eligibility improper payment rates, this report summarizes the findings of OIG's prior audits. (See Appendix B for a list of the eight prior OIG reports.)¹

OBJECTIVE

The objective of our audit was to summarize the results of OIG audits of four States' Medicaid eligibility determinations for newly and non-newly eligible beneficiaries to assist CMS in achieving greater efficiencies in its operation of the Medicaid program.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, States must cover certain population groups. States may also provide coverage to other optional populations. Federal and State Governments jointly fund and administer the Medicaid program. 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 most eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL).

States operate and fund Medicaid in partnership with the Federal Government through 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 States' per capita income.² The standard FMAP varies by State and ranged from 50 to 75 percent during our audit period.³

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

Beginning in 2014, the ACA provided States with the authority to expand their Medicaid programs to cover more low-income people, including adults without dependent children who were not previously eligible, formerly referred to as the "new adult group."⁴ In States that

¹ OIG also issued reports on Medicaid eligibility determinations in two other States: *Ohio Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* ([A-05-18-00027](#)), issued Nov. 10, 2020, and *Louisiana Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* ([A-06-18-02000](#)), issued Jan. 27, 2021. The results of these two audits are not included in this report because the health insurance exchanges in these States are operated by the CMS-administered Federal marketplace. See page 2 for more details on Federal and State marketplaces.

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

³ 77 Fed. Reg. 71420, 71422 (Nov. 30, 2012) and 79 Fed. Reg. 3385, 3387 (Jan. 21, 2014).

⁴ ACA § 2001(a)(1)(C).

elected to expand their programs under the ACA, individuals were newly eligible for Medicaid if they met certain criteria such as age (not being younger than 19 or older than 64 years of age) and income (not having an income exceeding 133 percent of FPL) in addition to meeting citizenship and State residency requirements.^{5,6}

The ACA also required each State to establish its own health insurance exchange (marketplace) or elect to operate through the CMS-administered Federal marketplace. A marketplace is designed to serve as a “one-stop shop” where individuals can review their health insurance options and are evaluated for Medicaid eligibility. Furthermore, States were required to make several 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 (e.g., Medicaid, the Children’s Health Insurance Program, and qualified health plans) available through the marketplaces.⁷ Finally, in most cases the ACA required States to use Modified Adjusted Gross Income (MAGI) to determine a person’s income.⁸

Section 2001 of the ACA authorized an FMAP of 100 percent for qualified expenditures incurred by States on behalf of newly eligible beneficiaries.⁹ This “newly eligible FMAP” was set at 100 percent through 2016 and gradually decreased to 90 percent in 2020. As of September 2021, it remained at 90 percent.¹⁰

Medicaid Eligibility Verification Requirements

States must maintain individual records on each applicant and beneficiary that are essential to determining initial and continuing Medicaid eligibility.¹¹ States are required to have an income and eligibility verification system for determining Medicaid eligibility and, upon CMS’s request,

⁵ 42 CFR § 435.119(b)(5). Section 1902(a)(10)(A)(i)(VIII) of the Act established the FPL threshold at 133 percent but allows for what is known as a “5-percent income disregard,” making the effective threshold 138 percent of FPL.

⁶ 42 CFR §§ 435.403 and 435.406.

⁷ ACA § 1413(b).

⁸ ACA § 2002; 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. Adjusted gross income, or AGI, is an individual’s total income for the year, minus certain adjustments such as Individual Retirement Account contributions and student loan interest. MAGI is AGI plus untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

⁹ The Act § 1905(y)(2)(A) defines a “newly eligible” beneficiary 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.”

¹⁰ 42 CFR § 433.10(c)(6).

¹¹ 42 CFR § 431.17.

a verification plan describing the State agency’s policies and procedures for implementing the eligibility verification requirements.¹² States must verify individuals’ eligibility information, such as citizenship or lawful presence and entitlement to or enrollment in Medicare, through electronic sources.¹³ 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.¹⁴

For more details on the various Federal and State requirements, see Appendix C.

CMS Programs to Review States’ Medicaid Eligibility Determinations

CMS and States monitor and assess the accuracy of Medicaid eligibility determinations using the PERM and Medicaid Eligibility Quality Control (MEQC) programs. In July 2017, CMS published a final rule that modified PERM and MEQC requirements and incorporated changes required by the ACA.¹⁵ One modification involved CMS hiring a contractor to perform PERM eligibility reviews.¹⁶ After the conclusion of the contractor’s PERM reviews, States must develop a corrective action plan to address any findings. CMS also revised Federal regulations to allow it to disallow the Federal share of Medicaid payments associated with eligibility errors detected through PERM reviews for the period beginning July 1, 2020.¹⁷ States must also conduct MEQC reviews during the 2-year interval between their designated PERM review periods and submit to CMS a corrective action plan to address any errors and deficiencies found during their MEQC reviews.

The COVID-19 pandemic was declared a nationwide public health emergency in January 2020. In March 2020, Congress enacted the Families First Coronavirus Response Act, which provided States with a temporary increase of 6.2 percentage points to their regular FMAP rates.¹⁸ In order to qualify for this enhanced FMAP, States must adhere to the maintenance-of-

¹² The Act §§ 1137(a) and (b); 42 CFR § 435.945(j).

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

¹⁴ 42 CFR §§ 435.945(a) and 435.956.

¹⁵ 82 Fed. Reg. 31158 (July 5, 2017), “Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act.” Available online at <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicare-program-and-childrens-health-insurance-program-chip-changes-to-the>.

¹⁶ The PERM program uses a 3-year rotational cycle to produce and report the Medicaid improper payment rate. In year one of the cycle, a PERM review is conducted to establish an eligibility improper payment rate. In years two and three of the cycle, States will conduct MEQC reviews to identify errors and deficiencies and implement potential corrective actions.

¹⁷ 42 CFR § 431.1010.

¹⁸ The Families First Coronavirus Response Act (P.L. 116-127).

eligibility requirement, which ensures continuous coverage for current Medicaid beneficiaries during the public health emergency.¹⁹ The Medicaid eligibility status for these beneficiaries during this time must continue, regardless of any changes in circumstances or redeterminations at scheduled renewals that would otherwise result in termination.²⁰

CMS ACTIONS TO IMPROVE MEDICAID PROGRAM INTEGRITY

While the primary responsibility for ensuring proper payments in Medicaid lies with States, CMS plays a significant role in supporting States' efforts and holding them accountable through appropriate oversight. In June 2020, CMS released its Comprehensive Medicaid Integrity Plan (CMIP) for fiscal years (FYs) 2019-23 that included initiatives designed to improve Medicaid program integrity. These initiatives included stronger audit functions, increased beneficiary eligibility oversight, development of a Medicaid scorecard, and enhanced enforcement of State compliance with Federal rules.²¹ CMS also offers training to State Medicaid program integrity officials through its Medicaid Integrity Institute. The training includes coursework covering Medicaid fraud investigations, data mining and analysis, provider enrollment, managed care oversight, emerging trends, and case development.²²

As part of its CMIP, CMS audits Medicaid beneficiary eligibility determinations, including in States previously audited by OIG. In 2020, CMS's Center for Program Integrity completed three such audits of newly eligible beneficiaries enrolled in Louisiana, New York, and Kentucky. In addition, in June 2019 CMS released an Informational Bulletin to States reiterating and clarifying existing Federal requirements for eligibility and enrollment processes.²³ Specifically, the bulletin provided technical guidance on eligibility determinations, claiming the appropriate FMAP, program monitoring, and other program integrity tools.²⁴

¹⁹ Beneficiaries covered under CMS's maintenance-of-eligibility requirement include those enrolled in Medicaid as of March 18, 2020, or at any time thereafter during the public health emergency period.

²⁰ CMS's maintenance-of-eligibility requirement does not pertain to: (1) beneficiaries who are deceased, (2) a beneficiary who is no longer a State resident, (3) beneficiary fraud or abuse, or (4) eligibility determination errors made by a State Medicaid agency.

²¹ The Medicaid scorecard includes Medicaid performance measures voluntarily reported by States as well as measures reported by the Federal Government.

²² CMS, "Medicaid Integrity Institute." Available online at <https://www.cms.gov/medicaid-integrity-institute>. Accessed on July 9, 2021.

²³ CMS, "Oversight of State Medicaid Claiming and Program Integrity Expectations." Available online at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf>. Accessed on July 9, 2021.

²⁴ Additional program integrity tools include implementing recommendations from previously completed beneficiary eligibility audits and implementing corrective action plans associated with the PERM and MEQC programs.

HOW WE CONDUCTED THIS AUDIT

The 8 previously conducted OIG audits summarized in this report covered 3,158,955 newly eligible beneficiaries and 14,304,225 non-newly eligible beneficiaries with Medicaid payments totaling \$51.6 billion (\$33.6 billion Federal share). In these audits, we reviewed States' Medicaid eligibility determinations for a sample of 460 newly eligible and 515 non-newly eligible beneficiaries. All but one of the prior audits covered the period October 1, 2014, through March 31, 2015. Our audit of Colorado's newly eligible beneficiaries covered services provided during the period January 1, 2014, through September 30, 2015. See Appendix D for details on the eight audits, including total Medicaid and Federal paid amounts, sampling frames, and sample sizes.

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 D contains our statistical sampling methodology, Appendix E contains sample results and estimates from our audits of newly eligible beneficiaries, and Appendix F contains sample results and estimates from our audits of non-newly eligible beneficiaries.

FINDINGS

Our previous audits of four States' Medicaid eligibility determinations found that Medicaid eligibility was not always determined in accordance with Federal and State requirements. We found that during the 2014 and 2015 audit periods, New York, California, Colorado, and Kentucky made Medicaid payments on behalf of newly and non-newly eligible beneficiaries who did not meet or may not have met Medicaid eligibility requirements. Specifically, we found that 3 States (New York, California, and Colorado) incorrectly determined eligibility for 78 of the 460 newly eligible beneficiaries (payments for these beneficiaries totaled \$74,196) and 2 States (New York and California) incorrectly determined eligibility for 20 of the 515 non-newly eligible beneficiaries (payments for these beneficiaries totaled \$53,707).

On the basis of our sample results, we estimated that the previously mentioned 3 States were reimbursed \$777.6 million on behalf of 548,465 ineligible newly beneficiaries and \$1 billion on behalf of 1,186,635 ineligible non-newly beneficiaries. In addition, we found that all 4 States may have incorrectly determined eligibility for 31 of the 460 newly eligible beneficiaries (payments for these beneficiaries totaled \$323,630). We estimated that three States (California, Colorado, and Kentucky) were reimbursed \$594.2 million for this population of

beneficiaries.²⁵ Finally, we found that all 4 States may have incorrectly determined eligibility for 78 of the 515 non-newly eligible beneficiaries (payments for these beneficiaries totaled \$4,476,711). We estimated that the four States were reimbursed \$4 billion for this population of beneficiaries. We determined that both human and system errors contributed to these incorrect and potentially incorrect Medicaid eligibility determinations.

In total, we estimated that out of the \$51.6 billion of total Medicaid payments covered by the 8 previous audits, the 4 States received Federal Medicaid payments totaling more than \$6.4 billion on behalf of 5.7 million newly and non-newly eligible beneficiaries who were ineligible or potentially ineligible for the Medicaid group that they were enrolled in. Specifically, we estimated that the Federal Government reimbursed the 4 States almost \$1.4 billion for more than 700,000 ineligible or potentially ineligible newly eligible beneficiaries and more than \$5 billion for almost 5 million ineligible or potentially ineligible non-newly eligible beneficiaries. See appendices E and F for details on our sample results and estimates.

STATES MADE MEDICAID PAYMENTS ON BEHALF OF NEWLY AND NON-NEWLY ELIGIBLE BENEFICIARIES WHO DID NOT MEET MEDICAID ELIGIBILITY REQUIREMENTS

Three of the four States we audited (New York, California, and Colorado) made Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. New York, California, and Colorado incorrectly determined Medicaid eligibility for 78 of the 460 newly eligible sampled beneficiaries, and New York and California incorrectly determined Medicaid eligibility for 20 of the 515 non-newly eligible sampled beneficiaries.²⁶

Specifically, States did not: (1) properly determine whether beneficiaries met income, citizenship, or residency requirements (51 newly eligible and 13 non-newly eligible beneficiaries); (2) ensure that specific coverage group requirements were met (21 newly eligible and 7 non-newly eligible beneficiaries); or (3) verify whether individuals applying to be newly eligible were already eligible for Medicaid under a different coverage group (8 newly eligible beneficiaries).

Human and system errors, as well as a lack of policies and procedures, contributed to these incorrect determinations. Examples of human error that led to incorrect eligibility determinations include State officials who did not consider all relevant information when determining eligibility and a caseworker who determined a beneficiary was newly eligible for although application data clearly demonstrated that the beneficiary was pregnant and should have been enrolled under a different coverage group. In addition, an example of a system error that led to incorrect eligibility determinations was a State's enrollment system that could not

²⁵ We determined that the number of potentially ineligible beneficiaries found in the sample from our audit of New York was immaterial. As a result, we did not include any estimates related to these potentially ineligible beneficiaries.

²⁶ We identified more than 1 deficiency with States' determinations for 2 of the 78 sampled newly eligible sampled beneficiaries.

retrieve and use information from other Government databases, such as those managed by the Department of Homeland Security, to verify certain eligibility requirements. In addition, States did not develop policies and procedures to produce more accurate eligibility determinations. For example, one State did not have written policies and procedures to ensure that applicants who did not want or did not intend to apply for Medicaid are not determined eligible.²⁷ A massive influx of Medicaid applications was also a contributing factor.

A majority of OIG's recommendations to the States addressed these deficiencies. Although the States concurred with all 31 recommendations from our prior audits, 15 of these recommendations remain unimplemented. Specifically, States have not ensured that:

- eligibility caseworkers accurately input case actions and properly verify eligibility requirements (10 unimplemented recommendations),
- additional policies and procedures are developed to produce more accurate eligibility determinations and to resolve eligibility discrepancies in a timely manner (2 unimplemented recommendations), and
- eligibility verification systems are improved to properly and in a timely manner verify all eligibility information (1 unimplemented recommendation).²⁸

On the basis of our sample results covering our 2014 and 2015 audit periods, we estimated that New York, California, and Colorado made Federal Medicaid payments totaling \$778 million on behalf of 548,465 newly eligible beneficiaries who were ineligible for Medicaid. We also estimated that New York and California made Federal Medicaid payments totaling more than \$1 billion on behalf of 1,186,635 non-newly eligible beneficiaries who were ineligible for Medicaid.

STATES MADE MEDICAID PAYMENTS ON BEHALF OF NEWLY AND NON-NEWLY ELIGIBLE BENEFICIARIES WHO MAY NOT HAVE MET MEDICAID ELIGIBILITY REQUIREMENTS

All four States made Medicaid payments on behalf of beneficiaries who may not have met eligibility requirements. Specifically, for 31 of the 460 newly eligible sampled beneficiaries and 78 of the 515 non-newly eligible beneficiaries, State agencies did not have sufficient

²⁷ In this case, the State determined that the beneficiary was newly eligible even though the beneficiary signed a form to withdraw her application for Medicaid prior to the eligibility determination. The State provided what CMS refers to as a "reasonable opportunity period" of 90 days to resolve a discrepancy between the eligibility information that the beneficiary attested to in their application and information that was available through the State's eligibility verification system.

²⁸ The remaining two unimplemented recommendations are related to States redetermining, as appropriate, the Medicaid eligibility status of sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements.

documentation to support their eligibility determinations or did not verify Medicaid eligibility in accordance with Federal and State requirements.

Generally, States did not maintain documentation showing that applicants' reported income, resources, citizenship, and residency were adequately supported or had been verified, as required. In addition, one State (Kentucky) enrolled newly eligible beneficiaries without verifying whether the applicants met all eligibility requirements. These potentially incorrect Medicaid eligibility determinations were the result of human and system errors.

On the basis of our sample results covering our 2014 and 2015 audit periods, we estimated that 3 States (California, Colorado, and Kentucky) made Federal Medicaid payments totaling \$594 million on behalf of 152,253 newly eligible beneficiaries who were potentially ineligible for Medicaid. We also estimated that all 4 States made Federal Medicaid payments totaling more than \$4 billion on behalf of 3,797,803 non-newly eligible beneficiaries who were potentially ineligible for Medicaid.

The 15 unimplemented recommendations described earlier were also made to address these deficiencies involving payments on behalf of beneficiaries who may not have met eligibility requirements.

CONCLUSION

Determining whether individuals are eligible for Medicaid is a complex process that is vulnerable to errors. However, determining Medicaid eligibility correctly and enrolling only eligible individuals in the Medicaid program is critical to ensuring appropriate use of both Federal and State dollars, and the proper and efficient administration of the program.

Recent CMS audits and PERM program reviews found that States continue to make incorrect eligibility determinations when income or other eligibility requirements were not met or when there was insufficient documentation to support the States' Medicaid eligibility determinations—issues we also identified during our prior audits. Specifically, Medicaid eligibility improper payment rates under the PERM program for reporting years 2019 and 2020 were 20.60 and 22.32 percent, respectively.²⁹ Furthermore, more than 42 percent of the total errors related to the national Medicaid improper payment amount in 2020 were due to insufficient documentation to support eligibility determinations and eligibility requirements not being verified.³⁰

²⁹ Reporting year 2019 covered services provided during the period July 1, 2017, through June 30, 2018. Reporting Year 2020 covered services provided during the period July 1, 2018, through June 30, 2019.

³⁰ CMS, *2020 Medicaid & CHIP Supplemental Improper Payment Data*. Available online at <https://www.cms.gov/files/document/2020-medicaid-chip-supplemental-improper-payment-data.pdf>. Accessed on May 26, 2021.

While States are primarily responsible for determining whether an individual applying for Medicaid meets eligibility requirements, CMS plays a significant role in supporting States' efforts and holding them accountable for determining Medicaid eligibility in accordance with Federal and State requirements. For example, CMS reviews States' corrective action plans that are submitted to address any findings from their PERM and MEQC reviews. Additionally, CMS provides training and technical advice to States, and has other available remedies to hold States accountable. Finally, as part of its efforts to hold States accountable for determining Medicaid eligibility in accordance with Federal and State requirements, CMS should also ensure that States are implementing all of OIG's recommendations, especially those for which the States have concurred with the recommendations.

Addressing OIG's 15 unimplemented recommendations can help CMS and States ensure that eligibility verification works as intended and may help States successfully perform these verifications once the public health emergency ends. Once the maintenance-of-eligibility requirement expires, States will likely conduct a high volume of eligibility determinations and redeterminations. Ensuring that eligibility systems and verification processes have minimal errors will ensure that beneficiaries who remain eligible maintain their coverage and individuals who are no longer eligible are appropriately removed from Medicaid enrollment.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- Work with States to implement all of the recommendations made in OIG's prior audits.
- Maintain its efforts to improve the integrity of the Medicaid program by continuing to provide training, technical advice, and guidance to States to address the causes identified in OIG's prior audits in order to ensure that States:
 - improve the accuracy of eligibility caseworkers who manually input case actions and verify eligibility requirements,
 - improve their eligibility verification systems to properly verify all eligibility information in a timely manner, and
 - develop additional policies and procedures to produce more accurate eligibility determinations and to resolve eligibility discrepancies in a timely manner.
- Explore using or expanding the use of available remedies to prevent and reduce the amount of improper payments made on behalf of ineligible beneficiaries. As appropriate, this could include disallowance of the Federal share associated with eligibility errors or proposing changes to eligibility determination practices and rules.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS generally concurred with our recommendations and provided detail on a number of actions CMS has taken to improve States' Medicaid eligibility determinations. CMS requested that we remove our first recommendation and provided additional documentation regarding the number of unimplemented recommendations identified in our draft report. While CMS indicated that it will continue to work with the States to implement OIG's prior audit recommendations, it stated that it already has taken a number of actions to monitor and assist States with implementation and has established standard operating procedures for working with States to clear OIG recommendations through its audit resolution process. CMS concurred with our second and third recommendations and described steps it has taken or the plans it has to address them. Specifically, CMS described its efforts to improve the integrity of the Medicaid program by providing ongoing technical assistance to States and stated that it will consider whether it is appropriate to use rulemaking to revise certain eligibility determination and documentation requirements to reduce errors associated with improper payments.

After reviewing CMS's comments and additional documentation, we revised our finding related to the number of unimplemented recommendations from the prior audits. However, we did not remove our first recommendation for the reasons detailed below.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix G.

CMS COMMENTS

CMS noted that our report summarizes audits of Medicaid eligibility determinations made in New York, California, Colorado, and Kentucky during 2014 and 2015—the first 2 years after the enactment of the ACA. CMS stated that, although it recognizes that many States experienced challenges during the initial implementation of ACA requirements, it worked with States to resolve many of the issues identified in OIG's prior audits. CMS stated that two of the States that OIG audited have fully implemented OIG's recommendations and another State has implemented more than half of our recommendations. CMS stated that it will continue to monitor and work with States to implement OIG's remaining unimplemented recommendations, as appropriate.

CMS explained that among its efforts to assist States, it provides significant training, technical advice, and guidance through bulletins, group calls, and webinars. In addition, CMS stated that it directly supports States with one-on-one technical assistance via reviews of States' verification plans and submissions for Medicaid State plan amendments. Furthermore, CMS detailed how it works with eligibility systems vendors to continue to design and implement systems that reduce errors made by eligibility caseworkers. CMS also stated that it provided States with enhanced Federal funding to design and develop new or improved Medicaid eligibility verification systems to accommodate new ACA requirements.

CMS also stated that it conducted its own eligibility audits of three States in 2019, including two that OIG previously audited (New York and Kentucky).³¹ According to CMS, it found that the system errors identified in OIG’s prior audits had been corrected and that other reported errors had been appropriately addressed. In addition, CMS indicated that statutory changes to Medicaid and CHIP brought about by the ACA required States to implement a new process for eligibility determinations and required CMS to update how it measured improper payment rates in States’ beneficiary eligibility determinations under the PERM and MEQC programs.^{32, 33}

Finally, CMS explained that States have prioritized their activities to directly respond to the COVID-19 public health emergency and recognized that States will be faced with a large number of eligibility and enrollment actions that will need to be completed once the public health emergency ends. CMS stated that it will continue to support States once the public health emergency ends and has already released guidance that outlines policy changes to assist States in addressing these emerging issues.

OFFICE OF INSPECTOR GENERAL RESPONSE

We commend CMS for its efforts to work with States to resolve many of the issues identified in OIG’s prior audits. Based on our review of additional documentation provided, we revised our finding related to the number of unimplemented recommendations from the prior audits. We maintain that our findings and recommendations associated with this audit are appropriate.

Furthermore, we recognize that our findings and recommendations summarized by this report described challenges that States faced during the initial years of ACA implementation in 2014 and 2015. However, CMS’s more recent PERM audits examining States’ eligibility determinations 5 years later indicate that States still face significant challenges in implementing and operating effective eligibility systems and processes. Our reports provide useful information about the types of challenges and causes of problems related to eligibility determinations that CMS can use as it continues to work with States. CMS should use the

³¹ CMS also described how it conducted its own risk analysis and, based on those results, began four additional audits in other States in 2020.

³² To accommodate statutory changes, CMS stated that it did not conduct the eligibility measurement component of the PERM program or operate the MEQC program for FYs 2015 through 2018. However, it recently completed reviews of all States under the new eligibility component of the PERM program and established a baseline of the improper payment rate in 2021. CMS indicated that, as a result, it will be able to track improvement in compliance with eligibility requirements when States are measured a second time during their applicable review cycles.

³³ CMS stated that it restructured the MEQC program into an ongoing series of pilots that States are required to conduct during the two off-years between their designated year for a review under the PERM program. CMS acknowledged that, under current regulations, it can pursue disallowances for States that exceed the minimum error percentage threshold (i.e., 3 percent) during two consecutive PERM program reviews and if those States fail to demonstrate a “good faith effort” to satisfy the requirements established by (1) corrective action plans established by States under the PERM program and (2) the results of the MEQC pilot.

information and recommendations in our reports—in combination with CMS’s audits, the PERM and MEQC processes, and other CMS efforts—to help States ensure that their eligibility systems and processes work as intended. As we recognized in this report, identifying and addressing the causes of challenges with eligibility determinations will be especially important as CMS and States prepare for the end of the public health emergency. Effectively addressing these issues now could help ensure that individuals and families who remain eligible for Medicaid do not have their enrollment inappropriately ended and those who no longer qualify are appropriately unenrolled once States resume normal operations. Additionally, we believe that prioritizing these recommendations can help CMS and States reduce the high improper payment rates in States’ beneficiary eligibility determinations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

The 8 OIG audits summarized in this report covered 3,158,955 newly eligible beneficiaries and 14,304,225 non-newly eligible beneficiaries associated with Medicaid payments totaling \$51.6 billion (\$33.6 billion Federal share). We reviewed States' Medicaid eligibility determinations for a sample of 460 newly eligible and 515 non-newly eligible beneficiaries. All but one of the prior audits covered the period October 1, 2014, through March 31, 2015. The audit of Colorado's newly eligible beneficiaries covered services provided during the period January 1, 2014, through September 30, 2015. See Appendix D for details on the individual States' audit periods, total Medicaid and Federal paid amounts, sampling frames, and sample sizes.

For each of the eight audits, we limited our review of internal controls to those applicable to our objective. Specifically, we tested controls to confirm that States' policies and procedures for determining Medicaid eligibility were operating as intended and reviewed supporting documentation to evaluate whether States determined Medicaid eligibility in accordance with Federal and State requirements.

METHODOLOGY

To accomplish the objective for this audit, we:

- summarized the results of the prior eight OIG audits on Medicaid eligibility determinations made by New York, California, Colorado, and Kentucky (Appendix B);
- discussed with CMS the steps it has taken since the issuance of the eight OIG audits to strengthen and improve the integrity of the Medicaid program; and
- discussed the results of our review with CMS officials.

To accomplish our objective for the 8 prior audits, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility;
- assessed internal controls in each State by gaining an understanding of how an applicant's information is processed and an applicant's eligibility for enrollment in Medicaid is verified;
- interviewed State agency and/or marketplace officials in each State to obtain an understanding of the policies, procedures, and guidance for determining Medicaid eligibility in that State;

- created sampling frames for each audit that included 3,158,955 newly eligible beneficiaries and 14,304,225 non-newly eligible beneficiaries for which State agencies made Medicaid payments totaling \$51,608,377,669 (\$33,599,911,427 Federal share);
- selected random samples from the sampling frames for each audit that included 460 newly eligible and 515 non-newly eligible beneficiaries (see Appendix D for individual State sample details);
- obtained for each sampled beneficiary, when possible, application data and documentation supporting the Medicaid eligibility determination and determined whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements;
- estimated the total number of ineligible and potentially ineligible beneficiaries in each State;
- estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible and potentially ineligible beneficiaries in each State; and
- discussed the results of each audit with State agency officials.

We conducted these performance audits in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audits 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: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place</i>	<u>A-07-18-02812</u>	3/24/2020
<i>Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-07-16-04228</u>	8/30/2019
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries</i>	<u>A-02-16-01005</u>	7/17/2019
<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>	02/20/2018
<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: FEDERAL AND STATE REQUIREMENTS FOR MEDICAID ELIGIBILITY DETERMINATIONS

Federal Requirements Pertaining to Eligibility Based on Income

An individual who has a household income that is at or below 133 percent of the FPL for the applicable family size may be newly eligible for Medicaid (42 CFR § 435.119(b)(5)). The ACA allows for a 5-percent income disregard, making the effective income threshold 138 percent of the FPL (the Act § 1902 and the ACA § 2002). In accordance with the Act and the ACA, State Medicaid agencies claimed Federal Medicaid reimbursement for newly eligible Medicaid beneficiaries at 100 percent FMAP through calendar year 2016 (the Act § 1905(y)(1) and the ACA § 2001).

Federal regulations require State Medicaid agencies to verify financial information related to wages, net earnings from self-employment, and unearned income, and resources from the State Wage Information Collection Agency, Internal Revenue Service, Social Security Administration (SSA), and State unemployment insurance (42 CFR § 435.948(a)(1)). The State agency must request additional information or documentation from the beneficiary if the attested income is not reasonably compatible with electronic sources (42 CFR § 435.952(c)(2)).

Federal Requirements Pertaining to Enrollment in Correct Medicaid Eligibility Group

If an individual is eligible for Medicaid through any mandatory category, the individual cannot be enrolled in Medicaid as newly eligible (the Act § 1902(a)(10)(A)(i)).

The ACA § 2001 authorized an FMAP of 100 percent for qualified expenditures incurred by newly eligible beneficiaries. The Federal statute states: “The term ‘newly eligible’ means, with respect to an individual described in [the Act § 1902(a)(10)(A)(i)(VIII)], an individual who is not under 19 years of age (or such higher age as the State may have elected)” (the Act § 1905(y)(2)(A)). (Emphasis added.)

A dependent child’s parent or caretaker relative is not newly eligible “unless such child is receiving benefits under Medicaid, [CHIP], . . . or otherwise is enrolled in minimum essential coverage as defined by § 435.4 of this part” (42 CFR § 435.119(c)).

Federal Requirements Pertaining to Eligibility Based on Citizenship

To verify citizenship or nationality status of beneficiaries applying for Medicaid, States must confirm that those individuals declaring to be citizens or nationals of the United States have presented satisfactory documentary evidence of citizenship or nationality (the Act § 1903(x)). States may verify citizenship or nationality by electronically verifying status with SSA (42 CFR §§ 435.406 and 435.949). However, if a State is unable to verify citizenship or nationality, there is a 90-day inconsistency (that is, reasonable opportunity) period to resolve a discrepancy (the Act § 1902(ee)), during which time the beneficiary is provided Medicaid benefits. Qualified

aliens are not eligible for full Medicaid benefits until 5 years from the date they enter the United States with qualified alien status (8 USC § 1613(a)). In addition, the State agency “must promptly evaluate information received or obtained by it . . . to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled” (42 CFR § 435.952(a)).

Federal Requirements Pertaining to Eligibility for Medicare

To be newly eligible for Medicaid, an individual must not be entitled to or enrolled in Medicare Parts A or B (42 CFR § 435.119(b)).

Federal and California State Requirements Pertaining to Eligibility Based on Coverage Group Requirements

The State agency provides Medicaid coverage to a parent or other relative caretaker of a dependent child under the age of 18 and who has a household income at or below 109 percent of the FPL (42 CFR § 435.110 and State plan amendment CA-13-0021, effective January 1, 2014). In addition, the State agency provides full-scope Medicaid services to a pregnant woman in the third trimester who has a household income at or below 109 percent of the FPL (State plan amendment CA-13-0021, effective January 1, 2014).

The State agency provides Medicaid coverage to medically needy individuals who are under the age of 21 or who are 65 years of age or older and who are eligible because their income and resources (e.g., the balance of a bank account and the surrender value of a life insurance policy) are within limits established by the State plan (42 CFR §§ 435.308 and 435.320; State plan attachment 2.2-A). Generally, a parent’s income must be considered when determining a child’s eligibility for the medically needy coverage group (22 California Code of Regulations §§ 50557 and 50373).

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 (42 CFR §§ 435.301 and 435.320).

The State agency must provide Medicaid to children who are 6 through 18 years of age and whose household income is at or below 133 percent of the FPL (42 CFR § 435.118 and State plan amendment CA-13-0021 (effective January 1, 2014)). The State agency may also provide Medicaid to optional targeted low-income children under the age of 19 who meet additional financial and categorical standards, such as having income under 261 percent of the FPL and having no other coverage (42 CFR § 435.4 and State plan amendment CA-13-0021 (effective January 1, 2014)).

If an application for Medicaid is filed by the last day of the month following the month in which the presumptive eligibility determination was made, the presumptive eligibility period ends on

the date the eligibility determination for Medicaid is made (State plan amendment CA-13-0027 (effective January 1, 2014)).

Federal Requirements Pertaining to Eligibility Redetermination

The State agency must redetermine the eligibility of beneficiaries once every 12 months and also promptly redetermine eligibility when it receives information about a change in a beneficiary's circumstance that may affect eligibility (42 CFR §§ 435.916 and 435.952(a)).

Federal and California State Requirements Pertaining to Eligibility Based on Residency Requirements

The State agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State (42 CFR § 435.403). The State agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished (42 CFR § 435.403(j)(3)).

Generally, in California an absence from the State of more than 60 days is presumptive evidence of intent to change residence to a place outside of California unless the individual declares orally or in writing an intent to return to California (State plan amendment CA-13-0025, effective January 1, 2014).

Federal and Colorado State Requirements for Verification of Changes in Income

Colorado's verification plan (required under 42 CFR § 435.945(j)) says that the State agency will verify income on a post-eligibility basis using data matches approximately 2 to 4 months after a beneficiary self-attests income and an eligibility determination has been made.³⁴

Federal Requirements Pertaining to Verification Systems

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 (the Act §§ 1137(a) and (b); 42 CFR § 435.945(j)). States must verify individuals' eligibility information such as citizenship or lawful presence and entitlement to or enrollment in Medicare through electronic sources (42 CFR §§ 435.945(a) and (b) and 435.949). 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 (42 CFR §§ 435.945(a) and 435.956).

³⁴ The verification plan is a standalone document separate from the State Medicaid plan and any State Plan Amendments. Although this document is undated, the State agency confirmed to us during our review that its provisions were applicable during our entire audit period.

Federal Requirements Pertaining to Maintaining Documentation

Marketplaces must maintain—and ensure that their contractors, subcontractors, and agents maintain—for 10 years documents and records that are sufficient to enable the Department of Health and Human Services 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 (45 CFR § 155.1210(b)(4)). In addition, the State agency must maintain or supervise the maintenance of the records necessary to properly and efficiently operate the Medicaid program (42 CFR § 431.17). The State agency must also include in each applicant's case record facts to support its decision on a beneficiary's application (42 CFR § 435.914).

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

For each audit, we created a database that consisted of newly eligible or non-newly eligible beneficiaries for whom the State agency made Medicaid payments for services provided during the audit period. As shown in Table 2, the resulting sampling frames totaled 3,158,955 newly eligible beneficiaries for which State agencies made Medicaid payments totaling \$10,528,233,605 (\$10,363,711,239 Federal share) and 14,304,225 non-newly eligible beneficiaries for which State agencies made Medicaid payments totaling \$41,080,144,064 (\$23,236,200,188 Federal share).

Table 2: Sampling Frames and Sample Sizes

Newly Eligible Audits					
State	Audit Period	Medicaid Paid	Federal Share	Sampling Frame (Beneficiaries)	Sample Size (Beneficiaries)
New York	October 2014 - March 2015	\$561,656,265	\$531,713,733	228,217	130
California	October 2014 - March 2015	6,213,350,143	6,095,345,087	1,886,854	150
Colorado	January 2014 - September 2015	2,246,254,206	2,246,254,206	579,070	60
Kentucky	October 2014 - March 2015	1,506,972,991	1,490,398,213	464,814	120
Newly Eligible Totals		\$10,528,233,605	\$10,363,711,239	3,158,955	460

Non-Newly Eligible Audits					
State	Audit Period	Medicaid Paid	Federal Share	Sampling Frame (Beneficiaries)	Sample Size (Beneficiaries)
New York	October 2014 - March 2015	\$24,568,360,392	\$13,239,935,181	5,351,560	130
California	October 2014 - March 2015	11,276,688,182	6,713,413,002	7,072,052	125
Colorado	October 2014 - March 2015	2,148,608,419	1,114,319,044	979,496	140
Kentucky	October 2014 - March 2015	3,086,487,071	2,168,532,961	901,117	120
Non-Newly Eligible Totals		\$41,080,144,064	\$23,236,200,188	14,304,225	515

SAMPLE UNIT

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

SAMPLE DESIGN

All but one of the audits used a stratified random sample to determine whether newly eligible and non-newly eligible beneficiaries met Federal and State Medicaid eligibility requirements. The audit of Colorado's newly eligible beneficiaries used a simple random sample to evaluate

the State agency's compliance with Medicaid eligibility requirements. Details of each State's sample design can be found in the respectively issued audit report. (See Appendix B.)

SAMPLE SIZE

As shown in Table 2, we selected a total of 460 newly eligible Medicaid beneficiaries and 515 non-newly eligible Medicaid beneficiaries.

SOURCE OF RANDOM NUMBERS

For each audit, we generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

For the seven audits for which we used stratified random sampling, we consecutively numbered the Medicaid beneficiaries within each stratum. For the remaining audit, Medicaid claims in the sampling frame were consecutively numbered. After generating the random numbers, we selected the corresponding Medicaid beneficiaries in the sampling frames for each audit's sample.

ESTIMATION METHODOLOGY

For each audit, we used the OAS statistical software to estimate the total number of ineligible and potentially ineligible Medicaid beneficiaries, as applicable. Also, for each audit we 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 each of these estimates.

APPENDIX E: NEWLY ELIGIBLE SAMPLE RESULTS AND ESTIMATES³⁵

Table 3: Sample Detail and Results for Ineligible Beneficiaries

State	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
New York	228,217	\$531,713,733	130	\$396,635	37	\$15,836
California	1,886,854	6,095,345,087	150	1,023,489	27	45,665
Colorado	579,070	2,246,254,206	60	225,351	14	12,695
Kentucky	464,814	1,490,398,213	120	418,707	0	0
Totals	3,158,955	\$10,363,711,239	460	\$2,064,182	78	\$74,196

Table 4: Sample Detail and Results for Potentially Ineligible Beneficiaries

State	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
New York	228,217	\$531,713,733	130	\$396,635	4*	\$7,273
California	1,886,854	6,095,345,087	150	1,023,489	14	278,388
Colorado	579,070	2,246,254,206	60	225,351	4	8,991
Kentucky	464,814	1,490,398,213	120	418,707	9	28,978
Totals	3,158,955	\$10,363,711,239	460	\$2,064,182	31	\$323,630

* We determined that the number of potentially ineligible beneficiaries found in the sample from our audit of New York was immaterial. As a result, we did not include any estimates related to these potentially ineligible beneficiaries.

³⁵ The values included in this appendix are the Federal share amounts of the payments associated with the ineligible or potentially ineligible beneficiaries.

ESTIMATES

Table 5: Estimated Number of Ineligible Beneficiaries and the Value of Associated Improper Payments
(Limits Calculated at the 90-Percent Confidence Level)

	New York		California		Colorado		Total	
	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries
Point Estimate	47,271	\$26,221,803	366,078	\$628,838,417	135,116	\$122,523,781	548,465	\$777,584,001
Lower Limit	34,148	11,640,159	236,815	396,812,234	85,085	66,525,688	356,048	474,978,081
Upper Limit	60,394	\$40,803,447	495,341	\$951,144,692	197,159	\$218,704,996	752,894	\$1,210,653,135

**Table 6: Estimated Number of Potentially Ineligible Beneficiaries
and the Value of Associated Improper Payments**
(Limits Calculated at the 90-Percent Confidence Level)

	California		Colorado		Kentucky		Total	
	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries
Point Estimate	79,055	\$402,358,529	38,605	\$86,777,017	34,593	\$105,075,377	152,253	\$594,210,923
Lower Limit	23,726	\$191,003,455	13,372	\$26,797,483	15,489	\$47,151,981	52,587	264,952,919
Upper Limit	134,385	\$756,204,716	84,598	\$212,929,387	53,697	\$162,998,772	272,680	\$1,132,132,875

APPENDIX F: NON-NEWLY ELIGIBLE SAMPLE RESULTS AND ESTIMATES³⁶

Table 7: Sample Detail and Results for Ineligible Beneficiaries

State	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
New York	5,351,560	\$13,239,935,181	130	\$1,245,560	6	\$28,780
California	7,072,052	\$6,713,413,002	125	\$9,836,625	14	24,927
Colorado	979,496	\$1,114,319,044	140	\$688,063	0	0
Kentucky	901,117	\$2,168,532,961	120	\$735,446	0	0
Totals	14,304,225	\$23,236,200,188	515	12,505,694	20	\$53,707

Table 8: Sample Detail and Results for Potentially Ineligible Beneficiaries

State	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
New York	5,351,560	\$13,239,935,181	130	\$1,245,560	14	\$91,993
California	7,072,052	\$6,713,413,002	125	\$9,836,625	52	4,328,670
Colorado	979,496	\$1,114,319,044	140	\$688,063	5	48,556
Kentucky	901,117	\$2,168,532,961	120	\$735,446	7	7,492
Totals	14,304,225	\$23,236,200,188	515	12,505,694	78	\$4,476,711

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

ESTIMATES

Table 9: Estimated Number of Ineligible Beneficiaries and Value of Associated Improper Payments
(Limits Calculated at the 90-Percent Confidence Level)

	New York		California		Total	
	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments for Ineligible Beneficiaries
Point Estimate	383,893	\$520,295,792	802,742	\$536,039,109	1,186,635	\$1,056,334,901
Lower Limit	114,266	\$80,414,611	401,400	\$296,532,275	545,666	376,946,886
Upper Limit	653,520	\$960,176,973	1,204,085	\$919,149,766	1,857,605	\$1,879,326,739

Table 10: Estimated Number of Potentially Ineligible Beneficiaries and Value of Associated Improper Payments
(Limits Calculated at the 90-Percent Confidence Level)

	New York		California		Colorado	
	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries
Point Estimate	618,057	\$1,297,308,200	3,100,260	\$2,616,843,793	9,555	\$55,699,358
Lower Limit	299,478	726,192,069	2,474,568	1,961,634,853	3,603	23,839,146
Upper Limit	936,636	\$1,868,424,330	3,725,952	\$3,502,017,605	20,448	\$110,260,315

	Kentucky		Total	
	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries	Total Number of Potentially Ineligible Beneficiaries	Total Value of Improper Payments for Potentially Ineligible Beneficiaries
Point Estimate	69,931	\$72,763,721	3,797,803	\$4,042,615,072
Lower Limit	28,066	23,342,402	2,805,715	2,735,008,470
Upper Limit	111,796	\$122,185,039	4,794,832	\$5,602,887,289

APPENDIX G: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: November 15, 2021

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure *Chiq B LaS*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Prior Audits of Medicaid Eligibility Determinations in Four States Identified Millions of Beneficiaries Who Did Not or May Not Have Met Eligibility Requirements (A-02-20-01018)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to working with states to ensure that they comply with federal laws and regulations in order to assure the accuracy of Medicaid eligibility determinations, and states' ability to appropriately claim Federal Financial Participation (FFP).

OIG's report summarizes audits of Medicaid eligibility determinations made in New York, California, Colorado, and Kentucky during 2014 and 2015 - the first two years after the enactment of The Affordable Care Act (ACA). CMS recognizes that many states experienced challenges during the initial implementation of the requirements in the ACA. However, with support from CMS, many of the issues that arose during the time period of the OIG's audits have subsequently been resolved. Since the issuance of the eight state audits (with final reports being issued between May 2017 and March 2020), CMS has worked closely with the four states to ensure that the OIG's recommendations are implemented as appropriate. Currently, two states have fully implemented all of their recommendations, and another state has implemented over half of their recommendations. CMS will continue to monitor and work with the states until the remaining recommendations are implemented as appropriate.

States and CMS share responsibility for operating the Medicaid program, consistent with title XIX of Social Security Act (the Act), and ensuring its overall fiscal integrity. This federal-state partnership is central to the success of the Medicaid program, and CMS plans to continue its work with states to strengthen Medicaid program integrity efforts. As noted in the OIG's report, the Comprehensive Medicaid Integrity Plan,¹ released in June 2020, sets forth CMS's strategy to safeguard the integrity of the Medicaid program during federal fiscal years (FYs) 2019–2023. This 5-year plan includes new and enhanced Medicaid program integrity initiatives that build upon existing program integrity efforts.

¹ CMS, *Comprehensive Medicaid Integrity Plan for Fiscal Years 2019 – 2023*, Available at <https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf>

CMS has historically measured improper payment rates in states' beneficiary eligibility determinations through the Payment Error Rate Measurement (PERM) program. CMS also uses the Medicaid Eligibility Quality Control (MEQC) program to assist states in identifying vulnerable or error-prone areas. Statutory changes to Medicaid and CHIP brought about by the ACA required states to implement a new process for eligibility determinations, and required CMS to update the PERM and MEQC programs. As a result, for FYs 2015 through 2018, CMS did not conduct the eligibility measurement component of the PERM program or operate the MEQC program. A July 2017 final rule² implemented both policy and operational improvements to the PERM program that aimed to reduce state burden, improve program integrity, and promote state accountability. CMS completed the measurement of all states under the new eligibility component and established a baseline in 2021. Moving forward, CMS will be able to track improvement in compliance with eligibility requirements as each cycle of states is measured a second time. Further, to reduce redundancies between the MEQC and PERM programs, and ensure continuous oversight of state eligibility determinations, CMS restructured the MEQC program into an ongoing series of pilots that states are required to conduct during the two off-years between their triennial PERM. States have great flexibility in developing their MEQC pilots and may focus their reviews on state-specific vulnerabilities or error prone areas to identify the causes of erroneous determinations of eligibility. In addition, states are required to devote part of their MEQC pilots to reviews of improper denials or terminations, which are not addressed through PERM reviews. These reviews are intended to help ensure access to coverage for those beneficiaries who are eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage.

Through the PERM process, CMS identifies and classifies types of improper payments and shares this information with each state. States then analyze the findings to determine the root causes for payment errors, which is a necessary step in the development and implementation of effective state Corrective Action Plans (CAPs) to reduce improper payments. CMS works directly with states to help identify vulnerabilities and overcome barriers that prevent resolution of identified errors with the goal of eliminating repeat findings. CMS requires states to meet more stringent CAP requirements if they have consecutive PERM eligibility improper payment rates exceeding the three percent national standard per section 1903(u) of the Act. Under current regulations, CMS can also pursue disallowances for states exceeding the threshold that fail to demonstrate a good faith effort by satisfying PERM CAP and MEQC pilot requirements.

In addition to the PERM and MEQC programs, CMS began conducting eligibility audits in 2019 in several states, including some of those previously audited by OIG. CMS audits in New York,³ Kentucky,⁴ and Louisiana⁵ focused on whether beneficiaries were appropriately found eligible for the newly eligible adult group and whether services for those beneficiaries were reimbursed at the statutorily-authorized matching rate. The CMS audits also assessed how states have

² CMS, 82 *FR* 31158, Available at <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicare-program-and-childrens-health-insurance-program-chip-changes-to-the>

³ CMS, *New York Medicaid Eligibility Determinations for the Adult Expansion Population*, Available at <https://www.cms.gov/files/document/new-york-medicare-beneficiary-eligibility-review-report.pdf>

⁴ CMS, *Kentucky Medicaid Eligibility Determinations for the Adult Expansion Population*, Available at <https://www.cms.gov/files/document/kentucky-medicare-beneficiary-eligibility-review-report.pdf>

⁵ CMS, *Louisiana Medicaid Eligibility Determinations for the Adult Expansion Population*, Available at <https://www.cms.gov/files/document/louisiana-medicare-beneficiary-eligibility-review-report.pdf>

progressed in ensuring that the eligibility and enrollment systems accurately verify applicant information with appropriate data sources and in maintaining documentation to support eligibility determinations. For CMS' New York and Kentucky audits, when comparing CMS' review findings to the OIG's previous findings, CMS found that system defects identified by the OIG were corrected and all other errors identified by the OIG had been appropriately addressed by the states. In 2020, CMS began four additional audits in other states based on a risk analysis informed by issues noted during the review of State Plan Amendments (SPAs) for expansion approval, findings from the PERM and MEQC programs, and audits conducted by the OIG, the Government Accountability Office, or state auditors.

As noted in the OIG's report, the ACA brought about many changes that led to a significant increase in applications for Medicaid coverage. Starting in 2014, the ACA gave states the option to expand Medicaid coverage to adults age 19 or older and under the age of 65 with income at or below 133 percent of the federal poverty level (FPL), provided that the individual met certain non-financial eligibility criteria, such as citizenship or satisfactory immigration status. Some of the other key changes applicable to all states, regardless of a states' decision to expand Medicaid coverage, included requiring: the use of Modified Adjusted Gross Income (MAGI) methodologies for income determinations, a single streamlined application, an HHS-managed data services hub for access to federal verification sources, and applicant self-attestation of most eligibility elements. In March of 2012, CMS published a final rule⁶ that implemented several provisions of the ACA related to Medicaid eligibility, enrollment, and coordination with the Health Insurance Exchanges, CHIP, and other insurance affordability programs.

As OIG noted, determining whether individuals are eligible for Medicaid is a complex process. CMS knew that these changes would require time and expertise to implement, and as such provided significant technical assistance to states prior to, and immediately following, the effective date of the initial regulatory changes. Since the new requirements went into effect in 2014, CMS has continued to support states with direct one-on-one technical assistance, often through the review of verification plan and SPA submissions. CMS also provides training, technical advice, and guidance to states through Informational Bulletins, FAQs, Eligibility Technical Assistance Group calls, and Medicaid and CHIP Learning Collaborative webinars. Additional examples of the ongoing support CMS provides to states include:

- Leading Medicaid and CHIP Learning Collaborative projects that identify and share state best practices in program integrity;
- Providing one-on-one technical assistance to states regarding application processing, eligibility determinations, enrollment, retention, and verification policies;
- Working intensely with states when regulatory compliance issues are identified regarding eligibility, enrollment, verification, or renewal policies to diagnose root causes and then develop mitigation and/or corrective action plans; and
- Working closely with states to ensure eligibility and enrollment rules are appropriately incorporated into states' Medicaid and CHIP eligibility and enrollment systems, the Federally-Facilitated Exchange, and State-Based Exchanges.

⁶ CMS, *Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010*, Available at <https://www.federalregister.gov/documents/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010>.

In addition, in June 2019, CMS released an Informational Bulletin⁷ that reiterated and clarified the federal requirements for eligibility and enrollment processes. Specifically, the Informational Bulletin provided guidance on requirements related to eligibility and enrollment systems, including the system requirements necessary to ensure accurate eligibility determinations, processes to distinguish newly eligible adults from non-newly eligible adults, and capacities to conduct trend analysis for eligibility-related fraud, waste and abuse. CMS also noted that states are required to provide a training program for their Medicaid agency personnel, which should include continuing training opportunities that aim to improve the operation of their program. The Informational Bulletin further clarified that these trainings must include information on updates to eligibility requirements for any Medicaid eligibility group that is newly added or for whom the eligibility requirements have changed, so that staff can make accurate eligibility determinations and ensure the proper and efficient administration of the program. In December 2020, CMS released an Informational Bulletin⁸ reminding states of the federal requirements and expectations for making accurate and timely redeterminations of eligibility, both during regular periodic renewals and when the state agency receives information indicating a change in a beneficiary's circumstances that may impact eligibility. Finally, CMS has issued various guidance documents on preventing inappropriate terminations.⁹

In addition to providing technical assistance and guidance to states regarding the implementation of the requirements in the ACA, CMS also recognized that massive system transformations were needed in most states to accomplish these changes. As such, CMS provided states with enhanced FFP for the design and development of new or improved Medicaid Eligibility and Enrollment (E&E) systems that were needed to accommodate the new rules. CMS further recognized that states may have been phasing in system upgrades that implemented MAGI-based eligibility determinations first, with subsequent releases to include non-MAGI and/or other human services programs eligibility. The enhanced FFP for E&E systems was meant to ensure that states had the resources necessary to complete and maintain updated IT systems. CMS released guidance to states in March¹⁰ and June¹¹ of 2016 that provided guidelines for E&E system development requirements as well as step-by-step details regarding documentation needed to obtain enhanced funding approval.

Finally, it is also important to note that since the declaration of the Novel Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) in early 2020, states have needed to prioritize activities that respond directly to the PHE. Due to disruptions to state operations during the COVID-19 PHE, and the continuous enrollment requirement in the Families First Coronavirus

⁷ CMS, *Oversight of State Medicaid Claiming and Program Integrity Expectations*, Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf>

⁸ CMS, *Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements*, Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>

⁹ CMS, *Ensuring Continuity of Coverage and Preventing Inappropriate Terminations*, Available at <https://www.medicaid.gov/resources-for-states/mac-learning-collaboratives/expanding-coverage-under-medicaid-and-chip/index.html>

¹⁰ CMS, *Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding*, Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16004.pdf>

¹¹ CMS, *Mechanized Claims Processing and Information Retrieval Systems – APD Requirements*, Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16009.pdf>

Response Act (FFCRA), CMS also recognizes that states will be faced with a large number of eligibility and enrollment actions that will need to be completed once the PHE ends. CMS will continue to support states as they transition back to normal operations when the PHE ends and has released guidance in August 2021¹² outlining policy changes CMS made to better support states as they address the large volume of pending eligibility and enrollment actions.

CMS is committed to working with states to ensure the accuracy of Medicaid eligibility determinations, and appreciates the opportunity to comment on the OIG's report. OIG's recommendations and CMS' responses are below.

OIG Recommendation

Work with States to implement all of the recommendations made in OIG's prior audits.

CMS Response

CMS regularly provides the OIG updates on the status of recommendations and will continue to work with states to implement the remaining 15 recommendations. As noted above, CMS has worked closely with New York, California, Colorado, and Kentucky to ensure that the OIG's recommendations are implemented as appropriate. Currently, two states have fully implemented all of their recommendations, and another state has implemented over half of their recommendations. At this time, 50% of the recommendations from the prior OIG audits have already been implemented, which shows that CMS is committed to working with states to close out these recommendations as soon as possible. Additionally, as stated above, it is important to note that since the declaration of the COVID-19 PHE in early 2020, states have needed to prioritize activities that respond directly to the PHE.

Because Medicaid is jointly funded by states and the Federal Government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program, and work together closely to carry out these responsibilities. One of the roles that CMS plays in this federal-state partnership is to promote the fiscal integrity of the Medicaid program through the audit resolution process. As it relates to individual state audits, CMS's role includes resolving and monitoring the implementation of recommendations resulting from audits of Medicaid and CHIP. The audit resolution process also includes clearing the audit recommendations within six months of issuance of the final audit report, monitoring and verifying implementation of the audit recommendations, and initiating the disallowance process as necessary. CMS has well established and documented processes and procedures for working with state Medicaid agencies throughout the audit resolution process. CMS will continue to follow these standard operating procedures in working with states to implement the remaining 15 recommendations.

Given the work CMS has done, and will continue to do, with the states to close these recommendations, we request OIG remove this recommendation.

¹² CMS, *Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*, Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>

OIG Recommendation

Maintain its efforts to improve the integrity of the Medicaid program by continuing to provide training, technical advice, and guidance to States to address the causes identified in OIG’s prior audits in order to ensure that States:

- improve the accuracy of eligibility caseworkers who manually input case actions and verify eligibility requirements,
- improve their eligibility verification systems to properly verify all eligibility information in a timely manner, and
- develop additional policies and procedures to produce more accurate eligibility determinations and to resolve eligibility discrepancies in a timely manner

CMS Response

CMS concurs with this recommendation. CMS will continue its efforts to improve the integrity of the Medicaid program through the ongoing provision of technical assistance. As previously noted, CMS provides significant training, technical advice, and guidance to states through Informational Bulletins, FAQs, Eligibility Technical Assistance Group calls, and Medicaid and CHIP Learning Collaborative webinars. CMS also supports states with direct one-on-one technical assistance, often through the review of verification plans and SPA submissions. Through these ongoing activities, CMS has helped states address the issues identified in OIG’s prior audits. Further, CMS closely engages with eligibility systems vendors to continue to design and implement systems that have validation and quality checks built in to support the identification and reduction of errors made by eligibility workers. CMS will continue to partner with states, and as well as those in the private industry that support Federal programs, to continuously innovate and develop better ways to assist states in producing more accurate eligibility determinations and resolve discrepancies in a timely manner.

OIG Recommendation

Explore using or expanding the use of available remedies to prevent and reduce the amount of improper payments made on behalf of ineligible beneficiaries. As appropriate, this could include disallowance of the Federal share associated with eligibility errors or proposing changes to eligibility determination practices and rules.

CMS Response

CMS concurs with this recommendation. As noted above, CMS provides intensive technical assistance to states in the development and review of their verification plans, to ensure that verification practices are in accordance with regulations. As noted in the 2019 Information Bulletin, and described in regulation at 42 CFR 435.945(j), each state’s verification plan must be maintained in accordance with federal verification requirements and is required to be submitted to CMS upon request or when changes are made. CMS has provided states with a MAGI-based

verification plan template¹³ and detailed instructions¹⁴ on how each section of the template should be completed. As part of verification plan reviews, CMS discusses the states' verification policies, available options, implementation plan, and provides technical assistance to ensure the state is following all applicable federal requirements. Current CMS regulations do not require state's use of specific data sources to verify income. However, based on each state's unique circumstances, CMS strongly recommends states take up additional data sources where appropriate and provides technical assistance for states to do so. While CMS appreciates the OIG's suggestion of proposing changes to eligibility determination practices and rules, CMS must conduct an assessment of a state's verification plan in accordance with the current regulations. Dependent on those results, CMS will consider whether rulemaking to revise certain eligibility determination and documentation requirements to reduce errors associated with improper payments is appropriate.

Under current regulations, CMS can pursue disallowances under the PERM program for states that exceed the statutory threshold for eligibility-related improper payments and fail to demonstrate a good faith effort to meet that threshold by satisfying PERM CAP and MEQC pilot requirements. Pursuant to 42 CFR 431.1010, CMS may begin issuing disallowances under the PERM program in 2022. The 2022 date was established under the 2017 PERM regulation¹⁵ so that states would have an opportunity to demonstrate a good faith effort by the time they are measured for a second time under the revised PERM eligibility component methodology. As noted above, CMS will only pursue disallowances if a state did not demonstrate a good faith effort to meet the three percent threshold as required by Section 1903(u) of the Act. CMS does not have statutory authority to recoup overpayments for eligibility errors that are identified outside of the PERM program. Recouping for such errors outside of the PERM program would require a statutory change to Section 1903(u) of the Act.

¹³ CMS, *Verification Plan Template - Guidance and Instructions*, Available at <https://www.medicaid.gov/sites/default/files/2019-12/verification-plan-template.pdf>

¹⁴ CMS, *Verification Plan Template - Guidance and Instructions*, Available at <https://www.medicaid.gov/sites/default/files/2019-12/verification-plan-template-instructions.pdf>

¹⁵ CMS, *82 FR 31158*, Available at <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicaid-program-and-childrens-health-insurance-program-chip-changes-to-the>