

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Inspector General**

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A-02-15-01015**

Office of Inspector General

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Report in Brief

Date: January 2018

Report No. A-02-15-01015

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



Why OIG Did This Review

The Patient Protection and Affordable Care Act (ACA) gave States the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these newly eligible beneficiaries. As of January 1, 2017, New York was one of 31 States and the District of Columbia that had chosen to expand Medicaid to include the newly eligible beneficiaries.

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

How OIG Did This Review

We reviewed a stratified random sample of 130 newly eligible beneficiaries who received Medicaid-covered services during the period October 2014 through March 2015 (audit period). We reviewed supporting documentation to evaluate whether New York determined the applicants' eligibility in accordance with Federal and State requirements (e.g., met income, citizenship, and pregnancy requirements). We also reviewed New York's internal controls as well as the internal controls at New York's health insurance marketplace.

New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

What OIG Found

New York did not always determine Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State requirements. In our sample of 130 beneficiaries, New York correctly determined eligibility for 90 beneficiaries. However, it did not determine eligibility for 37 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that beneficiaries were newly eligible for the remaining 4 potentially ineligible beneficiaries. The total exceeds 130 because 1 beneficiary was found to be ineligible for one determination period and found to be potentially ineligible for another period. On the basis of our sample results, we estimated that New York made Federal Medicaid payments of \$26.2 million on behalf of 47,271 ineligible beneficiaries.

What OIG Recommends and New York's Comments

We recommend that New York (1) redetermine, as appropriate, the current Medicaid eligibility status of the sample beneficiaries and (2) improve the design of its enrollment system.

New York disagreed with our recommendations and some of our findings and provided additional documentation under separate cover to support its stance on the findings with which it disagreed. New York also requested that we revise some statements in our report and remove information related to our testing of potential changes in Medicaid requirements, which we initially reported as an audit finding. Based on our review of New York's comments and additional documentation, we revised some of our findings and are no longer reporting the information related to our testing of potential changes in Medicaid requirements as an audit finding with a related recommendation. We maintain that our remaining recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2010, Congress passed the Patient Protection and Affordable Care Act (P.L. No. 111-148) and the Health Care and Education Reconciliation Act (P.L. No. 111-152), collectively known as the Affordable Care Act (ACA). The ACA gave States the option to expand Medicaid coverage to 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

OBJECTIVE

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

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 Federal Poverty Level (FPL).

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures, called the FMAP, which is developed from criteria such as

¹ In this report, we refer to these low-income adults without dependent children who receive a higher FMAP as “newly eligible” beneficiaries. These beneficiaries are sometimes referred to as the “new adult group” or “group VIII beneficiaries” (based on the section of legislation that added the expansion eligibility category).

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 modifies its MEQC and PERM requirements to incorporate changes mandated by the ACA.⁶

Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act

The ACA requires the establishment in each State of a health insurance exchange (marketplace), which is designed to serve as a "one-stop shop" where individuals review their health insurance options and are evaluated for Medicaid eligibility.

Medicaid is the Nation's primary health insurance program for low-income individuals and families, providing coverage to approximately 68 million people as of August 2017. 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} As of January 1, 2017, 31 States and the District of Columbia had elected to expand Medicaid coverage. In States that elected to implement this option, individuals were newly eligible for Medicaid if they met, in addition to citizenship and State residency requirements, all of the following criteria:⁹

² Social Security Act (the Act) § 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 February 13, 2017.

⁴ 79 Fed. Reg. 3385 (Jan. 1, 2014).

⁵ The U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, "FY2015 Federal Medical Assistance Percentages." Accessed at <https://aspe.hhs.gov/pdf-report/fy2015-federal-medical-assistance-percentages> on February 13, 2017.

⁶ 81 Fed. Reg. 40596 (June 22, 2016).

⁷ ACA § 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" (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)). The decision allowed each State the option to refuse to expand its Medicaid program and not face any reduction in current Medicaid funding.

⁹ The Act § 1902(a)(10)(A)(i)(VIII).

- not younger than 19 or older than 64 years of age;
- not pregnant;
- not eligible for or enrolled in Medicare;
- not eligible for Medicaid through any category other than the new adult category;¹⁰
- not having an income exceeding 133 percent of the FPL;¹¹ and
- not living with a dependent, uninsured child.¹²

Individuals who are U.S. citizens or qualified aliens are eligible to receive welfare and public benefits, including Medicaid. However, a qualified alien is not eligible for full Medicaid benefits until 5 years from the date he or she enters the United States with qualified alien status, which is also known as the 5-year bar.¹³ Federal regulations restrict full Medicaid benefits for individuals who are not citizens or qualified aliens.^{14, 15} The State agency is required to verify citizenship status at the time of application. In New York, any discrepancy between an applicant’s attested citizenship status and the information verified by the State agency must be resolved within a 90-day period known as the inconsistency period. The beneficiary is conditionally enrolled in Medicaid during the inconsistency period.

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

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

¹² 42 CFR § 435.119(c).

¹³ Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

¹⁴ 8 USC § 1613(a).

¹⁵ Examples of a “qualified alien” include individuals who are lawfully permitted permanent residency, individuals granted asylum, refugees admitted to the United States, and individuals granted conditional entry.

The ACA § 2001 authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled through the new adult category.^{16, 17} This “newly eligible FMAP” was set to remain at 100 percent through 2016, gradually decreasing to 90 percent by 2020.¹⁸

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.¹⁹ In most cases, the ACA required States to use Modified Adjusted Gross Income (MAGI), a measure of income based on Internal Revenue Service (IRS) rules, to determine a person’s income.²⁰

New York’s Medicaid Eligibility Process

The State agency is responsible for operating New York’s Medicaid program and uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims. From October 1, 2014, through March 31, 2015 (audit period), the State agency made Medicaid payments totaling approximately \$531.7 million (Federal share) on behalf of 228,217 newly eligible Medicaid beneficiaries.

As of January 1, 2017, New York was 1 of 12 States that had established a State-based marketplace, which is known as New York State of Health. To verify eligibility, New York State of Health uses multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub). The data sources available through the Data Hub are provided by HHS, the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the IRS, among others. New York State of Health also used data sources maintained by

¹⁶ The Act § 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.”

¹⁷ Not all beneficiaries enrolled through the new adult 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 as of December 1, 2009, the standard FMAP applies because the State already covered those 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 February 13, 2017.

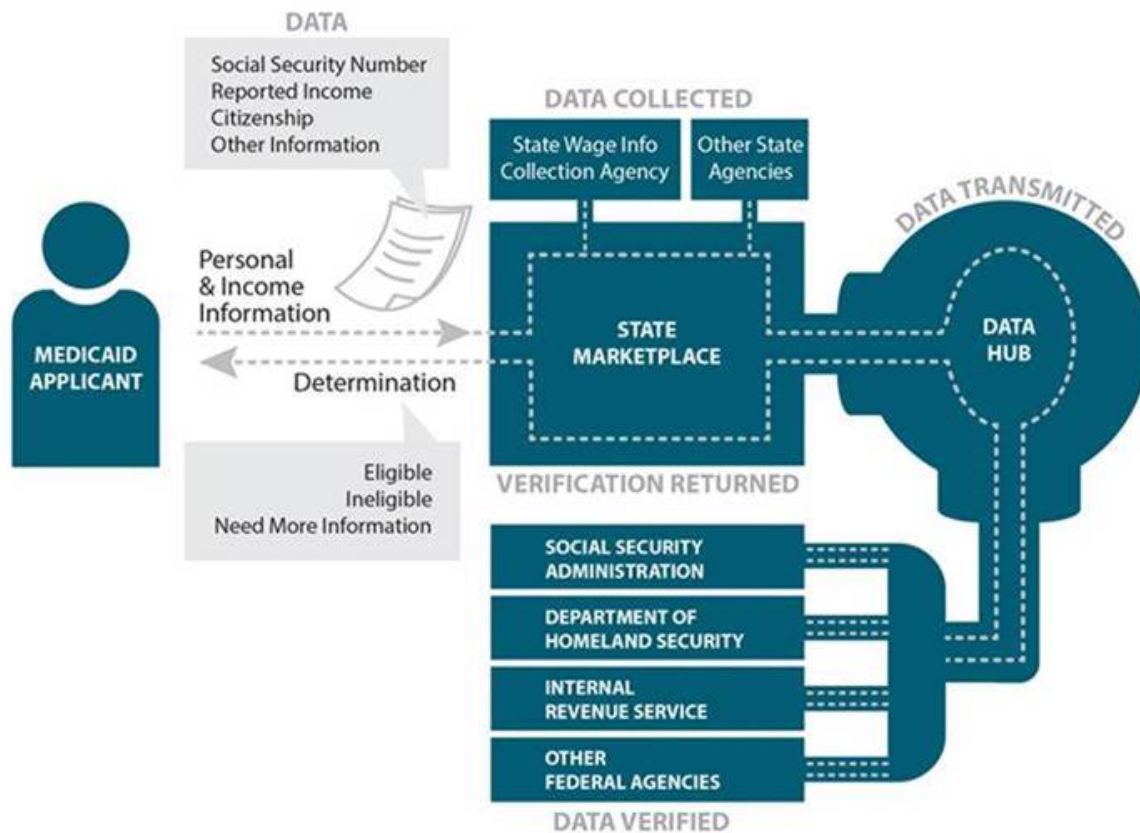
¹⁸ 42 CFR § 433.10(c)(6).

¹⁹ ACA § 1413(b).

²⁰ The Act §§ 1902(e)(14)(A)–(D); 26 USC § 36B(d)(2)(B). Certain categories of beneficiaries, such as seniors age 65 and older and medically needy individuals, are exempt from the use of this methodology.

New York, such as the State Wage Information Collection Agency (SWICA). (See the figure below.)

Figure: Medicaid Eligibility Process



HOW WE CONDUCTED THIS REVIEW

Our review covered newly eligible Medicaid beneficiaries who received services during the audit period, October 1, 2014, through March 31, 2015. We reviewed the Medicaid eligibility determinations made by the State agency’s local departments of social services and the New York marketplace for a stratified random sample of 130 beneficiaries. We also reviewed the internal controls in place at the State agency and at the New York marketplace.

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

Appendix A contains the details of our audit scope and methodology, Appendix 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 for newly eligible beneficiaries in accordance with Federal and State requirements. From our sample of 130 beneficiaries, the State agency correctly determined eligibility for 90 beneficiaries. However, it did not determine eligibility for 37 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that beneficiaries were newly eligible for the remaining 4 potentially ineligible beneficiaries.²¹

The State agency did not always meet Federal and State requirements when making eligibility determinations because of human or system errors related to new eligibility determination processes. In addition, the State agency did not always maintain applications or documentation to support eligibility determinations.

On the basis of our sample results, we estimated that the State agency made Federal Medicaid payments of \$26,221,803 on behalf of 47,271 ineligible beneficiaries.

NEW YORK DID NOT CORRECTLY DETERMINE MEDICAID ELIGIBILITY FOR SOME NEWLY ENROLLED BENEFICIARIES

New York Incorrectly Determined Beneficiaries' Eligibility Category Based on Income Requirements

Individuals who have household income at or below 133 percent of the FPL for the applicable family size may be eligible for Medicaid under the new adult group (42 CFR § 435.119(b)(5)). The ACA allows for a 5-percent income disregard, making the effective threshold 138 percent of the FPL (ACA § 1902). The State agency must verify financial information related to wages, net earnings from self-employment, unearned income, and resources from SWICA, IRS, SSA, and State unemployment insurance (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 compatible²² with electronic sources (42 CFR § 435.952(c)(2)).

For 28 of 130 sampled beneficiaries, the State agency incorrectly determined the beneficiaries to be newly eligible when the beneficiaries did not meet income requirements. Specifically:

²¹ Total exceeds 130 because 1 beneficiary was found to be both ineligible and potentially ineligible. This beneficiary had multiple Medicaid eligibility determinations during our audit period. However, for one of these determinations, there was insufficient documentation provided to verify that the beneficiary met newly eligible income requirements, and for another determination, the documentation provided indicated that the beneficiary became eligible under a different Medicaid eligibility group and was therefore not newly eligible.

²² New York's verification plan defines "reasonably compatible" as when both the attested to income and verification income are below or at the 138-percent FPL standard or when the verified income is above 138 percent of the FPL but within 10 percent of the beneficiary's attested income, which is at or below 138 percent of the FPL.

- For 20 beneficiaries, the State agency incorrectly determined beneficiaries to be newly eligible even though the beneficiaries' income determinations demonstrated that their household income amounts were below the allowed minimum threshold of 100 percent of the FPL. For example, one beneficiary attested to having an annual income of \$13,000 with a household size of two, which was then verified by data sources in 2014. However, the allowed minimum income threshold to be determined newly eligible is 100 percent of the FPL, which is \$15,730 for a household size of two. Therefore, this beneficiary's income was under the allowed minimum threshold of 100 percent of the FPL.
- For eight beneficiaries, the State agency incorrectly determined beneficiaries to be newly eligible even though the beneficiaries' income determinations demonstrated that their household income amounts were above the allowed maximum threshold of 138 percent of the FPL. For example, one beneficiary attested to having an annual income of approximately \$35,000 with a household size of one, which was then verified by data sources in 2014. However, the allowed maximum income threshold to be determined newly eligible is 138 percent of the FPL, which is \$16,105 for a household size of one. Therefore, this beneficiary's income was over the allowed maximum threshold of 138 percent of the FPL.

In addition, for five beneficiaries, the State agency incorrectly determined the beneficiaries' Medicaid eligibility category and did not determine the beneficiaries to be newly eligible when the beneficiaries' verified income determinations demonstrated that their household income amounts met requirements to be newly eligible.²³

New York Did Not Always Verify Whether Beneficiaries Were Eligible Under a Different Medicaid Eligibility Group

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

For 2 of 130 sampled beneficiaries, the State agency inappropriately determined beneficiaries to be newly eligible when they should have been enrolled under a different Medicaid eligibility group. Specifically, the beneficiaries' case files indicated that they were certified as disabled and were receiving Social Security disability benefits, which is a mandatory eligibility group.

²³ These beneficiaries should have been claimed by the State agency at a higher FMAP, and the discrepancies noted were reflected in our results of estimated payments on behalf of ineligible beneficiaries.

New York Did Not Always Verify Whether Beneficiaries Met Citizenship Requirements

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 citizenship 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 period to resolve a discrepancy (the Act § 1902(ee)) during which the beneficiary is presumed eligible. 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)).

For 1 of 130 sampled beneficiaries, the State agency identified a citizenship status discrepancy during the application process, but it did not terminate the beneficiary's Medicaid coverage when the beneficiary was unable to provide satisfactory documentation to resolve the discrepancy after the 90-day inconsistency period ended.²⁴

New York Did Not Always Verify Whether Beneficiaries Were Eligible Under the Pregnancy-Related Group

To be newly eligible under Medicaid, an individual must not be pregnant because there are other mandatory eligibility categories that include pregnant women. New York accepts an individual's self-attestation regarding her pregnancy status unless the State has information that is not consistent with information provided by the individual (42 CFR § 435.952). If, during the time between eligibility determinations, a woman becomes pregnant, she has the option of either staying enrolled as newly eligible or requesting that the State move her to a pregnancy-related eligibility group. However, if at the time of application or redetermination, she attests that she is pregnant or the State is aware of the pregnancy, she no longer meets the new eligibility requirements and must be enrolled in the pregnancy-related eligibility group.

For 1 of 130 sampled beneficiaries, the State agency incorrectly enrolled the beneficiary as being newly eligible and should have enrolled her in the pregnancy-related eligibility group.²⁵ Specifically, the State agency had documentation indicating it was aware of the pregnancy before the redetermination and incorrectly enrolled the beneficiary in the newly eligible category.

²⁴ If the State agency had terminated coverage at the end of the 90-day period, the beneficiary would not have received Medicaid services for the last 2 months of his eligibility period.

²⁵ The pregnancy-related eligibility group is reimbursed at a lower FMAP than the newly eligible category.

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

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 (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).

For 4 of 130 sampled beneficiaries, the State agency did not provide the necessary documentation to verify that beneficiaries were newly eligible. Specifically:

- For two beneficiaries, the State agency did not provide documentation indicating that any of the eligibility requirements were met.
- For one beneficiary, the State agency did not provide documentation that it had performed an income verification.
- For one beneficiary, the income verification information supplied through the Data Hub indicated that the beneficiary's attested income was not reasonably compatible with other data sources. The State agency did not provide additional documentation to support that the individual's attested income subsequently verified his newly eligible determination.

Without the necessary documentation, we could not determine whether the State agency enrolled potentially ineligible beneficiaries who did not meet the requirements to be considered newly eligible for Medicaid, resulting in potential improper Federal expenditures.

RECOMMENDATIONS

We recommend that the State agency:

- redetermine, as appropriate, the current Medicaid eligibility status of the sample beneficiaries who did not meet Federal and State eligibility requirements; and
- improve the design of its enrollment system to ensure that it maintains applications, verifies income and citizenship eligibility data, and determines eligibility by using available electronic data sources, as appropriate.

**OTHER MATTERS: INCOME DATA AVAILABLE SUBSEQUENT TO THE
ELIGIBILITY DETERMINATION IDENTIFIED BENEFICIARIES WHO MAY HAVE NO
LONGER QUALIFIED AS NEWLY ELIGIBLE FOR MEDICAID IN NEW YORK IF MORE
FREQUENT DETERMINATIONS WERE REQUIRED**

Under Federal law, States are required to make “point-in-time” eligibility determinations. That is, when making an eligibility determination, States must use information that is current and available at the time of the determination.²⁶ New York implemented continuous coverage for beneficiaries determined to be eligible for Medicaid based on income requirements.²⁷ Based on an annual determination, beneficiaries are eligible to receive Medicaid coverage for all of their 12-month authorization period. The State agency is not required to redetermine Medicaid eligibility before the end of this period unless it is notified of updated information that would affect the beneficiary’s eligibility status.²⁸

Although current law does not require the State agency to verify income more frequently than once every 12 months, we tested the effect of more frequent income verifications using income data that was available subsequent to the State agency’s eligibility determination.

We note that the State agency complied with Federal requirements for performing income verifications; however, we obtained income data applicable to our audit period that was available to the State agency subsequent to the eligibility determination.²⁹ We found that for 26 of 130 sampled beneficiaries, the State agency correctly determined the beneficiaries to be newly eligible at the time of their annual determination; however, income data available subsequent to that determination indicated that these beneficiaries may have no longer qualified to be newly eligible if more frequent determinations were required.³⁰ Specifically:

²⁶ This point-in-time principle is explicitly retained in the ACA as it relates to the application of the MAGI-based methodology. In accordance with this requirement, States must use an individual’s current monthly income in evaluating the eligibility of new applicants and either current monthly income or projected annual income for the remainder of the year for current beneficiaries.

²⁷ Section 366(4)(c) of the New York Social Services Law, and New York’s demonstration project (waiver) under section 1115 of the Act.

²⁸ Under the Medicaid eligibility rules, the State is not required to perform redeterminations more than once every 12 months. However, if the State is notified of a change in the status of a beneficiary that affects eligibility, it is required to redetermine eligibility for Medicaid before the 12-month authorization period expires.

²⁹ If available, we obtained quarterly SWICA data and Federal tax information (FTI) via the State marketplace or local districts.

³⁰ Before a State agency terminates eligibility or reduces benefits based on available electronic data for financial information, it must first request additional information from the beneficiary. We did not conduct this additional step; therefore, these beneficiaries may have had additional information that would have supported their eligibility.

- For 13 beneficiaries, income during our audit period was above the maximum effective income eligibility threshold (138 percent of the FPL) to be newly eligible. These beneficiaries were correctly determined to be newly eligible when they applied for Medicaid; however, income data for these beneficiaries that was applicable to our audit period and available subsequent to their eligibility determination may have made them no longer qualified to be newly eligible if more frequent determinations were required. For example, one beneficiary with an annual income of approximately \$14,000 was determined newly eligible in the previous redetermination. However, quarterly SWICA data from after that determination indicated that the beneficiary earned approximately \$35,000 during 2014 and approximately \$10,000 during the first quarter of 2015, thereby making her potentially no longer qualified to be newly eligible if more frequent determinations were required.
- For 13 beneficiaries, income during our audit period was below the minimum income eligibility threshold (100 percent of the FPL) to be newly eligible. These beneficiaries were correctly determined to be newly eligible when they applied for Medicaid; however, income data for these beneficiaries that was applicable to our audit period and available subsequent to their eligibility determination may have made them no longer qualified to be newly eligible if more frequent determinations were required. Nevertheless, their income levels may have still allowed them to be eligible for Medicaid under another eligibility group, albeit one with a lower FMAP reimbursement rate. For example, one beneficiary was determined newly eligible in the previous redetermination with an annual income of approximately \$12,500. After that determination, the beneficiary's 2014 FTI indicated that his annual income was less than the minimum threshold of 100 percent of the FPL (household income of \$11,670 for his associated family size) required to be newly eligible.

In conclusion, the State agency complied with Federal requirements for performing eligibility determinations. However, if the State agency were to perform more frequent income verifications, we estimate that it could reduce Federal Medicaid payments by as much as \$78,092,929 for 50,102 beneficiaries who may have no longer qualified as newly eligible for Medicaid in New York based on income data that was available to the State agency after its eligibility determination. Based on our method for testing, this would be the maximum amount the State would save; depending on the frequency of income verifications the State were to choose to perform, the potential cost savings could be less than the \$78,092,929 that was calculated based on our sample results.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our recommendations and described steps it has taken to ensure that its eligibility determinations comply with Federal and State requirements. The State agency also addressed each of our

findings and stated that it agreed in part with some of them and that it would take steps to correct the associated deficiencies. Under separate cover, the State agency provided additional documentation to support its stance on those findings with which it disagreed.

The State agency noted that the draft report contained information that was inaccurate or inconsistent with the objective of the audit and requested that we modify the report. Specifically, the State agency requested that we clarify our description of Federal regulations on verifying applicants' citizenship status to indicate that, if citizenship cannot be verified electronically, the State agency must conditionally enroll applicants in Medicaid (if the applicant is otherwise eligible) for 90 days and give applicants this reasonable opportunity period to resolve the inconsistency before determining them ineligible. The State agency also indicated that our testing of potential changes in Medicaid requirements was not related to our audit objective and that we applied criteria not in effect during the audit period. The State agency stated that our including this information in the audit report is not only inappropriate but also purposefully inflammatory; therefore, we should remove it.³¹ However, the State agency stated that if our intention was to suggest that prospective implementation of proposed changes to Medicaid requirements could result in further cost avoidances, we should make that clear. The State agency's comments appear in their entirety as Appendix D.

After reviewing the State agency's comments and the additional documentation provided, we revised our determinations for 10 beneficiaries identified in our draft report as ineligible based on income, citizenship, and pregnancy, and for 9 beneficiaries³² identified in our draft report as potentially ineligible because of insufficient documentation. However, 2 of the 10 ineligible beneficiaries for which we revised our determinations remained ineligible for other reasons, and 1 of the 9 potentially ineligible beneficiaries remained potentially ineligible for another reason. We revised our report and findings accordingly, but as discussed in detail below, we maintain that our recommendations related to these findings are valid. We also revised our description of Federal requirements for verifying applicants' citizenship status.

Regarding our testing of the effect of more frequent income verifications using income data that was available subsequent to an eligibility determination, we revised our report so that this information is no longer included as a finding and removed the related recommendation. Nevertheless, while our objective was to determine whether the State agency determined Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements, we maintain this testing was appropriate because it aligns with the Office of Inspector General's (OIG's) mission to promote economy and efficiency throughout HHS. Accordingly, we believe it is important to share this information with the State agency as

³¹ This information was included as a finding with a related recommendation in our draft report.

³² This includes two beneficiaries who, based on the additional documentation, we determined to be ineligible.

it illustrates the potential effect of more frequent income verifications and the potential cost savings to the Medicaid program.³³

NEW YORK INCORRECTLY DETERMINED BENEFICIARIES' ELIGIBILITY CATEGORY BASED ON INCOME REQUIREMENTS

State Agency Comments

The State agency disagreed with our determinations for 21 of the 30 beneficiaries identified in our draft report as incorrectly found to be newly eligible because they did not meet income requirements, but the State agency agreed with the remaining 9. Specifically, the State agency stated that it had correctly determined eligibility for 13 of the 18 beneficiaries we determined were ineligible because their household incomes were below 100 percent of the FPL. The State agency also disagreed with our determinations for 8 of the 12 beneficiaries whose household incomes were above 138 percent of the FPL. In addition, the State agency disagreed with our determination that five beneficiaries should have been determined newly eligible because their household incomes met newly eligible income requirements. The State agency contends it had correctly determined eligibility for these beneficiaries.

Although the State agency stated that it correctly determined eligibility for these beneficiaries, it acknowledged that some "claiming errors" may have occurred because of a defect in its enrollment system that applied an incorrect code, resulting in the processing of incorrect claiming adjustments. The State agency indicated that it remedied this defect in 2015 and stated that it is in the process of taking the necessary steps to ensure that claims for all accounts affected by the defect are correctly adjusted.

Office of Inspector General Response

We maintain that the 13 beneficiaries referenced in the State agency's comments do not qualify as newly eligible because their household incomes were below 100 percent of the FPL. However, we revised the total amount of improper Federal Medicaid payments made on behalf of one of these beneficiaries.

Additionally, based on our review of the State agency's comments and additional documentation, we revised our determinations for four beneficiaries identified in our draft report as not newly eligible because their household incomes exceeded 138 percent of the FPL. However, the additional documentation provided for one of these beneficiaries indicated that the beneficiary's household income was below 100 percent of the FPL. Therefore, we included the beneficiary in our count of ineligible beneficiaries whose household income was below

³³ This information may also be useful to policymakers in Congress considering implementing changes to Federal Medicaid requirements.

100 percent of the FPL.^{34, 35} We maintain that our determinations for the remaining four beneficiaries contested by the State agency in its comments are valid, as the associated beneficiaries' incomes were above 138 percent of the FPL.

Finally, we maintain that five beneficiaries should have been determined to be newly eligible based on the documentation provided by the State agency. Specifically, the verified income determinations for all five of these beneficiaries indicated that their household incomes met income requirements to be newly eligible.

NEW YORK DID NOT ALWAYS VERIFY WHETHER BENEFICIARIES MET CITIZENSHIP REQUIREMENTS

State Agency Comments

The State agency disagreed with our findings for six beneficiaries identified in our draft report as ineligible because they did not meet Federal citizenship requirements. Specifically, the State agency stated that it correctly determined that all six beneficiaries were newly eligible based on their verified status as a qualified alien or their attested citizenship/immigration status. The State agency explained that Federal law requires States to provide reasonable opportunity periods for an applicant to provide documentation to support their attested citizenship or immigration status and to conditionally cover the individual during these periods.

While the State agency stated it had correctly determined eligibility for all six beneficiaries, it acknowledged that it did not correctly claim reimbursement for one beneficiary. According to the State agency, this occurred because the "reasonable opportunity period" for the beneficiary to provide documentation of his attested citizenship status should have expired in September 2014, not November 2014.

Office of Inspector General Response

After reviewing the State agency's comments and additional documentation, we revised our determinations for five of the six beneficiaries. For the remaining beneficiary, we maintain that he failed to provide documentation to support his attested citizenship status before the reasonable opportunity period ended; therefore, the State agency should have terminated the beneficiary's Medicaid coverage. Nevertheless, we adjusted the total amount of improper Federal Medicaid payments made on behalf of this beneficiary based on the State agency's comments and additional documentation.

³⁴ For this beneficiary, the additional documentation submitted by the State agency in response to our draft report contained verified income that was different from what the State agency initially provided.

³⁵ We note that the revised total for the number of beneficiaries for whom the State agency incorrectly determined to be newly eligible when they did not meet income requirements reflects a change in our determination for this beneficiary and another beneficiary initially determined to be potentially ineligible. See the "Office of Inspector General Response" section on page 16.

NEW YORK DID NOT ALWAYS VERIFY WHETHER BENEFICIARIES WERE ELIGIBLE UNDER THE PREGNANCY-RELATED GROUP

State Agency Comments

The State agency disagreed with one of two determinations we made in our draft report regarding its enrolling pregnant beneficiaries as newly eligible instead of enrolling them in the pregnancy-related eligibility group. According to the State agency, there was no evidence in the beneficiary's application that she attested to being pregnant.

Office of Inspector General Response

After reviewing the State agency's comments, we revised our determination for this beneficiary and revised our report accordingly.³⁶

NEW YORK DID NOT ALWAYS VERIFY WHETHER BENEFICIARIES WERE ELIGIBLE UNDER A DIFFERENT MEDICAID ELIGIBILITY GROUP

State Agency Comments

The State agency did not agree that it inappropriately determined one beneficiary to be newly eligible when she should have been enrolled under a different Medicaid eligibility group. Specifically, the State agency provided documentation indicating that the individual attested to being disabled with an income of 124.39 percent of the FPL. Accordingly, the State agency contends that the individual was eligible for Medicaid under the MAGI category, not under the State's optional program for disabled individuals.

Office of Inspector General Response

We maintain that this beneficiary was not newly eligible because she was eligible under a different mandatory eligibility group. Specifically, the beneficiary was certified to be disabled and was receiving Social Security disability benefits, which prohibits enrollment in the newly eligible category.

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

State Agency Comments

The State agency generally disagreed with our determination that it did not provide sufficient documentation to verify that beneficiaries were newly eligible. Specifically, for the five

³⁶ The additional documentation provided by the State agency in response to our draft report contained a self-attestation from this beneficiary indicating she was not pregnant when she applied.

beneficiaries identified as lacking income verifications, the State agency said that such a verification was performed by the local district and that the beneficiaries' verified income was available in case records. In addition, the State agency disagreed with our eligibility determination for one of the two beneficiaries for whom income verification information supplied through the Data Hub indicated that the beneficiary's attested income was not reasonably compatible with other data sources. For this beneficiary, the State agency said there was no income verification requested because of a system defect. However, on the beneficiary's next determination, her attested income *was* compatible with data sources; therefore, income verification was not required. Finally, the State agency stated that the applications for two beneficiaries *did* contain immigration documentation to support the State agency's verification of their citizenship status.

The State agency also stated that it located documentation not previously provided for the three beneficiaries we determined to be potentially ineligible because documentation was not provided to support that any eligibility requirements were met.

Office of Inspector General Response

After reviewing the State agency's comments and additional documentation, we revised our determinations for nine of the potentially ineligible beneficiaries. Specifically, we accepted additional documentation to support that income verifications were performed (five beneficiaries), the verification of attested income (one beneficiary), citizenship requirements were met (two beneficiaries), and newly eligible requirements were met (one beneficiary). However, based on our review of the documentation, we determined that two of these nine beneficiaries were ineligible because they did not meet newly eligible requirements,³⁷ and that one of these two beneficiaries remains potentially ineligible for another reason (i.e., the documentation provided did not include evidence that an income verification had been performed).

We maintain that the State agency did not provide the necessary documentation to support that two beneficiaries met any eligibility requirements because the additional documentation provided did not include the verifications necessary to determine whether these beneficiaries were newly eligible.

³⁷ This includes one beneficiary whose household income was below the allowed minimum threshold of 100 percent of the FPL and one beneficiary who should have been enrolled under a different Medicaid eligibility group.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

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

We limited our review of internal controls to those applicable to our objective. Our testing of controls included a review of supporting documentation at the State agency to evaluate whether the State agency 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 eligible beneficiaries enrolled under the enhanced Medicaid coverage met the eligibility requirements described in the ACA.

We performed fieldwork from March through December 2016 at the State agency and the New York marketplace in Albany, New York, and local departments of social services throughout the State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility;
- obtained and reviewed New York's Verification Plan, which details how its marketplace meets all legal and operational requirements to execute marketplace activities;
- assessed internal controls by:
 - interviewing officials from the New York marketplace to obtain an understanding on how the New York marketplace (1) processes an applicant's information, (2) verifies an applicant's eligibility for enrollment in Medicaid, and (3) transmits enrollment data to the State agency;
 - holding discussions with State agency officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
 - performing a walk-through of the applicant information and determination of eligibility verification processes for enrollment in Medicaid; and

- determining how the system documents that the verification and determination of eligibility processes occurred;
- obtained a database of all Medicaid paid claims data in New York with service dates during the audit period (excluding claims for services provided to American Indians/Alaska Natives already covered by 100-percent FMAP);
- created a sampling frame of 228,217 Medicaid beneficiaries for which the State agency made Medicaid payments totaling \$561,656,265 (\$531,713,733 Federal share);
- selected a stratified random sample of 130 Medicaid beneficiaries receiving services in New York during the audit period;
- for each sample item, where possible, obtained application data and documentation to support the eligibility determination made for the services to determine:
 - the organization or agency that made the eligibility determination (i.e., New York marketplace or local department of social services);
 - whether the agency making eligibility determinations followed implemented procedures to verify eligibility documentation;
 - for all strata, whether beneficiaries determined to be newly eligible under provisions described in the ACA met Federal and State eligibility requirements, such as income level, residency, immigration status, and documentation of U.S. citizenship; and
 - for two strata, whether beneficiaries whose Medicaid eligibility categorization changed between the new adult eligibility group and another Medicaid eligibility group during the audit period were eligible for Medicaid based on their applicable categorization;
- where possible, obtained sufficient independent information to determine whether each beneficiary was newly eligible during the audit period;
- obtained for each beneficiary, where possible, income data (e.g., quarterly SWICA data and FTI) applicable to our audit period that was available to the State agency subsequent to its eligibility determinations and tested the effect of more frequent income verifications;
- estimated the total number of ineligible beneficiaries and beneficiaries who may have no longer qualified as newly eligible during our audit period;

- estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible beneficiaries and beneficiaries who may have no longer qualified as newly eligible during our audit period; 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 to be newly eligible for Medicaid under the ACA, excluding American Indians and Alaskan Natives,³⁸ for whom the State agency made Medicaid payments for services provided during the audit period.

SAMPLING FRAME

The sampling frame consisted of Access databases containing 228,217 newly eligible Medicaid beneficiaries under the ACA in New York who received services during the audit period. The State agency made Medicaid payments totaling \$561,656,265 (\$531,713,733 Federal share) for these beneficiaries. We obtained the data for the Medicaid beneficiaries from New York's Medicaid Management Information System. 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: beneficiaries who were categorized as solely being newly eligible for Medicaid with total payments of less than \$2,600—110,771 beneficiaries with payments totaling \$177,672,864 (\$177,255,384 Federal share).
- Stratum 2: beneficiaries who were categorized as solely being newly eligible for Medicaid with total payments greater than or equal to \$2,600—49,388 beneficiaries with payments totaling \$184,087,257 (\$183,474,024 Federal share).
- Stratum 3: beneficiaries whose Medicaid eligibility categorization changed between the new eligibility category and another Medicaid eligibility group during the period October 1, 2014, through March 31, 2015, with total payments of less than \$2,600—54,339 beneficiaries with payments totaling \$127,169,856 (\$108,887,821 Federal share).
- Stratum 4: beneficiaries whose Medicaid eligibility categorization changed between the new eligibility category and another Medicaid eligibility group during the period October 1, 2014, through March 31, 2015, with total payments of greater than or equal

³⁸ American Indians and Alaskan Natives are subject to different eligibility requirements and were not a part of this review.

to \$2,600—13,719 beneficiaries with payments totaling \$72,726,288 (\$62,096,504 Federal share).

SAMPLE SIZE

We selected a sample of 130 beneficiaries as follows:

- 40 beneficiaries from stratum 1,
- 30 beneficiaries from stratum 2,
- 30 beneficiaries from stratum 3, and
- 30 beneficiaries from stratum 4.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total number of any ineligible Medicaid beneficiaries and Medicaid beneficiaries who may have no longer qualified as newly eligible based on income data that was available subsequent to their eligibility determination but applicable to our audit period. We also estimated the total amount of Medicaid payments for any ineligible beneficiaries and Medicaid beneficiaries who may have no longer qualified as newly eligible based on income data that was available subsequent to the eligibility determination but applicable to our audit period and for which the State agency claimed reimbursement. We used this software to calculate the lower and upper limits of the 90-percent confidence intervals associated with these estimates.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Detail and Results for Ineligible Beneficiaries³⁹

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	110,771	\$177,255,384	40	\$65,547	5	\$3,970
2	49,388	183,474,024	30	162,992	1	676
3	54,339	108,887,821	30	58,551	13	6,646
4	13,719	62,096,504	30	109,545	18	4,544
Totals	228,217	\$531,713,733	130	\$396,635	37	\$15,836

Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	110,771	\$177,255,384	40	\$65,547	1	\$421
2	49,388	183,474,024	30	162,992	0	0
3	54,339	108,887,821	30	58,551	0	0
4	13,719	62,096,504	30	109,545	3	6,852
Totals	228,217	\$531,713,733	130	\$396,635	4	\$7,273

³⁹ The values included in this appendix are Federal share amounts of the payments associated with the beneficiaries.

Table 3: Sample Detail and Results for Beneficiaries Who May Have No Longer Qualified as Newly Eligible Based on Income Data Available Subsequent to Eligibility Determinations

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Beneficiaries Who May Have No Longer Qualified as Newly Eligible Based on Subsequent Income Data	Value of Payments for Beneficiaries Who May Have No Longer Qualified as Newly Eligible Based on Subsequent Income Data
1	110,771	\$177,255,384	40	\$65,547	10	\$9,672
2	49,388	183,474,024	30	162,992	7	24,004
3	54,339	108,887,821	30	58,551	5	2,802
4	13,719	62,096,504	30	109,545	4	14,688
Totals	228,217	\$531,713,733	130	\$396,635	26	\$51,166

ESTIMATES

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

	Total Number of Ineligible Beneficiaries	Total Value of Payments Associated With Ineligible Beneficiaries
Point estimate	47,271	\$26,221,803
Lower limit	34,148	11,640,159
Upper limit	60,394	40,803,447

Table 5: Estimated Number of Beneficiaries Who May Have No Longer Qualified as Newly Eligible Based on Income Data Available Subsequent to Eligibility Determinations and Value of Associated Payments
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Beneficiaries Who May Have No Longer Qualified as Newly Eligible Based on Subsequent Income Data	Total Value of Payments Associated With Beneficiaries Who May Have No Longer Qualified as Newly Eligible Based on Subsequent Income Data
Point estimate	50,102	\$78,092,929
Lower limit	34,594	38,667,572
Upper limit	65,610	117,518,287

APPENDIX D: STATE AGENCY COMMENTS



ANDREW M. CUOMO
Governor

Department
of Health

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

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

July 14, 2017

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

Ref. No: A-02-15-01015

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-15-01015 entitled, "New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
Dennis Rosen
Erin Ives
James Dematteo
James Cataldo
Brian Kiernan
Elizabeth Misa
Geza Hrazdina
Jeffrey Hammond
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**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-15-01015 entitled
“New York Did Not Correctly Determine Medicaid Eligibility for Some
Newly Enrolled Beneficiaries”**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-15-01015 entitled, "New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries."

Background:

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to \$8,305 in 2015, consistent with levels from a decade ago.

General Comments:

The Department acknowledges that the Federal and State eligibility requirements governing New York State's Medicaid program are voluminous and complex. That is the principal reason why it provided OIG with ample access to a subject matter expert (SME) when field work began. The SME was readily available to OIG to answer policy and system questions, as well as discuss individual cases. However, OIG staff did not utilize this valuable resource. The Department raised concerns at a conference call on November 22, 2016 after OIG first shared a preliminary list of documentation/verification that they believed was missing. In many cases, the information had been made available to OIG. However, the information was disregarded or overlooked by the reviewers. Based on the high number of incorrect eligibility findings in the draft report, it appears that OIG is continuing to ignore or misinterpret the requirements and policies that apply to New York State's Medicaid program despite the policy and system clarifications provided by the Department at various times in November and December 2016.

Separate from this response, the Department will work with OIG to securely identify the individual cases and claims the Department disagrees with and to provide supporting documentation with notations highlighting the critical information that was disregarded. The Department will also arrange for OIG to independently re-review case-specific information, specifically federal tax information (FTI), if needed.

The following comments address specific statements or sections of the report. The Department requests that the findings, report and tables be appropriately modified to address the information provided herein and separately.

- **Page 3, last paragraph:** The following statements are not accurate.

The State agency is required to verify citizenship status of all applicants before authorizing enrollment for Medicaid. In New York, any discrepancy between an applicant's attested citizenship status and the information verified by the State agency must be resolved within a 90-day period known as the inconsistency period.

Federal regulations (42 CFR 435.956) require states to verify citizenship status using Social Security Administration data at application. However, if citizenship cannot be verified electronically, states must enroll applicants in Medicaid, if otherwise eligible, for 90 days, and give the applicants this reasonable opportunity period to resolve the inconsistency before determining them ineligible. It is not true that citizenship must be verified prior to granting enrollment in Medicaid.

- **Page 6, last paragraph:** The test OIG did regarding potential changes in Medicaid requirements is inconsistent with the objective of the audit, which is clearly stated on page 1 and indicates that the purpose was "to determine whether the Department (State agency) determined Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements. The test criteria applied by OIG does not reflect actual Federal and State eligibility requirements in effect during the audit period," therefore, this paragraph, as well as the last section that begins on page 10 and continues through page 12, the third recommendation on page 12, and the corresponding Tables in Appendix C ought to be removed from the report.

If OIG continues to present its test information in any manner (e.g., outside the report), it's recommended that it correct the wording used in the draft report. The footnote (22) used in this paragraph is incomplete because it fails to mention that New York State received Federal approval that supersedes the requirement that is stated. New York State law, SSL 366(4)(c), requires that Modified Adjusted Gross Income (MAGI) Medicaid enrollees receive 12 months of continuous Medicaid eligibility regardless of changes in income during the year. The implementation of State law was approved by the federal government in a 1115 waiver. The Department has no discretion to end coverage for changes in income before the 12-month continuous authorization period ends.

Additionally, the last two sentences are incorrect. The following edits are necessary to make them accurate:

For 26 of the 76 beneficiaries for whom the State agency correctly determined eligibility at the time they applied, we determined, after reviewing income information covering our audit period, that the beneficiaries may not have remained ~~been~~ newly eligible if the State agency had been required to conduct more frequent income verifications. Based on our sample results for this specific step, we estimated that the State agency made Federal Medicaid payments of \$78,092,929 on behalf of 50,102 beneficiaries who may have been determined ineligible if different Medicaid requirements were changed to require regarding more frequent income verifications were required of the State agency during the audit period.

- **Page 7, section entitled, *New York Incorrectly Determined Beneficiaries' Eligibility Based on Income Requirements*, first bullet:** The Department does not agree with 13 of OIG's 18 eligibility determination findings in this section. Eligibility was correctly determined and the appropriate aid code was assigned for 13 cases.

The Department agrees with OIG's eligibility determination findings in five cases. In all five cases, the district worker assigned the wrong category code for various reasons, which resulted in the individual incorrectly appearing as if their income was above 100 percent of the Federal Poverty

Level (FPL). The appropriate districts were notified of the errors so that retraining could be conducted.

The Department agrees that some claiming errors may have occurred for eight cases in this section even though eligibility was correctly determined based on verified income. The correct aid code was assigned by the system when the reviewed determination was made. The system also assigned the correct, but different, aid code at the subsequent administrative renewal or redetermination when income changed. However, the subsequent aid code was incorrectly applied by the system retroactive to the prior eligibility period, which resulted in some incorrect claiming adjustments being processed. This system defect was remediated on April 11, 2015. The Department is in the process of taking the necessary steps to ensure that the claims for all accounts impacted by this defect are correctly adjusted.

- **Page 7, section entitled, *New York Incorrectly Determined Beneficiaries' Eligibility Based on Income Requirements*, second bullet:** The Department does not agree with 8 of OIG's 12 eligibility determination findings in this section. Eligibility was correctly determined and the appropriate aid code was assigned for 8 cases.

The Department agrees with OIG's eligibility determination findings in four cases. In one case, the district worker incorrectly disregarded Social Security retirement benefits as Supplemental Security Income. In another case, the income section of the renewal application was left blank and the district failed to follow-up. In the third case, income was over 138 percent of the FPL for the January to March 2015 period, but it was under the allowable threshold for October to December 2014 period. The appropriate districts were notified of these errors so that retraining could be conducted.

In the remaining case, a NY State of Health consumer was correctly determined eligible for Medicaid based on verified income below 138 percent of the FPL, but coverage for March 2015 was incorrectly claimed since the period of continuous coverage based on the verified income below 138 percent of the FPL should have ended after 12 months. When the consumer's household size changed and her FPL increased to above 138 percent, the consumer was correctly determined eligible for continuous Medicaid. However, the system did not timely identify the account for renewal and the consumer incorrectly received continuous Medicaid beyond the 12th month. The account was forced into a manual renewal and with the subsequent renewal redetermination, the consumer was correctly determined eligible for Medicaid based on verified income between 100 -138 percent of the FPL. System programming corrective actions were implemented prior to the audit to avoid similar future occurrences. Currently, the system identifies all accounts that are due for renewal, and any that have not been picked up in the annual or monthly renewal cycle are systematically issued a renewal notice and advised to update their account so their eligibility can be redetermined timely.

The Department also agrees that some claiming errors may have occurred for three cases in this section even though eligibility was correctly determined based on verified income. In these three cases, the correct aid code was assigned by the system when the reviewed determination was made. The system also assigned the correct, but different, aid code at the subsequent administrative renewal or redetermination when income changed. However, the subsequent aid code was incorrectly applied by the system retroactive to the prior eligibility period, which resulted in some incorrect claiming adjustments being processed during the audit period. This system defect was remediated on April 11, 2015. The Department is in the process of taking the necessary steps to ensure that the claims for all accounts impacted by this defect are correctly adjusted.

- **Page 8, section entitled, *New York Incorrectly Determined Beneficiaries' Eligibility Based on Income Requirements*, first paragraph:** The Department does not agree with

OIG's eligibility findings for the five cases identified in this section. All cases were correctly determined eligible based on verified income between 100-138 percent of the FPL.

However, the Department agrees that some claiming errors may have occurred for these cases. In four cases, the correct aid code was assigned by the system when the reviewed determination was made. The system also assigned the correct, but different, aid code at the subsequent administrative renewal when income changed. However, the subsequent aid code was incorrectly applied retroactive to the prior eligibility period, which resulted in some incorrect claiming adjustments being processed. This system defect was remediated on April 11, 2015. The Department is in the process of taking the necessary steps to ensure that the claims for all accounts impacted by this defect are correctly adjusted.

In the fifth case, an incorrect aid code of 90 was assigned by the system for some of the service dates. This resulted in incorrect claiming for October 2014 only. This system defect was remediated on July 29, 2016. The account and claiming has been corrected.

- **Page 8, section entitled, *New York Enrolled Beneficiaries Who Did Not Meet Citizenship Requirements*, first bullet:** The Department does not agree with OIG's eligibility findings for the six cases identified in this section. All six consumers were correctly determined to be newly eligible and qualified for Federal Financial Participation (FFP) based on either their attested citizenship/immigration status during the reasonable opportunity period mandated by federal law, or based on their verified status as qualified aliens who are eligible for FFP.

New York is required by federal law to provide coverage to someone who has verified their income at the Medicaid level and who attests to having the appropriate citizenship/immigration status. Moreover, New York is currently required to provide multiple reasonable opportunity periods per federal regulations and guidance from the Centers for Medicare and Medicaid Services (CMS). Pursuant to federal law, FFP is available for coverage provided during a person's reasonable opportunity period(s). During this period, a State/Federal charge code is not assigned; the code is assigned only when the individual is determined fully eligible.

The Department does agree that one case was not correctly claimed. This occurred because the verification clock expired in November 2014 instead of September 2014.

- **Page 9, section entitled, *New York Enrolled Pregnant Beneficiaries*:** The Department disagrees with one of OIG's eligibility findings and agrees with the other. For the NY State of Health case, there is no evidence in the application that the consumer attested to being pregnant; therefore, she was correctly determined eligible in the adult group and assigned the appropriate aid code.

In the other case, the local district incorrectly assigned a category code in the adult group when documentation showed the consumer was pregnant. This was caused by worker error. The appropriate district was notified of the error so that retraining could be conducted.

- **Page 9, section entitled, *New York Enrolled a Beneficiary Who Was Eligible Under a Different Medicaid Eligibility Group*:** The Department does not agree that it inappropriately determined one beneficiary to be newly eligible when she should have been enrolled under a different Medicaid eligibility group. The individual attested to being disabled with income at 124.39 percent of the FPL. She correctly received a MAGI eligibility determination and coverage as she was fully eligible for Medicaid under the MAGI category. She would not be fully eligible under the State's optional Medically Needy program for

disabled individuals. The individual would only be referred for a non-MAGI determination under the Medically Needy category of assistance if she was determined income ineligible. CMS approved enhanced reimbursement for disabled individuals in the MAGI category with incomes above 100 percent of the FPL (newly eligible). This determination was based on the State's 2009 Medically Needy income level that was converted to MAGI for disabled individuals (which resulted in a gross amount that is lower than 100 percent of the FPL).

- **Page 10, section entitled, *New York Did Not Provide Documentation to Verify That Beneficiaries Were Newly Eligible*, first bullet:** The Department does not agree with OIG's eligibility findings in this section. For all five cases identified, income verification was performed by the local district and the verified income was available in the case record made available to OIG.

Four of the five cases were redetermined eligible at renewal and, per 08 OHIP/ADM-4, districts can allow attestation of income and residence at renewal unless the recipient seeks coverage for long term care. The Administrative Directive (ADM) also states if there is no Resource File Integration (RFI) hit for the recipient, they remain Medicaid eligible based on attested income.

- **Page 10, section entitled, *New York Did Not Provide Documentation to Verify That Beneficiaries Were Newly Eligible*, second bullet:** The Department located the supporting documentation that was not previously provided by the district in its electronic imaging system, and will forward a copy to OIG. It appears that applications for the incorrect periods were previously sent to OIG in December 2016. If OIG had raised this issue with the Department prior to June 2017, this could have been rectified before the report was drafted.
- **Page 10, section entitled, *New York Did Not Provide Documentation to Verify That Beneficiaries Were Newly Eligible*, third bullet:** The Department disagrees with one of OIG's eligibility findings and agrees with the other. One consumer was required to submit income documentation and the verified income was available in the NY State of Health application. The consumer was correctly determined eligible based on the verified income documentation. However, this case was impacted by the system defect previously described in several places in this response. This defect was remediated on April 11, 2015 and the Department is in the process of taking the necessary steps to ensure that the claims are correctly adjusted.

For the other case, income verification was not requested due to a system defect, which was remediated on September 2, 2015. On the consumer's next determination, the attested income was compatible with the data sources so income verification was not required.

- **Page 10, section entitled, *New York Did Not Provide Documentation to Verify That Beneficiaries Were Newly Eligible*, fourth bullet:** The Department does not agree with OIG's eligibility findings in this section. In both cases, the consumers attested to being immigrant non-citizens. Based on the available immigration documentation in the NY State of Health application, one consumer's lawful presence was established, and the other was identified as Permanently Residing in the United States Under Color of Law and the correct State/Federal charge code was assigned.
- **Pages 10 and 11, section entitled, *New York Determined Beneficiaries to be Newly Eligible Who Would Have Been Ineligible Based on Subsequent Income Data***

As stated earlier, OIG's test is inconsistent with the stated objective of the audit, which was "to determine whether the Department (State agency) determined Medicaid eligibility for newly eligible

beneficiaries in accordance with Federal and State eligibility requirements. Therefore, this entire section and other related sections, such as the Tables in Appendix C, need to be deleted from the report.

Inclusion of this section in the audit report by OIG is not only inappropriate, but it is purposefully inflammatory. As written, it erroneously implies that the State may be non-compliant for these 26 cases even though the actual Federal and State eligibility requirements regarding frequency of verifications and continuous coverage were appropriately followed. At no point during the audit period was New York required to adhere to the approach that OIG tested. Furthermore, the approach that OIG tested was not an allowable option for New York during the audit period because of the continuous coverage requirement. Therefore, it is improper to characterize the 26 beneficiaries as ineligible or potentially ineligible, and the payments as inappropriate or potentially inappropriate. These facts were discussed at length with OIG staff at the exit conference held on December 13, 2016, but they appear to have been intentionally ignored when the report was drafted. Thus, statements like the ones below are not only false, but their inclusion in the report suggest a calculated attempt to be intentionally misleading and inflammatory:

For 26 of 130 sampled beneficiaries, the State agency correctly determined the beneficiaries to be newly eligible at the time of their annual determination; however, these beneficiaries may have been subsequently ineligible based on their income during our audit period.

...thereby making them potentially ineligible for Medicaid based on income requirements.

The State agency has access to quarterly SWICA data and, although not required to, could have performed more frequent income verifications to prevent potentially inappropriate expenditures.

The New York marketplace has access to Federal tax information and, although not required to, could have performed more frequent income verifications to prevent potentially inappropriate FMAP expenditures.

If OIG's intention was to suggest that prospective implementation of their proposal could result in a future cost avoidance, that should be made more clear when it is presented in the correct manner (i.e., outside this report). OIG should also take steps to ensure that any saving estimates that it advances includes an evaluation of the beneficiaries that could move into the newly eligible group category due to more frequent income verifications, as well as the increased administrative and programming costs that will be incurred. Both factors will likely offset a large portion of the potential cost-savings OIG believes it has identified.

Moreover, continuous coverage was adopted by the Legislature to reduce churning on and off coverage due to small fluctuations in income, thereby improving continuity of care and health outcomes for enrollees. The elimination of paperwork barriers to continuous coverage and improved access creates cost savings to the program not captured by OIG.

Recommendation #1:

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

Response #1

The Department does not agree with this recommendation. More than two years have passed since the last coverage month reviewed by OIG, which means that all the beneficiaries reviewed by OIG

have had their eligibility redetermined at least twice since that time if they are still enrolled. Steps have been taken to retrain staff, as appropriate, or system modifications have been made to limit future occurrences. In addition, the Department will take steps to correct the claiming deficiencies that it agrees exist.

Recommendation #2:

Improve the design of its enrollment system to ensure that it maintains applications, verifies income and citizenship eligibility data, and determines eligibility by using available electronic data sources, as appropriate.

Response #2

The Department does not agree with this recommendation. The Department is continuously monitoring its eligibility and enrollment system via various quality assurance activities and, as needed, takes steps to make improvements to ensure that it is operating effectively.

Recommendation #3:

Consider working with lawmakers in New York to require income verifications be performed more frequently than once per 12 months to determine eligibility for Medicaid.

Response #3

The Department does not agree with this recommendation. Additionally, as explained in the previous section, it does not belong in an audit report.