Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA MADE MEDICAID PAYMENTS ON BEHALF OF NEWLY ELIGIBLE BENEFICIARIES WHO DID NOT MEET FEDERAL AND STATE REQUIREMENTS

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Office of Inspector General

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Report in Brief
Date: February 2018
Report No. A-09-16-02023

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

California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements

Why OIG Did This Review

The Patient Protection and Affordable Care Act gave States the option to expand Medicaid coverage to low-income adults without dependent children. It also mandated changes to Medicaid eligibility rules and established a higher Federal reimbursement rate for services provided to these beneficiaries, which led us to review whether States were correctly determining eligibility for these newly eligible beneficiaries. (States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services.) California was one of 31 States, along with the District of Columbia, that chose to expand Medicaid coverage.

Our objective was to determine whether California made Medicaid payments on behalf of newly eligible beneficiaries who did not meet Federal and State eligibility requirements.

How OIG Did This Review

We reviewed a stratified random sample of 150 newly eligible beneficiaries for whom Medicaid payments were made for services provided from October 2014 through March 2015. We reviewed supporting documentation to determine whether California made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the newly eligible group or other coverage groups (e.g., income, citizenship, and pregnancy requirements).

What OIG Found

For our sample of 150 beneficiaries, California made Medicaid payments on behalf of 112 eligible beneficiaries. However, for the remaining 38 beneficiaries, California made payments on behalf of ineligible beneficiaries (e.g., a woman who did not meet eligibility requirements for the newly eligible group because she was pregnant) and potentially ineligible beneficiaries (e.g., a beneficiary who may not have met the residency requirement). On the basis of our sample results, we estimated that California made Medicaid payments of $738.2 million ($628.8 million Federal share) on behalf of 366,078 ineligible beneficiaries and $416.5 million ($402.4 million Federal share) on behalf of 79,055 potentially ineligible beneficiaries. (These estimates represent Medicaid payments for fee-for-service, managed-care, the drug treatment program, and mental health services.) These deficiencies occurred because California's eligibility determination systems lacked the necessary system functionality and eligibility caseworkers made errors.

We also identified a weakness in California's procedures related to determining eligibility of individuals who may not have intended to apply for Medicaid.

What OIG Recommends and California Comments

We recommend that California (1) redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries; (2) ensure its eligibility determination systems have the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements; and (3) develop and implement written policies and procedures, as appropriate. The "Recommendations" section in the body of the report lists in detail our recommendations.

California disagreed with our specific recommendation related to beneficiaries who may not have met the residency requirement. After reviewing information that California provided, we maintain that our recommendation is valid. California should have sent the beneficiary in our sample the required residency confirmation letter or taken action to verify residency when California identified that the beneficiary may have been receiving public assistance in another State. California agreed with our remaining recommendations and provided information on actions that it had taken or planned to take to address those recommendations.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91602023.asp.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2010 Congress passed the Patient Protection and Affordable Care Act (ACA).[1] Generally, the 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 beneficiaries.[2] The ACA also included changes to Medicaid eligibility rules, such as requiring that income be calculated on the basis of Modified Adjusted Gross Income (MAGI)[3] and that income be at or below 133 percent of the Federal Poverty Level (FPL) for newly eligible beneficiaries. These changes led us to review whether States were correctly determining eligibility for newly eligible beneficiaries. If these beneficiaries' eligibility had been incorrectly determined, payments made on their behalf would have been reimbursed at a higher Federal reimbursement rate than they should have been or should not have been reimbursed at all.

This review is part of an ongoing series of Office of Inspector General (OIG) reviews of newly eligible beneficiaries. We selected California to ensure that our reviews cover States in different parts of the country.[4]

OBJECTIVE

Our objective was to determine whether California's Department of Health Care Services (State agency) made Medicaid payments on behalf of newly eligible beneficiaries who did not meet 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, States must 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.

[1] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

[2] In this report, we refer to these low-income adults for whom the States receive a higher Federal reimbursement rate as "newly eligible beneficiaries" or "the new adult group."

[3] Social Security Act (the Act) §§ 1902(e)(14)(A)–(D); 26 U.S.C. § 36B(d)(2)(B). This methodology to determine a person's income is based on Internal Revenue Service (IRS) rules.

[4] Previous OIG reports covered Kentucky and New York: *Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (A-04-15-08044), issued May 10, 2017, and *New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (A-02-15-01015), issued January 5, 2018.

citizenship. For many eligibility groups, income is calculated in relation to a percentage of the FPL.

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures, called the Federal medical assistance percentage (FMAP), which is developed from criteria such as the State's per capita income.[5, 6] The standard FMAP varies by State and generally ranges from 50 to 75 percent.[7, 8]

CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs, which are designed to reduce improper payments. In July 2017, CMS modified its MEQC and PERM requirements to incorporate changes mandated by the ACA.[9]

Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act

Before implementation of the ACA, most State Medicaid programs did not cover certain groups of individuals (e.g., childless, low-income individuals from the ages of 19 to 64). The ACA expanded Medicaid coverage to these groups of individuals (i.e., newly eligible beneficiaries). Medicaid provided coverage to approximately 69 million people in 2015.[10]

Medicaid Coverage Before Implementation of the Affordable Care Act

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These mandatory coverage groups included low-income parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly. A State had the option, under its State plan, to provide coverage to other groups (i.e., optional coverage groups), such as individuals presumed to be eligible before the State had made a formal determination (the presumptive eligibility coverage

[5] The Act § 1905(b).

[6] CMS, "Financing & Reimbursement." Accessed at https://www.medicaid.gov/medicaid/financing-and-reimbursement/ on January 23, 2017.

[7] 79 Fed. Reg. 3385, 3387 (Jan. 21, 2014).

[8] Office of the Assistant Secretary for Planning and Evaluation, "FY2015 Federal Medical Assistance Percentages." Accessed at https://aspe.hhs.gov/basic-report/fy2015-federal-medical-assistance-percentages on April 11, 2017.

[9] 82 Fed. Reg. 31158 (July 5, 2017).

[10] CMS, "2015 CMS Statistics," p. 15. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf on January 19, 2017.

group). We refer to these mandatory and optional groups that are not part of the new adult group as "other coverage groups."

Medicaid Coverage After Implementation of the Affordable Care Act

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.[11, 12] In States that elected to implement this option, individuals were eligible for Medicaid in the new adult group 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 the FPL),[13] in addition to meeting citizenship and State residency requirements.[14]

Section 2001 of the ACA authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group.[15, 16] This "newly eligible FMAP" was set to remain at 100 percent through 2016, gradually decreasing to 90 percent by 2020.[17]

The ACA required States to make a number of changes to their Medicaid application and enrollment processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual's eligibility for all potential health coverage options, including Medicaid, the Children's Health Insurance Program (CHIP), and

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[11] ACA § 2001(a)(1)(C).

[12] 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 States the option to refuse to expand their Medicaid programs and not face any reduction in current Medicaid funding.

[13] 42 CFR § 435.119(b)(5). The Act established the FPL threshold at 133 percent but allows for a 5-percent income disregard, making the effective threshold 138 percent of the FPL (§ 1902).

[14] The Act § 1902(a)(10)(A)(i)(VIII).

[15] The Act 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 . . ." (§ 1905(y)(2)(A)).

[16] Not all beneficiaries enrolled in the new adult group are eligible for the higher FMAP. For beneficiaries in the new adult group who would have been eligible for Medicaid benefits in their State under an existing group as of December 1, 2009, the standard FMAP applies because the State already covered those beneficiaries. 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 January 19, 2017.

[17] 42 CFR § 433.10(c)(6).

qualified health plans available through the health insurance marketplaces.[18] In most cases, the ACA required States to use MAGI, a measure of income that is based on IRS rules, to determine an individual's income.[19]

As of January 1, 2017, 31 States (including California) and the District of Columbia had elected to expand Medicaid coverage.[20]

Medicaid Eligibility Verification Requirements

The ACA required the establishment in each State of a health insurance exchange (marketplace). A marketplace serves as a "one-stop shop" where individuals review their health insurance options and are evaluated for Medicaid eligibility.[21] An individual may begin the Medicaid enrollment process through the State marketplace and submit a single, streamlined enrollment application by providing basic personal information, such as name, birth date, and Social Security number.

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.[22] States must verify individuals' eligibility information, such as citizenship or lawful presence, and entitlement to or enrollment in Medicare, through electronic sources.[23] States may accept an individual's attestation for certain information, such as a beneficiary's pregnancy status and household composition (e.g., household size and family relationships), without further verification.[24]

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[18] ACA § 1413(b).

[19] The Act §§ 1902(e)(14)(A)–(D); 26 U.S.C. § 36B(d)(2)(B). The use of MAGI to determine Medicaid eligibility does not apply to certain groups of beneficiaries, such as seniors who are 65 years of age or older and medically needy individuals.

[20] Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision." Accessed at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ on January 19, 2017.

[21] As of January 1, 2017, 12 States, including California, were operating a State-based marketplace (State marketplace). Kaiser Family Foundation, "State Health Insurance Marketplace Types: 2017." Accessed at http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ on January 23, 2017.

[22] The Act §§ 1137(a) and (b); 42 CFR § 435.945(j).

[23] 42 CFR §§ 435.945(a) and (b) and 435.949.

[24] 42 CFR §§ 435.945(a) and 435.956.

California's Process for Determining Medicaid Eligibility

In California, the State agency administers the Medicaid program, known as Medi-Cal. The State agency is responsible for making Medicaid eligibility determinations. An individual may apply for Medicaid in various ways, such as through the Covered California (California's State marketplace) website[25] or in person at a county office.

The State Agency's Income and Eligibility Verification Systems

To determine Medicaid eligibility, the State agency uses the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)[26] and Statewide Automated Welfare Systems (SAWS). CalHEERS is used to verify information provided by applicants and determine their eligibility on the basis of MAGI. SAWS is used to verify information and determine eligibility on the basis of criteria other than MAGI, such as age. SAWS is also used for case management after an eligibility determination is made.

The processes for determining eligibility for applicants who apply through the Covered California website and through a county are as follows:

- When an individual applies through the Covered California website, CalHEERS determines whether the applicant is eligible for Medicaid. If the applicant is determined eligible, his or her case information is sent to SAWS for case management. If CalHEERS cannot verify the applicant's information to determine eligibility on the basis of his or her MAGI, it sends the information to SAWS for manual review[27] or for a determination of eligibility on the basis of criteria other than MAGI (also known as a referral).

- When an individual applies through a county, e.g., in person at a county office or on the county website, or if SAWS receives a referral from CalHEERS, the eligibility caseworkers use SAWS to determine the applicant's eligibility. SAWS interfaces with CalHEERS to verify the applicant's information through electronic data sources available through the Federal Data Services Hub (Data Hub).[28] If CalHEERS does not verify the applicant's information electronically, the county eligibility workers perform manual review.

[25] The CoveredCA.com website is a joint partnership between Covered California and the State agency.

[26] CalHEERS is an online platform that uses a single, streamlined application to determine eligibility for Medicaid and Covered California's qualified health plans and insurance affordability programs under the ACA. It is cosponsored by Covered California and the State agency.

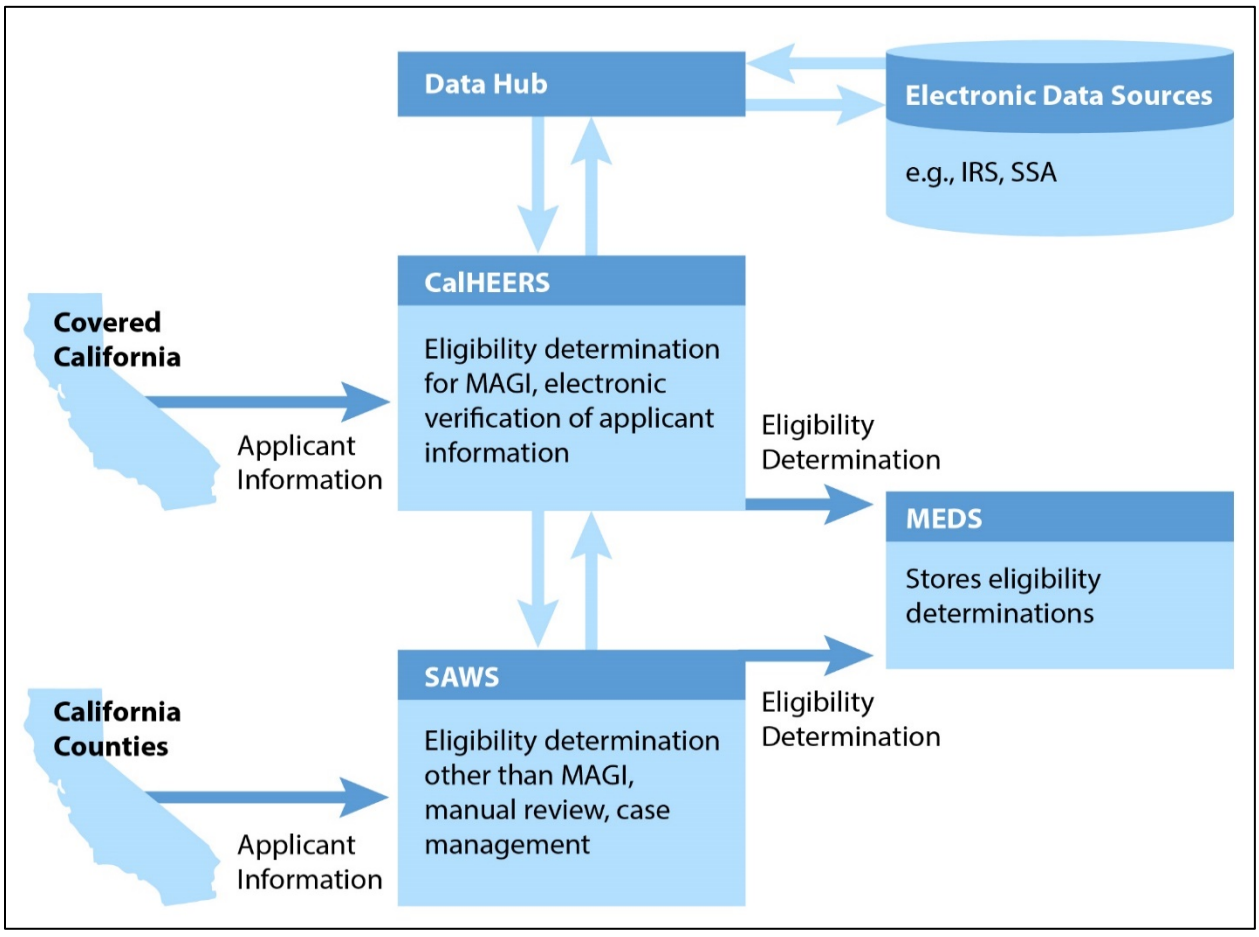
[27] Manual review is the process in which an eligibility caseworker checks other information sources available to the State, such as an applicant's file for other public assistance programs, or requests information or documentation from the applicant, if needed, to verify the applicant's information.

[28] ACA § 1411(c). The Data Hub is a single conduit that sends electronic data to and receives electronic data from multiple Federal agencies; it does not store data. Federal agencies connected to the Data Hub include the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the IRS.

The State agency can determine a beneficiary eligible for Medicaid under different coverage groups during a period of time. For example, a beneficiary can be determined eligible for Medicaid under the new adult group during one month and then under another coverage group during the next month. After determining an applicant eligible for Medicaid, CalHEERS or SAWS sends eligibility determination information to the Medi-Cal Eligibility Data System (MEDS), which is the State agency's system for storing eligibility determination information for Medicaid beneficiaries.

Figure 1 illustrates California's eligibility determination process, the systems involved, and the data exchanges between them.

Figure 1: California's Eligibility Determination Process and Data Exchanges



The State Agency's Use of Aid Codes for the New Adult and Other Coverage Groups and Federal Reimbursement

The eligibility determination information in MEDS includes aid codes. An aid code identifies, for a beneficiary, the coverage group and the scope of benefits within a coverage group (i.e., full-

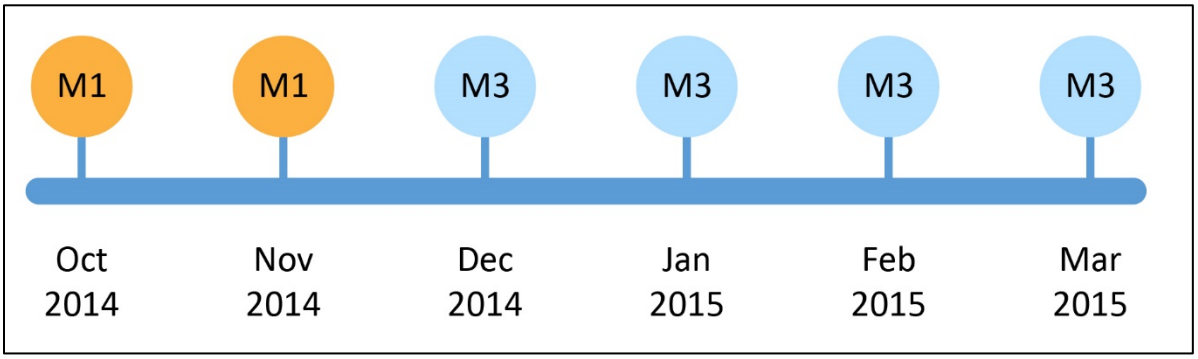
scope or restricted-scope services[29]). Generally, the aid code also determines the FMAP. For example, the aid code M1 is assigned to beneficiaries under the new adult group who are eligible for full-scope services. The State agency is reimbursed at an FMAP of 100 percent for services provided to these beneficiaries. The aid code P3 is assigned to beneficiaries under the presumptive eligibility coverage group (i.e., beneficiaries who are presumed eligible for Medicaid before a formal determination has been made). The State agency is reimbursed at an FMAP of 50 percent for services provided to these beneficiaries. Figure 2 provides examples of aid codes under the new adult and other coverage groups and their respective FMAPs.

Figure 2: Examples of Aid Codes for the New Adult and Other Coverage Groups and the Respective Federal Medical Assistance Percentages

New Adult Group			Other Coverage Groups		
Aid Code	**Scope of Benefits**	**FMAP**	**Aid Code**	**Coverage Group**	**FMAP**
M1	Full-Scope	100%	M3	Parent or Other Caretaker Relative	50%
M2	Restricted-Scope (e.g., Emergency and Pregnancy Services)	100%	P3	Presumptive Eligibility	50%

Aid codes are generally assigned to each month for which the beneficiary is eligible. As a result, a beneficiary can have more than one aid code during a given period. Figure 3 shows an example of a beneficiary who was newly eligible under the new adult group in October 2014 and then eligible for coverage under the parent or other relative caretaker group beginning in December 2014.

Figure 3: Example of a Beneficiary's Aid Codes by Month



[29] The State agency defines full-scope services as those covering the full range of health care benefits. California provides a set of core benefits, including doctor visits, prescription drugs, and hospital and nursing home care. The State agency defines restricted-scope services as emergency or pregnancy-related services.

HOW WE CONDUCTED THIS REVIEW

Our review covered 1,886,854 newly eligible beneficiaries in California for whom Medicaid payments were made for services provided from October 1, 2014, through March 31, 2015 (audit period), and reported on Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) for this period. These beneficiaries may have been determined newly eligible for only part of the audit period. We reviewed all payments made on behalf of these newly eligible beneficiaries throughout the audit period regardless of their coverage groups (i.e., the new adult group or other coverage groups). We obtained payment data from four payment systems that the State agency used to report expenditures on Form CMS-64.[30]

We reviewed a stratified random sample of 150 newly eligible beneficiaries:

- For 90 beneficiaries, the State agency made payments associated with only the new adult group. During our audit period, these beneficiaries had payments with only one aid code—M1 or M2 (for full-scope or restricted-scope services, respectively).

- For 60 beneficiaries, the State agency made payments associated with the new adult and other coverage groups. During our audit period, these beneficiaries had payments under the new adult group for at least 1 month in addition to payments under other coverage groups (e.g., the presumptive eligibility coverage group).

For all 150 sampled beneficiaries, we reviewed supporting documentation (e.g., verification records and SAWS case file information) to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the new adult or other coverage groups. For beneficiaries we determined ineligible for the aid code associated with the payments made on their behalf (i.e., the original aid code), we reviewed supporting documentation to determine whether they met eligibility requirements for other coverage groups (i.e., the revised aid code).[31]

We limited our review of internal controls to those applicable to our objective.

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.

[30] The four payment systems processed payments for fee-for-service claims, managed-care plans, the Drug Medi-Cal Treatment Program, and mental health services.

[31] If the FMAPs of the original and revised aid codes differed, we used the difference of the Federal shares in our estimate of the Federal share amount related to ineligible beneficiaries.

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

FINDINGS

The State agency made Medicaid payments on behalf of newly eligible beneficiaries who did not meet or may not have met Federal and State eligibility requirements. For our sample of 150 beneficiaries, the State agency made payments on behalf of 112 eligible beneficiaries. However, for the remaining 38 beneficiaries, the State agency made payments on behalf of 27 ineligible beneficiaries (e.g., a woman who did not meet requirements for the new adult group because she was pregnant) and 14 potentially ineligible beneficiaries (e.g., a beneficiary who may not have met the residency requirement).[32]

On the basis of our sample results, we estimated that the State agency made Medicaid payments of $738,180,945 ($628,838,417 Federal share) on behalf of 366,078 ineligible beneficiaries and $416,520,734 ($402,358,529 Federal share) on behalf of 79,055 potentially ineligible beneficiaries.[33, 34]

These deficiencies occurred because (1) the State agency's income and eligibility verification systems lacked system functionality (e.g., the capability to discontinue Medicaid for an ineligible beneficiary after a previous determination had already been made on the basis of the beneficiary's MAGI) and (2) eligibility caseworkers made errors. The State agency could not explain the causes for some deficiencies (e.g., the reason why the State agency made payments on behalf of one sampled beneficiary whose presumptive eligibility period had ended).

Further, we identified a weakness in the State agency's procedures related to determining eligibility for individuals who may not have intended to apply for Medicaid. Although Federal requirements do not prohibit a State from determining a nonapplicant eligible for Medicaid, the State agency's procedures may pose a risk that individuals are determined eligible for Medicaid without their knowledge.

[32] The total is higher than 38 because 3 of the beneficiaries had payments associated with coverage groups for which they were ineligible and potentially ineligible. Therefore, we included these beneficiaries in both groups.

[33] Because of the nature of the sampling process, it is possible that the actual Medicaid payment amounts and associated Federal shares, as well as the numbers of ineligible and potentially ineligible beneficiaries, are higher or lower than reported here. The confidence intervals reported in Appendix C provide a measure of this imprecision.

[34] These estimates represent Medicaid payments for fee-for-service claims, managed-care plans, the drug treatment program, and mental health services (as noted in footnote 30). If we determined that a beneficiary was eligible under a different aid code (as noted in footnote 31), we accounted for the difference of the Federal shares in our estimate.

THE STATE AGENCY MADE MEDICAID PAYMENTS ON BEHALF OF NEWLY ELIGIBLE BENEFICIARIES WHO DID NOT MEET ELIGIBILITY REQUIREMENTS

The State agency made Medicaid payments on behalf of 27 sampled beneficiaries[35] who did not meet Federal and State eligibility requirements under the new adult group or other coverage groups or both. The State agency should not have claimed Federal reimbursement for these beneficiaries or should have claimed Federal reimbursement at an FMAP for a different coverage group.

Payments Were Made on Behalf of Beneficiaries Who Were Not Eligible for the New Adult Group

In addition to meeting citizenship and State residency requirements, to be eligible for the new adult group, an individual must:

- have a household income at or below 138 percent of the FPL;[36]
- be from 19 to 64 years of age;
- not be eligible for any other mandatory coverage group, such as a parent or other caretaker relative of dependent children, or not be an individual under the age of 26 who was formerly a child in foster care;[37]
- not be pregnant; and
- not be entitled to or enrolled for Medicare benefits under Parts A or B of Title XVIII of the Act (42 CFR § 435.119(b)).

In addition, a State must require that an applicant, as a condition of eligibility for Medicaid benefits, furnish a Social Security number, if available, and a written declaration that he or she is a citizen or lawfully present (i.e., an application subject to the penalty of perjury) (the Act §§ 1137(a)(1) and (d)(1)).

[35] Two of the twenty-seven beneficiaries had ineligible payments under both the new adult and other coverage groups.

[36] 42 CFR § 435.119(b)(5). The Act established the FPL threshold at 133 percent but allows for a 5-percent income disregard, making the effective threshold 138 percent of the FPL (§ 1902).

[37] Section 1902(a)(10)(A)(i) of the Act lists the other Medicaid eligibility groups for which beneficiaries in the new adult group may not be eligible (subclauses I through VII and IX).

The State agency made Medicaid payments on behalf of 24 sampled beneficiaries who did not meet eligibility requirements for the new adult group:

- Twelve beneficiaries had incomes above 138 percent of the FPL. For example, on July 7, 2014, one beneficiary in the new adult group reported a change in income that was above the FPL threshold. Although the State agency electronically verified that this income was above the threshold, it did not determine that the beneficiary was ineligible for the new adult group and continued to make payments on behalf of this beneficiary during the audit period. Neither CalHEERS nor SAWS had the functionality to discontinue Medicaid for an ineligible beneficiary after a previous determination had already been made on the basis of the beneficiary's MAGI.[38]

- Seven beneficiaries were eligible for one of the other mandatory coverage groups. For example, a beneficiary who was under the age of 26 and formerly a child in foster care was improperly determined to be eligible for the new adult group. The State agency should have determined the beneficiary eligible for Medicaid under the mandatory coverage group for children formerly in foster care; however, CalHEERS lacked the system functionality to properly process cases for beneficiaries who formerly belonged to a foster-care youth program.

- Two beneficiaries were pregnant. For example, for one of the beneficiaries who attested to being pregnant on her Medicaid application, an eligibility caseworker did not input that she was pregnant into SAWS or CalHEERS. The State agency should have determined the beneficiary eligible for Medicaid under a different coverage group.

- Two beneficiaries were entitled to or enrolled in Medicare. CalHEERS was programmed to accept a beneficiary's attestation that he or she was not enrolled in Medicare or the absence of an attestation as meeting the eligibility requirement (i.e., not being entitled to or enrolled in Medicare). CalHEERS did not use data from SSA to verify whether a beneficiary was entitled to or enrolled in Medicare as required.[39]

- One beneficiary did not provide a Social Security number and a declaration of citizenship or lawful presence status. The beneficiary did not submit a Medicaid application. A State agency official stated that the eligibility determination was "inadvertently manually entered into the MEDS" but did not explain why the error occurred.

[38] According to the State agency's Medi-Cal Eligibility Division Information Letters 15-19 and 15-23 (Aug. 3, 2015, and Aug. 10, 2015, respectively), this system functionality to discontinue Medicaid coverage (or to deny a Medicaid application) was implemented on July 27, 2015. We did not verify the effectiveness of this functionality because it was outside the scope of our review.

[39] According to CalHEERS Release Notes 16.7, additional system functionality was implemented on August 1, 2016, to address some of these limitations. We did not verify the effectiveness of the implemented functionality because it was outside the scope of our review.

Payments Were Made on Behalf of Beneficiaries Who Were Not Eligible for Other Coverage Groups

The State agency made Medicaid payments under other coverage groups for five sampled beneficiaries who were not eligible for those groups.[40]

Two Beneficiaries Did Not Meet Eligibility Requirements for Coverage as a Child

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 Jan. 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 Jan. 1, 2014)).

The State agency made payments on behalf of two sampled beneficiaries who did not meet the eligibility requirements for coverage as a child. In one example, a beneficiary was determined eligible for coverage as a child before he was 19 years old; however, after the beneficiary turned 19, he continued to have coverage as a child. According to the State agency, SAWS, which was responsible for case management, may have had a system issue that prevented it from receiving the beneficiary's case information.

One Beneficiary's Presumptive Eligibility Period Had Ended

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 Jan. 1, 2014)).

The State agency made payments on behalf of one sampled beneficiary whose presumptive eligibility period had ended. On December 10, 2014, the beneficiary was determined eligible for the presumptive eligibility group, which covers full-scope services. On February 20, 2015, the beneficiary's presumptive eligibility ended when the State agency determined that the beneficiary was eligible for only restricted-scope services under Medicaid. However, the State agency made two payments for services provided on February 26, 2015, under the presumptive eligibility coverage group. The State agency did not explain the reason for these two payments.

[40] We reviewed Medicaid payments under other coverage groups because the State agency also made Medicaid payments on behalf of these beneficiaries under the new adult group for other months during our audit period.

One Beneficiary Did Not Meet Eligibility Requirements for the Parent or Other Relative Caretaker Group

The State agency must provide Medicaid 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 Jan. 1, 2014)).

The State agency made payments on behalf of one sampled beneficiary who did not meet eligibility requirements for the parent or other relative caretaker coverage group. Specifically, the beneficiary's household income was above 109 percent of the FPL when her eligibility was redetermined[41] on July 8, 2014. However, the eligibility caseworker incorrectly inputted an income amount below the 109-percent FPL threshold when redetermining eligibility.[42]

One Beneficiary Was Incorrectly Determined Eligible for a Medically Needy Group

The State agency provides Medicaid coverage to medically needy individuals, including individuals under the age of 21, who are eligible because their income and resources are within limits established by the State plan (42 CFR § 435.308 and State plan attachment 2.2-A (effective June 1, 2010)). The State agency must maintain individual records on each applicant and beneficiary, including information on income and eligibility verification, and facts essential to determination of initial and continuing eligibility (42 CFR § 431.17 and State plan § 4.7 (effective Oct. 1, 1975)).

The State agency made payments on behalf of one sampled beneficiary who was incorrectly determined eligible for a medically needy coverage group. The beneficiary had an aid code of M1 (i.e., new adult group with an FMAP of 100 percent) in MEDS for October 2014 through January 2015; however, the aid code was changed to aid code 34 (i.e., a medically needy group with an FMAP of 50 percent) for February and March 2015. The State agency informed us that the beneficiary was eligible for the new adult group for the entire audit period and that an eligibility caseworker may have inadvertently sent the medically needy eligibility determination to MEDS.[43] The State agency did not explain why the beneficiary was determined eligible under a medically needy coverage group.

[41] Medicaid eligibility redeterminations are required at least every 12 months or when the State agency receives information about anticipated changes in a beneficiary's circumstances that may affect eligibility (42 CFR § 435.916).

[42] We also identified another sampled beneficiary for whom an eligibility caseworker did not correctly input the income amount. However, we determined that the State agency's eligibility determination was correct because the beneficiary's income was under the income threshold.

[43] After reviewing documentation provided by the State agency, we determined that the beneficiary was eligible for the new adult group. We included the Federal share associated with this sample beneficiary as an underpayment (i.e., a negative amount) in determining the total estimated Federal share amount for ineligible beneficiaries.

THE STATE AGENCY MADE MEDICAID PAYMENTS ON BEHALF OF NEWLY ELIGIBLE BENEFICIARIES WHO MAY NOT HAVE MET ELIGIBILITY REQUIREMENTS

The State agency made Medicaid payments on behalf of 14 sampled beneficiaries who may not have met Federal and State eligibility requirements under the new adult group or other coverage groups or both. The State agency may have claimed Federal reimbursement for these beneficiaries when it should not have.

Payments Were Made on Behalf of Beneficiaries Whose Eligibility Was Not Verified in Accordance With Federal and State Requirements

States must verify individuals' eligibility for Medicaid in accordance with 42 CFR §§ 435.948–435.956 (42 CFR § 435.945). In addition, a State agency must maintain individual records on each applicant and beneficiary, including information on income and eligibility verification, and facts essential to determination of initial and continuing eligibility (42 CFR § 431.17 and State plan § 4.7 (effective Oct. 1, 1975)).

The State agency made Medicaid payments on behalf of seven sampled beneficiaries without verifying all of their eligibility requirements.[44] Specifically, the supporting documentation did not show that all of their eligibility requirements had been verified. For example, one beneficiary's verification records showed that none of the eligibility requirements for the new adult group (e.g., citizenship) had been verified. In addition, the State agency did not explain why the seven beneficiaries were determined eligible without having all eligibility requirements verified. Because these beneficiaries' eligibility was not verified in accordance with Federal and State requirements, we could not conclusively determine whether the beneficiaries were eligible for the new adult or other coverage groups.

Payments Were Made on Behalf of Beneficiaries Who Had Not Been in the United States for 5 Years but Were Determined Eligible for Full-Scope Medicaid Services

Generally, a lawful permanent resident is ineligible for full-scope Medicaid services[45] until 5 years from the date he or she enters the United States with qualifying status (8 U.S.C. § 1613(a)). Medicaid eligibility for lawful permanent residents who are subject to the 5-year bar is limited to emergency and pregnancy-related services only (42 CFR § 435.406(a)(2)(ii)).

[44] For four other sampled beneficiaries, we identified that the State agency did not verify income or lawful presence until after the eligibility determination had been made. In addition, for one other sampled beneficiary, the State agency did not maintain income verification documentation. However, after reviewing other supporting documentation, we determined that the State agency's eligibility determinations for these five beneficiaries were correct or the beneficiaries were reported as being ineligible for the new adult group for other reasons.

[45] The State agency refers to full-scope services as those covering the full range of health care benefits provided by California, including doctor visits, prescription drugs, and hospital and nursing home care.

The State agency made payments on behalf of six sampled beneficiaries[46] who had not been in the United States for 5 years but were determined eligible for full-scope Medicaid services under the new adult group. These beneficiaries were actually eligible for only emergency and pregnancy-related services. For example, one beneficiary became a U.S. resident on April 19, 2012, according to his lawful permanent resident card. However, he received full-scope services during the audit period (October 2014 to March 2015) even though he had not met the 5-year-bar requirement.

State agency officials stated that California allowed immigrants who did not meet the 5-year-bar requirement to enroll in the new adult group and receive full-scope Medicaid services. After enrolling them in this group, the State agency would retroactively adjust claims each quarter to avoid claiming nonemergency and non-pregnancy-related services for these beneficiaries. As a result, these full-scope services would be fully funded by the State.

However, we determined that the State agency may not have adjusted these claims correctly. For example, after reviewing managed-care payment data, we determined that four of the six sampled beneficiaries would not have been included in the claim adjustment because the data indicated that the individuals were not subject to the adjustment. Further, the State agency did not provide any policies or procedures to support its adjustment methodology. In addition, CalHEERS did not have the system functionality to retrieve and use information from the Department of Homeland Security to determine whether a beneficiary had met the 5-year-bar requirement to be eligible to receive full-scope Medicaid services.[47]

Payments Were Made on Behalf of a Beneficiary Who May Not Have Met the Residency Requirement

To be eligible for Medicaid, an individual must be a resident of the State in which the benefit is received (42 CFR §§ 435.403(a) and (m)).

States are required to conduct data matching through the Public Assistance Reporting Information System (PARIS) to verify whether Medicaid applicants are receiving duplicate public assistance benefits in two or more States (the Act § 1903(r)(3) and 42 CFR § 435.945(d)). In California, if a beneficiary is identified through the PARIS data match, a letter is sent to the beneficiary asking for information on the beneficiary's residence. If the beneficiary does not respond or indicates he or she lives in a different State, the beneficiary is discontinued from the Medicaid program (California's verification plan). The verification plan indicated that California conducts PARIS matches every quarter.

[46] Two other beneficiaries did not meet the 5-year-bar requirement; however, their incomes were also above the 138-percent FPL threshold. Therefore, we reported these beneficiaries as ineligible.

[47] According to CalHEERS Release Notes 15.3 and 16.7, functionality to retrieve data related to the 5-year bar was implemented on March 1, 2015; however, the functionality to use the data was not implemented until August 1, 2016. We did not independently verify whether this functionality was properly implemented because it was outside the scope of our review.

The State agency made payments on behalf of one sampled beneficiary who may not have met the residency requirement. Specifically, the beneficiary was identified through the PARIS data match as having public assistance benefits in a State besides California. However, the State agency did not send the required letter to the beneficiary to verify whether the beneficiary was a California resident.

THE STATE AGENCY HAD A WEAKNESS IN PROCEDURES RELATED TO DETERMINING ELIGIBILITY OF INDIVIDUALS WHO MAY NOT HAVE INTENDED TO APPLY FOR MEDICAID

We identified a weakness in the State agency's procedures related to determining the eligibility of individuals who may not have intended to apply for Medicaid. Although Federal requirements do not prohibit a State from determining a nonapplicant eligible for Medicaid, the State agency's procedures may pose a risk that individuals are determined eligible for Medicaid without their knowledge.

The State agency made payments on behalf of two sampled beneficiaries who may not have intended to apply for Medicaid but were determined eligible for the new adult group:[48]

- One sampled beneficiary was included on her husband's application, which indicated that she did not want Medicaid benefits. However, the eligibility caseworker determined the beneficiary eligible for Medicaid when her husband was determined eligible for Medicaid.

- One sampled beneficiary signed a form to withdraw her application on the same day that she was determined eligible for the new adult group. The beneficiary's case documentation did not indicate whether she attempted to withdraw her application before or after the eligibility determination was made.

The State agency did not have written policies or procedures to address situations in which individuals did not want or did not intend to apply for Medicaid. According to the State agency, if an applicant indicated that he or she did not want Medicaid benefits, CalHEERS and SAWS would not authorize benefits.[49]

[48] We determined that the beneficiaries met the eligibility requirements on the basis of the documentation in the case files. The State agency made managed-care payments on behalf of these beneficiaries; however, on the basis of the payment data, we could not determine whether the beneficiaries received services or were aware of their eligibility.

[49] We did not verify whether these systems had this functionality because it was outside the scope of our review. However, State agency officials stated that an eligibility caseworker could erroneously input into the system that a person requested benefits when the person did not request benefits, which would result in an eligibility determination. The State agency did not explain why these two sampled beneficiaries were determined eligible.

If an individual who did not intend to apply for Medicaid is determined eligible for Medicaid, payments (e.g., managed-care payments) may be made on behalf of the beneficiary without the beneficiary's knowledge or use of medical services.

CONCLUSION

On the basis of our sample results, we estimated that the State agency made Medicaid payments of $628,838,417 (Federal share) on behalf of 366,078 ineligible beneficiaries and $402,358,529 (Federal share) on behalf of 79,055 potentially ineligible beneficiaries.

Ineligible or potentially ineligible beneficiaries were determined eligible for the new adult or other coverage groups because the State agency's eligibility determination systems lacked functionality or eligibility caseworkers made errors. We also identified other beneficiaries for whom the State agency did not properly input application information and verify income or lawful presence. Further, we determined that the State agency lacked written policies and procedures to ensure that applicants who did not want or did not intend to apply for Medicaid were not determined eligible.

If the State agency does not determine Medicaid eligibility according to Federal and State requirements, there is an increased risk that the State agency will make payments on behalf of ineligible beneficiaries. If the State agency makes payments on behalf of ineligible beneficiaries, it may claim unallowable Federal reimbursement for those beneficiaries.

RECOMMENDATIONS

We recommend that the State agency:

- redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements;

- ensure that CalHEERS and SAWS have the system functionality to:

    - deny or discontinue Medicaid for an ineligible beneficiary after a previous determination has already been made on the basis of the beneficiary's MAGI,

    - properly process cases for beneficiaries who were formerly in the foster-care youth program,

    - use SSA data to verify whether a beneficiary is entitled to or enrolled in Medicare,

    - properly redetermine eligibility when a beneficiary is no longer a child, and

- retrieve and use information from the Department of Homeland Security to determine whether a beneficiary has met the 5-year-bar requirement to be eligible to receive full-scope Medicaid services;

- ensure that eligibility caseworkers properly input applicant information;

- ensure that all eligibility requirements are properly verified;

- ensure that eligibility determinations are made in accordance with Federal and State requirements for beneficiaries:

    - who do not provide the required information, e.g., citizenship or lawful presence status,

    - whose presumptive eligibility period has ended, and

    - who may not have met the residency requirement;

- develop and implement written policies and procedures, as necessary, to ensure that all payments for nonemergency and non-pregnancy-related services are adjusted for beneficiaries who are subject to the 5-year bar; and

- develop and implement written policies and procedures to ensure that applicants who did not want or did not intend to apply for Medicaid are not determined eligible.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our recommendation related to eligibility determinations for beneficiaries who may not have met the residency requirement (the third part of our fifth recommendation). However, the State agency agreed with our remaining recommendations and provided information on actions that it had taken or planned to take to address those recommendations. The State agency's comments are included in their entirety as Appendix D. The State agency also provided additional information (not included in the appendix) for the sampled beneficiary who may not have met the residency requirement.

After reviewing information that the State agency provided both during our fieldwork and after our draft report was issued, we maintain that our recommendation related to eligibility determinations for beneficiaries who may not have met the residency requirement is valid.

STATE AGENCY COMMENTS

Regarding our recommendation related to eligibility determinations for beneficiaries who may not have met the residency requirement, the State agency commented that it determined that

the beneficiary in our sample had moved to California from Texas and therefore was a California resident at the time of the PARIS data matches. The State agency said that the county office verified residency and completed eligibility determinations in accordance with Federal and State requirements.

After submitting its written comments, the State agency provided additional information for the sampled beneficiary who may not have met the residency requirement:

- The State agency explained that, to verify the beneficiary's residency, the county relied on the beneficiary's May 2014 application and a June 2014 self-attestation regarding his homelessness as instructed in the State agency's Medi-Cal Eligibility Division Information Letters (Information Letters).[50]

- The State agency explained that it did not send the beneficiary a residency verification letter although the PARIS data matches showed that the beneficiary had interstate matches,[51] because, "Like all states, California filters the match results due to limited resources . . . . [The State agency] filters data from the PARIS Interstate File removing beneficiaries who appear to be recent inbound clients . . . to focus on beneficiaries who are more likely ineligible nonresidents." To support its decision to filter the PARIS data matches, the State agency provided CMS training material, dated January 18, 2017, that stated: "Upon return of the match file, the state may employ various filters to eliminate inconsequential matches, and lessen the numeric burden." According to the State agency, during the CMS training, CMS also directed the States "to take appropriate action, such as send[ing] out the residency confirmation letter, when evidence is sufficient to warrant such action, and to refrain from sending residency confirmation letters when an applicant's/beneficiary's residency is not questionable."

The State agency's comments on our remaining recommendations are summarized below:

- Regarding our first recommendation, the State agency stated that it would perform a detailed analysis of each of the 38 sampled beneficiaries' eligibility determinations and redetermine eligibility, if appropriate, no later than March 31, 2018.

[50] The State agency's Information Letters No. 14-29 (May 16, 2014) and No. 14-44 (Aug. 1, 2014) suspended paper verification of residency and allowed counties to "consider residency to be verified for all pending and current applications, if the applicant has attested to living within California by verbal contact or by listing a California address in applicable fields for physical address on the web or paper application."

[51] The PARIS data matches are conducted quarterly by the Defense Manpower Data Center in February, May, August, and November of each year. The data matches conducted in August 2014, November 2014, and February 2015 showed that the beneficiary in our sample had interstate matches, indicating that the beneficiary may have been receiving public assistance in another State.

- Regarding our second recommendation, the State agency commented that it (1) had added system functionality in CalHEERS and SAWS to discontinue eligibility for individuals ineligible on the basis of MAGI for Medi-Cal programs; (2) had implemented program logic in CalHEERS and SAWS to allow CalHEERS to perform eligibility determinations for children who were formerly in foster care; (3) had added system functionality in CalHEERS and SAWS to electronically verify Medicare status through an interface with SSA; (4) would work with SAWS to ensure that there is functionality to automatically perform an eligibility redetermination when an individual "ages out of" a coverage group; and (5) had updated CalHEERS to facilitate the sharing of Department of Homeland Security information with SAWS for eligibility determinations.

- Regarding our third recommendation, the State agency commented that it would remind counties of the importance of properly entering applicant information into the system.

- Regarding our fourth recommendation, the State agency commented that it would remind counties to ensure that all required data elements are verified before completion of an eligibility determination.

- Regarding the first and second parts of our fifth recommendation, the State agency commented that it would (1) remind counties to ensure that all required data elements are verified before completion of an eligibility determination and (2) identify the reason for the two erroneous payments for services provided to a beneficiary under the presumptive eligibility coverage group and correct the cause.

- Regarding our sixth recommendation, the State agency commented that it had already implemented processes to identify immigrants who are subject to the 5-year bar and to adjust payments appropriately. The State agency also commented that it implemented the needed system changes in June 2016 to keep Federal reimbursement for "qualified noncitizens/lawfully present who are pregnant and under 21 per the approved state plan."

- Regarding our seventh recommendation, the State agency commented that it would issue a policy letter to counties that addresses situations in which an individual declines a Medi-Cal determination.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing information that the State agency provided both during our fieldwork and after our draft report was issued, we maintain that our recommendation related to eligibility determinations for beneficiaries who may not have met the residency requirement is valid.

Although the State agency commented that it determined that the sampled beneficiary who may not have met the residency requirement had moved to California at the time of the PARIS data matches and that the county office verified the beneficiary's residency, it did not provide documentation to support that it had sent the beneficiary the required letter or taken action to verify residency after the beneficiary was identified through the data match. Instead, the State agency relied on the beneficiary's attestation before receiving the PARIS data match results.

In addition, after reviewing additional information that the State agency provided for the sampled beneficiary, we concluded the following:

- The Information Letters do not address the State agency's process of verifying the residency of beneficiaries when the PARIS data matches have identified interstate matches. We understand that the State agency relied on the beneficiary's May 2014 application and June 2014 self-attestation for homelessness in accordance with the Information Letters when determining the beneficiary's eligibility. However, the State agency continued to rely on the application and self-attestation and did not take any actions when it later received interstate matches in three consecutive quarters, including our audit period.[52]

- The CMS training material that the State agency provided was dated January 18, 2017, which was almost 2 years after our audit period. Further, the training material instructed the States to eliminate "inconsequential" matches and, according to the State agency, refrain from sending residency confirmation letters when a beneficiary's residency is not questionable. We believe that the PARIS data match results from three consecutive quarters showing that the beneficiary in our sample had interstate matches were not "inconsequential" matches and were sufficient evidence to warrant sending the beneficiary the required residency confirmation letter.

Therefore, the State agency should have sent the beneficiary the required letter or taken action to verify whether he was a California resident when the State agency identified that the beneficiary had interstate matches, indicating that he may have been receiving public assistance in another State.

OTHER MATTERS: THE STATE AGENCY MAY NOT HAVE ADJUSTED THE FEDERAL SHARE OF ALL PAYMENTS WHEN BENEFICIARIES' AID CODES WERE RETROACTIVELY ASSIGNED

For each of five sampled beneficiaries, the beneficiary's aid code at the time of payment was different from the aid code at the time of our review for the same eligibility month. According to the State agency, this occurred because an updated aid code was entered into MEDS to replace the aid code already in MEDS, such as when eligibility was redetermined, and was

[52] During our fieldwork, the State agency provided case notes showing that, in July 2015, the beneficiary provided to county staff, by telephone, a self-attestation of California residency, which was 11 months after the initial PARIS data match result and 4 months after our audit period.

retroactively assigned to the prior months. The payment made on behalf of a beneficiary was associated with the aid code in MEDS at the time of the payment.[53]

For example, for one beneficiary, the aid code at the time of the payments from October 2014 through March 2015 was M1 (i.e., new adult group), which was originally assigned in April 2014. In MEDS, the State agency retroactively assigned the aid code M3 (i.e., parent or caretaker relative of a dependent child) to each of these months when the beneficiary's eligibility was redetermined in March 2015. Aid code M1 is reimbursed at an FMAP of 100 percent. Aid code M3 is reimbursed at an FMAP of 50 percent.

According to the State agency, it retroactively adjusts the Federal share of managed-care payments every month for the prior 12-month period to account for aid codes that are retroactively assigned. However, it does not make retroactive adjustments for other types of claims, such as mental health service claims. Because the aid codes at the time of the payments differed from the aid codes retroactively assigned in MEDS, the State agency could not ensure that it claimed the correct Federal share amounts of all payments.

[53] For three of the five beneficiaries, if the aid code in MEDS after the retroactive assignment had been used to calculate the Federal share rather than the aid code at the time of payment, an overpayment would have resulted. For the remaining two beneficiaries, an underpayment would have resulted. We identified four other sampled beneficiaries who had aid code discrepancies but with no impact on the Federal share.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 1,886,854 newly eligible beneficiaries in California for whom Medicaid payments were made for services provided from October 1, 2014, through March 31, 2015, and reported on Form CMS-64 for this period. We reviewed a stratified random sample of 150 newly eligible beneficiaries to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the new adult or other coverage groups.

We limited our review of internal controls to those applicable to our objective. Specifically, we gained an understanding of the State agency's and three California counties' policies and procedures for determining eligibility of individuals using CalHEERS and SAWS and for storing eligibility determination information in MEDS.

We performed fieldwork from November 2015 through February 2017 at the State agency and CalHEERS offices in Sacramento, California, and three county offices in Los Angeles, Riverside, and San Diego, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility;

- reviewed the California State plan and California's verification plan, which describes the State agency's policies and procedures related to verifying an applicant's citizenship and lawful presence status, income, entitlement to and enrollment in Medicare, and other eligibility requirements in determining and redetermining Medicaid eligibility;

- obtained an understanding of internal controls by:

    - interviewing officials from CalHEERS and its contractors to obtain an understanding of how CalHEERS (1) processes an applicant's information, (2) verifies an applicant's eligibility for enrollment in Medicaid, and (3) transmits enrollment data to SAWS and MEDS;

    - holding discussions with State agency and county officials to obtain an understanding of policies, procedures, and guidance for determining and redetermining Medicaid eligibility;

- performing walk-throughs at three counties of the processes for verifying and determining Medicaid eligibility; and

- determining how CalHEERS and SAWS document that the processes for verifying and determining eligibility occurred and how the eligibility determination information was stored in MEDS;

- obtained an understanding of how eligibility determinations affect Federal reimbursement;

- obtained from the State agency 4 sets of files that contained records of Medicaid claims and monthly capitation payments during the audit period;[54]

- created a sampling frame of 1,886,854 Medicaid beneficiaries for whom the State agency made Medicaid payments totaling $6,213,350,143 ($6,095,345,086 Federal share);[55]

- selected a stratified random sample of 150 Medicaid beneficiaries, consisting of 90 beneficiaries who had payments associated with only the new adult group and 60 beneficiaries who had payments associated with the new adult and other coverage groups;

- obtained for each sampled beneficiary, when possible, application data and documentation supporting the eligibility determination and determined whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the new adult or other coverage groups;

- used CMS's Medicare Enrollment Database to determine whether each sampled beneficiary was entitled to or enrolled in Medicare during the audit period;

- estimated the total number of ineligible and potentially ineligible beneficiaries;

[54] Each set of files contained records of payments processed by one of four different payment systems. The four systems processed payments for fee-for-service claims, managed-care plans, the Drug Medi-Cal Treatment Program, and mental health services. We excluded from our review Medicaid fee-for-service dental expenditures. State agency officials stated that these expenditures were reported for Federal reimbursement on the basis of estimates that were reconciled semiannually, not on the basis of actual Medicaid paid claims.

[55] Because the State agency was not able to provide us with Federal shares for either fee-for-service or managed-care payments at the record level, we calculated the total Federal share using the methodology discussed with the State agency.

- estimated the total payments made on behalf of ineligible[56] and potentially ineligible beneficiaries and the associated Federal shares; 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.

[56] If a beneficiary was ineligible for the aid code associated with the payment made on his or her behalf (i.e., the original aid code), we determined whether the beneficiary met eligibility requirements for an aid code under another coverage group (i.e., the revised aid code). If the FMAPs of the original and revised aid codes differed, we used the difference of the Federal shares in our estimate of the Federal share amount related to the ineligible beneficiary.

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 Alaska Natives,[57] for whom the State agency made Medicaid payments for services provided during the audit period and reported on Form CMS-64 for the audit period.

SAMPLING FRAME

The sampling frame consisted of Microsoft Access databases containing 1,886,854 newly eligible Medicaid beneficiaries under the ACA in California who received services during the audit period and for whom the State agency made Medicaid payments totaling $6,213,350,143 ($6,095,345,086 Federal share). We obtained the data for the Medicaid beneficiaries from four payment systems.[58] We excluded from our sampling frame American Indian and Alaska Native beneficiaries as well as beneficiary records that did not have a Federal share and were not reported on Form CMS-64 during the audit period.

SAMPLE UNIT

The sample unit was a newly eligible Medicaid beneficiary.

SAMPLE DESIGN

We used a stratified random sample, consisting of five strata:

- Stratum 1 consisted of beneficiaries who were categorized as being eligible for Medicaid solely under the new adult group established by the ACA with total payments of less than $3,400: 847,965 beneficiaries with payments totaling $1,795,659,508 ($1,793,391,527 Federal share).

- Stratum 2 consisted of beneficiaries who were categorized as being eligible for Medicaid solely under the new adult group established by the ACA with total payments equal to or greater than $3,400 but less than $6,100: 764,949 beneficiaries with payments totaling $3,014,009,374 ($3,013,304,195 Federal share).

- Stratum 3 consisted of beneficiaries who were categorized as being eligible for Medicaid solely under the new adult group established by the ACA with total payments equal to

[57] American Indians and Alaska Natives are subject to different eligibility requirements and were not a part of this review.

[58] See footnote 54.

or greater than $6,100: 33,701 beneficiaries with payments totaling $476,005,748 ($471,818,191 Federal share).

- Stratum 4 consisted of beneficiaries whose Medicaid eligibility group changed between the new adult group and another Medicaid eligibility group during the audit period with total payments equal to or less than $6,500: 223,969 beneficiaries with payments totaling $621,804,072 ($564,202,197 Federal share).

- Stratum 5 consisted of beneficiaries whose Medicaid eligibility group changed between the new adult group and another Medicaid eligibility group during the audit period with total payments greater than $6,500: 16,270 beneficiaries with payments totaling $305,871,441 ($252,628,977 Federal share).

SAMPLE SIZE

We selected a sample of 150 beneficiaries, which consisted of:

- 90 beneficiaries who had payments associated with only the new adult group (35 beneficiaries from stratum 1, 35 beneficiaries from stratum 2, and 20 beneficiaries from stratum 3) and

- 60 beneficiaries who had payments associated with the new adult and other coverage groups (30 beneficiaries from stratum 4 and 30 beneficiaries from stratum 5).

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the Medicaid beneficiaries within strata 1 through 5. After generating the random numbers for each of these strata, we selected the corresponding Medicaid beneficiaries in the sampling frame.

ESTIMATION METHODOLOGY

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS[59]

Table 1: Sample Detail and Results for Ineligible Beneficiaries

Stratum	Number of Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	847,965	$1,793,391,527	35	$68,770	8	$11,012
2	764,949	3,013,304,195	35	135,756	5	13,791
3	33,701	471,818,191	20	229,319	0	0
4	223,969	564,202,197	30	86,688	8	7,125
5	16,270	252,628,977	30	502,956	6	13,737
Totals	**1,886,854**	**$6,095,345,087**	**150**	**$1,023,489**	**27**	**$45,665**

Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries

Stratum	Number of Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	847,965	$1,793,391,527	35	$68,770	0	0
2	764,949	3,013,304,195	35	135,756	2	$9,187
3	33,701	471,818,191	20	229,319	1	17,527
4	223,969	564,202,197	30	86,688	4	5,133
5	16,270	252,628,977	30	502,956	7	246,541
Totals	**1,886,854**	**$6,095,345,087**	**150**	**$1,023,489**	**14**	**$278,388**

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

ESTIMATES

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

	Total Number of Ineligible Beneficiaries	Total Value of Payments for Ineligible Beneficiaries
Point estimate	366,078	$628,838,417
Lower limit	236,815	396,812,234
Upper limit	495,341	951,144,692

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

	Total Number of Potentially Ineligible Beneficiaries	Total Value of Payments for Potentially Ineligible Beneficiaries
Point estimate	79,055	$402,358,529
Lower limit	23,726	191,003,455
Upper limit	134,385	756,204,716

APPENDIX D: STATE AGENCY COMMENTS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7TH Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled, *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements.*

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report. Please contact Ms. Sarah Hollister, External Audit Manager, at (916) 319-8529 if you have any questions.

Sincerely,

Jennifer Kent
Director

Enclosure

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Department of Health Care Services Response to: The Office of Inspector General audit report entitled, *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements*

Finding 1:	**DHCS made Medicaid payments on behalf of newly eligible beneficiaries who did not meet or may not have met Federal and State eligibility requirements. For OIG's sample of 150 beneficiaries, DHCS made payments on behalf of 112 eligible beneficiaries. However, for the remaining 38 beneficiaries, DHCS made payments on behalf of 27 ineligible beneficiaries and 14 potentially ineligible beneficiaries.**
Recommendation 1:	DHCS should re-determine, if necessary, the current Medicaid eligibility of the sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements.
Response:	DHCS agrees with the recommendation. DHCS staff will perform a detailed analysis of each of the 38 cases and re-determine eligibility if appropriate. Estimated date of completion: No later than March 31, 2018.

Finding 2:	**DHCS made Medicaid payments on behalf of 24 sampled beneficiaries who did not meet eligibility requirements for the new adult group.** **Twelve beneficiaries had incomes above 138 percent of the Federal Poverty Level (FPL). For example, on July 7, 2014, one beneficiary in the new adult group reported a change in income that was above the FPL threshold. Although DHCS electronically verified that this income was above the threshold, it did not determine that the beneficiary was ineligible for the new adult group and continued to make payments on behalf of this beneficiary during the audit period. Neither the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) nor the Statewide Automated Welfare Systems (SAWS) had the functionality to discontinue Medicaid for an ineligible beneficiary after a previous determination had already been made on the basis of the beneficiary's Modified Adjusted Gross Income (MAGI).**
Recommendation 2:	DHCS should ensure CalHEERS and SAWS have the system functionality to deny or discontinue Medicaid for an ineligible

	beneficiary after a previous determination has already been made on the basis of the beneficiary's MAGI.
Response:	DHCS agrees with the recommendation. DHCS fully implemented this recommendation. Effective July 27, 2015, CalHEERS and SAWS added system functionality to discontinue eligibility for individuals ineligible on a MAGI-basis for Medi-Cal programs.
Finding 2a:	**Seven beneficiaries were eligible for one of the other mandatory coverage groups. A beneficiary who was under the age of 26 and formerly a foster care child was improperly determined to be eligible for the new adult group. DHCS should have determined the beneficiary eligible for Medicaid under the mandatory coverage group for former foster care children; however, CalHEERS lacked the system functionality to properly process cases for beneficiaries who formerly belonged to a foster-care youth program.**
Recommendation 2a:	DHCS should ensure CalHEERS and SAWS have the system functionality to properly process cases for beneficiaries who were formerly in the foster-care youth program.
Response:	DHCS agrees with the recommendation. DHCS fully implemented this recommendation. Effective October 12, 2015, CalHEERS/SAWS implemented the program logic for the former foster care youths. This logic allows CalHEERS to perform eligibility determination for this MAGI-based coverage group.
Finding 2b:	**Two beneficiaries were entitled to or enrolled in Medicare. CalHEERS was programmed to accept a beneficiary's attestation that he or she was not enrolled in Medicare or the absence of an attestation as meeting the eligibility requirement (i.e., not being entitled to or enrolled in Medicare). CalHEERS did not use data from Social Security Administration (SSA) to verify whether a beneficiary was entitled to or enrolled in Medicare as required.**
Recommendation 2b:	DHCS should ensure that CalHEERS and SAWS have the system functionality to use SSA data to verify whether a beneficiary is entitled to or enrolled in Medicare.
Response:	DHCS agrees with the recommendation.

	DHCS fully implemented this recommendation. Effective August 1, 2016, CalHEERS/SAWS added system functionality that electronically verifies Medicare status through an interface with Social Security Administration.
Finding 2c:	**DHCS made payments on behalf of two sampled beneficiaries who did not meet the eligibility requirements for coverage as a child. In one example, a beneficiary was determined eligible for coverage as a child before he was 19 years old; however, after the beneficiary turned 19, he continued to have coverage as a child.**
Recommendation 2c:	DHCS should ensure CalHEERS and SAWS have the system functionality to properly re-determine eligibility when a beneficiary is no longer a child.
Response:	DHCS agrees with the recommendation. Although SAWS triggers re-determinations due to age for both non-MAGI and MAGI cases; DHCS will work with SAWS to ensure that there is functionality to automatically perform a redetermination when an individual ages out of a coverage group. Estimated date of completion: No later than March 31, 2018.
Finding 2d:	**Payments were made on behalf of beneficiaries who had not been in the United States for 5 years, but were determined eligible for full-scope Medicaid services. In addition, CalHEERS did not have the system functionality to retrieve and use information from the Department of Homeland Security to determine whether a beneficiary had met the 5-year-bar requirement to be eligible to receive full-scope Medicaid services.**
Recommendation 2d:	DHCS should ensure that CalHEERS and SAWS have the system functionality to retrieve and use information from the Department of Homeland Security to determine whether a beneficiary has met the 5-year-bar requirement to be eligible to receive full-scope Medicaid services.
Response:	DHCS agrees with the recommendation. This recommendation is fully implemented. DHCS provides state-funded full scope Medi-Cal to eligible qualified noncitizens and makes a quarterly adjustment to pay back the federal government

as necessary for immigrants who are subject to the 5-year bar. DHCS also has an approved state plan under which California can claim federal funds for full scope Medi-Cal provided to eligible lawfully present pregnant women and children during the 5-year bar. The processes to identify these immigrants and to adjust payments appropriately are already in place. In addition, the CalHEERS system already uses Department of Homeland Security (DHS) information for eligibility determinations.

In September 2017, DHCS updated the CalHEERS system to facilitate the sharing of DHS information (such as Grant Date) with the SAWS systems.

Finding 3	**DHCS made payments on behalf of one sampled beneficiary who did not meet eligibility requirements for the parent or other relative caretaker coverage group. Specifically, the beneficiary's household income was above 109 percent of the FPL when her eligibility was re-determined on July 8, 2014. However, the eligibility caseworker incorrectly inputted an income amount below the 109-percent FPL threshold when re-determining eligibility.**
Recommendation 3:	DHCS should ensure that eligibility caseworkers properly input applicant's information.
Response:	DHCS agrees with the recommendation. DHCS will remind counties of the importance of properly entering applicant's information into the system. Estimated date of completion: No later than December 31, 2017.

Finding 4:	**DHCS made Medicaid payments on behalf of seven sampled beneficiaries without verifying all of their eligibility requirements. Specifically, the supporting documentation did not show that all of their eligibility requirements had been verified.**
Recommendation 4:	DHCS should ensure that all eligibility requirements are properly verified.
Response:	DHCS agrees with the recommendation. DHCS will remind counties to ensure that all required data elements are verified prior to the completion of an eligibility determination.

Estimated date of completion: No later than December 31, 2017.

Finding 5:	**DHCS made Medicaid payments on behalf of newly eligible beneficiaries who may not have met eligibility requirements. DHCS made Medicaid payments on behalf of seven sampled beneficiaries without verifying all of their eligibility requirements. Specifically, the supporting documentation did not show that all of their eligibility requirements had been verified.**
Recommendation 5:	DHCS should ensure that eligibility determinations are made in accordance with Federal and State requirements for beneficiaries who do not provide the required information, e.g., citizenship or lawful presence status.
Response:	DHCS agrees with the recommendation. DHCS will remind counties to ensure that all required data elements are verified prior to the completion of an eligibility determination. Estimated date of completion: No later than December 31, 2017.

Finding 5a:	**DHCS made payments on behalf of one sampled beneficiary whose presumptive eligibility period had ended. On December 10, 2014, the beneficiary was determined eligible for the presumptive eligibility group, which covers full-scope services. On February 20, 2015, the beneficiary's presumptive eligibility ended when the State agency determined that the beneficiary was eligible for only restricted-scope services under Medicaid. However, the State agency made two payments for services provided on February 26, 2015, under the presumptive eligibility coverage group.**
Recommendation 5a:	DHCS should ensure eligibility determinations are made in accordance with Federal and State requirements for beneficiaries whose presumptive eligibility period has ended.
Response:	DHCS agrees with the recommendation. DHCS will identify the reason for the two erroneous payments and correct the cause. Estimated date of completion: No later than March 31, 2018.

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Finding 5b:	**DHCS made payments on behalf of one sampled beneficiary who may not have met the residency requirement. Specifically, the beneficiary was identified through the Public Assistance Reporting Information System (PARIS) data match as having public assistance benefits in a State besides California. However, DHCS did not send the required letter to the beneficiary to verify whether the beneficiary was a California resident or contact the beneficiary after the eligibility determination. DHCS did not provide an explanation of why it did not take any action to contact the beneficiary.**
Recommendation 5b:	DHCS should ensure that eligibility determinations are made in accordance with Federal and State requirements for beneficiaries who may not have met the residency requirement.
Response:	DHCS disagrees with the recommendation. Utilizing the information in the PARIS match, DHCS determined the client had moved to California from Texas and therefore was a California resident at the time of the PARIS Matches. The county office verified residency and completed eligibility determinations in accordance with Federal and State requirements.

Finding 6:	**DHCS made payments on behalf of six sampled beneficiaries who had not been in the United States for 5 years but were determined eligible for full-scope Medicaid services under the new adult group. These beneficiaries were actually eligible for only emergency and pregnancy-related services.**
Recommendation 6:	DHCS should develop and implement written policies and procedures, as necessary, to ensure that it adjusts all payments for non-emergency and non-pregnancy-related services for beneficiaries who are subject to the 5-year bar.
Response:	DHCS agrees with the recommendation. This recommendation is fully implemented. DHCS provides state-funded full scope Medi-Cal to eligible qualified noncitizens and makes a quarterly adjustment to pay back the federal government as necessary for immigrants who are subject to the 5-year bar. DHCS also has an approved state plan under which California can claim federal funds for full scope Medi-Cal provided to eligible lawfully present pregnant women and children during the 5-year bar. The processes to identify these immigrants and to adjust payments appropriately are already in place. The needed system

changes were implemented via SDN 15006 in June 2016 to keep federal financial participation (FFP) for qualified non-citizens/lawfully present who are pregnant and under 21 per the approved state plan.

Finding 7:	**DHCS did not have written policies or procedures to address situations in which individuals did not want or did not intend to apply for Medicaid.**
Recommendation 7:	DHCS should develop and implement written policies and procedures to ensure that applicants who did not want or did not intend to apply for Medicaid are not determined eligible.
Response:	DHCS agrees with the recommendation. DHCS will issue a policy letter to counties that addresses situations where an individual declines a Medi-Cal determination. Estimated date of completion: No later than December 31, 2017.