

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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



Daniel R. Levinson
Inspector General

December 2018
A-09-17-02002

Office of Inspector General

<https://oig.hhs.gov>

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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

Notices

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

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief

Date: December 2018

Report No. A-09-17-02002

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



Why OIG Did This Review

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

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

How OIG Did This Review

We reviewed a stratified random sample of 125 non-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 non-newly eligible group (e.g., income, citizenship, and pregnancy requirements).

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

What OIG Found

For our sample of 125 beneficiaries, California made payments on behalf of 60 eligible beneficiaries. However, for the remaining 65 beneficiaries, California made payments on behalf of ineligible beneficiaries (e.g., a beneficiary who did not meet the income requirement for the medically needy coverage group) and potentially ineligible beneficiaries (e.g., beneficiaries for whom there was no documentation to support that California redetermined eligibility as required). On the basis of our sample results, we estimated that California made Medicaid payments of \$959.3 million (\$536 million Federal share) on behalf of 802,742 ineligible beneficiaries and \$4.5 billion (\$2.6 billion Federal share) on behalf of 3.1 million potentially ineligible beneficiaries. (These estimates represent Medicaid payments for fee-for-service, managed-care, drug treatment program, and mental health services.) According to California, these deficiencies occurred because (1) the counties experienced “a massive influx of applications for Medicaid and vast changes in policy brought forth by the ACA,” (2) eligibility caseworkers made errors, and (3) system delays occurred during a system conversion.

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 redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries and ensure that (1) all eligibility requirements are verified properly and annual redeterminations are performed as required, (2) information is maintained in case files to support eligibility determinations, and (3) eligibility determinations are performed only for individuals who apply for Medicaid. The “Recommendations” section in the body of the report lists in detail our recommendations.

California agreed with our findings. California partly agreed with our recommendation regarding beneficiaries determined eligible for Medicaid based on eligibility for another assistance program, but it provided information on actions being taken to address this recommendation. Although California did not explicitly agree or disagree with our other recommendations, it provided information on actions that it had taken or planned to take to address those recommendations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Review	1
Objective	1
Background	1
The Medicaid Program.....	1
Medicaid Coverage and Changes to Medicaid Eligibility Rules	
Under the Affordable Care Act.....	2
Medicaid Eligibility Verification Requirements.....	3
California’s Process for Determining Medicaid Eligibility.....	4
How We Conducted This Review	7
FINDINGS	8
The State Agency Made Medicaid Payments on Behalf of Beneficiaries Who Did Not Meet Eligibility Requirements.....	9
Payments Were Made on Behalf of a Beneficiary Who Did Not Meet the Citizenship Requirement	9
Payments Were Made on Behalf of a Beneficiary Who Did Not Meet the Residency Requirement	10
Payments Were Made on Behalf of Beneficiaries Who Did Not Meet Requirements for Coverage Groups for Which They Were Determined Eligible.....	10
Payments Were Made on Behalf of Beneficiaries Who Did Not Submit the Required Tax Information Form.....	12
The State Agency Made Medicaid Payments on Behalf of Beneficiaries Who May Not Have Met Eligibility Requirements.....	13
Payments Were Made on Behalf of Beneficiaries for Whom There Was No Documentation Supporting That Eligibility Redeterminations Were Performed Properly or All Eligibility Requirements Were Verified Properly....	13
Payments Were Made on Behalf of Beneficiaries for Whom Medicaid Eligibility Determinations Were Not Performed.....	15
Payments Were Made on Behalf of Beneficiaries for Whom the State Agency Did Not Apply Alternative Renewal Procedures Properly.....	15
The State Agency Had a Procedural Weakness Related to Determining Eligibility of Individuals Who May Not Have Intended To Apply for Medicaid	16

CONCLUSION.....	17
RECOMMENDATIONS	17
STATE AGENCY COMMENTS	18
APPENDICES	
A: Audit Scope and Methodology	20
B: Statistical Sampling Methodology	23
C: Sample Results and Estimates	25
D: Related Office of Inspector General Reports	27
E: State Agency Comments	28

INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)¹ included changes to Medicaid eligibility rules, such as requiring that income be calculated on the basis of Modified Adjusted Gross Income (MAGI), a measure of income that is based on Internal Revenue Service (IRS) rules.² The ACA also provided States with the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these newly eligible beneficiaries. These changes led to a significantly increased number of applications for Medicaid coverage.

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid (traditional coverage groups). After the passage of the ACA, many beneficiaries remained eligible under these traditional coverage groups. We refer to these beneficiaries as “non-newly eligible beneficiaries.”

This review is part of an ongoing series of Office of Inspector General (OIG) reviews of States’ Medicaid eligibility determinations. We conducted these reviews to address the concern that State agencies might have difficulty accurately determining eligibility for Medicaid beneficiaries.

We selected California to ensure that our reviews covered States in different parts of the country.³ (See Appendix D for a list of related OIG reports.)

OBJECTIVE

Our objective was to determine whether California’s Department of Health Care Services (the State agency) made Medicaid payments on behalf of non-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 groups of individuals

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 26 U.S.C. § 36B(d)(2)(B).

³ A previous OIG report covered California’s newly eligible beneficiaries: *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements* (A-09-16-02023), issued February 20, 2018.

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

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures, called the Federal medical assistance percentage (FMAP), which is developed from criteria such as the State's per capita income.^{4,5} The standard FMAP varies by State and generally ranges from 50 to 75 percent.^{6,7} In addition, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its Medicaid program, including program administration, eligibility criteria, service coverage, and provider reimbursement.⁸

When making a Medicaid eligibility determination, a State must follow Federal requirements as well as the process outlined in its State plan and State eligibility verification plan.⁹ CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control and Payment Error Rate Measurement programs, which are designed to reduce improper payments.

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

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These traditional coverage groups included low-income parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly. A State had the option, under its State plan, to provide Medicaid coverage to other groups, such as individuals presumed to be eligible before the State had made a formal determination. The ACA expanded coverage to childless, low-income individuals from the ages of 19 to 64 (i.e., newly eligible beneficiaries).

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

⁵ CMS, "Financial Management." Accessed at <https://www.medicaid.gov/medicaid/finance> on July 19, 2018.

⁶ 79 Fed. Reg. 3385, 3387 (Jan. 21, 2014).

⁷ 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.

⁸ When a State is planning to make a change to its program policies or operational approach, it sends a State plan amendment to CMS for review and approval. A State must also submit a State plan amendment to request permissible program changes, make corrections, or update its Medicaid or Children's Health Insurance Program (CHIP) State plan with new information.

⁹ Each State is required to develop a Medicaid verification plan describing its eligibility verification policies and procedures (42 CFR § 435.945(j)).

In addition, the ACA included changes to Medicaid eligibility rules for non-newly eligible beneficiaries. In most cases, the ACA required States to use MAGI to determine an individual's income.¹⁰

The ACA also 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, such as Medicaid, CHIP, and qualified health plans available through the health insurance marketplaces.^{11, 12}

An individual may begin the Medicaid enrollment process through a marketplace and submit a single, streamlined enrollment application by providing basic personal information, such as name, birth date, and Social Security number.

Medicaid Eligibility Verification Requirements

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

States are required to have an income and eligibility verification system for determining Medicaid eligibility, and upon CMS's request, a verification plan describing the State agency's policies and procedures for implementing the eligibility verification requirements.¹³ States must verify individuals' eligibility information, such as citizenship or lawful presence, and entitlement to or enrollment in Medicare, through electronic sources.¹⁴ States may accept an individual's attestation for certain information, such as pregnancy status and household composition (e.g., household size and family relationships), without further verification.¹⁵

¹⁰ The Act §§ 1902(e)(14)(A)–(D). 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.

¹¹ ACA § 1413(b).

¹² A health insurance marketplace serves as a “one-stop shop” where individuals review their health insurance options and are evaluated for Medicaid eligibility. Each State had an option to establish and run its own State-based marketplace.

¹³ The Act §§ 1137(a) and (b); 42 CFR § 435.945(j).

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

¹⁵ 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-based marketplace) website¹⁶ 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)¹⁷ 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 review¹⁸ 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 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).¹⁹ If CalHEERS does not verify the applicant's information electronically, the caseworkers perform manual review.

¹⁶ The [CoveredCA.com](https://www.coveredca.com) website is a joint partnership between Covered California and the State agency.

¹⁷ 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, such as the advance premium tax credit, under the ACA. It is cosponsored by Covered California and the State agency.

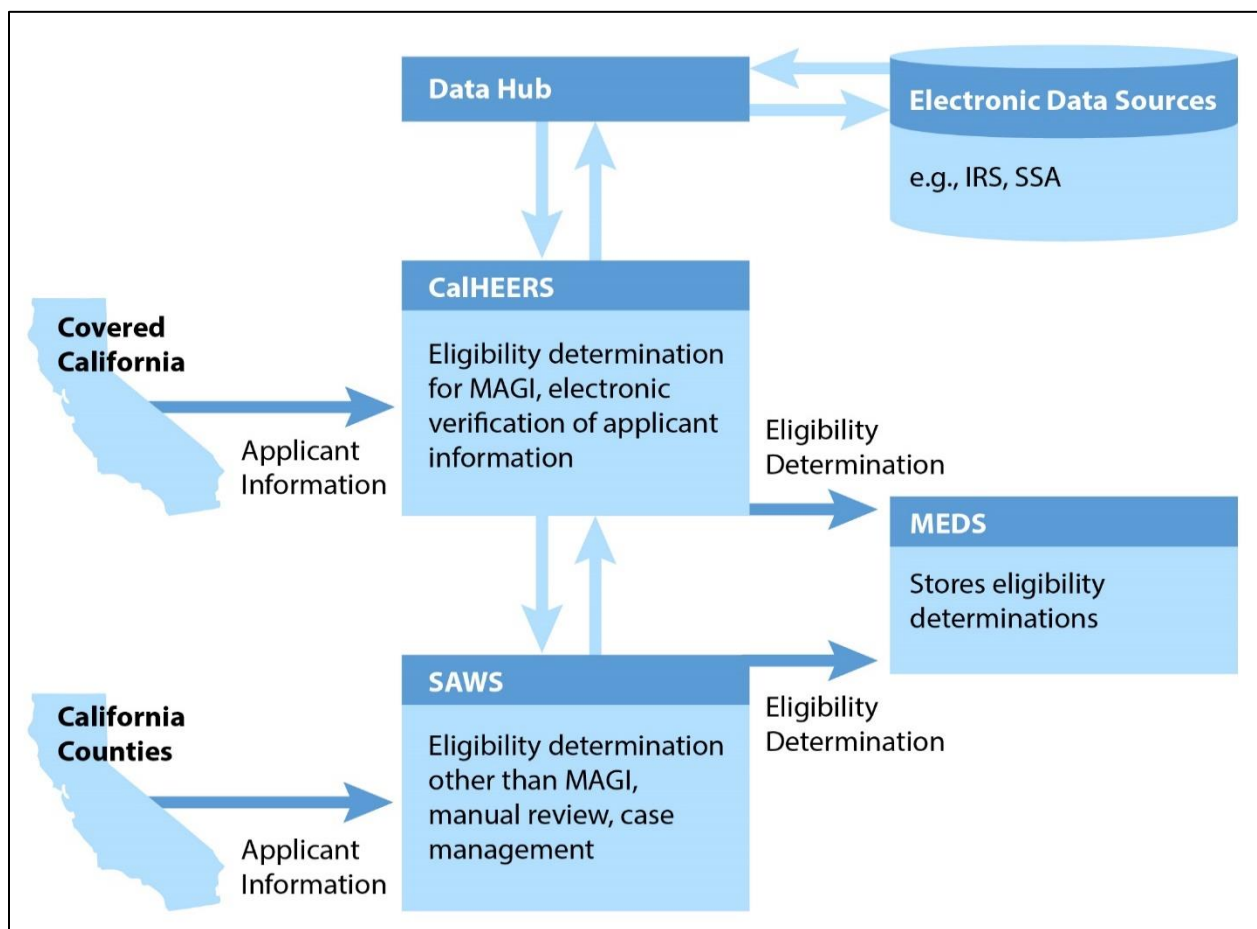
¹⁸ Manual review is the process in which an eligibility caseworker (caseworker) checks other information sources available to the State, such as an applicant's file for other public assistance programs, or requests information or documentation from the applicant, if needed, to verify the applicant's information.

¹⁹ 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 specific period. For example, a beneficiary can be determined eligible for Medicaid under a pregnancy-related coverage group for one month and under another coverage group for 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 below 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 Eligibility Redetermination Process

Generally, the State agency must renew a beneficiary’s Medicaid coverage by redetermining his or her eligibility every 12 months and also promptly redetermine eligibility when it receives information about a change in a beneficiary’s circumstances that may affect eligibility. Before the beneficiary’s renewal month, the county attempts to renew the beneficiary’s eligibility

using information that is available to the county, without contacting the beneficiary. If the beneficiary's eligibility cannot be redetermined based on available information, the county sends the beneficiary a renewal packet, which requests information to be used in the redetermination. The beneficiary can provide information by mail, in person, or by telephone. When the county receives the information, it verifies any reported changes by using the same eligibility verification systems used by the State agency: CalHEERS and SAWS.

For beneficiaries who were determined eligible for Medicaid coverage before January 1, 2014, but would have been subject to new MAGI rules after that date, the State agency was granted waivers from CMS to (1) delay eligibility renewals scheduled for January 1 through May 31, 2014, for 5 months and (2) perform a simplified process for renewals occurring from June 1 through December 31, 2014.²⁰ (We refer to this simplified process as the "alternative renewal procedures.")

The alternative renewal procedures allowed the State agency to renew Medicaid coverage for beneficiaries who were subject to the MAGI rules and who submitted a Request for Tax Household Information renewal form (tax information form), which is part of the renewal packet. The tax information form includes information on a household's income and household composition for tax purposes, which is used to determine eligibility under the MAGI rules. Generally, under the alternative renewal procedures, a county may rely on the tax information form without conducting further verifications to determine a beneficiary's eligibility. If a beneficiary did not return the form, the waivers required the State agency to terminate the beneficiary's Medicaid coverage.

The State Agency's Use of Aid Codes To Identify Coverage Groups

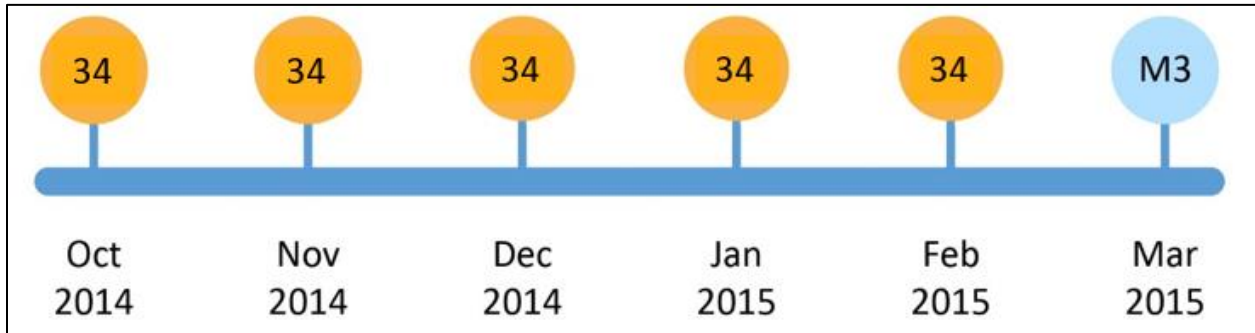
Beneficiary eligibility information in MEDS includes aid codes. An aid code identifies, for a beneficiary, the coverage group and the scope of benefits within a coverage group (i.e., full-scope or restricted-scope services²¹). Aid codes are generally assigned to each month for which a beneficiary is eligible. As a result, a beneficiary can have more than one aid code during a given period. Figure 2 on the following page shows an example of a beneficiary who was eligible for Medicaid coverage under the medically needy group²² (identified by aid code 34) in October 2014 and then eligible for Medicaid coverage under the parent or other relative caretaker group (identified by aid code M3) beginning in March 2015.

²⁰ CMS letters to the State agency's State Medicaid director, dated Dec. 23, 2013, and Jan. 13, 2015. The waivers also provided the State agency the authority to enroll a beneficiary into Medicaid on the basis of Supplemental Nutrition Assistance Program (SNAP) eligibility.

²¹ The State agency defines full-scope services as those covering the full range of healthcare 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.

²² This group consists of individuals who are eligible because their income and resources (e.g., the balance of a bank account and the surrender value of a life insurance policy) are within limits established by the State plan.

Figure 2: Example of a Beneficiary's Aid Codes by Month



HOW WE CONDUCTED THIS REVIEW

Our review covered 7,072,052 non-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.²³ We reviewed payments made on behalf of these beneficiaries throughout the audit period. We obtained payment data from four payment systems that the State agency used to report expenditures on Form CMS-64.²⁴

We reviewed a stratified random sample of 125 beneficiaries whom the State agency determined or redetermined to be eligible for Medicaid for our audit period. For all 125 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 their coverage groups. For beneficiaries we determined ineligible for the aid code associated with the payments made on their behalf, we reviewed supporting documentation to determine whether they met eligibility requirements for other coverage groups.

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.

²³ A provider may be paid for services provided under the fee-for-service program, or a health plan may be paid a monthly set amount for each beneficiary assigned to the plan whether or not that beneficiary seeks care under the managed-care program.

²⁴ The four payment systems processed payments for fee-for-service claims, managed-care plans, the Drug Medi-Cal Treatment Program, and mental health services.

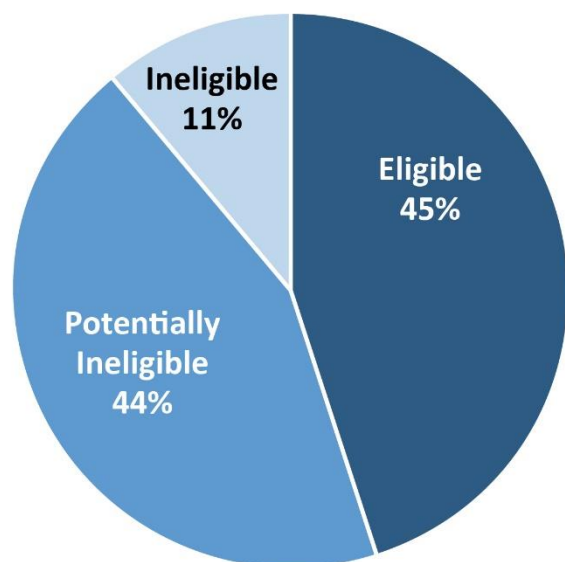
Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency made Medicaid payments on behalf of non-newly eligible beneficiaries who did not meet or may not have met Federal and State eligibility requirements. For our sample of 125 beneficiaries, the State agency made payments on behalf of 60 eligible beneficiaries. However, for the remaining 65 beneficiaries, the State agency made payments on behalf of 14 ineligible beneficiaries (e.g., a beneficiary who did not meet the income requirement for the medically needy coverage group) and 52 potentially ineligible beneficiaries (e.g., beneficiaries for whom there was no documentation to support that the State agency redetermined the beneficiaries' eligibility as required).²⁵

On the basis of our sample results, we estimated that the State agency made Medicaid payments of \$959,292,678 (\$536,039,109 Federal share) on behalf of 802,742 ineligible beneficiaries and \$4,519,740,806 (\$2,616,843,793 Federal share) on behalf of 3,100,260 potentially ineligible beneficiaries.^{26, 27} Figure 3 illustrates the percentage of total estimated beneficiaries who were eligible, ineligible, or potentially ineligible.

Figure 3: Percentage of Total Estimated Beneficiaries Who Were Eligible, Ineligible, or Potentially Ineligible



According to the State agency, these deficiencies occurred because (1) the counties experienced a “massive influx of applications [for Medicaid] and vast changes in policy brought forth by the ACA,”²⁸ (2) caseworkers made errors, and (3) system delays occurred during a system conversion. In addition, the State agency could not

²⁵ The total is higher than 65 because 1 beneficiary had payments associated with coverage groups for which she was ineligible and another coverage group for which she was potentially ineligible. Therefore, we categorized this beneficiary as both ineligible and potentially ineligible.

²⁶ 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.

²⁷ 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 24).

²⁸ The State agency provided this statement in its written response to our questions about various sampled beneficiaries.

explain why the counties did not always have sufficient documentation (e.g., notes in the case files) to support eligibility determinations and redeterminations. Finally, the State agency used the eligibility determination of a public assistance program other than Medicaid without CMS approval and misinterpreted a waiver that was granted by CMS when determining the Medicaid eligibility of beneficiaries.

Further, 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 MEDICAID PAYMENTS ON BEHALF OF BENEFICIARIES WHO DID NOT MEET ELIGIBILITY REQUIREMENTS

The State agency made payments on behalf of 14 sampled beneficiaries who did not (1) meet the citizenship requirement, (2) meet the residency requirement, (3) meet the requirements for the respective coverage groups for which they were determined eligible, or (4) submit the required tax information form.

Payments Were Made on Behalf of a Beneficiary Who Did Not Meet the Citizenship Requirement

The State agency must provide Medicaid to otherwise eligible residents of the United States who are either citizens or nationals of the United States or qualified aliens.²⁹ Generally, citizens and nationals must provide satisfactory documentary evidence of their status (42 CFR § 435.406). If an individual's citizenship is unable to be verified, the State agency generally provides the individual a 90-day reasonable opportunity period to provide satisfactory documentation, during which the individual is eligible for Medicaid (State plan amendment CA-13-0026, effective Jan. 1, 2014). Nonqualified aliens (e.g., undocumented immigrants) are eligible for emergency Medicaid services only (8 U.S.C. § 1611).

The State agency made payments on behalf of one sampled beneficiary who did not meet the citizenship requirement. The beneficiary indicated on her renewal form dated October 9, 2014, that she was an undocumented immigrant. The case file also included a government-issued identification card from a different country. A caseworker indicated in a case note that the beneficiary was undocumented.³⁰ However, CalHEERS application data dated October 18, 2014, which the county used to verify the beneficiary's citizenship, incorrectly indicated that the beneficiary attested to being a U.S. citizen.

²⁹ "Qualified alien" is defined in 8 U.S.C. § 1641. The term includes individuals who are lawfully admitted for permanent residence.

³⁰ Before the audit period, the beneficiary had the aid code 3V, which indicated that her eligibility status was undocumented and that she received restricted-scope services.

CalHEERS verification data dated October 18, 2014, showed that the county did not electronically verify the beneficiary's citizenship. When citizenship was not verified, the State agency provided the beneficiary with full-scope services during the reasonable opportunity period in accordance with California's State plan. Subsequently, CalHEERS verification data dated October 29, 2014, showed that a caseworker manually verified that the beneficiary was a citizen. However, there was no documentation in the case file (e.g., a U.S. passport) to show how the caseworker manually verified the beneficiary's citizenship. The State agency did not explain why the beneficiary was determined eligible when the beneficiary had attested to not being a U.S. citizen.

Payments Were Made on Behalf of a Beneficiary Who Did Not Meet the Residency Requirement

The State agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State (42 CFR § 435.403). The State agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished (42 CFR § 435.403(j)(3)). Generally, an absence from the State of more than 60 days is presumptive evidence of intent to change residence to a place outside of California unless the individual declares orally or in writing an intent to return to California (State plan amendment CA-13-0025, effective Jan. 1, 2014).

The State agency made payments on behalf of one sampled beneficiary who did not meet the residency requirement. A case note dated September 15, 2014, indicated that the beneficiary's mother reported that on September 1, 2014, the beneficiary went to visit her boyfriend and obtained a job in another State, and was trying to transfer her job to California. As of March 16, 2015, there was no documentation in the case file that showed that the beneficiary had returned or had declared an intent to return to California. However, the beneficiary continued to have Medicaid coverage throughout our audit period. The beneficiary's Medicaid coverage should have been terminated beginning in November 2014 because she was absent from California for more than 60 days and did not meet the residency requirement. According to the State agency, it did not terminate the beneficiary's Medicaid coverage because of an influx of applications and policy changes resulting from the enactment of the ACA.

Payments Were Made on Behalf of Beneficiaries Who Did Not Meet Requirements for Coverage Groups for Which They Were Determined Eligible

The State agency made Medicaid payments on behalf of five sampled beneficiaries who did not meet requirements for coverage groups for which they were determined eligible.

Three Beneficiaries Did Not Meet the Income Requirement for the Parent or Other Relative Caretaker Coverage Group or the Pregnancy Coverage Group

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

The State agency made payments on behalf of three sampled beneficiaries who did not meet the income requirement for the parent or other relative caretaker coverage group or the pregnancy coverage group. The State agency did not explain why these three beneficiaries were determined eligible when their incomes were above the income limit.

Example of a Beneficiary Who Did Not Meet the Income Requirement

For one sampled beneficiary, a case note dated May 23, 2014, indicated that she attested to having a monthly household income of \$3,105. The case file included April and May 2014 pay stubs to support her attestation. This income was 156 percent of the 2014 FPL for her household of four, which was above the Medicaid income limit.

Two Beneficiaries Did Not Meet the Income or Resource Requirements for the Medically Needy Coverage Group

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

The State agency made payments on behalf of two sampled beneficiaries who did not meet requirements for the medically needy coverage group because their income or resources were over the established limit:

- For one sampled beneficiary who was under the age of 21, a case note dated May 15, 2014, indicated that a caseworker found out that a beneficiary's mother had

a monthly income of \$3,000 to \$4,000, which was not reported to the county.³¹ This income was above the income limit of \$934 for his family of three and made the beneficiary ineligible for the medically needy group. After the caseworker identified the unreported income, the county terminated the beneficiary's coverage from a different public assistance program, California Work Opportunity and Responsibility to Kids (CalWORKs),³² but the county did not terminate the beneficiary's Medicaid coverage. The State agency did not explain why the county did not take any action to terminate the beneficiary's Medicaid coverage.

- For the other sampled beneficiary, the county did not terminate the beneficiary's Medicaid coverage when the beneficiary's resource amount was over the limit. The beneficiary had a life insurance policy worth \$4,097. This amount was above the resource limit of \$2,000 and made him ineligible for the medically needy group. A notice of action indicated that the county instructed the beneficiary to transfer the insurance policy to his spouse by January 21, 2015, or the beneficiary's Medicaid coverage would be terminated effective February 1, 2015. However, the county did not terminate the coverage on February 1, 2015, even though the beneficiary did not transfer the policy to his spouse by the required date.³³ According to the State agency, the county made a data entry error; however, it did not explain why this error caused the beneficiary to remain eligible for Medicaid coverage.

Payments Were Made on Behalf of Beneficiaries Who Did Not Submit the Required Tax Information Form

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

For individuals who were determined eligible before January 1, 2014, but would have been subject to new MAGI rules after that date, the State agency was granted waivers to delay renewals and conduct redeterminations using the alternative renewal procedures.³⁴ One of these waivers also allowed the State agency to renew Medicaid coverage for beneficiaries if

³¹ The county determined that the beneficiary's mother had unreported earnings by using a report from the Income Eligibility Verification System (IEVS) and receiving confirmation from the employer of the beneficiary's mother. IEVS is a federally mandated system established to obtain, use, and verify information relevant to a determination of eligibility, including income data from California's Employment Development Department (EDD). EDD is responsible for maintaining employment records and collecting payroll taxes.

³² CalWORKs provides cash aid and services to eligible families that have at least one child in the home and is California's implementation of the Federal program Temporary Assistance for Needy Families.

³³ As of September 25, 2015 (after our audit period), the beneficiary had transferred the life insurance policy to his spouse.

³⁴ See page 6 for information on the alternative renewal procedures.

they submit a tax information form that the counties use to redetermine eligibility. Medicaid coverage for individuals who do not return the form should be terminated.

The State agency made payments on behalf of seven sampled beneficiaries who did not return the required tax information form. The State agency did not terminate Medicaid coverage for these beneficiaries. According to the State agency, it did not do so because of a delay in a system conversion or the influx of applications and the backlog triggered by the implementation of ACA's policy changes.

Example of a Beneficiary Who Did Not Return a Tax Information Form

For one sampled beneficiary, on August 9, 2014, the county sent a renewal packet to the beneficiary because October 2014 was his renewal month. The beneficiary did not return the required tax information form. The State agency did not terminate the beneficiary's Medicaid coverage at the end of October 2014 and continued to make Medicaid payments on behalf of the beneficiary throughout the audit period. According to the State agency, the Medicaid coverage had been terminated as of August 31, 2016, after our audit period.

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

The State agency made Medicaid payments on behalf of 52 sampled beneficiaries who may not have met eligibility requirements. Because the State agency did not have sufficient supporting documentation or did not verify eligibility in accordance with Federal and State requirements, we could not conclusively determine whether the beneficiaries were ineligible for Medicaid. The State agency may have claimed Federal reimbursement for these beneficiaries when it should not have.

Payments Were Made on Behalf of Beneficiaries for Whom There Was No Documentation Supporting That Eligibility Redeterminations Were Performed Properly or All Eligibility Requirements Were Verified Properly

The State agency made payments on behalf of 33 sampled beneficiaries for whom there was no documentation supporting that (1) redeterminations of eligibility were performed properly or (2) all eligibility requirements were verified properly.

The State Agency Did Not Have Documentation To Support That Redeterminations Were Performed Properly

The State agency must maintain individual records on each applicant and beneficiary, including (1) information on income and eligibility verifications and (2) 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 must redetermine eligibility of beneficiaries once every 12 months and also promptly redetermine eligibility when it receives information about a change in a beneficiary's circumstances that may affect eligibility (42 CFR §§ 435.916 and 435.952(a)).

The State agency made payments on behalf of 22 sampled beneficiaries for whom there was no documentation to support that the counties performed the required annual redeterminations of eligibility properly. According to the State agency, these deficiencies occurred because of an increase in workload related to the implementation of the ACA and because of human error.

Example of a Beneficiary for Whom the State Agency Did Not Have Documentation of Performing the Redetermination Properly

One sampled beneficiary had not had a Medicaid eligibility redetermination since 2011. There were no case notes or other documentation (e.g., renewal forms) between November 2011 and April 2017. The State agency did not explain why the county had not performed a redetermination since 2011.

The State Agency Did Not Have Documentation To Support That All Eligibility Requirements Were Verified Properly

The State agency must maintain individual records on each applicant and beneficiary, including (1) information on income and eligibility verifications and (2) 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 must request and use information from available electronic sources and the beneficiary relevant to verifying an individual's eligibility for Medicaid (42 CFR § 435.945(b)).

The State agency made payments on behalf of 11 sampled beneficiaries for whom documentation did not support that all eligibility requirements, such as those related to income and resources, had been verified properly. These deficiencies occurred because of caseworker errors or for reasons the State agency could not explain.

Example of a Beneficiary for Whom Income Was Not Verified Properly

One sampled beneficiary attested to having no household income. There was no documentation in the case file to support that the beneficiary's income was verified (e.g., documentation showing that the county requested information from the Income Eligibility Verification System (IEVS) at the time of application). The State agency indicated that because the beneficiary reported household income of \$0, the county did not need to verify this amount. However, Federal requirements state that the State agency must attempt to verify income information using available electronic sources.

Payments Were Made on Behalf of Beneficiaries for Whom Medicaid Eligibility Determinations Were Not Performed

The State agency must maintain individual records on each applicant and beneficiary, including (1) information on income and eligibility verifications and (2) facts essential to determination of initial and continuing eligibility (42 CFR § 431.17 and State plan § 4.7, effective Oct. 1, 1975). Generally, effective January 1, 2014, States are required to use MAGI, a measure of income that is based on IRS rules, to determine income eligibility for Medicaid (42 CFR § 435.603(e)). The use of MAGI does not apply to certain groups of beneficiaries, such as seniors who are 65 years of age or older and medically needy individuals (42 CFR § 435.603(j)).

The State agency made payments on behalf of 16 sampled beneficiaries for whom Medicaid eligibility determinations were not performed. The State agency relied on the counties' departments of social services' eligibility determinations for CalWORKs as the basis for determining Medicaid eligibility.³⁵ These beneficiaries were subject to Medicaid determinations on the basis of MAGI. However, the CalWORKs eligibility determinations did not use MAGI. In addition, the State agency did not have CMS approval to rely on CalWORKs eligibility determinations as the basis for determining Medicaid eligibility.

The State agency indicated that income requirements for the CalWORKs program are more restrictive than the MAGI income requirements for Medicaid and that they were working with CMS on obtaining approval to use CalWORKs determinations as a basis for Medicaid eligibility.³⁶

Payments Were Made on Behalf of Beneficiaries for Whom the State Agency Did Not Apply Alternative Renewal Procedures Properly

For individuals who were determined eligible before January 1, 2014, but would have been subject to new MAGI rules after that date, the State agency was granted waivers to delay renewals and conduct redeterminations using the alternative renewal procedures.

The State agency made payments on behalf of three sampled beneficiaries for whom it did not apply the alternative renewal procedures properly. These beneficiaries had Medicaid coverage under a coverage group (i.e., the aged, blind, and disabled group) that required the counties to perform a regular redetermination of eligibility.³⁷ Instead, the county renewed the beneficiaries' eligibility, indicating that it had applied the alternative renewal procedures.

³⁵ CalWORKs has different income requirements from Medicaid.

³⁶ As of March 2018, the State agency was working with CMS to obtain approval for a State plan amendment to facilitate Medicaid enrollment of individuals who were determined eligible for CalWORKs. Although the State agency indicated that CalWORKs requirements were more restrictive than Medicaid requirements, we did not review the CalWORKs determinations because the California Department of Social Services is responsible for those determinations and they were outside the scope of our audit.

³⁷ See page 5 for information on the regular redetermination process.

Under those procedures, the counties could rely on the tax information form without conducting further verifications to determine the beneficiary's eligibility. Under the regular redetermination process, the counties were required to verify that a beneficiary met eligibility requirements by using available information sources or documentation provided by the beneficiary.

The State agency believed that it had received CMS's approval to apply the alternative renewal procedures to all beneficiary coverage groups. According to the State agency: "The CMS approval letter received by [the State agency] on December 23, 2013, states 'Your request to extend the dates for the state's eligibility renewals scheduled for January 1 through March 31, 2014, is approved.' The approval does not explicitly exclude renewals for the aged, blind and disabled populations."

The State agency misinterpreted the waivers. Certain coverage groups, such as the aged, blind, and disabled group, were not subject to determinations on the basis of MAGI.³⁸ Therefore, the State agency was not approved to renew the Medicaid eligibility of beneficiaries under these groups using the alternative renewal procedures.³⁹

THE STATE AGENCY HAD A PROCEDURAL WEAKNESS 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 did not apply for Medicaid. These beneficiaries had completed a SNAP⁴⁰ application. The State agency was authorized to make Medicaid eligibility determinations on the basis of individuals' eligibility for SNAP.⁴¹ According to CMS guidance, SNAP applicants can indicate that they want to apply for Medicaid by, for example, checking a box on the SNAP application. However, in response to the application question, "Are you interested in applying for Medi-Cal?" the two sampled beneficiaries answered "no." In addition, the case files for these two beneficiaries did not have any documentation to support that they applied for Medicaid. The State agency did not explain

³⁸ 42 CFR § 435.603(j).

³⁹ CMS confirmed our understanding of the waivers.

⁴⁰ In California, SNAP is known as CalFresh.

⁴¹ Generally, to qualify for SNAP, a household's gross income cannot exceed 130 percent of the FPL, and the income of most SNAP participants is lower. According to the State agency, the Federal waiver that allowed the State agency to enroll SNAP beneficiaries in Medicaid expired on June 30, 2017.

why these beneficiaries were determined eligible for Medicaid when they had not requested Medicaid.

CONCLUSION

On the basis of our sample results, we estimated that the State agency made Medicaid payments of \$959,292,678 (\$536,039,109 Federal share) on behalf of 802,742 ineligible beneficiaries and \$4,519,740,806 (\$2,616,843,793 Federal share) on behalf of 3,100,260 potentially ineligible beneficiaries.

According to the State agency, these deficiencies occurred because (1) the counties experienced a “massive influx of applications [for Medicaid] and vast changes in policy brought forth by the ACA,” (2) caseworkers made errors, and (3) system delays occurred during a system conversion. In addition, the State agency could not explain why the counties did not always have sufficient documentation (e.g., notes in the case files) to support eligibility determinations and redeterminations. Finally, the State agency misinterpreted a waiver that was granted by CMS and used CalWORKs’ eligibility determinations without CMS approval when determining the Medicaid eligibility of beneficiaries.

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 and claim unallowable Federal reimbursement for those payments.

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 and
- ensure that:
 - caseworkers properly verify all eligibility requirements;
 - annual redeterminations are performed as required and properly terminate Medicaid coverage for beneficiaries, if necessary;
 - information is maintained in case files to support that eligibility determinations were performed in accordance with Federal and State requirements;
 - beneficiaries are not determined eligible for Medicaid on the basis of their CalWORKs eligibility without approval from CMS; and

- eligibility determinations are performed only for individuals who apply for Medicaid.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings. The State agency partly agreed with the fourth part of our second recommendation (regarding beneficiaries who were determined eligible for Medicaid on the basis of their CalWORKs eligibility) but provided information on actions being taken to address this recommendation. Although the State did not explicitly agree or disagree with our other recommendations, it 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 E.

Regarding our first recommendation, the State agency commented that it will review the sampled beneficiary cases and ensure that current eligibility is correct (by March 2019).

Regarding our second recommendation, the State agency had the following comments:

- The State agency commented that it addressed with counties the issue of ensuring that caseworkers properly verify all eligibility requirements. It stated that on April 24, 2018, it issued a Medi-Cal Eligibility Division Information Letter that instructed counties to perform an eligibility determination only on individuals who request an evaluation for healthcare programs on the application.⁴²
- The State agency commented that in March 2017 it implemented focused reviews of counties to ensure that redeterminations are performed in accordance with Federal and State requirements and, when applicable, Medicaid coverage is terminated in a timely manner.
- The State agency commented that it will remind counties of their responsibility to ensure that documents used during the redetermination process are retained in the case files and estimated that the recommendation will be implemented by winter 2018.
- The State agency provided two reasons for its partial agreement with our recommendation that it ensure beneficiaries are not determined eligible for Medicaid on the basis of their CalWORKs eligibility without approval from CMS: (1) CalWORKs beneficiaries are aware of their eligibility for Medicaid, and (2) the State agency's extensive research confirms that it is highly improbable that a CalWORKs beneficiary

⁴² The State agency provided the same comment for the first and fifth parts of the second recommendation. Although the State's agency's comment as written does not directly address the first part of the second recommendation, the Medi-Cal Eligibility Division Information Letter also instructed the counties to (1) verify income electronically or manually before affirming or reaffirming eligibility and (2) take precautions, to the extent possible, to ensure that data are entered accurately into the eligibility systems.

would not meet Medicaid requirements because CalWORKs eligibility requirements are more stringent. The State agency commented that it is working collaboratively with CMS on a State plan amendment that will formalize the process to allow enrollment of CalWORKs beneficiaries in Medicaid without a separate eligibility determination. The State agency estimated that this recommendation will be implemented by December 2019 or upon CMS's approval of the State plan amendment.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 7,072,052 non-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 payments made on behalf of these non-newly eligible beneficiaries throughout the audit period. We reviewed a stratified random sample of 125 beneficiaries to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for their coverage groups. For beneficiaries we determined ineligible for the aid code associated with the payments made on their behalf, we reviewed supporting documentation to determine whether they met eligibility requirements for 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 May 2017 through February 2018 at the State agency offices in Sacramento, California, and three county offices in Los Angeles, San Francisco, and San Bernardino, 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 county offices 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;⁴³
 - created a sampling frame of 7,072,052 Medicaid beneficiaries for whom the State agency made Medicaid payments totaling \$11,276,688,182 (\$6,713,413,002 Federal share);⁴⁴
 - selected a stratified random sample of 125 Medicaid beneficiaries, consisting of four strata based on payment amounts;
 - 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 their Medicaid coverage groups;
 - estimated the total number of ineligible and potentially ineligible beneficiaries;
 - estimated the total payments made on behalf of ineligible and potentially ineligible beneficiaries and the associated Federal shares; and
 - discussed the results of our review with State agency officials.

⁴³ 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.

⁴⁴ 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.

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

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 all beneficiaries, excluding (1) those determined newly eligible for Medicaid under the ACA, (2) those who had only dental fee-for-service payments, and (3) American Indians and Alaskan Natives,⁴⁵ for whom the State agency made Medicaid payments for services provided during the audit period and reported on Form CMS-64 for this period.

SAMPLING FRAME

The State agency provided us with four sets of files⁴⁶ that contained Medicaid claims or monthly capitation payments during the audit period. The sampling frame, which matched our target population, consisted of 7,072,052 Medicaid beneficiaries for whom the State agency made Medicaid payments for services totaling \$11,276,688,182 (\$6,713,413,002 Federal share) during the audit period.

SAMPLE UNIT

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

SAMPLE DESIGN

We used a stratified random sample consisting of four strata:

- Stratum 1 consisted of beneficiaries who each had total payments of less than \$1,550: 5,504,647 beneficiaries with payments totaling \$3,612,808,343 (\$1,833,479,328 Federal share).
- Stratum 2 consisted of beneficiaries who each had total payments greater than or equal to \$1,550 and less than \$9,200: 1,453,603 beneficiaries with payments totaling \$4,794,198,665 (\$3,313,164,708 Federal share).
- Stratum 3 consisted of beneficiaries who each had total payments greater than or equal to \$9,200 and less than \$1,000,000: 113,797 beneficiaries with payments totaling \$2,851,076,557 (\$1,557,466,658 Federal share).

⁴⁵ American Indians and Alaskan Natives are subject to eligibility requirements that were not a part of this review.

⁴⁶ The files contained Medicaid beneficiary data from four payment systems. See footnote 24.

- Stratum 4 consisted of beneficiaries who each had total payments greater than or equal to \$1,000,000: five beneficiaries with payments totaling \$18,604,617 (\$9,302,308 Federal share).

SAMPLE SIZE

We selected 125 Medicaid beneficiaries: 60 beneficiaries from stratum 1, 30 beneficiaries from stratum 2, 30 beneficiaries from stratum 3, and all 5 beneficiaries from stratum 4.

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 4. After generating the random numbers for strata 1 through 3, we selected the corresponding Medicaid beneficiaries in the sampling frame. We reviewed all 5 beneficiaries in stratum 4.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to calculate the point estimates and the 90-percent confidence intervals for the total number of ineligible and potentially ineligible Medicaid beneficiaries in the sampling frame. This software was also used to calculate the point estimates for the total dollar value of the payments for ineligible and potentially ineligible Medicaid beneficiaries. The 90-percent confidence intervals for these latter estimates was calculated using the empirical likelihood approach, which we programmed using Microsoft Excel software.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS⁴⁷

Table 1: Sample Detail and Results for Ineligible Beneficiaries

Stratum	Number of Beneficiaries in Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	5,504,647	60	\$24,671	7	\$2,083
2	1,453,603	30	77,440	3	5,783
3	113,797	30	432,206	4	17,061
4	5	5	9,302,308	0	0
Total	7,072,052	125	\$9,836,625	14	\$24,927

Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries

Stratum	Number of Beneficiaries in Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	5,504,647	60	\$24,671	27	\$9,543
2	1,453,603	30	77,440	12	22,910
3	113,797	30	432,206	11	165,319
4	5	5	9,302,308	2	4,130,898
Total	7,072,052	125	\$9,836,625	52	\$4,328,670

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 (Federal Share)	Total Value of Payments for Ineligible Beneficiaries (Federal and State)
Point estimate	802,742	\$536,039,109	\$959,292,678
Lower limit	401,400	296,532,275	545,051,601
Upper limit	1,204,085	919,149,766	1,626,946,583

⁴⁷ The values included in Tables 1 and 2 are Federal share amounts of the payments associated with the beneficiaries.

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 (Federal Share)	Total Value of Payments for Potentially Ineligible Beneficiaries (Federal and State)
Point estimate	3,100,260	\$2,616,843,793	\$4,519,740,806
Lower limit	2,474,568	1,961,634,853	3,447,948,297
Upper limit	3,725,952	3,502,017,605	5,856,964,000

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

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

APPENDIX E: STATE AGENCY COMMENTS



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 responses to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft audit report entitled, *California Made Medicaid Payments on Behalf of Non-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 Nicole Jacot, External Audit Specialist at (916) 713-8812 if you have any questions.

Sincerely,

Jennifer Kent
Director

Enclosure

Director's Office
Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413, Sacramento, CA 95899-7413
(916) 440-7400 / (916) 440-7404 FAX
Internet address: <http://www.dhcs.ca.gov>

Ms. Lori Ahlstrand
Page 2

cc: Mari Cantwell
Chief Deputy Director
Health Care Programs
State Medicaid Director
Department of Health Care Services
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Erika Sperbeck
Chief Deputy Director
Policy and Program Support
Department of Health Care Services
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Rene Mollow
Deputy Director
Health Care Benefits and Eligibility
Department of Health Care Services
MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

Bruce Lim
Deputy Director
Audits & Investigations Division
Department of Health Care Services
MS 2000
P.O. Box 997413
Sacramento, CA 95899-7413

The Department of Health Care Services'
Responses to the Office of Inspector General Draft Report Entitled: California
Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did
Not Meet Federal and State Requirements
Report Number: A-09-17-02002, (16-24)

Finding 1: The Department of Health Care Services (DHCS) made Medicaid payments on behalf of non-newly eligible beneficiaries who did not meet or may not have met federal and state eligibility requirements. The State agency made payments on behalf of 14 sampled beneficiaries who did not (1) meet the citizenship requirement, (2) meet the residency requirement, (3) meet the requirements for the respective coverage groups for which they were determined eligible, or (4) submit the required tax information form.

DHCS Agreement: Fully agrees with finding

Recommendation 1: Re-determine the current Medicaid eligibility of the sampled beneficiaries who did not meet or may not have met federal and state eligibility requirements.

Response: DHCS will review these cases and ensure that current eligibility is correct.

Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: March 2019
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

Finding 2: DHCS made Medicaid payments on behalf of beneficiaries who may not have met eligibility requirements.

DHCS agreement: Fully agrees with finding

Recommendation 2: Ensure that caseworkers properly verify all eligibility requirements.

Response: DHCS did address this issue with counties. On April 24, 2018, DHCS issued Medi-Cal Eligibility Division Information Letter (MEDIL) No.18-06 that instructs counties to perform an eligibility determination only on individuals who request

The Department of Health Care Services'
Responses to the Office of Inspector General Draft Report Entitled: California
Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did
Not Meet Federal and State Requirements
Report Number: A-09-17-02002, (16-24)

an evaluation for health care programs on the application. A copy of the MEDIL may be found at <http://www.dhcs.ca.gov/services/med-cal/eligibility/Documents/MEDIL/2018/118-06.pdf>

Implementation Status: Fully Implemented:
Implementation Date: April 24, 2018
 Not Fully Implemented:
Estimated Implementation Date:
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

Recommendation 3: Ensure that annual redeterminations are performed as required and properly terminate Medicaid coverage for beneficiaries, if necessary.

Response: DHCS conducts focused reviews on counties to ensure that redeterminations are performed in accordance with federal and state requirements, and, when applicable, Medicaid coverage is terminated timely.

Implementation Status: Fully Implemented:
Implementation Date: March 2017
 Not Fully Implemented:
Estimated Implementation Date:
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

Recommendation 4: Ensure that information is maintained in case files to support that eligibility determinations were performed in accordance with federal and state requirements.

Response: DHCS will remind counties of their responsibility to ensure documents obtained and used to reaffirm eligibility during the redetermination process are retained in the case file.

The Department of Health Care Services'
Responses to the Office of Inspector General Draft Report Entitled: California
Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did
Not Meet Federal and State Requirements
Report Number: A-09-17-02002, (16-24)

Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: Winter 2018
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

Recommendation 5: Ensure that beneficiaries are not determined eligible for Medicaid on the basis of their California Work Opportunity and Responsibility to Kids (CalWORKs) eligibility without approval from the Centers for Medicare and Medicaid Services (CMS).

Response: DHCS partly agrees with this recommendation for the following reasons:

1. CalWORKs beneficiaries are aware of their eligibility to the Medicaid program.
2. DHCS performed extensive research that confirms it is highly improbable that a CalWORKs beneficiary will not meet Medicaid program requirements. CalWORKs eligibility requirements are significantly more stringent than those of Medicaid.

DHCS is working collaboratively with CMS on a state plan amendment that will formalize the process used by DHCS to allow enrollment of CalWORKs beneficiaries into the Medicaid program without a separate eligibility determination.

Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: December 2019 or upon CMS' approval of DHCS' state plan amendment.
 Will Not Implement

