Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MASSACHUSETTS GENERALLY COMPLETED MEDICAID ELIGIBILITY ACTIONS DURING THE UNWINDING PERIOD IN ACCORDANCE WITH FEDERAL AND STATE REQUIREMENTS

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

Christi A. Grimm
Inspector General

August 2024
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Office of Inspector General

https://oig.hhs.gov

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REPORT HIGHLIGHTS

August 2024 | A-02-24-01001

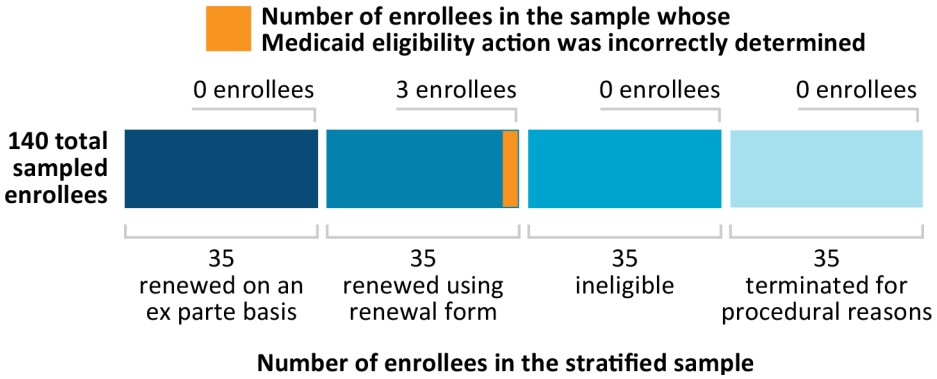
Massachusetts Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

Why OIG Did This Audit

- In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure that most individuals were continuously enrolled for Medicaid benefits (enrollees).
- The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees.
- This audit is part of a series and examined whether Massachusetts completed Medicaid eligibility actions during its unwinding period in accordance with Federal and State requirements.

What OIG Found

Of the 352,408 enrollees covered during our audit period (April through September 2023), we sampled 140 enrollees and determined that 3 enrollees had their Medicaid eligibility incorrectly determined.



On the basis of our sample results, we estimated that Massachusetts incorrectly renewed Medicaid eligibility for 7,040 of the 190,043 Medicaid enrollees whose eligibility was renewed during our audit period. Additionally, we found that, in its reports to CMS, Massachusetts incorrectly reported on its eligibility actions for eight enrollees in our sample. We also estimated that Massachusetts' reports to CMS during our audit period incorrectly reported on eligibility actions for 17,749 of 352,408 enrollees.

What OIG Recommends

We made three recommendations to Massachusetts, including that it redetermine eligibility for the three sampled enrollees whose eligibility was incorrectly determined and take appropriate action, provide periodic training to caseworkers, and revise its policies and procedures related to its reports to CMS. The full recommendations are in the report. Massachusetts concurred with our first two recommendations and partially concurred with our third recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

On January 31, 2020, the Department of Health and Human Services (HHS) declared a public health emergency (PHE) for COVID-19.[1] In March 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA) in response to the PHE.[2] The FFCRA provided States with a temporary increase of 6.2 percentage points to their regular Federal medical assistance percentage (FMAP) rates. To receive the increased FMAP, the FFCRA required, among other conditions, States to ensure that most individuals who were enrolled for Medicaid benefits (enrollees) as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ended (continuous enrollment condition). These enrollees should have remained enrolled for Medicaid, unless the enrollee requested a voluntary termination of eligibility, ceased to be a resident of the State, or died.

The Consolidated Appropriations Act, 2023 (CAA) amended the expiration of the continuous enrollment condition to March 31, 2023.[3] As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees. In accordance with guidance issued by the Centers for Medicare & Medicaid Services (CMS), States have up to 12 months to initiate and an additional 2 months to complete Medicaid eligibility actions for all enrollees (unwinding period). States were able to begin their unwinding period as early as February 1, 2023, and could begin terminating Medicaid enrollment on or after April 1, 2023, for individuals who were no longer eligible.[4]

The COVID-19 pandemic created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.[5] This audit of the Massachusetts' Executive Office of Health and Human Services (State agency) is one in a series of reports related to States' unwinding periods.

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[1] Administration for Strategic Preparedness & Response, "Determination That A Public Health Emergency Exists." Available online at https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx. Accessed on Feb. 12, 2024. (The PHE ended May 11, 2023.)

[2] The Families First Coronavirus Response Act (P.L. No. 116-127) (Mar. 18, 2020).

[3] Division FF, § 5131, Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022).

[4] CMS State Health Official (SHO) Letter No. 23-002 (issued Jan. 27, 2023).

[5] OIG's COVID-19 response strategic plan and oversight activities can be accessed at HHS-OIG's Oversight of COVID-19 Response and Recovery | HHS-OIG.

OBJECTIVE

Our objective was to determine whether the State agency completed Medicaid eligibility actions in accordance with Federal and State requirements during its unwinding period following the end of the continuous enrollment condition.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the FMAP, which varies depending on the State's per capita income.[6] Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time.

Federal Requirements and CMS Guidance Related to the Continuous Enrollment Condition and the Unwinding Period

In March 2020, Congress enacted the FFCRA in response to the COVID-19 PHE. Section 6008 of the FFCRA provided a temporary increase of 6.2 percentage points to each qualifying State's FMAP effective January 1, 2020. To qualify for the increased COVID-19 FMAP, States were required to ensure that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ended.

Federal regulations (42 CFR § 433.400, effective November 2, 2020) interpret and implement section 6008(b)(3) of the FFCRA. The regulations outline exceptions to the continuous enrollment condition requirement. A State could terminate an enrollee's Medicaid enrollment during the PHE if:

- the enrollee or the enrollee's representative requests a voluntary termination of eligibility,

- the enrollee ceases to be a resident of the State, or

[6] The Act § 1905(b).

- the enrollee dies.

The CAA, enacted on December 29, 2022, included significant changes to the FFCRA's continuous enrollment condition. The CAA addresses the end of the continuous enrollment condition, the phase down and end of the temporary FMAP increase, and the unwinding process. Under section 5131 of the CAA, the end of the continuous enrollment condition and receipt of the temporary FMAP increase are no longer linked to the end of the PHE. The CAA amended section 6008(b)(3) of the FFCRA to end, on March 31, 2023, continuous Medicaid enrollment as a condition for claiming the temporary FMAP increase. Further, the FFCRA's temporary FMAP increase gradually phased down beginning April 1, 2023, and ended on December 31, 2023. The CAA required States to initiate all eligibility actions for all enrollees when the continuous enrollment condition ended.

In accordance with CMS-issued guidance, in preparation for and at the end of the continuous enrollment condition:

- States could begin their unwinding period as early as February 1, 2023, but were required to begin initiating eligibility actions no later than April 2023.

- For States that initiated renewals prior to April 1, 2023, terminations of Medicaid eligibility could not be effective earlier than April 1, 2023.

- States must initiate renewals for all individuals enrolled in Medicaid within 12 months of the beginning of the State's unwinding period and must complete renewals for all individuals within 14 months of the beginning of the State's unwinding period.[7]

Monthly Reporting Requirements for States During the Unwinding Period

In March 2022, CMS announced that States would be expected to submit data demonstrating progress in completing the required eligibility and enrollment actions during the unwinding period.[8] Subsequently, the CAA required States to report, and CMS to publicly report, on a broad set of metrics, including some of the specific metrics described in CMS's monthly *Unwinding Eligibility and Enrollment Data Reporting Template* (unwinding data report).[9, 10] These metrics in the monthly unwinding data report are designed to demonstrate the State's progress toward restoring timely application processing and initiating and completing renewals

[7] CMS SHO Letter No. 23-002 (issued Jan. 27, 2023).

[8] CMS SHO Letter No. 22-001 (issued Mar. 3, 2022).

[9] Division FF, § 5131(b), Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022).

[10] As of Dec. 6, 2023, this process is further outlined under 42 CFR §§ 435.927 and 435.928.

of eligibility for all Medicaid and Children's Health Insurance Program (CHIP) enrollees.[11] The categories of metrics that are reported monthly by the States are:

- application processing (e.g., pending applications that were received during the continuous enrollment condition),
- renewals initiated,
- renewals and outcomes, and
- Medicaid fair hearings.

In the unwinding data reports, States must report on the numbers of applications processed, renewals initiated, renewals and outcomes, and Medicaid fair hearings. The numbers of renewals and outcomes are defined as follows:

- enrollees renewed and retained, which includes:
    - enrollees renewed on an ex parte basis[12] and
    - enrollees renewed using a renewal form;
- enrollees determined to be ineligible; and
- enrollees whose coverage was terminated for procedural reasons (i.e., the enrollee failed to respond).

Massachusetts' Medicaid Program

The State agency provides health care coverage for more than 2.3 million Massachusetts enrollees and is responsible for the administration and oversight of the Medicaid program in Massachusetts. The State agency's Medicaid and CHIP program is known as MassHealth. Combined with MassHealth, the State-based health insurance marketplace called the Health Connector, utilize a shared eligibility determination system called the Health Insurance Exchange Integrated Eligibility System (HIX). HIX also serves as a central repository to store documentation supporting Medicaid eligibility.

[11] CHIP provides health coverage to eligible children of families with incomes too high to qualify for Medicaid but too low to afford private coverage.

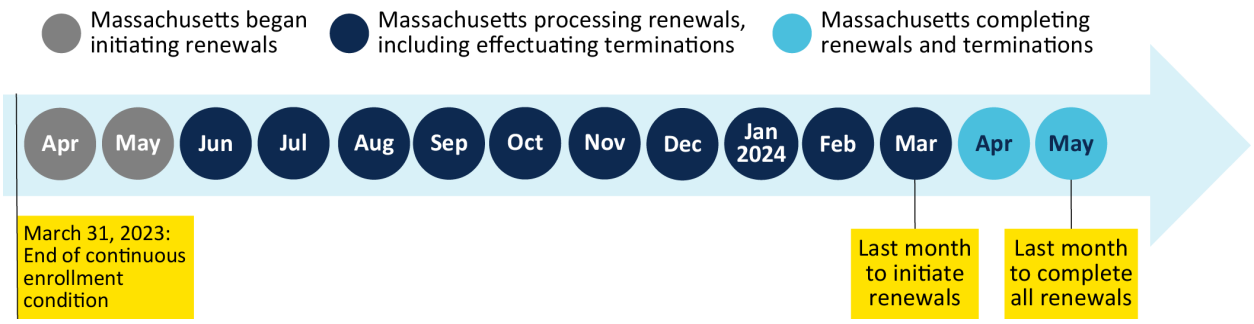
[12] An ex parte renewal is any renewal that is completed without contacting the enrollee for information or verification (42 CFR § 435.916(a)(2)). The State agency refers to ex parte renewals as "passive" (i.e., completed all electronically) or "manual" (i.e., involving some caseworker intervention).

State Agency's Unwinding Process for Renewing Medicaid Eligibility

According to Massachusetts' *Operational Plan for Redeterminations* (published March 31, 2023, revised on November 10, 2023) and in preparation for the end of the unwinding period, the State agency implemented Federal guidance as well as best practices from national organizations and other States in order to minimize coverage interruptions for eligible individuals. The State agency began initiating unwinding-related renewals on April 1, 2023, at the end of the continuous enrollment condition. Accordingly, the State agency had 12 months to initiate renewals and 14 months to complete all renewals.

Figure 1 illustrates the State agency's renewal process timeline during its 14-month unwinding period.

Figure 1: State Agency's Unwinding Timeline



Whenever possible, MassHealth attempts to automatically process renewals through a passive ex parte process, also known as auto-renewal. A renewal is considered initiated when MassHealth begins the passive ex parte process.

To verify the accuracy of enrollees' eligibility information during the passive ex parte process, MassHealth uses multiple electronic data sources, including sources available through the State Wage Information Collection Agency (SWICA), the Massachusetts Department of Unemployment Assistance, and the Federal Data Services Hub (Data Hub). The Social Security Administration and Department of Homeland Security, among others, provide the data sources available through the Data Hub.[13]

MassHealth verifies individuals' application information against Federal and State data for various eligibility factors requiring verification. If the data are verified at the same or greater benefit level for all household members, then the enrollee's eligibility can be renewed on a passive ex parte basis.

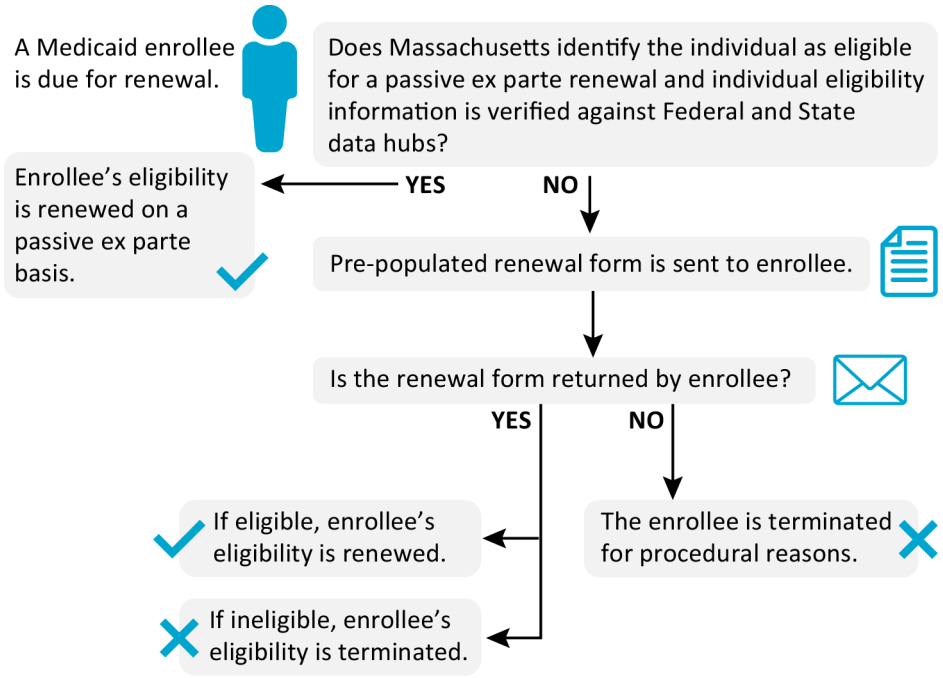
[13] States are required to request financial information from other agencies, such as SWICA, and the Department of Unemployment Assistance, to the extent the agency determines such information is useful for verifying the financial eligibility of an individual (42 CFR § 435.948).

According to the State agency's internal processes during the unwinding period, if an enrollee's eligibility cannot be renewed using the passive ex parte process, the State agency will send the enrollee a prepopulated renewal form. If the enrollee responds within 45 days with the requested information, they will receive the highest-level benefit for which they qualify. If additional information is required to process their renewal form, a "Request for Information" (RFI) will be sent to the enrollee and they will have 90 days to provide the requested information to MassHealth.

If the individual does not respond to the renewal notice within 45 days, or if they were sent an RFI and did not respond within the required 90-day period, the enrollee may receive the highest benefit they are eligible for based on the data available to MassHealth obtained during the renewal process. If there is no data available from the renewal process and the enrollee does not respond to the RFI, their coverage will be terminated.

Figure 2 illustrates the State agency's renewal process for enrollees during the unwinding period.

Figure 2: State Agency's Medicaid Eligibility Process During Unwinding



HOW WE CONDUCTED THIS AUDIT

Our audit covered 352,408 enrollees[14] who were listed on Massachusetts' monthly unwinding data reports and who had their Medicaid eligibility renewed or terminated during April 1 through September 30, 2023 (audit period), following the end of the continuous enrollment

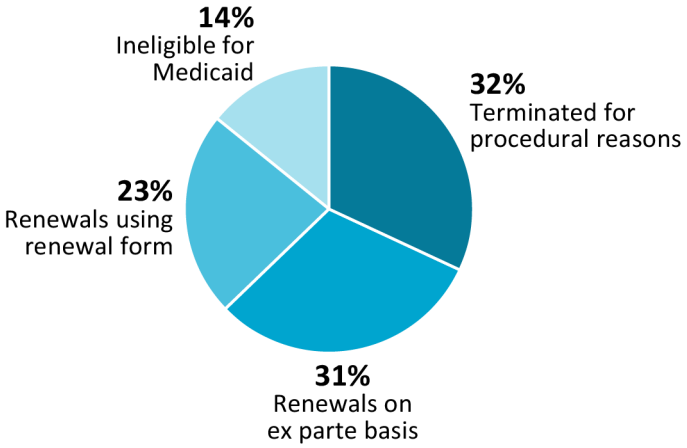
[14] This audit excludes the enrollees who had coverage through CHIP before their renewal months.

condition. Of the 352,408 enrollees whose Medicaid eligibility was renewed or terminated during the audit period, we identified:

- 107,909 enrollees whose eligibility was renewed on an ex parte basis,
- 82,134 enrollees whose eligibility was renewed using a renewal form,
- 48,176 enrollees who were determined to be ineligible and whose Medicaid coverage was terminated and
- 114,189 enrollees whose Medicaid coverage was terminated for procedural reasons (i.e., failure to respond).

See Figure 3 for the percentage of the 352,408 enrollees who had their Medicaid eligibility renewed, were determined ineligible, or had their coverage terminated for procedural reasons during our audit period.

Figure 3: Percentage of Enrollees Who Had Various Medicaid Eligibility Actions Taken Following the End of the Continuous Enrollment Condition (April Through September 2023)



We reviewed documentation in MassHealth's HIX for the Medicaid eligibility actions taken by the State agency for a stratified random sample of 140 enrollees. These 140 sampled enrollees consisted of:

- 35 enrollees who were listed on the unwinding data reports as having had their eligibility renewed on an ex parte basis,
- 35 enrollees who were listed on the unwinding data reports as having had their eligibility renewed using a renewal form,

- 35 enrollees who were listed on the unwinding data reports as having been determined to be ineligible and having their Medicaid coverage terminated, and

- 35 enrollees who were listed on the unwinding data reports as having had their Medicaid coverage terminated for procedural reasons.

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

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

FINDINGS

The State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period following the end of the continuous enrollment condition. Of the 140 sampled enrollees, 137 enrollees had their Medicaid eligibility actions correctly completed. Specifically, the State agency correctly completed Medicaid eligibility actions for 35 sampled enrollees listed on the unwinding reports as having had their Medicaid coverage renewed on an ex parte basis, 35 sampled enrollees listed on the unwinding reports as having had their Medicaid coverage determined to be ineligible and having their Medicaid coverage terminated, 35 sampled enrollees listed on the unwinding reports as having had their Medicaid coverage terminated for procedural reasons, and 32 of the 35 sampled enrollees listed on the unwinding data reports as having had their Medicaid coverage renewed using a renewal form. For the remaining three sampled enrollees listed on the unwinding data reports as having had their Medicaid coverage renewed using a renewal form, the State agency incorrectly renewed the enrollees' Medicaid eligibility during our audit period.

The State agency incorrectly renewed enrollees' Medicaid eligibility during our audit period because the State agency caseworkers who reviewed the renewals did not identify the enrollees for disenrollment after certain eligibility factors were not verified. The findings we identified suggest that although the State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period, caseworkers may benefit from periodic training that focuses on verifying and documenting information used and steps performed during the eligibility renewal process.

Additionally, we found that for the 140 sampled enrollees listed on the unwinding data reports, the State agency correctly reported the Medicaid eligibility actions completed for 132 enrollees. However, we found that the State agency incorrectly reported the Medicaid eligibility actions completed for the remaining eight enrollees. Specifically:

- five enrollees' eligibility had not yet been determined but they were incorrectly reported on the unwinding reports as having been successfully renewed using a pre-populated renewal form,

- two enrollees had their Medicaid coverage terminated for not timely providing required documentation but were incorrectly reported on the unwinding reports as having been ineligible for Medicaid rather than having been terminated for procedural reasons, and

- one enrollee was reenrolled in Medicaid but was incorrectly reported on the unwinding reports as having had their Medicaid coverage terminated for procedural reasons.

These deficiencies occurred because the State agency's policies and procedures for reporting on enrollees included reporting instructions that were inconsistent with the CMS guidance for preparing the unwinding reports. Specifically, for reporting on enrollees whose Medicaid eligibility was renewed using a renewal form, the State agency's policies and procedures indicated that individuals who sent back their pre-populated forms would continue to receive services until determined ineligible and should be included on unwinding reports while the State agency was awaiting documentation to perform its redeterminations. Further, the State agency's policies and procedures for reporting on enrollees determined ineligible for Medicaid directed staff to include individuals who did not timely provide required documentation but were determined ineligible for Medicaid based on current information available to the State agency. In addition, the State agency indicated that the one enrollee was inappropriately reported as having their Medicaid coverage terminated for procedural reasons due to a clerical error.

On the basis of our sample results, we estimated that the State agency incorrectly renewed Medicaid eligibility for 7,040 of the 190,043 enrollees whose eligibility was renewed during our audit period.[15] We also estimated that the State agency reported eligibility actions for 17,749 of the 352,408 enrollees with Medicaid eligibility actions on the incorrect line of the unwinding reports submitted to CMS during our audit period.[16]

Appendix C contains our sample results and estimates.

MEDICAID ELIGIBILITY ACTIONS WERE GENERALLY COMPLETED CORRECTLY DURING THE UNWINDING PERIOD

Of the 140 sampled enrollees, the State agency correctly completed eligibility actions for all 105 enrollees whose eligibility was renewed on an ex parte basis, whose coverage was terminated based on a determination of ineligibility, and whose coverage was terminated for procedural reasons. However, for 3 of the remaining 35 sampled enrollees who were renewed

[15] The lower and upper limits at the 90-percent confidence level are 555 and 13,525, respectively.

[16] The lower and upper limits at the 90-percent confidence level are 7,529 and 27,968, respectively.

using a renewal form, the State agency incorrectly completed eligibility actions during our audit period.

All 35 Sampled Enrollees' Eligibility Was Correctly Renewed on an Ex Parte Basis

The State agency must make a redetermination of eligibility without requiring information from the individual if the State agency is able to do so based on reliable information contained in the enrollee's case file or other more current information available to the agency. During the unwinding period, a renewal is considered initiated when the State agency begins the renewal process by attempting to renew eligibility on an ex parte basis. If the State agency can electronically verify the enrollee's eligibility using information from the Data Hub, the enrollee's eligibility can be renewed on an automatic ex parte basis.[17]

For all 35 sampled enrollees whose eligibility was renewed on an ex parte basis, Medicaid eligibility actions were correctly completed.

The example describes an enrollee whose eligibility was correctly renewed on an ex parte basis.

Example 1:
Enrollee whose eligibility was correctly renewed on an ex parte basis.

For an adult enrollee in our sample, the State agency listed the enrollee on the September 2023 unwinding data report as having had eligibility renewed. In July 2023, the enrollee's renewal was initiated on an automatic ex parte basis. The State agency processed the renewal using the enrollee's current monthly income of $1,430, as indicated in the case file. The State agency verified the enrollee's monthly income using data obtained from approved electronic sources and correctly renewed the enrollee's eligibility.

Three Sampled Enrollees' Eligibility Was Incorrectly Renewed Using a Renewal Form

When an enrollee's eligibility under Modified Adjusted Gross Income (MAGI) rules cannot be renewed using a passive ex parte renewal, the enrollee's information must be verified directly with the enrollee using a prepopulated renewal form.[18] According to the State agency's internal processes during the unwinding period, after the State agency sends an enrollee the renewal form, the enrollee may renew their eligibility by completing the renewal form, by contacting their caseworker by telephone or in person, or by using MassHealth's online self-service portal. The enrollee benefit is then determined based on the new information submitted.

[17] 42 CFR § 435.916(a)(2).

[18] This process is specific to the renewal of individuals whose Medicaid eligibility is based on modified adjusted gross income methods (42 CFR § 435.916(a)(2)-(3)).

Of the 35 sampled enrollees listed on the unwinding data reports as having had their eligibility renewed using a renewal form, eligibility actions for 32 enrollees were correct. However, the State agency incorrectly determined eligibility for the remaining three enrollees. Specifically, we identified that for two enrollees, the State agency did not verify the enrollee's income, and for one enrollee, the State agency did not timely verify the enrollee's residency. These actions were not in accordance with Federal and State requirements, and related processes in place during the unwinding period.

The following are examples of enrollees whose eligibility was renewed using a renewal form.

Example 2:
Enrollee whose eligibility was correctly renewed with a renewal form.

For an enrollee in our sample, the State agency listed the individual on the September 2023 unwinding data report as having had their eligibility renewed. In August 2023, the individual's renewal was initiated through the ex parte process; however, the ex parte process failed because the individual's residency could not be verified. The State agency sent the enrollee a renewal form in August 2023 requesting proof of residency. The enrollee returned the renewal form along with a utility bill showing proof of their address by the due date. The caseworker added the newly verified proof of residency to the case record, found the enrollee eligible for Medicaid, and correctly renewed the enrollee's Medicaid coverage.

Example 3: Enrollee was incorrectly renewed without verifying residency.

For an enrollee in our sample, the State agency listed the individual on the September 2023 unwinding data report as having had their eligibility renewed. During the renewal process, the individual's residency could not be verified on an ex parte basis and, as a result, a pre-populated form and, subsequently, a request for information were sent to the enrollee in October 2023. The enrollee did not provide any evidence of residency within 90 days of the request for information and there was no evidence in the enrollee's case file indicating that they submitted a utility bill or other proof of residency within the required 90-day timeframe.

All 35 Sampled Enrollees' Eligibility Was Correctly Determined Ineligible and Had Their Coverage Terminated

The State agency must make a redetermination of Medicaid eligibility without requiring information from the enrollee if the State agency is able to do so based on reliable information contained in the enrollee's case file or other more current information available to the State agency. When an enrollee's eligibility cannot be renewed on an ex parte basis, the State

agency must send the enrollee a renewal form to request information and verify the information that the enrollee provides.[19] After the State agency sends an enrollee the renewal form, the enrollee may respond with the requested information by contacting the State agency by telephone or in person, or through an online portal. A caseworker is responsible for entering the information into the case management system and processing the renewal.

For all 35 sampled enrollees who were determined ineligible and had their coverage terminated, Medicaid eligibility actions were correctly completed.

The following example describes an enrollee who was correctly determined to be ineligible and had their coverage terminated.

Example 4:
Enrollee who became ineligible for Medicaid and whose coverage was correctly terminated.

For an adult enrollee in our sample, the State agency listed the enrollee on the July 2023 unwinding data report as having been determined ineligible and having had coverage terminated. In July 2023, the enrollee's renewal was initiated and the State agency verified their income exceeded the eligibility limit for Medicaid. A caseworker documented this in the State agency's system and the enrollee was sent a notice that they were no longer eligible for Medicaid. The enrollee was correctly determined to be ineligible.

All 35 Sampled Enrollees Had Their Coverage Correctly Terminated for Procedural Reasons

The State agency must make a redetermination of eligibility without requiring information from the individual if the State agency is able to do so based on reliable information contained in the enrollee's case file or other more current information available to the State agency.[20] The State agency will send the individual a renewal form if the State agency is unable to make a redetermination of the individual based on available information. If the enrollee does not respond to the renewal form within 45 days and no other relevant information becomes available to the State agency, the enrollee's coverage will be terminated. [21]

For all 35 sampled enrollees whose eligibility was correctly determined and had their coverage terminated for procedural reasons, the State agency correctly completed Medicaid eligibility actions.

[19] 42 CFR §§ 435.916(a)(2) and (3).

[20] 42 CFR § 435.916(a)(2).

[21] 42 CFR § 435.916(a)(3) and 42 CFR § 435.912(c)(3)(ii).

The example describes an enrollee whose eligibility was correctly terminated for procedural reasons.

Example 5:
Enrollee whose coverage was correctly terminated for procedural reasons.

For an adult enrollee in our sample, the State agency listed the enrollee on the June 2023 unwinding data report as having had coverage terminated for procedural reasons. In July 2023, the enrollee's renewal was initiated on an ex parte basis; however, the renewal process was not completed because the enrollee's income could not be verified. The enrollee was sent a renewal form to be completed by August 17, 2023; however, the enrollee did not respond to this request. The State agency sent another notice on August 18, 2023, requesting income verification, but the enrollee did not respond to the request. A caseworker followed State agency procedures to notify the enrollee that coverage would be terminated because the State agency had not received the information necessary to complete the enrollee's eligibility redetermination. The enrollee's coverage was correctly terminated.

MEDICAID UNWINDING REPORTS WERE INACCCURATE

The CAA required States to report, and CMS to publicly report, on a broad set of metrics in unwinding data reports. The metrics in the monthly unwinding data reports are designed to allow monitoring of States' progress in meeting timelines and completing required eligibility and enrollment actions.[22]

In its guidance to States on how to prepare the unwinding reports,[23] CMS stated that Line 5 of the report is meant to represent the total number of enrollees due for renewal in the reporting period. Specifically:

- Line 5a represents the number of enrollees renewed and that remained enrolled in Medicaid or CHIP,
    - Line 5a(1) represents the number of enrollees renewed on an ex parte basis,
    - Line 5a(2) represents the number of enrollees renewed using a pre-populated renewal form,

[22] CMS SHO Letter No. 22-001 (issued on Mar. 3, 2022).).

[23] CMS's Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding (updated in December 2022).

- Line 5b represents the number of enrollees determined ineligible for Medicaid or CHIP and transferred to the Marketplace,

- Line 5c represents the number of enrollees whose Medicaid eligibility was terminated for procedural reasons (i.e., failure to respond), and

- Line 5d represents the number of enrollees whose Medicaid eligibility renewal was not completed or the State agency had not made a final eligibility determination.

We found that for the 140 sampled enrollees listed on the unwinding data reports, the State agency correctly reported the Medicaid eligibility actions completed for 132 enrollees. However, we found that the State agency incorrectly reported the Medicaid eligibility actions completed for the remaining eight enrollees. Specifically:

- five enrollees' eligibility had not yet been determined and were incorrectly reported on the unwinding reports on Line 5a(2) as having been successfully renewed using a pre-populated renewal form,

- two enrollees had their Medicaid coverage terminated for procedural reasons (i.e., failure to respond) but were incorrectly reported on the unwinding reports on Line 5b as having been ineligible for Medicaid, and

- one enrollee was reenrolled in Medicaid during the renewal process but was incorrectly reported on the unwinding reports on Line 5c as having had their Medicaid coverage terminated for procedural reasons.

The example describes an enrollee who was incorrectly reported on the monthly unwinding data reports.

Example 6:
Enrollee who was determined ineligible for Medicaid coverage was incorrectly reported as having coverage terminated for procedural reasons

For an adult enrollee in our sample, the State agency listed the individual on the June 2023 unwinding data report as having their coverage terminated for procedural reasons (line 5c). However, the State agency had failed an attempt to complete an ex parte renewal and the enrollee was requested to provide additional income information. The enrollee subsequently provided updated income information and was determined to be ineligible for Medicaid coverage because the enrollee's income was determined to be too high. Therefore, this enrollee should have been reported as determined ineligible for Medicaid (line 5b).

Inaccurately reporting Medicaid eligibility actions on unwinding data reports can result in improper actions being taken, or not taken, by CMS or Federal and State lawmakers when trying to ensure that eligibility renewals are being appropriately processed. In addition, stakeholders are obtaining inaccurate information which could affect their ability to assess eligibility actions during the unwinding period.

RECOMMENDATIONS

We recommend that the Massachusetts' Executive Office of Health and Human Services:

- redetermine eligibility for the three sampled enrollees whose eligibility was incorrectly determined and take appropriate action,

- provide periodic training to caseworkers about verifying and documenting enrollees' income and residency during the renewal process, and

- revise policies and procedures to be consistent with CMS guidance related to preparing unwinding data reports and any future reports of a similar nature.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our first and second recommendations and described actions that it had taken or planned to take to address them. The State agency's actions include: (1) appropriate steps taken to correct the Medicaid eligibility determinations for the sampled enrollees whose eligibility was incorrectly renewed during our audit period and (2) continuing to regularly provide and enhance ongoing training for staff in addition to planning to conduct an additional eligibility renewal-related training by the end of 2024.

The State agency partially concurred with our third recommendation and did not agree that it incorrectly reported the Medicaid eligibility actions for all eight sampled enrollees. The State agency described scenarios where it believes OIG erred in determining that some sampled enrollees should have been reported as procedurally terminated rather than ineligible for Medicaid and transferred to the Marketplace. However, the State agency is reviewing updated CMS reporting guidance released after our audit period and plans to meet with CMS to better understand CMS's detailed reporting requirements. Additionally, the State agency indicated that it is reviewing its reporting logic to determine if it needs to make any changes to ensure it complies with applicable reporting requirements. The State agency's comments are included in their entirety as Appendix D.

CMS also provided written technical comments on the draft report, which we addressed as appropriate.

Based on our review of the State agency's comments, we maintain that our findings and recommendations are valid. For the scenarios described by the State agency, it obtained income information from its data sources that would have determined the associated sampled enrollees as ineligible for Medicaid and subsequently transferred to the Marketplace. However, we maintain that these sampled enrollees were primarily terminated from Medicaid for procedural reasons. Specifically, the State agency sent a prepopulated form to these sampled enrollees after it failed to renew their eligibility on an ex parte basis. However, the sampled enrollees failed to provide a response to the prepopulated forms, which should trigger procedural terminations. Once these enrollees were terminated from Medicaid, the State agency then referred them to the Marketplace based on the information from its data sources.

We believe that the actions the State agency has taken or plans to take are consistent with our recommendations and should help the State agency to remedy the deficiencies identified during our audit.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 352,408 enrollees listed on Massachusetts' monthly unwinding data reports who either had their Medicaid eligibility renewed or terminated during April 1 through September 30, 2023 (audit period), following the end of the continuous enrollment condition. We reviewed the Medicaid eligibility actions made by the State agency for a stratified random sample of 140 enrollees, as described in Appendix B.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. As part of our internal control assessment, we reviewed the State agency's policies and procedures for processing eligibility renewal actions during the unwinding period. However, because our review was limited to the processes in place during the unwinding period, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We conducted our audit from October 2023 through June 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with State agency officials to gain an understanding of the electronic systems used in Massachusetts' Medicaid program and unwinding process;
- obtained and reviewed the State agency's policies and procedures covering the unwinding process;
- obtained Medicaid data supporting the information that the State agency reported to CMS in its April through September 2023 unwinding data reports;[24]
- identified 352,408 enrollees who were either renewed or terminated during April 1 through September 30, 2023;
- selected a stratified random sample of 140 enrollees (Appendix B);

[24] The unwinding data reports submitted to CMS contained aggregate totals of Medicaid eligibility actions performed by the State agency associated with enrollees. We worked with the State agency to identify the enrollees that comprised the aggregate information in the unwinding data reports.

- reviewed eligibility documentation associated with the 140 sampled enrollees;

- on the basis of our sample results, estimated:

    - the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form, and

    - the total number of enrollees in the sampling frame whose Medicaid eligibility actions were incorrectly reported on the unwinding report; and

- discussed the results of our audit with State agency officials.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of an Excel workbook that contained 352,408 Massachusetts enrollees who had their Medicaid eligibility either renewed or terminated during our audit period, following the end of the continuous enrollment condition.

SAMPLE UNIT

The sample unit was an enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing four strata. Stratum 1 contained enrollees whose eligibility was renewed on an ex parte basis. Stratum 2 contained enrollees whose eligibility was renewed using a renewal form. Stratum 3 contained enrollees who were determined to be ineligible and had their Medicaid coverage terminated. Stratum 4 contained enrollees whose Medicaid coverage was terminated for procedural reasons (i.e., failure to respond).

Table 1: Sample Design and Size

Stratum	Medicaid Eligibility Actions	Frame Size (Enrollees)	Sample Size
1	Renewals on Ex Parte Basis	107,909	35
2	Renewals Using Renewal Form	82,134	35
3	Terminated Due to Ineligibility Determination	48,176	35
4	Terminated for Procedural Reasons	114,189	35
Total		**352,408**	**140**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the State agency's Medicaid enrollee number (smallest to largest) and then consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers for each of these strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate: (1) the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed, and (2) the total number of enrollees in the sampling frame whose Medicaid eligibility actions were incorrectly reported on the unwinding report. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval for each of these estimates.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

ENROLLEE CHARACTERISTICS FOR ESTIMATION

Incorrect Eligibility Renewals: enrollee's eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form.

Incorrectly Reported on Unwinding Report: enrollee was reported on the incorrect line of the Unwinding Report.

Table 2: Sample Results

Stratum	Frame Size (Enrollees)	Sample Size	Incorrect Eligibility Renewals	Incorrect Eligibility Terminations	Incorrectly Reported on Unwinding Report
1	107,909	35	0	N/A	0
2	82,134	35	3	N/A	5
3	48,176	35	N/A	0	2
4	114,189	35	N/A	0	1
Total	**352,408**	**140**	**3**	**0**	**8**

Table 3: Estimates for Each Characteristic in the Sampling Frame
(Limits Calculated at the 90-percent Confidence Level)

Attribute	Statistical Estimates		
	Point Estimate	Lower Limit	Upper Limit
Incorrect Eligibility Renewals	7,040	555	13,525
Incorrectly Reported on Unwinding Report	17,749	7,529	27,968

APPENDIX D: STATE AGENCY COMMENTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
COMMONWEALTH OF MASSACHUSETTS
OFFICE OF MEDICAID
ONE ASHBURTON PLACE, BOSTON, MA 02108

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

KATHLEEN E. WALSH
SECRETARY

MIKE LEVINE
ASSISTANT SECRETARY
FOR MASSHEALTH

July 12, 2024

Report Number: A-02-24-01001

Jennifer Webb, Regional Inspection General for Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Sent electronically via Kiteworks

Dear Ms. Webb,

Thank you for your letter dated June 13, 2024, regarding the Office of the Inspector General (OIG) draft report *Massachusetts Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements* (the "draft report").

Per your request, please find comments from the Massachusetts Executive Office of Health and Human Services (EOHHS), via the MassHealth program, beginning on Page 2 below.

Given the tremendous and unprecedented efforts of our team, partners, and community to support Medicaid members in Massachusetts over the COVID-19 unwinding period, MassHealth is gratified by OIG's assessment that Massachusetts generally complied with applicable eligibility requirements. Further, we appreciate OIG's thoughtful review and the opportunity to respond to OIG's three recommendations as described in the draft report.

Should you have any questions about this communication, please do not hesitate to contact Michael Somers, Deputy Director, Audit Response and Fraud Enforcement, at michael.somers@mass.gov.

Sincerely,

Mike Levine
Assistant Secretary for MassHealth

MassHealth Comments Regarding OIG Draft Report

Report Number: A-02-24-01001

Updated July 12, 2024

Recommendation 1: Redetermine eligibility for the three sampled enrollees whose eligibility was incorrectly determined and take appropriate action.

MassHealth concurs with this recommendation.

MassHealth has taken appropriate steps to ensure that these members have the correct eligibility determinations. Accordingly, MassHealth considers this recommendation to have been resolved.

Recommendation 2: provide periodic training to caseworkers about verifying and documenting enrollees' income and residency during the renewal process

MassHealth concurs with this recommendation.

MassHealth currently provides robust training to staff on the renewal process, including (but not limited to) how to appropriately process member renewals, how to generate and process requests for income-related information, how to verify factors such as residency and immigration, and all other relevant topics and procedures. To reinforce these procedures and support ongoing compliance with applicable state and federal rules, MassHealth will conduct an additional renewal-related training for staff by the end of calendar year 2024, in addition to continuing to regularly provide and enhance ongoing training for eligibility personnel.

Recommendation 3: revise policies and procedures to be consistent with CMS guidance related to preparing unwinding data reports and any future reports of a similar nature.

MassHealth does not concur with this recommendation in full for all reporting scenarios identified by the OIG that led to this recommendation. For example, the OIG identified scenarios where they felt cases had been incorrectly reported and should have been reported as procedurally terminated. In these scenarios, however, MassHealth had reliable data sources for these cases that showed the individuals were ineligible. In response to this recommendation, MassHealth is in the process of reviewing updated CMS guidance released since the time period of this audit, as well as meeting with CMS to better understand CMS' detailed reporting requirements in certain areas. In parallel, MassHealth is also performing a review of its reporting logic to determine if any changes need to be made to ensure compliance with applicable reporting requirements, and, if so, MassHealth will assess the timing of making such changes relative to other system updates already in queue.