Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Office of Inspector General

https://oig.hhs.gov

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REPORT HIGHLIGHTS

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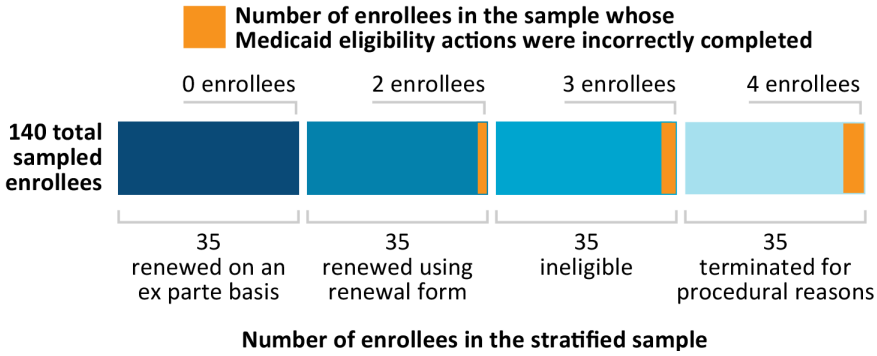
California Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

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, including terminating Medicaid enrollment of ineligible individuals.
- This audit of California is part of a series of audits examining whether States completed Medicaid eligibility actions during the unwinding period in accordance with Federal and State requirements.

What OIG Found

Of the 1,830,923 enrollees who had their Medicaid eligibility renewed or coverage terminated during April 1 through August 31, 2023 (audit period), we sampled 140 enrollees and determined that California incorrectly completed Medicaid eligibility actions for 9 enrollees.



On the basis of our sample results, we estimated that California incorrectly renewed eligibility or incorrectly terminated coverage for 78,853 of the 1,830,923 enrollees during our audit period.

What OIG Recommends

We recommend that California: (1) redetermine eligibility for the sampled enrollees that we identified as having incorrect eligibility determinations, (2) provide caseworkers additional training to reduce errors, (3) revise its guidance to instruct counties to document in case files essential information to support enrollees' continuing eligibility, and (4) identify and correct the system issues that caused incorrect Medicaid eligibility actions. The full recommendations are in the report.

California concurred with all our recommendations and described actions that it planned to take to address them.

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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 in 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 California Department of Health Care 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 on 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 on Jan. 27, 2023).

[5] OIG's COVID-19 response strategic plan and oversight activities can be accessed at https://oig.hhs.gov/coronavirus/index.asp.

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
- the enrollee dies.

[6] The Act § 1905(b).

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. Furthermore, 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 before 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 reports 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 in 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).

California's Medicaid Program

The State agency provides health care coverage for more than 15 million California enrollees. The State agency is responsible for the administration and oversight of the Medicaid program in California, known as Medi-Cal. The State agency relies on each of 58 local county offices and their caseworkers to review Medicaid applications, complete Medicaid eligibility determinations, and process Medicaid renewals and terminations for enrollees using the county case management system.[13] This system enables counties to upload and store

[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 an ex parte renewal as "automatic" (i.e., completed the renewal electronically) or "manual" (i.e., involved some caseworker intervention).

[13] As of Oct. 30, 2023, all 58 counties had transitioned to using a single county case management system, known as the California Statewide Automated Welfare System. Before this date, there were multiple county systems.

documentation provided by enrollees to support eligibility determinations. When an enrollee's eligibility determination is made, the county case management system transmits eligibility determination information (e.g., whether the person is eligible for Medi-Cal) to the Medi-Cal Eligibility Data System (MEDS), which is the State agency's system for storing enrollees' eligibility determination information.

State Agency Oversight of County Operations for the Unwinding Period

The State agency's Medi-Cal Eligibility Division is responsible for overseeing and monitoring eligibility determinations, including providing guidance and technical assistance to counties and developing policy and procedures used in determining eligibility for Medicaid. According to the State agency's *Medi-Cal COVID-19 Public Health Emergency and Continuous Coverage Operational Unwinding Plan* (published on March 7, 2023) and to prepare for the end of the unwinding period, the State agency took several steps to ensure that renewal determinations for enrollees were conducted accurately and in a timely manner, including:

- requesting eligibility-related flexibilities from CMS, such as using the U. S. Postal Service instate forwarding addresses to update enrollees' contact information;[14]

- preparing counties by issuing policy guidance, providing a readiness toolkit, and offering webinar trainings on topics such as the renewal process and income verifications;

- reviewing eligibility system functionality and designing system changes to resume normal renewal actions; and

- collaborating with a variety of stakeholders, including counties, managed care plans, and community organizations, to prepare for the unwinding period.

In addition, the State agency provided information to counties by holding biweekly support calls and developed a question-and-answer document based on the support calls to provide additional guidance to counties, such as answering questions on renewal processes.[15]

State Agency's Unwinding Process for Determining Medicaid Eligibility

The State agency directed counties to begin initiating unwinding-related renewals of Medicaid eligibility in April 2023, the month after the continuous enrollment condition had ended. In

[14] The State agency received waiver authorities from CMS under section 1902(e)(14)(A) of the Act for obtaining address information from the Medicaid managed care plans and the National Change of Address database (effective Oct. 18, 2022).

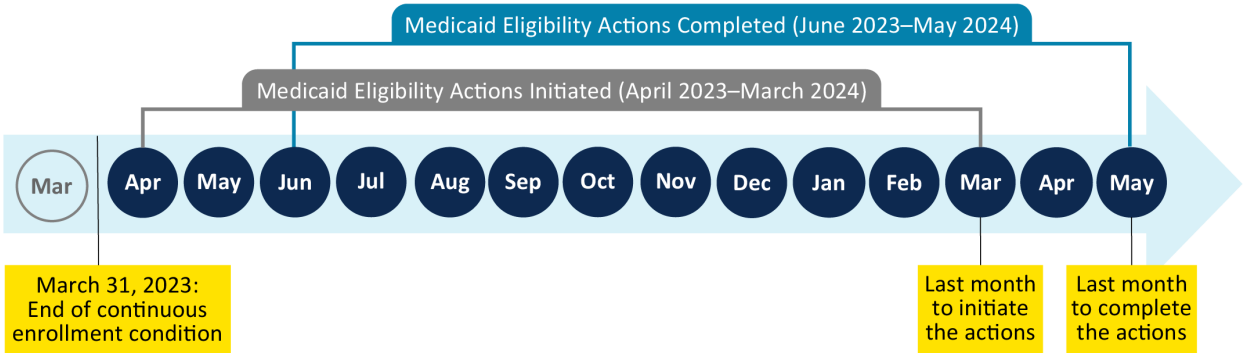
[15] According to the State agency's Medi-Cal Eligibility Division Information Letter No.: I 23-06 (issued Feb. 7, 2023), the document *County Support Webinars Q&A: Continuous Coverage Unwinding Process* provides policy clarifications based on information provided during the biweekly support calls for counties.

June 2023, counties began taking Medicaid eligibility actions to process renewals and terminations of enrollees' coverage.

Counties began the renewal process for an enrollee approximately 85 days before the last day of the enrollee's renewal month.[16] A renewal is considered initiated when a county attempts to verify an enrollee's eligibility on an ex parte basis. For example, if an enrollee had a June 2023 renewal month, the county initiated the renewal process on an ex parte basis in April 2023 (2 months before the renewal month). This procedure allowed the county enough time to send a renewal form to the enrollee, if necessary, and to complete Medicaid eligibility actions before the end of the enrollee's renewal month if the renewal on an ex parte basis was unsuccessful. By the beginning of March 2024, counties should have initiated Medicaid eligibility actions for all enrollees and completed all those actions by the end of May 2024, the end of the 14-month unwinding period.

Figure 1 illustrates the State agency's timeline for initiating and completing all Medicaid eligibility actions for enrollees during its 14-month unwinding period.

Figure 1: State Agency's Unwinding Timeline



To verify the accuracy of eligibility information for an enrollee whose eligibility is determined on the basis of modified adjusted gross income (MAGI), a county uses information from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).[17] CalHEERS uses data from multiple electronic data sources, including the Federal Data Services Hub, which accesses information (such as income and incarceration status) from the Internal Revenue Service, Social Security Administration, and Department of Homeland Security. CalHEERS also uses data from State-approved data sources. CalHEERS compares the data provided by these data sources with the enrollee's information to determine whether the information is electronically verified. If CalHEERS is able to electronically verify the information, the enrollee's

[16] An enrollee's renewal month is the month in which the redetermination is due. Generally, the renewal month is set 12 months after the application month.

[17] CalHEERS is an online platform that uses a single, streamlined application to determine eligibility for Medicaid and California's health insurance marketplace's qualified health plans and insurance affordability programs under the Affordable Care Act.

eligibility can be renewed on an automatic ex parte basis. In addition, a county may attempt a renewal on a manual ex parte basis at the time of the enrollee's annual renewal. This manual process consists of reviewing information available to the county in the enrollee's case file.[18]

As part of the State agency's processes, to verify accuracy of eligibility information for an enrollee whose eligibility is not determined on the basis of MAGI, a county attempts a renewal on a manual ex parte basis at the time of the enrollee's annual renewal.[19]

If a county cannot renew an enrollee's eligibility on an ex parte basis, the county sends a renewal form to the enrollee with some information filled in and requests that the individual: (1) verify the information on the form or provide updated information and (2) return the form and other requested information (e.g., proof of current income, such as pay stubs or the prior year's tax return).[20] The enrollee may provide the information requested on the renewal form through any available means, including by telephone, by mail, or through an online portal.[21]

If the enrollee returns the form and the requested information, the county caseworker processes the renewal by entering the information into the county case management system to determine whether the enrollee is eligible. If the enrollee is determined to be eligible, Medicaid coverage will be renewed. If the enrollee is determined to be ineligible, Medicaid coverage will be terminated.

If the enrollee does not respond or provides incomplete information, the county will attempt to contact the enrollee at least two more times before the due date on the renewal form.[22] If the county does not receive the necessary information by the due date (i.e., the enrollee failed to respond), the county sends to the enrollee a notice of action (notice letter) at least 10 days before the end of the enrollee's renewal month explaining the reason for the termination of

[18] California Welfare and Institutions Code § 14005.37(e).

[19] Enrollees whose eligibility is not determined on the basis of MAGI include individuals aged 65 or older and individuals who are blind. The State agency does not perform automatic ex parte renewals for these enrollees.

[20] 42 CFR § 435.916(a)(3); California Welfare and Institutions Code § 14005.37(f).

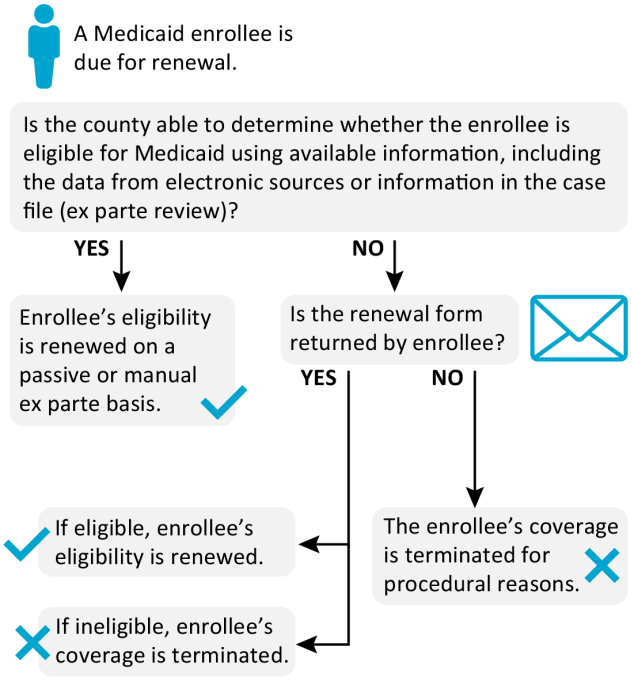
[21] California Welfare and Institutions Code § 14005.37(f)(1)(B).

[22] States are required to make a good-faith effort to contact, using more than one modality, any enrollee who is determined ineligible based on returned mail before discontinuing coverage for that enrollee (Division FF, § 5131, Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022). CMS's SHO No. 23-002 further interprets the "good faith" effort standard in CAA's section 5131.

the enrollee's Medicaid coverage (i.e., the enrollee's coverage is terminated for procedural reasons).[23]

Figure 2 provides an overview of the State agency's eligibility determination process for enrollees during the unwinding period.

Figure 2: Overview of the State Agency's Medicaid Eligibility Determination Process During the Unwinding Period



HOW WE CONDUCTED THIS AUDIT

Our audit covered 1,830,923 enrollees who were listed on California's monthly unwinding data reports and who had their Medicaid eligibility renewed or coverage terminated during April 1 through August 31, 2023 (audit period), following the end of the continuous enrollment condition.[24] Of the 1,830,923 enrollees whose Medicaid eligibility was renewed or coverage was terminated during the audit period, we identified:

- 894,660 enrollees whose eligibility was renewed on an ex parte basis,

[23] The enrollee is entitled to a 90-day period to provide the required information if Medicaid coverage is terminated for failing to provide information or verifications. If the enrollee is determined to be eligible during this 90-day period, the county grants coverage retroactively to the date of termination so that there is no lapse in Medicaid coverage (42 CFR § 435.916(a)(3)(iii); California Welfare and Institutions Code § 14005.37(i) and 22 California Code of Regulations (CCR) § 50179).

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

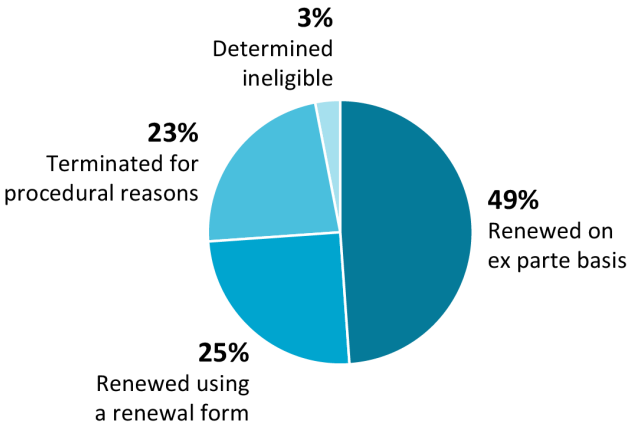
- 465,976 enrollees whose eligibility was renewed using a renewal form,

- 53,260 enrollees who were determined to be ineligible and whose Medicaid coverage was terminated, and

- 417,027 enrollees whose Medicaid coverage was terminated for procedural reasons (i.e., the enrollee failed to respond).

See Figure 3 for the percentage of the 1,830,923 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 August 2023)



For a stratified random sample of 140 Medicaid enrollees, we reviewed the Medicaid eligibility actions taken by the State agency. 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 had 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.

For each of the sampled enrollees, we reviewed the State agency's documentation from the county case management system and the State agency's MEDS that supported the eligibility determinations, including renewal forms, income support (e.g., pay stubs), notice letters, and caseworker notes. We also reviewed verification results from CalHEERS for eligibility factors such as income and incarceration status.[25]

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, the State agency correctly completed eligibility actions for all 35 enrollees whose eligibility was renewed on an ex parte basis. However, for 9 of the remaining 105 sampled enrollees, the State agency incorrectly completed eligibility actions for enrollees whose eligibility was renewed using a renewal form, who were determined ineligible and had their coverage terminated, or whose coverage was terminated for procedural reasons during our audit period. Specifically:

- Of the 35 sampled enrollees whose eligibility was renewed using a renewal form, the Medicaid eligibility actions were incorrectly completed for 2 enrollees.

- Of the 35 sampled enrollees who were determined ineligible and had their coverage terminated, the Medicaid eligibility actions were incorrectly completed for 3 enrollees.

- Of the 35 sampled enrollees whose coverage was terminated for procedural reasons, the Medicaid eligibility actions were incorrectly completed for 4 enrollees.

On the basis of our sample results, we estimated that the State agency incorrectly renewed eligibility or incorrectly terminated coverage for 78,853 of the 1,830,923 enrollees during our audit period.[26] In addition, we estimated that the State agency incorrectly terminated coverage

[25] We relied on the electronic verification results from CalHEERS's comparison of the enrollee's attested information with data received from electronic data sources. We did not review whether the data originally received from the electronic data sources and the result of the comparison were accurate.

[26] The lower and upper limits at the 90-percent confidence level are 30,384 and 127,322, respectively.

for 52,225 enrollees based on a determination of ineligibility or for procedural reasons.[27] We have chosen not to report an estimate for the number of enrollees whose eligibility was incorrectly renewed by the State agency because of the low number of enrollees in our sample who were incorrectly renewed on an ex parte basis or using a renewal form. (Appendix C contains our sample results and estimates.)

In addition, we determined that caseworkers' failure to perform certain actions, such as not attempting to renew an enrollee's eligibility on a manual ex parte basis and failing to maintain documentation to support an enrollee's attested information for the household, could have resulted in incorrect eligibility determinations for five sampled enrollees. Furthermore, caseworkers made errors during the income verification process that did not affect the sampled enrollees' eligibility determinations, but errors like those identified in this report could potentially result in other enrollees having their eligibility incorrectly renewed or having their coverage incorrectly terminated.

These deficiencies occurred because caseworkers, among other reasons, incorrectly entered or incorrectly calculated enrollees' incomes. In addition, system issues prevented the State agency's MEDS from being updated or from sending appropriate termination notices, resulting in incorrectly completed Medicaid eligibility actions. Furthermore, according to State agency officials, the State agency and counties experienced staffing challenges, including having new or inexperienced staff, and staff who had not conducted renewals for several years.

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 35 enrollees whose eligibility was renewed on an ex parte basis. However, for 9 of the remaining 105 sampled enrollees, 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.[28] 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

[27] The lower and upper limits at the 90-percent confidence level are 14,564 and 89,887, respectively.

[28] 42 CFR § 435.916(a)(2).

electronically verify the enrollee's eligibility using information from the Federal Data Services Hub, the enrollee's eligibility can be renewed on an automatic ex parte basis.[29]

For all sampled 35 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 July 2023 unwinding data report as having had eligibility renewed. In May 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 $2,387 shown in the case file. The State agency verified the enrollee's monthly income using data obtained from approved electronic sources, and it correctly renewed the enrollee's eligibility.

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

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.[30] After the State agency sends an enrollee the renewal form, the enrollee may respond with the requested information by contacting the county by telephone, in person, or through an online portal.[31] A caseworker is responsible for entering the information into the county case management system and processing the renewal.

The State agency provides Medicaid coverage to: (1) a parent or other relative caretaker of a dependent child younger than 18 years of age and who has a household income at or below 109 percent of the Federal Poverty Level (FPL) and (2) an individual aged 19 or older or younger than 65 who has household income at or below 138 percent of the FPL.[32]

If an enrollee's income varies from month to month, the State agency shall determine the enrollee's income by estimating the amount that the enrollee expects to receive in the month.

[29] 42 CFR § 435.916(a)(2); California Welfare and Institutions Code § 14005.37(e). The State agency's *Medi-Cal COVID-19 Public Health Emergency and Continuous Coverage Operational Unwinding Plan* (Mar. 7, 2023).

[30] 42 CFR §§ 435.916(a)(2) and (3); California Welfare and Institutions Code §§ 14005.37(e) and (f).

[31] California Welfare and Institutions Code § 14005.37(f)(1)(B).

[32] 42 CFR § 435.119; State Plan Amendment (SPA) 13-0028-MM1 (effective Jan. 1, 2014); 42 CFR § 435.110; and SPA 13-0021-MM1 (effective Jan. 1, 2014).

This estimate shall be made considering the enrollee's actual income received in the last month, the enrollee's income pattern over the last year, and the enrollee's statement of anticipated income.[33]

Of the 35 sampled enrollees whose eligibility was renewed using a renewal form, the State agency correctly completed Medicaid eligibility actions for 33 enrollees. However, the State agency incorrectly completed eligibility actions for two enrollees. Specifically, the State agency determined the enrollees as being eligible when their incomes exceeded the FPL limit applicable to them. These deficiencies occurred because caseworkers incorrectly calculated enrollees' income or incorrectly entered into the case management system the frequency at which one of the enrollees was paid.

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

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

For an adult enrollee in our sample, the State agency listed the enrollee on the July 2023 unwinding data report as having had eligibility renewed using a renewal form. In May 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 State agency sent the enrollee a renewal form in May 2023 requesting income information. On June 30, 2023, the enrollee returned the form in person to the county office. Additionally, on July 7, 2023, the county received a sworn statement from the enrollee's spouse attesting to the enrollee's monthly income of $2,000, which served as a form of income verification. A caseworker correctly determined that the enrollee was eligible.

Example 3:
Enrollee whose eligibility was incorrectly renewed based on an incorrect income amount.

For an adult enrollee in our sample, the State agency listed the enrollee on the June 2023 unwinding data report as having had eligibility renewed using a renewal form. In April 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 county sent a renewal form to the enrollee in April 2023. The enrollee returned the form in May 2023 and attested to income for the enrollee and the enrollee's spouse totaling $4,180. The enrollee included pay stubs of $775 for the enrollee and $1,319 for their spouse, showing a pay frequency of twice a month for each individual, totaling $4,188 for a month. However, a caseworker incorrectly entered the enrollee's income frequency as

[33] 22 CCR § 50518.

monthly instead of twice a month.[34] This action resulted in renewal of the enrollee's eligibility even though the enrollee's household income exceeded the income limit for Medicaid coverage based on the enrollee's household size.[35]

Three Sampled Enrollees Were Incorrectly 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.[36] After the State agency sends an enrollee the renewal form, the enrollee may respond with the requested information by contacting the county by telephone or in person, or through an online portal.[37] A caseworker is responsible for entering the information into the county case management system and processing the renewal.

A final date of eligibility shall be established when the county determines that the enrollee will no longer meet all eligibility requirements as of the first day of the following month. The final date shall be the last day of: (1) the current month if the termination is not an adverse action, (2) the current month if the termination is an adverse action and the 10-day advance notice is sent in the current month, or (3) the following month if the termination is an adverse action and the 10-day advance notice requirements will not be met in the current month.[38, 39]

Of the 35 sampled enrollees who were determined ineligible and had their coverage terminated, the State agency correctly completed Medicaid eligibility actions for 32 enrollees. However, the State agency incorrectly completed eligibility actions for three enrollees. Specifically:

[34] The enrollee's income of $775 was incorrectly entered as monthly instead of twice a month, which resulted in the household income being calculated as $3,413 a month: (enrollee's monthly income of $775) + (spouse's income of $1,319 × twice a month, or $2,638).

[35] The enrollee's household income was 167.5 percent of the FPL, which exceeded the Medicaid income limit (109 percent of the FPL) for the parent or caretaker relative group and the income limit (138 percent of the FPL) for individuals aged 19 or older and younger than 65.

[36] 42 CFR §§ 435.916(a)(2) and (3); California Welfare and Institutions Code §§ 14005.37(e) and (f).

[37] California Welfare and Institutions Code § 14005.37(f)(1)(B).

[38] 22 CCR § 50195(f).

[39] Generally, an adverse action is an action taken by a county that discontinues Medicaid eligibility or increases the Medi-Cal Family Budget Unit's share of cost (22 CCR § 50015). The Medi-Cal Family Budget Unit comprises the individuals who will be included in the Medi-Cal eligibility and share-of-cost determination (22 CCR § 50060).

- Two enrollees had their Medicaid coverage terminated but later had their eligibility incorrectly renewed because caseworkers did not verify the enrollees' incomes correctly.

- One enrollee was determined ineligible; however, the enrollee's eligibility status was not updated in the State agency's MEDS, which resulted in the renewal of the enrollee's eligibility. According to State agency officials, a system issue caused the enrollee's coverage not to be terminated.[40]

The following are examples of enrollees who were determined to be ineligible for Medicaid.

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 May 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 county sent a renewal form to the enrollee. The county received the enrollee's completed renewal form and proof of income. A caseworker determined that the enrollee's household income exceeded the income limit for the enrollee's household size. The enrollee was correctly determined to be ineligible.

Example 5:
Enrollee whose Medicaid coverage was not terminated after the end of the renewal month because of a system issue.

For an adult enrollee in our sample, the State agency listed the enrollee on the June 2023 unwinding data report as having been determined ineligible and having had coverage terminated. The county correctly determined the enrollee to be ineligible because the enrollee's income exceeded the Medicaid income limit. The county sent a notice letter on June 10, 2023, stating that coverage would end on the last day of June 2023, which was the enrollee's renewal month. However, the county sent another notice letter on August 20, 2023, indicating that the enrollee's coverage would be extended through August 2023. According to State agency officials, an issue within the county's case management system prevented the termination of coverage in the State agency's MEDS. These officials could not explain the cause of the system issue.

[40] The State agency also said that additional enrollees were determined ineligible for Medicaid on June 30, 2023, in the county case management system but remained active in the State agency's MEDS. The State agency said that the issue was fixed on Aug. 17, 2023, and MEDS terminated the enrollees' coverage effective Sept. 1, 2023.

Four Sampled Enrollees Had Their Coverage Incorrectly 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.[41] The State agency is required to send an enrollee a written notice at least 10 days before the first month in which the action becomes effective, which is defined as "the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective."[42]

Of the 35 sampled enrollees whose coverage was terminated for procedural reasons, the State agency correctly completed Medicaid eligibility actions for 31 enrollees. However, the State agency incorrectly completed eligibility actions for four enrollees. Specifically:

- Three enrollees should have had their eligibility renewed through the ex parte process; instead, the enrollees' coverage was incorrectly terminated. The enrollees were not renewed on an ex parte basis because system issues prevented the renewal or for a reason the State agency could not explain.

- One enrollee was not notified that their coverage was being terminated for not responding to the renewal form because a system issue caused the enrollee's name not to be included in the termination notice that was sent to the enrollee's household.

The following are examples of enrollees whose Medicaid coverage was terminated for procedural reasons.

Example 6:
Enrollee whose coverage was correctly terminated for procedural reasons.

For an adult enrollee in our sample, the State agency listed the enrollee on the August 2023 unwinding data report as having had coverage terminated for procedural reasons. In June 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. On June 21, 2023, the county sent the enrollee's spouse a renewal form to be completed by August 19, 2023.[43] The county sent two reminder notices to the enrollee's spouse in July 2023 stating that the county had not received the requested information. The county sent a notice letter dated August 19, 2023, to the enrollee's household stating that the household's Medicaid coverage would be terminated on the last day of August 2023. A caseworker followed State agency procedures to notify the enrollee that

[41] 42 CFR § 435.916(a)(2).

[42] 42 CFR § 431.201; 22 CCR § 50179.

[43] The enrollee's spouse was listed as the primary applicant in the case file for the household.

coverage would be terminated because the county had not received the information necessary to complete the enrollee's eligibility redetermination. The enrollee's coverage was correctly terminated.

Example 7:
Enrollee whose coverage was incorrectly terminated for procedural reasons.

For an enrollee in our sample (a 13-year-old child), the State agency listed the enrollee on the June 2023 unwinding data report as having had coverage terminated for procedural reasons. In April 2023, the enrollee's renewal was initiated on an ex parte basis; however, the renewal process was not completed because the enrollee's household income could not be verified. The county sent a renewal form to the enrollee's household on April 24, 2023, with a due date of June 21, 2023, for submission of the requested information. On June 14, 2023, the county electronically verified the enrollee's household monthly income of $1,718. Although the income was electronically verified, the county sent a notice letter dated June 15, 2023, to the enrollee's parent stating that the enrollee's coverage would be terminated as of the last day of June 2023 for failing to complete the renewal process. Because the electronically verified household income of $1,718 did not exceed the Medicaid income limit for the enrollee's household size, the enrollee should have been determined eligible for Medicaid coverage.[44] According to State agency officials, the child's coverage was not renewed because of a system issue, but the officials could not explain what caused the issue.[45]

CASEWORKERS' FAILURE TO PERFORM CERTAIN ACTIONS COULD HAVE RESULTED IN INCORRECT ELIGIBILITY DETERMINATIONS, AND CASEWORKERS MADE ERRORS THAT DID NOT AFFECT ELIGIBILITY DETERMINATIONS

Caseworkers' failure to perform certain actions, such as not attempting to renew an enrollee's eligibility on a manual ex parte basis and failing to maintain documentation to support an enrollee's attested information for the household, could have resulted in incorrect eligibility determinations for five sampled enrollees. Additionally, caseworkers made errors during the income verification process that did not affect the sampled enrollees' eligibility determinations.

[44] The enrollee's household income was 68.7 percent of the FPL, which was below the Medicaid income limit (133 percent of the FPL) for children aged 6 through 18.

[45] On Dec. 20, 2023, the county rescinded the termination of coverage and retroactively restored the enrollee's Medicaid eligibility.

Caseworkers' Failure To Perform Certain Actions Could Have Resulted in Incorrect Eligibility Determinations for Five Sampled Enrollees

The State agency must make a redetermination of 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.[46] The State agency must maintain individual records on each applicant and enrollee that contain information on the facts essential to determining initial and continuing eligibility.[47]

For 5 of the 140 enrollees in our sample, caseworkers' failure to perform certain actions could have resulted in incorrect eligibility determinations. Specifically:

- For three enrollees, the State agency did not demonstrate that caseworkers attempted to renew the enrollees' eligibility on a manual ex parte basis when an automatic ex parte process was not applicable (e.g., for enrollees who were aged 65 or older or who were blind). The case files for each enrollee did not contain documentation that a renewal through the manual ex parte process had been attempted. State agency guidance to counties (e.g., Medi-Cal Eligibility Director Information Letters) did not explicitly instruct caseworkers to document renewal attempts on a manual ex parte basis before sending a renewal form.[48]

- One enrollee was determined to be eligible even though there was no documentation in the enrollee's case file to support the attested information for the enrollee's household, including income and household size, after the enrollee's parent went into the county office. State agency guidance to counties did not explicitly instruct caseworkers on what information needed to be documented in the case file to demonstrate that the county received information for an enrollee.[49]

- One enrollee's Medicaid coverage was terminated because the enrollee did not provide supporting documentation for attested income, even though the caseworker did not attempt to electronically verify the enrollee's income.

[46] 42 CFR §§ 435.916(a)(2) and (3); California Welfare and Institutions Code §§ 14005.37(e) and (f).

[47] 42 CFR § 431.17(b).

[48] We confirmed with State agency officials that the State agency did not have a policy regarding the documenting of casework activities. The officials commented that counties were to perform the ex parte process as outlined in State agency policies.

[49] See footnote 48.

The following are examples of caseworker inactions that could have resulted in incorrect eligibility determinations.

Example 8:
Enrollee who may have been determined to be eligible for coverage if a renewal on a manual ex parte basis had been attempted.

For an adult enrollee in our sample (aged 65 or older), the State agency listed the enrollee on the July 2023 unwinding data report as having had coverage terminated for procedural reasons. On May 11, 2023, the county sent the enrollee a renewal form and in June 2023 sent two followup reminder letters. On July 20, 2023, the county sent the enrollee a notice letter stating that the enrollee would no longer be enrolled as of July 31, 2023, because of a failure to provide renewal information. However, there was no documentation in the enrollee's case file that a renewal through the manual ex parte process had been attempted. As a result, the State agency was unable to demonstrate that the enrollee's coverage should have been terminated.

Example 9:
Enrollee whose Medicaid eligibility could have been incorrectly renewed because information attested to by the parent was not documented.

For an enrollee in our sample (a 9-year-old child), the State agency listed the enrollee on the August 2023 unwinding data report as having had eligibility renewed using a renewal form. On June 13, 2023, the county sent a renewal form to the enrollee's parent. A note in the case file indicated that the enrollee's parent went into the county office to see a caseworker in person; however, a completed renewal form was not included in the case file. There were no other details or supporting documentation to indicate what information was provided or attested to by the enrollee's parent. According to the State agency, the enrollee's parent may have provided the renewal form in person, but the county may have failed to upload the form. Without documentation to support the information attested to by the enrollee's parent, the State agency was unable to demonstrate whether the enrollee should have had their eligibility renewed.

Example 10:
Enrollee whose coverage was terminated but who could have been determined eligible for coverage if the caseworker had checked electronic data sources.

For an enrollee in our sample (a 10-year-old child), the State agency listed the enrollee on the June 2023 unwinding data report as having had coverage terminated for procedural reasons. The enrollee's case file did not contain documentation showing that there had been an attempt to renew the enrollee's eligibility on an automatic ex parte basis. In addition, the county sent a renewal

form to the household on April 13, 2023, and the county received the completed form on June 7, 2023. The enrollee's parent attested to income of between $1,800 and $2,300 every 2 weeks but did not provide any proof of income.[50] On June 20, 2023, the county sent a notice letter informing the enrollee's parent that the enrollee's household's Medicaid coverage would end on the last day of June 2023 for failure to provide proof of income. The enrollee's case file did not contain documentation showing that a caseworker attempted to verify the enrollee's household income using electronic data sources. Without documentation to support that the caseworker attempted to verify the enrollee's household income, the State agency could not demonstrate that the enrollee's coverage should have been terminated.

Caseworkers Made Errors During the Income Verification Process That Did Not Affect Eligibility Determinations for Three Sampled Enrollees

The State agency must make a redetermination of eligibility 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.[51] According to the State agency's guidance, counties are instructed to perform a renewal on an ex parte basis utilizing all case information and electronic sources of information available. In addition, counties must use the most current information.[52]

The State agency's unwinding plan states that any potential negative actions resulting from changes in an enrollee's circumstance reported before the end of the continuous enrollment condition and during the 12-month unwinding period shall be paused until an enrollee's annual redetermination is initiated at the end of the continuous coverage requirement as determined by the redetermination date on the enrollee's case record.[53]

For 3 of the 140 enrollees in our sample, caseworkers made errors while verifying enrollees' income, but those errors did not adversely impact the Medicaid eligibility actions taken for enrollees. Specifically, caseworkers did not always use a reported change in enrollee income, correctly enter the frequency of income, or correctly calculate income. Although these errors did not affect the sampled enrollees' eligibility determinations, errors like these could potentially result in other enrollees having their eligibility incorrectly renewed or having their coverage incorrectly terminated.

[50] If the caseworker had been able to verify the enrollee's household income, the child would have been eligible for Medicaid coverage.

[51] 42 CFR § 435.916(a)(2); California Welfare and Institutions Code § 14005.37(e).

[52] Medi-Cal Eligibility Division Information Letter No.: I 22-28 (issued July 11, 2022).

[53] The State agency's *Medi-Cal COVID-19 Public Health Emergency and Continuous Coverage Operational Unwinding Plan* (Mar. 7, 2023).

The following are examples of errors made by caseworkers during the income verification process that did not affect the eligibility outcomes for the sampled enrollees.

Example 11:
Enrollee whose Medicaid eligibility was correctly renewed, but the caseworker did not use the current income amount for the child's household.

For an enrollee in our sample (a 1-year-old child), the State agency listed the child on the August 2023 unwinding data report as having had eligibility renewed using a renewal form. On June 13, 2023, a caseworker electronically verified the enrollee's household income amount of $1,916 per month, which was the income that the enrollee's parent reported to the county on July 29, 2021. However, on May 15, 2023, before the enrollee's renewal month, the enrollee's parent had reported that the prior income was no longer being received as of September 14, 2021, and that the income had increased to $5,833 per month. The caseworker should have attempted to electronically verify the increased income amount when the enrollee's parent reported it. Even if the increased income amount had been verified, the enrollee would still have been eligible for Medicaid. Therefore, we determined that the caseworker's error did not affect the enrollee's eligibility determination.

Example 12:
Enrollee whose coverage was correctly terminated but whose income frequency was incorrectly entered.

For an adult enrollee in our sample, the State agency listed the enrollee on the August 2023 unwinding data report as having been determined ineligible and having had coverage terminated. While completing the redetermination, a caseworker applied a pay frequency of every 2 weeks when the enrollee's pay stubs showed a weekly pay frequency. If the caseworker had applied the correct income frequency, the enrollee still would have been ineligible for Medicaid coverage. Therefore, we determined that the caseworker's error did not affect the enrollee's eligibility determination.

CONCLUSION

Although the State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period, the findings in this report demonstrate that the State agency could do more to ensure that Medicaid eligibility determinations are accurate. The State agency incorrectly completed Medicaid eligibility actions for some of the enrollees in our sample, and caseworkers did not perform certain actions or made errors during the income verification process for some enrollees. Some of these errors did not affect enrollee's eligibility determinations, but errors like those identified in

this report could result in other enrollees having their eligibility incorrectly renewed or having their coverage incorrectly terminated.

State agency officials attributed the deficiencies to various factors, such as caseworker errors. In addition, according to State agency officials, the State agency and counties experienced staffing challenges, including having new or inexperienced staff. Even though the State agency provided webinar trainings and guidance through biweekly calls, additional training to address the errors we identified could help reduce errors in the future. In addition, system issues resulted in incorrect Medicaid eligibility actions, including incorrect eligibility determinations.

RECOMMENDATIONS

We recommend that the California Department of Health Care Services:

- redetermine eligibility for the nine sampled enrollees whose eligibility was incorrectly determined and the five sampled enrollees whose eligibility may have been incorrectly determined;

- provide caseworkers additional training to reduce errors related to: (1) calculating and verifying income, (2) entering income information into the county case management system, and (3) using electronic data sources when verifying enrollees' reported income;

- revise its guidance to instruct counties to document in case files essential information to support enrollees' continuing eligibility, including: (1) attempts to review enrollees' eligibility on a manual ex parte basis and (2) income and household information provided by the enrollee in person; and

- identify and correct the system issues that prevented the State agency from renewing enrollees' eligibility on an ex parte basis when those enrollees should have been determined eligible and from sending a notice of termination to enrollees.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all our recommendations and described actions that it planned to take to address them. The State agency's planned actions include: (1) working with counties to correct the records for the sampled enrollees who were identified as having incorrect eligibility determinations, (2) reminding county representatives during one of their biweekly calls to have county staff review State agency training materials and policy letters regarding income verification and calculation, (3) issuing a Medi-Cal Eligibility Division Information Letter notifying counties of our audit findings and essential case actions that should be documented in case journal entries, and (4) working with business partners to identify and correct any system issues preventing individuals from being renewed through the automatic ex parte process or from receiving the

appropriate notice of action upon adverse actions. The State agency's comments are included in their entirety as Appendix D.

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

OTHER MATTERS

Three enrollees in our sample attested to having no income. The State agency verified that the enrollees had no income by using information obtained through electronic sources (e.g., the State tax board and the Social Security Administration). However, each of the enrollee's case files included documentation from another data source (i.e., income and employment data from a commercial credit bureau) that showed that the enrollee had current income. Although the State agency followed its approved process by verifying attested income using electronic data sources, each enrollee's case file had income information that conflicted with the attestation of having no income. The case files did not show any actions taken by the caseworkers to evaluate the conflicting information. All three enrollees had their Medicaid eligibility renewed.

The following is an example of an enrollee's attestation of having no income, which was electronically verified even though the enrollee's case file had conflicting information.

Example 13:
Enrollee whose income was electronically verified through the State agency's approved data sources even though the case file contained conflicting information.

For an adult enrollee in our sample, the State agency listed the enrollee on the June 2023 unwinding data report as having had eligibility renewed on an ex parte basis. The enrollee's attested monthly income of $0 was electronically verified using electronic data sources. However, the case file contained information from another data source showing that the enrollee was currently employed as of March 21, 2023, and had an hourly pay rate of $22.73.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 1,830,923 enrollees who were listed on California's monthly unwinding data reports and who had their Medicaid eligibility renewed or coverage terminated during April 1 through August 31, 2023, following the end of the continuous enrollment condition.

For a stratified random sample of 140 enrollees, we reviewed the Medicaid eligibility actions taken by the State agency. (See Appendix B.) For each of the sampled enrollees, we reviewed the State agency's documentation from the county case management system and the State agency's MEDS that supported the eligibility determinations, including renewal forms, income support (e.g., pay stubs), notice letters, and caseworker notes. We also reviewed verification results from CalHEERS for eligibility factors such as income and incarceration status.[54]

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 actions during the unwinding period. We also performed a walk-through of the systems involved in the eligibility determination process, such as the California Statewide Automated Welfare System and CalHEERS, to obtain an understanding of how the State agency maintains documentation for eligibility determinations. 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 March 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 California's Medicaid program and the State agency's unwinding process;
- obtained and reviewed the State agency's policies and procedures covering the unwinding process;

[54] See footnote 25.

- obtained Medicaid data supporting what the State agency reported to CMS in its unwinding data reports for June through August 2023;[55]

- identified 1,830,923 enrollees whose eligibility was renewed or whose coverage was terminated during April 1 through August 31, 2023;

- selected a stratified random sample of 140 enrollees (Appendix B);

- 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 coverage was incorrectly terminated based on a determination of ineligibility or for procedural reasons and

    - the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed or whose coverage was incorrectly terminated (Appendix C); 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.

[55] The data provided by the State agency to support these reports included enrollees whose renewal month was June, July, or August 2023 but who also had renewal or termination dates before June 2023. Because the State agency began ex parte actions on Apr. 1, 2023, we included enrollees whose eligibility was renewed or whose coverage was terminated beginning on Apr. 1, 2023.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of an Access database that contained 1,830,923 California Medicaid enrollees whose eligibility was renewed or whose coverage was terminated during April 1 through August 31, 2023, 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 for Medicaid and had their coverage terminated. Stratum 4 contained enrollees whose coverage was terminated for procedural reasons (i.e., the enrollee failed to respond).

Table 1: Sample Design and Size

Stratum	Medicaid Eligibility Actions	Frame Size (Enrollees)	Sample Size
1	Renewals on ex parte basis	894,660	35
2	Renewals using renewal form	465,976	35
3	Coverage terminated based on a determination of ineligibility	53,260	35
4	Coverage terminated for procedural reasons	417,027	35
Total		**1,830,923**	**140**

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the State agency's Medicaid enrollee identification number (from 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 coverage was incorrectly terminated based on a determination of ineligibility or for procedural reasons and (2) the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed or whose coverage was incorrectly terminated. 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.

Incorrect Eligibility Terminations: enrollee was incorrectly determined to be ineligible for Medicaid and coverage was terminated or coverage was incorrectly terminated for procedural reasons.

Incorrect Medicaid Eligibility Actions: enrollee's eligibility was either incorrectly renewed or coverage was incorrectly terminated.

Table 2: Sample Results

Stratum	Frame Size (Enrollees)	Sample Size	Incorrect Eligibility Renewals	Incorrect Eligibility Terminations	Incorrect Medicaid Eligibility Actions
1	894,660	35	0	NA	0
2	465,976	35	2	NA	2
3	53,260	35	NA	3	3
4	417,027	35	NA	4	4
Total	**1,830,923**	**140**	**2**	**7**	**9**

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	NA	NA	NA*
Incorrect eligibility terminations	52,225	14,564	89,887
Incorrect Medicaid eligibility actions	78,853	30,384	127,322

* We have chosen not to report the estimated number of incorrect eligibility renewals in the sampling frame because of the low number of enrollees in our sample whose eligibility was incorrectly renewed on an ex parte basis or using a renewal form.

APPENDIX D: STATE AGENCY COMMENTS

April 8, 2024

THIS LETTER SENT VIA EMAIL

Jessica Kim
Regional Inspector General
Office of Audit Services, Region IX
U.S. Department of Health and Human Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

RE: RESPONSE TO DRAFT AUDIT REPORT A-09-24-02001

Dear Ms. Kim:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the Office of Inspector General (OIG) draft audit report number A-09-24-02001, titled, "California Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance with Federal and State Requirements."

In the above draft audit report, OIG found that California generally completed Medicaid eligibility actions during the extraordinary COVID-19 unwinding period in accordance with federal and state requirements and issued four recommendations for DHCS. DHCS agrees with all four recommendations and will embark on responsive corrective action plans, including working with its business and county partners.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any questions, please contact the DHCS Office of Compliance, Internal Audits at (916) 445-0759.

Sincerely,

Michelle Baass
Director

Enclosure

cc: See Next Page

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Audit: California Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance with Federal and State Requirements

Audit Entity: Office of Inspector General
Report Number: A-09-24-02001 (24-05) (COVID-19 Public Health Enrollment)
Response Type: Response to Draft Audit Report

Finding 1: MEDICAID ELIGIBILITY ACTIONS WERE GENERALLY COMPLETED CORRECTLY DURING THE UNWINDING PERIOD

Recommendation 1
OIG recommends Department of Health Care Services (DHCS) redetermine eligibility for the nine sampled enrollees whose eligibility was incorrectly determined and the five sampled enrollees whose eligibility may have been incorrectly determined.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS will work with counties to correct the records for the sampled enrollees who were identified as having an incorrect eligibility determination.

Recommendation 4
OIG recommends DHCS identify and correct the system issues that prevented the State agency from renewing enrollees' eligibility on an ex parte basis when those enrollees should have been determined eligible and from sending a notice of termination to enrollees.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS will work with business partners to identify and correct any system issues preventing individuals from being renewed through the auto ex parte process and/or from receiving the appropriate notice of action upon adverse actions.

Finding 2: CASEWORKERS' FAILURE TO PERFORM CERTAIN ACTIONS COULD HAVE RESULTED IN INCORRECT ELIGIBILITY DETERMINATIONS, AND CASEWORKERS MADE ERRORS THAT DID NOT AFFECT ELIGIBILITY DETERMINATIONS

Recommendation 2
OIG recommends DHCS provide caseworkers additional training to reduce errors related to:
(1) calculating and verifying income,
(2) entering income information into the county case management system, and
(3) using electronic data sources when verifying enrollees' reported income;

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS will leverage one of its biweekly calls with counties to provide a reminder for county representatives to have staff review DHCS training materials and policy letters regarding income verification and calculation, ensure only those individuals who are eligible for Medi-Cal are reenrolled into the program upon the completion of a renewal, and provide clear documentation of casework activities, which includes documentation of the manual ex parte process and utilization of electronic data sources to verify income.

DHCS will issue a Medi-Cal Eligibility Division Information Letter notifying counties of the audit findings, and areas where counties should provide additional training to staff.

Recommendation 3
OIG recommends DHCS revise its guidance to instruct counties to document in case files essential information to support enrollees' continuing eligibility including;
(1) attempts to review enrollees' eligibility on a manual ex parte basis and
(2) income and household information provided by the enrollee in person.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:
DHCS will issue a Medi-Cal Eligibility Division Information Letter notifying counties of essential case actions which should be documented in case journal entries.