



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

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Medicaid: Compliance with Eligibility Requirements

Testimony of:

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Good morning, Chairman Toomey, Ranking Member Stabenow, and distinguished Members of the committee. I am Brian P. Ritchie, Assistant Inspector General for Audit Services, U.S. Department of Health and Human Services. Thank you for your longstanding commitment to ensuring that the Medicaid program's 67 million beneficiaries are well served and the taxpayers' approximately \$600 billion investment is well spent. I appreciate the opportunity to discuss the Office of Inspector General's (OIG's) work on Medicaid beneficiary eligibility determinations and what more can be done to secure the future of this important program.

Introduction

Medicaid spending represents one-sixth of the national healthcare economy, and Medicaid serves more people, including some of the Nation's most vulnerable individuals, than any other Federal healthcare program. In 2010, Congress enacted the Patient Protection and Affordable Care Act (P.L. No 111-148) and the Health Care and Education Reconciliation Act (P.L. No. 111-152), collectively known as the Affordable Care Act (ACA). The ACA mandated changes to Medicaid eligibility rules, such as calculating income based on modified adjusted gross income, a measure of income that is based on Internal Revenue Service rules. The ACA also provided States with the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these "newly eligible beneficiaries."

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These traditional coverage groups include low-income parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly. Although many “newly eligible beneficiaries” applied for Medicaid coverage for the first time after the passage of the ACA, many people who applied for coverage qualified for these traditional coverage groups. We refer to these individuals as “non-newly eligible beneficiaries.”

OIG shares the Committee’s commitment to protecting Medicaid from fraud, waste, and abuse and has an extensive body of oversight work in this area. A strong program integrity strategy starts with prevention. Correctly determining beneficiary eligibility prevents Medicaid from making improper payments for people who are not eligible for the program.

For the past several years, OIG has conducted several audits of States’ Medicaid eligibility determinations under the Medicaid eligibility rules changed by the ACA. To date, OIG has issued seven audit reports of four States: four on newly eligible beneficiaries and three on non-newly eligible beneficiaries.

We found that these States made payments on behalf of beneficiaries who were not eligible, or who may not have been eligible, for Medicaid. We also identified instances where States received higher Federal reimbursement rates than appropriate on behalf of beneficiaries who

were eligible for a traditional eligibility group; but were incorrectly enrolled as newly eligible. These four States did not comply with requirements to verify applicants' income, citizenship, identity, and other eligibility criteria. We estimated that almost \$6.3 billion in Federal payments were associated with these incorrect, or potentially incorrect, eligibility determinations.

My testimony today details this work, which was done in California, Colorado, Kentucky, and New York. I will discuss the types of errors, the estimated number of beneficiaries affected, and the associated amount of dollars impacted for both newly eligible and non-newly eligible groups; as well as how both human and system errors contributed to these payments. Our audit period for California, Kentucky, and New York was October 1, 2014, to March 31, 2015; and our audit period for Colorado was January 1, 2014, to September 30, 2015. We have additional ongoing audits in Louisiana and Ohio assessing Medicaid eligibility determinations for newly eligible beneficiaries, as well as an audit in Colorado for non-newly eligible beneficiaries. These reports will be issued as they are completed.

States do not always correctly determine Medicaid eligibility for both newly eligible and non-newly eligible beneficiaries

Correctly determining beneficiary eligibility is vital to the accuracy of Medicaid payments. To ensure that Medicaid makes payments on behalf of the right beneficiary, it is critical to determine whether the beneficiary receiving services is actually eligible for Medicaid, as well as for the specific eligibility category the beneficiary has been placed in. The seven recent OIG

audits of four States estimated that almost \$6.3 billion in Federal Medicaid payments has been made on behalf of beneficiaries who are ineligible or who may have been ineligible for Medicaid or their assigned eligibility category. Beneficiaries that States determined to be newly eligible accounted for almost \$1.3 billion of these payments, and the remaining \$5 billion was for beneficiaries that States determined to meet one of the non-newly eligible Medicaid categories.

Methodology

For each of our seven audits, we reviewed the Medicaid eligibility determinations made by the State Medicaid agency for a random sample of beneficiaries, classified as newly eligible or non-newly eligible depending on the audit, to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

For each sampled beneficiary, we obtained, where possible, application data and documentation used to support the State agency's eligibility determination. Reviewing that data and documentation, we determined whether the State agency followed Federal and State requirements and its own procedures to verify eligibility information when making the eligibility determinations. In instances where the eligibility documentation, data, or the State's determination was unclear, we followed-up with State agency officials.

If we were able to determine that a beneficiary was not eligible for Medicaid based on the application data and documentation, we refer to the beneficiary as ineligible. As an example, a

sampled beneficiary attested to having income, supported by documentation, which was above the Medicaid income limit. In this example, the State agency incorrectly determined the beneficiary to be eligible and incorrectly claimed Federal reimbursement for payments made on behalf the ineligible beneficiary. We also refer to a beneficiary as ineligible if the beneficiary was eligible for a traditional coverage group but the State incorrectly determined that the beneficiary was newly eligible. As an example, a sampled beneficiary attested to having income that was below 100 percent of the Federal poverty level. The beneficiary qualified for Medicaid under a traditional coverage group but was not newly eligible. As result, the State agency incorrectly received a higher Federal reimbursement rate for this beneficiary. In this type of case, we used the difference between the higher Federal reimbursement rate for the newly eligible population and the lesser reimbursement rate for the traditional population when determining the amount of Federal reimbursement that was incorrectly claimed.

If we were unable to conclusively determine eligibility because the State agency did not have sufficient supporting documentation or did not verify eligibility in accordance with Federal and State requirements, we refer to the beneficiary as potentially ineligible. As an example, a sampled beneficiary had not had a Medicaid eligibility redetermination since 2011. There were no case notes or other documentation between November 2011 and April 2017, and the State agency could not explain why no annual redetermination had been performed, as required, since 2011. For this type of situation, the State agency may have claimed Federal reimbursement for an ineligible beneficiary.

Based on our sample results in each audit, we estimated the total number of ineligible beneficiaries and beneficiaries who were potentially ineligible during our audit period; we also estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible beneficiaries and potentially ineligible beneficiaries during our audit period.

Results from four audits on Medicaid eligibility for newly eligible beneficiaries

OIG reviewed whether certain States correctly determined eligibility, following changes made by the ACA to Medicaid eligibility rules.

OIG reviews of Medicaid eligibility determinations by California, New York, Colorado, and Kentucky revealed that these States did not always comply with Federal and State requirements to verify applicants' income, citizenship, identity, and other eligibility criteria. Generally, errors associated with newly eligible beneficiary determinations were due to the State agencies not properly verifying income or citizenship requirements; or the beneficiary being eligible under a different Medicaid eligibility group. In total, across these four States, OIG estimated that more than \$721 million in Federal Medicaid payments were made on behalf of 498,434 ineligible beneficiaries. More than \$534 million in Federal Medicaid payments were made on behalf of 127,020 beneficiaries who may have been ineligible. In total, that is almost \$1.3 billion in Federal Medicaid payments made for more than 625,000 beneficiaries that were ineligible or potentially ineligible.

Both human and system errors contributed to these payments. As an example, human error occurs when State agency officials making eligibility determinations do not correctly act on known information. We identified instances where State agency officials incorrectly determined beneficiaries to be newly eligible even though the beneficiaries' application data or supporting documentation clearly demonstrated that their household income amounts were above the allowed maximum threshold of 138 percent of the Federal poverty level.

We found that some enrollment data systems were lacking the ability to (1) deny or terminate ineligible beneficiaries; (2) properly redetermine eligibility when a beneficiary aged out of an eligibility group; (3) maintain records, in accordance with Federal requirements, relating to eligibility determinations and verifications; and (4) retrieve and use information from other Government databases, such as those managed by the Social Security Administration and Department of Homeland Security. For example, we identified instances where a State agency electronically verified that a change in beneficiary income was above the allowable threshold but the system continued to make payments on behalf of the beneficiary. This occurred because the State systems did not have the functionality to discontinue Medicaid for a beneficiary who became ineligible due to a change in income after a previous determination had already been made.

Results from three audits on Medicaid eligibility for non-newly eligible beneficiaries

OIG also reviewed whether certain States were correctly determining eligibility for non-newly eligible beneficiaries in accordance with Federal and State requirements. Errors associated with

non-newly eligible beneficiaries were generally due to beneficiaries not meeting income requirements (including not submitting required tax information forms) or specific coverage group requirements. Additionally, there were a few errors due to beneficiaries not meeting citizenship and residency requirements. As a result of States incorrectly determining beneficiaries' eligibility, payments were made on behalf of those beneficiaries that were ineligible or potentially ineligible, resulting in improper and potentially improper costs to the Federal Government.

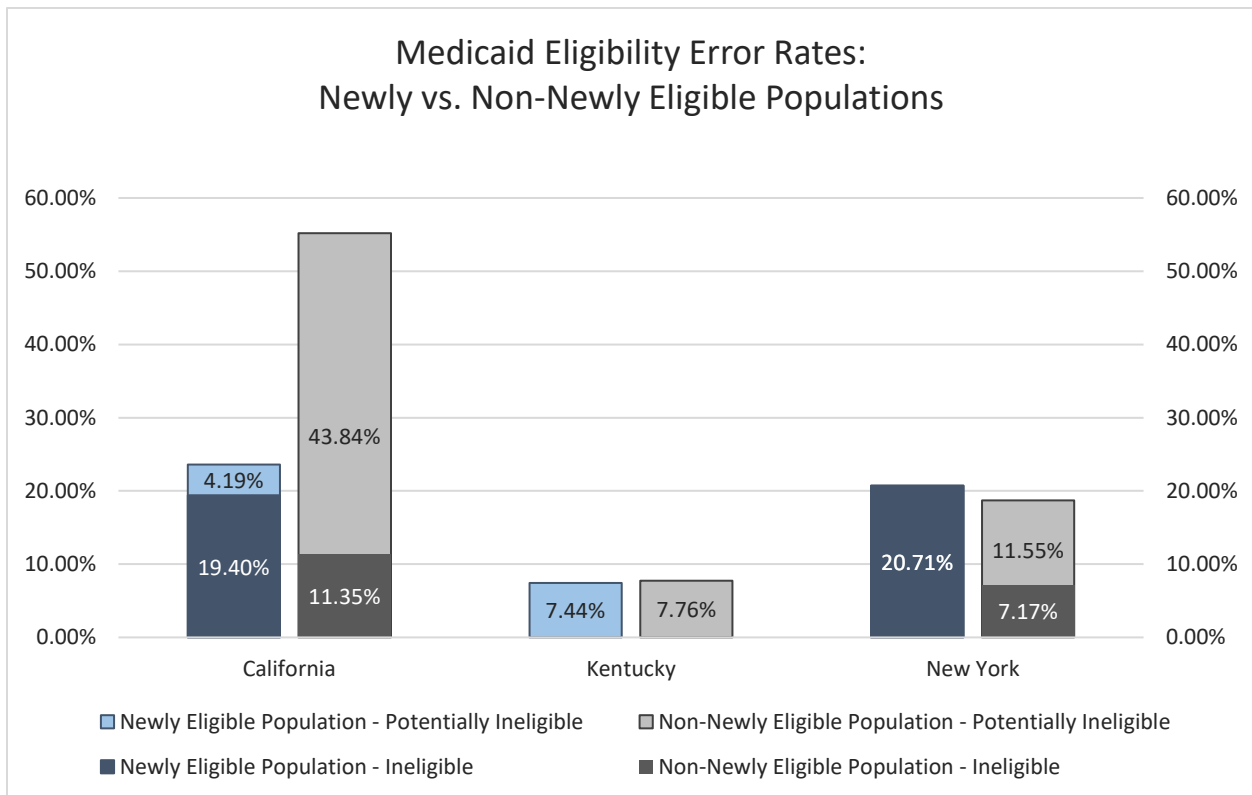
OIG reviews of Medicaid eligibility determinations by California, New York, and Kentucky revealed that these States did not always comply with Federal and State requirements to verify applicants' eligibility. In total, across these three States, OIG estimated that more than \$1.05 billion in Federal Medicaid payments were made on behalf of 1,186,635 ineligible beneficiaries. More than \$3.98 billion in Federal Medicaid payments were made on behalf of 3,788,248 beneficiaries who may have been ineligible. In total, more than \$5 billion in Federal Medicaid payments were made for more than 4.9 million beneficiaries who were ineligible or potentially ineligible.

As with OIG's newly eligible audits, the non-newly eligible audits showed that both human and system errors contributed to these payments; specifically, (1) State agency staff did not consider all relevant information when making determinations, (2) caseworkers made errors, (3) system delays occurred during a system conversion, and (4) State agencies did not always

maintain documentation to support their eligibility determinations.

Comparison of newly eligible and non-newly eligible errors

In the three States where we have completed audits of both newly eligible and non-newly eligible beneficiary eligibility determinations, we have found eligibility determination errors in both groups. Kentucky and New York had relatively comparable error rates between both the two beneficiary groups, whereas California had a higher error rate for the non-newly eligible group. (See chart below.)



Conclusion

Correct determination of beneficiary eligibility is vital to the accuracy of Medicaid payments.

Seven recent OIG audits of four States estimated that almost \$6.3 billion in Federal Medicaid

payments has been made on behalf of beneficiaries who were ineligible or who may have been ineligible. These include inaccurate eligibility determinations for both the newly eligible and the non-newly eligible beneficiary groups. (See Attachment A listing information on our seven reports.)

To address the concerns that we identified, we recommended that these States ensure that enrollment data systems be able to verify eligibility criteria, develop and implement written policies and procedures to address vulnerabilities, and undertake redeterminations as appropriate.

OIG will continue to prioritize Medicaid oversight to prevent fraud, waste, and abuse and take appropriate action when they occur. We are committed to ensuring that Medicaid pays the right amount, to the right provider, for the right service, on behalf of the right beneficiary.

Thank you for your ongoing leadership and for affording me the opportunity to testify on this important topic.

Attachment A

Report Title	Report Number	Date Issued	Ineligible		Potentially Ineligible	
			Beneficiaries	Dollars	Beneficiaries	Dollars
<i>Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	A-07-16-04228	August 2019	85,085	\$66,525,688	13,372	\$26,797,483
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries</i>	A-02-16-01005	July 2019	383,893	\$520,295,792	618,057	\$1,297,308,200
<i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	A-09-17-02002	December 2018	802,742	\$536,039,109	3,100,260	\$2,616,843,793
<i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	A-09-16-02023	February 2018	366,078	\$628,838,417	79,055	\$402,358,529
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	A-02-15-01015	January 2018	47,271	\$26,221,803	0	-
<i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements</i>	A-04-16-08047	August 2017	0	-	69,931	\$72,800,000
<i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	A-04-15-08044	May 2017	0	-	34,593	\$105,075,377
Totals			1,685,069	\$1,777,920,809	3,915,268	\$4,521,183,382
			Beneficiaries	Dollars		
Grand Totals			5,600,337	\$6,299,104,191		