Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK GENERALLY DETERMINED ELIGIBILITY FOR ITS BASIC HEALTH PROGRAM ENROLLEES IN ACCORDANCE WITH PROGRAM REQUIREMENTS

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

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September 2022
A-02-20-01028

Office of Inspector General

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Report in Brief
Date: September 2022
Report No. A-02-20-01028

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

New York Generally Determined Eligibility for Its Basic Health Program Enrollees in Accordance With Program Requirements

Why OIG Did This Audit

The Affordable Care Act gave States the option of creating a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. To date, New York is one of only two States that have established BHPs. We audited New York's BHP because we considered program funds to be at risk due to the significant amount of Federal funds allocated to the initiative. New York's BHP is funded primarily by Federal funds with some State funding.

Our objective was to determine whether New York determined eligibility for BHP enrollees in accordance with applicable Federal and State eligibility requirements.

How OIG Did This Audit

Our audit covered eligibility determinations for 966,693 BHP policies for which New York received Federal funding totaling $4.7 billion during the period April 1, 2018, through March 31, 2019 (audit period). We selected a stratified random sample of 150 policies. We reviewed eligibility data for each policy to determine whether eligibility verifications and determinations were performed in accordance with Federal and State requirements.

What OIG Found

New York generally determined eligibility for its BHP enrollees in accordance with Federal and State requirements. Specifically, for 145 of 150 sampled policies, New York correctly determined that the associated enrollees were eligible for the program. However, for five sampled policies, New York enrolled individuals who were ineligible or potentially ineligible for the program and received improper monthly payments totaling $8,615. Specifically, for three sampled policies, New York enrolled individuals who were eligible for Medicaid. For one sampled policy, New York did not properly verify income. For the remaining sampled policy, New York received BHP payments from the Centers for Medicare & Medicaid Services on behalf of a disenrolled deceased enrollee. According to New York, system defects prevented controls that were in place from working as intended.

On the basis of our sample results, we estimated that the financial impact of the incorrect or potentially incorrect eligibility determinations made by New York for its BHP during the audit period totaled $69.9 million.

What OIG Recommends and New York's Comments

We recommend that New York reimburse its BHP Trust Fund $8,615 associated with the improper monthly payments identified in our sample. In addition, we recommend that New York identify and reimburse the BHP Trust Fund all improper payments, which we estimate to total $69.9 million, resulting from system defects identified in our report. We also made recommendations for New York to improve its system for enrolling individuals in its BHP.

In written comments on our draft report, New York stated that it would reimburse $8,615 to the BHP Trust Fund and did not indicate concurrence or nonconcurrence with our remaining recommendations; however, it described actions it had taken or planned to take to address the deficiencies identified in the draft report. New York stated that we overstated the extent to which our findings were extrapolated. After reviewing New York's comments, we maintain that our findings and recommendations are valid. In addition, we acknowledge New York's efforts to identify system defects and limitations and its efforts to monitor and remediate such issues. We also maintain that our statistical approach resulted in a legally valid estimate of the improper and potentially improper payment amounts received by New York.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/22001028.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

Section 1331 of the Patient Protection and Affordable Care Act (ACA) gave States the option of creating a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace (Marketplace). To date, New York is one of only two States that have established BHPs.[1] We audited New York's BHP because we considered program funds to be at risk due to the significant amount of Federal funds allocated to the initiative.[2] New York's BHP is funded primarily by Federal funds with some State funding.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) determined eligibility for BHP enrollees in accordance with applicable Federal and State requirements.

BACKGROUND

Basic Health Program

The BHP generally provides health benefits coverage for citizens and lawfully present non-citizens with family incomes between 133 and 200 percent of the Federal Poverty Level (FPL) who do not qualify for Medicaid. Applicants who are lawfully present non-citizens ineligible for Medicaid or the Children's Health Insurance Program (CHIP) because of their immigration status are eligible for the BHP if their household income is between 0 and 200 percent of the FPL. To date, only Minnesota and New York have established BHPs, which are funded primarily by Federal funds.

If determined eligible, an individual may receive BHP coverage for 12 months. States are not required to redetermine BHP eligibility before the end of this period but may do so if enrollees notify States of updated information that would affect their eligibility status.

Basic Health Program Costs and Payments

The amount of the monthly premium and cost-sharing, if applicable, charged to BHP enrollees may not exceed the amount of the monthly premium and cost-sharing those enrollees would have paid if they were to receive coverage from a qualified health plan through the

[1] New York began operating its BHP, known as the Essential Plan, on Apr. 1, 2015. Minnesota began operating its BHP, known as MinnesotaCare, on Jan. 1, 2015.

[2] The *Annual Report for State Basic Health Programs* for 2018 and 2019 indicated that Federal funding for the program was $4.6 billion and $5.4 billion, respectively.

Marketplace. States that operate a BHP receive Federal funding equal to 95 percent of the premium tax credit and the cost-sharing reductions that would have been provided to (or on behalf of) eligible individuals if they received coverage from a qualified health plan.[3]

Federal BHP payments are made prospectively—to cover anticipated costs—and are deposited into the State's BHP trust fund on a quarterly basis.[4] To determine the Federal payment amount, the State agency provides quarterly enrollment estimates and other information to the Centers for Medicare & Medicaid Services (CMS), which calculates the Federal BHP payment amount based on a number of factors. The prospective payments are later reconciled using State-submitted finalized BHP enrollment data. Using final enrollment data, along with factors such as geographic area, coverage status, household size, and income range, CMS makes Federal BHP payments to the State agency under what are known as Family IDs.[5] In this report, we refer to Family IDs as "policies." The payments are a month-based calculation and are paid quarterly.

New York's Basic Health Program Eligibility

In New York, individuals apply for the BHP through the New York State of Health Marketplace system (the system). Initial BHP eligibility determinations are based on Marketplace regulations.[6] For renewals, the State has adopted (and CMS has approved) alternative procedures.[7] Under the alternative procedures, the State agency bases its renewal determinations on more recent income attestations or on recent wage data.

To determine whether individuals are eligible for BHP, Marketplace staff review information provided by individuals and query multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub).[8] The data sources available through the Data Hub are provided by the U.S. Department of Health and Human Services, the Social Security Administration, the U.S. Department of Homeland Security, and the Internal Revenue

[3] The amount received from Federal funding may vary from the premium amount that States pay to insurers to cover BHP enrollees. If a State pays insurers a premium amount less than the Federal funding received, this will result in a savings to the State's BHP Trust Fund.

[4] 42 CFR §§ 600.615 and 600.700.

[5] New York's BHP uses a Family ID to identify coverage for one or more enrollees assigned to a policy. A Family ID is the personal ID of the policyholder or primary tax filer, or the Medicaid identification number assigned to the oldest BHP enrollee. Depending on several factors, family members within the same Family ID may have different payment amounts (i.e., premiums charged to the BHP Trust Fund).

[6] States must verify BHP eligibility consistent with either Medicaid or Marketplace regulations (42 CFR § 600.345). New York chose to apply Marketplace rules (NYS BHP Blueprint).

[7] 42 CFR § 600.340(c); 45 CFR § 155.335(a)(2)(iii).

[8] The Data Hub is a portal developed by CMS for exchanging information between State-based marketplaces, the Federal marketplace, and Medicaid agencies, among other entities, and CMS's external partners.

Service, among others. Data sources maintained by New York are provided by the New York State Department of Taxation and Finance.

HOW WE CONDUCTED THIS AUDIT

Our audit covered eligibility determinations for 966,693 BHP policies for which the State agency received Federal funding totaling $4.7 billion during the period April 1, 2018, through March 31, 2019 (audit period).[9, 10] We selected a stratified random sample of 150 policies. We reviewed eligibility data for each policy to determine whether eligibility verifications and determinations were performed in accordance with Federal and State requirements.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of the State agency's internal controls to those applicable to our objective. This included reviewing the State agency's policies and procedures for ensuring that individuals enrolled in BHP met Federal and State requirements.

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, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.[11]

FINDINGS

The State agency generally determined eligibility for its BHP enrollees in accordance with Federal and State requirements. Specifically, for 145 of 150 sampled policies, the State agency correctly determined that the associated enrollees were eligible for the program. However, for five sampled policies, the State agency enrolled individuals who were ineligible or potentially ineligible for the program and received improper monthly payments totaling $8,615.[12] Specifically, for three sampled policies, the State agency enrolled individuals who were eligible for Medicaid. For one sampled policy, the State agency did not properly verify income. For the remaining sampled policy, the State agency received BHP payments from CMS on behalf of a

[9] This audit period reflects the most recent data available at the start of this audit.

[10] For reporting purposes, we refer to a BHP policy as all individual applicants assigned to one Family ID.

[11] The values included in this report are Federal share amounts of the payments associated with the policies containing incorrect or potentially incorrect eligibility determinations.

[12] The total improper monthly payment amount does not include $2,184 associated with one sampled policy for which the applicant's eligibility could not be determined due to the lack of income documentation.

disenrolled deceased enrollee. According to the State agency, system defects prevented controls that were in place from working as intended.

On the basis of our sample results, we estimated that the financial impact of the incorrect or potentially incorrect eligibility determinations made by the State agency for its BHP during the audit period totaled $69.9 million.[13]

NEW YORK DID NOT TRANSFER BHP ENROLLEES TO THE MEDICAID PROGRAM AFTER THEY BECAME ELIGIBLE FOR MEDICAID

Lawfully present non-citizens are eligible for the BHP if they are ineligible for Medicaid due to immigration status (42 CFR § 600.305(a)(2)). For an individual to receive full-scope Medicaid benefits, he or she must be a citizen of the United States or a qualified alien. However, a qualified alien, barring certain exceptions, is not eligible for full Medicaid benefits until 5 years from the date he or she enters the United States with qualified alien status, often referred to as "the 5-year bar."[14]

For three sampled policies, the State agency did not transfer BHP enrollees to the Medicaid program after they became eligible for Medicaid. Specifically, the State agency properly enrolled the individuals into the BHP when they initially applied for enrollment because, due to their immigration status, they were ineligible for Medicaid. The State agency had a system control in place to disenroll Medicaid-eligible individuals from the BHP who were approaching the 5-year mark, but the control did not always work as intended. According to the State agency, a defect prevented the system from properly identifying the end of the 5-year bar period for individuals who had a pending coverage end-date for a BHP renewal notice that was already set to expire. This caused individuals to remain marked as eligible for BHP instead of being transferred to Medicaid. As a result, the State agency improperly received 12 monthly payments for the 3 sampled policies during the audit period totaling $7,416.

NEW YORK ENROLLED AN APPLICANT WHOSE ANNUAL HOUSEHOLD INCOME WAS NOT PROPERLY VERIFIED

The State agency must verify BHP eligibility consistent with either Medicaid or Marketplace regulations.[15] For renewals, the State has adopted (and CMS has approved) alternative

[13] Our actual estimate is $69,862,030. The 90-percent confidence interval estimate for the incorrect or potentially incorrect payments ranges from $24,514,742 to $160,614,771 (Appendix C). To estimate the precision of our design, we calculated a two-sided 90-percent confidence interval. Intervals calculated in this manner will contain the actual population error amounts roughly 90 percent of the time. Confidence intervals account for the variability in the sample frame, the size of the sample, and the number of items in the frame.

[14] 8 U.S.C. § 1613.

[15] 42 CFR § 600.345. New York chose to apply Marketplace rules (NYS BHP Blueprint).

procedures.[16] According to the State agency, under these alternative procedures, BHP applicants whose income cannot be confirmed are temporarily enrolled for 90 days while inconsistencies are resolved. If the individual does not submit documentation, he or she is enrolled in the program based on income information received from electronic data sources.

For one sampled policy, the State agency improperly determined an enrollee's household income as verified when the enrollee's attested income was not reasonably compatible with electronic data sources.[17] According to the State agency's income verification procedures, if an applicant's attestation to projected annual household income is more than 10 percent below the annual household income computed through electronic sources, the system will place the individual in what is known as an "income inconsistency period" for 90 days and send the individual a notice requesting additional documentation.[18] Once the 90-day income inconsistency period has ended, if the individual does not provide income verification documentation, the State determines eligibility based on the income computed through electronic data sources.

An individual was placed in an income inconsistency period of 90 days but was eventually disenrolled from the BHP prior to the expiration of the 90-day inconsistency period for not paying their share of their monthly insurance premiums. Subsequently, the individual paid their premium and BHP coverage was reinstated by their insurance plan. These events led to the system removing the enrollee's placement in an income inconsistency period when the individual should have remained in an income inconsistency period and been given the opportunity to provide additional documentation to resolve the inconsistency. Because the individual was removed from the inconsistency period, the State did not receive any additional documentation to resolve the income inconsistency. As a result, the individual may have been ineligible for the BHP and the State agency may have improperly received 4 monthly payments for the sampled policy during the audit period totaling $2,184.[19]

[16] 42 CFR § 600.340(c); 45 CFR § 155.335(a)(2)(iii).

[17] The State agency established its reasonable compatibility threshold at a 10-percent discrepancy between the applicant's self-attested income and the same individual's income as subsequently reported by his or her employer.

[18] When there is an income inconsistency, the system starts a 90-day clock, referred to as an income verification clock. This gives the individual 90 days to submit documentation to support their attested income.

[19] Due to the system defect removing the individual's placement in an income inconsistency period, the individual was no longer required to submit documentation to verify their attested income. Accordingly, we determined that this individual was potentially ineligible for the BHP. Because eligibility could not be determined due to the lack of income documentation, we are not recommending reimbursement of the $2,184.

NEW YORK RECEIVED PAYMENTS FROM CMS ON BEHALF OF A DISENROLLED DECEASED INDIVIDUAL

States may not use their BHP trust funds for coverage for individuals not eligible for the BHP.[20]

For one sampled policy, the State agency received BHP payments from CMS on behalf of an individual after the State agency identified the individual as deceased and disenrolled him from the BHP, effective January 2019. Specifically, the individual was placed in an income inconsistency period to verify their income, but the individual died before the end of the inconsistency period. The system had a defect that prevented the individual's date of death from preceding the date it had given the individual to submit documentation to verify income, which resulted in the State agency receiving two monthly payments (January and February 2019) for this individual. As a result, the State agency improperly received two monthly payments for the sampled policy during the audit period totaling $1,199.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- reimburse New York's BHP Trust Fund $8,615 associated with the improper monthly payments identified in our sample;

- identify and reimburse the BHP Trust Fund all improper payments resulting from system defects identified in our report (we estimated improper and potentially improper payments during our audit period to be $69,853,415 ($69,862,030 less $8,615));

- implement system changes to ensure that BHP enrollees with a pending coverage end-date are transferred from BHP to Medicaid upon the end of their 5-year bar;

- implement system changes to ensure that income verification clocks are not improperly removed, and applicants' attested incomes are verified to be reasonably compatible with data sources; and

- implement system changes to ensure that claims for BHP payments are not made on behalf of deceased individuals.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency stated that it would reimburse $8,615 to the BHP Trust Fund (first recommendation) and did not indicate concurrence or nonconcurrence with our remaining recommendations; however, it described actions it had taken or planned to take to address the deficiencies identified in the draft report. The State

[20] 42 CFR § 600.705(d)(4).

agency stated that we overstated the extent to which our findings were extrapolated and that our extrapolation methodology assumes that BHP enrollees who received similar Federal payment amounts had the same probability of experiencing the system issues described in the report. The State agency also requested feedback on why our finding for potentially incorrect determinations is roughly 10 times higher than the initial amount provided in March 2022.

The State agency's comments are included in their entirety as Appendix D.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. In addition, we acknowledge the State agency's efforts to identify system defects and limitations and its efforts to monitor and remediate such issues.

We carefully considered the State agency's comments on our sampling and estimation methods, and we maintain that our statistical approach resulted in a legally valid estimate of the improper and potentially improper payment amounts received by the State agency. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[21] The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[22] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. Finally, our sampling and estimation methodology is not dependent upon the nature of the errors identified.

Our estimate of the financial impact of the incorrect or potentially incorrect eligibility determinations is higher than the initial amount we provided to the State agency in March 2022 because we revised our findings based on new information provided by the State agency after March 2022. Based on the new information, we determined that some BHP payments previously determined to be improper were potentially improper. We then combined these

[21] See *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

[22] See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), aff'd 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), aff'd, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

sample results (i.e., improper and potentially improper) to estimate the total value of payments for incorrect or potentially incorrect eligibility determinations.[23]

OTHER MATTERS: NEW YORK'S BHP TRUST FUND CONTAINED A LARGE SURPLUS

Generally, Federal funding for a State's BHP is the amount equal to 95 percent of what the Federal Government would have provided the State if individuals enrolled in the BHP were enrolled in a qualified health plan through the State Marketplace.[24, 25] Each BHP is required to establish a BHP trust fund, which may be used only to reduce premiums and cost-sharing for eligible individuals enrolled in standard health plans under the BHP or provide additional benefits for eligible individuals enrolled in standard health plans determined by the State. BHP trust funds may not be expended for any other purpose.[26]

As of December 31, 2019, New York's BHP Trust Fund contained a surplus of more than $2.5 billion carried over from prior years.[27] This surplus was due to the difference in Federal contributions and the amount the State agency paid insurers to cover BHP enrollees since New York began operating its BHP in 2015.

Although current law allows States to retain surplus funds, States are limited in how they may use these funds.[28, 29] Based on the difference between Federal funding and State agency payments, and limitations on how States may use surplus funds, we anticipate that New York's BHP trust fund surplus will continue to grow.

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[23] In March 2022, we notified the State agency of the amount of estimated improper payments and indicated that we planned to recommend reimbursement of these payments using the lower limit of the 90-percent confidence interval. However, based on the new information received from the State agency, we subsequently decided to report an estimate of the combined improper and potentially improper payments at the point estimate. This change resulted in an increase in our reported estimate as compared to our March 2022 results.

[24] ACA § 1331(d)(3)(A)(i).

[25] Payments are determined on a per-enrollee basis and must consider all relevant factors necessary to determine the value of the premium tax credit and cost-sharing reductions that would have been provided to eligible individuals. Payments are made before the start of each quarter. Initially, these amounts are calculated based on estimated levels of enrollment provided by the State. After the end of each quarter, the State submits enrollment data to CMS and the payment is reconciled based on actual enrollment.

[26] 42 CFR § 600.705(d).

[27] The State reported this figure to CMS in its *2019 Annual Report for State Basic Health Programs* covering calendar year 2019.

[28] As described above, BHP trust funds may be used only to reduce premiums and cost-sharing for eligible individuals enrolled in standard health plans under the BHP or provide additional benefits for eligible individuals enrolled in standard health plans determined by the State (42 CFR § 600.705(e)).

[29] 42 CFR § 600.705(d).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered eligibility determinations for 966,693 BHP policies for which the State agency received Federal funding totaling $4,709,194,493 during the period April 1, 2018, through March 31, 2019 (audit period). We selected a stratified random sample of 150 policies. We reviewed eligibility data for each policy to determine whether eligibility verifications and determinations were performed in accordance with Federal and State requirements.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of the State agency's internal controls to those applicable to our objective. This included reviewing the State agency's policies and procedures for ensuring that individuals enrolled in BHP met Federal and State requirements. Further, we accessed the State agency's Marketplace system to evaluate whether eligibility determinations and relevant supporting documentation met BHP requirements.

We performed our audit work from September 2020 through June 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

- met with State agency officials to obtain an understanding of its administration and monitoring of the State's BHP, including understanding how the State agency (1) verified applicants' identities, (2) verified information submitted on the enrollment application and made eligibility determinations, and (3) maintained and updated eligibility and enrollment data;

- obtained from the State agency enrollment records for applicants who were determined eligible for the State's BHP during our audit period;

- tested the completeness and reliability of the enrollment records and records of Federal funding received for individuals enrolled during our audit period;

- created a sampling frame of 966,693 policies (total payment amount of $4,709,194,493) from CMS's finalized BHP quarterly payment data files;

- selected for review a stratified random sample of 150 BHP policies;

- obtained and reviewed eligibility data for each applicant of the selected policies to determine whether required eligibility verifications and determinations were performed in accordance with regulatory requirements;

- estimated the total number of policies in the sampling frame that were associated with incorrect or potentially incorrect eligibility determinations and estimated the financial impact of those determinations during our audit period; and

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

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of an Access database containing Federal BHP payments made for 966,693 unique Family IDs (policies) valued at $4,709,194,493 during the period April 1, 2018, through March 31, 2019.[30, 31]

SAMPLE UNIT

The sample unit was the enrollee(s) under a Family ID.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows.

Stratum Number	Range of Federal BHP Payments	Number of Frame Units	Frame Dollar Value	Sample Size
1	> $0 and ≤ $3,285.99	361,870	$608,693,438	20
2	> $3,285.99 and ≤ $8,478.39	501,773	$2,829,222,606	90
3	> $8,478.39	103,050	$1,271,278,449	40
Totals		**966,693**	**$4,709,194,493**	**150**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted the items in each stratum by Family ID number in ascending order and then consecutively numbered the items in each stratum in the sampling frame. After generating 150 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate the point estimate and 90-percent confidence interval for the total number of policies in the sampling frame that were associated

[30] We selected this audit period because it contained the latest data of finalized BHP payments. At the start of this audit, CMS had not yet finalized BHP payments beyond March 2019.

[31] We refer to a BHP policy as all individual applicants under a Family ID. A Family ID can contain one or more individuals.

with incorrect or potentially incorrect eligibility determinations. We also used this software to calculate the point estimate and 90-percent confidence interval for the total dollar value of payments made on behalf of policies associated with incorrect or potentially incorrect eligibility determinations. Note that in the latter case, we calculated the 90-percent confidence interval using the empirical likelihood option.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES[32]

Table 1: Sample Detail and Results

Stratum	Number of Frame Units	Value of Frame	Sample Size	Value of Sample	Policies Containing Incorrect or Potentially Incorrect Eligibility Determinations	Value of Payments for Incorrect or Potentially Incorrect Eligibility Determinations
1	361,870	$608,693,438	20	$36,730	1	$1,199
2	501,773	2,829,222,606	90	507,771	2	7,812
3	103,050	1,271,278,449	40	484,402	2	1,788
Totals	**966,693**	**$4,709,194,493**	**150**	**$1,028,903**	**5**	**$10,799**[33]

Table 2: Estimated Number of Policies in the Sampling Frame Containing Incorrect or Potentially Incorrect Eligibility Determinations and the Estimated Value of Associated Payments

(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Policies With Incorrect or Potentially Incorrect Eligibility Determinations	Total Value of Payments for Incorrect or Potentially Incorrect Eligibility Determinations
Point estimate	34,397	$69,862,030
Lower limit	1,428	$24,514,742
Upper limit	67,365	$160,614,771

[32] The values included in this appendix are Federal share amounts of the payments associated with the policies containing incorrect or potentially incorrect eligibility determinations.

[33] Amount includes potentially ineligible payments totaling $2,184 for which reimbursement is not recommended for recovery in this report. Therefore, the total recommended recovery amount is $8,615.

APPENDIX D: STATE AGENCY COMMENTS

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 6, 2022

Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: **A-02-20-01028**

Dear Brenda Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-20-01028 entitled, "*New York Generally Determined Eligibility for Its Basic Health Program Enrollees in Accordance with Program Requirements*."

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud

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Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
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New York State Department of Health
Comments to Draft Audit Report A-02-20-01028 entitled, "New York Generally Determined Eligibility For Its Basic Health Program Enrollees in Accordance With Program Requirements" by the Department of Health and Human Services Office of Inspector General

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The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report A-02-20-01028 entitled, "New York Generally Determined Eligibility For Its Basic Health Program Enrollees In Accordance With Program Requirements" by the Department of Health and Human Services, Office of Inspector General (OIG).

General Comments:

The following comments address specific statements made in the audit report.

Findings (page 2):

- *On the basis of our sample results, we estimated that the financial impact of the incorrect or potentially incorrect eligibility determinations made by the State agency for its Basic Health Program (BHP) during the audit period totaled $69.9 million.*

The Department asserts the dollar amount OIG cited for potentially incorrect eligibility determinations overstates the extent to which the five cases cited as findings apply to the broader BHP population. For example, the issue that impacted consumers subject to the five-year bar for federal financial participation in Medicaid should only be extrapolated to the population that policy applies to, which is less than half of the entire BHP population. The issue impacting income inconsistency periods was a known, short-term defect (i.e., occurring for only 29 days of the 365-day audit period) so that finding should only be extrapolated for the period prior to remediation (i.e., the defect was identified on September 25, 2018 and remediated on October 23, 2018). Lastly, as part of an existing report, the Department has determined that the issue concerning deceased consumers represents only 20 cases out of an average enrollment of over 740,000 during the audit period, and the Department has already taken steps to recover any claims paid after the consumer's date of death. As such, they can either be excluded from the extrapolation entirely or be reflected as 20 cases.

Lastly, OIG's extrapolation methodology stratifies consumers based on the amount of federal payment the state received on consumers' behalf and extrapolates their system issue findings based on which federal payment cohort consumers fall in. However, that approach assumes consumers who received similar federal payment amounts had the same probabilities of experiencing the system issues OIG cites. The Department believes the amount of federal payment received more likely reflects the length of coverage, which is independent of the characteristics that would have made those consumers likely to have been determined incorrectly or potentially incorrectly eligible. OIG should consider looking at consumers based on other factors—such as BHP rate cell or BHP level or whether they were subject to the five-year bar to extrapolate their findings.

The Department also requests OIG provide feedback on why its finding for potentially incorrect determinations is roughly ten times higher than the initial amount provided in March 2022.

Recommendation #1:

Reimburse New York's BHP Trust Fund $8,615 associated with the improper monthly payments identified in our sample.

Response #1:

The Department will reimburse the $8,615 to the BHP Trust Fund.

Recommendation #2:

Identify and reimburse the BHP Trust Fund all improper payments resulting from system defects identified in our report (we estimated improper and potentially improper payments during our audit period to be $69,853,415 ($69,862,030 less $8,615)).

Response #2:

As noted above, the Department asserts the amount estimated by OIG overstates the extent to which the five cases for which they suspect incorrect or potentially incorrect eligibility determinations can be extrapolated to the entire BHP population.

Recommendation #3:

Implement system changes to ensure that BHP enrollees with a pending coverage end-date are transferred from BHP to Medicaid upon the end of their 5-year bar.

Response #3:

The Department has comprehensive controls in place to accurately identify consumers who are approaching the end of their five-year bar period, and consistently takes timely action to transition the consumers to Medicaid as appropriate. However, due to a system defect, which the Department identified prior to the inception of the audit, a very small percentage of consumers temporarily remained in BHP for a short period of time even though the Department took timely action to transition the consumers to Medicaid. The Department is in the process of implementing enhanced system functionality to remediate this issue.

Recommendation #4:

Implement system changes to ensure that income verification clocks are not improperly removed, and applicants' attested incomes are verified to be reasonably compatible with data sources.

Response #4:

The Department consistently maintains verification clocks until their due date and takes timely and appropriate action to end consumers' coverage if they fail to provide the required documentation to verify their eligibility. The Department's robust quality assurance efforts identified a system defect as the cause of this issue prior to the inception of the audit. The defect was remediated within 29 days of being identified.

Recommendation #5:

Implement system changes to ensure that claims for BHP payments are not made on behalf of deceased individuals.

Response #5:

The Department has comprehensive system controls in place to identify deceased consumers and initiate timely and appropriate action to end their coverage. For example, the Department electronically checks a consumer's living status via the Social Security Administration (SSA) with every initial application, redetermination and renewal. Additionally, it sends a file to the SSA monthly to check the living status of consumers who are actively enrolled with coverage.

Due to a system limitation, in rare cases, a consumer's coverage may end within a month or two after the date of death. For the entire audit period, there were only 20 consumers impacted by this scenario and the Department has taken steps to recover all claims paid after the consumer's date of death.

The Department will continue its ongoing monitoring of payments made after a consumer's date of death to ensure the timely recoupment of BHP payments as appropriate.