

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**OHIO DID NOT CORRECTLY  
DETERMINE MEDICAID  
ELIGIBILITY FOR SOME NEWLY  
ENROLLED BENEFICIARIES**

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# *Office of Inspector General*

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## Report in Brief

Date: November 2020

Report No. A-05-18-00027

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



### Why OIG Did This Audit

The Patient Protection and Affordable Care Act gave States the option to expand Medicaid coverage to low-income adults without dependent children. It also mandated changes to Medicaid eligibility rules and established a higher Federal reimbursement rate for services provided to these beneficiaries, which led us to review whether States were correctly determining eligibility for these newly eligible beneficiaries. (States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services.) Ohio chose to expand Medicaid coverage.

Our objective was to determine whether Ohio determined Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements.

### How OIG Did This Audit

We reviewed a stratified random sample of 150 newly eligible beneficiaries who received Medicaid-covered services from October 2014 through March 2015 (audit period). We reviewed supporting documentation to evaluate whether Ohio determined the applicants' eligibility in accordance with Federal and State requirements (e.g., income, citizenship or lawful presence, and other relevant requirements).

## Ohio Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

### What OIG Found

For our sample of 150 beneficiaries, Ohio correctly determined Medicaid eligibility for 69 beneficiaries. However, Ohio did not determine eligibility for 18 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that the remaining 66 potentially ineligible beneficiaries were newly eligible. (The total exceeds 150 because 3 beneficiaries were found to be ineligible for 1 determination period and found to be potentially ineligible for another period.)

These deficiencies occurred because Ohio's eligibility determination system lacked the necessary system functionality, and eligibility caseworkers made errors. In addition, Ohio did not always maintain documentation to support eligibility determinations.

On the basis of our sample results, we estimated that Ohio made Medicaid payments of \$77.5 million (Federal share) on behalf of 51,219 ineligible beneficiaries and \$746.4 million (Federal share) on behalf of 241,998 potentially ineligible beneficiaries.

### What OIG Recommends and Ohio Comments

We recommend that Ohio: (1) redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries; (2) ensure that its eligibility determination system has the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements; (3) educate eligibility caseworkers about relevant Federal and State eligibility requirements; and (4) ensure that documentation supporting eligibility determinations is maintained in beneficiaries' records. The "Recommendations" section in the body of the report lists our recommendations in more detail.

In written comments on our draft report, Ohio did not indicate concurrence or nonconcurrence with our recommendations. However, Ohio described actions it has taken that address our recommendations. Ohio said that it redetermined the current Medicaid eligibility of the sampled beneficiaries, improved the functionality of its eligibility determination system, and provided training to caseworkers. In addition, Ohio plans to review randomly selected cases for eligibility and data entry errors and determine whether additional training needs exist.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA).<sup>1</sup> Generally, the ACA gave States the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate (Federal Medical Assistance Percentage, or FMAP) for services provided to these beneficiaries.<sup>2</sup> The ACA also included changes to Medicaid eligibility rules, such as requiring that income be calculated on the basis of Modified Adjusted Gross Income (MAGI)<sup>3</sup> and that income be at or below 133 percent of the Federal Poverty Level (FPL) for newly eligible beneficiaries. These changes led us to review whether States were correctly determining eligibility for newly eligible beneficiaries. If these beneficiaries' eligibility had been incorrectly determined, payments made on their behalf would have been reimbursed at a higher FMAP than they should have been or should not have been reimbursed at all.

This audit is part of an ongoing series of Office of Inspector General (OIG) audits of newly eligible beneficiaries (Appendix B). We selected Ohio to ensure that our audits cover States in different parts of the country.

### OBJECTIVE

Our objective was to determine whether the Ohio Department of Medicaid (State agency) determined Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements.

### BACKGROUND

#### The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, States must cover certain population groups. Generally, individual eligibility criteria are met by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of U.S.

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<sup>1</sup> The Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as the "ACA."

<sup>2</sup> In this report, we refer to these low-income adults for whom the States receive a higher FMAP as "newly eligible" beneficiaries" or "the new adult group." Other beneficiary groups that receive the standard FMAP are referred to as the "Traditional Medicaid group(s)."

<sup>3</sup> The Social Security Act (the Act) §§ 1902(e)(14)(A) through (D) and 26 U.S.C. § 36B(d)(2)(B). This methodology to determine a person's income is based on Internal Revenue Service (IRS) rules.

citizenship. For many eligibility groups, income is calculated in relation to a percentage of the FPL.

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures—the FMAP—which is developed from criteria such as the State’s per capita income.<sup>4, 5</sup> The standard FMAP varies by State and ranges from 50 to 75 percent.<sup>6, 7</sup>

CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs, which are designed to reduce improper payments. In July 2017, CMS modified its MEQC and PERM requirements to incorporate changes mandated by the ACA.<sup>8</sup>

### **Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act**

The ACA provided states with the option to expand their Medicaid programs to cover more low-income people, including nondisabled adults without dependent children.<sup>9</sup> Effective January 1, 2014, all individuals younger than 65 years of age with incomes up to 133 percent of the FPL became eligible for Medicaid;<sup>10</sup> this initiative is known as Medicaid expansion. A ruling by the U.S. Supreme Court allowed each State the option to decline to expand its Medicaid program and not face any reduction in current Medicaid funding (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)).

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<sup>4</sup> The Act § 1905(b).

<sup>5</sup> CMS, “Financial Management.” Available online at <https://www.medicaid.gov/medicaid/financial-management/index.html>. Accessed on April 7, 2020.

<sup>6</sup> 79 Fed. Reg. 3385, 3387 (Jan. 21, 2014).

<sup>7</sup> Office of the Assistant Secretary for Planning and Evaluation, “FY2015 Federal Medical Assistance Percentages.” Available online at <https://aspe.hhs.gov/basic-report/fy2015-federal-medical-assistance-percentages>. Accessed on April 8, 2020.

<sup>8</sup> 82 Fed. Reg. 31158, 31159 (July 5, 2017).

<sup>9</sup> ACA § 2001(a)(1)(C).

<sup>10</sup> The Act § 1902 established the FPL income threshold at 133 percent but allows for a 5-percent income disregard (a standard deduction applied to calculate income for Medicaid), making the effective threshold 138 percent of the FPL.



The ACA § 2001 authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group.<sup>11</sup> This “newly eligible FMAP” was set to remain at 100 percent through calendar year (CY) 2016, gradually decreasing to 90 percent by CY 2020.<sup>12</sup>

### **Requirements for Eligibility Determination and Verification Under the Affordable Care Act**

The ACA also required States to make changes to their Medicaid application, enrollment, and eligibility determination processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual’s eligibility for all potential health coverage options, including Medicaid, the Children’s Health Insurance Program, and qualified health plans available through the health insurance marketplaces.<sup>13</sup> In most cases, the ACA required States to use MAGI to determine an individual’s income.<sup>14</sup>

States are required to have an income and eligibility verification system for determining Medicaid eligibility and a verification plan (made available upon CMS’s request) describing the State agency’s policies and procedures for implementing the eligibility verification requirements (42 CFR § 435.945(j)). States must verify individuals’ eligibility information, such as citizenship or lawful presence and entitlement to or enrollment in Medicare, through electronic data sources (42 CFR §§ 435.945(a) and (b) and 435.949). States may accept an individual’s attestation for certain information, such as a beneficiary’s pregnancy status and household composition (e.g., household size and family relationships), without further verification (42 CFR §§ 435.945(a) and 435.956).

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<sup>11</sup> The Act defines a “newly eligible” beneficiary as “an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the [ACA], is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage” (the Act § 1905(y)(2)(A)).

<sup>12</sup> 42 CFR § 433.10(c)(6).

<sup>13</sup> ACA § 1413(b).

<sup>14</sup> See footnote 3. The use of MAGI to determine Medicaid eligibility does not apply to certain groups of beneficiaries, such as seniors who are 65 years of age or older and medically needy individuals.

Federal regulations provide standards under which income information obtained through electronic data sources is considered reasonably compatible with income information provided by or on behalf of an individual (42 CFR § 435.952).<sup>15</sup>

## **Ohio's Medicaid Eligibility Determination and Verification**

In Ohio, the State agency is responsible for ensuring that it performs eligibility determinations in accordance with all Federal and State Medicaid requirements. The State agency uses County Departments of Job and Family Services (local county agencies) to review Medicaid applications and make Medicaid program eligibility determinations.

From October 1, 2014, through March 31, 2015 (audit period), the State agency was converting its primary eligibility determination system from the Client Registry Information System—Enhanced (CRIS-E) to the Ohio Benefits system (Ohio Benefits), but it was still using both systems.<sup>16</sup> County caseworkers used these systems to determine and document eligibility for Medicaid as well as other programs (e.g., the Supplemental Nutrition Assistance Program and Temporary Assistance to Needy Families). The State agency provided oversight of county eligibility caseworkers' Medicaid eligibility determinations and documentation (e.g., providing training and monitoring compliance).

### *Medicaid Application Process*

In Ohio, residents and qualified entities<sup>17</sup> may submit electronic Medicaid applications through the Ohio Benefits Self-Service Portal, the Presumptive Eligibility Portal, or the Federally Facilitated Marketplace. In addition, county agencies accept paper and phone applications.

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<sup>15</sup> The term “reasonably compatible” refers to a Federal requirement (effective Jan. 1, 2014) that prohibits States from requiring Medicaid applicants to provide documentation except in cases in which applicants’ self-reported documentation was not reasonably compatible with information in Government databases (42 CFR § 435.952(c)). In accordance with this requirement, if (a) an applicant attests to income above the applicable income standard and a data source shows it to be below the standard or (b) an applicant’s attestation and electronic verification are both below the applicable standard, the State agency accepts the applicant’s attestation. In Ohio, if an applicant attests to income below the applicable standard and the data sources show income above the standard, income is considered reasonably compatible if the difference between the attested income and electronic data verifications is within an amount no more than 5 percent of 100 percent FPL for a family of one. If the difference exceeds this threshold, the State agency requests manual verifications. (Ohio MAGI-Based Eligibility Verification Plan).

<sup>16</sup> The State agency used CRIS-E for all Medicaid determinations before 2014 and for non-MAGI-based Medicaid determinations during the audit period. The State agency used Ohio Benefits, also referred to as the “Ohio Integrated Eligibility System,” for MAGI-based Medicaid eligibility determinations during the audit period.

<sup>17</sup> In Ohio, a qualified entity is the source of eligibility determinations for the presumptive eligibility program and is limited to a County Department of Job and Family Services and a hospital among several other entities (Ohio Administrative Code (OAC) 5160:1-1-01(B)(65)). The presumptive eligibility program allows uninsured residents to receive immediate health care services through Medicaid if they are presumed to be eligible.

The State agency enters the information that an applicant provides into Ohio Benefits. Ohio Benefits makes eligibility determinations based on the information provided by the applicant and the information received through electronic data sources.

### *Eligibility Verification Process*

The Ohio Verification Plan specifies that, when possible, electronic data sources are used for real-time matches for income verification at the time of application. To verify the accuracy of the eligibility information provided by an applicant, Ohio Benefits uses multiple electronic data sources, including sources available through the State Wage Information Collection Agency, State Unemployment Compensation, and the Federal Data Services Hub (Data Hub).<sup>18, 19</sup> Internal Revenue Service (IRS), Social Security Administration (SSA), and the Department of Homeland Security, among others, provide the data sources available through the Data Hub.

Ohio Benefits sends an electronic request to the Data Hub for each eligibility factor requiring verification. The Data Hub provides an electronic response to Ohio Benefits indicating whether the data match was successful. If Ohio Benefits is unable to electronically verify the applicant's information or there is a discrepancy between the information provided by the applicant and the Data Hub, eligibility caseworkers may, and in some cases must, request additional documentation from the applicant and perform a manual review.

The State agency may determine a beneficiary to be eligible for Medicaid under different coverage groups during a span of time. For example, a beneficiary may be determined eligible for Medicaid under the new adult group for 1 month and under another coverage group for the next month. After determining eligibility, Ohio Benefits transmits eligibility determination information to the Medicaid Information Technology System (MITS), which is the State agency's system for processing Medicaid payments on behalf of beneficiaries.

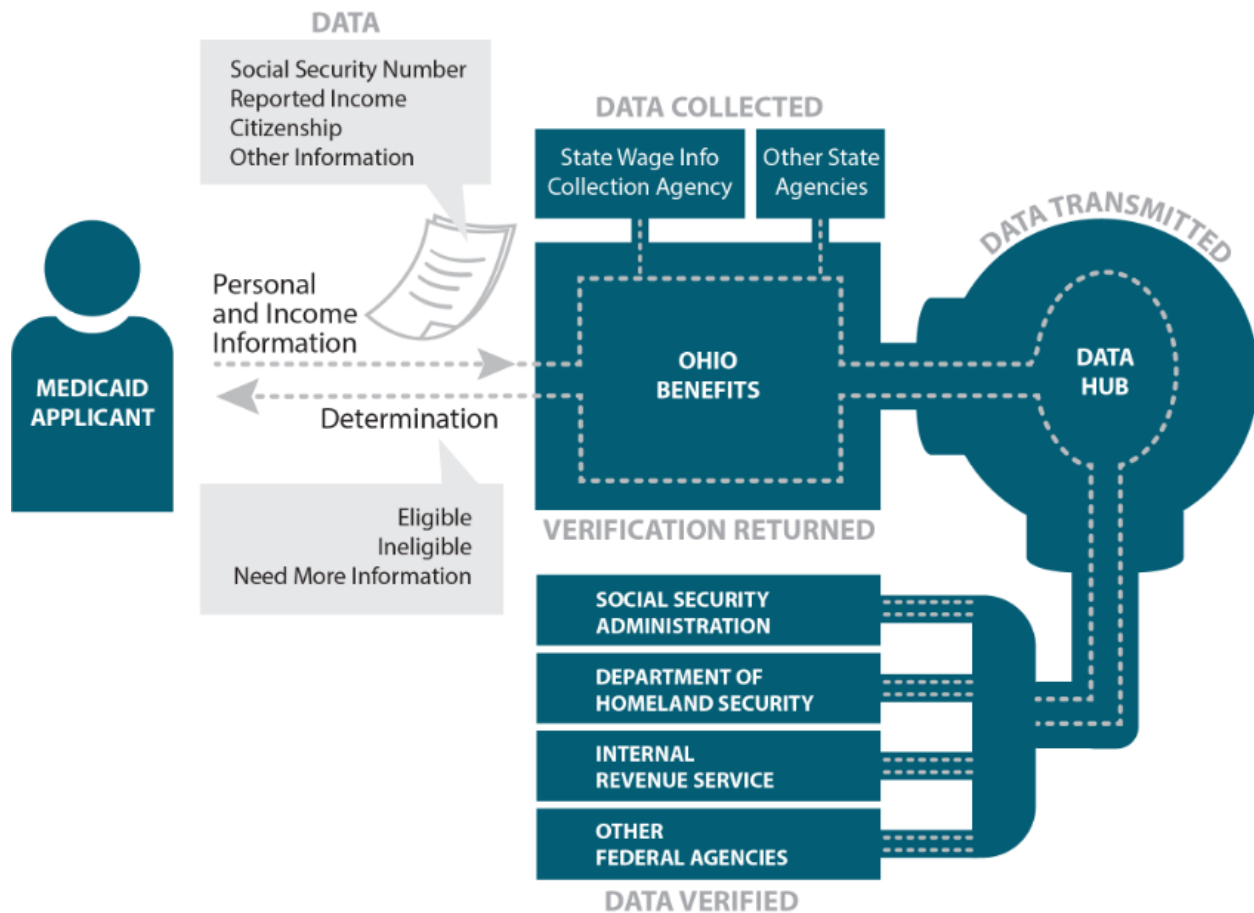
The figure (next page) depicts Ohio's Medicaid eligibility verification process.

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<sup>18</sup> ACA § 1411(c). The Data Hub is a single conduit that sends electronic data to and receives electronic data from multiple Federal agencies; it does not store data.

<sup>19</sup> Section B1 of Ohio's MAGI-Based Eligibility Verification Plan (Verification Plan) also lists "TALX The Work Number" as an additional electronic data source. The Work Number is a commercial database that is used by the State agency to verify employment and income.

**Figure: Ohio's Medicaid Eligibility Verification Process**



### *MetroHealth Care Plus Demonstration Project*

On February 5, 2013, CMS approved the State agency's request for a Medicaid section 1115(a) demonstration,<sup>20</sup> "MetroHealth Care Plus," which was discontinued on December 31, 2013.<sup>21</sup> The demonstration provided coverage to uninsured adults, ages 19 through 64, who: (1) had household income at or below 133 percent of the FPL, (2) resided in Cuyahoga County, and (3) were not otherwise eligible for comprehensive benefits under the Medicaid State plan or Medicare. The MetroHealth System (MetroHealth) and its community partner network providers provided benefits under this demonstration. MetroHealth determined applicants'

<sup>20</sup> Section 1115 of the Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serving Medicaid populations.

<sup>21</sup> The State agency notified us that, among other things, this demonstration was a pilot of the ACA's new adult group.

eligibility using electronic verification, where possible, or documentation from the individuals. MetroHealth maintained the eligibility information in its system. The State agency assessed an individual's eligibility based on the information in the MetroHealth system in October 2013. On January 1, 2014, the enrolled MetroHealth beneficiaries were administratively transferred and categorized as newly eligible beneficiaries under the State agency's Medicaid program. These beneficiaries were not required to reapply or provide additional information.

#### *Delayed Annual Eligibility Renewals and Redeterminations in 2014*

Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months. For Medicaid beneficiaries whose eligibility is determined on a basis other than MAGI, the State agency must redetermine eligibility at least every 12 months. In addition, the State agency must promptly redetermine eligibility whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility (42 CFR § 435.916).

Due to transition from CRIS-E to Ohio Benefits and anticipated eligibility determination issues, the State agency requested and CMS granted a waiver to delay renewals scheduled for a calendar year (CY) 2014 month until the corresponding month in 2015. In addition, CMS authorized the State agency to disregard any insignificant changes in income and other circumstances during CY 2014.<sup>22</sup> The State agency considered changes in a Medicaid household, an individual's birth or death, a move out of Ohio, and changes in blindness or disability status, among several other circumstances, to be significant (i.e., they would require eligibility redetermination).<sup>23</sup> However, a subsequent change (i.e., a change that occurred after the initial eligibility determination) in household income was not considered to be "significant" and did not require eligibility redetermination during CY 2014.

As a result of this waiver, the State agency had legal authority to ignore subsequent income changes (including those exceeding 138 percent of the FPL) of the Medicaid beneficiaries in CY 2014.

#### *Homewood Settlement*

On May 12, 2015, a class-action settlement was reached between Medicaid beneficiaries whose benefits had been terminated and the State agency.<sup>24</sup> The settlement stated that the State agency had improperly conducted individuals' renewal process and improperly terminated coverage for individuals who did not respond to the State agency's renewal packet. The settlement required the State agency to reinstate Medicaid coverage to all beneficiaries who lost coverage between January 1 and March 31, 2015, because they failed to respond to the

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<sup>22</sup> CMS's approval letter dated September 30, 2013.

<sup>23</sup> Ohio Department of Medicaid, *Medicaid Eligibility Procedure Letter No. 90* (effective Jan. 1, 2014).

<sup>24</sup> *Homewood v. McCarthy*, Case No. 2:15-CV-1119 (S.D. Ohio Apr. 2, 2015).

renewal packet. An estimated 180,000 beneficiaries had their coverage reinstated retrospectively to the date of termination without further review until the next renewal period.

## HOW WE CONDUCTED THIS AUDIT

Our audit covered 481,353 newly eligible beneficiaries in Ohio for whom the State agency made Medicaid payments totaling \$1,584,138,982 (\$1,557,183,825 Federal share) from October 1, 2014, through March 31, 2015 (audit period), for services provided during this period. These beneficiaries may have been determined newly eligible for only part of the audit period.

In developing our sampling frame, we excluded the beneficiaries: (1) who were part of ongoing OIG audits of the Medicaid program in Ohio<sup>25</sup> or (2) whose coverage group was adjusted by the State agency from the new adult group to another group after the audit period.

We reviewed the Medicaid eligibility determinations made by the State agency for a stratified random sample of 150 newly eligible beneficiaries:

- 50 beneficiaries whom the State agency had determined eligible for Medicaid solely under the new adult group, each associated with total payments of less than \$4,000;
- 40 beneficiaries whom the State agency had determined eligible for Medicaid solely under the new adult group, each associated with total payments equal to or greater than \$4,000;
- 20 beneficiaries whom the State agency had determined eligible for Medicaid under the new adult group during some months and another coverage group during other months, each associated with total payments of less than \$2,220;
- 20 beneficiaries whom the State agency had determined eligible for Medicaid under the new adult group during some months and another coverage group during other months, each associated with total payments equal to or greater than \$2,220; and
- 20 beneficiaries whom the State agency had determined eligible for Medicaid under a coverage group other than the new adult group, each associated with 1 or more payments under the new adult group.

We limited our review of internal controls to those applicable to our objective. Specifically, we reviewed the internal controls that the State agency had in place during the audit period for eligibility determinations and verifications.

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<sup>25</sup> *Ohio Made Medicaid Capitation Payments That Were Duplicative or Were Improper Based on Beneficiary Eligibility Status or Demographics* (A-05-16-00061), issued September 12, 2019, and *Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths* (A-05-17-00008), issued October 4, 2018.

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 related OIG reports, Appendix C contains the details of our statistical sampling methodology, and Appendix D contains our sample results and estimates.

## FINDINGS

The State agency did not always determine Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements. For our sample of 150 beneficiaries, the State agency correctly determined eligibility for 69 beneficiaries. However, it did not determine eligibility for 18 beneficiaries in accordance with Federal and State requirements and did not provide documentation to support that the remaining 66 potentially ineligible beneficiaries were newly eligible.<sup>26</sup>

These deficiencies occurred because: (1) the State agency's eligibility determination system lacked system functionality (e.g., the capability to alert an eligibility caseworker when a beneficiary turned 19 years old) and (2) eligibility caseworkers made errors (e.g., used incorrect household income or household size for the income test). In addition, the State agency did not always maintain documentation to support eligibility determinations.

On the basis of our sample results, we estimated that the State agency made Medicaid payments of \$77,455,592 (Federal share)<sup>27</sup> on behalf of 51,219 ineligible beneficiaries and \$746,424,941 (Federal share)<sup>28</sup> on behalf of 241,998 potentially ineligible beneficiaries during our audit period.

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<sup>26</sup> The total exceeds 150 because 3 beneficiaries were found to be ineligible for 1 determination period and found to be potentially ineligible for another period. Therefore, we included these beneficiaries in both groups.

<sup>27</sup> The 90-percent confidence interval for the amount paid on behalf of ineligible beneficiaries ranged from \$34,812,500 (lower limit) to \$152,374,685 (upper limit). (See Appendix D, Table 4.)

<sup>28</sup> The 90-percent confidence interval for the amount paid on behalf of potentially ineligible beneficiaries ranged from \$588,831,418 (lower limit) to \$957,174,491 (upper limit). (See Appendix D, Table 5.)

## **THE STATE AGENCY INCORRECTLY DETERMINED THAT SOME BENEFICIARIES MET REQUIREMENTS FOR THE NEW ADULT OR OTHER COVERAGE GROUPS**

The State agency incorrectly determined that 18 beneficiaries met Federal and State eligibility requirements: 15 for the new adult group and 3 for other coverage groups.<sup>29</sup>

### **Beneficiaries Did Not Meet Requirements for the New Adult Group**

In addition to meeting citizenship and State residency requirements, to be eligible for the new adult group, an individual must:

- have a household income at or below 138 percent of the FPL;<sup>30</sup>
- be from 19 to 64 years old;
- not be eligible for any other mandatory coverage under the Medicaid State plan, such as a parent or other caretaker relative of dependent children, or not be an individual under age 26 who was formerly a child in foster care;<sup>31</sup>
- not be pregnant; and
- not be entitled to or enrolled for Medicare benefits under Parts A or B of Title XVIII of the Act (42 CFR § 435.119(b)).

The ACA § 2001 added that a newly eligible beneficiary is an individual who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage.<sup>32</sup> The State agency notified CMS that the following categories of

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<sup>29</sup> Of the 18 beneficiaries, 3 had payments associated with coverage groups for which they were ineligible and potentially ineligible. (For example, we determined that a beneficiary in our sample was eligible for coverage under the new adult group between October 2014 and February 2015. However, the State agency incorrectly determined that the beneficiary met Federal and State requirements for another coverage group during this period. In addition, we determined that the beneficiary was potentially ineligible in March 2015 because the State agency did not provide the necessary documentation to verify that the beneficiary was newly eligible). Therefore, we included these beneficiaries in both groups.

<sup>30</sup> 42 CFR § 435.119(b)(5). The Act established the FPL threshold at 133 percent but allows for a 5-percent income disregard, making the effective threshold 138 percent of the FPL (the Act § 1902).

<sup>31</sup> Section 1902(a)(10)(A)(i) of the Act lists the other Medicaid eligibility groups for which beneficiaries in the new adult group may not be eligible (subclauses I through VII and IX).

<sup>32</sup> Section 1937(b)(1)(A) through (C) of the Act describes benchmark coverage requirements, and section 1937(b)(2) of the Act describes benchmark-equivalent coverage requirements.



beneficiaries (from 19 to 64 years old) were covered under the State plan as of December 1, 2009:

- parents and caretaker relatives with incomes up to 90 percent of the FPL,
- individuals 19 and 20 years old with incomes up to 44 percent of the FPL, and
- noninstitutionalized blind and disabled individuals with incomes up to 66 percent of the FPL with spenddown eligibility above that limit.<sup>33, 34, 35</sup>

In addition, a State must require that an applicant, as a condition of eligibility for Medicaid benefits, furnish a Social Security number, if available, and a written declaration that he or she is a citizen or lawfully present (i.e., an application subject to the penalty of perjury) (the Act §§ 1137(a)(1) and (d)(1)).

Federal regulations restrict full Medicaid benefits for individuals who are not citizens or qualified aliens.<sup>36, 37</sup> A qualified alien is not eligible for full Medicaid benefits until 5 years from the date he or she enters the United States with qualified alien status, which is also known as the 5-year bar.<sup>38</sup> Ohio provides optional coverage during pregnancy and 60 days postpartum to pregnant noncitizens in a valid nonimmigrant status who are lawfully present in the United States (State plan amendment OH-13-0030 (effective Jan. 1, 2014)).

The State agency considered changes in a Medicaid household, an individual's birth or death, a move out of Ohio, and changes in blindness or disability status, among several other circumstances, to be significant (i.e., they would require eligibility redetermination).<sup>39</sup>

The State agency incorrectly determined that 15 beneficiaries met Federal and State requirements for the new adult group. Specifically:

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<sup>33</sup> Before August 1, 2016, Ohio was a 209(b) State. In 209(b) States, individuals receiving Supplemental Security Income (SSI) or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for the new adult group if otherwise eligible.

<sup>34</sup> Percentages are based on the relevant MAGI-converted standards (Attachment A to page 6 of Supplement 18 to Attachment 2.6-A of Ohio State plan amendment OH-13-031 (effective Jan. 1, 2014)).

<sup>35</sup> The State agency submitted the *Group VIII Profile Q&A* to CMS on May 22, 2015.

<sup>36</sup> 8 U.S.C. § 1613(a).

<sup>37</sup> Examples of "qualified alien" include individuals who are lawfully permitted permanent residency, individuals granted asylum, refugees admitted to the United States, and individuals granted conditional entry.

<sup>38</sup> Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

<sup>39</sup> Ohio Department of Medicaid, *Medicaid Eligibility Procedure Letter No. 90* (effective Jan. 1, 2014).

- Eight beneficiaries were eligible for one of the other mandatory coverage groups. For example, a beneficiary who was under age 26 and formerly a child in foster care was improperly determined to be eligible for the new adult group.
- Four beneficiaries had household incomes more than 138 percent of the FPL and were ineligible for other coverage groups.
- One beneficiary was eligible only for the optional coverage under the nonimmigrant pregnant women group during her pregnancy and 60 days postpartum based on her valid nonimmigrant status and lawful presence (e.g., through a visitor visa) and ineligible for Medicaid coverage thereafter.
- One beneficiary was pregnant and had income more than 200 percent of the FPL.<sup>40</sup>
- One beneficiary died after being approved for enrollment in the new adult group. The State agency should have discontinued the coverage of the deceased beneficiary; however, the State agency either did not receive or did not retain the information about the death. Both Ohio Benefits and MITS indicated active coverage for the beneficiary after the date of death during the audit period.<sup>41</sup>

These deficiencies occurred because the State agency's eligibility determination system lacked the functionality to:

- properly categorize a beneficiary who was formerly in the foster care program as eligible for the mandatory coverage group,
- retrieve and use information from SSA to determine whether a beneficiary was disabled and eligible for the mandatory coverage group,
- prevent two cases for the same beneficiary from being open simultaneously in Ohio Benefits (under the new adult group) and CRIS-E (under the mandatory coverage group), and
- alert eligibility caseworkers when a beneficiary died and did not discontinue coverage for the beneficiary.

In addition, eligibility caseworkers made errors. Specifically, they:

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<sup>40</sup> In Ohio, pregnant women are eligible for the mandatory Medicaid coverage if their household income is at or below 200 percent of the FPL (State plan amendment OH-13-0025 (effective Jan. 1, 2014)).

<sup>41</sup> The beneficiary submitted a Medicaid application on July 2, 2014, and the application was approved by the State agency effective July 1, 2014. The beneficiary died on October 2, 2014. The State agency did not make any Medicaid payments after the death of the beneficiary.

- did not correctly determine an applicant's and beneficiary's household income and household size and
- did not properly enter applicant and beneficiary information into Ohio Benefits.

### **Beneficiaries Did Not Meet Requirements for Other Coverage Groups**

The State agency must provide Medicaid to children under age 19 whose household income is at or below 156 percent of the FPL (42 CFR § 435.118 and State plan amendment OH-13-0025 (effective Jan. 1, 2014)).

The State agency must provide Medicaid to parents or other caretaker relatives of a dependent child under age 18 and who have a household income at or below 90 percent of the FPL (42 CFR § 435.110 and State plan amendment OH-13-0025 (effective Jan. 1, 2014)).

The State agency incorrectly determined that three beneficiaries met Federal and State eligibility requirements for other coverage groups.<sup>42</sup> Specifically:

- Two beneficiaries were eligible for the coverage under the new adult group and were not eligible for the parents and other caretaker relatives group. The household income of one beneficiary exceeded 90 percent of the FPL, and a child of the second beneficiary turned 18 years old. However, the State agency did not adjust the beneficiaries' coverage from the parents and other caretaker relatives group to the new adult group.
- One beneficiary was eligible for coverage under the new adult group because the beneficiary turned 19 years old before our audit period. However, the State agency did not adjust the beneficiary's coverage from the infants and children under age 19 group to the new adult group.

These deficiencies occurred because the State agency's eligibility verification system did not alert eligibility caseworkers when a beneficiary or a beneficiary's child reached the age affecting the beneficiary's coverage group determination. In addition, an eligibility caseworker did not correctly determine the beneficiary's household income.

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<sup>42</sup> We reviewed Medicaid payments under other coverage groups because the State agency also made Medicaid payments on behalf of these beneficiaries under the new adult group for other months during the audit period.

## **THE STATE AGENCY DID NOT PROVIDE DOCUMENTATION TO SUPPORT THAT BENEFICIARIES WERE NEWLY ELIGIBLE**

States must verify individuals' eligibility for Medicaid in accordance with 42 CFR §§ 435.948 through 435.956 (42 CFR § 435.945). In addition, a State agency must maintain individual records on each applicant and beneficiary, including information on income and eligibility verification, and facts essential to determining initial and continuing eligibility (42 CFR §§ 431.17 and 435.914 and the State plan § 4.7 (effective Oct. 1, 1977)).

Individuals must declare their citizenship and provide satisfactory documentary evidence of citizenship or national status as described in 42 CFR § 435.407, and the State agency must document the individuals' citizenship in their eligibility files (42 CFR §§ 435.406(a) and 435.956(a)(4)).

The State agency must request financial information related to wages, net earnings from self-employment, unearned income, and resources from the State Wage Information Collection Agency, IRS, SSA, and State unemployment compensation (42 CFR § 435.948(a)(1)). When possible, the State agency must use electronic data sources to verify income (42 CFR § 435.948(b) and Ohio's Verification Plan).<sup>43</sup> If information an individual provides is not reasonably compatible with information obtained through an electronic data source, the State agency must seek additional information, which may include a reasonable explanation or paper documentation, or both (42 CFR § 435.952(c)(2)).<sup>44</sup>

When the normal sources of verification have been exhausted and documentation either does not exist or is not reasonably available, the State agency may accept the individual's statement when it is complete and consistent with other facts and statements. The use of such a statement must be on a case-by-case basis when no other approach is possible and must be used only in rare circumstances and does not apply for certain eligibility requirements such as citizenship and immigration status (42 CFR § 435.952).

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<sup>43</sup> Section B1 of Ohio's Verification Plan identifies electronic data sources for verifying financial information.

<sup>44</sup> Ohio's Verification Plan indicates that if an individual attests to income below the applicable income standard and an electronic data source shows income above the standard, the State agency will consider the income "reasonably compatible" if the difference between the self-attested income and electronic data verifications are within an amount less than or equal to 5 percent of 100-percent FPL for a family of one. If the difference in income exceeds this threshold, the State agency will request manual verification and use the verified income. If an individual's attestation and electronic verification are both below the applicable income standard, the State agency will accept the attestation. If the attested income is above the income standard and electronic data sources show income below the income standard, the State agency will use the self-attested income.

The State agency did not provide the necessary documentation to verify that 66 beneficiaries were newly eligible.<sup>45, 46</sup> Specifically, the State agency was unable to provide documentation supporting that self-reported income, citizenship status, or a combination of both, had been electronically or manually verified.

For the majority of the 66 beneficiaries, the State agency verified or attempted to verify the self-reported income and citizenship status through the Data Hub or other authorized electronic and manual data sources. However, the State agency either did not receive or did not retain verification results. In addition, the State agency did not verify household income of some beneficiaries who reported either a change in household composition (such as a beneficiary getting married) or not having any income.

During our audit period, the State agency experienced difficulties with data matches through the Data Hub (such as no response or a delayed response from the Data Hub). As a result, the State agency instructed eligibility caseworkers to rely on the “best available information,” which frequently meant accepting applicants’ and beneficiaries’ self-reported zero income without further verification.

Without the necessary documentation, we could not conclusively determine whether the 66 potentially ineligible beneficiaries met the requirements to be considered newly eligible for Medicaid. If these beneficiaries did not meet those requirements, a portion of the associated Federal reimbursement was also unallowable.

## **CONCLUSION**

The State agency did not always determine Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements. Ineligible and potentially ineligible beneficiaries were determined eligible for the new adult or other coverage groups because the State agency’s eligibility determination system lacked functionality, or because eligibility caseworkers made errors.

If the State agency does not determine Medicaid eligibility in accordance with Federal and State eligibility requirements, there is an increased risk that the State agency will make payments on behalf of ineligible beneficiaries and claim unallowable Federal reimbursement for those beneficiaries.

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<sup>45</sup> Of the 66 beneficiaries, 3 had payments associated with coverage groups for which they were ineligible and potentially ineligible. Therefore, we included these beneficiaries in both groups.

<sup>46</sup> MetroHealth determined initial Medicaid eligibility for 5 of the 66 beneficiaries. We requested supporting documentation from the State agency and did not separately contact MetroHealth.

On the basis of our sample results, we estimated that the State agency made Medicaid payments of \$77,455,592 (Federal share)<sup>47</sup> on behalf of 51,219 ineligible beneficiaries and \$746,424,941 (Federal share)<sup>48</sup> on behalf of 241,998 potentially ineligible beneficiaries during our audit period.

## RECOMMENDATIONS

We recommend that the Ohio Department of Medicaid:

- redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements;
- ensure that Ohio Benefits has the system functionality to:
  - properly categorize a beneficiary who was formerly in the foster care program,
  - retrieve and use information from SSA to determine whether a beneficiary is disabled,
  - disallow multiple cases for a beneficiary to be opened simultaneously,
  - alert eligibility caseworkers when a beneficiary dies and discontinue Medicaid coverage for the beneficiary, and
  - alert eligibility caseworkers when a beneficiary or beneficiary's child reaches the age affecting the beneficiary's coverage group;
- educate eligibility caseworkers on how to properly determine an applicant's or beneficiary's household income and household size;
- develop a process for: (1) monitoring data entered into Ohio Benefits by periodically testing a State agency-defined percentage of entries for accuracy and (2) implementing appropriate corrective actions, such as staff training, when data entry issues are discovered; and
- ensure that documentation supporting a beneficiary's initial and continuing eligibility determination is maintained in the beneficiary's record.

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<sup>47</sup> The 90-percent confidence interval for the amount paid on behalf of ineligible beneficiaries ranged from \$34,812,500 (lower limit) to \$152,374,685 (upper limit). (See Appendix D, Table 4.)

<sup>48</sup> The 90-percent confidence interval for the amount paid on behalf of potentially ineligible beneficiaries ranged from \$588,831,418 (lower limit) to \$957,174,491 (upper limit). (See Appendix D, Table 5.)

## STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. However, the State agency described the actions it has taken that address our recommendations.

Regarding our first recommendation, the State agency said that it redetermined eligibility for all the sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements. The State agency said that the applicable corrections will be made when the declared Covid-19 public health emergency ends.<sup>49</sup>

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

- The State agency is working to develop better reporting and communication among case managers to ensure that all former foster care youth are identified properly.
- Ohio Benefits has an interface with the SSA that alerts caseworkers when a beneficiary has been determined disabled.
- Ohio Benefits contains edits that prevent a beneficiary from being included in more than one Medicaid case.
- Ohio Benefits receives alerts from the Department of Commerce's National Technical Information Service when a beneficiary dies. Caseworkers must verify the date of death reported in the alert, update the case, and discontinue Medicaid coverage.
- The State agency corrected a defect in Ohio Benefits that adversely affected 19-year-old recipients.

Regarding our third recommendation, the State agency stated that it has provided multiple trainings related to household income and household size to caseworkers and is developing additional training.

Regarding our fourth and fifth recommendations, the State agency said that it plans to review randomly selected cases for eligibility and data entry errors as well as maintenance of appropriate documentation in beneficiaries' files and provide a monthly report to compliance staff. The State agency will analyze review results and determine whether targeted or statewide training is needed.

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

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<sup>49</sup> The State agency's September 2020 response noted that the Covid-19 public health emergency hold on redeterminations was scheduled to extend through October 22, 2020.

We recognize the corrective actions the State agency has implemented or plans to implement to address our recommendations. These corrective actions should ensure that the State agency determines Medicaid eligibility in accordance with Federal and State eligibility requirements.

### **OTHER MATTERS**

Federal financial participation is available for expenditures the State incurs for services provided to beneficiaries who are eligible for Medicaid in the month in which the medical care or services are provided (42 CFR § 435.1002(b)).

During our audit period, the State agency made unallowable Medicaid payments on behalf of eight of our sampled beneficiaries whose Medicaid coverage was discontinued in Ohio Benefits: five who requested that their coverage be discontinued, two who had incomes exceeding 138 percent of the FPL, and one who had not been in the United States for 5 years from the date of entry with qualified alien status.

Because Ohio Benefits did not transmit the coverage discontinuation information to the payment processing system, MITS, in a timely manner, the State agency made unallowable Medicaid payments after the coverage discontinuation.

On the basis of our sample results, we estimated that the State agency made unallowable Medicaid payments of \$4,384,160 (Federal share) on behalf of 2,148 beneficiaries whose coverage was discontinued.<sup>50</sup> We plan to review unallowable Medicaid payments made after the beneficiaries' Medicaid coverage discontinuation in a separate audit.

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<sup>50</sup> The 90-percent confidence interval for the amount paid on behalf of beneficiaries whose Medicaid coverage was discontinued ranged from \$2,235,069 (lower limit) to \$7,643,051 (upper limit). (See Appendix D, Table 6.)



## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered 481,353 newly eligible beneficiaries in Ohio for whom the State agency made Medicaid payments totaling \$1,584,138,982 (\$1,557,183,825 Federal share) from October 1, 2014, through March 31, 2015 (audit period), for services provided during this period. These beneficiaries may have been determined newly eligible for only part of the audit period.

In developing our sampling frame, we excluded the beneficiaries: (1) who were part of ongoing OIG audits of the Medicaid program in Ohio (listed in footnote 22) or (2) whose coverage group was adjusted by the State agency from the new adult group to another group after the audit period.

We reviewed the Medicaid eligibility determinations made by the State agency for a stratified random sample of 150 newly eligible beneficiaries as described in Appendix C.

Our fieldwork was delayed due to the following circumstances:

- We spent a considerable amount of time and effort to verify the validity, accuracy, completeness, consistency, and uniformity of the data received.
- During the audit, the State agency changed its audit liaison several times. Each change in liaison required time for the individual to become knowledgeable of all the issues affecting the performance of the audit.

We limited our review of internal controls to those applicable to our objective. Specifically, we gained an understanding of the State agency's policies and procedures for determining and redetermining Medicaid eligibility of individuals using Ohio Benefits and reviewed the internal controls for eligibility determinations and verifications that the State agency had in place during the audit period.

We performed fieldwork from March 2018 through July 2020 at the State agency office in Columbus, Ohio.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility;
- reviewed the Ohio State plan, State plan amendments, and Verification Plan;

- obtained an understanding of internal controls by:
  - interviewing State agency officials to obtain an understanding of how Ohio Benefits: (1) processes an applicant's information, (2) verifies an applicant's eligibility for enrollment in Medicaid, and (3) transmits enrollment data to MITS;
  - holding discussions with State agency and county officials to obtain an understanding of policies, procedures, and guidance for determining and redetermining Medicaid eligibility; and
  - reviewing documentation supporting the State agency's eligibility determinations;
- obtained an understanding of how eligibility determinations affect Federal reimbursement;
- obtained from the State agency Medicaid payments with the service and payment dates during the audit period;
- created a sampling frame of 481,353 Medicaid beneficiaries for whom the State agency made Medicaid payments totaling \$1,584,138,982 (\$1,557,183,825 Federal share);
- selected a stratified random sample of 150 Medicaid beneficiaries;
- obtained for each sampled beneficiary, when possible, application data and documentation supporting eligibility verification and determination and determined whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the new adult or other coverage groups;
- used CMS's Medicare Enrollment Database to determine whether each sampled beneficiary was eligible for or enrolled in Medicare during the audit period;
- obtained from the State agency Medicaid payment adjustments that were made on behalf of each sampled beneficiary and finalized after the audit period;
- used our sample results to calculate the statistical estimates listed in Appendix D; and
- discussed the results of our audit with State agency officials.

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

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place</i>	<a href="#"><u>A-07-18-02812</u></a>	3/24/2020
<i>Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<a href="#"><u>A-07-16-04228</u></a>	8/30/2019
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries</i>	<a href="#"><u>A-02-16-01005</u></a>	7/17/2019
<i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<a href="#"><u>A-09-17-02002</u></a>	12/11/2018
<i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<a href="#"><u>A-09-16-02023</u></a>	2/20/2018
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<a href="#"><u>A-02-15-01015</u></a>	1/5/2018
<i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements</i>	<a href="#"><u>A-04-16-08047</u></a>	8/17/2017
<i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<a href="#"><u>A-04-15-08044</u></a>	5/10/2017

## **APPENDIX C: STATISTICAL SAMPLING METHODOLOGY**

### **TARGET POPULATION**

The target population consisted of Ohio beneficiaries determined to be newly eligible for Medicaid under the ACA and for whom the State agency made Medicaid payments for services provided during the audit period (October 1, 2014, through March 31, 2015).

### **SAMPLING FRAME**

The sampling frame consisted of a Microsoft Access database containing 481,353 newly eligible Medicaid beneficiaries who received services and for whom the State agency made Medicaid payments totaling \$1,584,138,982 (\$1,557,183,825 Federal share) during the audit period.

In developing our sampling frame, we excluded beneficiaries: (1) who were part of ongoing OIG audits of the Medicaid program in Ohio (listed in footnote 22) or (2) whose coverage group was adjusted by the State agency from the new adult group to another group after the audit period.

### **SAMPLE UNIT**

The sample unit was a newly eligible Medicaid beneficiary.

### **SAMPLE DESIGN**

We used a stratified random sample, consisting of five strata:

- Stratum 1 consisted of beneficiaries who were categorized as being eligible for Medicaid solely under the new adult group with total payments of less than \$4,000: 286,893 beneficiaries with payments totaling \$561,577,510 (\$553,329,082 Federal share).
- Stratum 2 consisted of beneficiaries who were categorized as being eligible for Medicaid solely under the new adult group with total payments equal to or greater than \$4,000: 171,069 beneficiaries with payments totaling \$949,320,767 (\$938,950,713 Federal share).
- Stratum 3 consisted of beneficiaries whose Medicaid coverage group changed from the new adult group to another coverage group during the audit period with total payments of less than \$2,220: 9,348 beneficiaries with payments totaling \$10,670,867 (\$9,290,615 Federal share).
- Stratum 4 consisted of beneficiaries whose Medicaid coverage group changed from the new adult group to another coverage group during the audit period with total payments equal to or greater than \$2,220: 9,222 beneficiaries with payments totaling \$46,852,046 (\$40,703,605 Federal share).

- Stratum 5 consisted of beneficiaries who were categorized as being eligible for Medicaid under a coverage group other than the new adult group and for whom the State agency made one or more payments under the new adult group: 4,821 beneficiaries with payments totaling \$15,717,792 (\$14,909,810 Federal share).

## **SAMPLE SIZE**

We selected a sample of 150 beneficiaries, which consisted of:

- 50 beneficiaries from stratum 1,
- 40 beneficiaries from stratum 2,
- 20 beneficiaries from stratum 3,
- 20 beneficiaries from stratum 4, and
- 20 beneficiaries from stratum 5.

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the Medicaid beneficiaries within strata 1 through 5. After generating the random numbers for each stratum, we selected the corresponding Medicaid beneficiaries in the sampling frame.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to calculate the point estimates and the 90-percent confidence intervals for the total number of ineligible and potentially ineligible Medicaid beneficiaries in the sampling frame. We also used this software to calculate the point estimates for the total dollar value of the payments for ineligible and potentially ineligible Medicaid beneficiaries. We calculated the 90-percent confidence intervals for the dollar estimates using the empirical likelihood approach.

## APPENDIX D: SAMPLE RESULTS AND ESTIMATES

### SAMPLE RESULTS<sup>51</sup>

**Table 1: Sample Detail and Results for Ineligible Beneficiaries**

<b>Stratum</b>	<b>Number of Beneficiaries in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Ineligible Beneficiaries</b>	<b>Value of Payments for Ineligible Beneficiaries</b>
1	286,893	\$553,329,082	50	\$89,163	6	\$5,374
2	171,069	938,950,713	40	229,927	3	10,716
3	9,348	9,290,615	20	21,830	5 <sup>52</sup>	1,847
4	9,222	40,703,605	20	65,130	3	(355)
5	4,821	14,909,810	20	57,303	1	384
<b>Total</b>	<b>481,353</b>	<b>\$1,557,183,825</b>	<b>150</b>	<b>\$463,353</b>	<b>18</b>	<b>\$17,966</b>

**Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries**

<b>Stratum</b>	<b>Number of Beneficiaries in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Potentially Ineligible Beneficiaries</b>	<b>Value of Payments for Potentially Ineligible Beneficiaries</b>
1	286,893	\$553,329,082	50	\$89,163	28	\$53,785
2	171,069	938,950,713	40	229,927	17	98,738
3	9,348	9,290,615	20	21,830	8 <sup>53</sup>	8,907
4	9,222	40,703,605	20	65,130	8	17,221
5	4,821	14,909,810	20	57,303	5	14,256
<b>Total</b>	<b>481,353</b>	<b>\$1,557,183,825</b>	<b>150</b>	<b>\$463,353</b>	<b>66</b>	<b>\$192,907</b>

<sup>51</sup> The dollar values included in this appendix are Federal share amounts of the payments associated with the beneficiaries.

<sup>52</sup> Although we determined that two of the beneficiaries were ineligible, the State agency did not make any improper Medicaid payments on behalf of these beneficiaries.

<sup>53</sup> Although we determined that one of the beneficiaries was potentially ineligible, the State agency did not make any unallowable Medicaid payments on behalf of this beneficiary.

**Table 3: Sample Detail and Results for Beneficiaries Whose Medicaid Coverage Was Discontinued**

<b>Stratum</b>	<b>Number of Beneficiaries in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Beneficiaries Whose Medicaid Coverage Was Discontinued</b>	<b>Value of Unallowable Payments After the Coverage Discontinuation</b>
1	286,893	\$553,329,082	50	\$89,163	0	\$0
2	171,069	938,950,713	40	229,927	0	0
3	9,348	9,290,615	20	21,830	0	0
4	9,222	40,703,605	20	65,130	1	384
5	4,821	14,909,810	20	57,303	7	17,454
<b>Total</b>	<b>481,353</b>	<b>\$1,557,183,825</b>	<b>150</b>	<b>\$463,353</b>	<b>8</b>	<b>\$17,838</b>

**ESTIMATES**

**Table 4: Estimated Number of Ineligible Beneficiaries and Value of Improper Payments  
(Limits Calculated at the 90-Percent Confidence Level)**

	<b>Total Number of Ineligible Beneficiaries</b>	<b>Total Value of Payments for Ineligible Beneficiaries</b>
Point estimate	51,219	\$77,455,592
Lower limit	26,225	34,812,500
Upper limit	76,212	152,374,685

**Table 5: Estimated Number of Potentially Ineligible Beneficiaries and Value of Potentially Improper Payments  
(Limits Calculated at the 90-Percent Confidence Level)**

	<b>Total Number of Potentially Ineligible Beneficiaries</b>	<b>Total Value of Payments for Potentially Ineligible Beneficiaries</b>
Point estimate	241,998	\$746,424,941
Lower limit	201,722	588,831,418
Upper limit	282,273	957,174,491



**Table 6: Estimated Number of Beneficiaries Whose Medicaid Coverage Was Discontinued and Value of Unallowable Payments After the Coverage Discontinuation**  
*(Limits Calculated at the 90-Percent Confidence Level)*

	<b>Total Number of Beneficiaries Whose Medicaid Coverage Was Discontinued</b>	<b>Total Value of Unallowable Payments After the Coverage Discontinuation</b>
Point estimate	2,148	\$4,384,160
Lower limit	998	2,235,069
Upper limit	3,299	7,643,051

## APPENDIX E: STATE AGENCY COMMENTS



Department of  
Medicaid

Mike DeWine, Governor  
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

September 4, 2020

Ms. Sheri Fulcher  
Office of Inspector General  
Office of Audit Services, Region V  
233 North Michigan, Suite 1360  
Chicago, IL 60601

**Report Number: A-05-18-00027**

Dear Ms. Fulcher:

Thank you for the opportunity to respond to the draft report issued by the OIG entitled *Ohio Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries*.

The Ohio Department of Medicaid's (ODM) response to each OIG recommendation follows:

### **Recommendation 1**

Redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements.

### **Management Response**

Ohio redetermined eligibility for all beneficiaries sampled who did not meet or may not have met Federal and State eligibility requirements. However, states are prohibited from taking negative action during the COVID-19 public health emergency which currently extends through October 22, 2020. Negative action includes any loss of coverage or decrease in coverage based on what the beneficiary was receiving as of March 18, 2020. Applicable corrections will be made once the declared public health emergency ends.

### **Recommendation 2**

Ensure that Ohio Benefits has the system functionality to:

- properly categorize a beneficiary who was formerly in the foster care program;
- retrieve and use information from SSA to determine whether a beneficiary is disabled;
- disallow multiple cases for a beneficiary to be opened simultaneously;
- alert eligibility caseworkers when a beneficiary dies and discontinue Medicaid coverage for the beneficiary; and
- alert eligibility caseworkers when a beneficiary or beneficiary's child reaches the age affecting the beneficiary's coverage group;

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#### **Management Response**

Ohio requires that the PCSA worker submit a completed Medicaid application and ODM form 01958, Referral for Medicaid Continuing Eligibility Review, for an individual who has aged out of Foster Care so she may be properly identified and categorized. ODM is also working to develop better reporting for and communication between PCSA and JFS case managers to ensure all former foster care youth are identified properly.

Ohio has an interface with SSA which notifies case managers that a beneficiary has been determined disabled via an alert. Disability and income are reported through BENDEX and SDX matches and case workers can also request SSA payment information manually by completing a request through e-verify using SOLQ.

As referenced in the report, during the audit review period from October 1, 2014 through March 31, 2015, Ohio was in the process of converting our primary eligibility determination system from the Client Registry Information System–Enhanced (CRISE) to the Ohio Benefits System (Ohio Benefits), but we were still using both systems. This contributed to the issue of multiple cases being opened for a beneficiary simultaneously. Ohio successfully completed the conversion process to Ohio Benefits in August of 2016, and it remains our eligibility determination system.

Ohio Benefits does have measures in place to prevent a beneficiary from being open in more than one case. Currently, the rules engine looks for open Medicaid spans and will deny eligibility if an open span is found on another case. Analysis of the issue concluded that Ohio's Presumptive Eligibility (PE) Portal was a main source of duplicate individuals being created. Enhancements have been made to the clearance process in the PE Portal to adjust the matching criteria to ensure the individual is not known to Ohio Benefits before a 'new person' is created. In the event a potential duplicate is identified, the recipient is given a temporary billing number which allows them to access needed services. The case then falls out to a county caseworker to determine if the individual is truly a 'new' person, or if he/she is already 'known' to Ohio Benefits. If the person is 'new', the county will add the individual to Ohio Benefits as a new individual and create a new case. The individual will then receive a permanent billing number which is linked with their temporary billing number. If the individual is 'known', the county will select the existing individual known in Ohio Benefits and the existing individual's permanent billing number will be linked to their temporary billing number.

Ohio does receive alerts from the Department of Commerce's National Technical Information Service (NTIS), which is a clearinghouse that provides access to the SSA Death Master File (DMF). Because the DMF contains both first-party and third-party reports of death, states are not permitted to consider the information verified upon receipt. Caseworkers must verify the date of death reported in the alert, update the case and discontinue. We do use this information in our claims processing system, MITS, in order to discontinue the beneficiary's managed care plan assignment so that the state no longer pays capitation rates for someone who is deceased. In addition, when a case goes through the passive renewal process and an SSA death indicator is found, the case will fall out of the passive renewal process triggering an alert to the caseworker who must verify the information like they do the NTIS alert.

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Ohio has age batch sweeps which run monthly in Ohio Benefits. Any cases where EDBC cannot be completed will fall out of the process and generate an alert to the case worker to complete. At the time of this audit review period, there was a defect which impacted 19-year old recipients adversely, therefore the batch was suspended. This defect was corrected with the R2.2 release in March 2017.

#### **Recommendation 3**

Educate eligibility caseworkers on how to properly determine an applicant's or beneficiary's household income and household size.

#### **Management Response**

ODM's Technical Assistance Unit has provided a variety of trainings in 2019 and 2020 related to household income and household size.

- April 2019, revised and repeated February 2020 - Zero Income and Verification;
- September 2019 - Allowable 1040 Expenses, Correcting Aid Codes for Dual Eligibles (includes switching MAGI Adult to dual);
- October 2019 - SSN Statute and HUB Pings (training on properly verifying SSN via the HUB in order to get better matches with the IRS when verifying income through the HUB);
- December 2019 - MAGI Adult to MPAP and Buy-in;
- March 2020 and June 2020 - MAGI Basics (includes household formation and income processing). This is for new workers and has been provided quarterly for prior two years and continues quarterly;
- February 2019 - MAGI Households Small Bites – this is a training that remains available for viewing on the innerweb on demand;
- July 2020 - ODM and JFS jointly developed a new worker training for TANF, SNAP and Medicaid programs. This includes a MAGI pillar and includes household formation and household income training. Participants must complete online policy prerequisite sessions and then attend a virtual instructor led course. The first offering was 7/2020 and will continue quarterly; and
- August 2020 - MAGI Case Processing (includes a case processing guide).

In development: Income Processing Guide, PARIS alerts training, and alerts training (joint with ODJFS).

#### **Recommendation 4**

Develop a process for: (1) monitoring data entered into Ohio Benefits by periodically testing a State agency-defined percentage of entries for accuracy and (2) implementing appropriate corrective actions, such as staff training, when data entry issues are discovered.

#### **Management Response**

ODM's Medicaid Eligibility Quality Control staff will pull a random sample monthly to review; with 50 percent of cases in that sample coming from metropolitan counties and 50 percent of the cases coming from non-metropolitan counties. They will review cases for eligibility and data entry errors and provide a monthly report to ODM Compliance. Review results will be analyzed by ODM Compliance to

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determine if targeted or state-wide training needs exist. Technical Assistance will develop and deliver any identified training needs.

**Recommendation 5**

Ensure that documentation supporting a beneficiary's initial and continuing eligibility determination is maintained in the beneficiary's record.

**Management Response**

As part of the review described in Recommendation 4, ODM's Medicaid Eligibility Quality Control staff will review the sample of cases to determine if appropriate documentation is present in the beneficiary's record (applications, renewals, proof of income, etc.). ODM Technical Assistance will provide necessary training if appropriate documentation is not maintained.

ODM appreciates the OIG's review and recommendations. Thank you for the opportunity to provide informal comments on the draft report. Please let me know if you have questions or need additional information.

Sincerely,

/Maureen M. Corcoran/

Maureen M. Corcoran, Director