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

Why OIG Did This Review

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid (traditional coverage groups). After the passage of the Patient Protection and Affordable Care Act (ACA), many beneficiaries remained eligible under these traditional coverage groups. We refer to these beneficiaries as "non-newly eligible beneficiaries." This review is part of an ongoing series of OIG reviews of States' Medicaid eligibility determinations. We conducted these reviews to address the concern that States might have difficulty accurately determining eligibility for Medicaid beneficiaries.

Our objective was to determine whether California made Medicaid payments on behalf of non-newly eligible beneficiaries who did not meet Federal and State eligibility requirements.

How OIG Did This Review

We reviewed a stratified random sample of 125 non-newly eligible beneficiaries for whom Medicaid payments were made for services provided from October 2014 through March 2015. We reviewed supporting documentation to determine whether California made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the non-newly eligible group (e.g., income, citizenship, and pregnancy requirements).

California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements

What OIG Found

For our sample of 125 beneficiaries, California made payments on behalf of 60 eligible beneficiaries. However, for the remaining 65 beneficiaries, California made payments on behalf of ineligible beneficiaries (e.g., a beneficiary who did not meet the income requirement for the medically needy coverage group) and potentially ineligible beneficiaries (e.g., beneficiaries for whom there was no documentation to support that California redetermined eligibility as required). On the basis of our sample results, we estimated that California made Medicaid payments of $959.3 million ($536 million Federal share) on behalf of 802,742 ineligible beneficiaries and $4.5 billion ($2.6 billion Federal share) on behalf of 3.1 million potentially ineligible beneficiaries. (These estimates represent Medicaid payments for fee-for-service, managed-care, drug treatment program, and mental health services.) According to California, these deficiencies occurred because (1) the counties experienced "a massive influx of applications for Medicaid and vast changes in policy brought forth by the ACA," (2) eligibility caseworkers made errors, and (3) system delays occurred during a system conversion.

We also identified a weakness in California's procedures related to determining eligibility of individuals who may not have intended to apply for Medicaid.

What OIG Recommends and California Comments

We recommend that California redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries and ensure that (1) all eligibility requirements are verified properly and annual redeterminations are performed as required, (2) information is maintained in case files to support eligibility determinations, and (3) eligibility determinations are performed only for individuals who apply for Medicaid. The "Recommendations" section in the body of the report lists in detail our recommendations.

California agreed with our findings. California partly agreed with our recommendation regarding beneficiaries determined eligible for Medicaid based on eligibility for another assistance program, but it provided information on actions being taken to address this recommendation. Although California did not explicitly agree or disagree with our other recommendations, it provided information on actions that it had taken or planned to take to address those recommendations.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91702022.asp.