



Department of Health and Human Services

Centers for Medicare & Medicaid Services

**Center for Program Integrity
Kentucky Medicaid Eligibility Determinations for the Adult
Expansion Population**

Review Period: October 2017 through March 2018

Eligibility Review

Final Report

September 2020

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Executive Summary

In June 2018, the Centers for Medicare & Medicaid Services (CMS) announced a Medicaid Program Integrity Strategy that includes initiatives designed to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. A key component of the strategy is performing reviews of Medicaid beneficiary eligibility determinations in states identified as high-risk by previous U.S. Department of Health and Human Services Office of Inspector General (OIG) and state audit findings to hold states accountable for accurate beneficiary eligibility determinations.

CMS conducted a review of the Kentucky Department for Medicaid Service's (herein, referred to as Kentucky) eligibility determination process. CMS' primary review objective in the performance of this review was to identify whether the state determined Medicaid eligibility at the point of application or re-determination for beneficiaries in the adult expansion population using financial methodologies based on modified adjusted gross income (MAGI) in accordance with Federal and state eligibility requirements, and claimed the appropriate Federal Medical Assistance Percentage (FMAP) on behalf of these beneficiaries. Other objectives included comparing current review findings to similar findings of the OIG and to ensure those findings had been appropriately addressed, identifying and assessing the impact of any changes to Medicaid eligibility policy due to the Affordable Care Act (ACA), and determining whether non-expansion enrollment categories were impacted by the expansion enrollment process.

Kentucky provided technical comments in response to the draft report, which can be found in Appendix D. Several technical corrections were made to the final report as a result of these comments.

Kentucky Correctly Determined Medicaid Eligibility for 95 Percent of the Adult Expansion Population

Based on the extrapolated results of this review (review period: October 2017 - March 2018), Kentucky correctly determined Medicaid eligibility in accordance with Federal and state requirements for 95 percent of the adult expansion population beneficiaries. This review also determined that during the review period, Kentucky's improper eligibility determinations for the adult expansion population resulted in \$24,690,763.78 (Federal share) in improper payments.¹

For most eligibility determinations in the sample, Kentucky verified financial information related to wages, net earnings from self-employment and unearned income from a combination of the following data sources: the State Wage Information Collection Agency (SWICA), Internal Revenue Service (IRS), Social Security Administration (SSA), and state unemployment insurance. (42 CFR § 435.948(a)(1)) Kentucky requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible with electronic sources in accordance with the state's verification plan. (42 CFR §

¹ See Appendix C for extrapolation methodology and calculation.

435.952(c)(2)) Additionally, this review found that Kentucky verified citizenship or immigration status by electronically verifying citizenship status with the SSA and immigration status with the Department of Homeland Security (DHS).² Kentucky also correctly determined beneficiaries' Medicaid eligibility for the correct aid category.

In the sample of 90 adult expansion population beneficiaries, Kentucky correctly determined eligibility for 87 beneficiaries. For the three improper eligibility determinations, Kentucky did not always include, or calculate correctly, all applicable income for the newly enrolled adult group due primarily to system errors. As a result, out of the \$311,295.31 (Federal share) sampled, \$2,640.59 (Federal share) was identified as being paid in error. Based on the sampled errors, CMS estimates that during the review period, Kentucky made Federal Medicaid payments on behalf of an estimated 26,388 ineligible adult group beneficiaries, totaling an estimated \$24,690,764 (Federal share) in improper payments, out of 534,626 total adult group beneficiaries with Federal Medicaid payments of \$1,581,124,889.

Results of the Review

CMS identified three eligibility determination errors as a result of this review. CMS recommends that Kentucky ensure the enrollment system appropriately collects and calculates all income of the household reported by electronic data sources and also includes all other types of applicable income, including self-employment income and Retirement Survivors Disability Income (RSDI). CMS also recommends Kentucky consider implementing controls to substantiate financial offsets to MAGI, such as tuition expenses, when they cannot be electronically verified.

² 42 CFR §§ 435.406 and 435.949. Citizenship and non-citizen eligibility, Verification of information through an electronic service. Retrieved December 3, 2018 from https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1406&rgn=div8 and https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1949&rgn=div8.

Eligibility Review: Kentucky Medicaid Eligibility Determinations for the Adult Expansion Population

Background

Medicaid is a joint Federal and state program that, together with the Children’s Health Insurance Program (CHIP), provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.³

Federal law requires states to cover certain groups of individuals under the state’s Medicaid program. Low income families, qualified pregnant women and children and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.⁴

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, called the Federal Medical Assistance Percentage (FMAP), which is developed from criteria such as the state’s per capita income. The regular program FMAP varies by state and ranges from 50 to 75 percent. Kentucky’s regular FMAP for the review period (October 2017 through March 2018) was 71.17 percent.⁵

Medicaid Coverage for the Adult Expansion Population under the Affordable Care Act (ACA)

As of August 2019, 36 states, including the District of Columbia, elected to expand Medicaid coverage under the ACA.⁶ Prior to the ACA, low-income, non-disabled adults without dependent children generally were not eligible for Medicaid, regardless of income. Section 2001 of the ACA established a new eligibility group providing health care coverage to previously ineligible adults under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (subsequently codified in

³ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

⁴ Ibid.

⁵ Kaiser Family Foundation (2018). Federal Medical Assistance Percentage (FMAP) and Multiplier for States. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/State-indicator/Federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁶ Medicaid.gov. Adult Coverage Expansion Map as of July 2020. Retrieved August 3, 2020 from <https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf>.

regulations at 42 CFR § 435.119). These changes were significant in that, for the first time since the establishment of the Medicaid program in 1965, states could receive Federal Medicaid funds, without a waiver, to provide coverage to low-income individuals without regard to disability, parental status, or most other categorical limitations. The ACA's changes to Medicaid eligibility criteria expanded coverage to nearly all non-elderly adults with incomes at or below 138 percent⁷ of the Federal Poverty Level (FPL).

The ACA also established a new methodology for determining income eligibility for Medicaid and CHIP based on the applicant's modified adjusted gross income (MAGI). MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents, and adults. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. The MAGI-based methodology does not allow for income disregards that vary by state or by eligibility group, and does not allow for an asset or resource test.⁸

The ACA also provided enhanced FMAP for the adult expansion population. From 2014 to 2016, the Federal Government funded 100 percent of allowable health care costs for the newly eligible adult population. The FMAP dropped to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent for 2020 and beyond. States were eligible to receive the enhanced FMAP for those beneficiaries who would not have been eligible for benefits as of December 1, 2009, or who were eligible under a waiver but not enrolled in the program because of limits or caps on waiver enrollment.⁹ The ACA also provided enhanced FMAP (75 to 90 percent) to support states in the replacement or upgrade of outdated eligibility systems and to establish links to other data sources to implement new streamlined processes.

Beginning in January 2014, to promote program integrity when verifying eligibility while also minimizing the amount of paper documentation that applicants and beneficiaries needed to provide, states were required to primarily rely on available electronic data sources to verify information included on the application (or conduct the renewal process). Medicaid and CHIP agencies now rely primarily on information available through electronic data sources (e.g., the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the state Department of Labor) rather than paper documentation from applicants and beneficiaries for purposes of verifying eligibility for Medicaid and CHIP.¹⁰ Documentation or other information is requested when electronic data is unavailable or not reasonably compatible (i.e.,

⁷ Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR § 435.119 define the income standard for the group at 133 percent of the FPL; however, the income counting methodology allows for an income disregard equivalent to five percentage points of the FPL when a household is on the edge of eligibility for Medicaid or CHIP. As a result, the effective income standard for the adult group is 138 percent of the FPL.

⁸ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

⁹ Kaiser Family Foundation. (2014, September 29). Understanding How States Access the ACA Enhanced Medicaid Match Rates. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

¹⁰ Regulations at 42 CFR 435.945, 435.948 and 457.956 describe income and eligibility verification requirements.

consistent with electronic data) in accordance with a state's verification plan.¹¹ States are also able to accept self-attestation of some elements of eligibility when making determinations.

Regulations at 42 CFR 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state. States must submit their verification plans to CMS upon request. CMS issued a MAGI-based Eligibility Verification Plan template that all states submitted to CMS in preparation for 2014. CMS reviewed each plan and provided technical assistance as needed to ensure the plans were in compliance with Federal regulations. States must provide updated versions of the plans to CMS if the state subsequently changes verification policies and procedures captured in the template.

The implementation of the ACA established new policies that simplified enrollment of MAGI eligible individuals into Medicaid and CHIP. Required elements of the streamlined eligibility and enrollment process include:

- Provide a single, streamlined application for Medicaid, CHIP, and Marketplace coverage that individuals can submit online, by phone, in-person, or mail
- Eliminate use of asset tests for groups eligible based on MAGI
- Eliminate in-person interview requirement for individuals who apply or whose eligibility is being renewed on the basis of MAGI
- Utilize electronic data matches to verify eligibility criteria to the greatest extent possible and only request paper documentation when unable to obtain information electronically
- Complete renewals once every *12 months* and no more frequently than once every 12 months for groups eligible based on MAGI
- Seek to renew coverage based on information from the beneficiary's account and available data sources before requesting information from the individual (these renewals are addressed as ex parte¹²)

Medicaid Adult Expansion Population in Kentucky¹³

As of May 2019, Kentucky had 1,210,340 individuals enrolled in Medicaid and CHIP — a net increase of 603,535 since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.¹⁴ CMS reported that Kentucky's Medicaid and CHIP enrollment increased by 99.46 percent from 2013 to May 2019, by far the largest percentage increase of any state, and almost four times as much as the national average increase of 25.90 percent.¹⁵ From October 1, 2017 through March 31, 2018 (the review period), the state made

¹¹ Medicaid.gov. Keeping America Healthy. Medicaid/CHIP Eligibility Verification Plans. Retrieved December 9, 2018 from <https://www.medicaid.gov/medicaid/eligibility/verification-plans/index.html>

¹² An ex parte renewal is a redetermination of eligibility that can be made based on reliable information available to the agency, including information accessed through electronic data sources, without requiring information from the individual. This is also referred to as a passive renewal.

¹³ Health Insurance.org. (2018, November 25). Kentucky and the ACA's Medicaid Expansion. Retrieved March 14, 2019 from <https://www.healthinsurance.org/kentucky-medicaid/>.

¹⁴ Medicaid.gov. Medicaid and CHIP in Kentucky. Retrieved August 14, 2019 from <https://www.medicaid.gov/state-overviews/stateprofile.html?state=Kentucky>.

¹⁵ Medicaid.gov. Keeping America Healthy. Medicaid and CHIP in Kentucky. Retrieved August 14, 2019 from <https://www.medicaid.gov/state-overviews/stateprofile.html?state=Kentucky>.

Medicaid payments totaling approximately \$1.73 billion, on behalf of 534,626 beneficiaries, for all beneficiaries enrolled in the adult group.

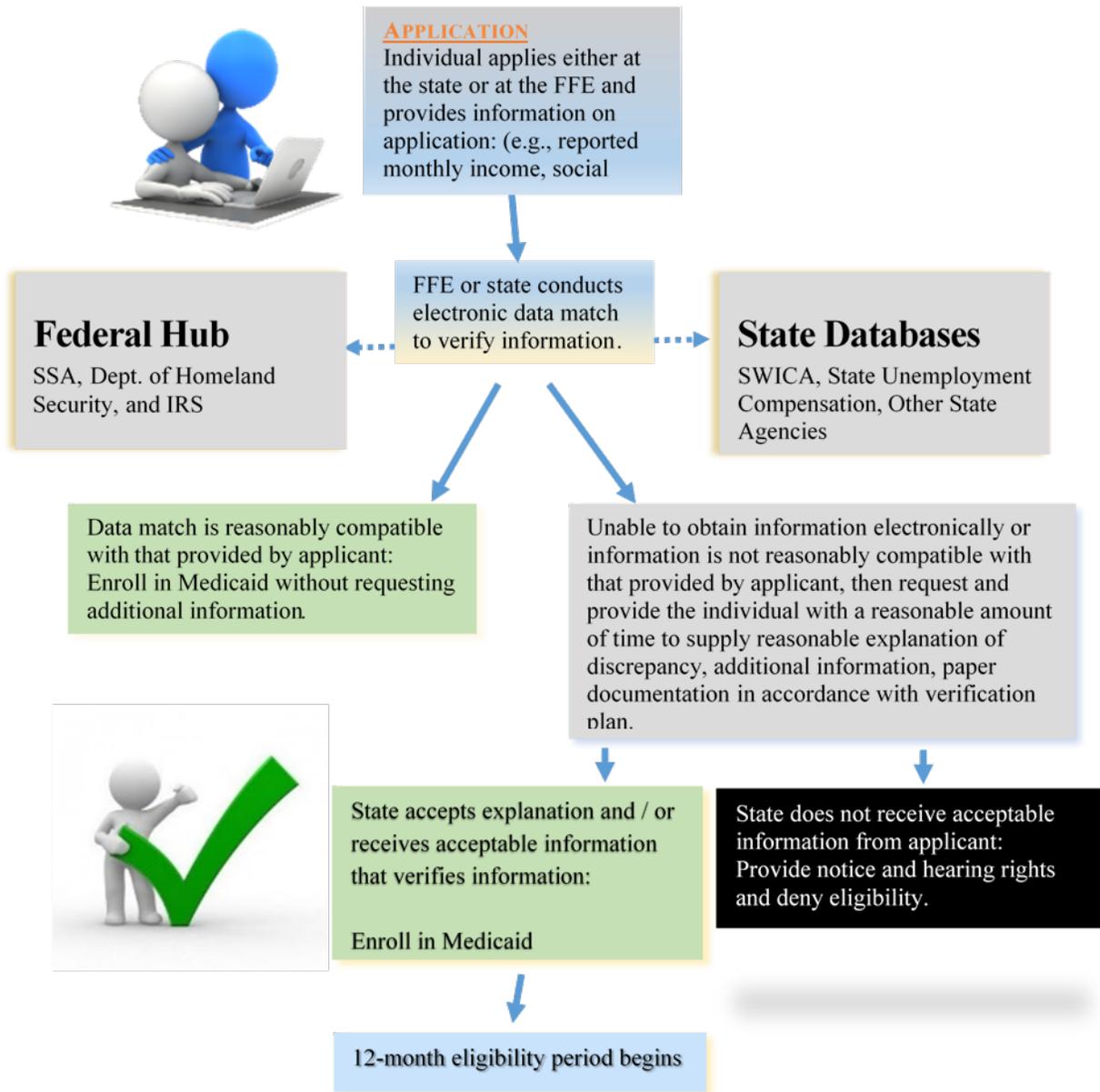
Kentucky's Medicaid Eligibility Process

Kentucky has expanded Medicaid to the adult group and initially adopted a state-based marketplace. The state subsequently, in 2017, began operating a state-based marketplace on the Federal platform, HealthCare.gov, in 2017. Individuals seeking coverage may submit an application to the federally-facilitated exchange (FFE) or to the state Medicaid agency. To verify eligibility for individuals who apply for coverage in the state, the Medicaid agency uses multiple electronic data sources¹⁶ available through the Federal Data Services Hub (Data Hub). The data sources used by Kentucky through the Data Hub are provided by HHS, the SSA, the DHS, and the Internal Revenue Service (IRS), among others. Kentucky is considered an assessment state and will use the information provided by the FFE, in addition, to state data sources, to determine eligibility for Medicaid.¹⁷ Kentucky also uses data sources maintained by the state, such as the State Wage Information Collection Agency (SWICA). See Figure 1 for the Kentucky Medicaid Eligibility Process for individuals who apply for coverage through the state agency.

¹⁶ Kentucky MAGI-Based Eligibility Verification Plan. Retrieved on September 16, 2019 from <https://www.medicaid.gov/medicaid/program-information/eligibility-verification-policies/downloads/kentucky-verification-plan-template-final.pdf>.

¹⁷ 42 CFR §§ 435.1200(c). Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs. Retrieved February 11, 2020 from <https://www.law.cornell.edu/cfr/text/42/435.1200>.

Figure 1: Kentucky’s Medicaid MAGI Eligibility Determination Process



Scope and Methodology of the Review

This review included individuals covered by Kentucky’s Medicaid adult expansion population. CMS chose Medicaid beneficiaries who received services during the review period of October 1, 2017 through March 31, 2018. A stratified random sample of 90 beneficiaries was selected for review.

Appendix A contains the details of the review scope and methodology, Appendix B contains the statistical sampling methodology, and Appendix C provides the sample results and estimates of ineligible beneficiaries and associated payments made for those beneficiaries.

Results of the Review

CMS conducted a review of the Kentucky eligibility determination process. CMS' primary review objective in the performance of this review was to identify whether the state determined Medicaid eligibility at the point of application and redetermination for individuals in the adult group using financial methodologies based on MAGI in accordance with Federal and state eligibility requirements and claimed the appropriate FMAP on behalf of these beneficiaries. Other objectives included: (1) comparing current review findings to similar findings of the OIG and to ensure those identified findings had been appropriately addressed, (2) identifying and assessing the impact of any changes to Medicaid eligibility policy due to the ACA, and (3) determining whether non-expansion enrollment categories were impacted by the expansion enrollment process.

In the sample of 90 beneficiaries, Kentucky correctly determined eligibility for 87 beneficiaries. For the three improper eligibility determinations, Kentucky did not always include, or calculate correctly, all applicable income for the newly eligible adult group. All three errors appear to be system errors, rather than human errors, related to eligibility determination processes implemented in response to the ACA.

Based on the extrapolated results of this review (review period: October 2017 - March 2018), Kentucky correctly determined Medicaid eligibility in accordance with Federal and state requirements for 95 percent of the adult expansion population beneficiaries. CMS estimates that during the review period, Kentucky made Federal Medicaid payments on behalf of an estimated 26,388 ineligible adult group beneficiaries, totaling an estimated \$24,690,764 (Federal share) in improper payments, out of 534,626 total adult group beneficiaries with Federal Medicaid payments of \$1,581,124,889.

Details regarding the findings of this review are below, including the three income eligibility errors that resulted in findings for this report, as well as report outcomes of the other review objectives and additional observations.

1. Eligibility Determinations

Based on the extrapolated results of this review, Kentucky correctly determined Medicaid eligibility in accordance with Federal and state requirements for 95 percent of the adult expansion population beneficiaries.

Specifically, in accordance with its MAGI verification plan, for 95 percent of the adult group beneficiaries, CMS found that Kentucky accurately:

- Used the Data Hub to verify financial information related to wages, net earnings from self-employment and unearned income from the IRS, and SSA. The state used state databases related to wages and unemployment compensation from SWICA and state unemployment insurance (42 CFR § 435.948(a)(1)).
- Requested additional information or documentation from beneficiaries if attested income was not reasonably compatible with electronic sources in accordance with the state's verification plan (42 CFR § 435.952(c)(2)).

- Verified citizenship or immigration status by electronically verifying citizenship status with the SSA and the DHS.¹⁸ Discrepancies were resolved timely during the 90-day reasonable opportunity period for individuals to resolve inconsistencies in immigration status.¹⁹
- Obtained information and maintained supporting documentation (e.g., paystubs, letters from employers, additional citizenship information) when such information was required to verify eligibility.

The three eligibility errors identified by CMS are described below. These errors show that Kentucky did not always include, or calculate correctly, all applicable income for the newly eligible adult group. All three errors appear to be system errors, rather than human errors, related to eligibility determination processes implemented in response to the ACA.

1.1) The individual was ineligible for Medicaid for the entire six months of the sample due to household income exceeding the income standard.

At the time of renewal, the case at issue included six individuals. The state attempted an ex parte renewal in November 2016 for the eligibility period of January through December 2017. Upon checking data sources, the state identified SWICA data for two household members that resulted in a household income above the applicable income standard. Kentucky requested clarifying information from the applicant, who failed to respond, and in error, the system approved the renewal without sufficient information to continue eligibility.

After addressing the system issue, Kentucky’s automated eligibility system attempted an ex parte renewal for the household in November 2017 for the eligibility period of January through December 2018. Based on SWICA data that indicated household income greater than the applicable income standard. A request for information was sent to the beneficiary for additional information. After a reasonable opportunity to respond, no information was received from the beneficiary, and the case was closed in March 2018, with the beneficiary’s enrollment being terminated although, the case should have closed December 31, 2017

Based on this error, the review estimates total managed care payments of \$763.15 were inappropriately paid during the review period.

1.2) The beneficiary was ineligible for Medicaid for the two months of the sample due to household income exceeding the income standard.

¹⁸ 42 CFR §§ 435.406 and 435.949. Citizenship and non-citizen eligibility, Verification of information through an electronic service. Retrieved December 3, 2018 from https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1406&rgn=div8 and https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1949&rgn=div8.

¹⁹ The Act § 1902(ee)). Retrieved December 8, 2018 from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

The case at issue included two individuals. For a household of two, income should not have exceeded \$1,892 per month for CY2018. Beginning on February 1, 2018, the beneficiary's spouse began receiving monthly RSDI benefits of \$1,423 in addition to the monthly self-employment income of \$865 reported by the beneficiary resulting in a monthly household income of \$2,288 for this beneficiary.

Kentucky's automated eligibility system did not include all known income in its determination of the beneficiary's eligibility as a result of system defect that occurred when the SSA file was integrated into the eligibility system. Kentucky's system automatically updates RSDI based on monthly notification from SSA. Effective February 1, 2018, the system stopped including the beneficiary's spouses reported monthly self-employment income of \$865 in the calculation of income. This coincided with the beneficiary's spouse beginning to receive a monthly RSDI payment of \$1,423. Both sources of income should have been included in the calculation. Only the RSDI was included beginning in February 2018.

Based on this error, the review estimates managed care payments of \$1,275.45 were inappropriately paid during February and March 2018.

1.3) The beneficiary was ineligible for Medicaid for one month of November 2017 of the sample due to household income exceeding the income standard.

At application, the case at issue included two individuals. For a household of two, income should not have exceeded the monthly FPL of \$1,868 for CY2017. The beneficiary attested to household income of \$3,224 per month, which matched the state wage data file and exceeded the applicable income standard.

Kentucky's automated eligibility system did not include all known income in its determination of the member's eligibility. Due to a defect, the system incorrectly prorated the monthly income to \$430 and used this amount to determine eligibility. The total monthly income of \$3,224 should have been used. The system calculated the income correctly in December 2017 when the case was disposed and eligibility was terminated.

Based on this error, the review estimates managed care payments of \$768.48 were inappropriately paid during November 2017.

2. Prior OIG Findings (A-04-15-08044)²⁰

Part of this review was to follow-up on findings from a similar review and report issued by the OIG in May 2017. The OIG's audit covered the period of October 1, 2014 through March 31, 2015.

OIG's eligibility findings included the following:

²⁰ Department of Health and Human Services, Office of Inspector General. (2017, May). Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries. Retrieved July 24, 2019 from <https://www.oversight.gov/sites/default/files/oig-reports/41508044.pdf>.

- For five of 120 beneficiaries sampled, Kentucky did not electronically verify income or request additional documentation from the beneficiary. Four beneficiaries attested to zero income; however, electronic sources indicated some income. Due to systems issues, Kentucky did not send the applicants required follow-up requests for information, and the attested income was accepted. For the fifth beneficiary, the state could not provide documentation supporting whether the attested income from which the eligibility determination was made was electronically or manually verified.
- For 4 of 120 beneficiaries sampled, Kentucky determined beneficiaries eligible without verifying citizenship in accordance with Federal requirements. The state could not provide documentation that they had received a citizenship verification response from the Data HUB prior to establishing Medicaid eligibility. During OIG fieldwork, the state demonstrated to the OIG that each of these beneficiaries were citizens as of August 2016; however, OIG included them in their overall estimate of potentially ineligible beneficiaries because at the time of their eligibility determination, the state did not maintain documentation that it had verified citizenship.

The OIG recommended that the state re-determine, if necessary, the current Medicaid eligibility status of the sample beneficiaries for whom income or citizenship verifications did not meet Federal and state requirements. Kentucky concurred with OIG's findings citing system errors on the income-related findings, and both system and human errors on the citizenship errors. The state noted all cases had undergone at least one renewal cycle and remained eligible indicating stated errors were procedural in nature and did not affect overall beneficiary eligibility.

During this review, CMS determined that while system eligibility issues related to income noted by the OIG appear to be resolved, other system issues still exist (see Finding 1). Documentation of citizenship errors appear to be corrected.

3. Policy Assessment

One of the objectives of this review was to identify and assess the impact of any changes to the state's Medicaid eligibility policy and practices due to the ACA. During the course of this review, CMS worked with state staff and reviewed state policies, as well as State Plan Amendments (SPAs).²¹ CMS' review did not find evidence that the new MAGI enrollment regulations established under the ACA have impacted any non-MAGI enrollment or eligibility policies.

²¹ A state plan is an agreement between a state and the Federal Government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. When a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to CMS for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information. Medicaid.gov, Medicaid State Plan Amendments. Retrieved January 3, 2020 from <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html>.

4. Enrollment in the Adult Expansion Category (Higher FMAP)

One of the objectives of this review was to ensure that only eligible individuals were enrolled in the adult expansion category and that the state claimed the appropriate FMAP for services on behalf of those individuals – either increased FMAP for individuals newly eligible, or regular FMAP for individuals not newly eligible. According to the sample review of 90 beneficiaries, the state’s system correctly determined each beneficiary’s Medicaid eligibility category at application and redetermination (e.g., Kentucky’s adult group) and claimed the appropriate FMAP for those beneficiaries. Test work did not indicate that any lower FMAP eligibility group individuals had been enrolled inappropriately.

Additionally, a review of non-expansion aid category population counts over time did not indicate that the state was shifting populations from lower FMAP populations to higher FMAP populations, such as the adult group.

Observations

During the course of the review, other issues were identified in the sample regarding the beneficiaries’ failure to notify the state of changes in circumstances and Kentucky’s system issue for processing household composition. These items do not represent an error to the state but, had the state been aware of these changes in a timelier manner, eligibility determinations may have been impacted.

1. The applicant did not report a significant change in income soon after the eligibility determination was made.

The individual applied for Medicaid on April 17, 2017 reporting a household of one and no income. Kentucky’s automated system identified income that was not reasonably compatible with the attestation from electronic data sources and sent a request for information to the individual. The applicant submitted a letter, signed by a third party, stating that the applicant was unemployed and had no income at this time. Based upon this verification, the applicant was determined eligible for the period of April 2017 through March 2018.

At the annual renewal, the income verification failed again. The state wage data file indicated income above the applicable income standard. A request for information was sent to the beneficiary, but no response was received. Eligibility was terminated effective April 1, 2018.

CMS performed a retrospective review of the SWICA data file during this review, which supported the applicant’s claim of little or no wages surrounding the time of initial application. However, the same review of the state wage data file also indicated a significant increase of income almost immediately following the initial enrollment into Kentucky’s Medicaid expansion population, which lasted through the remaining quarters of the eligibility period. If the beneficiary had promptly reported this increase in income, the beneficiary would not have met eligibility income requirements, and the enrollment would have been terminated before the next renewal.

2. The beneficiary did not report income changes for the MAGI calculation during passive renewals (i.e., tuition and fees expenses).

The beneficiary was originally determined eligible in 2014 for Kentucky's Medicaid expansion based on a reported \$3,996 of college tuition and fee expenses being deducted from income. The beneficiary's eligibility was renewed on an ex parte basis in 2015, 2016, and 2017, based on Kentucky's continued acceptance of the college tuition and fee expense information in the case file. The beneficiary never reported a change in tuition and fee expenses, nor did the beneficiary respond with any corrections to the information provided in the redetermination notices.

In January 2018, Kentucky mailed a renewal form to the beneficiary requesting income information. Later in January 2018, the beneficiary reported that the college had closed in March 2014, and the beneficiary had no qualifying college tuition and fees expenses. The beneficiary's income was below the MAGI threshold for January 2018 so the eligibility was maintained without any further deductions for the MAGI determination for 2018. The beneficiary's failure to report this change, coupled with the state's absence of controls surrounding validation of certain MAGI deductions that cannot be verified electronically through the Data HUB, resulted in the beneficiary potentially remaining inappropriately eligible for part of years 2014 through 2017.

3. Kentucky's current eligibility system did not correctly process household composition for the beneficiary.

The beneficiary's initial household size was five; on March 1, 2015, the spouse passed away resulting in a change to a household composition of four. The household appropriately reported the information to Kentucky, but when Kentucky transferred this information to the current eligibility system, the information reverted back to a household composition of five. In this instance, the error did not affect the eligibility of the beneficiary, but such errors could impact other cases.

Recommendations for Improvement

CMS recommends that Kentucky:

1. Ensure the eligibility system appropriately considers all income of the household reported by electronic data sources;
2. Ensure the eligibility system requests information about all types of applicable income, including self-employment income and RSDI;
3. Ensure the eligibility system appropriately calculates monthly incomes;
4. Consider implementing controls to substantiate financial offsets to MAGI, such as tuition expenses, which cannot be electronically verified; and
5. Ensure the eligibility system is appropriately recording changes to household composition.

Appendix A: Review Scope and Methodology

Scope

CMS' review covered Medicaid beneficiaries in the MAGI adult group under section 1902(a)(10)(A)(i)(VIII) and 42 CFR § 435.119 who received services from Kentucky for the period of October 1, 2017, through March 31, 2018 (review period).

CMS limited the review to those applicable to our objective. The testing included a review of supporting documentation at the state agency to evaluate whether the state agency determined the applicant's eligibility in accordance with Federal and state requirements and the controls surrounding those activities. In addition, CMS gained an understanding of the policies and procedures for determining whether individuals eligible for the adult group met the eligibility requirements described in the statute and regulations. CMS performed fieldwork from December 2018 through June 2019 with the state agency in Lexington, Kentucky.

Methodology

To accomplish the objectives, CMS:

- Reviewed applicable Federal and state laws, regulations, and other requirements related to Medicaid eligibility;
- Obtained and reviewed Kentucky's MAGI-Based Verification Plan, which captures the data sources the state uses to verify eligibility at application and redeterminations, along with information about the state's policies for requesting additional information from an individual when data sources are not sufficient to verify the individual's eligibility;
- Assessed internal controls by:
 - Interviewing officials from the Kentucky Cabinet of Health and Family Services, Department for Medicaid Services to obtain an understanding on how Kentucky (1) processes an individual's application and renewal information and (2) verifies an applicant's eligibility for enrollment in Medicaid.
 - Holding discussions with state agency officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
 - Performing a walk-through of the applicant information and determination of eligibility verification processes for enrollment in Medicaid; and
 - Determining how the system documents that the verification and determination of eligibility processes occurred.
- Obtained a database of all Medicaid paid claims data in Kentucky with service dates during the review period (excluding claims for services provided to American Indians/Alaska Natives already covered by 100 percent FMAP);
- Created a sampling frame of 534,626 Medicaid beneficiaries for which the state agency made Medicaid payments totaling \$1,673,079,865.41; and
- Selected a stratified random sample of 90 Medicaid beneficiaries receiving services in Kentucky during the review period.

- For each sample item, reviewed application and renewal data and documentation to support the eligibility determination made for the services to determine:
 - The organization or agency that made the eligibility determination;
 - Whether the agency making eligibility determinations followed implemented procedures to verify eligibility documentation; and
 - Whether beneficiaries determined to be eligible under the adult expansion population met Federal and state eligibility requirements, such as income level, residency, immigration status, and documentation of U.S. citizenship.
- Held discussions with state agency officials to obtain an understanding of how policies, procedures and guidance for determining Medicaid eligibility have changed with regards to verification both pre and post ACA.
- Followed up on previously submitted Department of Health and Human Services, Office of Inspector General Review Report (A-04-15-08044), issued in May 2017 to ensure all sound findings had been appropriately corrected and any resulting Federal share applicably adjudicated.
- Discussed the results of the review with state agency officials in an informal exit conference.

Appendix B: Statistical Sampling Methodology for Kentucky

Target Population

The target population consisted of all beneficiaries determined eligible for and enrolled in the adult expansion group under the ACA, excluding American Indians and Alaskan Natives, for whom the state agency made Medicaid payments for services provided from October 1, 2017, through March 31, 2018.

Sampling Frame

The sampling frame consisted of an Access database containing 534,626 adult group eligible Medicaid beneficiaries in Kentucky for whom the state agency made Medicaid payments totaling \$1,673,079,865.41 (\$1,581,124,888.59 Federal share) for services provided during the review period. CMS obtained the data for the Medicaid beneficiaries from Kentucky's Medicaid Management Information System (MMIS). CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frame. American Indians and Alaskan Natives are subject to different Federal matching ratios and were not a part of this review.

Sample Unit

The sample unit was an adult group eligible Medicaid beneficiary.

Sample Design

CMS used a stratified random sample.

- Stratum 1: Medicaid beneficiaries who were categorized as being adult group eligible for Medicaid under the ACA with total Federal Medicaid payments greater than or equal to \$4,350 per beneficiary. This stratum consisted of 138,811 Medicaid beneficiaries with payments totaling \$724,660,879.47 (\$684,833,488.22 Federal share).
- Stratum 2: Medicaid beneficiaries who were categorized as being adult group eligible for Medicaid under the ACA with total Federal Medicaid payments less than \$4,350 per beneficiary. This stratum consisted of 395,815 Medicaid beneficiaries with payments totaling \$948,418,985.94 (\$896,291,400.37 Federal share).

Sample Size

CMS selected a total sample of 90 Medicaid beneficiaries, divided across two strata of 45 beneficiaries in each stratum.

Source of Random Numbers

CMS generated the random numbers using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software called RAT-STATS 2010, their most recent version.²²

Estimation Methodology

CMS used the OIG/OAS statistical software to estimate the total number of ineligible Medicaid beneficiaries and the total amount of Medicaid payments for the ineligible beneficiaries for whom the state agency claimed Federal reimbursement. CMS also used this software to calculate the lower and upper limits of the 90 percent confidence intervals associated with these estimates.

In addition, CMS determined the percentage of ineligible beneficiaries by dividing the estimated number of ineligible beneficiaries by the total number of beneficiaries in the sampling frame. CMS also determined the percentage of Federal dollars expended for ineligible beneficiaries by dividing the estimated amount of Federal dollars expended by the total amount of Federal dollars in the sampling frame.

²² <https://oig.hhs.gov/compliance/rat-stats/index.asp>

Appendix C: Sample Results and Estimates

Sample Results

Table 1: Sample Detail and Results

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Federal Share of Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Improper Payments (Federal Share)
1	138,811	45	\$216,914.60	0	\$0
2	395,815	45	\$94,380.71	3	\$2,640.59
Totals	534,626	90	\$311,295.31	3	\$2,640.59

Estimates

Table 2: Estimated Number of Ineligible Beneficiaries and Value of Overpayments (Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments (Federal Share)
Point estimate	26,388	\$24,690,763.78
Lower limit	1,906	\$988,158.84
Upper limit	50,869	\$48,393,368.72

Table 3: Calculation of Overall Rate of Ineligible Beneficiaries and Payments

Number of Beneficiaries	Estimated No. of <u>Ineligible Beneficiaries</u>	26,388
		4.94%
	Total Number of Beneficiaries in Sample Frame	534,626
Dollar Value of Payments	Estimated Federal Dollars Associated with <u>Ineligible Beneficiaries</u>	\$24,690,764.78
		1.56%
	Total Federal Dollars in Sample Frame	\$1,581,124,888.59

Appendix D: Kentucky Department for Medicaid Services Comments

February 7, 2020

Jamie Scott, CPA, MS
Governance Management Group
Center for Program Integrity
Centers for Medicare & Medicaid Services

RE: Kentucky Medicaid Eligibility Determinations for the Expansion Population Draft Report

Dear Jamie Scott:

Thank You for the opportunity to provide comments on the draft CMS report titled, “Kentucky Medicaid Eligibility Determinations for the Expansion Population”. The Department is pleased that the review conducted by CMS only found three eligibility errors out of a sample size of 90 beneficiaries. The department strives to continuously improve all aspects of its operations in order to better serve the citizens of Kentucky. Please consider the following comments in drafting the final report.

The Sampling and Extrapolation is invalid for the following reasons:

- 1. Appendix B: Statistical Sampling Methodology for Kentucky contains a conflict:** The sample design, Stratum 2 is in conflict with Appendix C, Sample Results. Does Stratum 2 consist of 534,626 Medicaid beneficiaries?
- 2. Appendix C: Sample Results and Estimates:** The Department disagrees with the estimate because the point estimate is used to determine the overall rate of ineligible beneficiaries instead of the lower limit. CMS acknowledges in the Medicare Program Integrity Manual (PIM) that, “the lower limit of a one-sided 90 percent confidence interval should be used as the amount of overpayment to be demanded...”. CMS further states that this, “procedure, which through confidence interval estimation, incorporates the uncertainty inherent in the sample design, is a conservative method that works to the financial advantage of the provider/supplier.” See PIM, “Section 8.4.5.1 – The Point Estimate.” The lower limit is appropriate to use due to the inherent uncertainty and lack of high precision in the sample design.

In Table 3, using the lower limit, the estimated number of ineligible beneficiaries is 1906 which yields an error rate of **0.35%** and not 4.94%. Additionally, the total Federal share for the ineligible beneficiaries is **\$988,158.84** and not \$24,690,764.78.

Extrapolation is not appropriate in this review and should be removed. Even if CMS does not use the point estimate lower limit to calculate the error rate and overpayment, extrapolation should only be used if there is a sustained or high level of payment error and may be used after documented educational intervention has failed to correct the payment error. CMS has defined and acknowledged that a “high level of payment error” is “greater than or equal to 50 percent from a pre- or post-payment review”. This definition was added in guidance as a part of the PIM effective January 2, 2019. CMS determined that three out of 90 eligibility determinations were incorrect. This equates to only 3.3% of determinations in error which is not a “high level of payment error”. Additionally, HHS-OIG conducted an audit of eligibility determinations (Report No. A-04-15-08044) published May 2017 which found that the Department had incorrectly determined nine out of 120 eligibility determinations (review period October 1, 2014, through March 31, 2015.) This equates to only 7.5% of determinations in error which is not a “high level of payment error” as defined by CMS. The error rate in eligibility determinations dropped from 7.5% during the review period of October 1, 2014 through March 31, 2015 to 3.3% during the review period of October 1, 2017 through March 31, 2018. During the two audit periods, the error rate dropped by 4.2 points which is a 56% reduction in the error rate and a result of corrective actions taken by the Department. Therefore, due to the low number of errors and actions that were taken by the Department after the HHS-OIG audit, extrapolation is not appropriate. **Finally, if the lower limit of the point estimate is used as indicated by CMS in the PIM, then the actual error rate determined is 0.35% which is negligible therefore extrapolation is inappropriate in this review and the overpayment should be \$2,640.59 which is the actual value of the federal share of the overpayments.**

CMS recommendations for improvement:

1. Ensure the enrollment system appropriately collects all income of the household reported by electronic data;

Department Comments: Section 1.1 reflects the passive renewal logic in place during the audit period. That logic stated if the applicant passed any one of the three income sources checked, the case would renew without further information. This case passed on one of the income sources and was therefore renewed without further member information. This logic has been corrected to say the case must pass all the income sources or a Request for Information (RFI) is issued to the member for income verification. Secondly, system changes have been implemented to ensure that cases deny if there is no response to an RFI.

2. Ensure the enrollment system includes all types of applicable income, including self-employment income and RSDI;

Department Comments: Section 1.2 reflects a system defect happening when the SSA file was consumed. That defect has since been corrected and no further errors have been reported.

3. Ensure the enrollment system appropriately calculates monthly incomes;

Department Comments: The single example in Section 1.3 may have been a defect or a worker error. Whichever the case, the system did correct the income when the case was disposed the very next month. This is a good example of how the system can catch and correct errors.

4. Consider implementing controls to substantiate financial offsets to MAGI, such as tuition expenses, which cannot be electronically verified; and

Department Comments: Federal regulations require the state to accept many forms of verification including Client Statement. Where it is possible, the state verifies income and expenses using client documentation. Anytime documentation was not appropriately used for verification may be attributable to worker error. The state continuously trains workers to ensure errors remain at a minimum.

5. Ensure the enrollment system is appropriately recording changes to household composition.

Department Comments: The system does appropriately record changes in household sizes. The system cannot however, calculate correct household sizes when the members do not report changes in the household. The state believes this is not an error by the system or the state.

Thank you for the opportunity to provide feedback on the draft review report. If you would like to discuss further, please contact me (502-564-6890x2106) or Michelle Rudovich (502-564-5472x2021.)

Sincerely,
Lee Guice
Director

Cc: Michele Rudovich
Carl Ishmael
File