

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**KENTUCKY DID NOT ALWAYS
PERFORM MEDICAID ELIGIBILITY
DETERMINATIONS FOR NON-NEWLY
ELIGIBLE BENEFICIARIES IN
ACCORDANCE WITH FEDERAL AND
STATE REQUIREMENTS**

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



Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: August 2017

Report No. A-04-16-08047

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



Why OIG Did This Review

The Patient Protection and Affordable Care Act (ACA) mandated changes to Medicaid eligibility rules, such as calculating income based on Modified Adjusted Gross Income. These changes, along with intense public interest in the ACA, led to significantly increased Medicaid applications based on existing eligibility categories. We conducted this audit to address the concern that State agencies might have difficulty accurately determining Medicaid eligibility in these non-newly eligible categories in this challenging environment. We separately reviewed eligibility determinations based on a newly eligible Medicaid expansion category in a previous audit.

Our objective was to verify whether Kentucky met Federal and State requirements when determining Medicaid eligibility for services provided to non-newly eligible Medicaid beneficiaries from October 2014 through March 2015.

How OIG Did This Review

We reviewed a stratified random sample of 120 Medicaid beneficiaries who received Medicaid-covered services from October 2014 through March 2015. We reviewed supporting documentation to evaluate whether Kentucky determined the applicants' eligibility in accordance with Federal and State requirements. We did not determine whether beneficiaries were eligible or ineligible for Medicaid.

Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements

What OIG Found

Kentucky did not always determine Medicaid eligibility in accordance with Federal and State requirements. For our sample of 120 beneficiaries, Kentucky correctly determined eligibility for 113 beneficiaries, but it did not meet Federal and State requirements for eligibility determinations of 7 beneficiaries. Specifically, Kentucky did not always maintain documentation supporting that it electronically or manually verified citizenship. In addition, although it did not violate an eligibility requirement, Kentucky did not perform or did not maintain documentation of identity-proofing for 13 beneficiaries in accordance with Federal requirements. The Federal identity-proofing requirements are intended to reduce the potential for identity theft.

Kentucky did not always meet Federal and State requirements when making eligibility determinations because of human and system errors.

On the basis of our sample, we estimated that during our 6-month audit period, approximately 8 percent of non-newly eligible beneficiaries in Kentucky were potentially ineligible, and approximately 3 percent of Federal payments were made to those beneficiaries. As a result, we estimated that Kentucky made Federal Medicaid payments on behalf of 69,931 potentially ineligible beneficiaries totaling \$72.8 million. We did not include the identity-proofing errors in our estimate of potentially ineligible beneficiaries and payments, but we are highlighting the potential for identity theft if Kentucky does not correct these errors.

What OIG Recommends and Kentucky's Comments

We recommend that Kentucky maintain documentation that shows that it verified an applicant's citizenship and identity.

In its written comments on our draft report, Kentucky agreed with our recommendations and described actions it had taken to address them.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2010, Congress passed the Patient Protection and Affordable Care Act (P.L. No. 111-148) and the Health Care and Education Reconciliation Act (P.L. No. 111-152), collectively known as the Affordable Care Act (ACA). The ACA mandated changes to Medicaid eligibility rules, such as calculating income based on Modified Adjusted Gross Income (MAGI). These changes, along with intense public interest in the ACA, led to significantly increased applications for Medicaid coverage. Although many individuals applied for Medicaid coverage for the first time after passage of the ACA, they were part of a population that had traditionally been eligible for Medicaid based on one of the existing eligibility categories. We refer to this population as the non-newly eligible population. We conducted this audit to address the concern that State agencies might have difficulty accurately determining eligibility for Medicaid beneficiaries in this challenging environment.

The ACA also 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 newly eligible beneficiaries. We excluded the newly eligible beneficiaries from this audit because we reviewed them previously; see report *Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (A-04-15-08044).

OBJECTIVE

Our objective was to verify whether the Kentucky Department for Medicaid Services (State agency) met Federal and State requirements when determining Medicaid eligibility for services provided to non-newly eligible Medicaid beneficiaries for the 6-month period from October 1, 2014, through March 31, 2015.

BACKGROUND

The Medicaid Program

Medicaid is the Nation's primary health insurance program for low-income individuals and families, providing coverage to approximately 69 million people in 2015. The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, Federal law requires States to cover certain population groups. These groups include parents with children, pregnant women, people with disabilities, and individuals receiving Supplemental Security Income (SSI).¹

¹ SSI recipients are automatically eligible for Medicaid services.

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 FMAP, which is developed from criteria such as the State's per capita income.^{2,3} The "standard" FMAP varies by State and ranges from 50 to 75 percent.^{4,5} In addition, a State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its Medicaid program, including program administration, eligibility criteria, service coverage, and provider reimbursement. When making a Medicaid eligibility determination, States follow the Federal requirements, as well as the process outlined in their State plans and their State eligibility verification plans.⁶

The ACA required States to make a number of changes to their Medicaid application and enrollment processes. Changes included requiring States to develop a single, streamlined enrollment application that facilitates screening applicant eligibility for all potential health coverage options, including Medicaid, CHIP, and qualified health plans available through the health insurance marketplaces.⁷ In most cases, the ACA required States to use MAGI, a measure of income that is based on Internal Revenue Service rules, to determine a person's income.

CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs. In June 2016, CMS issued a notice of proposed rulemaking that modified its MEQC and PERM requirements to incorporate changes mandated by the ACA.⁸

Medicaid Eligibility Determinations and Identity-Proofing

Generally, individuals meet eligibility criteria by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of U.S.

² Social Security Act (the Act) § 1905(b).

³ CMS, "Financing & Reimbursement." Accessed at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html> on July 6, 2016.

⁴ 77 Fed. Reg. 71420, 71422 (Nov. 30, 2012).

⁵ Office of the Assistant Secretary for Planning and Evaluation. "FY2017 Federal Medical Assistance Percentages." Accessed at <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages> on July 6, 2016.

⁶ States are required to develop a Medicaid/Children's Health Insurance Plan (CHIP) verification plan describing their eligibility verification policies and procedures (42 CFR §§ 435.945(j) and 457.380(j)).

⁷ ACA § 1413(b).

⁸ 81 Fed. Reg. 40596 (June 22, 2016).

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

The ACA required States to rely primarily on information available through electronic data sources rather than paper documentation for verifying Medicaid eligibility. Among other eligibility requirements, a Medicaid beneficiary must be a resident of the State from which the beneficiary receives Medicaid benefits and be a citizen or national of the United States or a qualified alien.⁹ In addition, the State is required to verify the individual's Social Security number, status as a U.S. national or eligible immigration status, date of birth and age, household composition, and household income using the data sources and processes as required under Federal regulations and described in the State's eligibility verification plan.

Before an applicant can submit an online or phone application, the marketplace must verify the applicant's identity through identity-proofing. The purpose of identity-proofing is to (1) prevent an unauthorized individual from creating an account for another individual and applying for health coverage without the individual's knowledge and (2) safeguard personally identifiable information that is created, collected, and used by the marketplace. When completing an application through the health insurance marketplace, the applicant attests that answers to all questions are true and that the applicant is subject to the penalty of perjury.¹⁰ For paper applications, the applicant's signature is required before the State agency processes the application.¹¹

Kentucky Medicaid

The State agency is responsible for operating the Medicaid program and uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. From October 1, 2014, through March 31, 2015 (audit period), the State agency made Federal Medicaid payments totaling \$2.2 billion on behalf of 901,117 Medicaid beneficiaries.

During our audit period, Kentucky used two eligibility systems to determine Medicaid eligibility. Kentucky's legacy system was known as the Kentucky Automated Medicaid Eligibility System (KAMES). The second eligibility system was known as Kynect.¹²

KAMES is an integrated system that determines an individual's eligibility for all waiver services (e.g. Temporary Assistance for Needy Families, nursing homes, and long-term care). To verify

⁹ Examples of qualified aliens are individuals who are lawfully permitted permanent residents, individuals granted asylum, refugees admitted to the United States, and individuals granted conditional entry.

¹⁰ Any person who fails to provide correct information may be subject to a civil monetary penalty (ACA § 1411(h)).

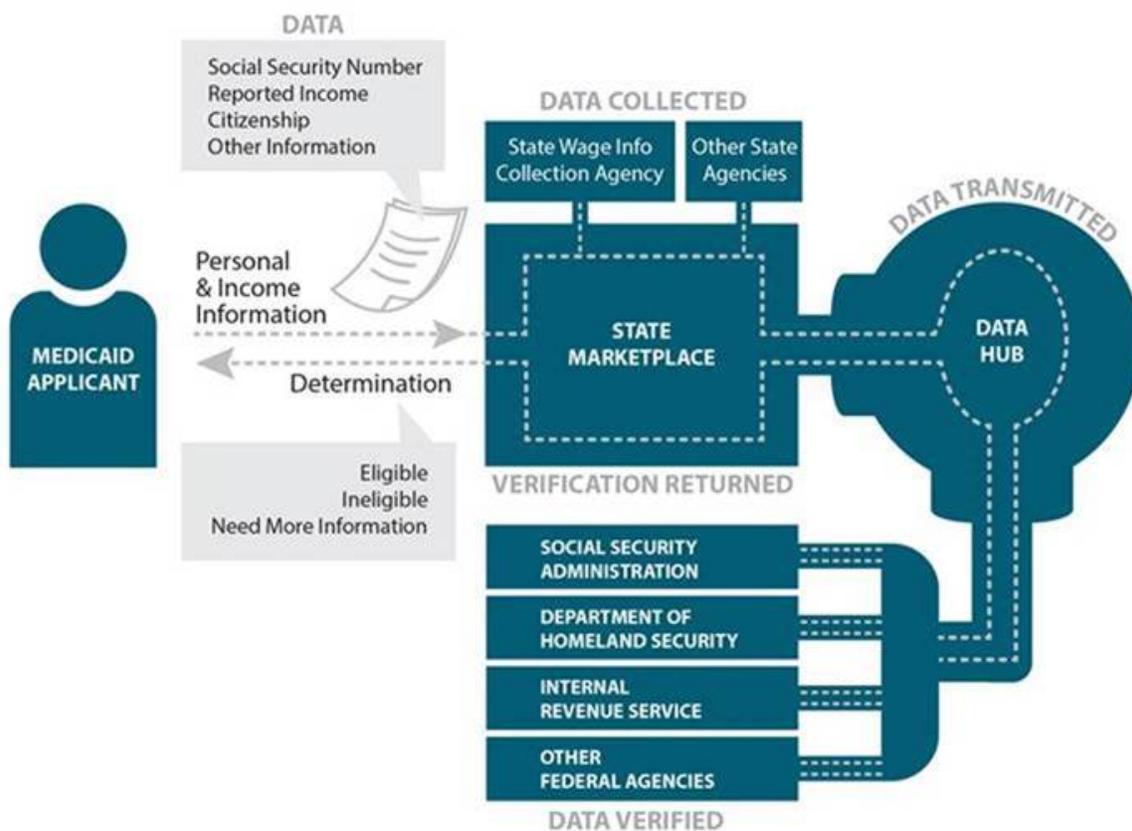
¹¹ CMS's *Guidance Regarding Identity Proofing for Marketplace, Medicaid and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub* (Identity-Proofing Guidance), June 11, 2013.

¹² After our audit period, Kentucky rebranded Kynect with a new name, Benefind, while still maintaining the same underlying functionality.

Medicaid eligibility during our audit period, KAMES used electronic sources such as the Social Security Administration’s Beneficiary and Earnings Data Exchange (BENDEX), State Wage Information Collection Agency, and Workforce Development. The State agency used paper documents submitted by the applicant to complete most of the KAMES eligibility determinations.

Kynect uses multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub). The data sources available through the Data Hub are provided by Health and Human Services (HHS), the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the Internal Revenue Service, among others. See the figure below for Kynect’s eligibility process. The Kentucky Office of Health Benefit and Health Information Exchange (KOHBHIE) oversees both KAMES and Kynect.

Figure: Kynect Medicaid Eligibility Process



HOW WE CONDUCTED THIS REVIEW

Our audit covered Medicaid beneficiaries who received services from October 1, 2014, through March 31, 2015. We reviewed a stratified random sample of 120 Medicaid beneficiaries who

the State agency determined or redetermined¹³ to be eligible for Kentucky Medicaid during this period. We reviewed the internal controls in place at the State agency and KOHBHIE and analyzed supporting documentation to evaluate whether the State agency determined the applicants' eligibility in accordance with Federal and State requirements.

Beneficiaries enrolled on the basis of determinations that did not meet Federal and State requirements may not be eligible for Medicaid coverage. We did not assess beneficiaries for eligibility categories other than the category in which the State agency placed them. We also did not contact beneficiaries to request additional documentation. As a result of these limitations, we could not conclusively determine whether beneficiaries were eligible or ineligible for Medicaid; we refer to these beneficiaries for whom eligibility was not determined in accordance with requirements as "potentially ineligible."

We limited our review of internal controls to those related to verifying applicant identity and determining applicant eligibility for Medicaid enrollment. In addition, we gained an understanding of the State agency's and KOHBHIE's policies and procedures for determining whether beneficiaries met eligibility requirements.

We performed fieldwork from June through December 2016 at the State agency in Frankfort, Kentucky.

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

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not always determine Medicaid eligibility in accordance with Federal and State requirements. For our sample of 120 beneficiaries, the State agency correctly determined eligibility for 113 beneficiaries, but it did not meet Federal and State requirements for eligibility determinations of 7 beneficiaries. Specifically, it did not always maintain documentation supporting that it electronically or manually verified citizenship. In addition, although it did not violate an eligibility requirement, the State agency did not perform or did not maintain documentation that it had performed identity-proofing for 13 beneficiaries in accordance with

¹³ Medicaid eligibility redeterminations are required at least every 12 months or when the State agency has information about anticipated changes in a beneficiary's circumstances that may affect eligibility (42 CFR § 435.916).

Federal requirements. The Federal identity-proofing requirements are intended to reduce the potential for identity theft.

The State agency did not always meet Federal and State requirements when making eligibility determinations because of both human and system errors. The State agency did not always perform, or maintain documentation that it had performed, identity-proofing because of both human and system errors related to processes implemented in response to the ACA that affected eligibility determinations for non-newly eligible Medicaid applicants.

On the basis of our sample results, we estimated that the State agency made Federal Medicaid payments on behalf of 69,931 potentially ineligible beneficiaries totaling \$72,763,721. Identity-proofing deficiencies are not considered eligibility determination errors and therefore are not included in our estimate of potentially ineligible beneficiaries and payments.

KENTUCKY DID NOT MAINTAIN DOCUMENTATION THAT IT VERIFIED CITIZENSHIP FOR SOME BENEFICIARIES

To properly verify citizenship or nationality status of beneficiaries enrolled in Medicaid, States must ensure that those individuals declaring to be citizens or nationals of the United States have presented satisfactory documentary evidence of citizenship or nationality (Social Security Act § 1903(x)). In addition, to satisfy the documentation requirements, States may verify citizenship by electronically verifying citizenship status with SSA (42 CFR §§ 435.406 and .949). States must maintain records that include facts essential to determination of initial and continuing eligibility (§ 431.17).

For 7 of 120 beneficiaries,¹⁴ the State agency determined these beneficiaries eligible for Medicaid without maintaining documentation that it verified citizenship in accordance with Federal requirements. For these beneficiaries, the State agency submitted their citizenship status through the Data Hub or BENDEX for verification with SSA. However, the State agency could not provide documentation that it had received a citizenship verification response. The State agency indicated that, because of human error and system errors, it could not find supporting documentation. The human error occurred because a caseworker did not scan the paper documentation provided by the beneficiary into the electronic case file. The system errors occurred because the eligibility systems indicated that it verified the citizenship status of potential beneficiaries with electronic sources but did not retain the confirmation that the beneficiaries were citizens.

¹⁴ During our fieldwork, we asked the State agency to attempt to verify the seven beneficiaries' citizenship using the Data Hub. Although the State subsequently provided evidence that these beneficiaries were citizens as of November 2016, we have included them in our 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 in accordance with Federal requirements.

Because the State agency did not maintain documentation that it had verified citizenship, we could not determine whether the State agency only enrolled individuals who met Medicaid eligibility requirements.

KENTUCKY DID NOT ALWAYS VERIFY IDENTITY OR MAINTAIN IDENTITY-PROOFING DOCUMENTATION

For 10 years, States must maintain, and ensure that their contractors, subcontractors, and agents maintain, documents and records that are sufficient to enable HHS or its designees to evaluate the marketplaces' compliance with Federal requirements (45 CFR § 155.1210(a)). The records must include information related to the marketplaces' eligibility verifications and determinations and enrollment transactions (§ 155.1210(b)(4)).

Marketplaces must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that they create, collect, use, or disclose and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it (§ 155.260(a)(4)).

According to CMS's identity-proofing guidance for State marketplaces, before a marketplace accepts an online or a telephone application for enrollment in Medicaid, it must conduct identity-proofing sufficient to provide assurance that only the appropriate individual has access to restricted data. The guidance explains that identity-proofing involves the (1) collection of core attributes, including the applicant's name, birth date, Social Security number (optional), address, phone number, and email address; (2) validation of core attributes with a trusted data source; and (3) collection and validation, for some applicants, of responses to questions about the applicant's personal history, e.g., the names of current and past employers.

The State agency did not always verify identity or maintain documentation from identity-proofing of beneficiaries. For 13 of 50 beneficiaries that applied using the State marketplace,¹⁵ the State agency did not verify identity during the application process or document that it had performed identity-proofing in accordance with Federal requirements.¹⁶ Specifically:

- For nine beneficiaries, State agency personnel completed the application either online or over the phone and did not verify identity. The State agency was unable to provide any documentation indicating that personnel followed Federal requirements to verify identity for these online or phone applications.

¹⁵ The remaining 70 beneficiaries did not require identity-proofing because they were either automatically eligible (SSI recipients, foster care, or subsidized adoption recipients) or they applied for coverage through KAMES, and identity-proofing was not required.

¹⁶ States perform identity-proofing of application filers. If a sample beneficiary was not the application filer, we reviewed supporting documentation for identity-proofing of the application filer. For example, the application filer may be a parent seeking coverage for a child who is the applicant.

- For four beneficiaries, the State agency either did not verify identity or did not maintain documentation of the verification because of Kynect system errors. For two of these beneficiaries, Kynect rendered the application source as unknown, meaning that the State agency could not identify whether the applicant applied online, over the phone, or by mail and thus could not provide the beneficiaries' identity-proofing documentation. For two other beneficiaries, the State agency performed identity-proofing through the Data Hub but did not have a control in place to maintain the Data Hub responses.

The State agency's failure to verify the identity of applicants or to maintain identity-proofing documentation increases the risks of undetected identity theft and ineligible applicants.

ESTIMATED PAYMENTS TO POTENTIALLY INELIGIBLE BENEFICIARIES

On the basis of our sample results, we estimated that during our 6-month audit period, approximately 8 percent of non-newly eligible beneficiaries in Kentucky were potentially ineligible, and approximately 3 percent of Federal payments were made to those beneficiaries. As a result, we estimated that Kentucky made Federal Medicaid payments on behalf of 69,931 potentially ineligible beneficiaries totaling \$72,763,721. We did not include the identity-proofing errors in our estimate of potentially ineligible beneficiaries and payments, but we are highlighting the potential for identity theft if the State agency does not correct these errors.

RECOMMENDATIONS

We recommend that the State agency maintain documentation that shows that it:

- verified an applicant's citizenship and
- verified an applicant's identity.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency agreed with our recommendations and described actions it had taken to address them. The State agency's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicaid beneficiaries, excluding those under the newly eligible group established by the ACA, who received services from October 1, 2014, through March 31, 2015 (audit period).

We limited our review of internal controls to those related to verifying applicant identity and determining applicant eligibility for Medicaid enrollment. Our testing of controls included a review of supporting documentation at the State agency to evaluate whether the State determined the applicant's eligibility in accordance with Federal and State requirements. In addition, we gained an understanding of the State agency and KOHBHIE policies and procedures for determining whether beneficiaries enrolled met eligibility requirements. We did not assess beneficiaries for eligibility categories other than the category in which the State agency placed them. In addition, we did not contact beneficiaries to obtain additional supporting documentation.

We performed fieldwork from June through December 2016 at the State agency in Frankfort, Kentucky.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements, regulations, and CMS guidance regarding the implementation of ACA changes related to Medicaid eligibility;
- interviewed State agency officials to obtain an understanding of internal controls regarding how their two eligibility systems process an applicant's information and verifies an applicant's eligibility for enrollment in Medicaid;
- selected a stratified random sample of 120 beneficiaries from a total of 901,117 beneficiaries who were determined or redetermined to be eligible during the audit period;
- obtained application data and documentation to verify the Medicaid eligibility of each sampled beneficiary;
- analyzed the State agency's documentation supporting beneficiaries' Medicaid eligibility;

- estimated the total number of potentially ineligible beneficiaries and the total amount of Medicaid payments made on behalf of those potentially ineligible beneficiaries during the audit period;
- calculated an overall eligibility error rate for both the number of payments and the dollar amounts; and
- discussed the results of our review with State agency officials.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of all beneficiaries, excluding those determined newly eligible for Medicaid under the ACA and American Indians and Alaskan Natives,¹⁷ for whom the State agency made Medicaid payments for services provided from October 1, 2014, through March 31, 2015.

SAMPLING FRAME

The sampling frame consisted of an Access database containing 901,117 Medicaid beneficiaries for whom the State agency made Medicaid payments totaling \$3,086,487,071 (\$2,168,532,961 Federal share) for services provided during the audit period. We obtained the data for the Medicaid beneficiaries from Kentucky's MMIS. We excluded newly eligible and American Indians/Alaskan Native beneficiaries from our sampling frame.

SAMPLE UNIT

The sample unit was a Medicaid beneficiary.

SAMPLE DESIGN

We used a stratified random sample.

- Stratum 1: Medicaid beneficiaries with total payments less than \$2,745 per beneficiary. This stratum consisted of 614,105 Medicaid beneficiaries with payments totaling \$725,687,607 (\$516,295,722 Federal share).
- Stratum 2: Medicaid beneficiaries with total payments greater than or equal to \$2,745 and less than \$15,133 per beneficiary. This stratum consisted of 255,614 Medicaid beneficiaries with payments totaling \$1,364,393,809 (\$954,809,799 Federal share).
- Stratum 3: Medicaid beneficiaries with total payments greater than or equal to \$15,133 per beneficiary. This stratum consisted of 31,398 Medicaid beneficiaries with payments totaling \$996,405,655 (\$697,427,440 Federal share).

SAMPLE SIZE

We selected 120 Medicaid beneficiaries: 60 from stratum 1, 30 from stratum 2, and 30 from stratum 3.

¹⁷ American Indians and Alaskan Natives are subject to different eligibility requirements that were not a part of this review.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the Medicaid beneficiaries within strata 1, 2, and 3. After generating the random numbers for each of these strata, we selected the corresponding Medicaid beneficiary in the sampling frame for our sample.

ESTIMATION METHODOLOGY

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

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Detail and Results

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Federal Share of Payments Associated With Sampled Beneficiaries)	Potentially Ineligible Beneficiaries	Value of Potentially Improper Payments (Federal Share)
1	614,105	60	\$48,054	6	\$5,205
2	255,614	30	102,414	1	2,287
3	31,398	30	584,978	0	0
Total	901,117	120	\$735,446	7	\$7,492

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

	Total Number of Potentially Ineligible Beneficiaries	Total Value of Potentially Improper Payments (Federal Share)
Point estimate	69,931	\$72,763,721
Lower limit	28,066	23,342,402
Upper limit	111,796	122,185,039

Table 3: Calculation of Overall Rate of Potentially Ineligible Beneficiaries and the Percent of Federal Dollars Impacted

Number of Beneficiaries	Estimated No. of Potentially Ineligible Beneficiaries	69,931	7.76%
	Total Number of Beneficiaries in Sample Frame	901,117	
Dollar Value of Payments	Estimated Federal Dollars Associated With Potentially Ineligible Beneficiaries	\$72,763,721	3.36%
	Total Federal Dollars in Sample Frame	\$2,168,532,961	

APPENDIX D: STATE AGENCY COMMENTS



CABINET FOR HEALTH AND FAMILY SERVICES DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Vickie Yates Brown Glisson
Secretary

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Stephen P. Miller
Commissioner

July 17, 2017

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Audit Services Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: Report Number A-04-15-08044

Dear Ms. Pilcher:

Pursuant to your request, please find the Department for Medicaid Services (DMS) comments to the recommendations contained in the above referenced draft report. The recommendations revolve around the finding that DMS through kynect did not correctly determine Medicaid eligibility for some beneficiaries enrolled between October 2014 and March 2015. The recommendations and responsive comments are set out below.

Recommendation:

Kentucky must maintain documentation that it verified citizenship for all beneficiaries.

Comments:

Kentucky DMS agrees that due to system and human error citizenship or qualified alien status verification was not maintained. During the audit timeframe noted above, the OIG identified this as a problem previously unknown by the state. When informed of the issue, DMS utilized staff communications and training to re-inforce correct procedures. Additionally, the state added this verification item to our quality reviews. Finally, kynect technical staff conducted reviews during the OIG visit and found no evidence the error continued beyond the audit period. There is no present evidence of this error.

Recommendation:

Kentucky must ensure that its eligibility system verifies applicants' identity and maintains identity-proofing documentation for the applicants.

Comments:

Kentucky DMS agrees. During the audit timeframe of October 2014 through March 2015, the system did not enforce Remote Identify Proofing (RIDP) for phone applications when completed. This allowed human error when state employees or contract employees did not complete RIDP as policy required. A

coding change, promoted on 12/9/15, no longer allows a user to complete a phone application for Financial Assistance programs without completing RIDP.

The state appreciates the opportunity to comment on your recommendations. We believe the issues identified have been successfully corrected. Thank you again for this opportunity.

Very Sincerely,

/Stephen P. Miller/

Stephen P. Miller, Commissioner
Department for Medicaid Services