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

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

Why OIG Did This Review

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.) California was one of 31 States, along with the District of Columbia, that chose to expand Medicaid coverage.

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

How OIG Did This Review

We reviewed a stratified random sample of 150 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 newly eligible group or other coverage groups (e.g., income, citizenship, and pregnancy requirements).

What OIG Found

For our sample of 150 beneficiaries, California made Medicaid payments on behalf of 112 eligible beneficiaries. However, for the remaining 38 beneficiaries, California made payments on behalf of ineligible beneficiaries (e.g., a woman who did not meet eligibility requirements for the newly eligible group because she was pregnant) and potentially ineligible beneficiaries (e.g., a beneficiary who may not have met the residency requirement). On the basis of our sample results, we estimated that California made Medicaid payments of $738.2 million ($628.8 million Federal share) on behalf of 366,078 ineligible beneficiaries and $416.5 million ($402.4 million Federal share) on behalf of 79,055 potentially ineligible beneficiaries. (These estimates represent Medicaid payments for fee-for-service, managed-care, the drug treatment program, and mental health services.) These deficiencies occurred because California's eligibility determination systems lacked the necessary system functionality and eligibility caseworkers made errors.

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 (1) redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries; (2) ensure its eligibility determination systems have the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements; and (3) develop and implement written policies and procedures, as appropriate. The "Recommendations" section in the body of the report lists in detail our recommendations.

California disagreed with our specific recommendation related to beneficiaries who may not have met the residency requirement. After reviewing information that California provided, we maintain that our recommendation is valid. California should have sent the beneficiary in our sample the required residency confirmation letter or taken action to verify residency when California identified that the beneficiary may have been receiving public assistance in another State. California agreed with our remaining recommendations and 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/region9/91602023.asp.