Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Pennsylvania Medicaid and CHIP Beneficiary Eligibility Determinations Audit

Audit Period: September 2019 through February 2020

Final Report

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Executive Summary

The Centers for Medicare & Medicaid Services' (CMS) conducted an audit of the Pennsylvania Department of Human Service's (hereinafter referred to as Pennsylvania) eligibility process. CMS' primary audit objective was to identify whether the State determined Medicaid and Children's Health Insurance Program (CHIP) eligibility at the point of application or re-determination in accordance with federal and state eligibility requirements and claimed the appropriate Federal Medical Assistance Percentage (FMAP) on behalf of these beneficiaries.

To meet the objectives of this beneficiary eligibility audit, CMS conducted in-depth reviews of eligibility determinations made by the State by examining individual cases, selected from samples, for compliance with federal and state rules and regulations. The audit period was September 2019 – February 2020. This report includes CMS' findings and recommendations, as well as observations, that were identified during the beneficiary eligibility audit.

Findings and Recommendations

Based on the results of this audit, Pennsylvania correctly determined general Medicaid, adult expansion, and CHIP eligibility in accordance with federal and state requirements each for 98 percent of the sampled beneficiaries. This audit also determined that, during the audit period, Pennsylvania's extrapolated improper and potentially improper eligibility determinations for the Medicaid, adult expansion, and CHIP populations resulted in $97,997,006, $51,682,572, and $8,284,201 (federal share), respectively, in improper and potentially improper payments. CMS's current statutory authority[1] only allows overpayments to be recovered through the Payment Error Rate Measurement Program (PERM), thus CMS is unable to recover the federal payments associated with the ineligible beneficiaries identified as a result of this audit.

For most eligibility determinations in the samples, Pennsylvania 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)). In general, Pennsylvania requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible[2] with electronic sources in accordance with the State's verification plan (§

[1] Section 1903(u) of the Social Security Act

[2] The term "reasonably compatible" refers to a federal requirement that prohibits states from requiring Medicaid applicants applying under Modified Adjusted Gross Income (MAGI) to provide documentation except in cases in which applicants' self-reported documentation was not reasonably compatible (a threshold determined by the state) with information in Government databases (§ 435.952(c)). In accordance with this requirement, if (a) an applicant attests to income above the applicable income standard and a data source shows it to be below the standard or (b) an applicant's attestation and electronic verification are both below the applicable standard, the state agency accepts the applicant's attestation. However, if an applicant attests to income below the applicable income standard and a data source shows it to be above the standard, the state applied its reasonable compatibility standard and potentially requests additional documentation. In Pennsylvania, an applicant's attestation of income is considered reasonably compatible if the difference between the attested income and electronic data verifications is within an amount no

435.952(c)(2)). Additionally, this audit found that Pennsylvania verified citizenship or immigration status by electronically verifying citizenship status with the SSA or immigration status with the Department of Homeland Security (DHS).[3] Pennsylvania also correctly determined beneficiaries' Medicaid eligibility for the correct aid category.

CMS identified seven recommendations for improvement as a result of this audit:

Recommendation #1: In accordance with §§ 435.601 and 435.602, Pennsylvania should ensure caseworkers are comprehensively trained countable resources and the associated resource limits when determining Medicaid eligibility for non-MAGI beneficiaries. The training should include the type(s) of resource documentation to be requested from applicants to verify assets, such as: checking, savings, money market, credit union, and certificates of deposit (CD) account statements; life insurance policies; deeds or appraisals for one's home and other real estate; copies of stocks and bonds; deeds to burial plots and copies of pre-paid funeral arrangements; annuities; IRAs; and 401(k) retirement accounts. Pennsylvania should also ensure caseworkers are consistent in using the Asset Verification System (AVS) in accordance with Section 1940(b)(2) of the Social Security Act.

Recommendation #2: In accordance with §§ 435.945, 435.948, 435.952, and 435.956(f), Pennsylvania should implement a continuing education plan or program that educates caseworkers on how to determine and define household compositions and correctly apply income to cases when determining eligibility. CMS also encourages the state to have supervisory checks in place to ensure that caseworkers are using the most current income available, when the Federal Data Services Hub (Data Hub) does not provide an assurance of financial eligibility, to make eligibility decisions and that they are verifying income and testing for reasonable compatibility as outlined in the state's verification plan.

Recommendation #3: In accordance with § 457.380(d), Pennsylvania should train caseworkers about the correct calculation and application of income to determine eligibility in the CHIP program.

Recommendation #4: In accordance with § 435.952, Pennsylvania caseworkers should be trained on how to utilize data from the SSA Earnings Reference File (ERF) when determining financial eligibility for applications and renewals for services, as well as alternative actions to take when reliable information is not available via the ERF. Caseworkers should use the most current income information available to make valid eligibility decisions. In the case of renewals, if the *ex parte* process does not confirm eligibility, Pennsylvania should follow the process of sending a renewal form directly to the enrollee for a response.

Recommendation #5: In accordance with § 435.406, Pennsylvania should train caseworkers on how to recognize qualified non-citizens (such as legal permanent residents or green card holders)

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more than 20 percent of 100 percent Federal Poverty Level (FPL) for a family of one. If the difference exceeds that threshold, the state agency requests manual verifications. (Pennsylvania MAGI-Based Eligibility Verification Plan).

[3] §§ 435.406 and 435.949. Citizenship and non-citizen eligibility, Verification of information through an electronic service. Retrieved August 10, 2021, from https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.4.435&rgn=div5

who have not met the five-year waiting period and are not eligible for full-scope Medicaid benefits but are eligible for Emergency Medical Assistance (EMA).

Recommendation #6: In accordance with §§ 435.406 and 435.407, Pennsylvania should have appropriate controls in place to ensure individuals are not determined eligible until all elements of eligibility such as citizenship,[4] date of birth and social security number, are verified.

Recommendation #7: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[5] Pennsylvania should perform an annual renewal of Medicaid and CHIP eligibility every twelve months to ensure beneficiaries maintain their eligibility.

[4] In accordance with Pennsylvania's SPA, cases can be opened for individuals who declare to be citizens or in satisfactory immigration status prior to the verification being received in other factors of eligibility are met.
[5] *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023* (SHO# 23-002), available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

Pennsylvania's Medicaid and CHIP Beneficiary Eligibility Determinations Audit

Background

The Comprehensive Medicaid Program Integrity Plan (CMIP) for Fiscal Years (FYs) 2019-2023 describes CMS' 5-year Medicaid program integrity strategy that aims to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools.[6] A key component of this strategy is conducting audits of Medicaid and CHIP beneficiary eligibility determinations.

CMS conducts in-depth reviews of eligibility determinations made by the State by examining individual cases, selected from samples, for compliance with federal and state rules and regulations during an established audit period. CMS identifies states for beneficiary eligibility audits by conducting a risk-based analysis informed by the review of State Plan Amendments proposing Medicaid and CHIP eligibility expansions; findings from other review programs; audits conducted by other entities such as the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), Government Accountability Office (GAO), and/or state auditors; and other sources. Through these audits, CMS identifies findings and related recommendations that will help states make proper eligibility determinations in the future. CMS also provides states with feedback and promising practices that may be used to enhance program integrity within the Medicaid and CHIP beneficiary eligibility determination process.

Overview of the Medicaid and CHIP Programs

Medicaid is a joint federal and state program that, together with CHIP, provides health coverage to over 77 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.[7]

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 individuals who are eligible under 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.[8]

CHIP builds on Medicaid's success, providing health coverage to uninsured children. States can use their federal CHIP funds to finance coverage for children whose family incomes are too high

[6] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[7] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2022, from https://www.medicaid.gov/medicaid/eligibility/index.html
[8] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2022, from https://www.medicaid.gov/medicaid/eligibility/index.html

to qualify for Medicaid. States may opt to use CHIP funds to expand Medicaid for children, cover children through a separate CHIP program, or combine the two approaches.

States operate and fund Medicaid and CHIP in partnership with the Federal Government. 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. The regular program FMAP varies by state and ranges from 50 to about 75 percent. Pennsylvania's regular Medicaid and CHIP FMAPs for the audit period (September 2019 through February 2020) were 59.16 percent and 82.91 percent, respectively. Congress authorized an enhancement to the regular FMAPs due to the COVID-19 Public Health Emergency, which increased Pennsylvania's Medicaid and CHIP FMAPs to 62.36 percent and 87.25 percent, respectively, for the portion of the audit period for January and February 2020.[9]

Medicaid and CHIP Coverage under the Affordable Care Act (ACA)

As of May 2023, 40 states, including the District of Columbia, elected to expand Medicaid coverage under the ACA to low-income adults.[10] Prior to the ACA, low-income, non-disabled, non-pregnant 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)(VII) of the Social Security Act (subsequently codified in regulation at 42 CFR § 435.119). These changes allowed states to 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 percent of the Federal Poverty Level (FPL).[11]

The ACA 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 generally considers taxable income and tax filing relationships to determine financial eligibility for Medicaid.[12] States must complete renewals once every 12 months and no more frequently than once every 12 months for groups based on MAGI.[13]

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[9] MACPAC FMAPS for Medicaid. Retrieved April 20, 2023, from https://www.macpac.gov/wp-content/uploads/2022/08/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-FMAPs-by-State-FYs-2020-2023-1.pdf

[10] Kaiser Foundation. Status of State Medicaid Expansion Decisions: Interactive Map. (November 9, 2022.) Retrieved November 10, 2022, from https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

[11] Section 1902(a)(10)(A)(i)(VII) 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 FPL.

[12] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2021, from https://www.medicaid.gov/medicaid/eligibility/index.html

[13] Regulations at 42 CFR § 435.916 describe the periodic renewal of Medicaid eligibility.

The ACA also provided enhanced FMAP for the adult expansion population. Beginning in 2020, the Federal Government funded 90 percent of allowable health care costs for the newly eligible adult population.[14] 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.

To promote program integrity when verifying eligibility while also minimizing the amount of paper documentation that applicants and beneficiaries need to provide, the ACA also required states to primarily rely on available electronic data sources to verify information included on the application (or conduct the renewal process), such as data from the SSA, the DHS, and the state Department of Labor.[15] Documentation or other information is requested when electronic data is unavailable or not reasonably compatible (i.e., consistent with electronic data) in accordance with a state's verification plan.[16] States are also able to accept self-attestation of some elements of eligibility when making determinations where the statute does not require other verification processes. States must also 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 known as *ex parte* renewals[17]).

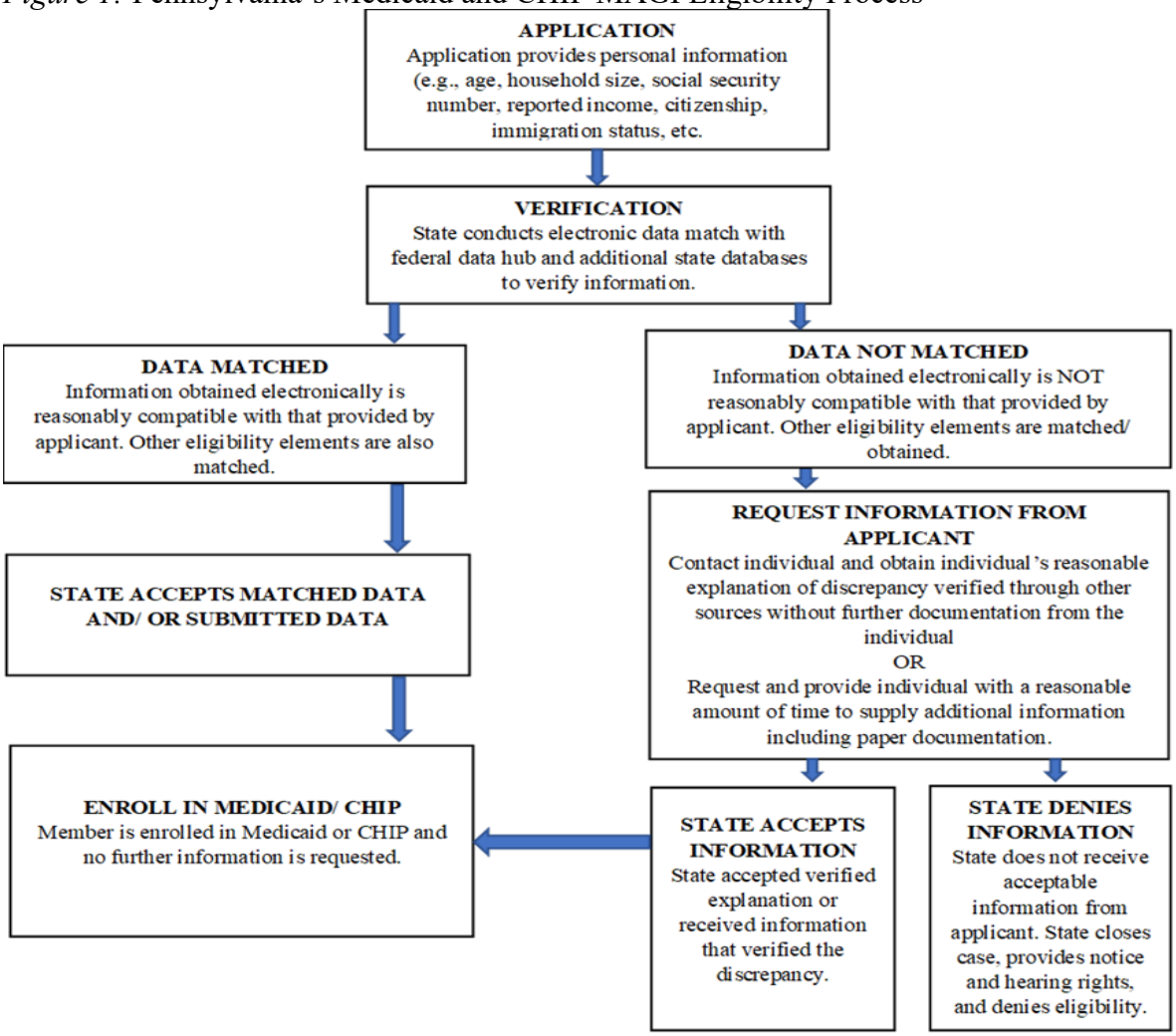
Regulations at §§ 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state. States must submit their verification plans to CMS upon request and provide updated versions of the plans to CMS if the state subsequently changes verification policies and procedures.

Overview of Pennsylvania's Medicaid and CHIP Eligibility Processes

Individuals seeking coverage may apply on-line, through a phone call, in person, or by mail. To verify eligibility for individuals who apply for coverage, Pennsylvania, or Pennsylvania's contracted managed care entities for CHIP eligibility, use multiple electronic data sources available through the Data Hub.[18] The data sources used by Pennsylvania through the Data Hub are provided by HHS, the SSA, the DHS, and the IRS, among others. Pennsylvania also uses data sources maintained by the state, such as the SWICA.

[14] 42 CFR § 433.10(c)(6).
[15] Regulations at 42 CFR §§§ 435.945, 435.948, and 435.956 describe income and eligibility verification requirement.
[16] Medicaid .gov. Keeping America Healthy. Medicaid / CHIP Eligibility Verification Plans. Retrieved August 11, 2021, from https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html
[17] 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.
[18] Pennsylvania MAGI-Based Eligibility Verification Plan. Retrieved October 13, 2022, from https://www.medicaid.gov/sites/default/files/2019-12/pennsylvania-verification-plan-template-final.pdf

Figure 1: Pennsylvania's Medicaid and CHIP MAGI Eligibility Process



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Overview of the Pennsylvania Medicaid and CHIP Eligibility Determinations Audit

In April 2022, CMS conducted an audit of Pennsylvania's general Medicaid, adult expansion population, and CHIP eligibility determinations for the audit period of September 2019 through February 2020.[20] During the audit, CMS identified a total of seven recommendations and six observations. This audit assessed how well Pennsylvania complied with Pennsylvania's MAGI verification plan as well as other federal regulatory requirements.

Pennsylvania's response to CMS' report can be found in Appendix D, and the final report reflects changes CMS made based on Pennsylvania's response.

[19] During the audit period, children enrolled in Medicaid and eligible for 12 months of continuous eligibility until the age of four; children enrolled in CHIP are eligible for 12 months of continuous eligibility regardless of age.
[20] The Audit Scope and Methodology can be found in Appendix A, the Statistical Sampling Methodology can be found in Appendix B, and the Medicaid and CHIP Sample Results and Estimates can be found in Appendix C.

The audit encompassed the following four areas:

A. <u>State Oversight of Eligibility Determinations.</u> CMS established requirements at § 431.10(c) that require the SMA to exercise appropriate oversight over the eligibility determinations and appeals decisions to ensure compliance with all relevant federal and state laws, regulations, and policies related to eligibility. Oversight includes, but is not limited to maintenance and content of eligibility records, such as those found under § 431.17, as well as any reporting requirements needed to facilitate such control and oversight. Additionally, §§ 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.

B. <u>Utilization of the Data Hub to Determine Financial Eligibility.</u> The Data Hub was created to verify financial information related to wages, net earnings from self-employment, and unearned income from the IRS and SSA.[21] States use state databases related to wages and unemployment compensation from SWICA and state unemployment insurance to verify more recent wage records or wage information, if necessary. The State may also request additional information or documentation from beneficiaries for a variety of reasons, including but not limited to attested income did not closely match verified income, verified assets exceeded what was attested, attested income was not reasonably compatible with electronic sources in accordance with the State's verification plan (§ 435.952(c)(2)).

C. <u>Non-Financial Elements of Eligibility.</u> The Data Hub also assists states in collecting non-financial eligibility criteria. Medicaid beneficiaries generally must be residents of the State in which they are receiving Medicaid. They must be either citizens of the United States or certain qualified non-citizens, such as lawful permanent residents (LPR) who have met the five-year bar. In addition, some eligibility groups are limited by age, or by pregnancy or parenting status. If the Data Hub does not provide sufficient information, the State must seek information from the beneficiary.

D. <u>Required Annual Renewals of Medicaid and CHIP Beneficiaries.</u> In accordance with § 435.916, periodic renewal of Medicaid eligibility, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, must be renewed once every 12 months, and no more frequently than once every 12 months. The State must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the State under §§ 435.948, and 435.956.

[21] Pennsylvania does not receive IRS data from the Data Hub. Any IRS data that Pennsylvania receives comes from SSA through the BENDEX Earnings Reference File (ERF) and is generally one to two years delayed. IRS data is not available for real time verifications and is not used in eligibility determinations.

Results of the Audit

Medicaid

General Population
Pennsylvania correctly determined general Medicaid eligibility in accordance with federal and state requirements for 98 percent of the sampled Medicaid beneficiaries. In the sample of 225 Medicaid beneficiaries, Pennsylvania correctly determined eligibility in accordance with federal and state requirements for 219 beneficiaries. CMS identified findings for four improper eligibility determinations in which Pennsylvania did not correctly determine eligibility in accordance with federal and state requirements. In addition, Pennsylvania did not provide sufficient documentation to support the eligibility determinations for four potentially ineligible beneficiaries. Because of a lack of supporting documentation, CMS could not definitively determine whether these four beneficiaries were eligible for Medicaid. CMS also identified several observations for instances in which eligibility was determined correctly for five beneficiaries although an error was made at some point during the eligibility process.

Of the universe of federal Medicaid payments totaling $6,098,534,780 made on behalf of 1,350,999 beneficiaries during the audit period, CMS' sample of 225 beneficiaries represented $18,591,563 in federal Medicaid payments. Based on the results of this audit, Pennsylvania made improper and potentially improper payments totaling $189,459 for the six sampled ineligible and potentially ineligible beneficiaries.[22] Extrapolating these errors to the entire Pennsylvania general Medicaid population, CMS estimates that during the audit period, Pennsylvania made federal Medicaid payments on behalf of an estimated 26,209 ineligible and potentially ineligible Medicaid beneficiaries, totaling an estimated $97,997,006 (federal share) in improper and potentially improper payments.

Adult Expansion Population
Pennsylvania correctly determined Medicaid adult expansion population eligibility in accordance with federal and state requirements for 98 percent of the sampled Medicaid beneficiaries. In the sample of 225 Medicaid adult expansion population beneficiaries, Pennsylvania correctly determined eligibility in accordance with federal and state requirements for 220 beneficiaries. CMS identified findings for five improper eligibility determinations in which Pennsylvania did not correctly determine eligibility in accordance with federal and state requirements. CMS also identified several observations for instances in which eligibility was determined correctly for five beneficiaries although an error was made at some point during the eligibility determination process.

Of the universe of federal Medicaid payments totaling $2,778,101,196 made on behalf of 932,013 beneficiaries during the audit period, CMS' sample of 225 beneficiaries represented $2,778,101,196 in federal Medicaid payments. Based on the results of this audit, Pennsylvania made improper and potentially improper payments totaling $498,624 for the five sampled ineligible and potentially ineligible beneficiaries.[23] Extrapolating these errors to the entire Pennsylvania adult expansion population, CMS estimates that during the audit period,

[22] Appendix C includes additional information on the improper payment calculations.
[23] Appendix C includes additional information on the improper payment calculations.

Pennsylvania made federal Medicaid payments for the adult expansion population on behalf of an estimated 15,554 ineligible Medicaid beneficiaries, totaling an estimated $51,682,573 (federal share) in improper payments.

CHIP

Pennsylvania correctly determined CHIP eligibility in accordance with federal and state requirements for 95 percent of the sampled CHIP beneficiaries. In the sample of 175 CHIP beneficiaries, Pennsylvania correctly determined eligibility in accordance with federal and state requirements for 168 beneficiaries. CMS identified findings for three improper eligibility determinations in which Pennsylvania did not correctly determine eligibility in accordance with federal and state requirements. In addition, Pennsylvania did not provide sufficient documentation to support the eligibility determinations for four potentially ineligible beneficiaries. Because of a lack of supporting documentation, CMS could not definitively determine whether these four beneficiaries were eligible for CHIP. CMS also identified an observation in which eligibility was determined correctly for two cases, but the monthly premium was assessed incorrectly.

Of the universe of federal CHIP payments totaling $219,839,379 made on behalf of 221,263 beneficiaries during the audit period, CMS' sample of 175 beneficiaries represented $171,916 in federal CHIP payments. Based on the results of this audit, Pennsylvania made improper and potentially improper payments totaling $4,975 for the seven sampled ineligible and potentially ineligible beneficiaries. [24] Extrapolating these errors to the entire Pennsylvania CHIP population, CMS estimates that during the audit period, Pennsylvania made federal CHIP payments on behalf of an estimated 11,909 ineligible and potentially ineligible CHIP beneficiaries, totaling an estimated $8,284,202 (federal share) in improper and potentially improper payments.[25]

Medicaid Findings

Findings are those errors where the State did not make an accurate eligibility determination based on eligibility application or renewal data for the case, consistent with federal requirements and the State's verification plan. The findings were largely caused by human and/or system errors. Findings result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Findings and recommendations for the four ineligible Medicaid beneficiaries are described below.

1. **The beneficiaries were not eligible for Medicaid because they were over the resource limit for eligibility.**

   1.A) An application was received via mail on August 5, 2019, for the coverage period of July 1, 2019, through June 30, 2020. The household of one declared monthly social security income of $806. An AVS match performed by the caseworker in July 2019 also verified a checking balance of $8,921.90, which would have caused the individual to be over the resource limit and therefore ineligible for Medicaid. The caseworker should have either disenrolled the beneficiary from Medicaid or referred the resource amount to

[24] Appendix C includes additional information on the improper payment calculations.
[25] Appendix C includes additional information on the improper payment calculations.

Pennsylvania's OIG for the pre-paid estate recovery program and kept the individual eligible for Medicaid.

Pennsylvania concurred with the finding. This appears to be a caseworker error.

Based on this error, total payments of $49,350.92 (federal share) were inappropriately paid for the sampled individual during the audit period.

1.B) An application was received on November 13, 2019, with a requested effective date of October 1, 2019.
The worksheet in the case record showed income of $1,996.01 and an incorrect resource amount of $5,840.64. The correct resource amount was $6,840.64. The beneficiary passed away on May 22, 2020.

Pennsylvania concurred with this finding. Subsequent to the audit, Pennsylvania identified an additional checking account with a balance of $13,288.55. With the addition of this asset the beneficiary should be determined ineligible. This appears to be a caseworker error.

Based on this error, total payments of $13,973.32 (federal share) were inappropriately paid for the sampled individual during the audit period.

1.C) The household of one mailed in a renewal for the Home and Community Based Services (HCBS) eligibility group. The renewal was received by Pennsylvania on October 10, 2018, for the coverage period of October 1, 2018, through September 30, 2019. The case was closed April 30, 2019, due to the beneficiary being over the resource limit. The beneficiary filed an appeal, which generated a new certification period of May 1, 2019, through April 30, 2020; however, no review of income or resources was performed by Pennsylvania for the new certification period.

Pennsylvania concurred with this finding. Pennsylvania agreed that no review of resources was performed prior to reopening the case after the appeal. The beneficiary was over the resource limit because OIG did not collect the beneficiary's excess resources for the pre-paid estate recovery. This appears to be a caseworker error.

Based on this error, total payments of $39,677.48 (federal share) were inappropriately paid for the sampled individual during the audit period.

Recommendation #1: In accordance with §§ 435.601 and 435.602, Pennsylvania should ensure caseworkers are comprehensively trained countable resources and the associated resource limits when determining Medicaid eligibility for non-MAGI beneficiaries. The training should include the type(s) of resource documentation to be requested from applicants to verify assets, such as: checking, savings, money market, credit union, and CD account statements; life insurance policies; deeds or appraisals for one's home and other real estate; copies of stocks and bonds; deeds to burial plots and copies of pre-paid funeral arrangements; annuities; IRAs; and 401(k) retirement accounts. Pennsylvania

should also ensure caseworkers are consistent in using the AVS in accordance with Section 1940(b)(2) of the Social Security Act.

2. **The beneficiary was not eligible for Medicaid coverage but may have been eligible for coverage under CHIP.**
   A beneficiary in the mandatory poverty level related (MPLR), children 6-18 eligibility group, had renewals that crossed two renewal periods during the audit period. The first renewal period was for the coverage period of December 1, 2018, through November 30, 2019, with a monthly income of $3,246.28. As a result, the beneficiary was correctly placed into MPLR 6-18.

   The second renewal was from December 1, 2019, through November 30, 2020. The renewal was mailed to the household on October 7, 2019. Because the household failed to return the form, Pennsylvania performed an *ex parte* review. Pennsylvania used Equifax to verify the household's income. Equifax provided income verification from the newest of November 22, 2019, to the oldest of October 25, 2019. Pennsylvania chose the oldest of the last four pay periods that was an average monthly income of $3,305.93. The most recent four pay periods verified an average monthly income of $6,283.89.

   Based on the most recent income, the beneficiary should have qualified for CHIP at 250 percent of the FPL instead of MPLR children 6-18.

   Pennsylvania concurred with this finding. Pennsylvania responded that the correct income information was indeed available to the caseworker at the time of the audit. This appears to be a caseworker error.

   Based on this error, total payments of $1,395.12 (federal share) were inappropriately paid for the sampled individual during the audit period.

   Recommendation #4: In accordance with § 435.952, Pennsylvania caseworkers should be trained on how to utilize data from the ERF when determining financial eligibility for applications and renewals for services, as well as alternative actions to take when reliable information is not available via the ERF. Caseworkers should use the most current income information available to make valid eligibility decisions. In the case of renewals, if the *ex parte* process does not confirm eligibility, Pennsylvania should follow the process of sending a renewal form directly to the enrollee for a response.

Potential Medicaid Findings

Potential findings represent the class of errors in which the State could not provide enough supporting documentation to determine whether the beneficiary was eligible. Potential findings result in potentially ineligible beneficiaries and potential improper payments. Potential findings result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Potential findings and recommendations for the two potentially ineligible Medicaid beneficiaries are described below.

1. **The beneficiary was potentially ineligible for Medicaid because they were over the resource limit for eligibility.**
   The resource worksheet in the case record indicated $2,266.12 in resources and monthly income of $1,338.60 for the audit period. A review packet for long term care services was mailed to the beneficiary on February 5, 2019, but not returned. Subsequently, the caseworker processed an *ex parte* review using the system to verify eligibility.

   No reported documents were scanned. Resources were not verified by the AVS. Social Security income of $1,182 per month was verified on March 29, 2019.

   Pennsylvania concurred with this finding. They agreed that there were no documents in imaging for this renewal and there appeared to be no other documented verification of resources. This appears to be a caseworker error.

   Based on this error, total payments of $16,911.95 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

   Recommendation #1: In accordance with §§ 435.601 and 435.602, Pennsylvania should ensure caseworkers are comprehensively trained countable resources and the associated resource limits when determining Medicaid eligibility for non-MAGI beneficiaries. The training should include the type(s) of resource documentation to be requested from applicants to verify assets, such as: checking, savings, money market, credit union, and CD account statements; life insurance policies; deeds or appraisals for one's home and other real estate; copies of stocks and bonds; deeds to burial plots and copies of pre-paid funeral arrangements; annuities; IRAs; and 401(k) retirement accounts. Pennsylvania should also ensure caseworkers are consistent in using the AVS in accordance with Section 1940(b)(2) of the Social Security Act.

2. **The renewal for the HCBS beneficiary was absent from September through November 2019.**
   CMS was not able to locate documentation in the case file to support the months of the September, October, and November 2019 renewal. Because the beneficiary was deceased, it was difficult for state staff to find documentation on the renewal; renewals for deceased beneficiaries were maintained within the legacy system and were difficult to retrieve.

   The HCBS beneficiary passed away after our audit period. The only reported income during the period was $1,674.42 monthly from Social Security, and resources were $2,230.44. Based upon the attested information, the beneficiary would potentially have been eligible.

   Pennsylvania did not concur with this finding. However, Pennsylvania did not provide verification of income or resources for September, October, or November of 2019. This appears to be a caseworker error.

Based on this error, total payments of $68,149.89 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period for the months of September through November 2019.

Recommendation #7: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[26] Pennsylvania should perform an annual renewal of Medicaid and CHIP eligibility every twelve months to ensure beneficiaries maintain their eligibility.

Medicaid Observations

During the course of the audit, other issues were identified in the sampled cases that do not represent an error to the State because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Observations and recommendations for the five beneficiaries are described below.

1. **Pennsylvania did not sufficiently act on any controls to reduce documented resources or close out accounts with no resource balances that could cause beneficiaries to appear ineligible.**
   A renewal for long term care services was received on December 13, 2019. The beneficiary declared fifty percent ownership in both a checking and savings account in the amount of $2,053.96. The last verification of the joint savings account was on October 31, 2018. Although this did not affect eligibility in this case, the lack of verification of accounts, as well as the failure to remove accounts from case records, could have resulted in other financial eligibility outcomes in other cases.

   Pennsylvania did not concur with this observation. Pennsylvania responded that the joint savings account was closed, and the last verified balance on the account as of November 2018 was only $285.08, and therefore, would not have made an eligibility difference. However, Pennsylvania did not provide documentation to support either the current amount of the account at the time of the audit, the closure date, or where the funds were dispersed. Pennsylvania also responded that the account was not removed from the eCIS. This appears to be a caseworker error.

   Recommendation #1: In accordance with §§ 435.601 and 435.602, Pennsylvania should ensure caseworkers are comprehensively trained countable resources and the associated resource limits when determining Medicaid eligibility for non-MAGI beneficiaries. The training should include the type(s) of resource documentation to be requested from applicants to verify assets, such as: checking, savings, money market, credit union, and CD account statements; life insurance policies; deeds or appraisals for one's home and other real estate; copies of stocks and bonds; deeds to burial plots and copies of pre-paid funeral arrangements; annuities; IRAs; and 401(k) retirement accounts. Pennsylvania

[26] *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023* (SHO# 23-002), available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

should also ensure caseworkers are consistent in using the AVS in accordance with Section 1940(b)(2) of the Social Security Act.

2. **Although the beneficiaries would have remained eligible, Pennsylvania did not use all available income when determining eligibility.**

2.A) A beneficiary in the MPLR children ages 6-18 eligibility group had renewals that crossed two renewal periods during the audit period.

The household of five initially applied for coverage on February 27, 2019, for the coverage period of February 27, 2019, through January 31, 2020.

In June of 2019, the household size was reduced to four because one child aged out of coverage under their parents' umbrella. No income was declared for Wage Earner #1. Wage Earner #2 reported self-employment income of $1,150 monthly for rental property. A case note from March 8, 2019, states current monthly income from two rental properties as $650 and $500. In June 2019, Pennsylvania was only counting $650 of the rental income. On July 30, 2019, Wage Earner #1 reported they began work. Three recent paystubs verifying a monthly income of $1,720.32 were provided. The new total new monthly income of $1,720.32 plus the rental income of $1,150 totaled $2,870.32.

A second renewal was mailed by Pennsylvania on December 13, 2019, and was returned on January 10, 2020, for the coverage period of February 1, 2020, through January 31, 2021. The renewal was processed on March 2, 2021, more than a year after the renewal was received by Pennsylvania.

Although the lack of inclusion of all income did not affect the eligibility for this beneficiary, the lack of Pennsylvania including all income and processing the renewal timely could affect the eligibility of other beneficiaries.

Pennsylvania concurred with this observation. This appears to be a caseworker error.

2.B) The household of one completed an online renewal for HCBS on July 1, 2019. This was for the coverage period of August 1, 2019, through July 31, 2020. On a prior renewal from June 15, 2018, the beneficiary declared no resources, monthly social security income of $1,202, and court ordered support of $583.33 each month. The review conducted in 2019 was *ex parte* and the court ordered support had been removed. Nothing in the system shows the court ordered support had ended. Pennsylvania had an opportunity to provide additional documentation demonstrating the court ordered support had been removed. While this did not financially affect eligibility for this case, it could have resulted in other financial eligibility outcomes in other cases. This appears to result from caseworker error.

Pennsylvania did not concur with this observation. Pennsylvania indicated that while there was no documentation of the support ending, the CAO has access to PACSES and may have used that for documentation, even though it was not imaged or narrated.

2.C) An application for the low-income family's category was received on August 24, 2019, for the coverage period of August 2019, through August 2020 for the household of three. The adult grandchild was a tax dependent of the grandparents. No income was declared for Wage Earner #1 or the adult child. Wage Earner #2 received unemployment checks of $924 bi-weekly. Pennsylvania erroneously coded $900 bi-weekly.

Although the lack of inclusion of all income did not affect the eligibility of this beneficiary, the lack of due diligence on the part of Pennsylvania could affect the eligibility of other beneficiaries.

Pennsylvania concurred with this observation. This appears to be a caseworker error.

Recommendation #2: In accordance with §§ 435.945, 435.948, 435.952, and 435.956(f), Pennsylvania should implement a continuing education plan or program that educates caseworkers on how to determine and define household compositions and correctly apply income to cases when determining eligibility. CMS also encourages Pennsylvania to have supervisory checks in place to ensure that caseworkers are using the most current income available, when the Data Hub does not provide an assurance of financial eligibility, to make eligibility decisions and that they are verifying income and testing for reasonable compatibility as outlined in Pennsylvania's verification plan.

3. **The beneficiaries' case files did not contain the required non-financial elements of eligibility.**
   The beneficiary submitted a renewal on August 8, 2019, for the coverage period of September 1, 2019, through August 31, 2020. The beneficiary had a household size of four with a date of birth of May 31, 2016. The household had monthly income of $1,636 from verified unemployment. No verification of citizenship, date of birth or social security number for the beneficiary was in the case record as of the date of the audit. The beneficiary was enrolled in MPLR children 1-5.

   Pennsylvania concurred with this observation. Pennsylvania responded that the only document found in the case record for the beneficiary was a social security card dated as received November 11, 2021. While there is no discrepancy with the data processed by DHS and SSA, the match results were not received until January 13, 2022. This appears to be a caseworker error.

   Recommendation #6: In accordance with §§ 435.406 and 435.407, Pennsylvania should have appropriate controls in place to ensure individuals are not determined eligible until all elements of eligibility such as citizenship, date of birth and social security number, are verified.

Adult Expansion Population Findings

Findings are those errors where the State did not make an accurate eligibility determination based on eligibility application or renewal data for the case, consistent with federal requirements and the State's verification plan. The findings were largely caused by human and/or system errors. Findings result in recommendations that will ensure the state comes into compliance with

federal requirements and the State's verification plan. Findings and recommendations for the five eligible adult expansion population beneficiaries are described below.

1. **The beneficiaries were over the income limit for the adult expansion program.**

   1.A) The household of two made an application on February 19, 2019, and declared no income. The Wage Earner stated on the application their last day of employment was within the last 30 days of this application.

   The caseworker should have requested verification of the last day of employment, the date and amount of the last pay from this employment. Case comments on February 20, 2019, show that the Wage Earner had applied for another job and would report if employment began. The Wage Earner received their first pay on March 21, 2019, and was required to report the change by April 10, 2019. The Wage Earner did not report the income from the new job. Wages from this job were not counted against the case until July 3, 2019. The case comments state at that time the household was over the income limit.

   Pennsylvania concurs with the finding. Payments continued to be paid on behalf of the beneficiary during our audit period of September 1, 2019, through February 29, 2020. This appears to be a caseworker error.

   Based on this error, total payments of $2,410.51 (federal share) were inappropriately paid for the sampled individual during the audit period.

   1.B) The household of five had an *ex parte* renewal on August 29, 2019. The household declared income of $2,250, verification of this income was a letter from the employer from January 27, 2015. No other verification was requested or received. The renewal was processed using the 2015 monthly income of $2,250. Pennsylvania attested that the income was not matched against the Data Hub.

   Pennsylvania concurred with the finding. This appears to be a caseworker error.

   Based on this error, total payments of $5,421.46 (federal share) were inappropriately paid for the sampled individual during the audit period.

   1.C) An auto-renewal was completed on May 10, 2019, for the coverage period of June 1, 2019, through May 31, 2020, for the household of four, two parents, the beneficiary (an adult child), and a sibling. Each year the system completed an auto-renewal as no changes were reported.

   The wage match from October 5, 2019, for tax years of 2018 and 2019, showed the beneficiary had earnings from an out of state employer. Wage Earner #1 had earnings in the first and second quarters of 2019. The wage match also verified Wage Earner #2 had earnings in 2018 and in 2019. None of these earnings were ever reported nor did the agency verify income at each renewal.

In 2019 the household had combined earnings of $70,278.51, or 273 percent of the Federal Poverty Level. None of these earnings were reported by the household nor did the agency verify income at each renewal. The beneficiary would not have been eligible for the adult expansion program for the coverage period of June 1, 2019, through May 31, 2020, based on the annual earnings in 2019 that began in 2018.

Pennsylvania did not concur with the finding. Pennsylvania responded they were unclear as to where the reviewers found the income information. During the audit, state staff guided the auditors through the wage match website, where the income information was disclosed. This appears to be a caseworker error due to a lack of research into available wage matches.

Based on this error, total payments of $2,700.23 (federal share) were inappropriately paid for the sampled individual during the audit period.

Recommendation #4: In accordance with § 435.952, Pennsylvania caseworkers should be trained on how to utilize data from the ERF when determining financial eligibility for applications and renewals for services, as well as alternative actions to take when reliable information is not available via the ERF. Caseworkers should use the most current income information available to make valid eligibility decisions. In the case of renewals, if the *ex parte* process does not confirm eligibility, Pennsylvania should follow the process of sending a renewal form directly to the enrollee for a response.

2. **The beneficiaries were qualified non-citizens who had not met the five-year waiting period and were not eligible to be enrolled in full-scope benefits, only episodic care and whose coverage was not eligible to be matched at the higher adult expansion FMAP.**

2.A) The beneficiary, an undocumented citizen, was processed for EMA through a Medical Assistance provider application. The application was submitted on April 23, 2020, requesting EMA for the beneficiary. The EMA Medical Review Team approved EMA for a coverage period of November 6, 2019, through February 10, 2020. The date of first admission for treatment was November 6, 2019.

The application was not received by Pennsylvania until April 23, 2020, almost six months after the first date of treatment. The application was backdated for these six months rather than three as allowable by federal regulation.[27]

As an undocumented citizen, the beneficiary was not eligible to enroll into coverage. EMA is not an entitlement program, and therefore, does not provide continual coverage. EMA is also not considered minimal essential coverage (MEC). EMA is episodic. The EMA Medical Review Team approved a coverage period of November 6, 2019, through February 10, 2020. Continued coverage beyond February 10, 2020, would

[27] 42 CFR § 435.915. Effective Date. Retrieved October 29, 2022 from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR2b847721e0bfa03/section-435.915

require another application and another decision by the EMA Medical Review Team to determine medical eligibility for EMA and the coverage period.

Additionally, EMA should be funded through Medicaid at the regular FMAP, rather than the enhanced funding of adult expansion.

In Pennsylvania's response, they did not address the section of the finding concerning the backdating of the application for more than three months in their response. Pennsylvania's response centered on the potential loss of the enhanced federal funding if Pennsylvania disenrolled the individual from coverage; however, an individual receiving EMA is not considered an enrolled beneficiary.

This appears to be a caseworker error.

Based on this error, total payments of $4,833.34 (federal share) were inappropriately paid for the sampled individual during the audit period.

2.B) The beneficiary was an LPR who had not yet met the five-year bar. The household of four consisted of Wage Earner #1 (beneficiary), Wage Earner #2, and two children. On October 25, 2019, the hospital applied EMA from June 25, 2019, to indefinite. A second application was submitted on December 31, 2019, for a hospital admission date of November 29, 2019.

The caseworker should have requested a reasonable explanation of the discrepancy between the reported income of $2,279.00 for Wage Earner #2 and the verified income of $3,070.04. Although Wage Earner #1 did not start employment until November 2019, based on Wage Earner #2's income, verification should have been requested as reasonable compatibility did not exist. It does not appear the case worker, on October 25, 2019, requested any verification of income when processing the EMA beginning June 25, 2019. The income limit for a household of four was $2,854.00 per month.

The reviewers also observed that EMA coverage was given on an indefinite basis. The case should have been reviewed at certain intervals to establish the need for ongoing care.

Additionally, the beneficiary was placed incorrectly into adult expansion. As an LPR yet to meet the five-year bar, the beneficiary was not eligible to enroll into coverage. EMA is not an entitlement program, and therefore, does not provide continual coverage. EMA is also not considered MEC. EMA is episodic.

Pennsylvania concurs with the finding. Pennsylvania agrees income verification should have been requested as reasonable compatibility did not exist based on the attested income on the application versus data sources. Pennsylvania did not address the misplacement of the case into adult expansion, at the higher FMAP. This appears to be a caseworker error.

Based on this error, total payments of $8,258.67 (federal share) were inappropriately paid for the sampled individual during the audit period.

Recommendation #5: In accordance with § 435.406, Pennsylvania should train caseworkers on how to recognize qualified non-citizens (such as legal permanent residents or green card holders) who have not met the five-year waiting period and are not eligible for full-scope Medicaid benefits but are eligible for EMA.

Adult Expansion Observations

During the course of the audit, other issues were identified in the sampled cases that do not represent an error to the State because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Observations and recommendations for the four adult expansion population beneficiaries are described below.

1. **Incomes and household sizes were not verified or calculated correctly when determining eligibility.**

   1.A) The caseworker did not use the full income amount for the eligibility calculation for the coverage period of October 2018 through November 2019. In addition, the beneficiary should have remained part of the household they were previously in, as they were claimed by their parents again in 2019 as tax dependents. The beneficiary should not have been in a household size of one, it should have remained in a household size of four.

   The case was closed November 7, 2019, and re-opened on November 8, 2019. Self-employment annual income for the Wage Earner was $11,662.92. The household of four's adjusted gross income was $25,429. Processed on December 12, 2019, the November 8, 2019, application reopening was for a household of one with a monthly income of $1,088.26. The new application stated that the beneficiary was claimed by their parents and therefore should be a household of four again. Although this particular case did not cause this beneficiary to become ineligible, the lack of due diligence could potentially cause issues with other cases.

   Pennsylvania concurs with this observation. This appears to be a caseworker error.

   1.B) A renewal for the household of one was received on June 4, 2019. The beneficiary declared no income. The Department of Labor (DOL) verified $2,802.50 from the first quarter of 2019, a monthly income of $934.17. Pennsylvania indicated the income was also verified by IEVS and even though reasonable compatibility was not met, no additional follow up was requested by Pennsylvania. The beneficiary would have remained eligible even though the verified income was greater than the declared income. Although this particular case did not cause this beneficiary to be ineligible, the lack of due diligence could potentially cause issues with other cases.

   Pennsylvania concurs with this observation. This appears to be a caseworker error.

1.C) The household of five submitted a renewal on July 22, 2019, declaring monthly income of $2,995.16, verified by paystubs from January 2019. There was a more current wage match performed by Pennsylvania on June 10, 2019, that verified DOL quarterly income of $10,045.60 or $3,348.53 monthly, 133 percent of the FPL. The case worker used paystubs from January 2019 rather than the more current income information, to verify income for a July 2019 renewal. Although this particular case did not cause the beneficiary to be ineligible, the lack of due diligence could potentially cause issues with other cases.

Pennsylvania partially concurred with the observation. Pennsylvania stated that, "January 2019, income was used but pre-tax deductions were not. Current income from the last 60 days is to be used; however, the recipient is still considered to be eligible." This appears to be a caseworker error.

1.D) In the case note computation pages, the incomes were under the wrong family members. Also, the beneficiary was old enough to be on their own case and not under their parent's.

On the renewal received on February1, 2019, Pennsylvania put the income of the beneficiary on the sixteen-year-old sibling and the parent's income on the fifteen-year-old sibling. The parent does not claim the beneficiary as a tax dependent. The beneficiary should have been in a case by them self instead of in the parent's household. The beneficiary provided an unemployment compensation letter for $332 bi-weekly. The beneficiary would be eligible for adult expansion whether they were included in the parent's household or not. Although this caseworker error did not cause this beneficiary to be ineligible, the issue could potentially impact other cases.

Pennsylvania did not concur that this observation was an error but did concur that the income on the case was coded incorrectly and that the beneficiary should have been in their own case. This appears to be a caseworker error.

Recommendation #2: In accordance with §§ 435.945, 435.948, 435.952, and 435.956(f), Pennsylvania should implement a continuing education plan or program that educates caseworkers on how to determine and define household compositions and correctly apply income to cases when determining eligibility. CMS also encourages Pennsylvania to have supervisory checks in place to ensure that caseworkers are using the most current income available, when the Data Hub does not provide an assurance of financial eligibility, to make eligibility decisions and that they are verifying income and testing for reasonable compatibility as outlined in Pennsylvania's verification plan.

CHIP Findings

Findings are those errors where the State did not make an accurate eligibility determination based on eligibility application or renewal data for the case, consistent with federal requirements and the State's verification plan. The CHIP findings were largely caused by human and/or

system errors. Findings result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Findings and recommendations for the seven ineligible CHIP beneficiaries are described below.

1. **The individuals were over income and not eligible for the CHIP program.**

   1.A) The household of four completed an online renewal on November 17, 2019, for the coverage period of October 1, 2019, through September 30, 2020. The household declared an annual income of $70,382.54.
   Income for Wage Earner #1 was verified, (self-employment $85,974.00 and rental property loss $10,728.00). The self-employment tax deduction, $6,074.00, for Wage Earner #1 was not verified. Wage Earner #2 declared an annual income of $1,210.54. Pennsylvania provided one paystub for Wage Earner #2 calculating $26,850.00 annually, $2,237.50 monthly, as of September 21, 2019.

   Additionally, no verification of the self-employment tax deduction for Wage Earner #1 was provided. This changes the net income to $102,096.00, (FPL of 396 percent). With the increased income from Wage Earner #2, the beneficiary was over the income standard of $80,885.00.

   Pennsylvania concurred with this finding. Pennsylvania confirmed Wage Earner #2's income was incorrectly added in the system and as a result the family's income would place them into the At-Cost level, rather than the jointly funded CHIP. The At-Cost/ Full-Cost CHIP coverage is a state benefit with no federal share. This appears to be a Managed Care Organization (MCO) error.

   Based on this error, total payments of $1,006.53 (federal share) were inappropriately paid for the sampled individual during the audit period.

   1.B) Pennsylvania received a renewal in the mail on March 25, 2019, for the coverage period of May 1, 2019, through April 30, 2020. The household of four declared annual income of $77,819.44. Pennsylvania/the MCO indicated verification of self-employment income of $77,819.44.

   Income documentation was requested from Pennsylvania/the MCO. Paystubs verified $1,732.00 every two weeks. Pennsylvania attested that the other income listed did not match the income on the IRS Form 1040 or other supporting schedules.

   Pennsylvania concurs with this finding. Pennsylvania believes the MCO failed to correctly input the accurate income information into the eligibility system and as a result, placed the beneficiary into CHIP rather than into the state funded At-Cost program. The At-Cost/Full-Cost CHIP coverage is a state benefit with no federal share. This appears to be an MCO error.

   Based on this error, total payments of $829.23 (federal share) were inappropriately paid for the sampled individual during the audit period.

1.C) The online application was received by Pennsylvania on July 16, 2019, for the coverage period of August 1, 2019, through July 31, 2020. The household of four declared income of $97,910.00. Gross earned income was $65,027.04 for the beneficiary's parents, verified through the County Administrative Office (CAO.) The gross unearned income was $35,295.00; this was also verified through the CAO. The total earned and unearned income totaled $100,322.04.

There were eight deductions attached, of which $17,550.00 was for self-employment. The total number of deductions on the eligibility explanation was $19,962.00, which included the eight deductions that were entered in July 2019 and one from July 2018. There was only one deduction for 2018 (all the others were for previous years), which totaled $2,412.00 annually. The correct income total was $100,322.04 with a deduction of $2,412.00, which equals $97,910.04 (FPL of 380 percent). The income range for a family of four is $74,160.01-$80,855.00. The beneficiary income appears to be $17,055.04 over the limit.

Pennsylvania explained this case was a "Healthcare Handshake" from the CAO. Furthermore, according to Pennsylvania they "cannot find any information regarding the large number of deductions used in the CHIP eligibility review from the MCO or the CAO." Pennsylvania agrees that the beneficiary's supported income would place them into the state only At-Cost level rather than the federal/state jointly funded CHIP program. The At-Cost/ Full-Cost CHIP coverage is a state benefit with no federal share.

Pennsylvania concurred with this finding. This appears to be a CAO/MCO error.

Based on this error, total payments of $780.78 (federal share) were inappropriately paid for the sampled individual during the audit period.

1.D) The household of five completed an online renewal on November 16, 2018, for the coverage period of December 1, 2018, through November 30, 2019. Annual attested income of $49,229.04 was verified. The upper income limit for a family of five was $64,272.

The beneficiary had no coverage, and no CHIP payments were made on behalf of the beneficiary, for the month of December 2019.

The second renewal was also received online. It was received on January 27, 2020, for the coverage period of January 1, 2020, through December 31, 2020. The household attested to income from two sources, $1,544.52 received every two weeks and the other $937.94 received every other week. Using Pennsylvania's income factoring.[28] this totals

[28] Pennsylvania's income factoring for CHIP if based on 48 pays if paid weekly, 24 pays, if paid biweekly or bimonthly if not an employee of school district, 22 pays for employees for employees of school districts who only receive earned income during the ten-month salary during the full calendar year, then 24 biweekly pays would apply. Twelve pays if paid monthly.

$59,544 annually. Income documentation was requested from the MCO; however, no documentation was received.

According to Pennsylvania, the MCO verified the paystub information in the system but did not provide the documentation in which to support the income, resulting in the error. This appears to be an MCO error.

Based on this error, total payments of $306.34 (federal share) were inappropriately paid for the sampled individual during the audit period for January and February 2020.

1.E) The household of three completed an online renewal on September 26, 2018, for the coverage period of October 1, 2018, through September 30, 2019. The household declared annual income of $39,006.00. The case record states the income was verified but does not document how verification was completed. Declared income was under the limit for CHIP eligibility of $45,432.

The second review period began as an online renewal received on September 26, 2019, for the coverage period of October 1, 2019, through September 30, 2020. Income of $51,050.64 stated it was verified by the MCO. Income was not under the limit of $46,260 for CHIP eligibility for a household of three. Income documentation was requested from the MCO; however, documentation was not received.

Pennsylvania explained that the income for this case was verified through electronic sources, Equifax, and the Department of Labor & Industry (DLI), at the time of the 2018 and 2019 review dates. The issue was due to the MCO not keeping electronic verification sources; the CHIP office has been working to resolve this since 2019. This appears to be a system and MCO issue.

Based on this error, total payments of $655.68 (federal share) were inappropriately paid for the sampled individual during the audit period.

1.F) Pennsylvania received the mailed-in renewal form on October 19, 2018, for the coverage period of November 1, 2018, through October 31, 2019. The household of four declared annual income of $70,009.44, of which $39,841.20 was self-employment income.

The second review was also from a mailed-in renewal form that was received by Pennsylvania on October 14, 2019, for the coverage period of December 1, 2019, to November 1, 2020. The household declared $66,684.56 in income, $35,441.00 of which was self-employment.

The self-employment income for both review periods was verified by the MCO using a document that the Wage Earner ultimately wrote out on a sheet of paper. Based on the amount of income the household made, the family would have been required to file federal taxes. Federal taxes would require the self-employed Wage Earner to report income and expenses related to self-employment on schedule SE. The tax return would

be a more reliable document for Pennsylvania to review when verifying income as opposed to a handwritten note.

Pennsylvania concurred with the findings of this error indicating the following, "the CHIP MCO incorrectly used the handwritten "profit and loss statement" and should have received the family's tax return." This appears to be an MCO error.

Based on this error, total payments of $634.92 (federal share) were inappropriately paid for the sampled individual during the audit period.

1.G) The household of nine submitted an online renewal on May 14, 2019, for the coverage period of June 1, 2019, through May 31, 2020. The household declared income of $107,642.00 from three sources. Pennsylvania/the MCO verified income from two sources but not the one for $4,400.00 monthly or $52,800.00 annually. The income limit for a household of nine was $152,641.15. Pennsylvania/the MCO did not provide any documentation to be reviewed by the CMS reviewers.

Pennsylvania responded with the following: "The MCO did not provide paystubs for the May 14, 2019, case determination. The MCO stated that they did receive all required employment/income statements on April 23, 2019, based on the comments in the system".

Pennsylvania concurred with the error finding because the MCO did not provide the income documentation. This appears to be an MCO error.

Based on this error, total payments of $761.99 (federal share) were inappropriately paid for the sampled individual during the audit period.

Recommendation #3: In accordance with § 457.380(d), Pennsylvania should train caseworkers about the correct calculation and application of income to determine eligibility in the CHIP program.

CHIP Observations

During the course of the audit, other issues were identified in the sampled cases that do not represent an error to the State because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Observations and recommendations for the two CHIP beneficiaries are described below.

1. **The CHIP beneficiaries were potentially charged the incorrect premium amounts because Pennsylvania/the MCO did not always verify and/or use the correct income amounts when calculating premiums.**

1.A) An online renewal dated January 24, 2019, was submitted to Pennsylvania for the coverage period of March 1, 2019, through February 29, 2020. The household of four declared income from two sources, for a total of $39,231.12 annually. Records indicate that Pennsylvania/the MCO verified both sources, $21,665.02 and $20,835.36 respectively, for a total of $42,500.38.

However, upon request, documentation from only one income source was produced for review and CMS was unable to replicate financial eligibility due to this missing documentation. Based on what the MCO verified, the beneficiary would have retained eligibility for CHIP; only the premium amount would have changed to a zero amount.

Pennsylvania concurs with this observation. This appears to be a caseworker error.

1.B) The household of four completed an online renewal dated March 27, 2019, for the coverage period of April 1, 2019, through March 31, 2020. The case record indicated an annual income of $55,575, less a student loan deduction of $356.00 annually for a net of $55,219. Documents were provided by the MCO to verify income. Verified documents totaled $63,188, with the student loan deduction of $356, for net income of $62,832. The premium should have been $53.00 for the beneficiary instead of no premium.

Pennsylvania did not concur with this observation. Pennsylvania explained that they believed that the MCO correctly calculated the household income because they used more current information such as recent paystubs. The auditors used the information that was made available at the time of audit, which was income information in the case file. More recent paystubs were requested but not provided, therefore, CMS relied on the information made available at the time of the audit. This appears to be an MCO error.

Recommendation #3: In accordance with § 457.380(d), Pennsylvania should train caseworkers about the correct calculation and application of income to determine eligibility in the CHIP program.

Appendix A: Audit Scope and Methodology

Scope

CMS' audit covered Medicaid and CHIP beneficiaries who received services from Pennsylvania for the period of September 1, 2019, through February 28, 2020 (audit period). While all CHIP beneficiaries were in the population, Medicaid enrollees in the following Medicaid eligibility categories were included in the audit population:

Program or Category of Service	Basis of Eligibility
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules	Non-MAGI
Individuals in Institutions Eligible under a Special Income Level	Non-MAGI
Independent Foster Care Adolescent	Non-MAGI
Medically Needy Populations based on Age, Blindness, or Disability	Non-MAGI
Low Income Families	MAGI
Mandatory Poverty Level Related Pregnant Woman	MAGI
Mandatory Poverty Level Related Children Infants	MAGI
Mandatory Poverty Level Related Children 1-5	MAGI
Mandatory Poverty Level Related Children 6-18	MAGI
Adult Expansion	MAGI

CMS limited the review of internal controls to those surrounding the determinations and/or redeterminations of applicant eligibility for Medicaid and CHIP beneficiaries. The testing of controls included a review of supporting documentation at the state agency to evaluate whether the State determined the applicants' eligibility in accordance with federal and state requirements.

CMS performed fieldwork remotely through secure, on-line data reviews of eligibility information from the State with the assistance of the Pennsylvania Department of Health and Human Services employees.

Methodology

To accomplish the objective, CMS:

- Reviewed applicable federal and state laws, regulations, and other requirements related to Medicaid and CHIP eligibility, including Pennsylvania's Medicaid eligibility verification plan.
- Selected a stratified random sample of 225 Medicaid beneficiaries, 225 adult expansion population beneficiaries, and 175 CHIP beneficiaries from a total of 1,350,999, 932,013 and 221,263 beneficiaries, respectively, who were determined or redetermined to be eligible during the audit period.
- Obtained application data and documentation to verify the Medicaid, adult expansion population or CHIP eligibility of each sampled beneficiary.
- Analyzed the State's documentation supporting beneficiaries' eligibility.

- Estimated the total number of payments made during the audit period on behalf of actual and potentially ineligible beneficiaries and the dollars associated with those payments.
- Calculated an eligibility error rate for both the number of payments and the dollar amounts for both actual and potentially ineligible beneficiaries.

Appendix B: Statistical Sampling Methodology

Target Population

The target population consisted of beneficiaries determined eligible and enrolled in the general Medicaid, adult expansion, and CHIP populations, excluding American Indians and Alaskan Natives, for whom the State made general Medicaid, adult expansion population, or CHIP payments for services provided during the audit period.

Sampling Frame

The general Medicaid sampling frame consisted of an Access database containing 1,350,999 general Medicaid beneficiaries in Pennsylvania for whom the State made general Medicaid payments totaling $6,098,534,780 for services provided during the audit period. The adult expansion population sampling frame consisted of an Access database containing 932,013 adult expansion population beneficiaries in Pennsylvania for whom the State made adult expansion payments totaling $2,778,101,196. The CHIP sampling frame consisted of an Access database containing 221,263 CHIP beneficiaries in Pennsylvania for whom the State made CHIP payments totaling $219,839,379 for services provided during the audit period. CMS obtained the data for the general Medicaid, adult expansion population, and CHIP beneficiaries from Pennsylvania's Medicaid Management Information System (MMIS). CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frames.

Sample Unit

The sample unit was a general Medicaid, adult expansion population, or CHIP beneficiary.

Sample Size

CMS selected 225 general Medicaid beneficiaries, 225 adult expansion population beneficiaries, and 175 CHIP beneficiaries.

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 2019, their most recent version.[29]

Method for Selecting Sample Units

CMS consecutively numbered the populations of beneficiaries within strata 1 through 5. After generating the random numbers for all five random strata, CMS selected the corresponding general Medicaid, adult expansion population, and CHIP beneficiaries in the sample frame for the sample.

[29] https://oig.hhs.gov/compliance/rat-stats/index.asp

Estimation Methodology

CMS used the OIG/OAS statistical software to estimate the total number of ineligible Medicaid beneficiaries, potentially ineligible Medicaid beneficiaries, ineligible adult expansion beneficiaries, CHIP beneficiaries, and potentially ineligible CHIP beneficiaries and the corresponding total amount of Medicaid, adult expansion population, and CHIP payments for the ineligible beneficiaries and potentially ineligible beneficiaries for whom the State claims federal reimbursement.

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

Appendix C: Medicaid, Adult Expansion Population and CHIP Sample Results and Estimates

Sample Results

Table 1.1: Medicaid Sample Detail and Results for Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	31	31	$12,574,912	0	$0.00
2	9,242	31	$3,309,625	2	$89,028.40
3	29,343	31	$1,230,969	0	$0.00
4	39,342	31	$919,223	1	$13,973.32
5	67,071	32	$426,842	0	$0.00
6	352,245	32	$90,295	0	$0.00
7	853,725	37	$39,697	1	$1,395.12
Totals	**1,350,999**	**225**	**$18,591,563**	**4**	**$104,396.84**

Table 1.2: Medicaid Sample Detail and Results for Potentially Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	31	31	$12,574,912	1	$68,149.89
2	9,242	31	$3,309,625	0	$0.00
3	29,343	31	$1,230,969	0	$0.00
4	39,342	31	$919,223	1	$16,911.95
5	67,071	32	$426,842	0	$0.00
6	352,245	32	$90,295	0	$0.00
7	853,725	37	$39,697	0	$0.00
Totals	**1,350,999**	**225**	**$18,591,563**	**2**	**$85,061.84**

Table 2.1: Adult Expansion Population Sample Detail and Results for Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	29	29	$8,630,420	1	$479,833.34
2	16,849	33	$416,699	1	$8,258.67
3	99,930	33	$186,180	1	$5,421.46
4	121,305	33	$151,495	0	$0.00
5	183,166	33	$100,865	1	$2,700.23
6	206,845	32	$85,940	1	$2,410.51
7	303,889	32	$35,281	0	$0.00
Totals	**932,013**	**225**	**$9,606,880**	**5**	**$498,624.21**

Table 3.1: CHIP Sample Detail and Results for Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	11,459	35	$49,353.15	0	$0.00
2	33,326	35	$44,562.19	0	$0.00
3	43,630	35	$35,110.56	1	$1,006.53
4	53,741	35	$28,603.98	4	$2,678.34
5	79,107	35	$14,285.83	2	$1,290.60
Totals	**221,263**	**175**	**$171,915.71**	**7**	**$4,975.47**

Estimates

Table 4.1: Medicaid 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 Payments for Ineligible Beneficiaries
Point estimate	24,939	$76,465,954.77
Lower limit	-13,076	$8,765,690.66
Upper limit	62,954	$144,166,218.89

Table 4.2: Medicaid Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Ineligible Beneficiaries	24,939
	Total Number of Beneficiaries in Sample Frame	1,350,999
		1.85%
Dollar Value of Payments	Estimated Total Dollars Associated With Ineligible Beneficiaries	$75,465,954.77
	Total Dollars in Sample Frame	$6,098,534,780
		1.25%

Table 5.1: Medicaid Estimated Number of Potentially Ineligible Beneficiaries and Value of Overpayments
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Potentially Ineligible Beneficiaries	**Total Value of Potentially Improper Payments**
Point estimate	1,270	$21,531,051.08
Lower limit	-817	$-13,758,368.21
Upper limit	3,357	$56,820,470.37

Table 5.2: Medicaid Calculation of Overall Rate of Potentially Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Potentially Ineligible Beneficiaries	1,270
	Total Number of Beneficiaries in Sample Frame	1,350,999
		0.094%
Dollar Value of Payments	Estimated Total Dollars Associated with Potentially Ineligible Beneficiaries	$21,531,051.08
	Total Dollars in Sample Frame	$6,098,534,780
		0.353 %

Table 6.1: Adult Expansion Population 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 Payments for Ineligible Beneficiaries**
Point estimate	15,554	$51,682,572.99
Lower limit	659	$6,501,260.30
Upper limit	30,449	$96,863,885.68

Table 6.2: Adult Expansion Population Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Ineligible Beneficiaries	15,554
	Total Number of Beneficiaries in Sample Frame	932,013
		1.67%
Dollar Value of Payments	Estimated Total Dollars Associated With Ineligible Beneficiaries	$51,682,572
	Total Dollars in Sample Frame	$2,778,101,196
		1.86%

Table 7.1: CHIP 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 Payments for Ineligible Beneficiaries**
Point estimate	11,909	$8,284,201.94
Lower limit	4,542	$3,086,160.32
Upper limit	19,275	$13,482,243.57

Table 7.2: CHIP Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Ineligible Beneficiaries	11,909
		5.38%
	Total Number of Beneficiaries in Sample Frame	221,263
Dollar Value of Payments	Estimated Total Dollars Associated With Ineligible Beneficiaries	$8,284,201.94
		3.77%
	Total Dollars in Sample Frame	$219,839,379

Appendix D: Beneficiary Eligibility Audit Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	In accordance with §§ 435.601 and 435.602, Pennsylvania should ensure caseworkers are comprehensively trained countable resources and the associated resource limits when determining Medicaid eligibility for non-MAGI beneficiaries. The training should include the type(s) of resource documentation to be requested from applicants to verify assets, such as: checking, savings, money market, credit union, and CD account statements; life insurance policies; deeds or appraisals for one's home and other real estate; copies of stocks and bonds; deeds to burial plots and copies of pre-paid funeral arrangements; annuities; IRAs; and 401(k) retirement accounts. Pennsylvania should also ensure caseworkers are consistent in using the AVS in accordance with Section 1940(b)(2) of the Social Security Act.	**X**	
Recommendation #2	In accordance with §§ 435.945, 435.948, 435.952, and 435.956(f), Pennsylvania should implement a continuing education plan or program that educates caseworkers on how to determine and define household compositions and correctly apply income to cases when determining eligibility. CMS also encourages Pennsylvania to have supervisory checks in place to ensure that caseworkers are using the most current income available, when the Data Hub does not provide an assurance of financial eligibility, to make eligibility decisions	**X**	

Classification	Issue Description	Agree	Disagree
	and that they are verifying income and testing for reasonable compatibility as outlined in Pennsylvania's verification plan.		
Recommendation #3	In accordance with § 457.380(d), Pennsylvania should train caseworkers about the correct calculation and application of income to determine eligibility in the CHIP program.	**X**	
Recommendation #4	In accordance with § 435.952, Pennsylvania caseworkers should be trained on how to utilize data from the ERF when determining financial eligibility for applications and renewals for services, as well as alternative actions to take when reliable information is not available via the ERF. Caseworkers should use the most current income information available to make valid eligibility decisions. In the case of renewals, if the *ex parte* process does not confirm eligibility, Pennsylvania should follow the process of sending a renewal form directly to the enrollee for a response.		**X** Pennsylvania does not receive IRS data from the Data Hub. The IRS data that Pennsylvania receives comes from the Social Security Administration through BENDEX Earnings Reference File (ERF) and is generally 1 or 2 years behind. It is not available for real time verification and is not used in eligibility determinations. This information is lead only.
Recommendation #5	In accordance with § 435.406, Pennsylvania should train caseworkers on how to recognize qualified non-citizens (such as legal permanent residents or green card holders) who have not met the five-year waiting period and are not	**X**	

Classification	Issue Description	Agree	Disagree
	eligible for full-scope Medicaid benefits but are eligible for EMA.		
Recommendation #6	In accordance with §§ 435.406 and 435.407, Pennsylvania should have appropriate controls in place to ensure individuals are not determined eligible until all elements of eligibility such as citizenship, date of birth and social security number, are verified.	**X**	
Recommendation #7	In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, Pennsylvania should perform an annual renewal of Medicaid and CHIP eligibility every twelve months to ensure beneficiaries maintain their eligibility.	**X**	

Acknowledged by:

__David R. Bryan, Manager, Audit Resolution Section, Bureau of Financial Operations, Department of Human Services

_____06/26/2023_____