



Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

**New York Medicaid Eligibility Determinations for the Adult
Expansion Population**

Review Period: October 2017 through March 2018

Eligibility Review

Final Report

September 2020

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Executive Summary

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

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

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

New York Correctly Determined Medicaid Eligibility for the Adult Expansion Population

Based on the results of this review (review period: October 2017 - March 2018), New York determined Medicaid eligibility for the adult expansion population beneficiaries (including both the adult expansion group and the newly eligible adult group) in accordance with Federal and state requirements. In the sample of 90 beneficiaries, New York correctly determined eligibility for all 90 beneficiaries.

During the review period, New York operated two systems to process Medicaid applications—a state-based marketplace known as the New York State of Health (NYSOH) and a legacy system known as the Welfare Management System (WMS). As of March 2018, NYSOH was responsible for processing 87 percent of all approved Medicaid adult expansion applications. The NYSOH 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)) New York requested additional information or documentation from applicants and beneficiaries if attested income was

not reasonably compatible with electronic sources in accordance with New York's verification plan. (42 CFR § 435.952(c)(2)) Additionally, this review found that the NYSOH verified citizenship or immigration status by electronically verifying citizenship status with the SSA and immigration status with the Department of Homeland Security (DHS).¹

As of March 2018, WMS was responsible for processing 13 percent of all approved adult expansion applications. WMS verified financial information related to wages, net earnings from self-employment, unearned income, and resources from daily data exchanges through the following systems: Wage Reporting System (WRS), Unemployment Insurance Benefits (UIB), Beneficiary & Earnings Data Exchange (BENDEX), and the State Directory of New Hires (SDNH). Local offices requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible with electronic sources. Additionally, this review found that the WMS correctly verified citizenship or immigration status, date of birth, and name electronically with the State Verification and Exchange System (SVES).²

New York also correctly determined beneficiaries' Medicaid eligibility for the correct aid category (e.g., coverage of adults under 100 percent of the Federal Poverty Level (FPL), newly eligible adult group covering adults from 101 to 138 percent³ of FPL, or some other Medicaid category, such as disability or parent-caretakers).

Results of the Review

CMS did not identify any findings as a results of this review. However, CMS identified one recommendation for improvement within New York's adult expansion group: New York should continue to complete the transition of their beneficiaries from the legacy system (the WMS) to the new eligibility system (the NYSOH).

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

² Ibid.

³ 42 CFR § 435.119(b)(5). The Act § 1902 established the FPL threshold at 133 percent but allows for a 5-percent income disregard (a standard deduction applied to calculate income for Medicaid), making the effective threshold 138 percent of the FPL.

Eligibility Review: New York Medicaid Eligibility Determinations for the Adult Expansion Population

Background

Medicaid is a joint Federal and state program that, together with the Children's Health Insurance Program (CHIP), provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.⁴

Federal law requires states to cover certain groups of individuals under the state's Medicaid program. Low income families, qualified pregnant women and children and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.⁵

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP), which is developed from criteria such as the state's per capita income. The regular program FMAP varies by state and ranges from 50 to 75 percent. New York's regular FMAP for the review period (October 2017 through March 2018) was 50 percent.⁶

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

As of August 2019, 36 states, including the District of Columbia, elected to expand Medicaid coverage under the ACA.⁷ Prior to the ACA, low-income, non-disabled adults without dependent children generally were not eligible for Medicaid, regardless of income. Section 2001 of the ACA established a new eligibility group providing health care coverage to previously ineligible adults under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (subsequently codified in regulations at 42 CFR § 435.119). These changes were significant in that, for the first time since

⁴ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

⁵ Ibid.

⁶ Kaiser Family Foundation (2018). Federal Medical Assistance Percentage (FMAP) and Multiplier for States. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷ Medicaid.gov. Adult Coverage Expansion Map as of July 2020. Retrieved August 3, 2020 from <https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf>

the establishment of the Medicaid program in 1965, states could receive Federal Medicaid funds, without a waiver, to provide coverage to low-income individuals without regard to disability, parental status, or most other categorical limitations. The ACA's changes to Medicaid eligibility criteria expanded coverage to nearly all non-elderly adults with incomes at or below 138 percent⁸ of the Federal Poverty Level (FPL).

The ACA also established a new methodology for determining income eligibility for Medicaid and CHIP based on the applicant's modified adjusted gross income (MAGI). MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents, and adults. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. The MAGI-based methodology does not allow for income disregards that vary by state or by eligibility group, and does not allow for an asset or resource test.⁹

The ACA also provided enhanced FMAP for the adult expansion population. From 2014 to 2016, the Federal Government funded 100 percent of allowable health care costs for the newly eligible adult population. The FMAP dropped to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent for 2020 and beyond. States were eligible to receive the enhanced FMAP for those beneficiaries who would not have been eligible for benefits as of December 1, 2009, or who were eligible under a waiver but not enrolled in the program because of limits or caps on waiver enrollment.¹⁰ The ACA also provided enhanced FMAP (75 to 90 percent) to support states in the replacement or upgrade of outdated eligibility systems and to establish links to other data sources to implement new streamlined processes.

Beginning in January 2014, to promote program integrity when verifying eligibility while also minimizing the amount of paper documentation that applicants and beneficiaries needed to provide, states were required to primarily rely on available electronic data sources to verify information included on the application (or conduct the renewal process). Medicaid and CHIP agencies now rely primarily on information available through electronic data sources (e.g., the Social Security Administration (SSA), the Department of Homeland Security (DHS) and the state Department of Labor) rather than paper documentation from applicants and beneficiaries for purposes of verifying eligibility for Medicaid and CHIP.¹¹

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

⁸ Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR § 435.119 define the income standard for the group at 133 percent of the FPL; however, the income counting methodology allows for an income disregard equivalent to five percentage points of the FPL when a household is on the edge of eligibility for Medicaid or CHIP. As a result, the effective income standard for the adult group is 138 percent of the FPL.

⁹ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

¹⁰ Kaiser Family Foundation. (2014, September 29). Understanding How States Access the ACA Enhanced Medicaid Match Rates. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

¹¹ Regulations at 42 CFR 435.945, 435.948 and 457.956 describe income and eligibility verification requirements.

verification plan.¹² States are also able to accept self-attestation of some elements of eligibility when making determinations.

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

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

- Provide a single, streamlined application for Medicaid, CHIP, and Marketplace coverage that individuals can submit online, by phone, in-person, or mail
- Eliminate use of asset tests for groups eligible based on MAGI
- Eliminate in-person interview requirement for individuals who apply or whose eligibility is being renewed on the basis of MAGI
- Utilize electronic data matches to verify eligibility criteria to the greatest extent possible and only request paper documentation when unable to obtain information electronically
- Complete renewals once every *12 months* and no more frequently than once every 12 months for groups eligible based on MAGI
- Seek to renew coverage based on information from the beneficiary's account and available data sources before requesting information from the individual (these renewals are addressed as *ex parte*¹³)

Medicaid Adult Expansion Population in New York

In 2000, New York began implementing the Family Health Plus program, which was designed to insure many of the state's low-income working adults. Family Health Plus expanded coverage up to 100 percent of the Federal Poverty Level (FPL) to adults without dependent children. For parents with dependent children, Family Health Plus increased that threshold to 150 percent of FPL. With the implementation of the ACA on January 1, 2014, New York fully expanded its Medicaid program to cover individuals who qualify for the newly eligible adult group.

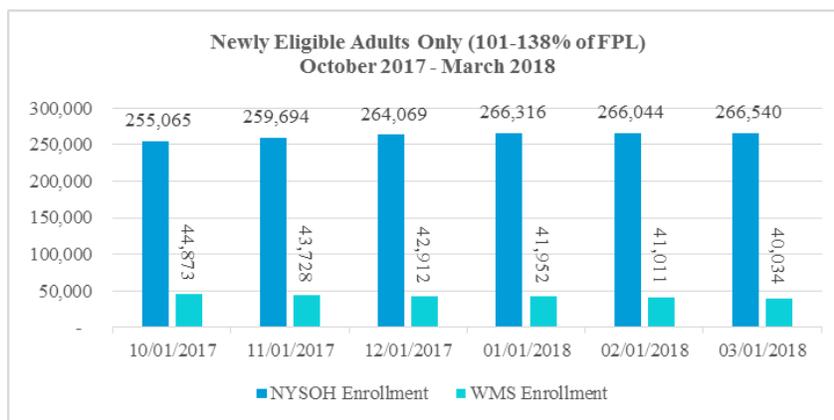
As of May 2019, New York had 6,508,602 individuals enrolled in Medicaid and CHIP—a net increase of 14.62 percent since the first NYSOH Open Enrollment Period and related Medicaid program changes in October 2013. This is lower than the national average of 25.90 percent for

¹² Medicaid.gov. Keeping America Healthy. Medicaid/CHIP Eligibility Verification Plans. Retrieved December 9, 2018 from <https://www.medicaid.gov/medicaid/eligibility/verification-plans/index.html>

¹³ 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.

the same time period.¹⁴ From October 1, 2017 through March 31, 2018 (the review period), the state made Medicaid payments totaling approximately \$6.69 billion, on behalf of 2,270,080 beneficiaries, for all beneficiaries enrolled in the adult group.

New York’s Medicaid adult expansion was covering more than 3.5 million people as of September 3, 2017; however, just 524,000, or 15 percent, of those beneficiaries were newly eligible as a result of the ACA’s expansion of Medicaid.¹⁵ The remaining 2,986,300, or 85 percent of beneficiaries, had been made eligible under pre-ACA guidelines. States, such as New York, that expanded Medicaid pre-ACA received a phased-in increase in their FMAP for adults without children under the age of 65 beginning in January 2014 so that by calendar year 2019 it will equal the enhanced matching rate available for newly-eligible adults.^{16,17}



New York’s Medicaid Eligibility Process

New York operates a state-based marketplace known as the New York State of Health (NYSOH) to enroll the majority of its applicants for the adult expansion population. The state passed legislation in 2012 that shifted the administration of Medicaid, including NYSOH along with eligibility and enrollment decisions, from county and New York City governments to the Department of Health (DOH). This transition is still in process.¹⁸ Currently, eligibility determinations, enrollment, and renewals for programs that use MAGI-based eligibility criteria are conducted via the NYSOH online application by the DOH Office of Health Insurance

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

¹⁵ Kaiser Family Foundation. (2017). State Health Fact. Medicaid Expansion Enrollment. Retrieved August 14, 2019 from <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22%7D%7D%7D&sortModel>.

¹⁶ Kaiser Family Foundation. (2014, September 29). Understanding How States Access the ACA Enhanced Medicaid Match Rates. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

¹⁷ Social Security Act § 1905(z)(2). Retrieved December 9, 2018 from https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

¹⁸ State Health Access Data Assistance Center (SHADAC). (2018, October 19). Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study. Case Study Summary Report – New York. Retrieved August 15, 2019 from <https://www.macpac.gov/wp-content/uploads/2018/11/New-York-Summary-Report.pdf>.

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Programs, Division of Eligibility and Marketplace Integration (DEMI). As of March 2018, NYSOH processed 87 percent of all approved adult expansion category applications.

To verify eligibility, the NYSOH uses multiple electronic data sources in accordance with the State's verification plan,¹⁹ including sources available through the Federal Data Services Hub (Data Hub). The data sources used by New York through the Data Hub are provided by HHS, the SSA, the DHS and the Internal Revenue Service (IRS), among others. NYSOH also used data sources maintained by the state, such as the State Wage Information Collection Agency (SWICA). See Figure 1 for the Medicaid MAGI Eligibility Determination Process.

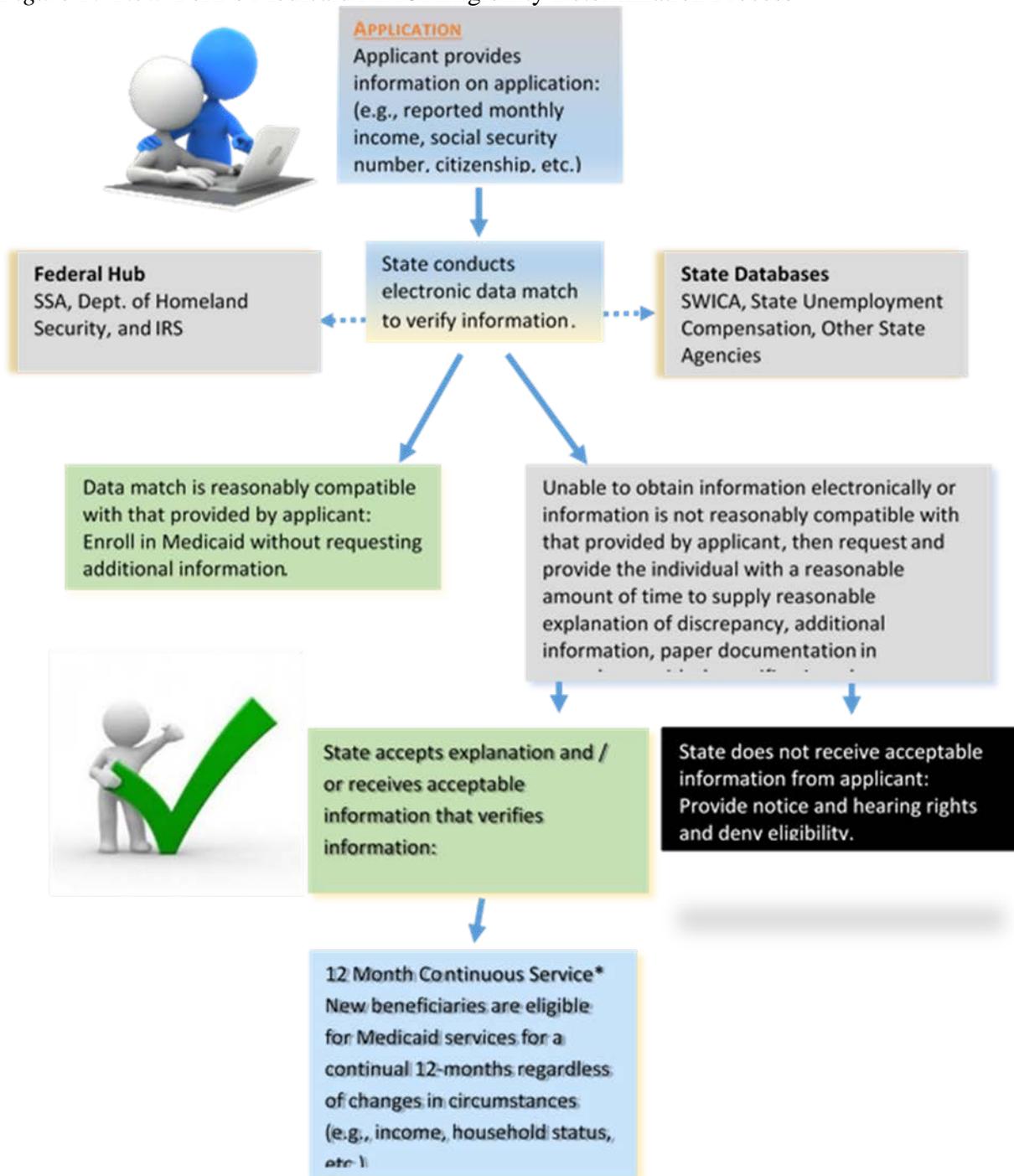
New York's legacy system, Welfare Management System (WMS), continued to operate at the time of this review and was responsible for 13 percent of the eligibility and enrollment decisions for the adult expansion population as of March 2018. Since the period under review in this report, New York continues to work to complete the transition of MAGI individuals from WMS to NYSOH throughout 2019. As of December 2019, WMS was responsible for 6 percent of eligibility and enrollment decisions for the adult expansion population.

WMS integrates with a range of external systems using batch file exchange mechanisms to verify reported employment and income. The resource file integration (RFI) retrieves consumer resource data from Federal and state verification sources. This matching process occurs daily with a number of external agencies for applicants and beneficiary renewals. 'Hits' from the various matches are available for review by local district eligibility workers. WMS has the following daily data exchanges with other systems: WRS, UIB, BENDEX, SVES, and SDNH.

¹⁹ New York MAGI-Based Eligibility Verification Plan. Retrieved on September 11, 2019 from <https://www.medicaid.gov/medicaid/program-information/eligibility-verification-policies/downloads/new-york-verification-plan-template-final.pdf>.

New York Medicaid Eligibility Determination Review

Figure 1: New York’s Medicaid MAGI Eligibility Determination Process



*12-month continuous service is offered because of New York State’s Medicaid Section 1115 Medicaid Redesign Team (MRT) Waiver

Note: In New York, the vast majority of beneficiaries seek in-person enrollment assistance from a broker, certified application counselor (CAC), facilitated enroller or navigator, while another seven percent seek assistance over the phone. All of the applications receiving assistance are

submitted through NYSOH's online system. Fewer than 20 percent of those enrolling in Medicaid enroll online via NYSOH without assistance.²⁰

Scope and Methodology of the Review

This review included individuals covered by New York's Medicaid adult expansion population (including both the adult expansion group and newly eligible adult group). CMS chose Medicaid beneficiaries who received services during the review period of October 1, 2017 through March 31, 2018. A stratified random sample of 90 beneficiaries was selected for review. Medicaid eligibility determinations made by the NYSOH and WMS were both reviewed. The WMS is comprised of two components: a Downstate system for New York City area beneficiaries and an Upstate system for beneficiaries in the rest of the state.

Enrollment for most Medicaid adult expansion applications are submitted electronically through the NYSOH website, an application portal that also provides eligibility determinations and manages communication with beneficiaries once they have enrolled. The WMS continues to use legacy systems to enroll a small portion of the adult population into Medicaid.

Appendix A contains the details of the review scope and methodology, and Appendix B contains the statistical sampling methodology.

Results of the Review

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

CMS did not identify any findings as a results of this review. Below, items 1 through 4 are positive outcomes correlating to the review objectives. However, one recommendation for improvement is discussed in detail in item 5.

²⁰ Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study. (2018, October 19). Case Study Report New York. State Health Access Data Assistance Center (SHADAC) Division of Health Policy and Management University of Minnesota, School of Public Health. Retrieved December 10, 2018 from <https://www.macpac.gov/wp-content/uploads/2018/11/New-York-Summary-Report.pdf>.

1. Eligibility Determinations

Based on the results of this review, New York determined Medicaid eligibility for the adult expansion group and the newly eligible adult group in accordance with Federal and state requirements. From the sample of 90 beneficiaries, the state correctly determined eligibility for all 90 beneficiaries.

In accordance with the state's MAGI verification plan, NYSOH verified financial information related to wages, net earnings from self-employment and unearned income from the SWICA, IRS, SSA and state unemployment insurance (42 CFR § 435.948(a)(1)). The state requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible with electronic sources (42 CFR § 435.952(c)(2)).

In accordance with the state's MAGI verification plan, the legacy system (WMS) verified financial information related to wages, net earnings from self-employment and unearned income from daily data exchanges with the following other systems: WRS, UIB, BENDEX, and SDNH. Local offices requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible with electronic sources (42 CFR § 435.952(c)(2)).

Additionally, this review found that the NYSOH verified citizenship or immigration status, date of birth and name electronically with the DHS, via the Data Hub.²¹ All discrepancies were resolved timely during the 90-day reasonable opportunity period for individuals to resolve inconsistencies in immigration status.²²

NYSOH and WMS continuously obtained information and maintained supporting documentation (e.g., paystubs, letters from employers, additional citizenship information) when making eligibility determinations.

2. Prior OIG Findings (A-02-15-01015)²³

Part of this review was to follow-up on findings from a similar review and report issued by the OIG in January 2018. The OIG's audit covered the period of October 1, 2014 through March 31, 2015. The OIG found that New York did not always determine eligibility for newly eligible beneficiaries in accordance with Federal and state requirements. According to the OIG report, the state inappropriately enrolled beneficiaries into the newly eligible adult group who did not meet income or citizenship requirements, or were eligible for a different Medicaid category. New York disagreed

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

²² The Act § 1902(ee). Retrieved December 8, 2018 from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

²³ Department of Health and Human Services, Office of Inspector General. (2018, January). New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries. Retrieved November 1, 2018 from <https://oig.hhs.gov/oas/reports/region2/21501015.pdf>.

with 12 out of 41 of the OIG's findings. After further review by CMS of the disputed findings, CMS agreed that New York made correct eligibility determinations in those cases. As a result of the OIG's remaining findings, the state made Federal share adjustments during the 3rd quarter of FFY2018; total adjustments were approximately \$6,000. Under CMS' review, it was identified that early system defects identified by both the state and OIG have been corrected. Additionally, all other errors identified by the OIG had been appropriately addressed by the state.

3. Policy Assessment

One of the objectives of this review was to identify and assess the impact of any changes to the state's Medicaid eligibility policy and practices due to the ACA. During the course of this review, CMS worked with state staff and reviewed state policies, as well as State Plan Amendments (SPAs)²⁴. CMS' review did not find evidence that the new MAGI enrollment regulations established under the ACA have impacted any non-MAGI enrollment or eligibility policies.

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

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

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

5. Verification Plan

During the review of the New York verification plan, it was noted that CMS issued a waiver in September 2016, under the authority in section 1902(e)(14)(A) of the Social Security Act, allowing the state to determine eligibility and provide coverage in the state's legacy system, based on the application of MAGI-based methods and income standards described in the state's mitigation plan. The authority extended until December 31, 2016, or until the beneficiaries regularly-scheduled 2016 renewal, if earlier. The state did not request an extension of the waiver and did not complete the transition of their beneficiaries from the legacy system (WMS) to the new eligibility system (NYSOH).

²⁴ A state plan is an agreement between a state and the federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. When a state is planning to make a change to its program policies or operational approach, states send SPAs to CMS for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information. Medicaid.gov, Medicaid State Plan Amendments. Retrieved January 3, 2020 from <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html>.

New York has confirmed that it does apply MAGI-based methodologies when determining eligibility for the beneficiaries that remain in the legacy system and its verification plan addresses how verification is conducted for these individuals at renewal. However, the renewals being performed in the legacy system will depart from the verification plan in several respects: self-attestation of income is accepted at renewal for Medicaid and CHIP with post-eligibility verification using state wage reporting and unemployment data matches; and the Data Hub will not be used for verification of these renewals, including IRS data.

Recommendations for Improvement

CMS recommends that the state continue to complete the transition of their beneficiaries from the legacy system (WMS) to the new eligibility system (NYSOH) in order for all renewals to follow the New York verification plan.

Appendix A: Review Scope and Methodology

Scope

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

CMS limited the review to those applicable to our objective. The testing included a review of supporting documentation at the state agency to evaluate whether the state agency determined the applicant's eligibility in accordance with Federal and state requirements and the controls surrounding those activities. In addition, CMS gained an understanding of the marketplace's policies and procedures for determining whether individuals eligible for the adult group met the eligibility requirements described in the statute and regulations. CMS performed fieldwork from November through December 2018 with the state agency in Albany, New York. CMS was able to access the WMS sample cases from the state agency office in Albany.

Methodology

To accomplish the objectives, CMS:

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

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- Created a sampling frame of 2,270,080 Medicaid beneficiaries for which the state agency made Medicaid payments totaling \$6,694,879,265; and
- Selected a stratified random sample of 90 Medicaid beneficiaries receiving services in New York during the review period.
- For each sample item, reviewed application and renewal data and documentation to support the eligibility determination made for the services to determine:
 - The organization or agency that made the eligibility determination (i.e., New York marketplace or one of the WMS offices);
 - Whether the agency making eligibility determinations followed implemented procedures to verify eligibility documentation; and
 - Whether beneficiaries determined to be eligible under the adult expansion population met Federal and state eligibility requirements, such as income level, residency, immigration status, and documentation of U.S. citizenship.
- Held discussions with state agency officials to obtain an understanding of how policies, procedures and guidance for determining Medicaid eligibility have changed with regards to verification both pre and post ACA.
- Followed up on previously submitted Department of Health and Human Services, Office of Inspector General Audit Report (A-02-15-01015) to ensure all sound findings had been appropriately corrected and any resulting Federal share applicably adjudicated.
- Discussed the results of the review with state agency officials in an informal exit conference.

Appendix B: Statistical Sampling Methodology for New York

Target Population

The target population consisted of beneficiaries determined to be included in the adult expansion group and the newly eligible adult group under the ACA, excluding American Indians and Alaskan Natives, for whom the state agency made Medicaid payments for services provided during the review period.

Sampling Frame

The original sampling frame consisted of a text-based document containing 2,270,080 beneficiaries in the adult expansion group and in the newly eligible adult group under the ACA in New York who received services during the review period. The state agency made Medicaid payments totaling \$6,694,879,265.04 for these beneficiaries, ranging from \$0.01 to \$698,680.33 during the time period under review. After discussion with the reviewers, it was decided that a minimum beneficiary total payment of \$50 would be required to be eligible for the review. That restriction resulted in a final review population of 2,256,587 beneficiaries (99.41 percent of the original population) and total Medicaid payments of \$6,694,616,766.04 (99.996 percent of the original population). CMS obtained the data for the Medicaid beneficiaries from New York's Medicaid Management Information System (MMIS). CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frame. American Indians and Alaskan Natives are subject to different Federal matching ratios and were not a part of this review.

Sample Unit

The sample unit was the adult expansion group and the newly eligible adult group.

Sample Design

CMS used a stratified random sample:

- Stratum 1: beneficiaries who had total payments of at least \$11,000. For this stratum in the sampling frame, there were 54,695 beneficiaries with payments totaling \$1,254,602,521.38.
- Stratum 2: beneficiaries had total payments of at least \$3,000 but less than \$11,000. For this stratum in the sampling frame, there were 945,070 beneficiaries with payments totaling \$3,318,998,595.38.
- Stratum 3: beneficiaries who had total payments of at least \$50 but less than \$3,000. For this stratum in the sampling frame, there were 1,256,822 beneficiaries with payments totaling \$2,121,015,649.28

Sample Size

CMS selected a total sample of 90 Medicaid beneficiaries, divided across three strata of 30 beneficiaries in each stratum. Sufficient additional sampling units were drawn and ordered to be used within the sample if and when selected sampling units were found to have been originally selected in error as part of the sampling frame before sampling.

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, statistical software called RAT-STATS 2010, their most recent version.²⁵

Method for Selecting Sample Units

CMS consecutively numbered the Medicaid beneficiaries within all three sampling strata, having been previously sorted in descending total payment order. After independently generating the random sampling numbers for each of the three strata, we selected the corresponding Medicaid beneficiaries in the sampling frame for our sample.

Estimation Methodology

No estimation methodology was needed for this review.

Table 1. Stratums, Expenditures, Beneficiaries and # of Beneficiaries in Sample

Stratum	Expenditure Range	Total Expenditures	# of Beneficiaries	# of Beneficiaries in Sample
Stratum 1	Over \$11,000	\$1,254,602,521.38	54,695	30
Stratum 2	\$3,000 to \$10,999	\$3,318,998,595.38	945,070	30
Stratum 3	\$50 - \$2,999	\$2,121,015,649.28	1,256,822	30

²⁵ U.S. Department of Health and Human Services. Office of Inspector General. RAT-STATS - Statistical Software. Retrieved August, 14, 2019 from <https://oig.hhs.gov/compliance/rat-stats/index.asp>.

Appendix C: New York State Department of Health Comments

New York State Department of Health Comments on the Center for Medicare & Medicaid Services, Center for Program Integrity Draft Report *New York Medicaid Eligibility Determinations for the Expansion Population*

The following are the New York State Department of Health's (Department) comments on the Center for Medicare and Medicaid Services, Center for Program Integrity draft report, entitled *New York Medicaid Eligibility Determinations for the Expansion Population*.

Clarifications and Other Comments

Page 1, paragraph 4

Additionally, this review found that the State verified citizenship or nationality status by electronically verifying citizenship status with the SSA.

NY State of Health utilizes the Department of Homeland Security, via the Federal Data Services Hub, to verify the status of immigrant non-citizens, non-immigrant visa holders and naturalized citizens.

Page 2, paragraph 2

The State also correctly determined beneficiaries' Medicaid eligibility for the correct aid category (e.g., New York's Family Health Plus covering adults under 100 percent of the Federal Poverty Level (FPL), newly eligible adult group covering adults from 101 to 138 percent of FPL, or some other Medicaid category, such as disability or parent-caretakers).

While New York State provides Medicaid for single adults and childless couples up to 100% of the Federal Poverty Level, it no longer calls this coverage Family Health Plus.

Page 6, paragraph 3

New York's legacy system, Welfare Management System (WMS), continued to operate at the time of this review and was responsible for 13 percent of the eligibility and enrollment decisions for the expansion population as of March 2018. Since the period under review in this report, New York continues to work to

complete the transition of MAGI individuals from WMS to NYSOH throughout 2019. As of August 2019, WMS was responsible for 8 percent of eligibility and enrollment decisions for the expansion population.

Through the Department's ongoing transition of MAGI consumers to NY State of Health, the number of eligibility and enrollment decisions for the expansion population in WMS has been further reduced to 6 percent as of December 31, 2019.

Page 9, paragraph 4

Additionally, this review found that the State verified citizenship or nationality status, date of birth and name electronically with the SSA or the SVES. All discrepancies were resolved timely during the 90-day reasonable opportunity period for individuals to resolve inconsistencies in immigration status.

As previously stated, NY State of Health utilizes the Department of Homeland Security, via the Federal Data Services Hub, to verify the status of immigrant non-citizens, non-immigrant visa holders and naturalized citizens.

Results of the Review section, Item 2

Part of this review was to follow-up on findings from a similar review and report issued by the OIG in January 2018. The OIG's audit covered the period of October 1, 2014 through March 31, 2015. The OIG found that New York did not always determine eligibility for newly eligible beneficiaries in accordance with Federal and state requirements. According to the OIG report, the state inappropriately enrolled beneficiaries into the newly eligible adult group who did not meet income or citizenship requirements, or were eligible for a different Medicaid category. As a result of the OIG review, the state made Federal share adjustments during the 3rd quarter of FFY2018 for OIG-identified errors; total adjustments were approximately \$6,000. Under CMS' review, it was identified that early system defects identified by both the state and OIG have been corrected. Additionally, all other errors identified by the OIG had been appropriately addressed by the state.

The Department disagreed with more than 70 percent of the eligibility findings cited by OIG. At the exit conference, the CMS review team concurred that all the disputed cases were correctly determined by the Department. Thus, most of the findings published in the OIG report were unfounded.

Also, in the instances where the Department agreed with OIG's findings, the root cause system defects were identified by the Department and corrected prior to the initiation of the OIG audit.

CMS Recommendations for Improvement

The State should strive to complete the transition of their beneficiaries from the legacy system (WMS) to the new eligibility system (NYSOH) in order for all renewals to follow the New York verification plan.

Response to the Recommendations for Improvement

As evidenced by its continued progress, the Department is committed to completing the transition of Medicaid eligible MAGI consumers from the legacy system.