



January 2020

# MEDICAID ELIGIBILITY

## Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors

## Why GAO Did This Study

In fiscal year 2018, Medicaid covered approximately 75 million individuals at an estimated cost of \$629 billion, \$393 billion of which were federal funds. Medicaid eligibility is governed by a network of federal and state laws and regulations. In assessing eligibility for Medicaid, states must determine whether applicants meet eligibility criteria, such as financial and citizenship requirements. The accuracy of eligibility decisions has implications for federal and state spending.

The Patient Protection and Affordable Care Act made significant changes to Medicaid eligibility rules beginning in 2014, including new ways of calculating income and new requirements related to electronically verifying applicants' information. Yet, little is known about the accuracy of states' Medicaid eligibility determinations since these changes were implemented.

GAO was asked to review Medicaid eligibility determinations. This report describes, among other things, what is known about the accuracy of Medicaid eligibility determinations, and CMS's efforts to recoup funds related to eligibility errors. GAO reviewed 47 state and federal audits of Medicaid eligibility determinations across 21 states published between 2014 and 2018. GAO also reviewed relevant federal laws and regulations, and interviewed CMS officials.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

# MEDICAID ELIGIBILITY

## Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors

### What GAO Found

States are responsible for determining applicants' eligibility for Medicaid, including verifying eligibility at application, redetermining eligibility, and disenrolling individuals who are no longer eligible. The Centers for Medicare & Medicaid Services (CMS) oversees states' Medicaid eligibility determinations. CMS did not publish an updated national Medicaid eligibility improper payment rate from 2015 through 2018 as states implemented the Patient Protection and Affordable Care Act. CMS released an updated rate in November 2019 that reflected new information on eligibility errors from 17 states.

In lieu of complete and updated data, GAO reviewed 47 state and federal audits published between 2014 and 2018 related to 21 states' eligibility determinations.

### Frequency of Eligibility Determination Accuracy Issues Identified in Audits

Accuracy issue categories	Number of audits	Number of states
Incorrect or incomplete income or asset information	24	13
Eligibility redeterminations not made in a timely manner	20	10
Ineligible individual not disenrolled in a timely manner	14	9
Unresolved income discrepancies	10	7
Individuals enrolled in incorrect basis of eligibility	11	6
Unidentified or unaddressed changes in circumstances	11	5

Source: GAO review of 47 state and federal audits conducted between 2014 and 2018. | GAO-20-157

The identified accuracy issues did not always result in erroneous eligibility determinations. For example, some audits found

- applicants were determined eligible based on incomplete financial information, but when the audits reviewed additional information they found that the applicants still would have been eligible for Medicaid; and
- eligibility determinations complied with state policies and federal requirements, but noted that changes in state practices—such as using additional data sources to verify applicant information or checking sources more frequently—could improve eligibility determinations.

While CMS is generally required to disallow, or recoup, federal funds from states for eligibility-related improper payments if the state's eligibility error rate exceeds 3 percent, it has not done so for decades, because the method it used for calculating eligibility error rates was found to be insufficient for that purpose. To address this, in July 2017, CMS issued revised procedures through which it can recoup funds for eligibility errors, beginning in fiscal year 2022. In addition, the President's fiscal year 2020 budget request includes a legislative proposal to expand the agency's authority to recoup funds related to eligibility errors. During this period of transition, federal and state audits will continue to provide important information about the accuracy of states' eligibility determinations.

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## Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
MAGI	modified adjusted gross income
MEQC	Medicaid Eligibility Quality Control
OIG	Office of Inspector General
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
SSI	Supplemental Security Income

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January 13, 2020

The Honorable Chuck Grassley  
Chairman  
Committee on Finance  
United States Senate

The Honorable Patrick J. Toomey  
Chairman  
Subcommittee on Health  
Committee on Finance  
United States Senate

The Honorable Greg Walden  
Republican Leader  
Committee on Energy and Commerce  
House of Representatives

The Honorable Michael C. Burgess  
Republican Leader  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

In fiscal year 2018, Medicaid covered approximately 75 million individuals at an estimated cost of \$629 billion, of which \$393 billion was financed by the federal government. Eligibility for the Medicaid program is governed by a combination of federal and state laws and regulations. As the day-to-day administrators of the Medicaid program, states are responsible for assessing applicants' eligibility for Medicaid. The Centers for Medicare & Medicaid Services (CMS)—within the Department of Health and Human Services (HHS)—is responsible for overseeing states' compliance with Medicaid eligibility requirements, including recouping funds spent in error, as the accuracy of states' determinations can have significant implications for federal and state spending.

To qualify for Medicaid coverage, individuals generally must fall within certain categories or populations, and must meet the eligibility criteria

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associated with an eligibility group that is covered by the state.<sup>1</sup> Depending on the group, individuals must meet certain financial eligibility criteria, such as having income below specified levels. Individuals must also meet nonfinancial criteria such as citizenship and residency requirements. Individuals may meet the criteria for more than one category and eligibility group; that is, they could have more than one potential basis for their eligibility. For example, a child who is pregnant could meet the criteria applicable to children and those applicable to pregnant women. In such cases, a state enrolls the individual under one basis of eligibility following its procedures.

In recent years, there have been changes to Medicaid eligibility rules and CMS's oversight of eligibility determinations. The Patient Protection and Affordable Care Act (PPACA) made changes to Medicaid eligibility rules, providing states the option to expand eligibility to certain nonelderly adults, as well as requiring changes to Medicaid eligibility processes beginning in 2014.<sup>2</sup> For example, PPACA specified a new way for states to calculate income for most nonelderly, nondisabled Medicaid applicants and included requirements related to electronic verification of Medicaid applicants' information. Given the changes required by PPACA, CMS suspended its programs for measuring Medicaid eligibility errors—such as the enrollment of ineligible individuals and the improper denial of eligible individuals—for fiscal years 2015 through 2018. Thus, less is known about the accuracy of states' Medicaid eligibility determinations during that time period. You asked us to review states' Medicaid eligibility determinations. In this report we describe

1. how selected states decide the basis of eligibility for individuals eligible for Medicaid under more than one basis;
2. what is known about the accuracy of Medicaid eligibility determinations and selected states' processes to improve the accuracy of determinations; and

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<sup>1</sup>Section 1905(a) of the Social Security Act lists 17 categories of individuals, also known as populations, who may receive Medicaid coverage if they meet applicable criteria. See 42 U.S.C. § 1396d(a). Most eligibility groups are defined in sections 1902(a)(10)(A)(i) (mandatory groups) and 1902(a)(10)(A)(ii) (optional groups) of the Social Security Act. See 42 U.S.C. §§ 1396a(a)(10)(A)(i), (ii).

<sup>2</sup>Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (hereafter, "PPACA").

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### 3. CMS efforts to recoup funds related to eligibility errors.

To describe how selected states decide the basis of eligibility for individuals eligible for Medicaid under more than one basis, we selected a nongeneralizable sample of five states: Maryland, New Mexico, Oklahoma, Tennessee, and Virginia. These states were selected to obtain variation in program characteristics, including whether the state opted to expand Medicaid eligibility as a result of PPACA; had integrated all bases of eligibility under a single eligibility system; and whether the state allowed CMS, through its Federally Facilitated Exchange, to determine Medicaid eligibility on its behalf.<sup>3</sup> For the selected states, we reviewed documentation of their policies and procedures, eligibility system rules, and Medicaid application questions. We also interviewed officials from each selected state's Medicaid agency and, if applicable, partner agencies responsible for eligibility determinations. For three of the five selected states, we also interviewed eligibility workers who process applications and provide information to individuals applying for Medicaid.<sup>4</sup>

To describe what is known about the accuracy of Medicaid eligibility determinations, we identified and reviewed state and federal audit findings related to the accuracy of states' Medicaid eligibility determinations. We focused on audits of eligibility determinations published from 2014 through 2018. In total, we identified 47 audits across 21 states by state audit organizations and HHS's Office of Inspector General (OIG).<sup>5</sup> Audits in our scope included those either specifically or partly focused on states' Medicaid eligibility determinations, including

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<sup>3</sup>PPACA directed each state to establish and operate a health insurance marketplace. In states electing not to establish a marketplace, the law required HHS (which delegated this role to CMS) to create a marketplace; this marketplace is referred to as the Federally Facilitated Exchange. These marketplaces were intended to provide a seamless, single point of access for individuals to enroll in private health plans and apply for income-based financial assistance, such as Medicaid. States that use the Federally Facilitated Exchange can choose to allow it to determine applicants' eligibility for Medicaid on its behalf.

<sup>4</sup>We limited our selection of five states to three of CMS's 10 regions and selected one state within each region for interviews with eligibility workers.

<sup>5</sup>To identify relevant state and federal audits, we first conducted internet searches, including searching the websites of state auditors and HHS-OIG. We then reached out to both the state auditors, through the National State Auditors Association, and HHS-OIG to identify any additional relevant audits.

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those conducted under the Single Audit Act.<sup>6</sup> To describe selected states' processes to improve the accuracy of determinations, we reviewed relevant federal laws and regulations that specify requirements for conducting Medicaid eligibility determinations, and interviewed officials from CMS and the five selected states.

To describe CMS efforts to recoup funds related to eligibility errors, we reviewed federal laws and regulations related to CMS's authority to recoup federal funds, in addition to a proposal in the President's fiscal year 2020 budget request related to the agency's recoupment authority. We also obtained information from CMS about its reviews of the accuracy of states' eligibility determinations and interviewed CMS officials about their efforts.

We conducted this performance audit from July 2018 to January 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

States have flexibility within broad federal requirements to design and implement their Medicaid programs. For example, while states must cover certain mandatory groups and benefits, they have the option to cover certain other groups of individuals and benefits. States' Medicaid plans outline the services provided, the populations covered by their programs, and how they implement and comply with other federal requirements. States share responsibility for oversight of Medicaid eligibility with CMS.

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## Medicaid Eligibility Processes

States are primarily responsible for assessing applicants' eligibility for, and enrolling eligible individuals into, Medicaid. These responsibilities include verifying individuals' eligibility at the time of application,

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<sup>6</sup>Organizations based in the United States with expenditures of federal funding of \$500,000 or more (\$750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization's fiscal year are required to send an audit report to the Office of Management and Budget, in accordance with the Single Audit Act, as amended, and the Office of Management and Budget implementing guidance. See 31 U.S.C. §§ 7501-7507; 2 C.F.R., pt. 200, subpt. F. (2019) (as added by 78 Fed. Reg. 78590, 78608 (Dec. 26, 2013)).



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performing redeterminations of eligibility, and promptly disenrolling individuals who are no longer eligible. In verifying individuals' eligibility, states must assess specified financial and nonfinancial information.

- **Financial:** Individuals applying for Medicaid generally must have an income below a certain limit.<sup>7</sup> PPACA requires states to calculate the income for most nondisabled, nonelderly applicants using a uniform method based on modified adjusted gross income (MAGI), which is derived from a federal tax-based definition of income. States have more flexibility in determining how to calculate incomes for individuals whose eligibility is determined on the basis of age or disability, because their income is not calculated using MAGI-based methods. For example, states may disregard certain types or amounts of income for these MAGI-exempt populations. Additionally, individuals eligible on the basis of age or disability generally must also have assets—cash or real or personal property that are owned and can be converted to cash—below specified standards that vary by state.<sup>8</sup>
- **Nonfinancial:** Individuals applying for Medicaid must also satisfy certain nonfinancial criteria. For example, to be eligible for Medicaid individuals generally must be residents of the state in which they are applying and must be either citizens of the United States or certain noncitizens, such as lawful permanent residents.<sup>9</sup>

States generally have flexibility in the sources of information they use to verify applicants' financial eligibility and citizenship or immigration status. However, to the extent practicable, states must use third party sources of data for these verifications prior to requesting documentation from the applicant.<sup>10</sup> When data from reliable third party sources are inconsistent with information from an application, the state must have processes in place to resolve these inconsistencies, such as through requesting

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<sup>7</sup>Not all Medicaid eligibility determinations require an income test; for example, individuals whose eligibility is based on enrollment in another program, such as certain individuals in foster care, do not need a determination of income by the Medicaid agency.

<sup>8</sup>For the purposes of this report, we use the term assets to refer to resources, which include anything owned, such as bank accounts or property, that can be converted to cash. See CMS, State Medicaid Manual § 3250 (definition of resource).

<sup>9</sup>See 42 C.F.R. § 435.406 for noncitizen eligibility requirements and exceptions.

<sup>10</sup>42 U.S.C. § 18083(c)(3); 42 C.F.R. § 435.952(c) (2018).

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additional documentation or accepting the applicant's attestation.<sup>11</sup> Additionally, states may accept self-attestation for some eligibility criteria, such as residency in the state and household composition (which is used in determining if applicants' income is below the limit).<sup>12</sup>

Once a state determines that an individual meets relevant financial and nonfinancial eligibility criteria, the state enrolls the individual into Medicaid under one basis of eligibility. Examples of bases of eligibility include those applicable to children, pregnant women, individuals eligible for Supplemental Security Income (SSI)—a program that provides cash assistance to low-income adults and children with disabilities—and other low-income adults under age 65 in states that expanded their Medicaid populations under PPACA.<sup>13</sup> (See table 1.)

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<sup>11</sup>States are not permitted to accept self-attestation of citizenship, immigration status, or applicants' Social Security numbers. However, states generally may accept self-attestation as verification of income and assets when authoritative data sources are not available, or when the electronic data source is not reasonably compatible with information provided on the application. Income information provided by the applicant is reasonably compatible with electronic data sources if both are at, above, or below the applicable income standard, or if they meet a threshold for reasonable compatibility established by the state. For example, information provided by the applicant could be considered reasonably compatible if it is below the eligibility threshold and within a state-specified percentage or dollar amount of the third party data source.

<sup>12</sup>States must accept self-attestation in certain special circumstances, which, for example, may arise when documentation is not available due to a natural disaster.

<sup>13</sup>PPACA established a new eligibility group for nonelderly, nonpregnant adults whose income does not exceed 133 percent of the federal poverty level, and who are not eligible under previously established mandatory eligibility groups. See Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)).

**Table 1: Examples of Bases of Eligibility for Medicaid**

<b>Basis of eligibility<sup>a</sup></b>	<b>Individuals included</b>	<b>Method for calculating income</b>
Pregnant woman	Women who are pregnant or post-partum, with household income at or below a standard established by the state.	Modified adjusted gross income (MAGI) <sup>b</sup>
Caretaker	Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.	MAGI
Child	Infants and children under age 19 (or under 21, at state option) with household income at or below standards established by the state based on age group.	MAGI
Adult	Nonpregnant individuals aged 19 through 64, not otherwise mandatorily eligible and not entitled to Medicare, with household income at or below 133 percent of the federal poverty level.	MAGI
Supplemental Security Income (SSI)	Individuals who are aged, blind, or disabled who receive cash assistance through SSI.	MAGI-exempt <sup>c</sup>
Aged, blind, or disabled	States have the option to cover other aged, blind, and disabled populations who have incomes and assets at or below a standard established by the state, including individuals who reside in an institution or require an institutional level of care. <sup>d</sup>	MAGI-exempt
Federal foster care or adoption assistance	Individuals for whom an adoption assistance agreement is in effect, or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Social Security Act.	MAGI-exempt <sup>e</sup>
Medicare Savings Programs	Medicare beneficiaries who are eligible, based on their household income and asset level, for assistance with paying Medicare premiums and cost-sharing. <sup>d</sup>	MAGI-exempt
Family planning	Individuals who are not pregnant, with household income equal to or below the highest standard for pregnant women, as specified by the state. Benefits are limited to family planning and related services.	MAGI

Source: GAO review of relevant CMS guidance. | GAO-20-157

<sup>a</sup>To qualify for Medicaid coverage, individuals generally must fall within certain categories or populations and meet the eligibility criteria associated with an eligibility group that is covered by the state. We refer to this collectively as the individual's basis of eligibility. For example, the child-related basis of eligibility would apply to, among others, an individual that falls within the category for individuals under the age of 21 and meets the state's criteria for an eligibility group for children, such as the mandatory group for poverty level related children ages 1 to 5.

<sup>b</sup>The MAGI method for calculating income is defined in law and is derived from a federal tax-based definition of income.

<sup>c</sup>To be eligible for SSI, individuals must have income and assets below a specified level, but states that automatically enroll individuals into Medicaid based on receipt of SSI do not perform separate assessments for income or assets. Not all states automatically enroll SSI recipients into Medicaid. Under Section 1902(f) of the Social Security Act, a state may use more restrictive Medicaid eligibility standards than SSI's standards, provided the standards are no more restrictive than those the state had in place as of January 1, 1972. 42 U.S.C. § 1396a(f).

<sup>d</sup>The Centers for Medicare & Medicaid Services (CMS) uses the term resources to describe what is commonly referred to as assets, namely anything owned, such as bank accounts or property, that can be converted to cash. See CMS, State Medicaid Manual § 3250 (definition of resource).

<sup>e</sup>Children enrolled in federal foster care or adoption assistance are automatically eligible for Medicaid without an additional income test; however, these programs may employ their own income standards as a condition of eligibility.

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Since individuals may meet the criteria for more than one category and eligibility group, they could have more than one basis of eligibility. For example, a child who is pregnant could meet the criteria applicable to children and those applicable to pregnant women. However, a state would enroll each individual under one basis of eligibility. CMS regulations specify that when states determine applicants eligible based on MAGI criteria, they must notify these individuals of the benefits and services available through any MAGI-exempt bases of eligibility for which they may qualify, in order to provide the individual information about whether to request a MAGI-exempt eligibility determination.<sup>14</sup> However, CMS officials explained that they advise states that they do not need to inform applicants of benefits and services under other eligibility groups if there is no meaningful difference in the benefits or cost-sharing that the individual would receive under one basis compared to another. CMS officials also noted that they have provided further guidance to states on assigning bases of eligibility, including that if an individual meets the criteria for more than one basis, the state should enroll the person into the most beneficial coverage in terms of factors such as the benefit package and out-of-pocket costs.

In 2014, CMS issued a framework based on federal rules for states to use in developing their systems to assess individuals' bases of eligibility.<sup>15</sup> The framework describes a hierarchy for states to use in developing their eligibility systems that begins with bases related to receipt of other federal benefits, such as SSI and federally funded foster care and adoption assistance, which often result in automatic eligibility for Medicaid. Following these bases of eligibility, states are to assess eligibility for bases subject to MAGI-based income rules, and should first evaluate for mandatory coverage before evaluating for optional coverage. Federal rules allow for some exceptions to this sequence, such as when an individual who may be eligible for bases subject to MAGI-based income rules requests consideration under a MAGI-exempt basis to access certain additional benefits, such as long-term services and supports.<sup>16</sup>

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<sup>14</sup>42 CFR §435.917 (2018).

<sup>15</sup>This framework is referred to as the Medicaid Information Technology Architecture and is available on CMS' website.

<sup>16</sup>Long-term services and supports comprise a broad range of health care, personal care, and support services to help individuals with physical, developmental, or cognitive disabilities maintain their quality of life.

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## Federal and State Oversight of Eligibility Determinations

CMS has historically operated two distinct, but complementary programs to oversee states' eligibility determinations in the Medicaid program.

- The Medicaid Eligibility Quality Control (MEQC) program, which is implemented by states and overseen by CMS, was created in 1978 to monitor the accuracy and timeliness of Medicaid eligibility determinations in order to avoid inappropriate payments and eligibility decision delays. MEQC was also designed to identify methods to reduce and prevent errors related to incorrect eligibility determinations by having states review sample cases to independently verify eligibility criteria and then report the results to CMS.<sup>17</sup>
- The Payment Error Rate Measurement (PERM) program is CMS's process to estimate the national Medicaid improper payment rate in accordance with the Improper Payments Information Act of 2002, as amended, and Office of Management and Budget guidance. To calculate the Medicaid improper payment rate through PERM, CMS computes an annual rolling average of improper payment rates across all states based on a 3-year rotation cycle of 17 states each year. PERM is comprised of three components, including one that measures errors in state determinations of Medicaid eligibility.<sup>18</sup>

For fiscal years 2015 through 2018, CMS suspended MEQC and the eligibility component of PERM to provide states with time to adjust to eligibility process changes in PPACA; in its place, CMS required states to implement pilots to assess the accuracy of their eligibility determinations. As a result, CMS did not publish an updated national estimate of improper payments due to Medicaid eligibility errors for fiscal years 2015 through 2018.<sup>19</sup> Eligibility reviews under PERM, which are conducted by a federal

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<sup>17</sup>MEQC requires states to review sample cases of both individuals found eligible for Medicaid coverage, as well as those found ineligible for coverage.

<sup>18</sup>The other two components of PERM are related to fee-for-service and managed care. The fee-for-service component measures errors in a sample of fee-for-service claims, which are records of services provided and the amount the Medicaid program paid for these services. The managed care component measures errors that occur in the periodic payments that state Medicaid agencies make to managed care plans to cover the provision of medical services to enrollees.

<sup>19</sup>Instead, CMS continued to report the fiscal year 2014 improper payment rate for eligibility errors of 3.11 percent as part of its overall PERM improper payment rate calculation.

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contractor, resumed in July 2017 for fiscal year 2019.<sup>20</sup> In November 2019, CMS released an updated national estimate of Medicaid eligibility errors, which reflected results of the first 17 states reviewed under the new PERM process.<sup>21</sup> Going forward, states are to resume MEQC reviews in the 2 years between their PERM reviews. The MEQC reviews will focus, in part, on specific areas of improvement for each state. For example, states might choose to focus on specific populations, such as whether pregnant women were assigned to the appropriate eligibility group, or specific processes, such as asset verification.<sup>22</sup>

The Medicaid statute includes a provision for CMS to recoup, or disallow, federal funds related to erroneous payments for ineligible individuals and overpayments for eligible individuals.<sup>23</sup> The provision generally requires CMS to recoup funds from states for eligibility-related improper payments if the state's eligibility error rate exceeds 3 percent.<sup>24</sup> CMS has general authority to recoup funds from states when it determines that an expenditure of federal funding is not an allowable expense; according to CMS, however, this general authority does not apply to eligibility-related errors, given the separate specific statutory authority. Therefore, it is the view of the agency that CMS cannot recoup funds from states whose eligibility-related improper payment rate is below the 3 percent threshold.

In addition to the PERM and MEQC oversight, state auditors review Medicaid eligibility determinations, including through audits conducted at the auditors' initiative and as part of audits required by provisions of the

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<sup>20</sup>Previously, states conducted their own PERM eligibility reviews on a fiscal year basis and reported results to CMS.

<sup>21</sup>The eligibility component of the fiscal year 2019 national Medicaid improper payment rate was 8.36 percent. This measurement includes a proxy estimate for the 34 states that have not yet been reviewed under the new PERM process. CMS noted that eligibility errors were primarily related to insufficient documentation to verify eligibility or noncompliance with eligibility redetermination requirements.

<sup>22</sup>MEQC reviews will also include a review of negative case actions—cases in which the state denies or terminates a beneficiary's eligibility, which PERM does not currently measure.

<sup>23</sup>42 U.S.C. § 1396b(u).

<sup>24</sup>CMS may waive the recoupment if the Medicaid agency has taken steps to demonstrate a good faith effort to get below the 3 percent allowable threshold. 42 U.S.C. § 1396b(u)(1)(B).

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Single Audit Act of 1984.<sup>25</sup> To guide auditors in performing reviews under the Single Audit Act, the Office of Management and Budget issues a document referred to as the Compliance Supplement, which identifies important compliance requirements that the federal government expects to be considered as part of such an audit.<sup>26</sup> Beginning in fiscal year 2014, the Compliance Supplement directed auditors to forgo review of eligibility determinations for individuals whose income is calculated based on MAGI. The supplement noted that testing was being performed under Medicaid eligibility review pilots, which would serve as CMS’s oversight during the initial years of PPACA implementation when the MEQC and the eligibility component of PERM were suspended. In June 2019, the Office of Management and Budget issued the 2019 Compliance Supplement that included changes to permit state auditors to test eligibility determinations of both MAGI and MAGI-exempt populations to ensure enrollees qualify for the Medicaid program and are in the appropriate enrollment category.<sup>27</sup>

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## Basis of Eligibility Decisions Can Vary Among Selected States despite Consideration of Similar Factors

The five selected states in our review considered similar factors when ranking the bases of eligibility to which individuals are assigned—such as bases related to children, pregnant women, or disabled individuals—but the resulting basis of eligibility in which individuals were placed could vary. Each of the five states ranked bases of eligibility by comparing how beneficial they were for enrollees across several key factors, and ordered the bases into a hierarchy starting with the most beneficial, according to officials. The states’ eligibility systems were programmed to apply these hierarchies in deciding each individual’s basis of eligibility; when an individual was potentially eligible for more than one basis of eligibility, the system would assign them to the basis highest in the ranking.

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<sup>25</sup>In some cases, states may contract with external audit entities to conduct audits required under the Single Audit Act.

<sup>26</sup>A single audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the schedule of expenditures of federal awards; (2) gaining an understanding of and testing internal control over financial reporting, and the entity’s compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain federal programs (i.e., the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain federal programs.

<sup>27</sup>2 C.F.R. pt. 200, subpt F, app. XI (2019). We, along with state auditors, proposed revisions to the Compliance Supplement. Our prior work has shown that oversight of the Medicaid program could be further improved through leveraging and coordinating program integrity efforts with state agencies, state auditors, and other partners.

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The key factors the selected states considered in ranking the bases of eligibility, according to state officials, included (1) whether eligibility was related to the receipt of benefits from other programs, (2) the services provided through the benefit package, and (3) the financial implications for the individual.

- **Eligibility related to other programs.** The selected states ranked bases of eligibility associated with enrollment in other federal and state assistance programs at or near the top of their hierarchies. For instance, eligibility associated with receipt of SSI was generally at the top of the states' hierarchies, and eligibility associated with receipt of federal foster care and adoption assistance benefits was ranked above other bases for which a child might be eligible.<sup>28</sup>
- **Services included in the benefit package.** Bases of eligibility that conveyed additional benefits, such as long-term services and supports, were ranked higher. Similarly, bases that offered limited benefits, such as only covering family planning services or assistance with cost-sharing for Medicare beneficiaries (i.e., the Medicare Savings Program) were ranked lower in the selected states' hierarchies.
- **Financial impact.** The selected states ranked bases of eligibility lower if they were associated with additional financial requirements for the individual, such as asset tests as a condition of eligibility, or out-of-pocket costs once enrolled. For example, bases of eligibility that required applicants to make copayments to receive certain services, or to pay a monthly premium, were ranked lower than those without such costs.

Although the selected states considered similar factors when deciding an individual's basis of eligibility for Medicaid, a similarly situated individual could be enrolled under a different basis of eligibility in one state versus another state. Decisions varied across states, in part, because of differences in (1) how states factored in the length of the enrollment period; and (2) the degree to which states' eligibility systems and processes were integrated.

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<sup>28</sup>Children enrolled in federally funded foster care or adoption assistance are automatically eligible for Medicaid. Three of the five selected states automatically enrolled individuals receiving SSI in Medicaid. The remaining two states perform Medicaid eligibility determinations for individuals receiving SSI, but prioritized assessment and enrollment of these individuals on this basis before other bases. Thus, there was limited difference in the resulting basis of eligibility for individuals receiving SSI across selected states.



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- **Length of the enrollment period.** Officials in selected states considered the length of the enrollment period when deciding bases of eligibility for certain populations, such as pregnant mothers (pregnant women who were also eligible as caretakers of dependent children). Pregnant women who are eligible for Medicaid have continuous eligibility, which guarantees enrollment through at least 60 days postpartum regardless of income changes. For this reason, Oklahoma enrolled pregnant mothers under a basis of eligibility applicable to pregnant women. In contrast, Virginia enrolled pregnant mothers under a basis of eligibility applicable to caretakers, because it has a 12-month enrollment period.<sup>29</sup> However, pregnant women have continuous eligibility through at least 60 days postpartum regardless of income changes or whether they are enrolled as caretakers or on some other basis. As such, if a pregnant woman enrolled as a caretaker no longer met the income standard for a caretaker, for example, she could still remain eligible through her postpartum period. Alternatively, a woman enrolled under a pregnancy-related basis of eligibility would be redetermined for eligibility at the end of her postpartum period and could continue enrollment as a caretaker if she continued to meet the financial and other eligibility criteria.<sup>30</sup> CMS noted that such variations in eligibility policies are allowable and expected among state Medicaid programs.
  - **Eligibility system integration.** Differences in the degree to which selected states integrated their eligibility systems affected how individuals were assessed for potential bases of eligibility and potentially resulted in different eligibility determinations. Officials in four of our five selected states—New Mexico, Oklahoma, Tennessee, and Virginia—reported operating unified or integrated eligibility systems through which individuals could be considered for both MAGI

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<sup>29</sup>States must redetermine eligibility for individuals enrolled as caretakers every 12 months. Additionally, eligibility for individuals enrolled as caretakers would need to be redetermined if the state learns that these individuals experience changes in circumstance, such as increases in income.

<sup>30</sup>Additionally, officials in the five selected states reported that there were no differences in the benefits or financial requirements for pregnant women enrolled as caretakers versus pregnant women.

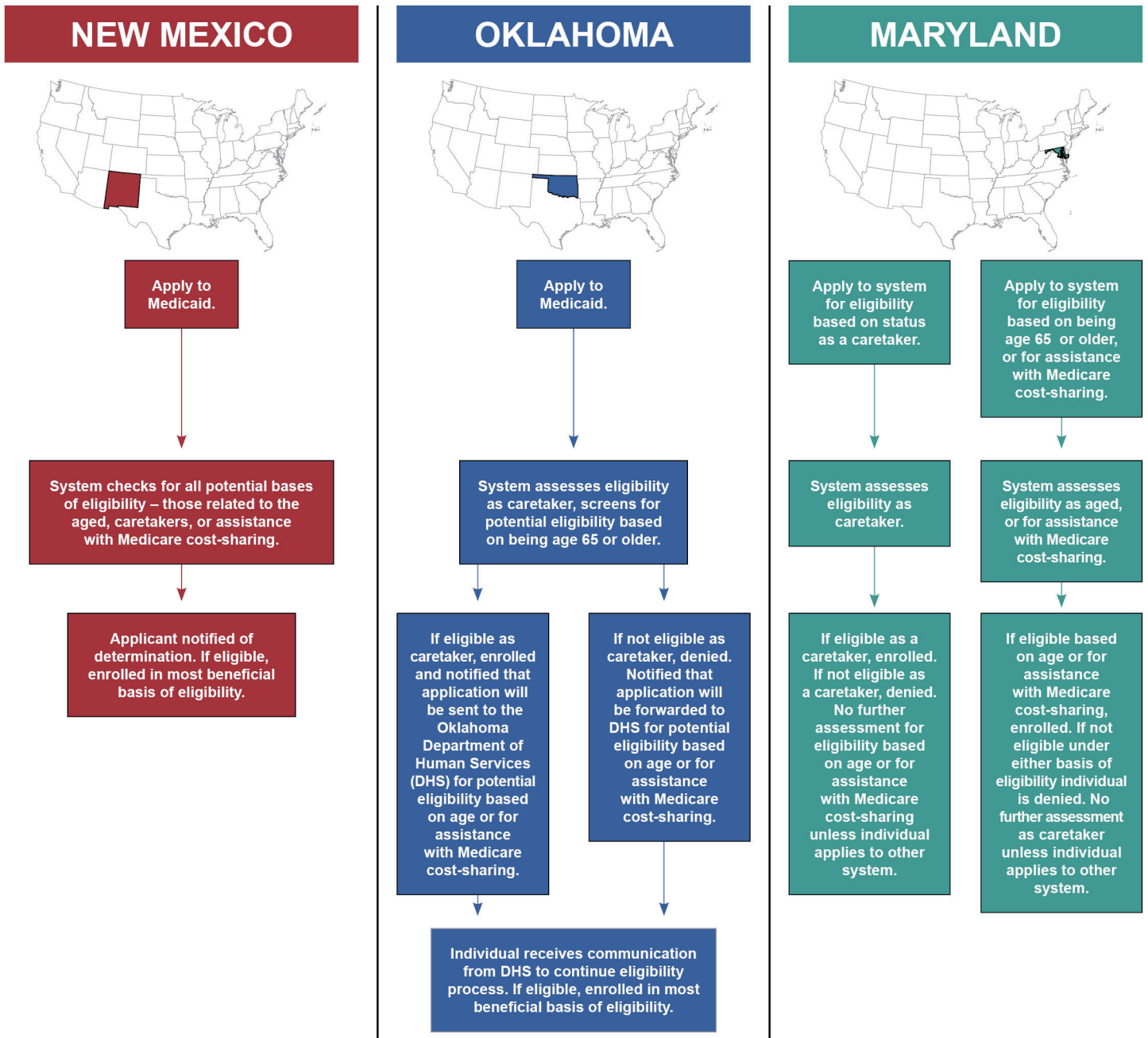
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and MAGI-exempt bases of eligibility.<sup>31</sup> The fifth state, Maryland, had separate eligibility systems for MAGI and MAGI-exempt bases of eligibility, so an individual would need to apply through both systems to have all potential bases of eligibility considered. As such, an individual who is over age 65 and a caretaker of a dependent child would have to submit two separate applications to be assessed for all potential bases of eligibility in Maryland. Depending on the system to which he or she applied, that individual could be enrolled in a less beneficial basis of eligibility or denied eligibility for Medicaid. For example, the individual might be determined ineligible for full Medicaid benefits and enrolled in a Medicare Savings Program, in which Medicaid covers out-of-pocket costs related to Medicare benefits. (See fig. 1.)

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<sup>31</sup>Oklahoma operates two separate eligibility systems: one for populations that can be determined eligible through an online process and another for populations that require interaction with an eligibility worker, such as eligibility related to a disability or based on receipt of benefits from other programs, such as adoption assistance. However, the two systems are integrated, meaning that individuals who apply through one system may have information shared with the other system automatically without additional steps required by the individual.

**Figure 1: Examples of How Selected States' Eligibility Systems Could Result in a Different Basis of Eligibility for a Caretaker over Age 65**



Source: GAO analysis of information from state Medicaid officials. | GAO-20-157

**Audits Identified Multiple Issues Related to the Accuracy of Eligibility Determinations; Selected States Had Processes Designed to Address Many Identified Issues**

Note: To qualify for Medicaid coverage, individuals generally must fall within certain categories or populations and meet the eligibility criteria associated with an eligibility group that is covered by the state. We refer to this collectively as the individual's basis of eligibility.

Our review of 47 state and federal audits across 21 states identified multiple issues affecting the accuracy of states' Medicaid eligibility determinations. The accuracy issues identified in the audits we reviewed generally fell into nine broad categories, such as eligibility determinations made with incorrect or incomplete income or asset information, unresolved discrepancies between what applicants reported as their income and electronic data sources, and unidentified or unaddressed changes in circumstances, such as changes in household income or size.<sup>32</sup> (See table 2.)

**Table 2: Frequency of Medicaid Eligibility Determination Accuracy Issues Identified in State and Federal Audits**

Accuracy issue category	Number of audits	Number of states
Incorrect or incomplete income or asset information	24	13
Eligibility redeterminations not made in a timely manner	20	10
Ineligible individual not disenrolled in a timely manner	14	9
Unresolved income discrepancies	10	7
Individuals enrolled in incorrect basis of eligibility	11	6
Unidentified or unaddressed changes in circumstances	11	5
Use of incomplete or incorrect information on household composition	5	4
Eligible individuals who were not enrolled	4	3
Other	23	14

Source: GAO review of 47 state and federal audits conducted between 2014 and 2018. | GAO-20-157

Note: Some states had multiple audits that found similar issues. As such, the number of audits that identified each type of accuracy issue may be greater than the number of states in which an issue was identified. Additionally, the accuracy issues identified did not always result in an eligibility error.

<sup>32</sup>In addition, we identified 29 audits across 15 states in which a lack of documentation resulted in auditors being unable to confirm the accuracy of eligibility determinations.

Within these nine broad categories, the audits identified several specific accuracy issues, including states that were

- not conducting income checks for individuals reporting no income;
- not terminating the enrollment of individuals who had moved out of state or died;
- enrolling individuals who did not provide required information (such as proof of citizenship) on a timely basis;
- months or years behind schedule in conducting required eligibility redeterminations; and
- not acting on—or not having adequate systems in place to detect—changes in enrollees’ circumstances that could affect eligibility, such as changes in income or household composition.

See table 3 for examples of audit findings related to each of the accuracy issue categories, and appendix I for an overview of the key findings for each audit we reviewed.

**Table 3: Examples of Medicaid Eligibility Audit Findings by Accuracy Issue Category**

Accuracy issue category	Example of audit findings
Incorrect or incomplete income or asset information	<ul style="list-style-type: none"> <li>• An audit of Virginia’s Medicaid program found that the state did not check electronic data sources of income for about 80 percent of the applicants who reported \$0 in income; of them, 18 percent had wages during the quarter they applied.</li> <li>• A New Jersey audit found that some applicants did not report all relevant sources of income, and the data sources the state used did not include certain types of income, including spousal income. Auditors checked a targeted sample of 1,337 applications against state tax data and found that 410 would not have been eligible.</li> <li>• Auditors found that workers in Minnesota approved eligibility for three individuals with assets above statutory limits out of a sample of 100 aged, blind, and disabled Medicaid enrollees.</li> </ul>
Ineligible individual not disenrolled in a timely manner	<ul style="list-style-type: none"> <li>• Auditors found that enrollment period end dates were not being used in New Jersey’s eligibility system for most enrollees (1.4 of 1.6 million). The state did not use the end date function, because it would cause enrollees who had not been redetermined in a timely manner to be wrongfully terminated. Without an end date, auditors noted, an enrollee could potentially receive benefits in perpetuity.</li> <li>• Repeat audits found that Michigan was not including correct termination dates in its eligibility systems for some enrollees, including enrollees receiving Transitional Medical Assistance, which offers up to a year of Medicaid coverage for certain families who would otherwise lose coverage.</li> </ul>
Eligibility redeterminations not made in a timely manner	<ul style="list-style-type: none"> <li>• Auditors reported that as of May 2017, Oregon had 115,200 enrollees with late redeterminations. More than 47,000 (41 percent) of these enrollees were ultimately deemed ineligible—about half no longer met requirements and half did not respond when contacted for verification information. Auditors estimated that the delay in eligibility redeterminations led to \$88 million in avoidable expenditures.</li> </ul>

Accuracy issue category	Example of audit findings
Unresolved income discrepancies	<ul style="list-style-type: none"> <li>An audit of Kentucky’s Medicaid program found that the state did not request documentation to resolve differences for four enrollees who reported income incompatible with information contained in an electronic data source used by the state to verify income.</li> <li>A Wisconsin audit found that only five of 10 cases flagged for discrepancies with state wage data were resolved in the required 45 day time period.</li> </ul>
Individuals enrolled in incorrect basis of eligibility	<ul style="list-style-type: none"> <li>An audit of New York’s program found that two of 130 sampled individuals identified as newly eligible under Medicaid expansion were instead eligible on the basis of a disability, and thus should not have been enrolled as newly eligible.<sup>a</sup></li> <li>Multiple Vermont audits identified Medicaid enrollees who did not meet criteria for the category under which they were enrolled—for example, by assigning adults to the child category.</li> </ul>
Unidentified or unaddressed changes in circumstances	<ul style="list-style-type: none"> <li>An audit of New Jersey’s Medicaid program found that the state was not identifying and disenrolling some deceased individuals. When auditors conducted a data match to a Social Security number verification service, they found managed care payments of \$510,834 and fee-for-service claims of \$217,913 for 41 individuals after their reported date of death.</li> <li>An audit of Minnesota’s Medicaid program found 10 cases where the state did not act to address changes in circumstances that made individuals ineligible for Medicaid in a timely manner—nine cases where individuals remained enrolled despite notifying an eligibility worker that they moved out of state, and one where the individual reported a change in income that made them ineligible.</li> </ul>
Use of incomplete or incorrect information on household composition	<ul style="list-style-type: none"> <li>Auditors in Montana found enrollees did not always report spouses on their Medicaid applications. Specifically, a review of state tax data for 100 Medicaid cases found 16 instances when a spouse was listed in tax data, but not in the state information system; and six instances where a spouse was listed in tax data, but was listed as a nonspouse in the system.</li> <li>Auditors found that Minnesota overpaid for the health care costs of four of the 100 households sampled, because household composition was not verified or was reported incorrectly. For example, case files erroneously listed children as parents, or did not correctly include a spouse.</li> </ul>
Eligible individuals who were not enrolled	<ul style="list-style-type: none"> <li>An audit of California’s Medicaid program identified more than 54,000 individuals who, as of December 2017, had been eligible for coverage for at least 3 months, but were not shown as eligible in the state’s system.</li> <li>Auditors in Minnesota found that nine of 25 children sampled were eligible for Medicaid, but enrolled in a program for higher-income families that required premiums and other out-of-pocket costs due to errors such as not resolving an income discrepancy, discrepancies between eligibility and payment system records, and systems incorrectly calculating income.</li> </ul>
Other	<ul style="list-style-type: none"> <li>In state fiscal years 2016 and 2017, an audit found the state of Washington did not perform all required post-enrollment income verifications due to high enrollment volumes and inadequate staffing. This backlog resulted in individuals who did not qualify for Medicaid receiving an average of 5 months of benefits, costing the state between \$15.1 and \$19.2 million in fiscal year 2017.</li> <li>A Louisiana audit found that in 5 percent of sampled cases the Medicaid agency allowed people to apply on behalf of other adults for whom they had no legal authority to submit an application.</li> <li>A Connecticut audit found issues related to Social Security numbers in a sample of 60 enrollees, including two cases where the numbers were not verified with the Social Security Administration, one case where the state received but did not act upon a discrepancy alert, and one case where there was no number on file for an enrollee who had received benefits for 5 years.</li> </ul>

Source: GAO review of 47 state and federal audits conducted between 2014 and 2018. | GAO-20-157

Note: Not all of the accuracy issues identified in the audits resulted in incorrect eligibility determinations. Additionally, in some cases, the auditors found that states were complying with their policies and federal requirements, but that changes in states’ policies could provide more information that could be used to improve the accuracy of eligibility determinations.

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<sup>a</sup>The Patient Protection and Affordable Care Act established a new eligibility group for nonelderly, nonpregnant adults whose income does not exceed 133 percent of the federal poverty level, and who are not eligible under previously established mandatory eligibility groups. Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)). A subset of individuals who gained coverage under the new adult group and who would not have been eligible under the state's Medicaid plan in effect on December 1, 2009, are generally considered "newly eligible," and federal financial participation for coverage of these individuals is provided at a higher matching rate.

In some cases, the accuracy issues identified by auditors resulted in errors in eligibility determinations, such as instances when applicants were determined eligible even though their incomes were above the applicable limit, or instances in which the state did not enroll eligible individuals. However, in other instances, the accuracy issues identified by auditors did not result in erroneous eligibility determinations. For example, in some cases the audit found that a state determined that an applicant was eligible based on incorrect or incomplete financial information; however, auditors found that the applicant would have still been eligible for Medicaid even after reviewing additional financial information. In other cases, auditors found that eligibility determinations complied with state policies and federal requirements, but that changes in state policies—such as using additional data sources or checking sources more frequently—could provide more information that could be used to improve eligibility determinations. For example, audits in three states found that the quarterly wage data the states used to verify income did not detect certain nonwage income; that income could have been identified had the states chosen to use state or federal tax data as a verification source.<sup>33</sup> Auditors in one of these states (Louisiana) also found that checking income data during individuals' coverage period, such as on a quarterly basis, could have saved the state tens of millions of dollars in managed

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<sup>33</sup>Officials from one of the states in which we conducted interviews noted that although federal tax data contain more complete information on nonwage income sources, the data can be up to 2 years out-of-date and that there are significant security requirements to access the data.

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care fees for individuals whose incomes exceeded eligibility thresholds during their enrollment period.<sup>34</sup>

The selected states we reviewed reported having processes in place that were designed to avoid or address many, but not all, of the accuracy issues identified. The following are examples of the states' processes related to specific accuracy issues.

**Incorrect or incomplete income or asset information.** All five selected states we reviewed reported checking electronic data sources to verify income, including for individuals who report \$0 in income. Officials from some states noted, however, that the electronic sources they have chosen to use do not include all relevant types of income, such as self-employment income.<sup>35</sup> The five states also reported having electronic asset verification systems to verify financial assets, such as bank and retirement accounts for applicants subject to asset limits. One state (New Mexico) reported that it recently implemented an asset verification system that includes information from financial institutions, property ownership records, and vehicle licensing.

**Eligibility redeterminations not made in a timely manner.** To help ensure that redeterminations are made in a timely manner, all five selected states reported conducting automatic redeterminations for at least some MAGI enrollees using electronic data sources to confirm continued eligibility. The proportion of MAGI enrollees whose eligibility was automatically redetermined ranged from about 10 to 80 percent. Officials from Virginia, which was cited by auditors in 2015 as having significant delays in conducting redeterminations, reported that automatic redeterminations have helped improve timeliness. Where automatic eligibility redeterminations are not conducted—such as for enrollees whose incomes could not be confirmed through electronic sources or who

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<sup>34</sup>Louisiana Legislative Auditor, *Medicaid Eligibility: Wage Verification Process of the Expansion Population* (2018). States are generally only required to redetermine enrollees' eligibility for MAGI-based Medicaid every 12 months and thus are not required to check income more frequently. See 42 C.F.R. § 435.916 (2018). In some cases, states may not terminate a beneficiary's eligibility despite a change in income, such as during a continuous eligibility period for a pregnant woman or child. See 42 C.F.R. §§ 435.926 (continuous eligibility for children), 435.170(c) (continuous eligibility for pregnant women) (2018).

<sup>35</sup>States generally have flexibility to determine the electronic data sources they use for verification of financial information based on the extent to which the state finds such information useful. See 42 C.F.R. § 435.948 (2018).



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are eligible on a MAGI-exempt basis—the five selected states reported having systems in place to generate a redetermination packet or notice to be sent to enrollees prior to the end of their eligibility period. Officials reported that enrollees who do not complete their redetermination would be disenrolled, with states varying in how quickly they would take such action. For example, Oklahoma officials reported that the state automatically terminates enrollment for individuals who do not reply with the required information by the end of their coverage period. In contrast, Virginia officials reported that redeterminations for which no response was provided are kept open, pending eligibility worker action; the state's systems do not automatically terminate enrollment.

**Unresolved income discrepancies.** Officials in the five selected states reported that their eligibility systems automatically identify income discrepancies. For example, Oklahoma officials indicated that if there is more than a 5 percent difference in the income reported on the application and the income from electronic data sources, their system either alerts eligibility workers or automatically sends a request for additional information to the enrollee.

**Individuals enrolled in incorrect basis of eligibility.** According to state officials, their eligibility systems have automated checks to reassess the eligibility for individuals reaching certain milestones, such as the maximum age for their basis of eligibility (i.e., children reaching adulthood and adults reaching age 65) and pregnant women who are approaching the end of their 60-day postpartum period. For example, to help ensure individuals are correctly assigned to the appropriate basis of eligibility, officials in Maryland noted that they apply system edits that preclude individuals who are pregnant, age 65 or older, or enrolled in Medicare from being incorrectly assigned to the new adult group.<sup>36</sup>

**Unidentified or unaddressed changes in circumstances.** Officials from the five selected states indicated that they generally had systems in place to identify if an enrollee had died or moved out of state. For

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<sup>36</sup>PPACA established a new eligibility group for nonelderly, nonpregnant adults whose income does not exceed 133 percent of the federal poverty level, and who are not eligible under previously established mandatory eligibility groups. Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)). A subset of individuals who gained coverage under the new adult group and who would not have been eligible under the state's plan in effect on December 1, 2009, are generally considered "newly eligible," and federal financial participation for coverage of these individuals is provided at a higher matching rate.

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example, officials from the five selected states reported conducting periodic checks of residency through the Public Assistance Reporting Information System—a federal data source that identifies individuals receiving benefits in other states—and following up with identified enrollees to see if they still reside in the state. None of the selected states conducted regular reviews to identify changes in MAGI enrollees’ incomes during the enrollment period, although one state—Oklahoma—planned to implement interim checks of income in response to a recent change in state law. Oklahoma also reported that it conducted quarterly checks of wage data for MAGI-exempt enrollees.<sup>37</sup>

**Use of incomplete or incorrect information on household composition.** The selected states generally did not have processes in place to detect accuracy issues related to household composition, although officials in four of the five states—Maryland, New Mexico, Oklahoma, and Virginia—noted that eligibility information from other benefit programs may be compared with Medicaid files to detect changes or discrepancies in household membership.

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## Previous Reviews CMS Used for Measuring Eligibility Errors Were Insufficient to Recoup Funds from States; New Procedures Are in Place for 2022

In 1983, CMS implemented its statutory requirement to recoup funds associated with Medicaid eligibility-related improper payments for states with an eligibility error rate above 3 percent through its MEQC program. The MEQC program required states to randomly sample Medicaid enrollees to verify eligibility. Claims related to enrollees determined ineligible were tallied and compared with total claims for the sample universe to calculate an error rate. Following federal validation, states were subject to recoupment of all or part of the federal funds expended related to erroneous state payments over the 3 percent error rate threshold.

However, in 1992, HHS’s Departmental Appeals Board—the department’s final level of administrative review—concluded that the MEQC error rate was not sufficiently accurate to provide reliable evidence to support recoupment of funds due to the small sample size from which the error rate was calculated. Consequently, the appeals board stated that it was “impossible to conclude with a reasonable certainty that the

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<sup>37</sup>States are not required to check for changes in income during the enrollment period, but if they are made aware of such changes, then they must redetermine individuals’ eligibility.

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States failed to meet their target rates....”<sup>38</sup> As a result of this opinion, CMS provided states the option, beginning in 1994, to either continue operating a traditional MEQC program or to conduct what CMS referred to as “MEQC pilots,” which focused on prospective improvements in eligibility determinations, rather than calculation of error rates. Since the “MEQC pilots” did not produce an error rate, CMS could not recoup federal funds expended due to erroneous eligibility determinations for states participating in the pilots. Between 2012, the earliest year for which CMS has maintained records, and 2014 when CMS suspended the MEQC program, 39 states participated in these “MEQC pilots” exempting them from possible recoupment of funds due to eligibility errors.<sup>39</sup> While the other 12 states that continued to operate traditional MEQC programs could still be subject to recoupment of funds, CMS officials reported that no recoupments related to eligibility errors had occurred since the 1992 appeals board ruling, because none of these states had an error rate exceeding the 3 percent threshold. Thus, CMS has not recouped federal funds due to eligibility errors in decades.

However, the agency has introduced new procedures through which it can, under certain circumstances, begin to recoup funds based on eligibility errors in fiscal year 2022. Specifically, in July 2017, CMS issued new regulations that included changes to its PERM process to satisfy the statutory requirements for recouping funds that MEQC was previously designed to operationalize.<sup>40</sup> Under the revised PERM rules, CMS calculated an eligibility error improper payment rate beginning with the cohort of states under review for the fiscal year 2019 reporting period. However, it will not recoup funding from states with error rates exceeding the 3 percent threshold until states have a second review under the revised PERM rules, which will occur for the first cohort of states in fiscal year 2022. This allows each state the opportunity to implement improvements based on its initial PERM review and the MEQC review it

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<sup>38</sup>Department of Health and Human Services, Departmental Appeals Board, *FY 1981 Medicaid Quality Control Disallowances*, No. 1332 (1992).

<sup>39</sup>CMS officials reported that due to their record retention requirements, the agency does not have information on the number of states that participated in “MEQC pilots” prior to 2012.

<sup>40</sup>82 Fed. Reg. 31182 (July 5, 2017) (codified at 42 C.F.R. pts. 431, 457 (2018)).

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will conduct in the off-cycle years to reduce the error rate or demonstrate a “good faith effort” to do so.<sup>41</sup>

CMS officials recognize the benefits of using state and federal audits, such as audits we reviewed for this report, as part of a broader strategy to improve program integrity and oversee states’ eligibility determination processes. However, CMS officials told us they do not have the authority to recoup federal funds related to eligibility errors identified outside of the PERM process, such as through state single audits. According to CMS officials, this is because of the specific statutory instruction limiting recoupments to instances when eligibility-related errors exceed the 3 percent error rate threshold, and because PERM is the process that CMS uses to calculate that error rate.<sup>42</sup> The President’s fiscal year 2020 budget request included a legislative proposal to expand HHS’s authority to issue disallowances for eligibility errors. Specifically, the proposal requests legislative authority to

- permit HHS to issue disallowances outside of PERM and allow HHS, including the HHS-OIG, to extrapolate findings on beneficiary eligibility to ensure federal recovery of incorrect eligibility determinations; and
- eliminate the current 3 percent threshold for states’ eligibility-related improper payments. In place of the current 3 percent disregard, HHS would issue rulemaking specifying criteria for the recoupment of funds, including limiting them to instances of monetary loss, such as cases in which ineligible individuals received benefits.

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<sup>41</sup>Under the revised PERM regulation, all states are required to conduct MEQC reviews during the 2 years between PERM reviews. States may target their MEQC reviews to specific populations or processes with the goal of decreasing errors in future PERM reviews. To demonstrate a “good faith” effort to reduce their error rates, states must implement a corrective action plan to address the findings from their PERM review and meet all requirements of the MEQC program.

<sup>42</sup>Although CMS does not recoup funds for eligibility errors identified outside of PERM, the agency does review states’ quarterly expenditure reports to determine if states are correctly claiming enhanced federal funding for individuals eligible for Medicaid under the expansion enacted as part of PPACA. While CMS may determine that states are not correctly claiming enhanced federal funds based on eligibility factors, such as the age of an enrollee, these reviews are for errors in claiming of federal funds, not eligibility errors, since they do not examine the accuracy of initial eligibility determinations. Any errors in claiming may require the state to adjust future expenditure reports to account for the funds spent in error. States that expand Medicaid are subject to quarterly reviews of these enhanced matching expenditures until they have four consecutive quarters with three or fewer errors. After that, reviews are conducted annually. Of the 32 states that expanded Medicaid and that have undergone at least four quarterly reviews as of July 2019, all but one has transitioned to annual reviews, according to CMS.

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## Concluding Observations

Determining whether individuals are eligible for Medicaid is a complex process that is vulnerable to error. The processes used to measure the extent of eligibility errors have been, and will continue to be, in a state of transition over the next several years as CMS implements its new PERM procedures and states implement improvements after their initial PERM reviews under these new procedures. Because CMS has not had a complete national estimate of improper payments due to eligibility errors since 2014, policymakers and other stakeholders have had an incomplete picture of the extent of eligibility errors in the Medicaid program nationally. This state of flux will make the findings from federal and state audits an even more important source of information on the accuracy of states' eligibility determinations. As we have previously reported, oversight of the Medicaid program could be further improved through leveraging and coordinating program integrity efforts with state auditors to further improve the integrity of the Medicaid program.

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## Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS, the Administrator of the CMS, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Summary of Federal and State Audits of the Accuracy of States' Medicaid Eligibility Determinations

Table 4 provides a summary of key findings from the 47 federal and state audits that discussed the accuracy of states' Medicaid eligibility determinations, published from 2014 through 2018, which we identified and reviewed.

**Table 4: Summary of Key Findings Related to the Accuracy of States' Medicaid Eligibility Determinations from Federal and State Audits**

State	Findings	Source (descending by state)
<b>U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG) Audits</b>		
California	<p>Auditors found that out of a sample of 125 enrollees, California made payments for 14 who were ineligible and 52 who were potentially ineligible.</p> <ul style="list-style-type: none"> <li>Of the 14 ineligible enrollees, some did not meet income or asset requirements for the coverage group in which they were enrolled, and others did not meet citizenship or residency requirements.</li> <li>The state did not document that annual eligibility redeterminations were performed properly or that all eligibility criteria were verified for most of the 52 potentially ineligible enrollees.</li> </ul> <p>Based on the sample, auditors projected that the state made Medicaid payments of over \$959 million for ineligible enrollees.</p>	HHS-OIG, <i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i> , 2018.
California	<p>Auditors found that out of a sample of 150 enrollees the state identified as newly eligible under the Patient Protection and Affordable Care Act (PPACA) Medicaid expansion, California made payments for 27 who were ineligible for the group in which they were enrolled and 14 who were potentially ineligible.<sup>a</sup></p> <ul style="list-style-type: none"> <li>Of the 27 enrollees not eligible for the group in which they were enrolled, some were eligible for enrollment on other bases, while others had incomes too high to be eligible for Medicaid.</li> <li>The state did not verify all eligibility criteria for some of the 14 potentially ineligible enrollees, and one of these enrollees was found to be receiving assistance in another state.</li> </ul>	HHS-OIG, <i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i> , 2018
Kentucky	<p>Auditors found that the state did not request documentation to resolve discrepancies related to four enrollees who reported incomes incompatible with information contained in an electronic data source, and that the state was not able to provide documentation of either income or citizenship verification for five additional individuals.</p>	HHS-OIG, <i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i> , 2017.
Kentucky	<p>Auditors found that the state did not have the required documentation to show that it verified enrollees' citizenship. Specifically, they found that the eligibility system did not retain confirmation of electronic verification and caseworkers did not scan paper documentation into the case file for seven of 120 sampled enrollees.</p>	HHS-OIG, <i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance with Federal and State Requirements</i> , 2017.

**Appendix I: Summary of Federal and State  
Audits of the Accuracy of States' Medicaid  
Eligibility Determinations**

<b>State</b>	<b>Findings</b>	<b>Source (descending by state)</b>
New York <sup>b</sup>	Auditors found that that New York did not follow federal and state standards for determining eligibility for 37 of 130 sampled enrollees. Issues primarily involved individuals identified as newly eligible under Medicaid expansion despite either not meeting income criteria or being eligible under another eligibility group, such as pregnant woman. Auditors also found that 26 of the 130 sampled enrollees had income changes during the enrollment period and no longer qualified as newly eligible even though the state correctly determined eligibility at the time of their annual redetermination.	HHS-OIG, <i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i> , 2018.
<b>State Audits of Medicaid Eligibility</b>		
California	<p>Auditors found that, due to discrepancies between state and county eligibility systems, individuals no longer eligible for the state's Medicaid program were not disenrolled in a timely manner, at an estimated cost of \$4 billion in federal and state Medicaid funds. Issues included the following:</p> <ul style="list-style-type: none"> <li>• One case where the state paid more than \$1 million in claims over an 18 month period for an individual who county systems showed was no longer eligible.</li> <li>• 170,000 enrollees with temporary Medicaid eligibility who were past the date when final eligibility should have been confirmed; most of whom were more than 1 year overdue.</li> </ul> <p>The audit also identified more than 54,000 individuals who, as of December 2017, had been eligible for coverage for at least 3 months, but were not enrolled in the state's system.</p>	California State Auditor, <i>Department of Health Care Services: It Paid Billions in Questionable Medi-Cal Premiums and Claims Because it Failed to Follow Up on Eligibility Discrepancies</i> , 2018.
Kansas	Auditors found that to address a backlog of initial eligibility determinations, state officials chose to stop processing annual redeterminations and deemed individuals submitting renewal applications eligible for continued Medicaid to allow staff to focus on new applications. As a result of this decision, as of mid-July 2016, nearly 35,000 redeterminations were waiting to be processed.	Legislative Division of Post Audit, <i>KanCare: Reviewing the Timeliness of Medicaid Eligibility Determinations</i> , 2016.
Louisiana	Auditors identified nearly 20,000 individuals who, based on state wage data, appeared to exceed the income limit. They examined case files for 200 of these individuals—100 selected at random and the 100 individuals with the highest wages—and found that 175 of them did not qualify based on income at some point during their coverage. Using results from the random sample, auditors estimated that the state unnecessarily paid \$73.5 million in managed care fees.	Louisiana Legislative Auditor, <i>Medicaid Eligibility: Wage Verification Process of the Expansion Population</i> , 2018.
Louisiana	<ul style="list-style-type: none"> <li>• Auditors examined a sample of 60 individuals and found that five (8 percent) were ineligible for Medicaid due to having too much or unverified income. This resulted in \$60,586 in managed care fees, which the auditors projected to equate to \$111 million for the entire population.</li> <li>• Auditors found that the state relied on state wage data and not federal or state tax data to verify income, and noted that using tax data would allow the state to verify household composition, as well as out of state and nonwage income sources (e.g., self-employment income).</li> <li>• Auditors also found other issues with the state's practices, such as inappropriate use of automatic redeterminations and signed applications that were not retained.</li> </ul>	Louisiana Legislative Auditor, <i>Medicaid Eligibility: Modified Adjusted Gross Income (MAGI) Determination Process</i> , 2018.

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<b>State</b>	<b>Findings</b>	<b>Source (descending by state)</b>
Louisiana	Auditors compared the attested incomes of approximately 860,000 enrollees to state tax data, which the state did not use for income verification, and found that a significant number of enrollees (83,850) reported incomes to Medicaid that differed from their tax returns by \$20,000 or more. Auditors also noted that the threshold the state used to determine if attested income is compatible with electronic sources allows for more variation than other states' Medicaid programs.	Louisiana Legislative Auditor, <i>Strengthening of the Medicaid Eligibility Determination Process</i> , 2018.
Louisiana	Auditors reviewed a sample of 160 Medicaid enrollees who had out-of-state addresses and no paid claims in 4 years. They found that all 160 had permanently moved out of the state and that the state had unnecessarily paid \$943,274 in managed care fees on behalf of the enrollees.	Louisiana Legislative Auditor, <i>Medicaid Recipient Eligibility: Managed Care and Louisiana Residency</i> , 2016.
Minnesota	Auditors found that eligibility was approved for three individuals with assets above statutory limits out of a sample of 100 aged, blind, or disabled Medicaid enrollees. They also found that 10 of the 100 had vehicles not reported as assets to the Medicaid program, though the value of these vehicles did not cause the individuals to exceed the asset limit, and thus did not affect eligibility.	Office of the Legislative Auditor, <i>Medical Assistance Eligibility: People Age 65 or Older and People Who Are Blind or Have a Disability</i> , 2018.
Minnesota	Auditors examined a sample of households and individuals and found the following: <ul style="list-style-type: none"> <li>• Enrollees did not always report changes in income, resulting in \$26,000 to \$38,000 in managed care payments for individuals after they were likely ineligible.</li> <li>• Eligibility workers did not always disenroll individuals after learning of a change in income or residency, or after individuals did not provide documentation of citizenship or income. The state made \$15,683 in managed care payments related to 12 individuals who remained enrolled after reporting changes.</li> <li>• Some individuals were enrolled under the wrong eligibility category (e.g., parent enrolled as an adult without children).</li> </ul>	Office of the Legislative Auditor, <i>Medical Assistance Eligibility: Adults Without Children</i> , 2018.
Minnesota	Auditors found several issues, including the following: <ul style="list-style-type: none"> <li>• Eligibility criteria, including applicants' Social Security numbers, citizenship, income, and household composition were not always verified, which resulted in ineligible individuals being enrolled.</li> <li>• Eligibility redeterminations were not always conducted in a timely manner. Of a sample of 62 Medicaid enrollees, 39 percent were 2 to 5 months past their 12-month redetermination time frame. The state paid over \$39,000 in benefits for enrollees in the months they were past their redetermination dates.</li> <li>• The state did not adequately verify that individuals were enrolled under the correct eligibility category, which affected managed care capitation payments.</li> </ul>	Office of the Legislative Auditor, <i>Oversight of MNsure Eligibility Determinations for Public Health Care Programs</i> , 2016.



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<b>State</b>	<b>Findings</b>	<b>Source (descending by state)</b>
Minnesota	<p>Auditors reviewed a sample of individuals recently enrolled in public health care programs, including 137 individuals in Medicaid, and found numerous eligibility errors and issues:</p> <ul style="list-style-type: none"> <li>• Due to a number of system errors, individuals were incorrectly enrolled in Medicaid; were denied Medicaid and enrolled in a program for higher-income individuals; or were enrolled under the incorrect eligibility category, which affected managed care capitation rates.</li> <li>• Three cases where individuals' incomes increased above the Medicaid eligibility limit after their initial enrollment. These individuals did not report changes to the state as required; however, even among individuals who did report changes, eligibility staff were unable to close their cases in the eligibility system as of September 2014.</li> <li>• Five cases where women who were previously eligible based on their pregnancy were not reassessed for eligibility after the post-partum period.</li> </ul>	Office of the Legislative Auditor, <i>Oversight of MNsure Eligibility Determinations for Public Health Care Programs</i> , 2014.
New Jersey	<ul style="list-style-type: none"> <li>• Auditors found that enrollment period end dates were not being used in the eligibility system for most enrollees (1.4 of 1.6 million) leading to untimely redeterminations. The state did not use the end date function to avoid wrongful terminations. Without an end date, auditors noted, an enrollee could potentially receive benefits in perpetuity.</li> <li>• Auditors also found that the electronic data sources the state used to verify income did not include all nonwage sources. When auditors checked the 1,337 applications received over the audit period against state tax data, 1,026 had relevant unreported income on their or their spouse's state tax return in the prior year. Auditors estimated \$3.9 million in improper capitation payments for individuals who likely would not have been eligible if nonwage income from the prior year's tax return had been considered.</li> </ul>	Office of Legislative Services, <i>Office of the State Auditor, NJ FamilyCare Eligibility Determinations</i> , 2018.
New York	Based on information from an independent verification service, auditors found that 354 enrollees were deceased during a 9-month period in 2014, and that the state made \$325,030 in Medicaid payments for a subset of these individuals. Auditors noted that the state's eligibility system did not have a standard process to periodically verify the life status of all enrollees and end coverage for deceased individuals.	New York State Office of the State Comptroller, <i>Appropriateness of Medicaid Eligibility Determined by the New York State of Health System</i> , 2015.
North Carolina	Auditors identified caseworker errors in both the processing of new applications and redeterminations, including data input errors, mathematical errors, and inaccurate recording of information. The audit also identified workload issues contributing to untimely redeterminations.	Office of the State Auditor, <i>North Carolina Medicaid Program Recipient Eligibility Determination</i> , 2017.
Oregon	Auditors reviewed 30 randomly selected individuals and identified errors in seven cases, one of which resulted in an applicant being determined eligible despite attesting to income above the limit. The state paid \$1,778 in managed care fees for this ineligible individual. The six other errors included determining applicants' eligibility based on incorrect household size and income evaluations.	Secretary of State, Audits Division, <i>OHA: Automated Medicaid eligibility is processed appropriately, yet manual input accuracy and eligibility override monitoring needs improvement</i> , 2017.
Oregon	Auditors reported that as of May 2017 the state had 115,200 enrollees with late redeterminations. More than 47,000 (41 percent) of these enrollees were ultimately determined ineligible—about half no longer met requirements and half did not respond when contacted for verification information. Auditors estimated that the delay in eligibility redeterminations led to \$88 million in avoidable expenditures.	Secretary of State, Audits Division, <i>Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments</i> , 2017.

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<b>State</b>	<b>Findings</b>	<b>Source (descending by state)</b>
Tennessee	Auditors found that redetermination information for enrollees was not always linked to their family members' cases in a timely manner, causing individuals to be determined ineligible for continued Medicaid enrollment when other family members had been approved.	Tennessee Comptroller of the Treasury, <i>Review of TennCare Eligibility Determinations</i> , 2017.
Virginia	Auditors found that <ul style="list-style-type: none"> <li>the state did not verify income against electronic data sources or other documentation for most applications for which the applicant reported \$0 income;</li> <li>eligibility workers did not search for unreported assets when assessing eligibility; and</li> <li>tens of thousands of redeterminations were late, in part, because of a decrease in case workers and a significant increase in applications.</li> </ul>	Joint Legislative Audit and Review Commission, <i>Eligibility Determination in Virginia's Medicaid Program</i> , 2015.
Washington	Auditors found that in state fiscal years 2016 and 2017, the state did not perform all required post-enrollment income verifications due to high enrollment volumes and inadequate staffing. This backlog resulted in individuals who did not qualify for Medicaid receiving an average of 5 months of benefits, costing the state between \$15.1 and \$19.2 million in fiscal year 2017.	Office of the Washington State Auditor, <i>Reducing Costs through Faster Medicaid Income Verifications</i> , 2017.
<b>State- or Department-Wide Audits with Findings Pertaining to Medicaid Eligibility</b>		
California <sup>c</sup>	Out of 140 enrollees sampled, auditors found 26 had eligibility issues, such as redeterminations not performed timely, an enrollee with assets exceeding the limit, and missing documentation.	California State Auditor, <i>State of California Federal Compliance Audit Report for the Fiscal Year Ended June 30, 2017</i> , 2018.
California <sup>c</sup>	Auditors found that redeterminations for seven of 69 enrollees sampled were not performed in a timely manner; they were overdue by 29 to 205 months. Three of the seven were ultimately ineligible, and auditors identified nearly \$24,000 in expenditures for these three individuals during the audit period.	California State Auditor, <i>State of California Federal Compliance Audit Report for the Fiscal Year Ended June 30, 2016</i> , 2017.
California <sup>c</sup>	Auditors found five instances where eligibility information was not obtained or documented across a sample of 140 enrollees, such as a missing redetermination form.	California State Auditor, <i>State of California Federal Compliance Audit Report for the Fiscal Year Ended June 30, 2015</i> , 2016.
Connecticut <sup>c</sup>	Auditors found that the agency did not enter a Social Security number into the eligibility system in four cases, which prevented electronic verification of income and other eligibility criteria. In addition, the audit cited various documentation issues, such as lack of documentation of a timely redetermination.	Auditors of Public Accounts, <i>State of Connecticut Single Audit Report</i> , 2018.
Connecticut <sup>c</sup>	Auditors found that the agency did not enter a Social Security number into the eligibility system in six cases, which prevented electronic verification of income and other eligibility criteria. Social Security numbers were never obtained for an additional three enrollees. In addition, the audit cited various documentation issues, such as lack of documentation of a timely redetermination.	Auditors of Public Accounts, <i>State of Connecticut Single Audit Report</i> , 2017.

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<b>State</b>	<b>Findings</b>	<b>Source (descending by state)</b>
Connecticut <sup>c</sup>	Auditors found that the agency did not enter a Social Security number into the eligibility system in three cases, which prevented electronic verification of income and other eligibility criteria. Social Security numbers were never obtained for an additional four enrollees who had been receiving Medicaid benefits for 3 to 10 years. In addition, auditors found cases where redeterminations were not performed timely, Social Security numbers had not been verified, and a case file was missing the application.	Auditors of Public Accounts, <i>State of Connecticut Single Audit Report</i> , 2016.
Connecticut <sup>c</sup>	Auditors found that the agency did not enter a Social Security number into the eligibility system in eight cases, which prevented electronic verification of income and other eligibility criteria. In addition, the audit cited various documentation issues, such as lack of documentation of a timely redetermination or no application on file.	Auditors of Public Accounts, <i>State of Connecticut Single Audit Report</i> , 2015.
Delaware <sup>c</sup>	Auditors identified documentation issues related to missing application forms and lack of evidence of timely redeterminations.	Department of Finance, <i>Division of Accounting, Comprehensive Annual Financial Report</i> , 2017.
Florida <sup>c</sup>	Auditors cited a lack of documentation to support that 8 percent of sampled enrollees met eligibility requirements.	Auditor General, <i>State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards</i> , 2018.
Maine <sup>c</sup>	Auditors found that the state did not document follow-up on a number of discrepancies identified through electronic data matching of eligibility information, such as earned income and unemployment income.	Office of the State Auditor, <i>Single Audit Report: Uniform Guidance</i> , 2018.
Maine <sup>c</sup>	Auditors found that the state did not document follow-up on a number of discrepancies identified through electronic data matching of eligibility information, such as earned income, unemployment income, and Social Security benefits.	Office of the State Auditor, <i>Single Audit Report: Uniform Guidance</i> , 2017.
Maine <sup>c</sup>	Auditors found that the state did not document follow-up on a number of discrepancies identified through electronic data matching of eligibility information, such as earned income and Social Security benefits.	Office of the State Auditor, <i>Single Audit Report: OMB Circular A-133</i> , 2016.
Maryland	Auditors examined a sample of Medicaid redeterminations for individuals with disabilities and found that 17 of 20 were not consistently performed, because of a lack of agency oversight of caseworkers under contract to conduct them.	Office of Legislative Audits, <i>Department of Mental Hygiene, Developmental Disabilities Administration</i> , 2016.
Michigan <sup>c</sup>	Auditors identified documentation issues related to income verification checks. Without this information, eligibility could be determined based on incomplete information. In addition, individuals were not disenrolled in a timely manner when their period of transitional Medicaid eligibility was over, or when they exceeded the age criteria for the “under age 21” eligibility group.	Office of the Auditor General, <i>State of Michigan Single Audit Report</i> , 2017.
Michigan <sup>c</sup>	Auditors identified documentation issues related to income verification checks. Without this information, eligibility could be determined based on incomplete information. Auditors also noted that individuals in the “under age 21” eligibility group did not have appropriate end dates to signal when they would age-out of this group.	Office of the Auditor General, <i>State of Michigan Single Audit Report</i> , 2015.

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Montana	Auditors found enrollees did not always report spouses on their Medicaid applications. Specifically, a review of state tax data for 100 Medicaid applications found 16 instances when a spouse was listed in tax data, but not on the application, and six instances where a spouse was listed in tax data, but was listed as a nonspouse on the application.	Legislative Audit Division, <i>State Efforts to Mitigate Fraud, Waste, and Abuse in the Montana Medicaid Program</i> , 2018.
North Carolina <sup>c</sup>	Auditors found that 6 percent of sampled cases had missing documentation.	Office of the State Auditor, <i>Single Audit Report</i> , 2017.
Vermont <sup>c</sup>	Auditors found the state had not been completing redeterminations in a timely manner, and had paid \$20.8 million for individuals with overdue redeterminations during the period of March 2016 to June 2017. Auditors also noted several other eligibility issues, such as documentation issues related to citizenship and evidence of disability status.	KPMG, <i>Auditors' Reports as Required by Uniform Guidance and Government Auditing Standards and Related Information</i> , 2017.
Vermont <sup>c</sup>	Auditors found the state had not been completing redeterminations in a timely manner, and had paid \$11.2 million for individuals with overdue redeterminations during the period of March 2016 to June 2016. Auditors also noted several other eligibility issues, such as documentation issues related to citizenship.	KPMG, <i>Auditors' Reports as Required by Uniform Guidance and Government Auditing Standards and Related Information</i> , 2016.
Vermont <sup>c</sup>	Auditors found that the state automatically reenrolled individuals without proper redeterminations in fiscal years 2014 and 2015 to avoid enrollees losing coverage due to system limitations. The audit noted several other eligibility issues, such as documentation issues related to citizenship and incorrect bases of eligibility based on age and income.	KPMG, <i>Auditors' Reports as Required by Office of Management and Budget Circular A-133 and Government Auditing Standards and Related Information</i> , 2015.
Vermont	Auditors found that there were 54,000 individuals enrolled in Medicaid between January 2014 and March 2015 whose incomes, immigration status, or both had yet to be verified. In addition, the state did not have a process to conduct redeterminations for individuals due to limitations in its new eligibility system.	Vermont State Auditor, <i>Vermont Health Connect: Future Improvement Contingent on Successful System Development Project</i> , 2015.
Vermont <sup>c</sup>	Auditors found several types of documentation issues, including lack of verification of citizenship status or meeting disability criteria.	KPMG, <i>Auditors' Reports as Required by Office of Management and Budget (OMB) Circular A-133 and Government Auditing Standards and Related Information</i> , 2014.
Virginia <sup>c</sup>	Auditors found 523 cases of Medicaid enrollees with unresolved discrepancies in Social Security numbers.	Auditor of Public Accounts, <i>Agencies of the Secretary of Health and Human Resources Report on Audit For the Year Ended June 30, 2017</i> , 2018.
Wisconsin <sup>c</sup>	Auditors found cases where income discrepancies identified through checks of wage data and unemployment compensation were not resolved within the 45 day time period.	Legislative Audit Bureau, <i>State of Wisconsin FY 2015-16 Single Audit</i> , 2017.

Source: GAO review of 47 state and federal audits conducted between 2014 and 2018. | GAO-20-157

Note: Not all of the accuracy issues identified in the audits resulted in incorrect eligibility determinations. Additionally, in some cases, the auditors found that states were complying with their policies and federal requirements, but that changes in states' policies could provide more information that could be used to improve the accuracy of eligibility determinations.

<sup>a</sup>PPACA established a new eligibility group for nonelderly, nonpregnant adults whose income does not exceed 133 percent of the federal poverty level, and who are not eligible under previously-established mandatory eligibility groups. Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)). A subset of individuals who gained coverage under the new adult group and who would not have been eligible under the state's Medicaid plan in effect on December 1, 2009, are generally considered "newly eligible," and federal financial participation for coverage of these individuals is provided at a higher matching rate.

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<sup>b</sup>The HHS-OIG published a related report in July 2019, after we had concluded our review period. The report, "New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries," contained similar findings to the above-referenced reports related to not verifying all eligibility criteria and not maintaining documentation to support eligibility determinations.

<sup>c</sup>Organizations based in the United States with expenditures of federal funding of \$500,000 or more (\$750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization's fiscal year are required to send an audit report to the Office of Management and Budget, in accordance with the Single Audit Act, as amended, and the Office of Management and Budget implementing guidance. See 31 U.S.C. §§ 7501-7507; 2 C.F.R., pt. 200, subpt. F. (2019) (as added by 78 Fed. Reg. 78590, 78608 (Dec. 26, 2013)).

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

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## Staff Acknowledgments

In addition to the contact named above, Michelle Rosenberg (Assistant Director), Perry Parsons (Analyst-in-Charge), and Heather Tompkins made key contributions to this report. Also contributing were Drew Long, Vikki Porter, and Jenny Rudisill.

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