Report Highlights

Why DLA Performed This Audit

The audit was requested in recognition of the State's declining fiscal condition and the high amount of State general funds spent on Medicaid and CHIP benefits. Audit objectives included determining whether Department of Health and Social Services staff properly determined eligibility and timely enrolled beneficiaries, terminated benefit coverage for individuals no longer eligible for benefits, and preserved and maximized the use of Medicaid and CHIP funds. Auditors were directed to estimate the amount that the State of Alaska paid for benefits on behalf of ineligible beneficiaries and to review the extent eligibility determination best practices were implemented.

What DLA Recommends

1. DPA's director should improve Medicaid and CHIP eligibility training and reestablish a case review process.
2. DPA's director should continue to resolve system weaknesses in Alaska's Resource for Integrated Eligibility Services System.
3. DPA's director should update Medicaid and CHIP regulations for modified adjusted gross income eligibility requirements.

A Special Review of the Department of Health and Social Services, Medicaid and Children's Health Insurance Program (CHIP) Eligibility

August 27, 2020

Audit Control Number 06-30094-20

REPORT CONCLUSIONS

The audit found that 42 percent of Division of Public Assistance (DPA) eligibility determinations tested were not accurate and 43 percent were not made in a timely manner. Many of the errors were procedural in nature with no fiscal impact, while some errors resulted in ineligible costs. Based on the testing results, the audit estimates $102 million of federal funds and $28 million of State general funds were spent on FY 19 benefits for ineligible recipients. The estimate is likely understated because DPA has no procedures for verifying household size, a critical component of eligibility, and auditors were unable to test the accuracy of household size.

The widespread errors were attributed to inadequate staffing and training. According to management, Medicaid expansion and an economic recession created a large backlog of applications. During this time, processing applications was prioritized over quality control activities, such as supervisory reviews and training. As a result, the accuracy and timeliness of eligibility determinations declined.

A new eligibility system implemented in 2014 to meet requirements of the Affordable Care Act (ACA) further contributed to eligibility errors. Rather than streamlining the eligibility process as envisioned by the ACA, the system was plagued with problems that created inefficiencies. At the time of the audit, the system continued to have material control weaknesses.

The audit identified several system-related "best practices" that may reduce workload, streamline the application process, and improve accuracy. Implementing the best practices will require information technology expertise and adequate funding.

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ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE
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October 20, 2020

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24, we have reviewed Medicaid and Children's Health Insurance Program eligibility and the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM ELIGIBILITY

August 27, 2020

Audit Control Number
06-30094-20

The audit reported on the accuracy and timeliness of Medicaid and Children's Health Insurance Program eligibility determinations for beneficiaries with claims paid between July 1, 2018, through March 31, 2019. The audit also estimated the amount paid for ineligible Medicaid and CHIP beneficiaries during fiscal year 2019. Further, the audit evaluated the Medicaid eligibility system controls and identified eligibility best practices.

The audit was conducted 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. Fieldwork procedures utilized in the course of developing the findings and recommendations presented in this report are discussed in the Objectives, Scope, and Methodology.

Kris Curtis, CPA, CISA
Legislative Auditor

ABBREVIATIONS

AAC	Alaska Administrative Code
ACA	Affordable Care Act
ACN	Audit Control Number
APA	Adult Public Assistance
ARIES	Alaska's Resource for Integrated Eligibility Services System
AS	Alaska Statute
CHIP	Children's Health Insurance Program
CISA	Certified Information Systems Auditor
CPA	Certified Public Accountant
DHCS	Division of Health Care Services
DHSS	Department of Health and Social Services
DLA	Division of Legislative Audit
DPA	Division of Public Assistance
DSDS	Division of Senior and Disabilities Services
EIS	Eligibility Information System
ET	Eligibility Technician
FFY	Federal Fiscal Year
FY	Fiscal Year
HPE	Hospital Presumptive Eligibility
IRS	Internal Revenue Service
IT	Information Technology
MAGI	Modified Adjusted Gross Income
MMIS	Medicaid Management Information System
OCS	Office of Children's Services
PFD	Permanent Fund Division
SSI	Supplemental Security Income

CONTENTS

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ORGANIZATION AND FUNCTION

Department of Health and Social Services (DHSS)

DHSS's purpose is to promote and protect the well-being of Alaskans. DHSS is responsible for administering Alaska's Medicaid program and Children's Health Insurance Program (CHIP). Organizationally, the department has 10 divisions, each with a specific mission. Five of the 10 divisions are involved with administering Medicaid and CHIP; however, only the following four divisions were material to this eligibility audit.

Division of Health Care Services (DHCS)

DHCS's mission is to provide, to all eligible Alaskans, access to the full range of appropriate Medicaid services and to protect Alaskans through provider certification and licensing. The division supervises Medicaid and CHIP, and is responsible for program and policy development. The division is also responsible for administering the Medicaid Management Information System (MMIS), also known as the Alaska Health Enterprise system, and processing claim payments to providers. DHCS contracts with a vendor, Conduent Alaska, for system-related administration of MMIS.

Division of Public Assistance (DPA)

DPA's mission is to promote self-sufficiency and provide basic living expenses for Alaskans in need. DPA is responsible for determining eligibility for a range of programs, including Medicaid and CHIP. DPA has 14 field offices located throughout Alaska. Eligibility technician (ET) IIs are primarily responsible for processing medical and public assistance applications, and making eligibility determinations. At the end of February 2019 there were 223 budgeted ET II positions located across the state, 48 of which were vacant.

Office of Children's Services (OCS)

OCS's mission is to ensure the safety, permanency, and well-being of children by strengthening families, engaging communities, and partnering with tribes. OCS determines Medicaid and CHIP eligibility for children in foster care, children in Division of Juvenile Justice custody, children adopted through OCS, and youth in State custody. OCS has 23 field offices located throughout Alaska.

Division of Senior and Disabilities Services (DSDS)

DSDS's mission is to promote health, well-being, and safety for individuals with disabilities, seniors, and vulnerable adults by facilitating access to support and services that foster independence, personal choice, and dignity. The agency oversees Medicaid Long Term Care and Waiver services, and coordinates with DPA to determine whether individuals meet the eligibility requirements for Medicaid services.

Qualified Hospitals

As of April 2019, 19 approved hospitals across Alaska have signed a memorandum of understanding with DPA, which allows the hospital to determine Medicaid and CHIP eligibility for patients without insurance coverage. Under the federal Affordable Care Act, the hospitals must only use the patient's self-attested income and household size to determine eligibility.

BACKGROUND INFORMATION

Description of Medicaid and Children's Health Insurance Program (CHIP)

Medicaid and CHIP are federal programs designed to provide comprehensive medical health care to eligible residents. A network of federal and state laws govern Medicaid and CHIP eligibility. Individuals qualify for Medicaid by meeting certain income and, if applicable, resource standards, and specific eligibility requirements related to age, family status, and disability status. Children qualify for CHIP by meeting certain income standards. The federal government and the State of Alaska jointly fund both programs.

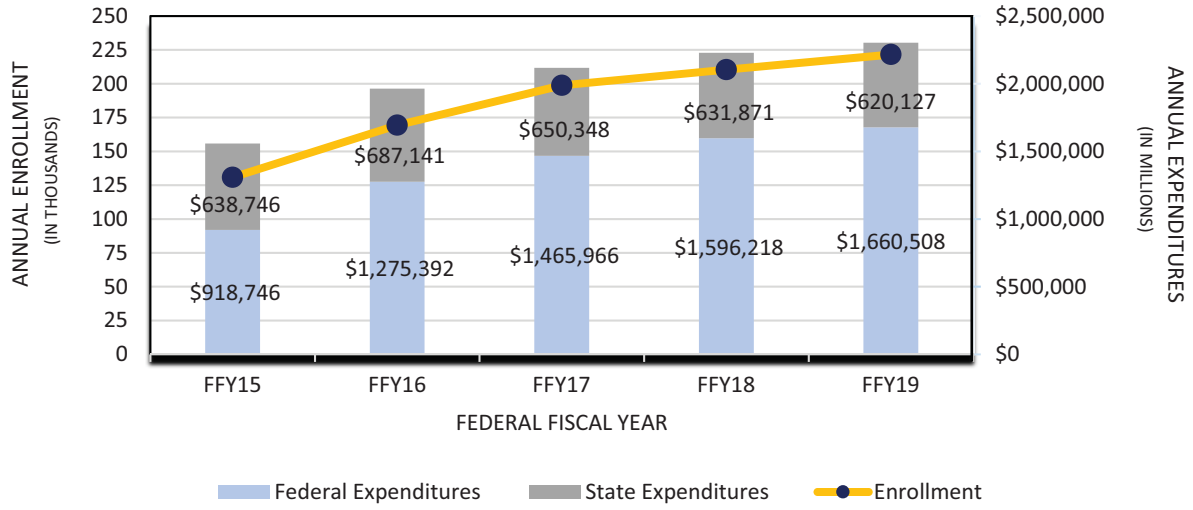
The federal Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), was signed into law March 2010. The ACA allowed states to expand Medicaid to cover individuals who were not previously eligible. Alaska implemented Medicaid expansion during September 2015. Prior to this time, Alaskan Medicaid coverage was provided to individuals in target coverage groups, such as the older aged, people with blindness or other disabilities, children, and adults with dependent children. Following the enactment of ACA, the Alaska Medicaid program expanded to cover other groups such as low-income adults from the ages of 19 to 64, parents and other caretaker relatives, and pregnant women. When Alaska expanded Medicaid, coverage also expanded to include more children through age 18 meeting certain income guidelines.

As shown in Exhibit 1 on the following page, from September 2015 to September 2019 Medicaid and CHIP enrollment increased from 130,815 to 221,587 individuals.[1] Annual federal expenditures for the same period increased from $918.7 million to $1.661 billion and State expenditures decreased from $638.7 million to $620.1 million.

[1] Enrollment count reported for the month of September by federal fiscal year.

Exhibit 1

Medicaid and CHIP Enrollment and Expenditures by Federal Fiscal Year 2015 through 2019
(Unaudited)



Source: www.medicaid.gov.

New Eligibility Determination Methodology Required by ACA

ACA required several changes to the Medicaid application, enrollment, and eligibility determination processes. Changes included use of a single, streamlined enrollment application to facilitate screening an individual's eligibility for all potential health coverage options, including Medicaid, CHIP, and qualified health plans available through health insurance marketplaces.

In most cases, ACA required the use of a modified adjusted gross income (MAGI) methodology to determine an individual's income as defined in the Internal Revenue Service (IRS) Code. The MAGI eligibility methodology has two components: household income and household size. Household income must be within established levels that vary by household size. MAGI household composition (household size) is based on tax filing rules.

Prior to ACA, eligibility for both Medicaid and CHIP used the non-MAGI methodology for the eligibility determination based on countable income (both earned and unearned) and countable

resources (non-home real property, property rights, and personal properties). Countable income was required to be within the established monthly income limits for Medicaid and total resources[2] were prohibited from exceeding more than $2,000 per person or $3,000 per couple. The family composition was based on people in the household and family relationships were based on blood, adoption, or marriage. Each category (i.e. children, pregnant women, parents, seniors, and people with disabilities) had its own income rules and restrictions.

Exhibit 2 below shows the MAGI and non-MAGI eligibility components.

Exhibit 2

Eligibility Components
MAGI Versus Non-MAGI

Component	Income	Family Composition	Resources
MAGI	Household income from IRS and ACA rules	Household size based on tax filing unit	Not counted
Non-MAGI	Countable income (both earned and unearned)	Based on people in household and family relationships	Counted

Source: Federal regulations.

The pre-ACA methodology referred to as "non-MAGI" was not completely replaced by ACA. The non-MAGI methodology continues to be used for "classic" Medicaid coverage groups that existed before implementation of ACA. Exhibit 3 on the following page lists the coverage groups for each eligibility methodology.

[2] Per DHSS public assistance manual, resources are measured at the first moment of the month.

Exhibit 3

Eligibility Coverage Group Categories	
MAGI	**Non-MAGI**
• Parents and Other Caretaker Relatives • Pregnant Women • Emergency Alien • Under 21 • Former Alaskan Foster Children (age 18 to 26) • Newborn • Children under age 19 • Expanded Groups	• Supplemental Security Income (SSI), Disabled Children, Working Disabled • Aged, Blind, Disabled • Long Term Care (Nursing Home, Community Based Waivers, etc.) • Medicare Savings Program • Chronic Acute Medical Assistance • Children receiving foster care, adoption assistance • 2101f Children

Source: DHSS Management.

As of June 2019, approximately 88 percent of Medicaid and CHIP eligibility determinations were for individuals in a MAGI coverage group and 12 percent were for individuals in a non-MAGI coverage group.

Information Systems Used to Process Eligibility

ACA required changes to the processing of eligibility determinations, including streamline processing of applications using MAGI. To fulfill ACA system requirements, the State's Department of Health and Social Services (DHSS) procured a new eligibility system: Alaska's Resource for Integrated Eligibility Services System (ARIES). ARIES went online October 2014 and included functionality to determine Medicaid and CHIP eligibility using MAGI criteria. As of December 31, 2019, over $70.9 million ($62.9 million federal and $8.0 million State) had been expended on the development of ARIES.

The Eligibility Information System (EIS) is the legacy eligibility system for public assistance program eligibility determinations, including certain categories of Medicaid and CHIP. EIS became

operational in July 1984. Since the deployment of ARIES, EIS is primarily used for Medicaid eligibility determinations following non-MAGI criteria. Additionally, EIS is used for MAGI eligibility determinations when ARIES is not capable of processing an application. In June 2019, approximately five percent of the MAGI eligibility determinations were processed in EIS.

Both ARIES and EIS interface with third-party data systems to verify eligibility. Further, ARIES and EIS eligibility assessment files are electronically transferred daily to the Medicaid Management Information System (MMIS). The beneficiary data is used by MMIS to process claims for eligible Medicaid and CHIP enrollees.

Eligibility Determinations by Division of Public Assistance (DPA), Office of Children's Services (OCS), and Qualified Hospitals

The entity responsible for determining eligibility for Medicaid and CHIP depends on the coverage group. DPA is the primary division within DHSS responsible for initial Medicaid and CHIP eligibility determinations for most coverage groups. OCS is responsible for Medicaid and CHIP eligibility determinations for children in State custody.

Eligibility is determined through an application process that considers an individual's eligibility based on a number of factors and information is verified through third-party database queries. Initial applications may be submitted to DPA (in-person, mail, fax, fee agent, or telephone) or electronically through the Federally Facilitated Marketplace[3] or the Alaska self-service portal. Applications submitted directly to DPA are reviewed by an eligibility technician (ET), also known as a caseworker. The flow of the Medicaid and CHIP eligibility determination process is illustrated in Exhibit 4 on the following page.

Eligibility approved by a qualified hospital is known as temporary hospital presumptive eligibility (HPE). Hospital staff do not verify

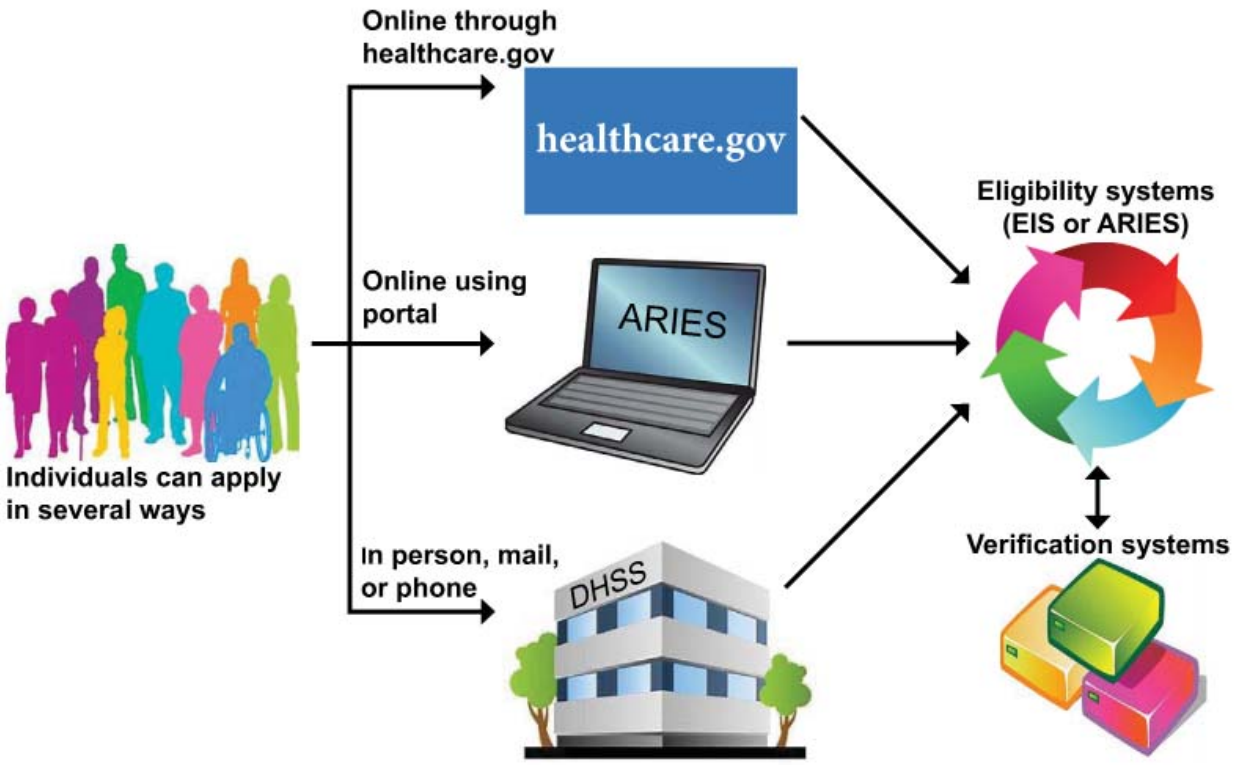
[3] The Federally Facilitated Marketplace carries out a number of the eligibility and enrollment functions for medical benefits required by ACA.

applicants' information and the period of eligibility is temporary. The HPE coverage period begins the day the hospital makes the determination and ends the last day of the following month.

HPE recipients are encouraged to submit an application for non-temporary Medicaid. If an HPE recipient submits a Medicaid application to DPA before the end of the HPE period, presumptive/ temporary eligibility ends the day a Medicaid or CHIP eligibility decision is made by DPA, whether approved or denied.

Exhibit 4

Medicaid/CHIP Application Process



Source: DHSS management.

Initial MAGI Eligibility Determinations

The MAGI eligibility determination process does not require an interview with the applicant. In general, an ET verifies non-financial information, such as citizenship or qualified alien status, and financial information, through querying various databases. An ET compares the income reported by the Alaska Department of Labor and Workforce Development and the Social Security Administration with the applicant's statement of income. For self-employed applicants, the statement of income is verified through a review of business records, tax forms, written or verbal third party contacts, and/or client statements. DPA applies a reasonable compatibility standard of 10 percent when comparing the financial information obtained from electronic data sources to information provided by the applicant. The applicant is contacted for additional information when discrepancies exceed the compatibility standard.

If an applicant applies via the Federally Facilitated Marketplace (healthcare.gov), no further evaluation is required by an ET as long as the federal system has determined the individual is eligible. If the Federally Facilitated Marketplace is unable to determine eligibility, the application is forwarded to DPA and an ET makes the eligibility determination by requesting additional information from the applicant.

Once eligibility has been determined, DPA will provide the applicant a written notice.

Initial Non-MAGI Eligibility Determinations

The initial process for non-MAGI eligibility determination requires an ET to review and verify information provided by the applicant. This process generally entails conducting an interview, reviewing the applicant's supporting documents, and verifying the non-financial information and financial information such as income, resources, and other information through interfacing EIS with other systems.[4] Medicaid recipients who also receive federal SSI,[5] Title IV-E, State

[4] Interface databases include those at the Department of Labor and Workforce Development, Social Security Administration, and Alaska Child Support Services.

[5] Approximately 11,350 non-MAGI recipients in June 2019 received SSI.

Adoption, or State Adult Public Assistance automatically qualify for Medicaid.

Once eligibility has been determined, DPA will provide the applicant a written notice.

Redetermination of Eligibility for Medicaid and CHIP

Regardless of which eligibility methodology is used (MAGI or non-MAGI), eligibility must be redetermined every 12 months. Within 45 days of the redetermination date, DHSS staff request information from recipients who provide evidence to support continued eligibility.

For MAGI, DHSS staff are required to use available information, such as third-party databases, to annually redetermine eligibility. DHSS must also provide a 90-day grace period in which an enrollee who has missed the 12-month renewal date can renew without submitting a new application. Benefits continue until DHSS determines the individual is no longer eligible or when the recipient notifies DPA of a change in status that stops eligibility.

For non-MAGI Medicaid, generally, a person must submit a renewal form for review by a DPA ET to continue receiving medical benefits. Eligibility for recipients that receive SSI is automatically renewed either systematically or manually via ET review and approval.

REPORT CONCLUSIONS

An audit of the Department of Health and Social Services (DHSS) Medicaid and Children's Health Insurance Program (CHIP) eligibility determination process was requested in recognition of the State's declining fiscal condition and the high amount of State general funds spent on Medicaid and CHIP benefits. Audit objectives included determining whether DHSS staff properly determined eligibility and timely enrolled beneficiaries, terminated benefit coverage for individuals no longer eligible for benefits, and preserved and maximized the use of Medicaid and CHIP funds. Auditors were directed to estimate the amount that the State of Alaska paid for benefits on behalf of ineligible beneficiaries and to review the extent eligibility determination best practices were implemented.

The audit found that 42 percent of Division of Public Assistance (DPA) eligibility determinations tested were not accurate and 43 percent were not made in a timely manner. Many of the errors were procedural in nature with no fiscal impact, while some errors resulted in ineligible costs. Based on the testing results, the audit estimates $102 million of federal funds and $28 million of State general funds were spent on FY 19 benefits for ineligible recipients. The estimate is likely understated because DPA has no procedures for verifying household size, a critical component of eligibility, and auditors were unable to test the accuracy of household size.

The widespread errors were attributed to inadequate staffing and training. According to management, Medicaid expansion and an economic recession created a large backlog of applications. During this time, processing applications was prioritized over quality control activities, such as supervisory reviews and training. As a result, the accuracy and timeliness of eligibility determinations declined.

A new eligibility system implemented in 2014 to meet requirements of the Affordable Care Act (ACA) further contributed to eligibility errors. Rather than streamlining the eligibility process as envisioned by the ACA, the system was plagued with problems that created

inefficiencies. At the time of the audit, the system continued to have material control weaknesses.

The audit identified several system-related "best practices" that may reduce workload, streamline the application process, and improve accuracy. Implementing the best practices will require information technology (IT) expertise and adequate funding.

Detailed conclusions are listed below.

Eligibility determinations in 42 percent of cases were not accurate.

Auditors evaluated the accuracy of eligibility determinations by reviewing a stratified random sample of 284 recipients with either Medicaid or CHIP claims from July 1, 2018, through March 31, 2019. For each recipient, auditors evaluated whether DPA's eligibility determination was accurate and complied with federal and state requirements. Auditors redetermined eligibility by checking available databases and by reviewing case file information, both hardcopy and electronic. If a recipient's eligibility changed during the audit period, auditors redetermined eligibility for each change associated with a paid claim using available information.

Auditors found that DPA eligibility technicians (ET) made at least one error when determining eligibility for 119 of 284 cases (42 percent) and 44 of 119 cases contained multiple errors. A description of the errors, number of cases associated with an error category, and related percentages are shown in Exhibit 5 on the following page.

Auditors found that 79 percent of the erred cases (94 of the 119 recipients) were eligible for Medicaid or CHIP regardless of the error(s), as the errors were procedural and not substantive. In other words, the errors made by ETs when processing/evaluating eligibility did not result in paying benefits for people that did not meet program requirements. For example, DPA was unable to locate an application, redetermination support, or a reported change form for 47 recipients. However, auditors confirmed that 44 of the 47 recipients were eligible for benefits by checking available

Exhibit 5

Summary of Accuracy Errors		
Error Category/Description	**No. of Errors**	**% of Errors**
Case file with application, redetermination, or reported change could not be located by DPA staff	47	26.7%
Income incorrectly counted or incorrectly excluded from calculation for eligibility determination	40	22.7%
No documentation that caseworker verified external databases for income, citizenship status, or social security number	39	22.2%
Income/resource verification not performed by caseworker	23	13.1%
Recipient enrolled in incorrect Medicaid category	11	6.3%
Recipient not eligible for program benefits	5	2.8%
Household size in system did not match support	4	2.3%
Discrepant information not followed up	3	1.7%
Tax filer status incorrect or not documented	3	1.7%
Social security number not obtained	1	.5%
Total	**176**	**100%**

case records, system case notes, and external databases. As another example, 39 cases lacked documentation that the caseworker verified external databases during the eligibility determination process; however, when auditors redetermined eligibility and checked the applicable databases, 35 of the 39 recipients were found to meet the eligibility requirements for either Medicaid or CHIP.

Overall, auditors found that 8.8 percent of the universe of cases tested (25 of 284 recipients)[6] were not eligible for either Medicaid or CHIP benefits. The most prominent error was a failure to verify income or resources. The inaccurate eligibility determinations resulted in claim payments for ineligible beneficiaries. (See Recommendation 1)

[6] 21 percent of the cases with errors (25 of 119).

In addition, during testing auditors noted that State Medicaid and CHIP eligibility regulations had not been updated for Modified Adjusted Gross Income (MAGI) eligibility determination requirements. (See Recommendation 3)

Eligibility determinations for 43 percent of cases were not timely.

Auditors reviewed the timeliness of eligibility determinations for the 284 recipients described above and found eligibility was not determined timely for 123 recipients (43 percent). The errors included eligibility determinations (for initial applications, redeterminations, and reported changes) not completed at the time of the audit and those completed late, outside federal and/or State timelines.

Federal guidelines generally require Medicaid and CHIP eligibility determinations be completed within 45 days and eligibility redetermined at least once every 12 months. State requirements direct that redeterminations generally must be completed within 30 days after receiving a renewal form. Changes that may impact eligibility reported to DPA must be reviewed and processed within 10 days per DPA policy.

For each of the 123 untimely eligibility determinations, auditors checked available databases, reviewed case file information, and found 20 recipients were not eligible for continued Medicaid or CHIP benefits. A multitude of factors caused the recipients to be ineligible, including income levels too high, unemployment information not provided, receipt of other health insurance, insufficient information, no information on self-employment income, no proof of applying for federal Supplemental Security Income (SSI), and/or no social security number found in case records. As a result of untimely redeterminations, the 20 recipients that no longer met federal and State eligibility requirements continued receiving benefits. The fiscal impact is discussed below. (See Recommendation 1)

During FY 19, DHSS paid $28 million of State general funds for ineligible benefits.

Auditors found that 45 of 284 recipients were ineligible for Medicaid and CHIP benefits at some point during the nine-month audit period. By projecting the statistically valid sample results to the universe of FY 19 benefits, auditors estimate $102 million of federal funds and $28 million of State general funds were paid for ineligible medical claims during FY 19. The $102 million of federal funds represents 6.2 percent of the total FY 19 federal participation in Medicaid and CHIP.

Inadequate staffing and training contributed to the errors. Under Medicaid expansion, beginning September 2015 the number of applications submitted to DPA increased significantly. In addition, DHSS management reported that an economic recession increased the need for Medicaid. Eligible beneficiaries grew from approximately 131,000 at the end of FFY 15 to over 221,000 at the end of FFY 19.

DHSS hired more ETs to cope with the increased workload and existing resources were diverted from quality control activities such as supervisory reviews and training in order to address the backlog. The new eligibility system further consumed scarce resources as ETs implemented manual work-arounds to deal with system deficiencies.

Estimate of funds paid for ineligible benefits is likely understated.

Eighty-eight percent of the Medicaid and CHIP recipients as of June 2019 were subject to the MAGI eligibility methodology. As described in this report's Background Information section, the MAGI eligibility methodology has two components: household income and household size. The federal government does not require states to verify MAGI household size. Similar to 48 other states, Alaska is designated as a "self-attest" state that accepts household size provided by applicants without verification. Consequently, DPA has no procedures to verify household size. Further, DHSS has chosen not to use the Internal Revenue Service (IRS) database to verify information because the costs of meeting IRS security mandates for the database are high and the income information is not current.

Because federal law prohibits auditors from using IRS data when testing compliance and no other information was available, auditors' redetermination of eligibility for the sample of 284 recipients described above did not evaluate the household size eligibility component. Given the high level of systematic accuracy errors related to income, and given that DPA has no procedures to verify household size, undetected errors related to household size likely exist in the test sample population. Consequently, the projection of funds spent on ineligible benefits is likely understated.

ETs manually redetermine eligibility for approximately 1,400 individuals with SSI.

One of the audit objectives was to determine whether DHSS staff efficiently processed eligibility for individuals that are automatically eligible for Medicaid in a timely manner. Individuals that qualify for SSI (generally aged, blind, and disabled with low income) are automatically eligible for Medicaid. Annually redetermining eligibility requires the verification of continued SSI. Approximately 11,300 of Alaska Medicaid recipients receive SSI.

The audit concluded that DHSS staff did not efficiently redetermine eligibility for certain Medicaid beneficiaries that also received SSI. DPA automated the Medicaid eligibility redetermination process for individuals receiving both SSI and Adult Public Assistance (APA) by creating an Eligibility Information System program that automatically verified continued receipt of SSI through interface with a third party system. For Medicaid SSI recipients that did not receive APA (approximately 1,400 individuals), no automated process existed and the annual redetermination was manually completed by DPA caseworkers through verification of continued SSI. DHSS management recognized the inefficiencies associated with the manual review and requested a system change to automate the process during the late 1990s, but the process was never automated due to competing priorities.

Auditors reviewed a random sample of 10 Medicaid recipients that received both SSI and APA, and a random sample of 25 Medicaid recipients that received SSI but no APA, and found eligibility was accurately redetermined in a timely manner for all 35 recipients.

Eligibility determinations by Office of Children's Service (OCS) staff were accurate and timely.

OCS ETs determine Medicaid eligibility for children in foster care or adoption assistance, and youth in State custody. A child that has been determined eligible for Title IV-E[7] is automatically eligible for Medicaid under federal law.

Auditors evaluated the eligibility determinations for a random sample of 25 OCS children that were Medicaid recipients and found all 25 met the federal and state requirements for Medicaid, and eligibility was determined in a timely manner.

Qualified hospitals accurately determined eligibility, however, DPA staff did not review applications in a timely manner, leading to payments for ineligible benefits.

Hospital presumptive eligibility (HPE) is an option under Medicaid and CHIP which allows staff at qualified hospitals to approve or deny temporary Medicaid/CHIP eligibility based on self-attested information. Federal regulations prohibit the verification of self-attested information when making an HPE determination. During FY 19, over 2,300 individuals received benefits in Alaska under the HPE option.

The lack of verification creates a risk that individuals receiving benefits do not meet eligibility criteria. Federal regulations mitigate the risk by limiting the HPE benefit period to the last day of the month following the HPE determination. If the HPE recipient submits an application for regular Medicaid, the HPE period ends the day a DPA ET makes the eligibility decision. DPA prioritizes HPE Medicaid applications for immediate review.

Auditors reviewed a random sample of 40 Medicaid/CHIP recipients that were found eligible by a qualified hospital during October 2018. All 40 were properly approved by hospital staff. Of the 40 HPE recipients tested, 23 (58 percent) submitted a Medicaid application to DPA during the HPE period.

DPA staff denied eligibility for 13 of the 23 applicants (57 percent) and the HPE benefit period should have ended. However,

[7] Title IV-E programs that qualify for Medicaid include foster care, adoption, and guardianship subsidies.

for 12 of the 13, DPA ETs made the eligibility decision untimely (between 54 and 228 days late) due to a backlog of application review. For the one applicant reviewed timely, DPA ETs failed to end the HPE coverage period, which resulted in payments for ineligible benefits.

Many weaknesses were identified in the new Medicaid and CHIP eligibility system.

Alaska's Resource for Integrated Eligibility Services System (ARIES) has been plagued with problems from the time it was implemented in 2014 and the system was not fully functioning at the time of the audit. Rather than streamlining the eligibility process as envisioned by the ACA, system problems caused staff to create manual work-arounds in order to process applications. The older legacy eligibility system was used to process applications when it was not possible to use ARIES.

An FY 19 examination of the ARIES system controls conducted by an IT specialist concluded DHSS staff did not maintain effective controls. Several of the deficiencies identified during the review are listed below:

- In one of 57 applications tested, an applicant was seeking coverage, but was incorrectly labeled in ARIES as not seeking coverage due to an unknown issue, and was therefore not considered for eligibility.
- In 22 of 341 applications tested, ARIES populated either incorrect or inconsistent benefit information within correspondence sent to applicants. This issue was reported to the help desk 155 times during FY 19.
- In two of 57 applications tested, correspondence to the applicant was not properly generated and delivered.
- In one of 57 cases tested, ARIES was unable to determine eligibility due to an error. ARIES, at times, incurred errors when processing applications for eligibility, which prevented an ET from completing the eligibility determination in ARIES. ETs reported the issue to

the help desk 872 times during FY 19 and, at the end of FY 19, 349 of the issues remained unresolved.

- In one of 57 applications tested, an application was processed without address validation being completed.

Not all system deficiencies identified during the IT review are listed above. The full examination report listing all deficiencies was provided to DHSS management in a separate confidential document and management provided auditors corrective action. Further details are not provided in this report to prevent the deficiencies from being exploited. (See Recommendation 2)

IT system best practices may reduce eligibility errors.

Auditors reviewed best practices employed by other states to reduce eligibility errors for Medicaid and CHIP, and identified the following practices that either improve accuracy or improve efficiency. Implementing the best practices will require IT expertise and adequate funding. The audit recommends management review the cost versus benefits of implementing the practices and incorporate improvements into future system-related projects when determined prudent.

- **Increase use of real-time eligibility determinations:** Implement the ability to conduct real-time eligibility determinations using electronic sources rather than paper documentation.

- **Perform automatic annual reviews:** Program ARIES to conduct automatic annual reviews and only send a pre-populated renewal form to those households that cannot be automatically renewed. In addition, program the legacy eligibility system to renew the non-MAGI population that is automatically eligible for Medicaid (i.e. individuals with SSI or Title IV-E).

- **Employ an electronic verification system/asset verification service:** Implement the service to verify that applicants and recipients meet eligibility requirements. In June 2020, DHSS procured a vendor to develop an electronic verification system/

asset verification service and, once implemented, DPA management stated that active cases would be matched to available eligibility data (income, assets, benefits in other states, unemployment, incarceration, etc.) in a batch process.

- **Access to the National Directory of New Hires:** Obtaining access to the directory will improve DPA's ability to determine if an applicant or recipient has recently gained employment. The new hire database is both current (required within 20 days of employment) and comprehensive (required of all employers nationwide and for all employees, including full-time, part-time, and temporary staff). In June 2020, DHSS hired a vendor to provide National Directory of New Hires review capabilities.

- **Create a single enrollment system for all Medicaid and CHIP applicants:** A single eligibility system for both MAGI and non-MAGI will make real-time eligibility and enrollment determinations, electronically verify data whenever possible, and mitigate the need for applicants to provide in-person paperwork to verify information provided.

- **Check a recipient's wage data at varying intervals after application or renewal:** Periodically reviewing recipients' eligibility will disenroll ineligible recipients in a more timely manner.

- **Use tax data to verify household size:** Household size for MAGI eligibility determinations is not verified by DPA. Access to the IRS database is available and may be used to verify the eligibility component.

- **Interface with the Permanent Fund Division (PFD) database to verify household size:** An interface of the PFD database is currently used to determine if the applicant has received PFD income. Expanding the search to include a physical address may help verify household size and reduce ineligible benefits.

- **Allow for telephonic applications:** Implementing the ability to receive and process telephonic applications with voice PIN signatures, either via a live ET or through an electronic application process, may improve efficiency.

FINDINGS AND RECOMMENDATIONS

Recommendation 1

Division of Public Assistance's (DPA) director should improve Medicaid and Children's Health Insurance Program (CHIP) eligibility training and reestablish a case review process.

In a statistically random sample of 284 cases, auditors found 42 percent of the cases tested had at least one error in the eligibility determination for either Medicaid or CHIP benefits and 43 percent of the cases had an untimely eligibility determination.

The DPA eligibility caseload for Medicaid and CHIP benefits increased significantly between FY 15 and FY 19 due to Medicaid expansion and an economic recession. DPA lacked resources to effectively address the changes and a backlog of applications, redeterminations, and reported changes developed. Hiring additional eligibility technicians and shifting existing resources to address the backlog was prioritized over training and case review.

Title 45 CFR 75.303(a) requires the State to establish and maintain effective internal controls over federal awards that provide reasonable assurance that the State is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the grant awards. The audit estimates that $102 million of federal funds and $28 million of State general funds were spent on ineligible medical claims during FY 19.

We recommend DPA's director improve Medicaid and CHIP eligibility training and reestablish a case review process.

Recommendation 2

DPA's director should continue to resolve system weaknesses in the Alaska's Resources for Integrated Eligibility Services System (ARIES).

An FY 19 examination of ARIES system controls conducted by an information technology specialist concluded Department of Health and Social Services (DHSS) staff did not maintain effective controls for ARIES.

Multiple factors contributed to control weaknesses, including known defects that have existed since the system was implemented in October 2014, limited resources, and competing department priorities. Maintaining a poorly functioning eligibility system has contributed to inaccurate eligibility determinations and a backlog of applications, redeterminations, and reported changes.

As of December 2019, approximately $71 million ($63 million federal share and $8 million State share) had been expended on ARIES, yet the system weaknesses had not been corrected. To address system errors related to eligibility determinations, DHSS procured a vendor to research and identify the root cause of specific errors, provide a plan for resolution, and produce a fix. The contract end date was December 2020.

Title 45 CFR 75.303(a) requires the State to establish and maintain effective internal controls over federal awards that provide reasonable assurance that the State is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the grant awards.

We recommend DPA's director continue to resolve system weaknesses in ARIES.

Recommendation 3

DPA's director should update Medicaid and CHIP regulations for Modified Adjusted Gross Income (MAGI) eligibility requirements.

Medicaid and CHIP State regulations have not been updated for the Affordable Care Act MAGI eligibility methodology.

State regulations were not updated due to management turnover, lack of resources, and conflicting priorities. Administration of Medicaid and CHIP is less effective when State regulations are not current.

Per AS 47.07.050:

> *The department shall take the steps necessary to adopt those regulations, prepare necessary documentation for the state and providers, and undertake the systems design that may be necessary to implement the provisions of this chapter…*

We recommend DPA's director update Medicaid and CHIP regulations for MAGI eligibility requirements.

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we have conducted a performance audit of the Department of Health and Social Services (DHSS), Alaska Medicaid program and Children's Health Insurance Program (CHIP) eligibility determination process.

Objectives

The objectives were to:

- Determine whether DHSS is complying with federal and State requirements for determining Medicaid and CHIP eligibility (income, citizenship, and other requirements).
- Determine whether DHSS is meeting eligibility timeliness and documentation requirements for Medicaid and CHIP applicants.
- Determine whether DHSS is timely processing and removing persons from the Alaska Medicaid and CHIP rolls who no longer meet requirements.
- Estimate the amount the State of Alaska paid for medical benefits on behalf of ineligible Medicaid and CHIP beneficiaries.
- Determine whether DHSS is processing both Medicaid and CHIP initial and reviewed eligibility for mandatory groups, such as individuals who qualify for Social Security Disability, in a timely and efficient manner.
- Determine whether DHSS is employing recognized best practices to reduce Medicaid and CHIP eligibility errors.

Scope

The audit reviewed the eligibility determinations made for Alaska Medicaid and CHIP recipients with claims that processed in the Medicaid Management Information System (MMIS) from July 1, 2018, through March 31, 2019. The audit examined the design and operating effectiveness of internal controls over the Alaska's Resource for Integrated Eligibility Services System (ARIES) from July 1, 2018, through June 30, 2019.

Methodology

To address the objectives, auditors:

- Gained an understanding of eligibility requirements and processes for Medicaid and CHIP by reviewing the following pertinent laws, legislation, and documents:
  - Applicable federal regulations (42 CFR 435 and 42 CFR 457).
  - Applicable state statutes and regulations governing Medicaid and CHIP (AS 47.05, AS 47.07, 7 AAC 40, 7 AAC 48, and 7 AAC 100).
  - Alaska State Medicaid Plan and State Plan Amendments which govern Medicaid and CHIP.
  - Applicable Division of Public Assistance (DPA) and Office of Children's Services (OCS) procedural manuals.
- Reviewed articles to identify potential issues pertaining to the eligibility determination process for Alaska Medicaid and CHIP.
- Reviewed reports and documents provided or issued by DHSS, the Centers for Medicare and Medicaid Services, the Government Accountability Office, and other state auditor offices to identify potential areas related to accuracy and timeliness and employed best practices for Medicaid and CHIP eligibility determinations.
- Conducted interviews with DHSS staff to gain an understanding of the policies and procedures for determining Medicaid and CHIP eligibility, and observed the eligibility determination process performed by DPA and OCS eligibility technicians.
- Conducted internet searches for potential best practices areas employed by other states related to Medicaid and CHIP eligibility determinations.
- Reviewed DPA's FY 19 enacted budget to gain an understanding of the agency funding and budgeted number of positions.

- Inquired with the Office of the Ombudsman to determine if any complaints were filed against DPA in relation to Medicaid and CHIP eligibility.

- Obtained MMIS paid claim data from Division of Health Care Services staff for the period July 1, 2018, through June 30, 2019, to determine the universe for recipient eligibility testing and for reporting purposes.

- Obtained Eligibility Information System (EIS) and ARIES eligibility data for Medicaid and CHIP beneficiaries from July 2018 through June 2019 to identify client data for comparison to MMIS claim data and reporting purposes.

- Obtained Medicaid and CHIP monthly enrollment and annual expenditure data by federal fiscal year from www.medicaid.gov for reporting purposes.

- Obtained count for Medicaid and CHIP eligibility verification policies from www.medicaid.gov for reporting purposes.

- Selected and tested non-stratified random samples of Medicaid and CHIP recipients with claims paid between July 1, 2018, and March 31, 2019. This included ensuring the eligibility determinations made for the recipients were accurate and timely, following federal and State requirements by reviewing case record information (both electronic and hardcopy) and redetermining the eligibility. Sample sizes were selected based on auditor judgment and low audit risk. Testing results for the random sample were not projected to the populations. The samples included the following:

    - A random selection of 10 of 9,900 recipients that received Supplemental Security Income (SSI), whose eligibility determinations were automated through EIS.

    - A random selection of 15 of 1,405 recipients that received SSI, whose eligibility determinations were made by DPA staff.

- A random selection of 25 of 5,099 recipients that were under State custody, whose eligibility determinations were made by OCS staff.

- A random selection of 40 of 220 recipients with a hospital presumptive eligibility (HPE) determination with a first service date in October 2018, whose eligibility determinations were made by staff at a qualified hospital.

- Selected and tested stratified random samples of Medicaid and CHIP recipients with claims paid between July 1, 2018, and March 31, 2019, excluding recipients categorized with SSI, HPE, or under State custody, and recipients with net claims less than $2,000. This included ensuring the eligibility determinations made by DPA staff for the recipients were accurate and timely, following federal and State requirements by reviewing case record information (both electronic and hardcopy) and redetermining the eligibility. Testing results for the stratified random samples were projected to the population. The stratified random samples included four strata consisting of:

    - Strata 1 - Medicaid or CHIP recipients with total net claim payments greater than or equal to $95,671.96; 1,631 recipients with payments totaling $266,627,012.33.

    - Strata 2 - Medicaid or CHIP recipients with total net claim payments less than $95,671.96 and greater than or equal to $31,966.74; 5,123 recipients with payments totaling $266,621,390.93.

    - Strata 3 - Medicaid or CHIP recipients with total net claim payments less than $31,966.74 and greater than or equal to $10,595.72; 15,311 recipients with payments totaling $266,627,715.74.

    - Strata 4 - Medicaid or CHIP recipients with total net claim payments less than $10,595.72 and greater than or equal to $2,000.00; 55,760 recipients with payments totaling $266,647,526.76.

Calculated a sample size of 284 Medicaid or CHIP recipients from a population of 77,825 recipients divided equally for a random sample selection from each of the four strata of 71 Medicaid or CHIP recipients. The sample size was based on a 95 percent confidence level with 3.5 percent tolerable error rate and 10 percent expected error rate.

- Contracted with BerryDunn, public accounting firm, to:
  - Test eligibility determinations made by DPA staff for 190 recipients from the stratified random sample of 284 Medicaid and CHIP recipients.
  - Evaluate the design and effectiveness of internal controls over ARIES for FY 19.
  - Evaluate whether DHSS employed recognized best practices to reduce Medicaid and CHIP eligibility errors and identify additional best practices to implement.
- Contracted with McDowell Group, a consulting firm, to:
  - Develop a sample design for the stratified random sample and methodology for selecting the sample size.
  - Estimate the Medicaid/CHIP spending from July 1, 2018, through March 31, 2019, for ineligible recipients based on the test results from the stratified random sample of 284 recipients drawn from four strata (71 recipients from each strata). McDowell Group's projection of claims paid for ineligible recipients is located in Appendix A.
- Calculated the FY 19 estimate of the Medicaid/CHIP spending for ineligible recipients based on the percent of projected federal and State total spending error determined from Appendix A applied to the FY 19 Medicaid and CHIP claims paid by recipient, excluding recipients categorized with SSI, HPE, or under State custody, and recipients with net claims less than $2,000.

- Compared Alaska Medicaid and CHIP regulations with federal requirements.

Internal controls over the Medicaid and CHIP eligibility determination processes at DPA and OCS were assessed to determine if controls were properly designed and implemented for recipients with claims paid through MMIS between July 1, 2018, and March 31, 2019. Internal controls over the design and operating effectiveness of ARIES and EIS were also assessed between July 1, 2018, and June 30, 2019.

APPENDIX SUMMARY

Appendix A presents the McDowell Group statistical analysis of Medicaid/CHIP spending for ineligible recipients based on results of testing.

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APPENDIX A

McDowell GROUP

Date: July 27, 2020

To: Kris Curtis, State of Alaska Division of Legislative Audit

From: Jim Calvin & Katie Berry, McDowell Group

RE: Legislative Audit – Estimated Medicaid/CHIP Spending for Ineligible Recipients

The following statistical analysis of Medicaid/CHIP spending for ineligible recipients is based on Medicaid/CHIP sampling data provided by the State Division of Legislative Audit (DLA). The Division reviewed spending for a random sample of Medicaid/CHIP recipients between July 1, 2018 and March 31, 2019.

Population Statistics and Sample

The Medicaid/CHIP recipient population was divided into four strata with equal total spending. A random sample of 284 recipients was drawn uniformly across the four strata (71 recipients in each strata). This sampling was conducted by DLA.

Table 1. Medicaid/CHIP Recipient Population, By Total Expenditure Strata

Strata	Spending	Count
Strata 1	$266,627,012.33	1,631
Strata 2	$266,621,390.93	5,123
Strata 3	$266,627,715.74	15,311
Strata 4	$266,647,526.76	55,760
Total	**$1,066,523,645.76**	**77,825**

Source: Alaska Legislative Audit

Table 2. Sample Medicaid/CHIP Recipient Population, By Total Expenditure Strata

Strata	Sample Spending	Sample Count
Strata 1	$11,616,404.80	71
Strata 2	$3,631,800.80	71
Strata 3	$1,227,126.26	71
Strata 4	$319,770.04	71
Total	**$16,795,101.90**	**284**

Source: Alaska Legislative Audit

Sample Results

DLA's analysis of the random sample of recipients found that the percentage ineligible in the four strata ranged from 8.5% to 29.6%. For the entire sample, 15.85% were ineligible.

(see table on next page)

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www.mcdowellgroup.net

APPENDIX A (Continued)

Table 3. Number in Error and Amounts Spent for Ineligible Recipients, By Strata

Strata	# error	Federal $	State $
Strata 1	7	$576,351.96	$130,122.99
Strata 2	6	$133,315.81	$37,015.82
Strata 3	21	$158,414.51	$24,471.43
Strata 4	11	$22,888.27	$12,212.78
Total	**45**	**$890,970.55**	**$203,823.02**

Source: Alaska Legislative Audit

Statistical Analysis

As noted above, 15.85% of the sampled recipients were ineligible. The confidence interval of that error rate is estimated at a lower bound of 7.58% and an upper bound of 24.11% at the 95% confidence level. This indicates that if Medicaid/CHIP recipients sampling was repeated, in 95% of trials the average percentage of ineligible recipients would be between 7.58% and 24.11%.

Table 4. Expected Error Rate and Standard Error of Estimate

Strata	% Error	Standard Error.	Lower Bound 95% CI	Upper Bound 95% CI
Strata 1	9.9%	0.035	2.9%	16.8%
Strata 2	8.5%	0.033	2.0%	14.9%
Strata 3	29.6%	0.054	1.9%	40.2%
Strata 4	15.5%	0.043	7.1%	23.9%
Total	**15.85%**	**0.0420**	**7.58%**	**24.11%**

Source: McDowell Group

Projected Total Ineligible Recipients

Using the sample statistics generated through random sampling of Medicaid/CHIP recipients and the total recipients, an estimated 12,331 out of 77,825 recipients were ineligible. The number of actual ineligible recipients is expected to be within the range from 5,896 to 18,767, at the 95% confidence level.

Table 5. Projected Total Ineligible Recipients

Strata	Point Estimate	Lower Bound 95% CI	Upper Bound 95% CI
Strata 1	161	48	274
Strata 2	433	101	764
Strata 3	4,529	2,903	6,154
Strata 4	8,639	3,946	13,332
Total	**12,331**	**5,896**	**18,767**

Note: Total claims do not equal to the sum of the four strata due to differences in expected error rates and the relative variance of each of those estimates. Source: McDowell Group.

APPENDIX A (Continued)

Projected Total Spending in Error

Medicaid/CHIP claims paid for ineligible recipients total an estimated $75.0 million in federal spending and $20.5 million in state spending. Actual spending in error is expected to be in the range from $36.3 million to $115.7 million in federal spending and in the range of $10.7 million to $34.2 million in state spending, at the 95% confidence level. Results by strata are provide in Tables 6 and 7.

Table 6. Projected Federal Spending in Error

Strata	Point Estimate	Lower Bound 95% CI	Upper Bound 95% CI
Strata 1	$13,239,860	$3,927,682	$22,552,037
Strata 2	$9,619,393	$2,254,684	$16,984,102
Strata 3	$34,161,754	$21,900,288	$46,423,221
Strata 4	$17,975,351	$8,210,097	$27,740,606
Total	**$74,996,358**	**$36,339,321**	**$115,659,738**

Note: Total claims do not equal to the sum of the four strata due to differences in expected error rates and the relative variance of each of those estimates. Source: McDowell Group.

Table 7. Projected State Spending in Error

Strata	Point Estimate	Lower Bound 95% CI	Upper Bound 95% CI
Strata 1	$2,989,163	$886,753	$5,091,574
Strata 2	$2,670,874	$626,024	$4,715,723
Strata 3	$5,277,212	$3,383,095	$7,171,329
Strata 4	$9,591,333	$4,380,764	$14,801,901
Total	**$20,528,582**	**$10,733,696**	**$34,162,897**

Note: Total claims do not equal to the sum of the four strata due to differences in expected error rates and the relative variance of each of those estimates. Source: McDowell Group.

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Agency Response from the Department of Health and Social Services

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

OFFICE OF THE COMMISSIONER

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LEGISLATIVE AUDIT

November 27, 2020

Ms. Kris Curtis, CPA, CISA
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

Dear Ms. Curtis,

RE: Confidential Preliminary Audit Report, Department of Health and Social Services (DHSS), Medicaid and Children's Health Insurance Program (CHIP) Eligibility.

The Department of Health and Social Services (DHSS) appreciates the opportunity to review and provide feedback to the associated findings and recommendations as shared in your management letter.

In response to the Report Organization and Conclusion: The audit report fails to include the work in process by the Division of Public Assistance and the strategic changes implemented to better fulfill its mission. DPA had been working on corrective action plans associated with the majority of these findings prior to the audit and during the period under review.

The department has the following comments to the following sections of the report:

- Organization and Function:
  - The Division of Behavioral Health (DBH) is missing. This Division manages the access to integrated behavioral health services for individuals experiencing behavioral health disorder; a serious mental illness and/or a substance use disorder; or at risk of a diagnosis for any of the three. Additionally, starting in FY2020 this agency administers the Administrative Services Organization (ASO) agency and its claims processing system.
- Background Information:
  - The statement on page 3 that from September 2015 to September 2019 Medicaid and CHIP enrollment increased from 130,815 to 221,587 individuals is based on the monthly count of enrollees in September as opposed to the annual unduplicated count.
    - The state reports rely on a state fiscal year and this analysis was performed based on a federal fiscal year hindering the department from performing a comprehensive one-to-one analysis. However, it is worth noting the reported increases are associated with both the state recession during SFY 2016-2019 that resulted in a significant increase in traditional Medicaid cases and the implementation of Medicaid expansion.
    - The unduplicated enrollment or beneficiary counts reported for SFY2015 were 163,505; for SFY2016 were 191,048 and for SFY2019 were 250,629.

- The unduplicated recipient counts reported for SFY2015 were 147,392; for SFY2016 were 177,597; and for SFY2019 were 204,980.
- The McDowell report indicates the use of Medicaid recipients and the statistical analysis was completed based on actual claim expenditures. The agency has concerns pertaining to these estimates:
  - The report states it is dependent on the spending sample from the Division of Legislative Audit (DLA), which is based on the claims data and not the actual expenditure amounts in the state's accounting system, IRIS, which is the basis of the state's Medicaid quarterly claim and which includes offsets that are not processed in the MMIS claims payment system;
  - The extrapolation performed by both McDowell Group and completed by DLA relies on numbers that have not been substantiated by the department.
- The department has concerns on the projected expenditures reported in error provided by this report because it extrapolates and/or estimates errors in a generalized fashion. This may inflate the end results because the process fails to incorporate utilization and actual spending trends by recipients or the complexities associated with eligibility including program allowances for retroactive eligibility or specialized extensions due to emergency situations, such as COVID that requires the state to maintain ineligible clients until the public health emergency is ended. Additionally, the utilization of Medicaid benefits between recipients (those who receive services) and those who are enrolled, has decreased from 93% in SFY2016 to 81.8% in SFY2019 with preliminary SFY2020 at 77.1%.

- Report Conclusions:
  - Estimates made for ineligible benefits: Household composition is verified by client attestation. Since 48 other states do this as well, Alaska should not be held to a different standard.
  - SSI Manual Redeterminations: SSI recipients are automatically eligible for Medicaid and a full annual redetermination is not needed. The agency only verifies that SSI is still in pay status and continues Medicaid. Automation of this process is not moving forward since the legacy system will be retired in the future.
  - IT System best practices
    - Real Time Eligibility Determinations - the agency's priority is to comply with federal requirements. Additionally, efforts are already underway to procure an Asset Verification System, which will aid in a more streamlined and efficient process for determining and re-determining eligibility. As of August, MAGI determinations that are being processed within 24 hours increased to an average of 10.6% for the months of June, July, and August. Now that the backlog is eliminated, the division's processing times will continue to improve.
    - Perform automatic annual reviews – The agency would need to procure a maintenance and operations contractor to make upgrades to the ARIES system, as well as meet security agreements for the external information to be automatically uploaded into ARIES. This would be a potential enhancement in the future, however at this time, priority will be given to known system issues that need to be addressed for accurate determinations to be made.
    - Employ the EVS/AVS - Efforts have been underway to procure an Asset Verification System, which will aid in a more streamlined and efficient process for determining and re-determining eligibility.
    - Access to the NDNH – The efforts are underway and the NDNH should be implemented as part of the Asset Verification System by the end of the calendar year.
    - Create a single enrollment/eligibility system for MAGI and non-MAGI Medicaid – This is planned as a future ARIES system enhancement, but priority will still be given to known system deficiencies.
    - Check a recipient's wage data at varying intervals after application or renewal – This is not a program requirement and if a client reports a change that requires a new determination, the agency will take action at that time. This statement appears to be contradictory to federal program requirements and the state follows program integrity rules.

- Use tax data to verify household size – IRS data may be outdated and not a reliable source of current situations. People move in and out of homes, and parents may alternate years claiming dependents. Additionally, there are security requirements that would be costly to the division to implement.
- Interface with the PFD database to verify household size – Alaska should not be held to a different standard than other states because we have the PFD and access to this database. Also, similar to the IRS, the information may be outdated and not a reliable source of clients' current situations.
- Allow for telephonic applications - This recommendation will need to be addressed at a statewide level with the Office of Information Technology and the State Security Office. DPA Policy MAGI Medicaid MS 806 provides for applications to be submitted on-line, by mail, in person, by fax, by phone, or by email. The ability to apply for Medicaid over the phone has been in effect since January 1, 2014 and was posted in our Family Medicaid manual December 2, 2013. Since Alaska is not yet able to collect voice or pin signatures for telephonic applications, the caseworker must send an application summary to the applicant for their signature on the statement of truth prior to processing. The process guide is pending an update as it currently says that telephonic applications are not allowed, but they are required by federal regulation. However, the division is operating within the scope of the federal regulation while ensuring it is exercising adequate controls to reduce the risk of fraud, waste, and improper payments.

Recommendation No. 1 – DPA's director should improve Medicaid and CHIP eligibility training and re-establish a case review process

DHSS concurs with this recommendation, however the COVID pandemic has impacted the agency's implementation and training model. The division's comprehensive, instructor-led training program is being expanded and enhanced. DPA has continued its effort in developing sufficient training for all Eligibility Technicians and who currently attend a three-week instructor led training at the time they are hired by the division. The initial training focuses on MAGI Medicaid and SNAP as they are the most common cases the eligibility staff encounter. The technicians are then introduced to the numerous job aids and checklists that have been developed since the adoption of MAGI Medicaid. The Division had also developed an internal SharePoint site that will allow all staff to access various job aids in an organized, central location. During the transition period staff can still view Medicaid specific training on the H&SS Learning Management System and the numerous job aids on the Staff Development & Training (SD&T) site.

Training is also being deployed via a different model beginning in FY2021. Rather than have staff travel for three weeks to Anchorage to attend training, SD&T will train lead workers in the local offices to be trainers. SD&T will still develop content and vet new material, but the network of trainers will provide a layer of support to Eligibility Technicians that cannot be achieved via electronic communication and long-distance learning. This will also eliminate the gap that staff face after being hired and being able to get in the next available class. In combination with the enhanced SharePoint site we believe more well-rounded technicians will reach active production in a shorter amount of time.

A Statewide Case Review team has been implemented, and 80% of their time is spent reviewing cases for new and seasoned staff.

Recommendation No. 2 – DPA's director should continue to resolve system weaknesses in ARIES

DHSS concurs with this finding. In SFY2020 DPA contracted with Resource Data Inc. (RDI) to complete installation of an ARIES development environment and resolve the six most frequently reported wrap-up errors. While the agency originally anticipated this work to begin in FY2020, delays have occurred due to the COVID pandemic resulting in work concluding in September 2020. The main components of the development environment are installed and debugging tools are in place. Resolution of the six most frequently reported wrap-up errors were not completed during the contract period. RDI, through the debugging tools, provided a mechanism for root cause identification of defects and completed the initial

analysis for several defects. Additional efforts may be required to further address known system issues. The agency anticipates soliciting for a support (maintenance and operations) contractor with the request for proposal planned for April to September of 2021.

Recommendation No. 3 – DPA's director should update Medicaid and CHIP regulations for MAGI eligibility requirements
DHSS concurs with this finding. DPA has initiated an internal review to coordinate the work necessary for this update.

Please contact Linnea Osborne at 907-465-6333 if you have any questions or concerns.

Sincerely,

Adam Crum
Commissioner

CC: Sana P. Efird, Assistant Commissioner
Albert E. Wall, Deputy Commissioner
Shawnda O'Brien, Director, Division of Public Assistance
Scott McCutcheon, DHSS Technology Officer III
Linnea Osborne, DHSS Accountant V

Legislative Auditor's Additional Comments

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

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November 30, 2020

Members of the Legislative Budget
and Audit Committee:

I have reviewed the Department of Health and Social Services (DHSS) commissioner's response to the audit report. Nothing contained in the response causes me to revise or reconsider the report conclusions and recommendations. However, I offer the following comments.

Medicaid is a federal program funded jointly by federal and state governments. Although the federal government dictates program requirements, it is in the State's best interest to administer the program in such a way as to maximize the public's return on State dollars. My recommendation to implement controls to ensure State funds are only spent on benefits for eligible recipients should not be discounted simply because such controls are not required by the federal government. Rather than dismissing best practices noted in the audit, I encourage a prudent evaluation of the costs versus benefits of implementing controls with the goal of prudently spending State funds.

Regarding the audit's estimate of funds spent on benefits for ineligible recipients, the commissioner states that the department has not substantiated the data supporting the audit's projection. In response, I note that the financial data supporting the errors was provided to DHSS in September 2020.

In summary, I reaffirm the report conclusions and recommendations.

Sincerely,

Kris Curtis, CPA, CISA
Legislative Auditor