STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTERNAL CONTROL REVIEW
MEDICAID ELIGIBILITY

OCTOBER 2016

To The Fiscal Committee Of The General Court:

This report presents the results of our assessment of the internal controls in operation at the Department of Health and Human Services (Department) related to the Medicaid client eligibility and enrollment process during the nine months ended March 31, 2016.

We conducted our work in accordance with auditing standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (GAGAS). 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 the evidence obtained provides a reasonable basis for our findings.

The work performed was for the purpose of meeting the audit objectives described on page 3 of this report and did not constitute an audit of financial statements in accordance with GAGAS. The work performed also was not designed for the purpose of expressing an opinion on the effectiveness of the Department's internal controls. Accordingly, we do not express an opinion on the effectiveness of the Department's internal controls.

The Department provided an auditee response which is included with each finding in this report. We did not audit the auditee's responses.

Office of Legislative Budget Assistant

Office Of Legislative Budget Assistant

October 2016

STATE OF NEW HAMPSHIRE
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This report can be accessed in its entirety on-line at:
http://www.gencourt.state.nh.us/LBA/AuditReports/financialreports.aspx

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* No comments suggest legislative action may be required.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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MEDICAID ELIGIBILITY

EXECUTIVE SUMMARY

Agency management is responsible for establishing and maintaining effective internal controls, including controls over financial reporting, and controls over compliance with the laws, administrative rules, regulations, contracts, and grant agreements applicable to the agency's activities. The Department of Administrative Services has developed an *Internal Control Guide* to help State agency personnel understand the concepts of internal control. The *Internal Control Guide* explains the purpose of internal control and also explains its five components: control environment, risk assessment, control activities, information and communication, and monitoring. In addition, the Department of Administrative Services also maintains a *Manual of Procedures*, approved by the Governor and Council, for use by all State agencies.

The objective of this audit was to evaluate whether the Department of Health and Human Services (Department or NH DHHS) has established and implemented suitable internal controls over the collection and processing of client information in determining and verifying client Medicaid eligibility. Criteria used in the evaluation included federal laws and regulations, State statute, the State Medicaid Plan, administrative rules, and policies and procedures, including the Department's *Medical Assistance Manual* and the Department of Administrative Services' *Internal Control Guide* and accepted State business practice. The purpose of this audit was not to render an opinion on the State's or Department's financial statements, internal control, or compliance.

Our audit was performed using auditing standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (GAGAS). 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 the evidence obtained provides a reasonable basis for our findings.

SUMMARY OF RESULTS

We found the Department's controls over the collection and processing of client information in determining and verifying client Medicaid eligibility were generally suitably designed to provide reasonable assurance that the specified internal control objectives would be achieved. However, we found opportunities for the Department to improve its controls through the establishment of a required asset verification system and a control for the referral of cases to the Department's Special Investigative Unit. Also, the Department could redesign certain controls to improve the efficient and effective use of available information, and the timeliness of certain case denial or termination actions.

We found certain of the Department's controls over the collection and processing of client information in determining and verifying client Medicaid eligibility did not consistently operate as designed during the audit period. In particular, it was not clear the supervisory case-review control was operating as intended.

BACKGROUND

The Department of Health and Human Services (Department) determines eligibility for Medicaid assistance in accordance with eligibility requirements defined in federal law and regulation, the approved State Medicaid Plan, RSA 167, N.H. Admin. Rules He-W 600 and He-W 800 series, and the Department's *Medical Assistance Manual*.

The eligibility determinations are the responsibility of the Department's Division of Client Services. The Department operates 11 district offices, each staffed with a Supervisor and a number of Family Services Specialists and Family Services Associates. The Supervisors are ultimately responsible for the overall operations of the District Office, the Family Services Specialists determine applicant eligibility, and the Family Services Associates provide support and customer service. Additionally, a Training Unit supports the training of all staff.

The New HEIGHTS information system is the primary system used to support and process eligibility determinations. Application for assistance can be made at district offices and also through NH EASY Gateway to Services, New Hampshire's electronic application system.

The Department evaluates general, financial, and medical requirements to make Medicaid eligibility determinations. While there are requirements that are common for each category of assistance, there are some differences. For example, an application for services under the Aid to the Needy Blind program requires an individual to have a medical necessity determination of legally blind.

Generally, an applicant for medical assistance must be either a citizen of the United States or an eligible qualified alien. There are limited emergency medical services available for some non-qualified aliens. An applicant must be a current resident of New Hampshire but does not need to have lived in the State for a specified length of time. An applicant must meet any program age requirements and, for all Medicaid programs, the law requires that each individual requesting assistance furnish a social security number or verify that an application for a social security number was filed.

Financial requirements are broken into components of income and resources. Although every program examines income to determine eligibility, not every program counts resources. If a program counts resources, an applicant must meet both the program's resource requirements as well as the income requirements to be financially eligible for the program.

Available income for all household/assistance group members is counted when eligibility is determined; however, certain expenses are subtracted. If household/assistance group resources are counted, resources owned by all members are considered to determine eligibility. Examples of resources are cash, bank accounts, stocks, bonds, some vehicles, permanently unoccupied real

estate, and some trusts. Not counted are certain resources such as the residential home, furniture, and some vehicles.

Individuals who apply for some Medicaid programs must be prepared to explore and develop all potential sources of income.

Certain Medicaid service categories require a determination of medical eligibility in addition to general and financial requirements. Determining that an applicant is medically eligible for Medicaid services involves an assessment of an applicant's medical condition, made by a Department medical review team based on an applicant's medical records and other medical documentation specifically related to an applicant's medical condition.

OBJECTIVES, SCOPE, AND METHODOLOGY

Audit Objectives

1. Assess the Department’s internal controls, including control environment, risk assessment, control activities, information and communication, and monitoring. Assess management’s policies and procedures for establishment and maintenance of an effective control system over the collection and processing of client information in determining and verifying client Medicaid eligibility.

2. Assess the adequacy of the design of internal controls over the collection and processing of client information in determining and verifying client Medicaid eligibility.

3. Assess establishment/implementation of controls as designed.

4. Assess the operation of the controls, including:

   - Functional compliance with written policies and procedures, laws, and rules related to the collection and processing of client information in determining and verifying client Medicaid eligibility.
   - Functional compliance with stated (but not necessarily documented) policies and procedures related to the collection and processing of client information in determining and verifying client Medicaid eligibility.
   - Adequacy of separation of duties and responsibilities for collection and processing of client information in determining and verifying client Medicaid eligibility.

Audit Scope

The scope of our audit included the adequacy of the Department’s internal controls relating to collection and processing of client information in determining and verifying client Medicaid eligibility.

The audit period was July 1, 2015 through March 31, 2016.

Audit Methodology

1. Interview agency personnel.

2. Review agency documentation, including:

   - Policies and procedures,
   - Documentation of systems, applications, forms and instructions, and client information.

3. Review laws, rules, regulations, and policies and procedures, including:

   - Federal laws and regulations,
   - State statutes,
   - The State Medicaid Plan,
   - New Hampshire Administrative rules, and
   - Internal Department and general State policies and procedures.

4. Observe processes.

5. Review the design and operation of internal controls through tests of eligibility determinations.

PRIOR AUDIT

There are no prior audits that specifically addressed the Department's controls over its collection and processing of client information in determining and verifying client Medicaid eligibility. The Office of the Legislative Budget Assistant issued a financial audit of the State of New Hampshire, Department of Health and Human Services, Medicaid Program, for the year ended June 30, 2002. The appendix on page 13 of this report presents the current status of the comments in the 2002 report that specifically address the Department's controls over Medicaid eligibility.

The prior report can be accessed at:

http://www.gencourt.state.nh.us/LBA/AuditReports/financialreports.aspx.

FINDINGS AND RECOMMENDATIONS

Observation No. 1: Review Effectiveness Of Monitoring Controls

Observation:

The Department has not established controls to reasonably ensure that Medicaid case determinations are made only after all required information is obtained and considered.

The Department's controls include a supervisory review of judgmental samples of assistance program determinations made by district office and family services specialists[1]. The Department reports the reviews generally focused on determinations made by family services specialists with less experience. All case actions initiated by eligibility staff in their first nine months of service are subject to a supervisory review. There are no standard policies and procedures for the reviews, and while the reviews identify the element and nature of any noted error, there is no documentation maintained of the extent of the review performed. A summary of results of the supervisory reviews of all assistance program determinations reported error rates by district office ranging from 7.8% to 22.2% during the nine months ended March 31, 2016.

Approximately 5.2% of two separate Medicaid case-determination samples tested during this audit were identified as having been improperly processed, either processed without having obtained all required documentation, or as having an incorrect eligibility determination made.

1. In six cases, or 4.8%, of a random sample of 126 positive action cases (cases where the client was deemed eligible) selected for testing, auditors identified the case as an error case as it had been improperly processed or an incorrect eligibility determination was made. Twenty of the 126 positive action cases in the sample, including one of the six noted error cases, were also subject to the Department's supervisory review control; however, the supervisory review control did not detect the error case identified by the audit.

   Certain of the case determinations in the sample that were classified as improperly processed were subsequently identified as properly determined, after the Department requested and received additional information following the auditor's testing of the case and inquiry.

2. In two cases, or 7.4%, of a random sample of 27 negative action cases (cases where the client was deemed ineligible) selected for testing, auditors identified the case as an error case as it had been improperly processed or an incorrect eligibility determination made. None of the negative action cases in the sample were subject to a supervisory review. As a matter of practice, the Department does not specifically review case denial or termination actions.

[1] The Department performs a combined review of determinations for multiple assistance programs. Data for supervisor reviews of Medicaid determinations is not separately reported.

Recommendation:

The Department should review its monitoring controls, including its supervisor case review process, to ensure that the control procedures are operating as intended and providing the intended control.

The Department should evaluate the disparity in the supervisory review statistics. Due to limited available information for the reviews performed, it is difficult to determine if the differences in the results of the reviews are due to differences in staff training, sample selection techniques, or diligence of the reviews. The Department should expand its policies and procedures for the reviews to allow management to have better understanding of the scope, comparability, and actionable basis of the information resulting from those reviews.

Auditee Response:

We concur.

The Department agrees that monitoring controls should be reviewed, including the supervisor case review process to ensure that it is performing the intended control. In fact, the Department does conduct those reviews and will continue to do so.

The Department has established policies and procedures relating to the Case Review Process. From July 2015 through March 2016, the timeframe of this audit, 25,491 supervisory cases reviews were reviewed for all programs (e.g. Temporary Assistance for Needy Families - TANF, State Supplemental, Child Care, Food Stamps, Medicaid). The Supervisory handbook provides case review guidance as well as helpful hints with the case review process. In addition, the handbook gives instructions on setting proficiency profiles within the eligibility system for specific staff to improve accuracy. When conducting a case review, there is a "driver flow" within the New HEIGHTS eligibility system to assure all components of the case are reviewed by the reviewer.

The Department also utilizes an updated Case Review Guide that was reviewed and accepted by the Department's Quality Control Staff in June 2016. The guide addresses specific areas that should be reviewed on cases, and if errors are cited, whether the errors are considered potential errors or actual errors. This review guide is given to all staff that conduct case reviews to ensure consistency by all reviewers. An updated version of this guidance was provided to the auditors on June 20, 2016.

The Department concurs that the Department should evaluate the disparity of the supervisory review statistics. The Department presently evaluates the review statistics on an ongoing basis, and will continue to do so.

The Department has well established policies and procedures for the review process. All cases processed by eligibility staff within the first 9 months of employment are reviewed prior to benefit issuance. After 9 months, profiles are established for each staff member to evaluate proficiencies. These profiles assure casework continues to be reviewed until proficiency is achieved. Once a staff member maintains a 95% or better accuracy rate, then they can confirm eligibility without a review. Currently, thirty percent of our eligibility staff are Trainees with less than one year of experience.

In addition to reviewing the work of recently hired staff who are trainees, each supervisor must review a minimum of an additional 30 cases each month of trained staff to be sure all staff are maintaining a proper accuracy rate. Regional Administrators also conduct these reviews to assist with supervisor coverage. At times, Regional Administrators randomly check reviews done by supervisors.

The Department recognizes that disparities in proficiencies are related to number of recently hired staff who are trainees, and, for that reason, all their case actions are reviewed for at least the first nine months of employment. The Case Review Guide was updated in collaboration with and acceptance by the Quality Control Unit to assure consistency in case reviews. The Department has a well-established training program for eligibility staff that is comprised of online, self-directed, instructor-led and one on one learning components.

New HEIGHTS is currently working on enhancements to the Case Review Database and Error Prone Profiling Subsystem to be released on October 28, 2016. These enhancements include more specific data elements to the MAGI [Modified Adjusted Gross Income] program as well as improving the profile proficiency reporting features to provide application dates and number of days pending on cases that need reviews to help prioritize reviews. This is an example of ongoing efforts to continuously improve program operations to assure accurate and timely processing.

Observation No. 2: Implement Required Asset Verification System Control

Observation:

The Department does not currently have an approved Asset Verification System (AVS) control in place for determining and redetermining an individual's eligibility for the Medicaid assistance program. During the nine months ended March 31, 2016, the Department used a manual verification process for determining whether an applicant's or recipient's assets met Medicaid program criteria. An asset verification system is intended, in part, to detect unreported resources of applicants for, or recipients of, Medicaid program assistance.

Section 7001(d) of Title VII, of the Supplemental Appropriations Act of 2008, (P.L. 110-252) added §1940 to the Social Security Act, which requires all States to implement a system for verifying the assets of certain applicants for, or recipients of, Medicaid. The federal legislation required a phased-in approach with 100% of states having an AVS implemented by the end of federal fiscal year 2013.

The Department reported it had contractor-provided AVS services during 2014; however, the contract was allowed to expire. The Department also reported that it started a new AVS project in late fiscal year 2015, however a compliant AVS was not operational during the nine months ended March 31, 2016.

In addition to being out of compliance with federal regulations, there is an increased risk that an improper eligibility determination might be made due to the limitations of the current manual resource verification process.

Recommendation:

The Department should implement an AVS control that is compliant with federal regulations and responsive to the Department's Medicaid program needs.

Pending the implementation of a compliant AVS, the Department should continue to maintain its manual process for determining whether an applicant's assets meet Medicaid program criteria.

Auditee Response:

We concur.

The Department conducted a pilot of an Asset Verification System in 2014 as stated in the audit report. As a result of that pilot, the Department was able to prepare a Request for Proposal (RFP) for a system that would better meet federal requirements and integrate with the New HEIGHTS eligibility system.

The Department is in the process of budgeting and contracting for an Asset Verification System as required by the Centers for Medicare and Medicaid Services (CMS), and the system is scheduled for contract issuance in January 2017 and implementation four months later. The federal government only requires the state to verify financial resources; the current system will do that. However, the system will not verify real property, life insurance, annuities, spousal resources, retirement funds, or securities. The Asset Verification System will check financial institutions in New Hampshire and other states in the Financial Institutions (F-I) network.

Eligibility staff will need to continue to research and verify those resources not addressed by the Asset Verification System.

The Asset Verification System will be used for all Medicaid programs that require a resource check for eligibility.

Observation No. 3: Redesign Controls To Include The Efficient And Effective Utilization Of Certain Available Information

Observation:

The current design of the Department's Medicaid eligibility controls do not include the efficient and effective utilization of certain available information to promptly redetermine eligibility whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility.

42 CFR 435.916 (c) states, "*Procedures for reporting changes*. The agency must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility…"

42 CFR 435.916 (d) states, "*Agency action on information about changes.* (1) Consistent with the requirements of §435.952 of this part, the agency must promptly redetermine eligibility between regular renewals of eligibility described in paragraphs (b) and (c) of this section whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility."

We noted the following instances where the Department could use certain available information to more efficiently and effectively monitor and redetermine where appropriate Medicaid eligibility.

1. The Department utilizes quarterly wage data provided by the New Hampshire Department of Employment Security (NHES) to cross-check client reported income at a client's initial application and as part of the client's annual eligibility redetermination process thereafter. According to the Department, it is unclear whether performing cross-checks on client reported income more frequently than annually would require a change in the State's Medicaid or Verification Plans.

2. The Department's written procedure for cross-checking client income data is that a cross-check difference of 10% or more will prompt the caseworker to request the client to provide documentation supporting the client's reported income. The Department's current practice does not require a review of the difference identified in the cross-check to determine whether it represents unreported sources of client income.

Upon auditor inquiry, the Department reported that it would request clarification from its federal partners as to whether increasing the frequency of the crosschecks would require changes to the State's Medicaid or Verification Plans.

Recommendation:

The Department should, within statutory, rule, and policy authority, and subject to an appropriate cost-benefit analysis, redesign its controls to include the efficient and effective utilization of certain available information to promptly redetermine eligibility upon the receipt of information that may affect beneficiaries' eligibility.

If it is determined current authority does not allow for improved utilization of available data for controls over eligibility, the Department should consider taking steps to revise current plans to allow for that authority.

Auditee Response:

We concur in part.

The Department is operating within its legal authority and designs its controls accordingly.

In regard to the auditor's recommendation to redesign controls to utilize the quarterly wage data provided by the New Hampshire Department of Employment Security (NHES) to cross-check client reported income on a more frequent basis, the Department has determined that there is no legal barrier to adopting such a control, however more frequent use for some Medicaid cases would require changes to the verification plan and the Centers for Medicare and Medicaid Services (CMS) approval.

The current verification process has been approved by CMS as being in complete compliance with federal requirements. The Department could consider redesigning its controls to exceed those federal requirements if the legislature would provide all necessary resources to utilize the NHES report on a quarterly basis. Increasing the cross check utilizing the NHES report to quarterly would triple the number of reviews required. The department would also need to determine whether any changes to the asset verification process would implicate any required Maintenance of Effort.

Observation No. 4: Reemphasize Monitoring Controls For The Timeliness Of Medicaid Eligibility Denial Or Termination Actions

Observation:

The Department's monitoring controls were not operating as designed to identify and respond to untimely processing of Medicaid eligibility denial or termination actions.

Seven out of 27, or 25.9%, of denial and termination actions randomly selected for testing occurred from four to 33 days after the anticipated due date for the action. While the Department reported it was aware of the possibility of cases not being processed timely, it was not aware of the extent of the untimely determinations.

The Department reported the untimely processing of the seven cases identified in the sample resulted in the Department paying $1,365 in additional Medicaid claims.

Recommendation:

The Department should reemphasize the use of its controls to monitor the timeliness of Medicaid eligibility denial or termination actions to ensure that resources can be effectively and efficiently allocated to maintain services and minimize unnecessary costs.

Auditee Response:

We concur.

The Department concurs and is aware of the fact that there is an issue concerning the timeliness of Medicaid eligibility denial and termination actions. The Department believes this is attributable to limited staff resources rather than a lack of information needed to monitor cases.

There is presently a systematic way to monitor the timeliness of Medicaid eligibility denial and termination actions within the New HEIGHTS Eligibility System. We will continue to emphasize to eligibility staff the importance of using system dashboards to monitor status, and taking timely action to assure benefits are issued appropriately. Insufficient personnel resources remain as a barrier to ensuring that denial and termination actions are implemented in a timely manner in order to minimize costs.

The successful monitoring of Medicaid eligibility denial and termination actions is directly related and attributable to the lack of sufficient staffing resources needed to ameliorate the timeliness issue.

Observation No. 5: Establish Controls For Referral Of Cases To The Department's Special Investigations Unit

Observation:

The Department has not established properly designed controls to reasonably ensure that certain denial and termination actions that have increased potential for the payment of ineligible claims are appropriately recognized, determined, and referred to the Department's Special Investigations Unit (SIU) for review and possible action.

The Department does not have policies and procedures describing criteria for determining when to refer certain Medicaid cases to the SIU. The Department reports that employees are trained to refer cases to the SIU when client Medicaid eligibility change events occurred that were not reported "timely" by the client, with timely being understood to be within 10 days of a change, or the timing of the change event was indeterminable. Reportable changes include a change in client income. The SIU investigates referred cases to determine if Medicaid claims were paid during a period of client ineligibility and if so, establishes a recovery process and refers the cases for possible prosecution, when appropriate.

Eight, or 29.6%, of a random sample of 27 cases with denial and termination actions selected for testing were denied or terminated as a result of an identified eligibility change. The clients in five, or 62.5%, of the eight test selections failed to report the change within the expected 10 days of the change event. There is no evidence in the Department's files for any of the five selections that the caseworkers who closed the cases made a determination of the date of the change event or considered whether the case should be referred to the SIU. According to Department personnel, further review of these cases confirmed that three of the cases should have been

referred to the Department’s SIU for possible medical assistance recovery. The Department reported that there was no need to report two of the cases, as the cases were closed prior to the end of the month. The Department provided no policy to support the criteria of not reporting cases closed prior to the end of the month.

Recommendation:

The Department should establish properly designed controls, including policies and procedures containing established criteria, to support employee training and to reasonably ensure that denial and termination actions that have increased potential for the payment of ineligible claims are appropriately recognized, determined, and referred to the Department’s Special Investigations Unit for review and possible action.

Auditee Response:

We concur.

For many years, the Special Investigations Unit (SIU), within the Office of Integrity and Improvement has maintained a guidance document for eligibility staff and provided training on when to do referrals for fraud and recovery for non-Medicaid programs and primarily focused on Food Stamp cases. The guidance document was recently revised to include Medicaid programs and the need for referrals.

In 2016, SIU conducted education sessions with district office staff, and will continue to train all of Client Services staff on making Medicaid referrals. The revised guidance document will be posted in a shared drive and will be incorporated in the Division’s ongoing training program.

The Department is also planning to seek information from third party vendors on automated systems that may improve identification of termination actions.

APPENDIX

Current Status Of Prior Audit Findings

The following is a summary, as of October 2016, of the current status of the observations contained in the financial and compliance audit report of the Department of Health and Human Services, Medicaid Program, for the year ended June 30, 2002 that are relevant to the scope of this audit. The prior audit report can be accessed at:

http://www.gencourt.state.nh.us/LBA/AuditReports/financialreports.aspx

		Status		
Internal Control Comment				
Material Weakness				
1.	General Computer Controls Must Be Improved	●	●	●
Federal Compliance Comments				
20.	Client Eligibility Files Should More Accurately And Completely Document Client Status	●	●	●
23.	Federally Required Quality Control Reporting Should Be Submitted	●	●	●
24.	The Organizational Independence Of The Surveillance Utilization Review Unit Should Be Increased	●	●	●
Management Issues Comment				
27.	Additional Support In The Surveillance Utilization Review Unit Should Be Considered	●	●	○

Status Key				**Count**
Fully Resolved	●	●	●	4
Substantially Resolved	●	●	○	1
Partially Resolved	●	○	○	0
Unresolved	○	○	○	0

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