



# OKLAHOMA HEALTH CARE AUTHORITY MEDICAID ELIGIBILITY

## Performance Audit

For the Period July 1, 2018 through June 30, 2019

**Cindy Byrd, CPA**  
State Auditor & Inspector

**Audit Report of the  
Oklahoma Health Care Authority  
Medicaid Eligibility**

**For the Period  
July 1, 2018 through June 30, 2019**

## EXECUTIVE SUMMARY



## Oklahoma Health Care Authority Medicaid Eligibility

Fiscal Year 2019

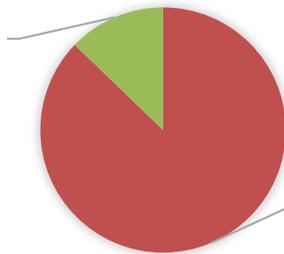
### PROGRAM IMPACT & ENGAGEMENT BACKGROUND

Medicaid is a jointly funded federal-state program that provides health care coverage and services to eligible low-income individuals and families with children.

As of June 30, 2019, approximately 1 million Oklahomans were enrolled in the Medicaid program (25% of our population) and received \$4.7 billion in services. Medicaid is Oklahoma's largest state appropriated program, and its cost is growing annually.

#### STATE FISCAL YEAR 2019 APPROPRIATIONS \$7.5 BILLION

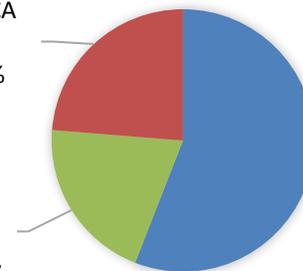
Total OHCA  
Appropriations,  
\$1.1 billion, 13%



Total Other State  
Agency  
Appropriations,  
\$7.5 billion, 87%

#### OHCA FUNDING FOR STATE FISCAL YEAR 2019

Total SFY 19 OHCA  
Other Funding  
\$1.4 billion, 24%



Total SFY 19 OHCA  
Federal Funding,  
\$3.3 billion, 57%

Total SFY 19  
OHCA State  
Appropriations,  
\$1.1 billion, 19%

In response to the Governor’s request, this audit was performed to assess whether Oklahoma Health Care Authority (OHCA), the agency that administers Medicaid in Oklahoma, has sufficient controls in place to ensure that only eligible individuals were enrolled in the Medicaid program and those individuals were enrolled and disenrolled in a timely manner, in accordance with laws and regulations, in state fiscal year 2019.

The populations tested included:

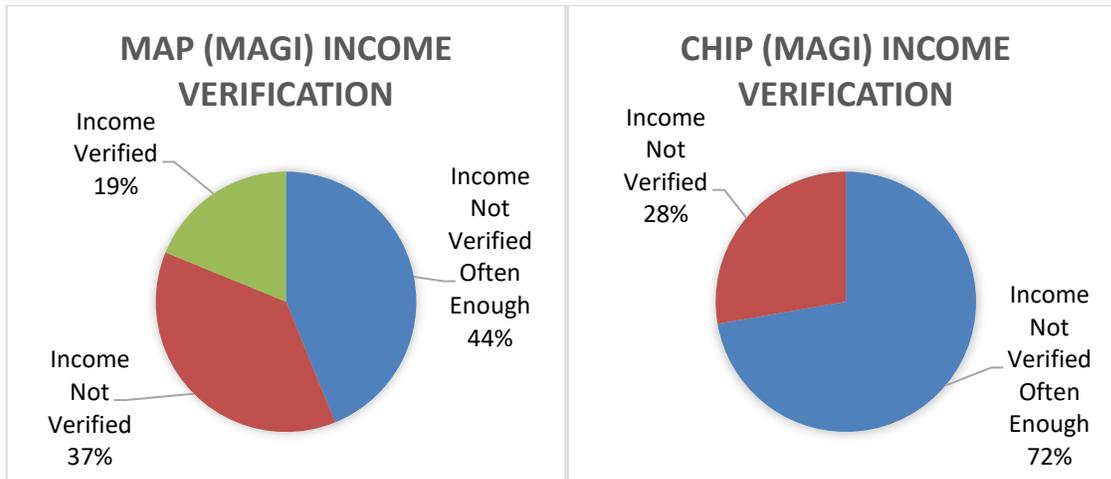
Population	Total Recipients	Total Claims Value	Sample Size Tested
<b>MAP MAGI recipients (OHCA)</b>	733,196	\$2,004,473,535	184
<b>MAP Non-MAGI recipients (OKDHS)</b>	182,647	\$2,306,734,463	184
<b>CHIP MAGI recipients (OHCA)</b>	211,921	\$348,620,899	184
<b>CHIP TEFRA recipients (OHCA/OKDHS)</b> <i>Included in the CHIP populations on the next page.</i>	140	\$1,839,691	7

We tested the maximum sample for the population size in accordance with Generally Accepted Auditing Standards.

## WHAT WE FOUND

The findings noted throughout the report are related to key factors in the eligibility determination process and the weaknesses detailed have allowed ineligible individuals to receive benefits.

Limited electronic data, along with inadequate income support, were the primary deficiencies noted specifically in the MAGI population. The following charts represent the percent of claims paid where income was verified, not verified often enough, or not verified at all:



The control deficiency of not verifying income as required resulted in noncompliance in both the MAP and CHIP MAGI populations and deviations in the CHIP population. Details include:

- **Oklahoma Employees Security Commission (OESC) is the only source of electronic wage data used to verify income.** Additional data sources are available through the Federal Data Services Hub (Hub) for verifying individuals' information. The Hub contains additional data such as IRS information.
- **Electronic wage data from OESC is not being used to verify income as frequently as required.** An estimated 44% of the MAP and 72% of CHIP claims may have paid on behalf of recipients whose income was not checked as often as it should have been.
  - **As a result, a projected \$29.7 million in CHIP claims were paid on behalf of ineligible recipients.**
- **Income is not verified for an estimated 37% of the MAP and 28% of the CHIP claims paid on behalf of the follow categories individuals:**
  - self-employed, work out of state, work for the federal government, or claim zero income, which accounted for approximately 21% of the MAP and 14% of the CHIP claims paid.
  - those receiving pregnancy-related services, which accounted for approximately 11% of the MAP and 2% of the CHIP claims paid.
  - some non-applicants or their spouses who do not provide their Social Security Numbers or other identifying information when applying for benefits for their dependents; therefore, income could not be verified through the data exchange. This accounts for approximately 5% of the MAP and 12% of the CHIP claims paid.

The control deficiency and noncompliance noted for the MAP Non-MAGI population include:

- **IRS restrictions on SSA data:** Social Security benefits, with the exception of Supplemental Security Income (SSI), are considered income, and therefore fall under the IRS Code 26 USC 6103 - Confidentiality Disclosure of Returns and Return Information. In addition, the Computer Matching and Privacy Protection Act Agreement (CMPPS) states that “State Agencies will not use or redisclose the data disclosed by SSA for any purpose other than to determine eligibility, for or the amount of, benefits under the state-administered income/health maintenance programs.” **Due to our inability to view this critical piece of financial data from an independent source, we had to rely on information maintained in case files in determining eligibility.**
- **Data exchanges with other entities are not consistently run at the required frequency, and discrepancies noted through data exchanges are not always resolved within the required 45-day timeframe. This could result in ineligible recipients not being identified before claims are paid.**
- **Additional issues were identified related to case file completeness, verification procedures, and compliance with pertinent laws and regulations.** Inconsistent and incomplete case notes caused us some difficulty in determining eligibility. In addition, recipients can have multiple case files if they receive benefits from other federal assistance programs (companion cases). In some instances, the recipient’s information, such as applications and renewal notices, was placed in the incorrect case file.

*Figures were calculated using statistical sampling and projection methodology under expert guidance; details are included in the report.*

## SOLUTIONS

As the State’s Administrator of Medicaid funds, OHCA is required to spend program funds as directed by federal and state laws and regulations. With expenditures growing, OHCA should take the necessary steps to ensure benefits are only being provided to eligible individuals.

Recommendations for OHCA are detailed in the report and include the following:

- Review the current controls in place in the eligibility system and update relevant processes, including these steps:
  - Design and implement more aggressive procedures to verify eligibility prior to certifying an applicant as eligible for the program.
  - Take steps to mitigate the risk of payments to ineligible recipients by expanding types of electronic wage verification systems. Currently, only data from the OESC is being utilized. The data from OESC is limited to approximately 48% of the OHCA applicant population,

while leaving approximately 36% of the applicants to self-attestation without any other verification.

One option is to utilize the Federal Data Services Hub (Hub). The Hub is a tool built by the Internal Revenue Service (IRS) and Health and Human Services (HHS). It combines data on income and employment from IRS records, health and entitlements from HHS records, identity from Social Security, citizenship from Department of Homeland Security records, criminality from Department of Justice records, residency from state records, and other sources. This system will provide timely, accurate information for wage verification of applicants.

- Incorporate additional steps for eligibility verification rather than just the minimum required by CMS. While CMS sets minimum requirements for determining eligibility, there is no federal restriction to prevent OHCA from designing internal controls and processes that will further ensure payments are made only for eligible recipients. These should include:
  - documented income verification (using all appropriate sources) and collection of personally identifying information for all required applicants,
  - timely wage data verification, and
  - updating the MMIS system to verify wage information received from OESC on a quarterly basis to determine continued eligibility of individuals.
- Fully implement the HOPE Act which was passed by the Oklahoma Legislature and became effective on November 1, 2017.
- Ensure the required conditions of eligibility are met in order to comply with 42 CFR § 435, OAC 317:35, and the State Plan.
- Collaborate with OKDHS, provide additional staff training, and update the Service Agreement, policies, and procedures as necessary, to comply with 42 CFR § 431.10(c)(2) and 42 CFR § 431.10(c)(3)(ii). These efforts should ensure:
  - data exchanges with other entities are performed at the required frequency,
  - discrepancies are cleared in a timely manner,
  - required case documentation is retained, and
  - timely notifications of eligibility decisions are provided as required.

Additional requests from the Governor that would strengthen the audit process:

- Request that the Internal Revenue Service allow auditors access to income information and other independent sources of information (e.g. the Hub) so that such information can be utilized when redetermining eligibility.

See full report at <http://www.sai.ok.gov>



Cindy Byrd, CPA | State Auditor & Inspector

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June 25, 2020

**TO GOVERNOR KEVIN STITT,  
KEVIN CORBETT, CHIEF EXECUTIVE OFFICER and the OKLAHOMA HEALTH  
CARE AUTHORITY BOARD**

We present the audit report of the Oklahoma Health Care Authority–Medicaid Eligibility for the period July 1, 2018 through June 30, 2019. The goal of the State Auditor and Inspector is to promote accountability and fiscal integrity in state and local government. Maintaining our independence as we provide this service to the taxpayers of Oklahoma is of utmost importance.

We wish to take this opportunity to express our appreciation for the assistance and cooperation extended to our office during our engagement.

This report is a public document pursuant to the Oklahoma Open Records Act (51 O.S. § 24A.1 et seq.), and shall be open to any person for inspection and copying.

Sincerely,

A handwritten signature in blue ink that reads "Cindy Byrd".

CINDY BYRD, CPA  
OKLAHOMA STATE AUDITOR & INSPECTOR



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Overview of  
Medicaid

Medicaid, also referred to as the Medical Assistance Program (MAP), is a jointly funded federal-state program that provides health care coverage and services to eligible low-income individuals and families with children. Medicaid is administered at the federal level by the Center for Medicare and Medicaid Services (CMS) under Title XIX of the Federal Social Security Act<sup>1</sup>, and administered at the state level by the Oklahoma Health Care Authority (OHCA, or the Authority) under the Oklahoma Administrative Code (OAC) 317:35.<sup>2</sup>

Because each state establishes and administers its Medicaid program, there is considerable variation from state to state. Each state specifies the nature and scope of its Medicaid program through a state plan.<sup>3</sup>

The Affordable Care Act (ACA) requires states to calculate the income for most nondisabled, nonelderly applicants using a uniform method based on modified adjusted gross income (MAGI)<sup>4</sup>, which is derived from a federal tax-based definition of income. States have more flexibility in calculating incomes for individuals whose eligibility is determined on the basis of age or disability, because their income is not required to be calculated using MAGI-based methods.

Federal regulations<sup>5</sup> require states to provide all eligible recipients certain basic services, including but not limited to inpatient and outpatient hospitalizations, physicians, and rural health clinic and nursing facility services.

*Oklahoma  
Medicaid*

In administering Oklahoma's Medicaid program, known as SoonerCare, OHCA sets guidelines regarding eligibility and services in Oklahoma. The official eligibility requirements are identified in the State Plans and Waivers, which reference to the codified requirements in 42 Code of Federal Regulations (CFR) section 435.

In addition to the MAP, the Children's Health Insurance Program (CHIP) provides health coverage to children in families with incomes too high to qualify for Medicaid but who cannot afford private health coverage. Like Medicaid, CHIP is a federal-state program.

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<sup>1</sup> [Social Security Act](#)

<sup>2</sup> [Oklahoma Administrative Code](#)

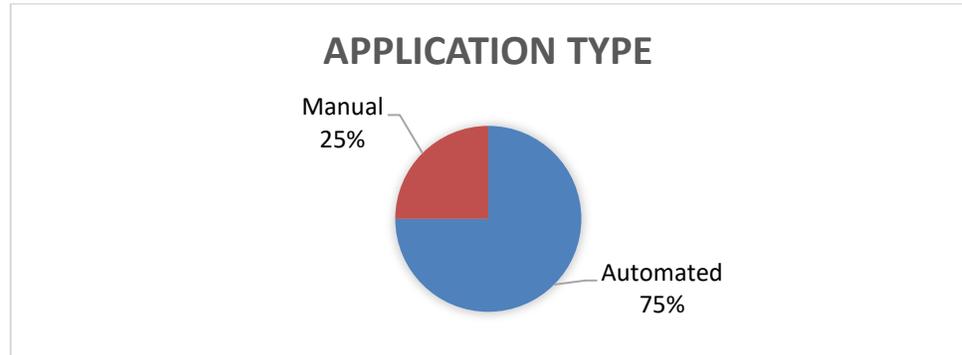
<sup>3</sup> [42 CFR § 431.10](#) The state plan is a formal, written agreement between a state and the federal government, submitted by the single state agency and approved by CMS, describing how that state administers its Medicaid program.

<sup>4</sup> The ACA definition of MAGI under the [Internal Revenue Code Section 36B\(d\)\(2\)\(B\)](#), and [42 CFR § 435.603\(e\)](#)

<sup>5</sup> [42 CFR § 440](#) – Services: General Provisions

## Oklahoma Health Care Authority Medicaid Eligibility Performance Audit

According to State Fiscal Year (SFY) 2019 data<sup>6</sup>, eligibility determinations for approximately 75% of the Medicaid recipients were made through the automated online system at OHCA; the other 25% were performed manually at the Oklahoma Department of Human Services (OKDHS) based on applications submitted in person, by mail, or by telephone.



Nearly 1 million Oklahomans were enrolled in the Medicaid program as of June 30, 2019, which is about 25 percent of Oklahoma’s population.<sup>7</sup>

As illustrated in the following table<sup>8</sup>, \$3.3 billion was federally funded to Medicaid in Oklahoma in federal fiscal year 2019, and approximately \$1.7 billion was state appropriated. Medicaid is Oklahoma’s largest state appropriated program.

Federal Fiscal Year	Total Expenditures	Federal Share	Other Revenue	State Share-OHCA	State Share-Other Agencies
2010	\$ 4,350,788,295	\$ 2,667,539,569	\$ 508,946,267	\$ 938,718,686	\$ 235,583,773
2011	\$ 4,419,400,740	\$ 2,707,196,795	\$ 414,614,124	\$ 978,015,721	\$ 319,574,101
2012	\$ 4,770,055,106	\$ 2,912,698,984	\$ 647,058,594	\$ 898,907,968	\$ 311,389,560
2013	\$ 4,974,580,067	\$ 3,024,867,483	\$ 577,749,094	\$ 906,983,007	\$ 464,980,484
2014	\$ 5,229,376,869	\$ 3,267,139,805	\$ 444,857,405	\$ 946,812,805	\$ 570,566,854
2015	\$ 5,116,208,204	\$ 3,052,334,755	\$ 666,527,145	\$ 902,948,977	\$ 494,397,327
2016	\$ 5,118,089,773	\$ 2,977,533,696	\$ 449,692,375	\$ 1,101,785,174	\$ 589,078,528
2017	\$ 5,292,148,089	\$ 3,076,929,283	\$ 435,083,205	\$ 1,197,368,765	\$ 582,766,836
2018	\$ 5,249,845,451	\$ 3,052,820,094	\$ 317,852,841	\$ 1,266,940,277	\$ 612,232,239
2019	\$ 5,470,272,539	\$ 3,274,709,406	\$ 504,839,789	\$ 1,126,465,946	\$ 564,257,398

<sup>6</sup> We utilized the SoonerCare Fast Fact Sheets for Enrollment from the OHCA website at <http://www.okhca.org/research.aspx?id=2987> and averaged each month for SFY 2019.

<sup>7</sup> According to the Census Bureau at <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-total.html>, Oklahoma’s population estimate was 3,956,971 at July 1, 2019. According to the [OHCA 2019 Annual Report](#), the total population enrolled in the Medicaid was 998,209. ( $998,209/3,956,971 = 0.25$ )

<sup>8</sup> OHCA – SFY 2019 Annual Report Appendix (Totals are based on a federal fiscal year and represent all expenditures related to the Medicaid program.), online at <http://www.okhca.org/research.aspx?id=87>.

## Oklahoma Health Care Authority Medicaid Eligibility Performance Audit

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### *Shared Eligibility System*

States are required to have an income and eligibility verification system for determining Medicaid eligibility, and upon CMS's request, a verification plan describing the state agency's policies and procedures for implementing the eligibility verification requirements.<sup>9</sup> The plan is reviewed and accepted by CMS and must specifically include how an individual's eligibility information, such as citizenship, social security number (SSN), and residency will be verified. Oklahoma's methods for verifying applicants' information are outlined in the State Verification Plan.<sup>10</sup>

Oklahoma operates a dual-eligibility determination system. OHCA uses an online application system to perform eligibility determinations for the portion of the Medicaid population whose eligibility is based on MAGI, as outlined in OAC 317:35-5-63 (a).<sup>11</sup> This application system is a subsystem of OHCA's benefits payment system (the Medical Management Information System or MMIS).

While Oklahoma's Medicaid program is administered by OHCA, a portion of the eligibility determination functions is delegated to OKDHS. A service agreement with OKDHS is in place to assure cooperation and collaboration between OHCA and OKDHS in performance of their respective duties to provide health care to eligible recipients.

The OKDHS staff works in partnership with the Authority in determining eligibility for those receiving other government assistance and those considered as the Aged, Blind, and Disabled (ABD) population.<sup>12</sup> Eligibility for these individuals is based on a non-MAGI (no modified adjusted gross income) methodology. Once an applicant is deemed eligible through OKDHS, payments for medical services are processed through MMIS.

Additional detailed information related to methods of verification and other facets of the Oklahoma Medicaid program is located in [Appendix A](#).

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<sup>9</sup> [42 CFR, 435.945\(j\)](#) *Verification plan*. The agency must develop, update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State agency to implement the provisions set forth in §§ 435.940 through 435.956 of this subpart in a format and manner prescribed by the Secretary.

<sup>10</sup> [State Verification Plan](#)

<sup>11</sup> Details are listed in [Appendix A](#)

<sup>12</sup> The criteria for determining eligibility for the ABD population is defined by the Social Security Administration. See Supplemental Security Income (SSI) Eligibility Requirements online at <https://www.ssa.gov/ssi/text-eligibility-ussi.htm>

## Scope & Methodology

### *Audit Request*

Our audit was conducted in response to the Governor’s request, as authorized by 74 § 212(C) and § 213.2(B). The purpose of the audit was to assess whether OHCA has sufficient controls in place to ensure only eligible individuals are enrolled in the Medicaid program, and to determine if individuals were enrolled and disenrolled in a timely manner, in accordance with laws and regulations.

This audit was performed in conjunction with the 2019 Single Audit.<sup>13</sup> The Office of Management and Budget issues guidance in the Compliance Supplement, which identifies important compliance requirements that the federal government expects to be considered as part of such an audit.<sup>14</sup> Because sufficient, appropriate audit evidence supporting the eligibility compliance requirement regarding MAP and CHIP could not be obtained, a determination of whether the State of Oklahoma complied with the requirement could not be made. Therefore, the State of Oklahoma 2019 Single Audit indicates a disclaimed opinion on eligibility. In addition, material weaknesses were noted and reported for the eligibility control system as a whole.

### *Scope Limitation*

As reflected above regarding the Single Audit, we determined that case records for some recipients lacked crucial documentation to support self-reported income which is needed to redetermine eligibility; therefore, we were unable to determine if Medicaid benefits should have been paid on behalf of those recipients.

### *Sample Method*

To determine compliance with applicable eligibility laws and regulations, we evaluated the OHCA and OKDHS controls over the eligibility determination process, and redetermined eligibility for a statistical sample by randomly selecting 184 Medicaid recipients from each of three separate data sets, and judgmentally selecting a sample of seven TEFRA recipients<sup>15</sup>, for a total of 559 cases. We then reviewed pertinent documentation in each recipient’s electronic case records. The populations and samples referred to throughout the report follow:

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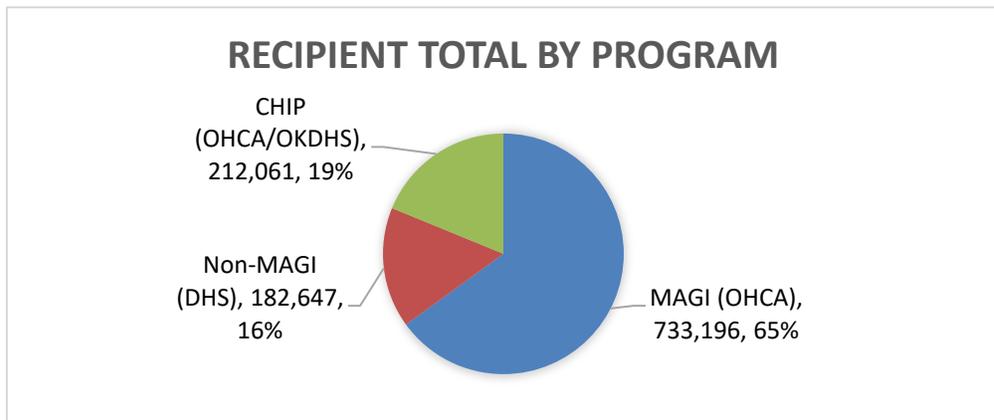
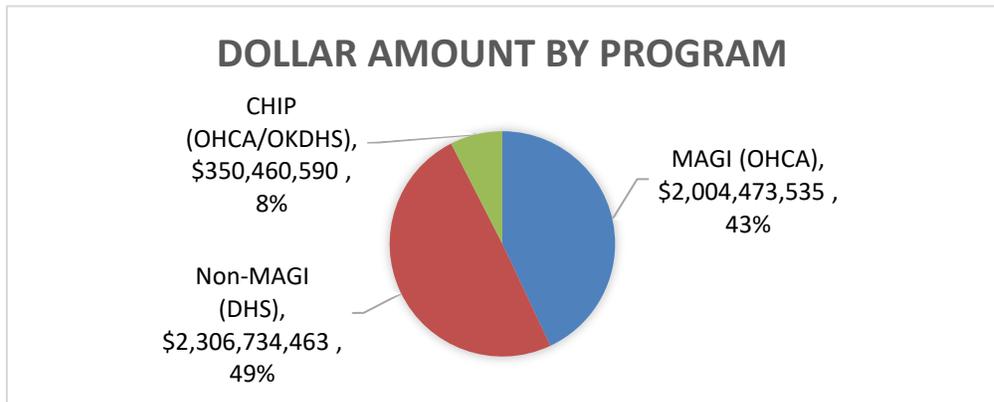
<sup>13</sup> Organizations based in the United States with expenditures of federal funding of \$500,000 or more (\$750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization’s fiscal year are required to send an audit report to the Office of Management and Budget, in accordance with the Single Audit Act, as amended, and the Office of Management and Budget implementing guidance. See [31 U.S.C. §§ 7501-7507](#); [2 C.F.R., pt. 200, subpart F. \(2019\)](#) (as added by 78 Fed. Reg. 78590, 78608 (Dec. 26, 2013)).

<sup>14</sup> 2019 Compliance Supplement online at <https://www.whitehouse.gov/omb/management/office-federal-financial-management/>

<sup>15</sup> See further explanation in [Appendix B](#).

**Oklahoma Health Care Authority  
Medicaid Eligibility  
Performance Audit**

Population	Total Recipients	Total Claims Value	Sample Size Tested
<b>Medicaid MAGI recipients (OHCA)</b>	733,196	\$2,004,473,535	184
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<b>CHIP MAGI recipients (OHCA)</b>	211,921	\$348,620,899	184
<b>CHIP TEFRA recipients (OHCA/OKDHS)</b> <i>Included in the CHIP populations below.</i>	140	\$1,839,691	7



Additional detailed methodology and applicable auditing standards are discussed in more detail in [Appendix B](#).

## Objective

1. Determine whether OHCA complied with 42 CFR § 435, OAC 317:35, and the State Plan when enrolling individuals to Medicaid (MAP) and Children's Health Insurance Program (CHIP).
2. Determine whether individuals enrolled in the MAP or CHIP programs meet state and federal eligibility requirements according to the same laws and regulations identified in objective 1.
3. Determine whether OHCA complied with timeliness requirements in 42 CFR § 435.912, 42 CFR § 435.916, and 42 CFR § 435.917 when adding or removing recipients from the MAP and CHIP program.

## Overall Conclusion

Overall, OHCA does not have adequate internal controls in place to ensure compliance with federal laws and regulations that require only eligible participants receive Medicaid and CHIP benefits. OHCA made payments on behalf of Medicaid recipients who did not meet, or may not have met, federal and state eligibility requirements.

Although the Authority is adding individuals to the program in a timely manner, in accordance with CFR § 435.912, 42 CFR § 435.916, **Oklahoma is the only state to approve 100% of MAGI applications within 24 hours. Federal regulations allow the Authority up to 45 days to verify an applicant's information, if necessary.** Utilizing additional days to verify the applicant's information would give the state better leverage to ensure only eligible applicants are receiving services.

At the time the Authority determines individuals to be ineligible, they are removed from the program timely in accordance with CFR § 435.912, 42 CFR § 435.916.

In some instances, individuals did not receive notifications regarding the decision made about their eligibility in accordance with 42 CFR § 435.917.

The following report discusses the deficiencies noted, opportunities for improvement, and recommendations based on the applicable laws and regulations.

## Findings

We reviewed the State Verification Plan, significant laws and regulations, and the federal program requirements in detail, then identified the significant controls<sup>16</sup> related to criteria for the eligibility determination process. As discussed earlier, there are significant differences between the eligibility determination processes at OHCA and at OKDHS. While eligibility determinations made at OHCA are specific to the MAGI populations and made through an automated online system, the OKDHS processes are specific to the non-MAGI populations and eligibility determinations are made manually by a Social Service Specialist.

Because the processes are different, the internal controls are expected to be different. However, all controls should be adequately designed and operating effectively to ensure:

- eligibility determinations are made in accordance with applicable laws and regulations;
- only eligible applicants receive benefits;
- current recipients continue to be eligible at the time of redetermination; and
- recipients are added to or removed from the program in a timely manner, in accordance with applicable laws and regulations.

We identified control deficiencies and areas of noncompliance at both OHCA and OKDHS.

### Wage Data Not Verified at the Required Frequency

Federal guidance requires states to participate in the state income and eligibility verification system (IEVS) and request financial information from other agencies and other state and federal programs, to the extent that such information is useful to verify the financial eligibility of an individual.<sup>17</sup> This includes information related to wages, net earnings from self-employment, and unearned income, as well as resources from

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<sup>16</sup> Internal controls are policies, procedures, and activities designed to assist an entity in meeting an objective. Controls can be automated or manual and examples include reconciliations; segregation of duties; review and approval authorizations; safeguarding and accountability for assets; and preventing or detecting error or fraud. Controls help ensure appropriate financial reporting, the achievement of operational objectives, and compliance with applicable laws, regulations, and written agreements.

<sup>17</sup>42 U.S.C. 1320b-7 online at <https://www.govregs.com/uscode/42/1320b-7>; [42 CFR § 435.948 \(a\)\(1\)](#)

## Oklahoma Health Care Authority Medicaid Eligibility Performance Audit

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the State Wage Information Collection Agency, the Internal Revenue Service (IRS), and the Social Security Administration (SSA).

Federal regulations also provide standards under which income information obtained through electronic data sources is considered reasonably compatible<sup>18</sup> with income information provided by or on behalf of an individual.<sup>19</sup>

Federal law requires that income be verified at the time of application and then again at redetermination.<sup>20</sup> The law states that “the agency must promptly evaluate information received or obtained by it in accordance with regulations to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.”<sup>21</sup>

In Oklahoma, income provided by an applicant is self-attested at the time of application and if the amount falls below the federal poverty level (FPL) based on the applicant’s household size, with less than a 5% compatibility limit, they are determined eligible. Income is then verified post enrollment from quarterly wage data received from the Oklahoma Employment Security Commission (OESC). Income is verified again at the time of renewal (within 12 months of the application date).

**Information from OESC is the only source of electronic wage data requested from another agency to verify an individual’s income eligibility.<sup>22</sup> OESC data only contains reported wage information from Oklahoma employers. It does not include income from self-employment, out-of-state employers, or federal employers.**

Income is confirmed using data from a full quarter of wages when verifying an applicant’s income. Therefore, if an individual applies for services in the 2<sup>nd</sup> quarter of a year, their income may not be verified until the 4<sup>th</sup> quarter. This is because the first available full quarter of wage data after application is the 3<sup>rd</sup> quarter (July-September) data. This data will not be provided to OHCA until the 4<sup>th</sup> quarter (October). See example:

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<sup>18</sup> The term “reasonable compatibility” refers to a Federal requirement (effective January 1, 2014) that prohibits States from requiring Medicaid applicants to provide documentation except in cases in which applicants’ self-reported documentation was not reasonably compatible with information in government databases ([42 CFR §435.952\(c\)](#)). In accordance with this requirement, the State agency established its reasonable compatibility threshold at a 10-percent discrepancy between the applicant’s self-attested income and the same individual’s income as subsequently reported by his or her employer. The State agency also established a 90-day reasonable opportunity period for an applicant to respond to the State agency regarding income discrepancies.

<sup>19</sup> [42 CFR § 435.952](#)

<sup>20</sup> [42 CFR § 435.948](#)

<sup>21</sup> [42 CFR § 435.952 \(a\)](#)

<sup>22</sup>According to OHCA management, the online enrollment for OHCA existed prior to ACA and the Hub. See discussion later in this report section.

# Oklahoma Health Care Authority Medicaid Eligibility Performance Audit



We reviewed wage data closest to the date of service selected for 237 recipients<sup>23</sup> and noted that **OHCA only verified a recipient's income twice a year, even though information from OESC was provided more frequently (quarterly).**

A recipient's income could change throughout the year without it being detected in a timely manner by OHCA, because wage information reported by the recipient is not verified at the frequency wage data is obtained. Therefore, a recipient's income could exceed the federal poverty level, making the recipient ineligible for Medicaid benefits.

A *control deficiency* was noted for the following:

### MAP Details

- In 85 of 184 (46%) case files tested, the quarterly wage data was not compared to household income often enough to determine if the recipient remained eligible throughout the year.

### CHIP Details

- In 152 of 184 (83%) case files tested, the quarterly wage data was not compared to household income often enough to determine if the recipient remained eligible throughout the year.
- In nine of these 152 (6%) cases, a *deviation* was noted where wages exceeded the max federal poverty level before the date of service sampled, making the recipient ineligible.

The statistical error rate for wages exceeding the federal poverty level deficiencies for the CHIP population is 8.54%. This suggests 207,595 claims, totaling \$29,772,225, were paid on behalf of ineligible recipients.

*The error rate suggests \$29,772,225 in CHIP claims were paid on behalf of ineligible recipients*

<sup>23</sup> MAGI cases from our sample subject to the IEVS discussed at the beginning of this report section

## Oklahoma Health Care Authority Medicaid Eligibility Performance Audit

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According to statistical sampling calculations, a projected 44% of the MAP and 72% of CHIP claims were paid on behalf of recipients whose income was not checked as often as it should have been.

Additional sources of data are available through the Federal Data Services Hub<sup>24</sup> to verify an individual's information. However, in an April 2013 letter to CMS, OHCA requested the use of alternative solutions for data verification.

The request included the following:

The Oklahoma Healthcare Authority, the single state Medicaid agency is requesting the use of alternative solutions for data verification. Our request for each is detailed below with corroborating information to justify the decisions.

The Oklahoma Healthcare Authority (OHCA), will not be attempting to use the IRS data received from the HUB for Release 2, effective October 1, 2013. Instead OHCA will continue to use the current processes of verification of income information. Those sources include:

- OESC (Oklahoma Employment Security Commission) weekly wage and unemployment data
- SSA (Social Security Administration) real-time interface verification for BENDEX and SDX information;
- Self-Employment self-attestation at point of application.

Our decision to go with the above income verification sources is based on the following: Both the OESC and SSA interfaces provide the most current and accurate income data; If and when questionable self-employment self-attestations arise, OHCA will continue to request 3rd party verification in written format. OESC requires confidentiality of the data it provides and thus does not allow the direct transfer of the data to the development vendor. The data from OESC is directly and securely passed to OHCA and securely transferred to the development vendor. This is an agreement between OHCA and OESC to ensure the confidentiality and security of OESC wage and unemployment data.

**A February 2014 waiver from CMS approved Oklahoma's request to use a mechanism other than the Federal Data Services Hub for verification of information.** It also stated that Center for Medicaid and

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<sup>24</sup> The **Federal Data Services Hub** is a tool used to facilitate the government-backed [Patient Protection and Affordable Care Act](#) health coverage program. It is built by the [Internal Revenue Service](#) (IRS) and [Health and Human Services](#) (HHS). It combines data on income and employment from IRS records, health and entitlements from HHS records, identity from [Social Security](#), citizenship from [Department of Homeland Security](#) records, criminality from [Department of Justice](#) records, and residency from state records. Also involved will be the [Department of Defense](#), the [Department of Veterans Affairs](#), the [Office of Personnel Management](#), the [Peace Corps](#), and state [Medicaid](#) administrations.

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CHIP Services (CMCS) had confirmed the electronic data sources and verification procedures that Oklahoma will use in place of the Hub.

The response letter also states that “CMS staff conducted a thorough review of Oklahoma's MAGI-based verification plan, participated in conference calls with the state, and engaged in follow-up consultations to clarify, complete and agree upon the enclosed final version.”

## Self-Reported or Zero Income Attestations Not Properly Verified

At the time of application, individuals attest to their income, which is an accepted method of determining financial eligibility per the State Verification Plan. Post-enrollment, OHCA uses the electronic wage data match to determine if other income has been reported. If no other income is reported by the wage exchange for self-reported or zero income applicants, the Authority does not request additional income documentation.

Federal regulations say that an individual must not be required to provide additional information or documentation *unless information needed cannot be obtained electronically or the information obtained electronically is not reasonably compatible.*<sup>25</sup>

**It is the Authority’s understanding that if no inconsistencies are identified from the wage data exchange, no additional documentation should be requested.**

However, the Authority’s rules state that if OHCA is unable to verify income through OESC, then it *must* be verified by the best available information, such as pay stubs.<sup>26</sup>

A *control deficiency* was noted for the following:

### MAP

- In 25 of 184 (14%) case files tested, income, such as self-employment, out-of-state wages, or other miscellaneous income, was self-reported without further verification.

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<sup>25</sup> [42 CFR § 435.952](#) Use of information and requests of additional information from individuals.

<sup>26</sup> [317:35-10-26. \(a\)\(2\)\(F\)\(3\)](#) *General provisions regarding income* - Income produced from resources must be considered as unearned income. Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required.

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- In 29 of 184 (16%) case files tested, income was self-reported as zero, without further verification.

CHIP

- In 48 of 184 (26%) case files tested, income, such as self-employment, out-of-state wages, or other miscellaneous income, was self-reported without further verification.

According to statistical sampling calculations, a projected 21% of the MAP and 14% of the CHIP claims were paid on behalf of individuals who are self-employed, work out-of-state, have other miscellaneous income, or their income was self-reported without further verification.

For individuals who reported self-employment income or zero income, we obtained tax information from the Oklahoma Tax Commission to determine if the information provided to OHCA was reasonably compatible with the individual's adjusted gross income reported on their Oklahoma Tax Return.

We identified 13 MAP recipients and three CHIP recipients whose self-reported income potentially exceeded the federal poverty level for their household size.<sup>27</sup>

**Because OHCA failed to obtain additional documentation to verify income for individuals whose income was not verified through the wage data exchange, we were unable to redetermine eligibility.**

OHCA may have paid benefits on behalf of ineligible recipients, because self-reported and zero income was not verified.

**Applicants  
Accepted for  
Pregnancy  
Related Services  
without Income  
Verification**

An individual's attestation can be accepted for certain information, such as pregnancy status and household composition (e.g., household size and family relationships), without further verification.<sup>28</sup>

However, according to OAC 317:35-5-46 (b), income is to be determined in accordance with the MAGI methodology for individuals related to the pregnancy group. Eligibility is based on the income received in the first

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<sup>27</sup> SAI obtained tax information from OTC; however, because a recipient's income can fluctuate, eligibility status may change often. Also, the Authority did not obtain additional documentation to support the self-attested income; therefore, we were unable to obtain sufficient, appropriate audit evidence to verify income for the point in time.

<sup>28</sup> [42 CFR § 435.945](#) (a) Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's

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month of certification with changes in income not considered after certification, and there is no resource test.

Because the law cited reads, “eligibility is based on the income received in the first month of certification with changes in income not considered after certification,” OHCA has accepted the self-attested income from those seeking pregnancy-related services without further verification or consideration of inconsistencies obtained electronically. This is partially due to electronic data not being obtained until after the certification month, and self-employed or zero income not being verified by other supporting documentation during the month of certification.

When pregnant women are determined eligible and enrolled in the Medicaid program, coverage must be provided through the last day of the month in which the 60-day postpartum period ends, regardless of change in household income.<sup>29</sup>

In addition, the newborn child is deemed eligible, on the date of birth to a woman who is eligible for and enrolled in pregnancy-related services, as categorically needy. The child's eligibility is not dependent on the mother's continued eligibility. Although the mother's coverage may expire at the end of the postpartum period, the newborn child is deemed eligible until age one, and consideration is not given to any income or resource.<sup>30</sup>

Our sample selection included pregnancy- and newborn-related cases and identified that income was self-attested without any additional documentation required.

*A control deficiency* was noted for the following:

### MAP Details

- In 10 of 184 (5%) case files tested, recipients were newborns.
- In nine of 184 (5%) case files tested, recipients were pregnant.

### CHIP Details

- In three of 184 (2%) case files tested, recipients were newborn.

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household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

<sup>29</sup> [42 CFR § 435.170](#)

<sup>30</sup> [317:35-6-60](#). Certification for SoonerCare for pregnant women and families with children (4) Certification of newborn child deemed eligible (A).

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According to statistical sampling calculations, a projected 11% of the MAP and 2% of the CHIP claims were paid on behalf of pregnant and newborn recipients.

**Without verifying income in the certification month for those seeking pregnancy- and newborn-related services, OHCA may be paying for services to ineligible recipients.**

**Income for  
Non-Applicants  
without a Social  
Security  
Number Could  
Not Be Verified**

The Social Security Act<sup>31</sup> requires as a condition of Medicaid eligibility that each applicant for or recipient of benefits provide their SSN. The SSN is utilized in the administration of the program to obtain records from the required income eligibility verification system.

Furthermore, 42 CFR § 435.948 (c) states, “The agency must request the information by SSN, or if an SSN is not available, using other personally identifying information in the individual's account, if possible.”

Some non-applicants and their spouses did not provide their SSN when applying and receiving benefits for their dependents. Although the non-applicants and their spouses are not required to provide their SSN, income could not be verified through the wage data exchange and additional income documentation was not obtained.

*A control deficiency was noted for the following:*

#### MAP Details

- In 11 of 184 (6%) case files tested, the non-applicant or spouse did not provide an SSN or other identifying information to electronically verify income.

#### CHIP Details

- In 23 of 184 (13%) case files tested, the non-applicant or spouse did not provide an SSN or other identifying information to electronically verify income.

According to statistical sampling calculations, a projected 5% of the MAP and 12% of the CHIP claims were paid on behalf of individuals where the

<sup>31</sup> [Social Security Act Section 1137\(a\); 42 U.S.C. Section 1320b-7\(a\)](#) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system which meets the requirements of subsection (d) and under which—

(1) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that program so as to enable the association of the records pertaining to the applicant or recipient with his account number.

non-applicant or spouse did not provide an SSN or other identifying information to electronically verify income.

According to OHCA management, regulations do not require non-applicants to provide an SSN in order for other household members to receive benefits. Following both State policy 317:35-5-25(a) and Federal policy 42 § 435.406, Medicaid is only provided to citizens and nationals of the United States.

**However, income is an eligibility factor and without an SSN or other personal identifiers, OHCA is unable to verify income through the wage data exchange, and additional wage documentation is not requested.**

**Child Support  
Wrongly  
Considered  
Income**

There are instances when certain types of income should not be considered as part of an individual’s household income.

According to 317:35-5-44, effective October 1, 2013, specific rules for an individual’s eligibility group should be considered to determine whether child or spousal support is counted as income.

As identified by CMS in the table below and outlined in the IRS code, child support is non-taxable income that is not counted when determining eligibility based on the MAGI income method.<sup>32</sup>

**Non-taxable income not counted in determining Medicaid/CHIP MAGI-based income:**

- Temporary Assistance to Needy Families (TANF) and other government cash assistance
- Supplemental Security Income (SSI)
- Child support received
- Veterans benefits
- Worker’s compensation payments
- Proceeds from life insurance, accident insurance, or health insurance
- Federal tax credits and Federal income tax refunds
- Gifts and Loans
- Inheritances

While many of these income types were countable for Medicaid/CHIP prior to MAGI, most non-taxable income is not countable for MAGI

*Source: CMS MAGI 2.0 Building MAGI Knowledge Part 2: Income Counting*

OHCA’s current Medicaid online enrollment application form includes two questions related to household income.

1. Does anyone in the household earn money from a job or business?

<sup>32</sup> Key Facts: Income Definitions for Marketplace and Medicaid Coverage.  
<https://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage/>

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2. Does anyone in the household receive taxable money or income from other sources?

When an applicant identifies “Child Support” as “other” income, OHCA automatically considers it part of a household’s income when determining financial eligibility.

Prior to 2013, the Authority’s application specifically asked about child support; however, notification from CMS directed the OHCA to revise the Medicaid application to reflect the following changes:

Necessary changes:	Date by which changes will be completed:
The state will disable pre-ACA income determination rules and remove non-MAGI income types and childcare expenses from the online application.	April 30, 2014

*Source: February 2014 letter from CMS to the State Medicaid Director*

**With no specific instruction on what is considered “other income,” the applicant may include child support as “other income” when applying for benefits. If the combination of the individual’s earned income and the child support exceeds the income limit based on the household size, it could cause the individual to be determined ineligible for Medicaid benefits, when they may actually be eligible.**

Our testwork identified four of 184 (2%) recipients had included child support as “other income” when applying for services. However, those recipients were still eligible for the Medicaid benefits they received.

**Auto Passive  
Renewal  
Performed  
Using Self-  
Reported  
Income**

A recipient’s eligibility may be auto passive renewed<sup>33</sup> to begin a new 12-month eligibility period if the Authority has enough reliable information available with respect to all eligibility criteria. If no data is returned from the electronic data sources, the Authority has no income information to make an eligibility determination. A renewal form is sent to the beneficiary requesting information to verify the recipient’s income and any other eligibility criteria the state does not have sufficient information to verify in accordance with the State Verification Plan.<sup>34</sup>

An auto passive renewal was completed on two of 368 (1%) recipients who self-reported income.

<sup>33</sup> Auto passive renewal: an automated method of renewing a recipient’s eligibility without requiring them to complete forms or submit paperwork when information can be verified through electronic data matches

<sup>34</sup> [42 CFR § 435.916 \(d\)\(ii\)](#) – Redeterminations of Medicaid Eligibility. If the agency has enough information available to it to renew eligibility with respect to all eligibility criteria, the agency may begin a new 12-month renewal period

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- In the first case, the individuals whose income was used to determine eligibility was self-reported. Another member in the household had income that was verified through the wage exchange and therefore, income was automatically considered verified electronically. However, the individual whose income was verified was not a part of the *specific recipient's* household, and their income was considered and should not have been.
- The second case was passively renewed using self-reported income dating back to the 2012 conversion of MAGI cases from OKDHS to OHCA. *This income was not addressed during any review over a 6-year period.*

**Without a redetermination of Medicaid eligibility within 12 months of the last eligibility determination or redetermination, an ineligible recipient may continue to receive benefits. In addition, the Authority is not in compliance with applicable laws and regulations.**

### Inadequate Case File Documentation at OKDHS

As permitted by federal regulations<sup>35</sup>, OHCA delegates authority to OKDHS to determine eligibility for non-MAGI recipients. The regulation still requires OHCA to exercise appropriate oversight over the eligibility determinations.<sup>36</sup>

OKDHS has not maintained cases files according to federal guidelines.<sup>37</sup>

- Two of the 184 (1%) OKDHS case files reviewed showed no evidence that an eligibility redetermination had been performed within 12 months of the previous eligibility determination. However, the recipients appeared to be eligible based on other information maintained in the case file.
- One of the 184 (1%) case files lacked sufficient documentation to fully support the eligibility determination. There was no documentation to support that the Asset Verification System

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<sup>35</sup> [42 CFR § 431.10\(c\)\(2\)](#), "The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis."

<sup>36</sup> [42 CFR § 431.10\(c\)\(3\)\(ii\)](#) states in part that the Medicaid agency must exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies.

<sup>37</sup> [42 CFR § 435.914](#) (a) Case documentation. The agency must include in each applicant's case record facts to support the agency's decision on his application.

42 CFR § 431.17 Maintenance of records. (a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes the kinds of records a Medicaid agency must maintain, the retention period, and the conditions under which microfilm copies may be substituted for original records. (b) Content of records. A State plan must provide that the Medicaid agency will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan.

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(AVS)<sup>38</sup> was reviewed to determine if the recipient had additional countable resources that should have been considered during the eligibility process.

Procedures reflected in the case files were not consistent with OKDHS's written policies and procedures to ensure compliance with applicable laws and regulations. Inconsistent and incomplete case notes caused us some difficulty in determining eligibility. In addition, recipients can have multiple case files if they receive benefits from other federal assistance programs (companion cases). We found that in some instances, the recipient's information, such as applications and renewal notices, was placed in the incorrect case file.

In addition, for 63 of the 184 (34%) cases, income could not be verified by the State Auditor and Inspector's Office (SAI) due to the restrictions of the IRS and SSA.<sup>39</sup>

**Due to our inability to view this critical piece of financial data from an independent source, we relied on the information maintained in each case file. Based on the financial information documented in the case files, the recipients appeared to be eligible for services.**

**The Authority did not exercise appropriate oversight over OKDHS to ensure the eligibility determination process has adequate controls in place to comply with applicable laws and regulations.**

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<sup>38</sup> The Asset Verification System (AVS) is a web portal built for OKDHS by Public Consulting Group (PCG), and funded by Oklahoma Health Care Authority, to facilitate the expedited exchange of financial account information with the local, regional, and national financial institution community.

<sup>39</sup> [IRS Code 26 USC 6103](#) - Confidentiality Disclosure of Returns and Return Information. In addition, the state of Oklahoma has an agreement with SSA called the Computer Matching and Privacy Protection Act Agreement (CMPPS) which is renewed annually and covers all state entities that receive SSA data. In section 10 of this agreement, Records Usage, Duplication, and Rediscovery Restrictions, subsection B, paragraph 1 says that "State Agencies will not use or redisclose the data disclosed by SSA for any purpose other than to determine eligibility, for or the amount of, benefits under the state-administered income/health maintenance programs identified in the IEA."

**Data Exchange  
Jobs Not Run at  
Required  
Frequency**

**Identified  
Discrepancies  
Not Cleared  
within Required  
Timeframe**

Federal regulations require that each state shall participate in the Income Eligibility and Verification System (IEVS), and review and compare the information obtained from each data exchange against information contained in the case record to determine whether the data affects the individual's eligibility or level of assistance, benefits, or services under the applicable program.<sup>40</sup>

Additionally, state rules outline that automated data exchange with other agencies provides OKDHS with information regarding household members' benefits, wages, taxes, Social Security numbers, and current addresses.<sup>41</sup> The system compares information obtained electronically with data stored within OKDHS electronic records to determine if there are discrepancies to be addressed. Automated data exchange information is also available within the OKDHS system to identify discrepancies. The Social Service Specialist is responsible for resolving data exchange discrepancy messages within 45 calendar days of the date the message is posted on the data exchange inquiry screen.

OKDSH data exchange jobs are performed by the Office of Management and Enterprise Services Information Services Division (OMES-ISD). OMES-ISD runs approximately 45 scheduled data exchange jobs with other federal and state agencies on daily, weekly, monthly, and quarterly frequencies.

To ensure the data exchange jobs were run at the frequencies identified by OKDHS and within the OHCA Verification Plan, we judgmentally selected 17 data exchange jobs run on daily, weekly, monthly, and quarterly frequencies.<sup>42</sup>

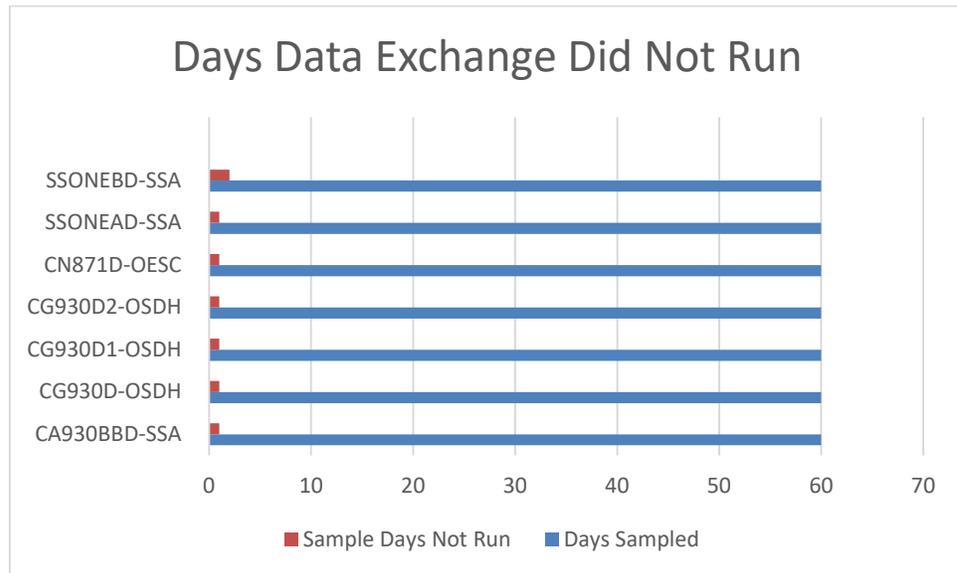
We noted several instances in which the exchanges did not run. On average, 2% of the selected daily data exchange jobs did not run.

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<sup>40</sup> [Social Security Act Section 1137](#)

<sup>41</sup> [OAC 340:65-3-4 \(4\)](#)

<sup>42</sup> See details regarding this testwork methodology in [Appendix B](#).



In addition, one (11%) of nine selected weekly jobs did not run.

Running data exchange jobs at the required frequencies allows recipient information to be verified with the most current information available to ensure eligibility.

When a discrepancy is noted between information provided by the recipient and the electronic data source, the Social Service Specialist is to investigate the discrepancy within the required 45-day period. OKDHS should identify the exceptions by error type and whether or not the error was resolved within 45 days in its G1DX Exception and Clearance Reports<sup>43</sup>.

Our review of the G1DX Exception and Clearance Reports showed that 184,183, or 46.98%, of a total of 392,079 exceptions were not resolved within the required 45 calendar day period.

*47% of the discrepancies noted through the data exchange verification system at OKDHS were not cleared in a timely manner.*

**OKDHS management is not closely monitoring the clearance of G1DX discrepancies per federal regulation and OKDHS policy.**

Exceptions may go undetected when information is not exchanged with independent sources, and when discrepancies are identified and not

<sup>43</sup> The method OKDHS uses to compile the discrepancy messages does not differentiate by program, so the messages were reviewed at the error type level. Therefore, the discrepancies noted are a culmination of multiple programs and the rate of error may not apply to each program individually.

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cleared timely, ineligible individuals may receive benefits. In addition, OKDHS has not complied with applicable laws and regulations.

Applicants  
Notified Promptly  
of Most Eligibility  
Decisions

Federal regulations require states to furnish Medicaid benefits to applicants promptly, without any delay.<sup>44</sup> Additionally, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility, or a denial or change in benefits and services.

Not All  
Applicants  
Provided  
Eligibility  
Renewal Notices

We noted during our testing procedures that all applicants received timely notifications of the decision of their eligibility, including an approval, denial, termination, or suspension of eligibility, or denial or change in benefits and services.

However, we found that OKDHS failed to provide eligibility renewal notices to four of 184 (2%) recipients.

**It appears the Social Service Specialist did not generate a renewal letter and send it to the recipient.** Without timely notice of eligibility, recipients may be unaware of their eligibility status. This error also caused OKDHS to be out of compliance with federal regulations.

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<sup>44</sup> [42 CFR § 435.930](#); [42 CFR § 435.912](#); [42 CFR § 435.917](#)

**Recommendations**

- We recommend the Authority review the eligibility system controls currently in place and update its processes to ensure the required conditions of eligibility are met in order to comply with state and federal regulations. This should include the following:
  - Update the MMIS system to verify wage information received from OESC on a quarterly basis to determine whether such information may affect the eligibility of an individual (to ensure compliance with 42 CFR § 435.952 (a))
  - Reconsider and evaluate the need to use the Federal Data Services Hub, to determine if additional data sources are available for verifying an individual’s information when determining eligibility
  - Require individuals who are self-employed or claim zero income to provide income documentation (to ensure compliance with OAC 317:35-10-26 (a)(2)(F)(3))
  - Require individuals seeking pregnancy services to provide income documentation prior to being certified eligible (to comply with OAC 317:35-5-46 (b))
  - Require individuals who do not have SSN or use other personally identifying information to provide income documentation (to ensure compliance with 42 CFR § 435.948 (c))
  - Continue to evaluate the benefits of utilizing other verification sources as required by the HOPE Act, such as the use of Oklahoma Tax Commission records for self-employed income verification
  
- We recommend the Authority collaborate with OKDHS and update the Service Agreement, and policies and procedures as determined necessary, to comply with 42 CFR § 431.10(c)(2) and 42 CFR § 431.10(c)(3)(ii). This should include the following:
  - Ensure data exchange jobs are run at the frequency required to ensure compliance with Social Security Act §1137 and OKDHS Policy OAC 340:65-3-4
  - Provide additional training to staff regarding:
    - The importance of monitoring and clearing discrepancies identified in the G1DX reports (to ensure compliance with OAC 340:65-3-4 (4))
    - Case documentation and maintenance of eligibility records (to comply with 42 CFR § 435.914 (a) 42 CFR § 431.17)
    - Timely notifications of eligibility decisions (to ensure compliance with 42 CFR § 435.917)

In the consideration of all recommendations, the Authority should seek further clarification from CMS.

APPENDIX A

*Background Information*

States have flexibility within broad federal requirements to design and implement their Medicaid programs. For example, while states must cover certain mandatory groups and benefits,<sup>45</sup> they have the option to cover certain other groups of individuals and benefits. Individuals must meet certain financial eligibility criteria, such as income below specified levels, and nonfinancial criteria such as citizenship and residency requirements.

Once it is determined that an individual meets relevant financial and nonfinancial eligibility criteria, the state enrolls the individual into Medicaid under one basis of eligibility. Examples of bases of eligibility include those applicable to children, pregnant women, and individuals eligible for Supplemental Security Income (SSI), a program that provides cash assistance to children with disabilities and low-income adults.

OHCA policy 317:35-5 to 6 coincides with the Title XIX - State Plan and Title XXI -CHIP State Plan. The policy addresses what types of documentation is required to determine eligibility and the time period to maintain documentation.

Oklahoma currently provides Medicaid benefits and services to the following populations:

- Adults who are Needy Caretakers with a household income up to and including 45 percent of the poverty level
- Children and Pregnant women with an income up to and including 210 percent of the federal poverty level
- Individuals receiving Supplemental Security Income (SSI) for the Aged, Blind, and Disabled
- Individuals qualified for adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.
- Some dual-eligible Medicare beneficiaries who are over age 65; for this population, Medicaid is the payer of last resort
- Individuals who are not U.S. citizens, but who meet specific requirements under federal law related to income, work, child support enforcement, and U.S. residency

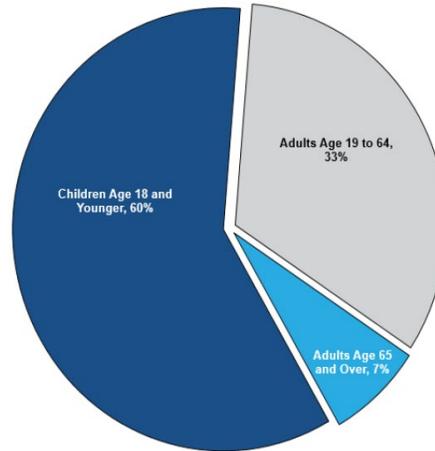
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<sup>45</sup> [Section 1905\(a\) of the Social Security Act](#) lists 17 categories of individuals, also known as populations, who may receive Medicaid coverage if they meet applicable criteria. See 42 U.S.C. § 1396d(a). Most eligibility groups are defined in sections 1902(a)(10)(A)(i) (mandatory groups) and 1902(a)(10)(A)(ii) (optional groups) of the Social Security Act. See 42 U.S.C. §§ 1396a(a)(10)(A)(i), (ii).

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Breakdown of enrollment by age:



Source: *Oklahoma Health Care Authority 2019 Annual Report Appendix*

Total population of recipients receiving Medicaid and CHIP benefits during SFY 19 was 1,127,904<sup>46</sup> with claims totaling \$4,661,668,588.30.

OHCA is responsible for determining eligibility for the following:

- children
- newborns
- pregnant women
- pregnancy-related services under Title XXI
- parents and caretaker relatives
- former foster care children
- Oklahoma Cares Breast and Cervical Cancer program participants
- SoonerPlan Family Planning program participants

OKDHS is responsible for determining eligibility for the following:

- TANF recipients
- adoption assistance or kinship guardianship assistance
- persons in state custody
- Refugee Medical Assistance
- Aged persons
- Blind persons
- Disabled persons
- Persons with tuberculosis
- the Qualified Medicare Beneficiary Plus (QMBP) program
- the Qualified Disabled and Working Individuals (QDWI) program

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<sup>46</sup> Recipients can move between MAP and CHIP programs during the year due to income requirements and therefore recipients could have been counted twice. The [OHCA annual reports](#) for FY 19 show the total population to be 998,209.

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- the Specified Low Income Medicare Beneficiaries (SLMB) program
- the Qualified Individual 1 (QI-1) program
- Long term care services
- alien emergency services

OHCA implemented the on-line enrollment system on September 7, 2010. The on-line enrollment system was developed for OHCA by HP, the contracted vendor who manages the MMIS. However, OHCA internally developed the rules engine, which sets the parameters for eligibility determinations in the system and is responsible for maintaining those rules.

When applicants apply for SoonerCare through the OHCA web portal, real-time verifications are conducted on the applicant's identity through electronic interfaces with other data exchange sources verifying Social Security number, citizenship, and immigration status.

When applying for the Medicaid program, applicants attest that the information they have provided on their application is true and that they will report any changes, including increases in income.

Eligibility determination results are real-time and communicated to the applicant on the results screen and through case status letters.

The data the client provides at the time of enrollment, such as social security numbers, citizenship, alien status via SAVE (Systematic Alien Verification Entitlement program system record), residency status, and addresses are verified and validated in real time by the system.

After initial eligibility determination, additional data is received from internal and external sources as outlined in the State Verification Plan, which may result in a redetermination of eligibility. As the information is received from the sources, the application for benefits is reprocessed and eligibility is determined.

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OKLAHOMA MEDICAID METHODS FOR VERIFYING APPLICANTS' ELIGIBILITY INFORMATION			
Eligibility Factor	Self-Attestation Accepted without Additional Verification	Electronic Data Source Used	When documentation is obtained to verify eligibility
Income	No	Oklahoma Employment Security Commission	Paper documents will only be requested when electronic sources are inconsistent with the attestation and are not within the reasonable compatibility threshold (5%).
Residency	No	PARIS	Oklahoma accepts attestation of residence; the state also matches against PARIS federal interstate match.
Citizenship	No	Social Security Administration (SOLQi)	Paper documentation will only be requested if information received from electronic sources is discrepant.
Household Composition	Yes	None	Self-attestation will be accepted in many cases. Oklahoma has internal system checks to review all applications.
Social Security Number	No	Social Security Administration (SOLQi)	Paper documentation will only be requested if information received from electronic sources is discrepant.
Immigration Status	No	SAVE through the Hub's VLP service	Paper documentation will only be requested if information received from electronic sources is discrepant.

The OHCA on-line enrollment system automatically assigns an end date to all applications. The end date is set at 12 months or less for all eligibility certifications. According to ACA regulations, if at renewal time electronic data can be used to confirm that the case information remains reasonably compatible with the information on file, the application can be passively renewed for another year without the applicant submitting a renewal application. According to OHCA management, passive renewals are not performed for self-employed members, or members claiming zero income.

For individuals related to the aged, blind, and disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for SSI or Retirement, Survivors, and Disability Insurance (RSDI) benefits. Oklahoma is an SSI criteria state, meaning anyone on SSI will usually be eligible for medical assistance as long as all required paperwork is completed and received by OKDHS. SSI eligibility does not guarantee eligibility for the State Supplemental Payment or Medicare Buy-In.

OKDHS uses an IMS Data Exchange system, which is linked with the Social Security Administration and the Oklahoma Employment Security Commission and verifies the data provided by the applicant. In addition,

## Oklahoma Health Care Authority Medicaid Eligibility Performance Audit

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other financial resources can be verified by the Social Services Specialist using the Asset Verification System (AVS).

### Oklahoma Health Exchange

The ACA requires states to either set up a state-run health insurance exchange or use the federal health exchange to help people obtain private health insurance if they are not eligible for public health coverage, such as Medicaid<sup>47</sup>. As of January 1, 2014, all enrollment applications are also matched against the Health Insurance Exchange (or FFM) data base. A health insurance exchange is a competitive marketplace that helps consumers compare available private health plan options, benefits, and prices, and purchase a plan.

### HOPE Act

In 2018, the Oklahoma Legislature passed HB 1270<sup>48</sup>, creating the Act to Restore Hope, Opportunity and Prosperity for Everyone. The HOPE Act; directed the OHCA to verify eligibility prior to awarding Medicaid assistance, except for applicants eligible under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and applicants with intellectual disabilities receiving a Home and Community Based Medicaid waiver and state-funded services.

In addition to the federal requirements for verifying information, the bill places additional requirements on the Authority requiring information such as earned and unearned income, financial resources, employment status, and changes in employment to be verified on a quarterly basis.

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<sup>47</sup> [42 U.S.C. 157 § 18001](#)

<sup>48</sup> HB 1270 Online at <http://www.oklegislature.gov/BillInfo.aspx?Bill=HB1270&Session=1800>

*APPENDIX B*

*Scope and General Methodology*

In planning and conducting our audit, we focused on the period July 1, 2018, through June 30, 2019.

Except as noted in the Scope Limitations section, we conducted this performance audit 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 except for the effects, of the scope limitations due to the inability to review recipient's income information from independent source records.

Our audit procedures included inquiries of OHCA and OKDHS appropriate personnel, inspections of documents and records, and observations of current operations. We utilized statistical sampling of Medicaid recipients to achieve our objectives. To ensure the samples were representative of the population and provided sufficient, appropriate evidence, the random sample methodology was used. We also judgmentally selected a sample of seven cases from the TEFRA population. We identified specific attributes for testing each sample.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, errors or fraud may occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

*Sample Methodology*

To evaluate OHCA and OKDHS controls over eligibility, we statistically sampled using a 95% confidence level, with a tolerable error rate of 5% and an expected error rate of 2% and we projected our results to the population using the upper error frequency rate. The random sample method was used when selecting 184 Medicaid recipients from each of three separate data sets, and we judgmentally selected an additional

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seven TEFRA recipients<sup>49</sup>, for a total of 559 cases. We then reviewed each recipient's electronic case records.<sup>50</sup>

- Medicaid MAGI recipients (OHCA) 733,196 with claims totaling \$2,004,473,534.93
  - Sample Size 184 cases, Sample Dollars \$65,349.78
- Medicaid Non\_MAGI recipients (OKDHS) 182,647 with claims totaling \$2,306,734,463.46
  - Sample Size 184 cases, Sample Dollars \$42,851.68
- CHIP MAGI recipients (OHCA) 211,921 with claims totaling \$348,620,899.30
  - Sample Size 184 cases, Sample Dollars \$32,037.65
- TEFRA recipients (OHCA/OKDHS) 140 with claims totaling \$1,839,690.61
  - Sample Size 7 cases, Sample Dollars \$1,884.77

### *Objective Methodology*

To accomplish our objectives, we performed the following:

- Reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility
- Reviewed the Oklahoma State Verification Plan, which describes the State agency's policies and procedures related to verifying an applicant's citizenship, income, and other eligibility requirements in determining and redetermining Medicaid eligibility
- Obtained an understanding of the eligibility process at OHCA and OKDHS by:
  - Interviewing staff from OHCA to obtain an understanding of how the MMIS system processes an applicant's information and verifies an applicant's eligibility for enrollment.
  - Interviewing staff from OKDHS to obtain an understanding of how the Social Workers process an applicant's information and how the applicant's information is verified for enrollment.
  - Performing walk-throughs with OHCA staff viewing case information in the MMIS system.
  - Performed walk-throughs with OKDHS staff viewing case information in the IMS system

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<sup>49</sup> TEFRA cases can be included in both the MAP and CHIP populations. When comparing the recipients in each population, we determined only seven of the TEFRA cases were CHIP only cases. Therefore, we tested those seven cases for the CHIP MAGI sample. All other cases were included in the MAP MAGI populations and had already had a chance to be selected for testing.

<sup>50</sup> Documentation related to eligibility determinations are contained in the electronic case record for each Medicaid recipient.

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- Documented and evaluated OHCA and OKDHS agency-wide controls
- Documented and evaluated OHCA and OKDHS eligibility determination controls
- Evaluated SFY 2019 Medicaid expenditures paid on behalf of recipients for both MAP and CHIP to determine the population was complete in both dollars and recipient count
- Identified significant laws and regulations related to the eligibility process and tested for compliance. Procedures included:
  - Reviewing a random statistical sample of 184 (.03%) from a population of 733,196 MAP recipients. For each recipient sampled, we selected one paid claim to redetermine eligibility for the date the service was provided. Claims selected for the sampled recipients totaled \$65,350 (.003%) from a population of \$2,004,473,535.
  - Reviewing a random statistical sample of 184 (.1%) from a population of 182,647 non-MAGI recipients. For each recipient sampled, we selected one paid claim to redetermine eligibility for the date the service was provided. Claims selected for the sampled recipients totaled \$42,852 (.002%) from a population of \$2,306,734,463.
  - Reviewing a random statistical sample of 184 (.09%) from a population of 211,921 CHIP recipients. For each recipient sampled, we selected one paid claim to redetermine eligibility for the date the service was provided. Claims selected for the sampled recipients totaled \$32,038 (.009%) from a population of \$348,620,899.
  - Reviewing a judgmentally selected sample of 7 (5%) from a population of 140 TEFRA recipients. For each recipient sampled, we selected one paid claim to redetermine eligibility for the date the service was provided. Claims selected for the sampled recipients totaled \$1,885 (.1%) from a population of totaling \$1,839,691.
- Documented and evaluated the data exchange processes for both OHCA and OKDHS
- Identified significant data exchange jobs related to Medicaid eligibility that run daily, weekly, monthly, and quarterly and the tested for compliance to ensure jobs ran at the frequency required. Procedures included:
  - OHCA
    - Reviewing a random sample of 60 days from each of the seven daily data exchange jobs selected

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- Reviewing a random sample of nine weeks from each of the two weekly data exchange jobs selected
- Reviewing a random sample of two months from the one monthly data exchange job selected
- Reviewing a random sample of two quarters from the one quarterly data exchange job selected

OKDHS

- Reviewing a random sample of 60 days from each of the eight daily data exchange jobs selected
  - Reviewing a random sample of nine weeks from each of the three weekly data exchange jobs selected
  - Reviewing a random sample of two months from each of the four monthly data exchange jobs selected
  - Reviewing a random sample of two quarters from each of the two quarterly data exchange jobs selected
  - Reviewed the GIDX Exception report to determine if discrepancies were cleared within the 45-day requirement
- Identified the laws and regulations significant to removing recipients from the MAP and CHIP programs and tested compliance to ensure the recipients were notified in a timely manner.
    - Reviewed a random sample of 60 (.05%) from a population of 110,923 MAP negative cases
    - Reviewed a random sample of 60 (.14%) from a population of 41,109 CHIP negative cases

**Note:** For the negative cases tested we used data that was provided to us by the Agency. Because there was no independent source of documentation to validate the completeness of this data, we relied on the Agency's representation to the extent necessary to present the condition in this report.

*Medicaid Acronyms*

CMS	Center for Medicare and Medicaid Services
OHCA	Oklahoma Health Care Authority
OAC	Oklahoma Administrative Code
ACA	Affordable Care Act
MAGI	modified adjusted gross income (federal tax-based income measure)
SAI	State Auditor and Inspector
CFR	Code of Federal Regulations
MAP	Medical Assistance Program
CHIP	Children’s Health Insurance Program
SFY	state fiscal year
SSI	supplemental security income
SSN	social security number
MMIS	Medical Management Information System (OHCA benefits payment system)
OKDHS	Oklahoma Department of Human Services
ABD	aged, blind, and disabled
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982 (discussed in <a href="#">Appendix B</a> )
IEVS	state income and eligibility verification system
IRS	Internal Revenue Service
SSA	Social Security Administration
FPL	federal poverty level
OESC	Oklahoma Employment Security Commission
CMCS	Center for Medicaid and CHIP Services
AVS	Asset Verification System (OKDHS web portal)
OMES-ISD	Office of Management and Enterprise Services – Information Services Division



**Kevin Corbett** | Chief Executive Officer

**J. Kevin Stitt** | Governor

May 21, 2020

Cindy Byrd, State Auditor and Inspector  
Office of the State Auditor and Inspector  
2300 N. Lincoln Blvd, Ste. 123  
Oklahoma City, OK 73105

## **Re: Oklahoma Health Care Authority Medicaid Eligibility Performance Audit**

Dear Auditor Byrd:

Please accept the following as the Oklahoma Health Care Authority's (OHCA) response to the performance audit for the 2019 fiscal year. OHCA welcomes the opportunity to provide comments on the recommendations contained in this report.

OHCA would first like to extend our gratitude to the State Auditor and Inspector for the work performed. Your work provides our agency with a unique perspective of the efficacy of the eligibility processes and procedures utilized to ensure eligible individuals have access to quality health care services regardless of their ability to pay. OHCA is committed to designing, maintaining, operating and continuing to strengthen our system of controls that provides us the highest assurance that only eligible Oklahomans receive Medicaid benefits in line with our vision: **For Oklahomans to be healthy and to have access to quality health care services regardless of their ability to pay** and for OHCA to practice good stewardship of Oklahomans' tax dollars. Our agency strives for continuous improvement and to create best-in-class innovative approaches, and our intent is to extend these practices to promptly develop solutions to the recommendations of the State Auditor and Inspector.

### **Oklahoma Health Care Authority Response**

OHCA has evaluated the control needs for eligibility processing and concurs these areas can and should be strengthened. Increasing the controls will reduce the risk of potentially misspent dollars as are identified in the projections made in this report. The estimated dollars, while not confirmed to have been spent on ineligible members, are significant to OHCA, and enhancements are in progress to make all reasonable efforts to verify the ongoing eligibility of members.



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OHCA has complied with available guidance on regulations and interpretation of such regulations as it has become available since the implementation of Modified Adjusted Gross Income (MAGI) in 2013. All procedures implemented prior to recent efforts to enhance eligibility determination controls were based on information available in regulations and guidance at implementation, and from subsequent updates from Centers for Medicare & Medicaid Services (CMS). OHCA has received further guidance on regulation interpretation and is diligently working toward implementing system and operational changes to address the newly identified procedural expectations. OHCA has identified areas for enhancement in procedures related to verification of income when data exchange information is unavailable, inadequate application of data exchange matches, zero income reported on applications, applications possibly exceeding the federal poverty level, and child support computing in total household income. To address these areas, OHCA has been working diligently to enhance and expand our income verification procedures within the online eligibility system, and operational procedures to align with federal regulations. Additionally, the agency is exploring additional wage matching options through CMS. Verification will be achieved through the use of alternate sources, including member requests, to ensure all sources of income, not available through electronic data exchange sources, are verified. The changes will include verification post initial determination, prior to renewal and when changes are reported. The expansion of these practices will occur after electronic verification has been attempted and will enhance OHCA's verification practices that were identified in this report.

OHCA has made significant efforts to establish an eligibility system and operational model that provides eligibility to members through real-time eligibility determination. Real-time eligibility determination allows Oklahomans to utilize the online eligibility system to provide relevant information and receive an immediate eligibility determination. The process allows for vastly improved approval timeframes and greatly reduced administrative costs. These efforts made Oklahoma a leader in achieving the CMS' goal of establishing real-time eligibility determination through a streamlined and automated eligibility determination process.

OHCA will update the State Verification Plan to more explicitly explain updated income verification practices, how the state utilizes self-attestation to benefit members at initial application, termination of income, and when reporting a change in income. In order to achieve the identified corrections, the agency intends to implement eligibility system changes, explore additional wage verification sources, update operational training, revise business processes, and increase staffing to meet the demand of increased documentation request processing.

## **Oklahoma Human Services Response**

Oklahoma Human Services (OHS), formerly known as Oklahoma Department of Human Services (OKDHS), contracts with the OHCA to perform eligibility for the Non-



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MAGI eligibility population. OHCA, in conjunction with OHS, will review the service agreement to evaluate if the recommendations of SAI require modification of the agreement.

Office of Management and Enterprise Services – Information Services (OMES-IS) runs scheduled data exchange jobs to gather the information from the various agencies for the Automated Caseload Evaluation System (ACES). As identified in the audit, there were a number of occasions when those processes did not run as scheduled. OHS' Adult and Family Services, Business Analysis and Product Unit are responsible for setting jobs to run in a production environment. Outlined below are the steps in place to be used when the system indicates the data exchange job failed to run:

- Take action to immediately follow-up the next business day.
- Consult with the customer to identify the error.
- Determine if and when the job will be re-run.
- OHS' Adult Family Services Business Analysis and Product Unit will continue to collaborate with the Office of Management and Enterprise Services – Information Services (OMES-IS) to ensure compliance with the Social Security Act §1137 and OKDHS Policy OAC 340:65-3-4 (4).

OHS' Social Service Specialist will be required to conduct the following during the Non-MAGI Medicaid eligibility determination/redetermination process:

- Monitor their County Worker Action (CWA) report weekly for pending applications and upcoming Medicaid redeterminations reviews.
- Review the Asset Verification System (AVS) and case notes steps via the online training tool QUEST Steps to Completing Annual Reviews <https://fsquest.oucpm.org/2017/programs/aged-blind-disabled/steps-to-completing-annual-reviews/>.
- Review the Notice List (NL) screen or DISC Image System following certification to ensure the Non-MAGI Medicaid recipients receive accurate eligibility notification.

OHS Adult Family Services Social Services Specialist will adhere to the steps above in order to ensure determinations and redeterminations of Non-MAGI Medicaid eligibility complies with applicable laws and regulations.

- County staff is responsible for clearing data match discrepancies (G1DX messages) on a weekly basis.
- Supervisors must review their staff's G1DX messages every two weeks to ensure that messages are properly being cleared and case noted.
- All data match discrepancies must be cleared and case noted within 45 calendar days of receiving the G1DX message.
- Conduct Back to Basics Training to address G1DX discrepancies.

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OHS AFS staff will continue to utilize the monitoring reports created for the G1DX discrepancies based on worker, supervisor, county and region. This will assist management with monitoring the type of discrepancy and number of outstanding days and identify staff responsible for clearing the discrepancy within the 45 days based on current Federal regulation 45 CFR 205.56(a)(1)(iv) and DHS Policy OAC 340:65-3-4-4 (C).

Regarding notices, OHS will identify if system-related issues have occurred preventing the notice from issuing, determine the root cause of the system issue, and develop a plan to improve/correct future system issues.

### **Authority Oversight**

The OHCA Member Audit team will conduct a post-implementation audit for each identified corrective action. The Member Audit team will complete additional reviews as determined necessary to resolve insufficiencies. The audit will include samples from OHCA and OHS to focus on specific issues such as income verification for OHCA and appropriate eligibility determination for OHS. The Member Audit team will evaluate new business processes, training materials, State Verification Plan changes, and completion of scheduled data exchange. Additionally, OHCA will work in partnership with the State Auditor and Inspector's office to ensure the agency's control systems are designed, maintained, and operated at the highest level of compliance with applicable laws and regulations.

We appreciate the tireless work of you and your team in conducting this performance audit on behalf of Oklahoma taxpayers. We recognize the need to enhance our internal controls and are committed to continuous improvement to ensure only eligible Oklahomans receive Medicaid benefits in line with our vision for a healthier Oklahoma.

Respectfully,



Kevin Corbett  
Chief Executive Officer



Stanley Hupfeld  
OHCA Board Chairman



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