Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# CMS PAID OVER $277 MILLION IN UNALLOWABLE CHIPRA BONUS PAYMENTS BASED ON INCORRECT ENROLLMENT DATA

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**Report in Brief**
Date: September 2019
Report No. A-04-17-08061

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

# CMS Paid Over $277 Million in Unallowable CHIPRA Bonus Payments Based on Incorrect Enrollment Data

## Why OIG Did This Review

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) directly affects both the Children's Health Insurance Program and Medicaid. Under CHIPRA, Congress appropriated $3.225 billion for qualifying States to receive performance bonus payments (bonus payments) for Federal fiscal years (FYs) 2009 through 2013 to offset the costs of increased enrollment of children in Medicaid.

In audits of CHIPRA bonus payments to individual States, we identified millions in unallowable bonus payments. Therefore, we determined that the CHIPRA bonus payments were a high-risk program area and that the combined findings of our audits should be considered by Centers for Medicare & Medicaid Services (CMS) officials when implementing any similar programs in the future.

Our objectives were to summarize the results of our previous audits of CMS's CHIPRA bonus payments to States and to identify any weaknesses that could affect similar programs in the future.

## How OIG Did This Review

We reviewed the CHIPRA bonus payments, totaling more than $645 million, that CMS paid to 12 States. This report combines the results of those 12 previously issued audits and provides additional feedback to CMS.

## What OIG Found

This report summarizes results from prior audits. Our previous audits of CHIPRA bonus payments identified over $277 million in unallowable payments from $645 million that CMS paid to 12 States. These unallowable payments represented approximately 43 percent of all bonus payments made to these States. CMS has taken significant action to recover these overpayments. Three States voluntarily returned overpayments totaling approximately $37 million to CMS, and CMS withheld almost $51 million from States with unspent bonus payment funds. Additionally, CMS issued letters to States initiating recovery of the remaining $189 million in unallowable payments our audits identified.

These unallowable payments occurred because the 12 States made errors when calculating their enrollment, which resulted in CMS calculating and paying excessive CHIPRA bonus payments. Additionally, CMS did not have access to accurate State data in time to make correct bonus payments and did not use these data once they became available to verify the accuracy of the current enrollment that the States reported for their bonus payments.

## What OIG Recommends and CMS Comments

We recommend that CMS continue to work with States to collect the remaining $189 million in unallowable payments from the over $277 million that we identified in 12 previously issued reports and consider the results of these reviews when designing internal controls for similar programs to ensure that timely and accurate data are available for adequate oversight, followup, and verification.

In written comments on our draft report, CMS concurred with our recommendations and described actions it has taken or plans to take to address them.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), has identified effective administration of the Medicaid program to improve oversight and address high improper payments as one of the top management challenges facing HHS.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) directly affects both the Children's Health Insurance Program and Medicaid. The goal of CHIPRA is to encourage and assist States in reaching and enrolling more uninsured children who are eligible for Medicaid. Under CHIPRA, Congress appropriated $3.225 billion for qualifying States to receive performance bonus payments (bonus payments) for Federal fiscal years (FYs) 2009 through 2013 to offset the costs of increased enrollment of children in Medicaid.

In audits of CHIPRA bonus payments to 12 individual States, we identified millions of dollars in unallowable bonus payments. Therefore, we determined that the CHIPRA bonus payments were a high-risk program area.

Appendix B lists our individual reports on the unallowable bonus payments received by each of those 12 States.

## OBJECTIVES

Our objectives were to summarize the results of our previous audits of the Centers for Medicare & Medicaid Services' (CMS's) CHIPRA bonus payments to States and to identify any weaknesses that could affect similar programs in the future.

## BACKGROUND

### The Medicaid Program: How It Is Administered

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although States have considerable flexibility in designing and operating their individual Medicaid programs, all must comply with applicable Federal requirements. CMS administers the Medicaid program at the Federal level.

**States' Medicaid Management Information Systems and CMS's Medicaid Statistical Information System**

Section 235 of the Social Security Amendments of 1972, P.L. No. 92-603, provided for 90-percent Federal financial participation (FFP) for the design, development, or installation and 75-percent FFP for the operation of eligible State mechanized claim processing and information retrieval systems. For Medicaid purposes, the mechanized claim processing and information retrieval system is the Medicaid Management Information System (MMIS).

The MMIS is an integrated group of procedures and computer processing operations designed to improve Medicaid program and administrative cost controls, service to beneficiaries and providers, operations of claim control and computer capabilities, and management reporting for planning and control.

Under the Balanced Budget Act of 1997, P.L. No. 105-33, States are required to submit Medicaid eligibility and claim data to CMS through the Medicaid Statistical Information System (MSIS).[1] The purpose of the MSIS was to collect, manage, analyze, and disseminate information on eligibility, beneficiaries, utilization, and payment for services covered by State Medicaid programs. CMS used MSIS data to produce Medicaid program characteristics and utilization information. Some of the types of information that States reported for Medicaid-eligible individuals were age, race, sex, and basis of eligibility (BOE). In 2013, CMS began working with States to transition from the MSIS to a new system with expanded data elements. The new system, known as T-MSIS, was developed to improve Medicaid data and data analytic capacity.

**Bonus Payments**

CHIPRA, P.L. No. 111-3, directly affects both the Children's Health Insurance Program under Title XXI of the Social Security Act (the Act) and Medicaid under Title XIX of the Act. Under CHIPRA, qualifying States received bonus payments for FYs 2009 through 2013 to offset the costs of increased enrollment of children in Medicaid. A State was eligible for a bonus payment if it increased its current enrollment of qualifying children (current enrollment) above the baseline enrollment of qualifying children (baseline enrollment) for a given year as specified in CMS guidance. A State must also have implemented at least five of the Medicaid enrollment and retention provisions specified in CHIPRA.

Bonus payments were two-tiered and based on the level of the State's enrollment increase above the baseline enrollment. The first-tier bonus payment was available for a State that increased its current enrollment up to 10 percent above the baseline enrollment in a year. A second-tier bonus payment was available for a State that increased its current enrollment by more than 10 percent above the baseline enrollment in a year.

[1] States and CMS have now transitioned to the Transformed Medicaid Statistical Information System (T-MSIS). However, the data collected and analyzed for this audit relied on the previous MSIS.

CMS was responsible for determining whether a State met the requirements to receive a bonus payment and, if so, the amount of the bonus payment. CMS made its determinations, in part, on the basis of Medicaid enrollment information that States provided in their requests for bonus payments.

## HOW WE CONDUCTED THIS REVIEW

We reviewed the CHIPRA bonus payments, totaling $645,009,558, that CMS paid to 12 States for FYs 2009 through 2013 (audit period).[2] This report summarizes the results of those 12 previously issued audits and provides additional feedback to CMS.

Our reviews focused on verifying the accuracy of enrollment information used in the bonus payment calculations and verifying that the information complied with Federal requirements. We did not assess the States' internal control structures beyond what was necessary to meet our objective. Similarly, we did not review the States' determinations of Medicaid eligibility. Also, we did not review whether the States implemented at least five of the Medicaid enrollment and retention provisions because we determined that there was a low risk of noncompliance relative to the calculation of Medicaid enrollments in the respective States.

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.

Appendix A contains the details of our scope and methodology, and Appendix C contains the Federal requirements related to CHIPRA bonus payments.

## FINDINGS

Our previous audits of CHIPRA bonus payments identified over $277 million[3] in unallowable payments from $645 million that CMS paid to 12 States. These unallowable payments represented approximately 43 percent of all bonus payments made to these States.

These unallowable payments occurred because the 12 States made errors when calculating their enrollment, which resulted in CMS calculating and paying excessive CHIPRA bonus payments. Additionally, CMS did not have access to accurate MSIS data in time to make correct bonus payments and did not use MSIS data once it became available to verify the accuracy of the current enrollment that the States reported for their bonus payments.

[2] See Table 1 for applicable dates in each State.

[3] The precise total of unallowable payments was $277,242,948.

## CMS MADE UNALLOWABLE CHIPRA BONUS PAYMENTS TO 12 STATES THAT REPORTED INCORRECT MEDICAID ENROLLMENT

### CMS Paid Over $277 Million in Unallowable Bonus Payments

CMS calculated and paid excessive CHIPRA bonus payments to States that overstated their current enrollments for FYs 2009 through 2013. We recalculated the bonus payments for the 12 States that we audited by using the correct (audited) current enrollment numbers for those FYs.

Of the original bonus payments received by the 12 States, CMS paid over $277 million in unallowable bonus payments (Table 1).

**Table 1: Unallowable Bonus Payments**

| State | Fiscal Years Audited | Original Payments | Allowable Payment | Unallowable Payment (Differences) | Percent Overpaid |
|---|---|---|---|---|---|
| Alabama | 2009–2010 | $95,353,417 | $7,155,919 | $88,197,498 | 92.50% |
| Alaska | 2009–2013 | 18,021,954 | 9,122,373 | 8,899,581 | 49.38% |
| Colorado | 2010–2013 | 157,519,647 | 119,146,261 | 38,373,386 | 24.36% |
| Idaho | 2010–2013 | 3,866,319 | 763,152 | 3,103,167 | 80.26% |
| Kansas | 2009–2013 | 36,560,970 | 18,764,372 | 17,796,598 | 48.68% |
| Louisiana | 2009–2011 | 7,124,602 | 0 | 7,124,602 | 100.00% |
| North Carolina | 2011–2013 | 42,738,736 | 7,925,294 | 34,813,442 | 81.46% |
| New Mexico | 2009–2013 | 23,860,195 | 7,894,437 | 15,965,758 | 66.91% |
| Ohio | 2010–2013 | 64,535,629 | 35,010,888 | 29,524,741 | 45.75% |
| Virginia | 2011–2013 | 60,316,957 | 46,555,128 | 13,761,829 | 22.82% |
| Washington | 2009–2012 | 61,289,069 | 41,804,425 | 19,484,644 | 31.79% |
| Wisconsin | 2010–2012 | 73,822,063 | 73,624,361 | 197,702 | 0.27% |
| **Total** | | **$645,009,558** | **$367,766,610** | **$277,242,948** | **42.98%** |

### States Submitted Incorrect Enrollment Numbers

According to CMS guidance,[4] States were instructed to calculate CHIPRA current enrollment by using the same State institutional data sources, such as the State's MMIS, that they used for reporting under the MSIS. CMS's guidance to States also defined current enrollment to mean the monthly average number of qualifying children in the State's Medicaid program. That current enrollment should have included only individuals whom the State identified and

[4] CMS, State Health Official (SHO) Letter #09-015, CHIPRA #10, and CMS email to State agencies on or about December 2011.

reported as having a BOE of "child" in the MSIS. Specifically, CMS guidance defined BOE codes of "child" as follows:

- Code 4: Child (not Child of Unemployed Adult, not Foster Care Child);
- Code 6: Child of Unemployed Adult (optional); and
- Code 8: Foster Care Child.

CMS established this guidance to ensure that States used the same information and basis (i.e., BOE codes) that CMS used to develop States' baseline enrollment.[5] CMS notified States of this requirement on multiple occasions, emphasizing this guidance in emails to States in December 2011. The emails stated, *"The same logic and basis that was used for developing the FY 2007 baseline should be used by each State for submitting the average monthly enrollment for children for the current fiscal year for which the bonus payment is being determined"* (emphasis in the original).

The 12 States we audited made the following errors when calculating enrollment:

- Nine States[6] did not follow CMS guidance to include in their CHIPRA current enrollment *only* individuals with a BOE of "child" in the MSIS. In addition to the above three BOE categories, States often incorrectly included individuals from other BOEs (e.g., BOE code 2, "Blind and Disabled") in their reports of CHIPRA current enrollments to CMS.
- Alabama did not follow CMS guidance to calculate a monthly average enrollment of qualifying children and, instead, calculated the total number of qualifying children ever enrolled in Medicaid during each respective FY.
- Wisconsin sought and obtained CMS approval to modify its baseline enrollment numbers retroactively because of a change in the State's program structure. However, the State provided CMS with information containing a mathematical error when it requested the baseline enrollment modification, which resulted in its baseline enrollment being understated.
- Virginia incorrectly inflated its current enrollment numbers by approximately 7 percent for each FY instead of using the adjustment process established by CMS to account for the actual individuals retroactively enrolled in Medicaid who should have been included in its current enrollment.

[5] The baseline enrollment level for a State used a formula that includes such factors as the levels of qualifying children under the Medicaid program and various adjustment factors that account for population growth.

[6] Alaska, Colorado, Idaho, Kansas, Louisiana, New Mexico, North Carolina, Ohio, and Washington.

These calculation errors resulted in the incorrect "State-Reported Enrollment" numbers shown in Table 2. We recalculated current enrollment numbers for these States following CMS's published guidance and obtained the enrollment numbers reflected in the "Correct Enrollment" column below.

**Table 2: State-Reported Current Enrollment Compared With Correct Enrollment**[7]

| State | State-Reported Enrollment | Correct Enrollment | Overreported (Number) | Percent Overreported |
|---|---|---|---|---|
| Alabama | 990,942 | 805,341 | 185,601 | 23.05% |
| Alaska | 371,901 | 361,936 | 9,965 | 2.75% |
| Colorado | 1,466,519 | 1,418,328 | 48,191 | 3.40% |
| Idaho | 616,520 | 585,404 | 31,116 | 5.32% |
| Kansas | 982,889 | 940,727 | 42,162 | 4.48% |
| Louisiana | 2,137,357 | 2,022,835 | 114,522 | 5.66% |
| New Mexico | 1,629,180 | 1,551,441 | 78,039 | 5.03% |
| North Carolina | 2,968,878 | 2,751,066 | 217,812 | 7.92% |
| Ohio | 4,791,854 | 4,640,465 | 151,389 | 3.26% |
| Virginia | 1,646,545 | 1,630,876 | 15,669 | 0.96% |
| Washington | 2,626,295 | 2,566,537 | 59,758 | 2.33% |

## CMS NEEDED MORE RELIABLE INFORMATION AND COULD HAVE USED AVAILABLE INFORMATION TO VALIDATE STATE-REPORTED ENROLLMENT

### MSIS Final Enrollment Data Were Not Available to CMS in Time To Make Correct Bonus Payments

CMS was tasked by Congress to make bonus payments to qualifying States within a relatively short period. Specifically, the Act, section 2105(a)(3)(A), required CMS to pay CHIPRA bonus payments for each FY (beginning with FY 2009 and ending with FY 2013) no later than the last day of the first calendar quarter of the following FY.[8] For example, the Act required CMS to pay bonuses to States for FY 2009 no later than December 31, 2009.

Because MSIS final enrollment data were not available, CMS had to rely on State-provided current enrollment data to calculate a State's bonus payments. Although CMS was able to establish the baseline enrollment for all States by using historical MSIS data, the States' current

[7] We did not include Wisconsin in Table 2 because the errors identified were with the baseline enrollment numbers CMS used in its bonus payment calculations and not with Wisconsin's current enrollment numbers. Wisconsin's baseline enrollment was understated by a total of 404 for FYs 2010 through 2012.

[8] CMS guidance also allowed for a subsequent adjustment to the bonus payment to a State once all enrollment numbers were finalized. We took these subsequent adjustments, where applicable, into account in calculating the unallowable payment to a State for a specific FY.

enrollment data were not available in the MSIS in time for CMS to calculate and make bonus payments within the prescribed deadline. Reliable MSIS data for current enrollments were not available because CMS allowed States to submit their MSIS eligibility files up to 3.5 months after the end of each quarter. Additionally, a prior OIG evaluation[9] found that it took an average of 1.5 years after the State's initial MSIS data submission to complete all phases of CMS's file submission and data validation processes, and many States submitted their initial MSIS data files after the CMS due dates.

As noted previously, our audits of CHIPRA bonus payments that CMS made to 12 States found that 11 of the States overstated their current enrollments when requesting the bonus payments. If CMS had more timely and accurate MSIS enrollment data, it could have prevented or mitigated the millions of dollars in unallowable payments that it made to these States through the CHIPRA bonus program.

To address the completeness, accuracy, and timeliness of MSIS data, CMS began transitioning from the longstanding MSIS to T-MSIS. CMS piloted the T-MSIS with 12 volunteer States starting in 2011 and began national implementation with States on a rolling basis in 2013. However, a 2017 OIG evaluation[10] found that the T-MSIS had not yet been implemented in all States and identified concerns with the completeness and reliability of T-MSIS data. A December 2017 Government Accountability Office (GAO) report[11] noted similar issues with CMS's implementation of the T-MSIS nation-wide. In August 2018, CMS announced that all States were successfully producing T-MSIS data, and CMS began shifting its efforts to assessing and improving the quality of T-MSIS data. Furthermore, in March 2019, CMS stated that it was continuing to work collaboratively with States to improve the quality of T-MSIS data and that CMS will begin to share and use T-MSIS data in CY 2019. OIG supports CMS's continued focus on improving the quality of T-MSIS data.

**CMS Could Have Improved Its Oversight of the CHIPRA Bonus Program by Using Available Data To Evaluate the Reasonableness of State-Submitted Current Enrollment**

According to GAO's *Standards for Internal Control in the Federal Government* (The Green Book), management is responsible for establishing activities to monitor performance measures and indicators. These performance measures and indicators may include comparisons and assessments relating different sets of data to one another so that analyses of the relationships can be made and appropriate actions taken. Management is also responsible for designing

[9] "MSIS Data Useful for Detecting Fraud, Waste, and Abuse," OEI-04-07-00240. Available online at https://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf. Accessed on February 23, 2018.

[10] "Status Update: T-MSIS Data Not Yet Available for Overseeing Medicaid," OEI-05-15-00050. Available online at https://oig.hhs.gov/oei/reports/oei-05-15-00050.pdf. Accessed on February 23, 2018.

[11] "Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight," GAO-18-70. Available online at https://www.gao.gov/assets/690/688857.pdf. Accessed on February 23, 2018.

controls aimed at validating the propriety and integrity of both entity and individual performance measures and indicators.[12]

Although CMS was unable to use MSIS data at the time it calculated the CHIPRA bonus payments, our use of MSIS data to audit States shows that CMS could have used MSIS data to enhance its oversight after the data became available. In 11 of our audits of CHIPRA bonus payments, we used MSIS monthly average enrollment numbers, which were available to CMS, to identify the States that may have received unallowable CHIPRA bonus payments.[13]

For example, as shown in Table 3, Alabama reported monthly average current enrollment numbers to CMS for FYs 2009 and 2010 of 474,473 and 516,569, respectively. CMS had accurate MSIS numbers available to it (if not at the time of Alabama's initial submission, then at least in the months following) that reflected a monthly average enrollment for Alabama of 382,103 and 423,238 for FYs 2009 and 2010, respectively. Once Alabama's MSIS data became available for each of the FYs for which it received bonus payments, CMS could have compared Alabama's reported enrollment of individuals having a BOE of "child" in MSIS with the current enrollment Alabama reported when requesting the CHIPRA bonus payment for each of the FYs. When we compared these two data sets, we determined that the current enrollment numbers that Alabama reported for the CHIPRA bonus program were more than 20 percent above the numbers reported in the MSIS. In this case, based on the overstated current enrollment, CMS paid Alabama more than $88 million in unallowable bonus payments.

**Table 3: Example of Alabama Overreported Current Enrollment**

| FY | Alabama-Reported Monthly Average Enrollment | MSIS Monthly Average Enrollment | Overreported Number | Enrollment Difference |
|---|---|---|---|---|
| 2009 | 474,473 | 382,103 | 92,370 | 24% |
| 2010 | 516,569 | 423,238 | 93,331 | 22% |

The result was over $277 million in improper CHIPRA bonus payments, or over 40 percent of all bonus payments that we audited. CMS has agreed with the recommendations in our previous 12 reports for States to repay the outstanding unallowable payments. Additionally, CMS has already taken significant action to recover these overpayments. Three States have voluntarily returned to CMS overpayments totaling approximately $37 million. In addition, CMS withheld almost $51 million from three States with unspent bonus payment funds and issued letters to

[12] The Green Book. Available online at https://www.gao.gov/assets/670/665712.pdf. Accessed on January 19, 2018.

[13] OIG is willing to share details with CMS on our methodology for identifying States with potential unallowable bonus payments, if requested.

States initiating recovery of the remaining $189 million[14] in overpayments that our audits identified. The States that have not voluntarily returned overpayments have appealed CMS's overpayment determination to the Departmental Appeals Board.

## RECOMMENDATIONS

We recommend that CMS:

- continue to work with States to collect the remaining $188,923,287 in unallowable payments from the $277,242,948 that we previously identified in the reports listed in Appendix B of this report and

- consider the results of these reviews when implementing similar programs to ensure that timely and accurate data are available for adequate oversight, followup, and verification.

## CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it has taken or plans to take to address them.

CMS's comments are included in their entirety as Appendix D.

[14] After their initial response to our draft report, CMS officials provided updated numbers and documentation for the amounts withheld from States and the remaining outstanding overpayments. The precise total of remaining overpayments was $188,923,287.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We reviewed the bonus payments that 12 States received for FYs 2009 through 2013.[15] Our review focused on verifying the accuracy of enrollment information used in the CHIPRA bonus payment calculations and ensuring that the information used complied with Federal requirements. We neither assessed the State agencies' internal control structure beyond what was necessary to meet our objective nor reviewed the State agencies' determinations of Medicaid eligibility. Also, we did not review whether the State agencies implemented at least five of the Medicaid enrollment and retention provisions because we determined that there was a low risk of noncompliance.

We performed fieldwork at CMS and at each of the respective States from April 2012 through September 2017.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- held discussions with CMS financial management officials to obtain an understanding of the process that States were required to follow when requesting bonus payments;
- reviewed CMS's detailed calculations[16] of 12 States' bonus payments;
- verified supporting documentation for all data elements used in each State's bonus payment calculations, including baseline enrollment and projected per capita State Medicaid expenditures;
- conducted a risk assessment to determine which States were at a higher risk of noncompliance;
- met with officials from each of the 12 States to:
  - discuss the State's requests for bonus payments,
  - obtain correspondence between the State and CMS,

[15] See Table 1 for applicable dates in each State.

[16] Appendix II of CMS, SHO Letter #09-015, CHIPRA #10, describes the data elements, processes, and methodologies for calculating the bonus payments.

- understand the State's methodology for determining the current enrollment reported in its requests for bonus payments, and
- understand the State's process for reporting MSIS enrollment data;

- analyzed the States' documentation supporting their requests for bonus payments;

- reviewed the States' MMIS enrollment data;

- reviewed each State's enrollment and expenditure data from CMS's MSIS;

- calculated each State's current enrollment by using allowable BOEs and average monthly enrollment figures;

- recalculated each State's bonus payments by using audited enrollment data; and

- discussed the results with State and CMS officials.

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.

## APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|---|---|---|
| *Virginia Received Millions in Unallowable Bonus Payments* | A-04-17-08060 | 1/10/2019 |
| *Alaska Received Millions in Unallowable Bonus Payments* | A-04-17-08059 | 8/9/2018 |
| *Idaho Received Millions in Unallowable Bonus Payments* | A-04-17-08056 | 3/30/2018 |
| *Ohio Received Millions in Unallowable Bonus Payments* | A-04-16-08049 | 11/3/2017 |
| *Kansas Received Millions in Unallowable Bonus Payments* | A-04-16-08050 | 11/3/2017 |
| *Colorado Received Millions in Unallowable Bonus Payments* | A-04-15-08039 | 8/11/2016 |
| *New Mexico Received Millions in Unallowable Bonus Payments* | A-04-15-08040 | 11/24/2015 |
| *North Carolina Received Millions in Unallowable Bonus Payments* | A-04-14-08035 | 7/21/2015 |
| *Wisconsin Received Some Unallowable Bonus Payments* | A-04-13-08021 | 3/18/2015 |
| *Washington Received Millions in Unallowable Bonus Payments* | A-04-14-08028 | 9/9/2014 |
| *Louisiana Received More Than $7.1 Million in Unallowable Bonus Payments* | A-04-14-08029 | 7/10/2014 |
| *Alabama Received Millions in Unallowable Performance Bonus Payments Under the Children's Health Insurance Program Reauthorization Act* | A-04-12-08014 | 8/27/2013 |

## APPENDIX C: FEDERAL REQUIREMENTS RELATED TO BONUS PAYMENTS

### PURPOSE OF THE BONUS PAYMENTS AND BASELINE CALCULATION METHODOLOGY

Section 2105(a)(3) of the Act states that performance bonus payments are intended to offset additional Medicaid and Children's Health Insurance Program child enrollment costs resulting from enrollment and retention efforts. The payments are made to a State for a FY as a single payment no later than the last day of the first calendar quarter of the following FY.[17] Additional guidance provided by CMS[18] requires that payments to qualifying States be made by December 31 of the calendar year (CY) following the end of the FY for which the criteria were implemented. The CHIPRA bonus payments were provided to a State through a grant award.

Section 2105(a)(3)(C)(iii)(I) of the Act states that the baseline number of child enrollees for FY 2009:

> is equal to the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX during FY 2007 increased by the population growth for children in that State from 2007 to 2008 (as estimated by the Bureau of the Census) plus 4 percentage points, and further increased by the population growth for children in that State from 2008 to 2009 (as estimated by the Bureau of the Census) plus 4 percentage points . . . .[19]

For each of the FYs, the baseline number of child enrollees "is equal to the baseline number of child enrollees for the State for the previous FY under title XIX, increased by the population growth for children in that State from the CY in which the respective FY begins to the succeeding CY (as estimated by the Bureau of the Census)" plus 3.5 percentage points for FYs 2010 through 2012 and 3 percentage points for FY 2013.[20]

CMS established the baseline enrollment for each State by using all of the "MSIS Coding Categories" for which States report individuals under the BOE of "child" in their Medicaid programs. Specifically, these BOEs are identified as BOEs 4, 6, and 8.[21]

[17] Section 2105(a)(3)(A) of the Act.

[18] CMS, SHO Letter #09-015, CHIPRA #10.

[19] Enrollment data for FY 2007 were obtained from the MSIS.

[20] Sections 2105(a)(3)(C)(iii)(II) and (III) of the Act.

[21] CMS, SHO Letter #09-015, CHIPRA #10.

CMS provided further guidance, which states:

> The FY 2007 baseline enrollment data obtained from MSIS may not represent an exact one-to-one mapping for each of the above statutory eligibility categories. However, . . . the baseline enrollment data represents all individuals identified and reported by each State with a BOE of "child;" we believe this approach appropriately addresses the intent of the statute in a way that is operationally feasible.[22]

**CMS GUIDANCE FOR CURRENT ENROLLMENT CALCULATION**

In guidance provided to States in October 2009, CMS requested that, in reporting their current enrollment, States include a description of the data sources and methodologies they used to appropriately identify individuals with a BOE of "child."

The instructions relating to the average monthly enrollment for children were reiterated in an email from CMS to participating CHIPRA Bonus States in or about December 2011. The email stated, *"The same logic and basis that was used for developing the FY 2007 baseline should be used by each State for submitting the average monthly enrollment for children for the current fiscal year for which the bonus payment is being determined"* (emphasis in the original).

[22] CMS BP-Clarification3.docx, October 2009.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

**DATE:** August 13, 2019

**TO:** Joanne Chiedi
Acting Inspector General

**FROM:** Seema Verma
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: CMS Paid Over $277 Million in Unallowable CHIPRA Bonus Payments Based on Incorrect Enrollment Data (A-04-17-08061)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to program integrity efforts in Medicaid and the Children's Health Insurance Program (CHIP).

Performance Bonus Payments (bonus payments) were federal payments authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) for fiscal years 2009-2013. Bonus payments are separate funding provided in addition to the amounts made available for annual CHIP allotments or Medicaid funding to encourage and assist states in reaching and enrolling more uninsured children who are eligible for Medicaid.

In December 2009, CMS issued State Health Official (SHO) letter #09-015, which discussed qualification criteria for bonus payments and the calculation of bonus payments, including data elements used in the payment calculation. CMS worked with states to determine whether they met at least five of eight program features required to qualify for a bonus payment. Once a state qualified, CMS calculated the bonus payment amounts using various data elements including current enrollment figures provided to CMS by states. The SHO letter and additional CMS guidance provided to states outlined the methodology for calculating the current enrollment data element.

As OIG notes, in their review of 12 states' bonus payments, they found instances of overpayments because states incorrectly calculated the current enrollment data element and CMS has already taken significant action to recover these overpayments. Three states have voluntarily returned overpayments totaling approximately $37 million to CMS. In addition, CMS withheld $40 million from states with unspent bonus payment funds. In April 2019, CMS issued letters to states initiating recovery of the remaining $190 million in overpayments identified through OIG audits. The states that have not voluntarily returned overpayments have appealed CMS's overpayment determination to the Departmental Appeals Board. We will continue to work with states on the recovery of overpayments.

OIG's recommendations and CMS' responses are below.

**OIG Recommendation**

Continue to work with the States to collect the remaining unallowable payments from the $277,242,948 that were previously identified in the reports listed in Appendix B of this report.

**CMS Response**

CMS concurs with OIG's recommendation. As stated above, CMS has already taken significant action to recover overpayments related to bonus payments identified by OIG and will continue to work to recover these funds.

**OIG Recommendation**

Consider the results of these reviews when implementing similar programs to ensure that timely and accurate data are available for adequate oversight, followup, and verification.

**CMS Response**

CMS concurs with OIG's recommendation. CMS will consider the results of OIG's audits when implementing similar programs in the future.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.