Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COLORADO DID NOT CORRECTLY DETERMINE MEDICAID ELIGIBILITY FOR SOME NEWLY ENROLLED BENEFICIARIES

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Office of Inspector General

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

Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

Why OIG Did This Review

The Patient Protection and Affordable Care Act (ACA) gave States the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these newly eligible beneficiaries. If these beneficiaries' eligibility had been incorrectly determined, payments made on their behalf (1) would have been reimbursed at a higher rate than they should have been or (2) should not have been reimbursed at all. This review is part of an ongoing series of reviews of newly eligible beneficiaries.

Our objective was to determine whether Colorado made Medicaid payments on behalf of newly eligible beneficiaries who did not meet Federal and State eligibility requirements under the ACA.

How OIG Did This Review

We reviewed a simple random sample of 60 newly eligible beneficiaries who received Medicaid-covered services from January 2014 through September 2015 (audit period). We reviewed supporting documentation to evaluate whether Colorado determined the applicants' eligibility in accordance with Federal and State requirements (e.g., income, citizenship or lawful presence, and other relevant requirements).

What OIG Found

Colorado made Medicaid payments on behalf of newly eligible beneficiaries who did not meet, or who may not have met, Federal and State eligibility requirements. Colorado correctly determined eligibility and, therefore, correctly claimed Federal Medicaid reimbursement, on behalf of 43 of the 60 beneficiaries in our statistical sample. However, of the remaining 17 beneficiaries whom Colorado determined to be newly eligible for Medicaid, 14 were ineligible and 4 may have been ineligible. We estimated that the financial impact of the incorrect eligibility determinations made by Colorado totaled at least $66.5 million on behalf of 85,085 ineligible beneficiaries and at least $26.8 million on behalf of 13,372 potentially ineligible beneficiaries.

These deficiencies occurred because Colorado did not always follow written policies and procedures when making eligibility determinations and because of system and procedural errors related to eligibility determinations, as well as human errors made by Colorado staff and caseworkers.

What OIG Recommends and Colorado Comments

We recommend that Colorado redetermine, as appropriate, the current Medicaid eligibility status of the sampled beneficiaries. We also make other procedural recommendations regarding improvements to the design, functionality, and accuracy of Colorado's eligibility determination system.

Colorado agreed with our recommendations and said that it had already implemented the necessary changes to correct the system and coding errors we identified. Colorado said that our review was duplicative of other Federal and State reviews and added that because Colorado had identified and addressed the errors before our audit, it did not need to take additional action. Colorado also said that our sample size was too small and questioned our statistical sampling and projection methodology.

We maintain that all of our findings and recommendations remain valid. We disagree that Colorado had identified and addressed, before our audit, the system errors we describe in this report. For many of the findings, we did not find evidence of corrective actions relevant to the findings, and Colorado did not identify or otherwise provide evidence that it had already taken corrective actions. Additionally, in other types of audits, small sample sizes and other aspects of the sampling methodology have routinely been upheld by Federal courts.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/71604228.asp.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA).[1] Generally, the ACA gave States the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate (Federal Medical Assistance Percentage or FMAP) for services provided to these "newly eligible" beneficiaries.[2] The ACA also included changes to Medicaid eligibility rules, such as requiring that income be calculated on the basis of modified adjusted gross income (MAGI)[3] and that income be at or below 133 percent of the Federal Poverty Level (FPL) for newly eligible beneficiaries. If these beneficiaries' eligibility had been incorrectly determined, payments made on their behalf (1) would have been reimbursed at a higher FMAP than they should have been or (2) should not have been reimbursed at all.

This review is part of an ongoing series of reviews of newly eligible beneficiaries. We selected Colorado to ensure that our reviews cover States in different parts of the country (Appendix B).

OBJECTIVE

Our objective was to determine whether the Colorado Department of Health Care Policy and Financing (State agency) made Medicaid payments on behalf of newly eligible beneficiaries who did not meet Federal and State eligibility requirements.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, States must cover certain population groups. Generally, individual eligibility criteria are met by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of U.S.

[1] The Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as "ACA."

[2] In this report, we refer to these low-income adults for whom the States receive a higher FMAP as "newly eligible" beneficiaries" or "the new adult group." Other beneficiary groups that receive the standard FMAP are referred to as the "Traditional Medicaid group(s)."

[3] The Social Security Act (the Act) §§ 1902(e)(14)(A)—(D); 26 U.S.C. § 36B(d)(2)(B). This methodology to determinate a person's income is based on Internal Revenue Service (IRS) rules.

citizenship. For both newly eligible and Traditional Medicaid groups, income is calculated in relation to a percentage of the FPL.

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures—the FMAP—which is developed from criteria such as the State's per capita income.[4,5] The standard FMAP varies by State and ranges from 50 to 75 percent.[6,7]

CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs, which are designed to reduce improper payments. In July 2017, CMS modified its MEQC and PERM requirements to incorporate changes mandated by the ACA.[8]

Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act

The ACA seeks to provide more Americans with access to affordable healthcare. This legislation addresses gaps in coverage for the poorest Americans by increasing the minimum Medicaid income eligibility level across the country. Effective January 1, 2014, all individuals under 65 years of age with incomes up to 133 percent of the FPL became eligible for Medicaid;[9] this initiative is known as Medicaid expansion. A ruling by the U.S. Supreme Court allowed each State the option to refuse to expand its Medicaid program and not face any reduction in current Medicaid funding (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)).

[4] The Act § 1905(b).

[5] CMS, "Financial Management." Accessed at https://www.medicaid.gov/medicaid/finance on Nov. 7, 2018.

[6] 77 Fed. Reg. 71420, 71422 (Nov. 30, 2012).

[7] Office of the Assistant Secretary for Planning and Evaluation. "FY [Federal fiscal year] 2017 Federal Medical Assistance Percentages." Accessed at https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages on Nov. 7, 2018.

[8] 82 Fed. Reg. 31158, 31159 (Jul. 5, 2017).

[9] The Act § 1902 established the FPL income threshold at 133 percent but allows for a 5-percent income disregard (a standard deduction applied to calculate income for Medicaid), making the effective threshold 138 percent of the FPL.

The ACA § 2001 authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group.[10] This "newly eligible FMAP" was set to remain at 100 percent through calendar year (CY) 2016, gradually decreasing to 90 percent by CY 2020.[11]

Requirements for Eligibility Determination and Verification Under the Affordable Care Act

The ACA also required States to make a number of changes to their Medicaid application, enrollment, and eligibility determination processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual's eligibility for all potential health coverage options, including Medicaid, the Children's Health Insurance Program (CHIP), and qualified health plans available through the health insurance marketplaces.[12] In most cases, the ACA required States to use MAGI to determine an individual's income.[13]

States are required to have an income and eligibility verification system for determining Medicaid eligibility and a verification plan (made available upon CMS's request) describing the State agency's policies and procedures for implementing the eligibility verification requirements (42 CFR § 435.945(j)). States must verify individuals' eligibility information, such as citizenship or lawful presence and entitlement to or enrollment in Medicare, through electronic data sources (42 CFR §§ 435.945(a) and (b) and 435.949). States may accept an individual's attestation for certain information, such as a beneficiary's pregnancy status and household composition (e.g., household size and family relationships), without further verification (42 CFR §§ 435.945(a) and 435.956).

[10] The Act defines a "newly eligible" beneficiary as "an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the [ACA], is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage" (the Act § 1905(y)(2)(A)).

[11] 42 CFR § 433.10(c)(6).

[12] ACA § 1413(b).

[13] See footnote 3. The use of MAGI to determine Medicaid eligibility does not apply to certain groups of beneficiaries, such as seniors who are 65 years of age or older and medically needy individuals.

Federal regulations provide standards under which income information obtained through electronic data sources is considered reasonably compatible with income information provided by or on behalf of an individual (42 CFR § 435.952).[14]

Colorado Medicaid Eligibility Determination and Verification

In Colorado, the State agency is responsible for ensuring that it performs eligibility determinations in accordance with all Federal and State Medicaid requirements. To perform these functions, the State agency uses the Colorado Benefits Management System (CBMS), which determines Medicaid eligibility, and which interfaces with other automated systems to verify application information. These interfaces include the Income Eligibility Verification System (IEVS), which is an electronic interface that the State agency uses to verify income.

Medicaid Application Process

Low-income individuals with a significant disability who are receiving Supplemental Security Income (SSI) are automatically eligible for Medicaid under the SSI mandatory category. All other individuals who apply must complete a Medical Assistance Application. This form can be submitted in person, by telephone, by mail, or online through the State agency's Program Eligibility and Application Kit (PEAK). The information from the applications is transferred either by State agency staff or automatically to the CBMS, which determines eligibility based on all of the information provided by the applicant and all of the information received through electronic interfaces.

Eligibility Verification Process

The CBMS uses electronic interfaces with other data sources to conduct automated verifications of information needed to determine beneficiaries' eligibility for Medicaid. For example, the CBMS verifies income, citizenship, immigration status, and identity using electronic interfaces. In some cases, paper documentation is used to verify these eligibility requirements. Information about the documents used for verification is entered into the CBMS by State agency staff. The State agency accepts self-attestation for other factors of eligibility.

[14] 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 (discussed later in this report) for an applicant to respond to the State agency regarding income discrepancies.

According to the State agency's MAGI-Based Eligibility Verification Plan (verification plan),[15] a beneficiary's income from a job can be self-attested at application (after which the State agency makes its initial eligibility determination) and is then verified 2 to 4 months after that initial determination through the IEVS electronic interface. The IEVS runs on a monthly basis, and once every 3 months, it receives income that beneficiaries' employers report to the Colorado Department of Labor and Employment (CDOLE) and passes this information through an electronic interface to the CBMS.[16] Then, the CBMS compares self-attested income to the income reported to the IEVS. If there is a discrepancy of greater than 10 percent between a beneficiary's self-attested income and the income as reported to CDOLE and if the interfaced income amount exceeds the applicable income threshold, then the CBMS determines that the beneficiary's income is not reasonably compatible.

Reasonable Opportunity Period

In such cases, the State agency gives beneficiaries a 90-day reasonable opportunity period to provide verification or reasonable explanation for the income discrepancies (footnote 14). If a beneficiary does not provide verification, he or she is considered to have exceeded the income threshold, and the individual's application for Medicaid is terminated.[17] If the information in the CBMS shows that the State agency has verified income from the current or previous month, through a means such as check stubs, then reasonable compatibility is not performed.

State Agency Controls After Eligibility Determination

After a beneficiary is determined to be eligible, the State agency uses the CBMS and its electronic interfaces with other data sources to identify changes that affect beneficiaries' eligibility. For example, the CBMS checks the IEVS each month for changes in beneficiaries' incomes.

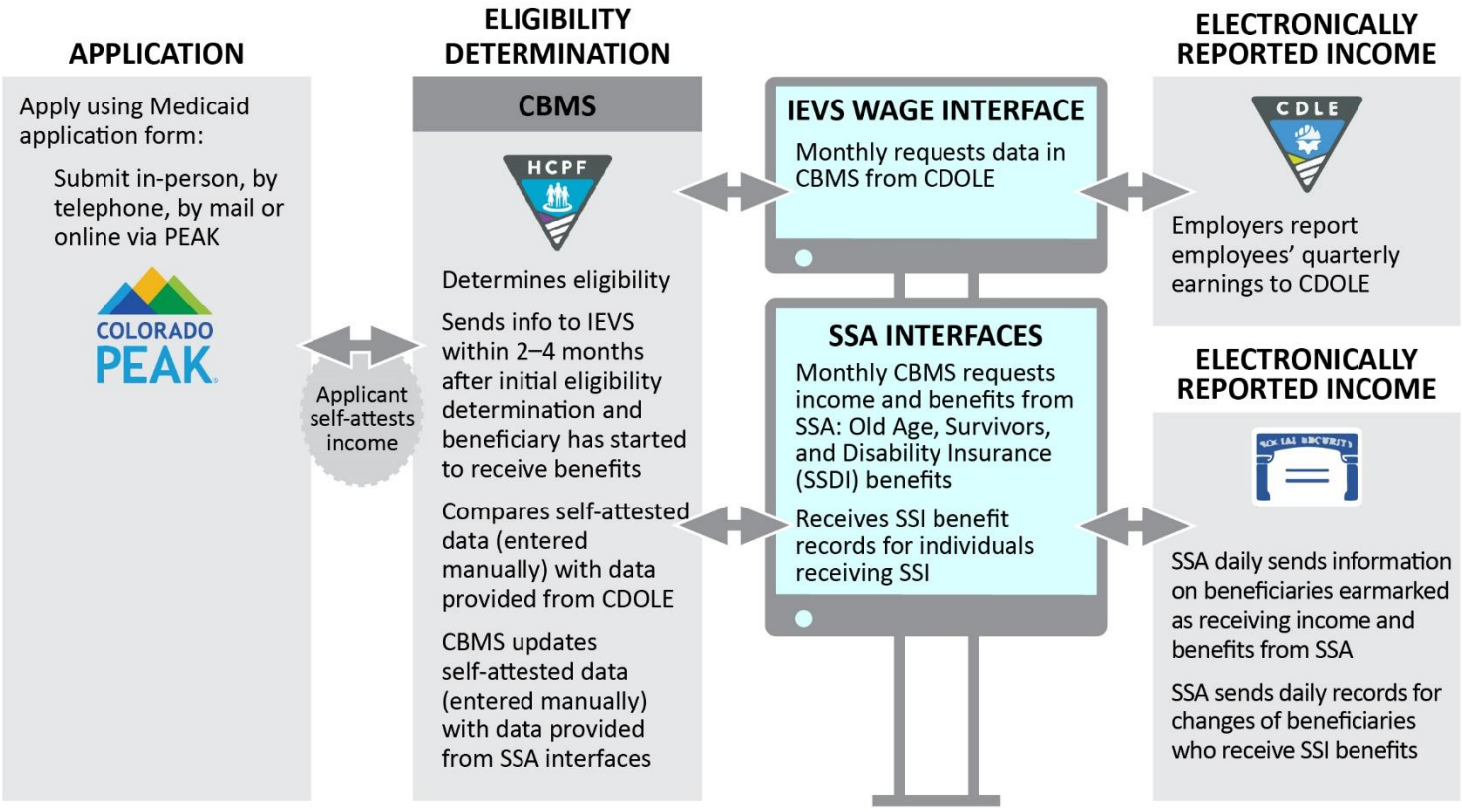
[15] The verification plan is a standalone document, separate from the State Medicaid plan and from any of the State plan amendments (SPAs). Although this document is undated, the State agency confirmed to us during our review that its provisions were applicable for our entire audit period (January 1, 2014, to September 30, 2015).

[16] For this report, we use "applicant" to refer to an individual who has applied or is applying for Medicaid and "beneficiary" to refer to that same individual once he or she has received an initial determination of eligibility from the State agency.

[17] State agency officials told us that the 90-day reasonable opportunity period was effective January 1, 2014. However, the 90-day reasonable opportunity period requirement was added to policy effective October 1, 2014, under 10 Code of Colorado Regulations (CCR) 2505-10 8.100.3.G.3. Before this date, the State agency's policy specified a 14-day reasonable opportunity period for citizenship (10 CCR 2505-10 8.100.3.H.9). The State agency said that it also used this 14-day reasonable opportunity period requirement for income discrepancies.

The figure below depicts Colorado's Medicaid application and income verification processes.

Figure: Colorado Medicaid Application and Electronic Income Verification Process



HOW WE CONDUCTED THIS REVIEW

Our review covered 579,070 beneficiaries determined to be newly eligible for Medicaid under the ACA (excluding American Indians and Alaska Natives) for whom the State agency made Medicaid payments from January 1, 2014, through September 30, 2015, for services provided during that period. We reviewed the Medicaid eligibility determinations made by the State agency for a simple random sample of 60 beneficiaries classified as newly eligible.[18]

We limited our review of internal controls to those applicable to our objective. Accordingly, we reviewed the internal controls for eligibility determinations and verifications that the State agency had in place during our audit period.

[18] We used a simple random sample of 60 items such that each item in the complete sampling frame had the same chance of being selected. A smaller sample would generally result in a less precise result. To estimate the precision of our design, we calculated a two-sided 90-percent confidence interval. Intervals calculated in this manner will contain the actual population error amounts roughly 90 percent of the time. Confidence intervals account for the variability in the sample frame, the size of the sample, and the number of items in the frame.

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 audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency made Medicaid payments on behalf of newly eligible beneficiaries who did not meet, or who may not have met, Federal and State eligibility requirements under the ACA. The State agency correctly determined eligibility and, therefore, correctly claimed Federal Medicaid reimbursement, on behalf of 43 of the 60 beneficiaries in our statistical sample. However, of the remaining 17 beneficiaries whom the State agency determined to be newly eligible for Medicaid, 14 were ineligible and 4 were potentially ineligible.[19]

Of the 14 beneficiaries in the new adult group whom we identified as ineligible (some beneficiaries had more than 1 error), the State agency:

- incorrectly determined that 8 beneficiaries were newly eligible even though the beneficiaries did not meet income requirements,

- incorrectly determined that 4 beneficiaries were eligible for the new adult group when it should have enrolled those beneficiaries under a mandatory Medicaid eligibility group,

- incorrectly classified as newly eligible 1 beneficiary who did not meet citizenship requirements, and

- determined 1 beneficiary to be eligible for a Traditional Medicaid group, yet incorrectly claimed the beneficiary under the new adult group rate (for which the State agency claimed Federal reimbursement at the enhanced FMAP of 100 percent).

[19] One of the beneficiaries in our sample fell under both groups—ineligible and potentially ineligible. (This circumstance is possible because within our audit period, an individual sampled beneficiary might have had more than one eligibility determination, based on new information either submitted by the beneficiary or captured by an interface in one or more of the State agency's automated systems. We refer to any subsequent eligibility determination for an individual as a redetermination.) In addition, four of the ineligible beneficiaries had more than one deficiency in the State agency's eligibility determinations. For example, the State agency used an incorrect income amount when redetermining one beneficiary as eligible and, for the same beneficiary, did not follow its reasonable compatibility process after it had identified an income discrepancy.

Of the four beneficiaries in the new adult group whom we identified as potentially ineligible:

- the State agency correctly determined that two beneficiaries were eligible for the new adult group, but lags in both the eligibility system and the State agency's reasonable compatibility process (footnotes 14 and 17) delayed disenrollment of these two beneficiaries when their incomes rose above the Medicaid eligibility limit and

- the State agency determined that two other beneficiaries were eligible for the new adult group but, contrary to the provisions of its own verification plan, relied on self-attestations rather than income verifications when making those determinations.

These deficiencies occurred because the State agency did not always follow written policies and procedures when making eligibility determinations and because of system and procedural errors related to eligibility determinations as well as human errors made by State agency staff and caseworkers.

On the basis of our sample results, we estimated that the financial impact of the incorrect eligibility determinations made by the State agency during the audit period totaled at least $66,525,688 on behalf of 85,085 ineligible beneficiaries and at least $26,797,483 on behalf of 13,372 potentially ineligible beneficiaries.

Because Federal reimbursement under the ACA was at 100 percent FMAP, the amounts identified as financial impacts were entirely Federal, not State, dollars.[20]

THE STATE AGENCY MADE MEDICAID PAYMENTS ON BEHALF OF SOME NEWLY ELIGIBLE BENEFICIARIES WHO DID NOT MEET FEDERAL AND STATE ELIGIBILITY REQUIREMENTS

The State agency made Medicaid payments on behalf of 14 beneficiaries whom the State agency classified as newly eligible but who did not meet Federal and State eligibility requirements.

[20] Although our statistical sampling methodology, as described in Appendix C, produced these estimated financial impacts and estimated numbers of ineligible and potentially ineligible beneficiaries, that methodology did not generally permit us to associate actual or estimated financial impacts with the individual findings below. Moreover, we did not determine whether the ineligible beneficiaries would be eligible for Traditional Medicaid groups, which paid at 50 percent FMAP for CY 2014 and at 51 percent for CY 2015. We did not take this step because although we point here to estimated financial impacts of incorrect and potentially incorrect eligibility determinations, this report does not question costs or recommend a refund to the Federal Government. Our recommendations are procedural.

The State Agency Incorrectly Determined Some Beneficiaries' Eligibility Groups Based on Income Requirements

Federal and State Requirements

In accordance with the Act and the ACA, State Medicaid agencies claimed Federal Medicaid reimbursement for newly eligible Medicaid beneficiaries at 100-percent FMAP through CY 2016. Federal regulations specify that individuals who have household incomes at or below 133 percent of the FPL for the applicable family size may be eligible for Medicaid under the new adult group. The ACA allows for a 5-percent income disregard (footnote 9), making the effective income threshold 138 percent of the FPL.

Federal regulations require State Medicaid agencies to verify financial information related to wages, net earnings from self-employment, unearned income, and resources and to request additional information or documentation from the beneficiary if the attested income is not reasonably compatible with electronic sources. Federal regulations also require State Medicaid agencies to promptly evaluate information that they receive or obtain so as to determine whether the information affects beneficiaries' eligibility or benefits to which they are entitled.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) includes requirements for determining the eligibility and amount of benefits of an alien for any means-tested public benefits program.[21] Under these provisions, the income and resources of the alien are deemed to include the income and the resources of any person who executed an affidavit of support as provided by the Immigration and Nationality Act on behalf of such an alien (i.e., an alien sponsor). We refer to this as "alien sponsor deeming." The PRWORA also specifies that a State is authorized to provide that the income and resources of the alien are deemed to include that of the sponsor for any State public benefits. Colorado State regulations convey this provision but make an exception for aliens who are pregnant or are children (10 CCR 2505-10 8.100.3.K). Further, CMS has confirmed that the requirements for alien sponsor deeming still apply under the ACA.[22]

For details on these Federal and State requirements, see Appendix E.

[21] The PRWORA, P.L. No. 104-193 (Aug. 22, 1996). Federal healthcare benefits are generally allowable when provided to a beneficiary who is either a U.S. citizen or a U.S. national or to an alien who is lawfully present in the United States. But when the alien beneficiary is not lawfully present in the United States, Federal healthcare benefits are not allowable (8 U.S.C. § 1611).

[22] 77 Fed. Reg. 17144, 17153 (Mar. 23, 2012).

Ineligible Beneficiaries

The State agency incorrectly determined that 8 of the 60 sampled beneficiaries were eligible for the new adult group even though the beneficiaries did not meet income requirements. Specifically:

- For five beneficiaries, the State agency correctly determined the beneficiaries to be newly eligible at the time of determination or redetermination; however, subsequent changes in their incomes made each of these five beneficiaries ineligible for the new adult group. The State agency received this information but did not update the CBMS to identify these beneficiaries as ineligible for the new adult group.[23]

- For two beneficiaries, the State agency correctly determined that the beneficiaries were ineligible for the new adult group because their household income amounts exceeded the allowed maximum income threshold of 138 percent of the FPL. However, the State agency did not promptly evaluate this information so as to determine whether it affected beneficiaries' benefits. As a result, the State agency continued to make payments on behalf of these beneficiaries and to claim Federal Medicaid reimbursement at the new adult group rate after it had determined that these beneficiaries were ineligible. The State agency made payments for 9 months on behalf of one of these beneficiaries and for 2 months on behalf the other.

- For one beneficiary, the State agency did not include alien sponsor income when determining income eligibility. When this income was taken into account, the beneficiary's income exceeded the allowed maximum income threshold of 138 percent of the FPL.

Reasons for Errors in State Agency's Incorrect Determinations of Some Beneficiaries' Eligibility Groups Based on Income Requirements

These errors in the State agency's eligibility determination process occurred because of procedural errors (six beneficiaries) and human errors (two beneficiaries), as discussed just below.

[23] Specifically, the State agency verified that the incomes reported through the IEVS for these beneficiaries (1) were more than 10-percent higher than their self-attested incomes and (2) exceeded the allowed maximum income threshold of 138 percent of the FPL. Although the State agency thus verified that these beneficiaries' incomes were no longer reasonably compatible, it did not correctly update the CBMS to identify these beneficiaries as ineligible for the new adult group.

Procedural Errors

For five of the eight beneficiaries associated with this finding, the errors were the result of procedural problems stemming from coding errors in the CBMS, which prevented the system from capturing income changes and resolving discrepancies. The State agency's policy states that if a beneficiary's income is not reasonably compatible (footnotes 14 and 17), the beneficiary must be given a 90-day reasonable opportunity period to establish his or her financial eligibility through a reasonable explanation.[24] In such cases, the State agency's procedure is to send a reasonable compatibility letter (discrepancy letter) to the beneficiary, with a specified deadline in which to respond. If no response is received, the beneficiary is terminated from coverage under Medicaid.

The 90-day reasonable opportunity period requirement did not take effect as part of the State agency's policy (through State regulations) until October 2014. From January through September 2014, the State agency's policy (and earlier regulations) specified that the reasonable opportunity period was 14 days (footnote 17). Moreover, our analysis of the errors we identified led us to conclude that the system edit to set the reasonable opportunity period at 90 days was not implemented in the CBMS until the middle of CY 2015.

Even after application of this system edit, errors in the State agency's administration of the CBMS prevented consistent and uniform application of the updated policy and applicable State regulations. The procedural errors we identified in cases up through June 2015 occurred because the State agency had given beneficiaries about 14 days to respond to discrepancy letters. That timeframe conflicted with the 90-day reasonable opportunity period that State agency staff told us had been effective since January 2014 and that had been specified in policy since October 2014. After the 14-day response due date had passed, though, the State agency did not terminate the beneficiaries. State agency officials said that giving beneficiaries 14 days to respond did not affect the income calculation or the 90-day reasonable compatibility process in the CBMS. State agency officials also told us that in July 2015, the State agency implemented procedural modifications to correct the error in which the CBMS had generated discrepancy letters that incorrectly told beneficiaries that they had 14 days (rather than 90) to respond.

Through our review and coordination with the State agency, we found that the procedural error involving the incorrect information in the response letters also affected the income calculations. The samples we reviewed showed that when calculating income, the CBMS was not taking action on each of the income discrepancies and was, instead, using attested income for the monthly income calculations. Moreover, the CBMS continued to use attested income as many as 90 days after the discrepancy letter had been sent and regardless of whether or not the discrepancy had been resolved. According to an email that the State agency sent to us, it

[24] 10 CCR 2505-10 8.100.4.C.2 and 10 CCR 2505-10 8.100.3.H.9, dated effective January 1, 2014. The 90-day reasonable opportunity period requirement was added to policy effective October 1, 2014, under 10 CCR 2505-10 8.100.3.G.3. Federal requirements refer to a discrepancy as an "inconsistency" (the Act § 1902(ee)), while at the State level, this timeframe is referred to as the "90-day reasonable opportunity period."

"had verbal discussions with CMS through the State Operations and Technical Assistance (SOTA) meetings and based on those discussions, the [State agency]'s understanding was that there was flexibility for exempting" the income discrepancies that the IEVS had identified for the last quarter of CY 2014 (which the State agency referred to as "the 1st IEVS hit"). "When the [State agency] submitted the official Verification Plan, clarification was received [from] CMS that action must be taken on each discrepancy and a plan of action was required to fix this." State agency officials told us that this CMS clarification was oral and that the State agency implemented procedural modifications in March 2016 to correct these errors in its income calculations.

Other procedural errors occurred when the income interface in the CBMS pulled erroneous information, such as old income, when creating the discrepancy letters. (State agency officials said that this system error was fixed in July 2015). In other cases, discrepancy letters were not created when discrepancies occurred, or discrepancy letters were sent late. For example, one discrepancy letter was not sent to the beneficiary until 3 months after the discrepancy in income had been reported to the CBMS.

For the sixth beneficiary for whom we identified a procedural error (of the eight beneficiaries associated with this finding), the CBMS determined that the beneficiary was ineligible for benefits, but the State agency claimed that beneficiary under the new adult group. The State agency explained that the information regarding this beneficiary's ineligible status was not sent from the CBMS to the State agency's Medicaid Management Information System (MMIS) in a timely manner.[25] The State agency added that it corrected this procedural error in November 2014.

Human Errors

For one of the eight beneficiaries associated with this finding, an eligibility caseworker incorrectly excluded alien sponsor income when calculating monthly income. The caseworker misinterpreted the applicable Federal and State requirements for income calculations in cases of alien sponsor deeming. This error resulted in the beneficiary's enrollment in the new adult category even though the beneficiary's income exceeded the allowed maximum income threshold of 138 percent of the FPL, which rendered the individual ineligible for this Medicaid eligibility group.

For one other of the eight beneficiaries associated with this finding, the State agency claimed the beneficiary for Medicaid benefits even though that individual had been identified as ineligible in the CBMS. The State agency explained that in this case, the individual in question had earlier been correctly determined to be eligible while she was in her mother's household. The individual in question subsequently submitted her own application and the State agency determined that she was ineligible for benefits, but neither she nor her mother notified the

[25] The MMIS is a computerized payment and information reporting system that the State agency uses to process and pay Medicaid claims and to manage information about Medicaid beneficiaries and services.

State agency that the daughter had moved out of her mother's household. Therefore, the State agency approved the individual in question under her mother's case during redetermination. We classify this as a human error, which could have been mitigated if the caseworker at the time of the more recent application had checked all Medicaid cases in which this individual appeared and had then updated all relevant files in the CBMS.

Risk Due to Incorrect Medicaid Eligibility Determinations

If the State agency does not correctly determine Medicaid eligibility in accordance with Federal and State requirements, there is a risk that it will make payments on behalf of ineligible beneficiaries and, in turn, claim unallowable Federal reimbursement for those payments.[26]

The State Agency Did Not Always Verify Whether Beneficiaries Were Eligible Under a Different Medicaid Eligibility Group

Federal and State Requirements

The Act states that if an individual is eligible for Medicaid through any mandatory category, the individual is not eligible for the new adult group.

Federal and State regulations allow parents or caretakers living with a dependent child—and who meet the rest of the eligibility criteria—to be eligible for the new adult group. The dependent child in such cases must be receiving Medicaid or CHIP or meet other criteria set in Federal statute and regulations.

State regulations specify that the MAGI Adult expansion category includes parents or caretaker relatives aged 19 through 64 with income that ranges from 69 percent to 138 percent of the FPL (footnote 9).[27]

For details on these Federal and State requirements, see Appendix E.

Ineligible Beneficiaries

The State agency incorrectly determined that 4 of the 60 sampled beneficiaries were eligible for the new adult group when it should have enrolled those beneficiaries under a mandatory Medicaid eligibility group. Specifically:

[26] We are not recommending recovery because, under Federal law, a disallowance of Federal payments for Medicaid eligibility errors can occur only if the errors are detected through the State's MEQC or PERM reviews.

[27] Under this provision, parents and caretakers with income over 68 percent of the FPL qualify for the new adult group since its implementation on January 1, 2014 (SPA CO-13-0045).

- The State agency determined that two beneficiaries were newly eligible even though they were SSI recipients and so should have been determined eligible for and enrolled in the SSI mandatory eligibility group.

- The State agency determined that two other beneficiaries were eligible for the new adult group even though in each case, the beneficiary's household income was below the 68 percent allowable maximum income threshold of the FPL specified for the parent/caretaker adult eligibility group. Because of their income levels, these beneficiaries should have been determined eligible for the Traditional Medicaid mandatory parent/caretaker eligibility group (with income at or below 68 percent of the FPL), rather than the new parent/caretaker adult eligibility group (with income between 69 and 138 percent of the FPL. One of these beneficiaries was enrolled under the new adult group during a period when that individual's child did not have Medicaid or other minimum essential coverage.

Reasons for Errors in State Agency's Incorrect Determinations That Some Beneficiaries Were Eligible for the New Adult Group

These four errors in the State agency's determination process occurred because of human errors. Specifically:

- For two beneficiaries receiving SSI income, the State agency's eligibility caseworkers either did not include or misinterpreted SSI income when entering the beneficiary's income from the Medicaid application to the CBMS. For example, one caseworker misinterpreted a beneficiary's SSI income as Social Security Disability Income (SSDI).

- For one beneficiary, an eligibility caseworker incorrectly included exempted income when calculating monthly income. This error granted the beneficiary enrollment in the newly eligible parent/caretaker adult eligibility group when the beneficiary was eligible for the Traditional Medicaid parent/caretaker eligibility group.

- For one beneficiary, an eligibility caseworker did not follow Federal regulations (42 CFR §§ 435.110 and 435.119(c)) about the parent/caretaker definition. CMS comments during Federal Rulemaking state that, if a parent has a child and the child has pending an eligibility determination for medical assistance, then the parent is not eligible for any medical assistance until the child is either approved or denied.[28] The State agency incorrectly claimed a beneficiary under the new adult eligibility group while the beneficiary's dependent child was pending an eligibility determination for medical coverage.

[28] 77 Fed. Reg. 17144, 17146 (Mar. 23, 2012).

*Risk of Claims for Unallowable Reimbursement as a Result of Incorrect Medicaid Eligibility Determination*s

If the State agency does not ensure that beneficiaries are claimed according to their correct eligibility groups, it may claim unallowable Federal reimbursement for payments made on behalf of those beneficiaries (footnote 26).

The State Agency Did Not Always Verify Whether Beneficiaries Met Citizenship Requirements

Federal Requirements

The Act and implementing Federal regulations require States to verify citizenship or nationality status of individuals applying for Medicaid by confirming that those individuals have presented satisfactory documentary evidence of citizenship or nationality. States may verify citizenship or nationality by electronically verifying citizenship status with the Social Security Administration (SSA). However, if a State is unable to verify citizenship or nationality, there is a 90-day inconsistency (that is, reasonable opportunity) period to resolve a discrepancy, during which time the beneficiary is presumed eligible. For details on these Federal requirements, see Appendix E.

Ineligible Beneficiary

The State agency incorrectly determined that 1 of the 60 sampled beneficiaries was newly eligible even though the beneficiary did not meet Federal and State citizenship requirements. Specifically, the CBMS used its electronic interface to try to verify the beneficiary's citizenship in December 2014 and in January, February, and May 2015. In each of these cases, the electronic interface did not verify citizenship.

The State agency sent several discrepancy letters to this beneficiary over a period of several months but did not receive responses to any of them. The electronic interface did not produce a positive data match to verify the beneficiary's citizenship status during the first attempted match in December 2014. That same month, according to information in the CBMS, the State agency sent the beneficiary a discrepancy letter that requested citizenship verification and that gave the beneficiary 90 days—until March 2015—to respond. The beneficiary did not provide satisfactory documentation to resolve the discrepancy by the end of that 90-day reasonable opportunity period. At that point, instead of terminating the beneficiary's Medicaid coverage, the State agency continued performing electronic interfaces to try to verify citizenship and continued sending discrepancy letters to the beneficiary. The State agency terminated the beneficiary's Medicaid coverage in August 2015 after it had sent multiple discrepancy letters with no response to any of them.

Procedural Error in State Agency's Process To Resolve Citizenship Verification Discrepancy

This error in citizenship verification occurred because of a procedural error in the State agency's eligibility verification process. Although the State agency's electronic interface identified a discrepancy (the failed data match) for this beneficiary, and although the State agency sent a discrepancy letter thereafter, State agency staff did not follow its process to terminate Medicaid coverage after a reasonable period to resolve the discrepancy had passed. Specifically, after the State agency was unable to verify the beneficiary's citizenship using the electronic interface, it requested that the beneficiary verify citizenship within the 90-day reasonable opportunity period to resolve the discrepancy. Through an error in its eligibility verification process, though, the State agency did not terminate Medicaid coverage when the beneficiary did not provide satisfactory documentation at the end of that reasonable opportunity period.

Risk of Claims for Unallowable Reimbursement as a Result of Unresolved Discrepancy

If the State agency does not correctly determine Medicaid eligibility in accordance with Federal and State requirements, there is a risk that it will make payments on behalf of ineligible beneficiaries and, in turn, claim unallowable Federal reimbursement for those beneficiaries (footnote 26).

The State Agency Incorrectly Claimed 100-Percent Federal Reimbursement on Behalf of a Beneficiary Who Was Eligible for a Traditional Medicaid Group

Federal Requirements

The ACA authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group. Also, a "newly eligible" individual cannot be under 19 years of age. For details on these Federal requirements, see Appendix E.

Ineligible Beneficiary

The State agency incorrectly claimed enhanced Federal Medicaid reimbursement (100-percent FMAP) on behalf of 1 of the 60 sampled beneficiaries whom it had determined to be eligible for coverage as a MAGI child. (Applicable State regulations for this eligibility group appear at 10 CCR 2505-10 8.100.4.G). Correct Medicaid reimbursement for this eligibility group was at the standard FMAP that was in effect for FY 2015 (51.01 percent FMAP).[29]

[29] Although this report does not question costs or recommend a refund to the Federal Government and although we are not generally able to associate financial impacts with our individual findings (footnote 20), we are able to place the financial impact of this particular finding in context. In the case of this beneficiary, the difference between the incorrectly claimed costs (at the 100-percent FMAP) and what the correctly claimed costs would have been (at the standard FMAP) was $568.85 for the third quarter of CY 2014.

State Agency Inability To Determine Reason for Error, and Risk of Claims for Unallowable Reimbursement as a Result

The State agency researched this deficiency after we identified it but could not identify a cause for the error. If the State agency does not ensure that beneficiaries are claimed according to their correct eligibility groups, it may claim unallowable Federal reimbursement for those beneficiaries (footnote 26).

THE STATE AGENCY MADE MEDICAID PAYMENTS ON BEHALF OF SOME NEWLY ELIGIBLE BENEFICIARIES WHO MAY NOT HAVE MET FEDERAL AND STATE ELIGIBILITY REQUIREMENTS

The State agency made Medicaid payments on behalf of four newly eligible beneficiaries who may not have met Federal and State eligibility requirements.

Delayed Disenrollment of Beneficiaries Whose Income Changed

Federal and State Requirements

Federal regulations specify that individuals who have household income at or below 133 percent of the FPL for the applicable family size may be eligible for Medicaid under the new adult group. The ACA allows for a 5-percent income disregard (footnote 9), making the effective income threshold 138 percent of the FPL.

Federal regulations also require State Medicaid agencies to verify financial information related to wages, net earnings from self-employment, unearned income, and resources. In addition, State Medicaid agencies must verify income using electronic sources and must request additional information or documentation from the beneficiary if the information needed cannot be obtained electronically or if the attested income is not reasonably compatible with electronic sources. Further, State Medicaid agencies must promptly evaluate information that they receive or obtain so as to determine whether the information affects beneficiaries' eligibility or benefits to which they are entitled.

The State agency's verification plan states that income will be verified approximately 2 to 4 months after a beneficiary self-attests and an eligibility determination has been made. If the CBMS determines that income information provided by the beneficiary is not reasonably compatible with income information obtained through the IEVS data match, the CBMS automatically creates a discrepancy letter that is sent to the beneficiary. The beneficiary is provided a 90-day reasonable opportunity period to provide a reasonable explanation of the discrepancy.

For details on these Federal and State requirements, see Appendix E.

Potentially Ineligible Beneficiaries

The State agency correctly determined that 2 of the 60 sampled beneficiaries were eligible for the new adult group; however, because of lags between when a beneficiary's income changed and eventual verification of that change in the CBMS, these 2 beneficiaries might no longer have been eligible to receive benefits.

The State agency's eligibility and income verification processes took up to 9 months. This was a result of delays in electronic reporting of income to the CBMS through data matches, additional delays between when the State agency received information on a change in beneficiary income and when it sent a discrepancy letter to the beneficiary, and delays inherent in the 90-day reasonable opportunity period that the State agency gives the beneficiary to respond to the discrepancy letter. These delays demonstrated that the State agency did not always promptly evaluate the information it had received or obtained so as to determine whether that information affected beneficiaries' eligibility or benefits.

When income attestation and relevant data matches are not reasonably compatible, the State agency's process is for the CBMS to automatically create a discrepancy letter asking the beneficiary for more information about the discrepancy and giving that individual 90 days to respond. For example, one of the two beneficiaries in question had income that exceeded the 138 percent FPL in the second quarter (April to June) of CY 2015. The change in income was reported to the CBMS on September 1, 2015, which was 2 months after the quarter ended. Contrary to the process established in the CBMS, under which a discrepancy letter is automatically created and sent to the beneficiary when the discrepancy has been identified, the State agency did not send a discrepancy letter to the beneficiary regarding this change in income until 3 months later, on December 4, 2015. In accordance with the State agency's process, that discrepancy letter gave the beneficiary an additional 90 days—until March 3, 2016—to respond with information about the change in income.

The beneficiary's income put her over the 138-percent FPL income threshold, but because of delays in electronically verifying income and then resolving the discrepancy, the beneficiary continued to receive medical assistance for approximately 9 months after the beneficiary's income had risen above the limit for Medicaid eligibility. According to the CBMS, the State agency disenrolled this beneficiary on April 30, 2016.

Reliance on Employer-Reported Income and Beneficiary Self-Attestations

The State agency explained that there may be a delay in identifying changes in income because employers might not report employee income to the CDOLE until several months after a quarter ends; consequently, the State agency does not have control over when the data match actually hits the electronic system.

In addition, the State agency's policy is to accept a beneficiary's attestation regarding an identified discrepancy in income. The State agency requests neither hardcopy documentation

of the change in income nor an employer verification. We note that these policies are legally sufficient.

Risks That Result From Delays in Disenrollment

These system and policy vulnerabilities combine to illustrate a risk that is inherent in the State agency's reliance on beneficiary self-attestation. A beneficiary could have already changed jobs by the time he or she is notified of a discrepancy in income or could simply reply to a discrepancy letter by saying that he or she is now working fewer hours, and the State agency has no mechanism to verify the accuracy of those statements.

If a beneficiary is not eligible for Medicaid benefits but continues to receive them, the State agency might make payments on behalf of ineligible beneficiaries and, in turn, claim unallowable Federal reimbursement for those payments (footnote 26).

Eligibility Determinations Were Incorrectly Made on the Basis of Self-Attestations Rather Than Electronically Verified Income

Federal and State Requirements

Federal regulations require State Medicaid agencies to verify financial information related to wages, net earnings from self-employment, unearned income, and resources and to request additional information or documentation from the beneficiary if the information needed cannot be obtained electronically or if the attested income is not reasonably compatible with electronic sources. Federal regulations also require State Medicaid agencies to promptly evaluate information that they receive or obtain so as to determine whether the information affects beneficiaries' eligibility or benefits to which they are entitled.

The State agency's verification plan states that income will be verified approximately 2 to 4 months after a beneficiary applies for medical assistance. If the data match reveals a discrepancy that exceeds the 10-percent reasonable compatibility threshold, the State agency's practice is to mail a discrepancy letter to the beneficiary, with a specified deadline (the 90-day opportunity period) in which to respond. If no response is received, the beneficiary is terminated from Medicaid coverage.

For details on these Federal and State requirements, see Appendix E.

Potentially Ineligible Beneficiaries

The State agency determined that 2 other of the 60 sampled beneficiaries were eligible for the new adult group but, contrary to the provisions of its own verification plan, relied on self-attestations, rather than income verifications, when making those determinations. In both of these cases, the State agency did not promptly evaluate the information it had received or

obtained so as to determine whether the information affected the beneficiaries' eligibility or benefits.

- For one of these two beneficiaries, the State agency was not able to provide any documentation or any record in the CBMS that a data match to verify income had occurred after the beneficiary self-attested to having a second employer.

- The other beneficiary self-attested his income on the application, but the State agency did not verify this reported income through either source documentation or a data match. Comments that State agency caseworkers had entered into the CBMS stated that the beneficiary had not provided verification of employment and added that the State agency had determined eligibility based on the beneficiary's self-attestation of income. Eventually, the State agency made a partial data match with an employer. That did not happen, though, until 8 months after the beneficiary's eligibility determination, and the employer's name in the data did not match the employer's name as attested to on the beneficiary's application.

Procedural Errors in State Agency's Followup Process To Ensure Electronic Verification of Beneficiary Income

These errors were procedural but also pointed to certain policy weaknesses. The root cause of these errors was that the State agency did not always follow up on applications in which the beneficiary had self-attested his or her income but the data match with the employer-reported income either did not occur or did not produce a match (within the 10-percent reasonable compatibility threshold (footnote 14). Our analysis of the beneficiaries we sampled showed that the State agency did not follow up on the beneficiary's application even when the application included information that the data match did not pick up.

Furthermore, the CBMS attempted to identify discrepancies by comparing self-attested income only to the income shown in the data match; this electronic system did not conduct one-to-one employer matches (that is, the system did not match or compare wage and other data from one employer to another for similar jobs). Thus, income from new employment that might not have been captured by the data match would not have been verified—and the State agency might not have followed up on the application to resolve such a discrepancy in income.

Risk of Claims for Unallowable Reimbursement as a Result of Reliance on Self-Attestation Rather Than Electronic Verification of Income

Because these two beneficiaries' eligibility had not been not verified in accordance with Federal and State requirements, we could not determine whether the beneficiaries were eligible for the new adult group or for some other Medicaid coverage group—or whether they were eligible for Medicaid coverage at all.

If a beneficiary is not eligible for Medicaid benefits but continues to receive them, the State agency might make payments on behalf of ineligible beneficiaries and, in turn, claim unallowable Federal reimbursement for those payments (footnote 26).

CONCLUSION

Our review found that the State agency did not always correctly determine Medicaid eligibility in accordance with Federal and State requirements. If the State agency does not ensure that costs for all Medicaid beneficiaries are claimed according to those beneficiaries' correct eligibility groups, it might claim unallowable Federal reimbursement for some of those beneficiaries.

On the basis of our sample results, we estimated that the financial impact of the incorrect eligibility determinations made by the State agency totaled at least $66,525,688 on behalf of 85,085 ineligible beneficiaries and at least $26,797,483 on behalf of 13,372 potentially ineligible beneficiaries. Because Federal reimbursement under the ACA was at 100 percent of the FMAP, the amounts identified as financial impacts were entirely Federal, not State, dollars. See also footnote 20 and Appendix D.

RECOMMENDATIONS

We recommend that the State agency:

- redetermine, as appropriate, the current Medicaid eligibility status of the sampled beneficiaries who did not meet Federal and State eligibility requirements, with specific attention to:
    - beneficiaries who did not meet income requirements,
    - beneficiaries who were eligible under a mandatory Medicaid eligibility group,
    - beneficiaries who did not meet citizenship requirements, and
    - beneficiaries who were not eligible for the new adult group but for whom the State agency claimed enhanced Federal Medicaid reimbursement;
- improve the CBMS to ensure that:
    - it verifies income and determines eligibility by using available electronic data sources on a timely basis,
    - it has system functionality to terminate Medicaid coverage for beneficiaries who do not provide satisfactory documentation to resolve a citizenship discrepancy after the reasonable opportunity period ends,

- the coding errors affecting eligibility determinations are identified and addressed in a timely manner, and

- it has the ability to verify income that is self-attested by beneficiaries on a timely basis and through multiple sources, to include one-to-one employer matches;

- implement in the CBMS system functions to ensure that:

  - benefits of ineligible beneficiaries are terminated in a timely manner and

  - income verifications are requested from beneficiaries when electronic verification does not occur within 4 months of application;

- improve the accuracy of manually input case actions by:

  - providing eligibility caseworkers with clear policies, procedures, and guidance on eligibility determinations that comply with Federal and State requirements and that address, among other things, income calculations and parent and caretaker definitions,

  - providing training to and monitoring of caseworkers to improve manual input accuracy, and

  - implementing a process to identify and review manually input eligibility data; and

- implement a process whereby it resolves discrepancies more promptly by reducing the time between the identification of a discrepancy and the dispatch of a discrepancy letter to the beneficiary.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency stated that it agreed with our recommendations and said that it had already implemented the necessary changes to correct the system and coding errors we identified. The State agency said that our review was duplicative of other Federal and State reviews, including the State agency's MEQC and internal reviews, quarterly CMS reviews, and annual reviews performed by the Colorado Office of the State Auditor. The State agency added that because the coding errors affecting eligibility determination had been identified and addressed "prior to the [Office of Inspector General (OIG)] Audit," it did not need to take additional action based on our report.

The State agency also said that it found that 7 beneficiaries (of the 17 ineligible and potentially ineligible beneficiaries we identified) remained "correctly eligible" following the resolution of the errors we had identified; 10 others, it said, had been redetermined to be ineligible because of changes in the beneficiaries' circumstances that occurred since our audit period. The State agency described corrective actions that it had taken, in specified timeframes as early as October 2014 and as late as June 2018, as well as the resulting eligibility determinations or redeterminations.

Additionally, the State agency referred to CMS policy guidance regarding implementation of the ACA, which directed States to implement new eligibility review pilots for FYs 2014 through 2017—a timeframe, the State agency noted, that bracketed our audit period—in place of the MEQC reviews. The State agency cited a Proposed Rule and CMS guidance that stated that CMS had suspended financial recoveries for errors identified through the pilot programs.[30] CMS guidance, according to the State agency, sought to give States the opportunity "to come into compliance with the ACA by overhauling their eligibility systems without the threat of recovery for erroneous payments made during the [pilot] period."

With respect to our statistical estimates, the State agency said that our sample size was too small, which caused an "extreme range" between the lower and upper limits of the estimates and an overestimated extrapolation of our estimated number of ineligible beneficiaries and our estimated improper payments.

The State agency's comments appear in their entirety as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations remain valid. With respect to the State agency's characterization of our review as duplicative of other Federal and State reviews, the fact that our review identified similar issues as the other reviews strengthens the validity of our findings. These findings and the associated procedural recommendations, taken together, demonstrate the need for the State agency to improve the accuracy of Medicaid eligibility determinations and to pursue corrective actions that will prevent a recurrence of similar issues.

Moreover, we disagree with the State agency's statement that it had identified and addressed, before our audit, the system errors we describe in this report. If these system errors had been identified and corrective actions implemented on a systemic basis before our audit, many of the findings that we report on here would have been subjected to corrective action before or during our audit period. We did not find evidence of corrective actions relevant to our findings,

[30] The State agency cited the Proposed Rule at 81 Fed. Reg. 40596, 40602 (Jun. 22, 2016) and CMS guidance in *CMS Medicaid & CHIP Eligibility Review Pilot Guidance, Pilot: 1st Round, Due June 2014* (Oct. 2016). We note that the Final Rule was published in 82 Fed. Reg. 31158, 31161 (Jul. 5, 2017).

and the State agency did not identify or otherwise provide evidence that it had already taken corrective actions. For example, with respect to our finding on eight sampled beneficiaries who did not meet income requirements, the State agency said that one error involved a beneficiary for whom the State agency did not count "an interfaced income record" (that is, income earned by the beneficiary's spouse).[31] This error occurred because the system was not sending out discrepancy letters in a timely manner. The State agency's comments indicated that this error was corrected in June 2018, but the State agency did not specify whether it only corrected the error for this one beneficiary or whether it addressed the system error. The State agency had not, as of the conclusion of our audit work in November 2018, reported this error to us as resolved or provided documentation to explain what corrective action it took in June 2018.

Furthermore, although the State agency said that it found that several beneficiaries remained eligible following the resolution of the errors we identified, it did not provide any additional documentation to support these redeterminations. Nor did the State agency explain whether the timeframes for which it had determined that these beneficiaries were eligible coincided with or followed the timeframes for which we had identified these beneficiaries as ineligible or potentially ineligible.

With the exception of the State agency's comments on our subrecommendation regarding training of caseworkers, its descriptions of corrective actions lacked specificity. In addition, these descriptions appeared to be restricted to corrections of the errors identified with respect to our sampled beneficiaries; the descriptions did not focus more broadly on systemic corrections. Accordingly, we cannot ascertain what specific system corrections the State agency has undertaken or plans to undertake to correct the system errors.

The verification of corrective actions on a system-wide basis is beyond the scope of this audit. Verification of corrective actions will take place during audit resolution between the State agency and CMS, the cognizant HHS operating division.

With respect to the State agency's comments on financial recoveries for errors identified through eligibility review pilot programs, our report only estimates the potential financial impact of the incorrect eligibility determinations (at the lower limit, as discussed below) but does not recommend any financial recovery. See also footnotes 20 and 26.

Regarding the State agency's comment on our statistical sampling and extrapolation methodology, small sample sizes, e.g., smaller than 100, have routinely been upheld by the Departmental Appeals Board and Federal courts. See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 10 (E.D.N.Y. 2012) (upholding a sample size of 95 claims) and *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *30-31 (S.D. Tex. 2012) (upholding a sample size of 30 claims). The

[31] See "The State Agency Incorrectly Determined Some Beneficiaries' Eligibility Groups Based on Income Requirements" earlier in this report. The beneficiary in question is the one to whom, as we explain in that section, a discrepancy letter was not sent until 3 months after the discrepancy in income had been reported to the CBMS.

legal standard for a sample size is that it must be sufficient to be statistically valid, not that it be the most precise methodology. See *John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014) and *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012).

Because absolute precision is not required, any imprecision in the sample may be remedied by reporting the results of the projection to the lower limit, which was done in this audit. See *Pruchniewski v. Leavitt*, 2006 U.S. Dist. LEXIS 101218 at *51-52 (M.D. Fla. 2006). This approach results in an estimate that is lower than the estimated financial impact 95 percent of the time, and thus it generally favors the auditee. See *Puerto Rico Dep't of Health*, DAB No. 2385, at 10 (2011) and *Oklahoma Dep't of Human Servs.*, DAB No. 1436, at 8 (1993) (stating that the calculation of the disallowance using the lower limit of the confidence interval gave the State the "benefit of any doubt" raised by use of a smaller sample size).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 579,070 beneficiaries determined to be newly eligible for Medicaid under the ACA (excluding American Indians and Alaska Natives) for whom the State agency made Medicaid payments from January 1, 2014, through September 30, 2015, for services provided during that period. We reviewed the Medicaid eligibility determinations made by the State agency for a simple random sample of 60 beneficiaries classified as newly eligible (footnote 18) to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the new adult group.

We limited our review of internal controls to those applicable to our objective. Specifically, we gained an understanding of the State agency's policies and procedures for determining the eligibility of applicants using CBMS and reviewed the internal controls for eligibility determinations and verifications that the State agency had in place during our audit period.

We conducted our audit work from November 2017 to November 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility;

- reviewed the Colorado State plan and SPA and the State agency's verification plan (which describes the State agency's policies and procedures related to verifying an applicant's citizenship and lawful presence status), income, entitlement to and enrollment in Medicare, and other requirements for determining and redetermining Medicaid eligibility;

- obtained an understanding of internal controls by:

    - interviewing officials from the State agency to obtain an understanding of how CBMS (1) processes an applicant's information, (2) verifies an applicant's eligibility for enrollment in Medicaid, and (3) transmits enrollment data to the MMIS;

    - holding discussions with State agency officials to obtain an understanding of policies, procedures, and guidance for determining and redetermining Medicaid eligibility;

- performing walk-throughs of the information provided by applicants to gain an understanding of how the information is used in determining eligibility and of the State agency's process for verifying enrollment in Medicaid; and

- determining how the eligibility system documents that the verification and determination of eligibility processes occurred;

- obtained a database of all Medicaid paid claims data in Colorado with service dates during the audit period (excluding claims for services provided to American Indians and Alaska Natives, who are already covered at a 100-percent FMAP);

- created a sampling frame of 579,070 Medicaid beneficiaries for whom the State agency made Medicaid payments totaling $2,246,254,206 (which amount was 100-percent Federal share) (Appendices C and D);

- selected a simple random sample of 60 Medicaid beneficiaries receiving services in Colorado during the audit period (footnote 18 and Appendices C and D); and,

- for each sampled beneficiary, obtained, where possible, application data and documentation to support the eligibility determination made, and determined:

    - whether the State agency followed Federal and State requirements and its own procedures to verify eligibility documentation when making the eligibility determinations and

    - whether beneficiaries determined to be newly eligible under provisions described in the ACA met Federal and State eligibility requirements, such as income level, residence, immigration status, and documentation of U.S. citizenship;

- estimated the total number of ineligible beneficiaries and beneficiaries who were potentially not newly eligible during our audit period;

- estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible beneficiaries and beneficiaries who potentially were not newly eligible during our audit period; and

- discussed the results of our review with State agency officials on May 23, 2018.

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
New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries	A-02-16-01005	7/17/2019
California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	A-09-17-02002	12/11/2018
California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	A-09-16-02023	2/20/2018
New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A-02-15-01015	1/5/2018
Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance with Federal and State Requirements	A-04-16-08047	8/17/2017
Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A-04-15-08044	5/10/2017

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of beneficiaries who were determined to be newly eligible for Medicaid under the ACA (excluding American Indians and Alaska Natives[32]) for whom the State agency made Medicaid payments for services provided during our audit period (January 1, 2014, through September 30, 2015).

SAMPLING FRAME

The sampling frame consisted of 579,070 newly eligible beneficiaries in Colorado for whom Medicaid payments were made for services provided from January 1, 2014, through September 30, 2015. The State agency made Medicaid payments totaling $2,246,254,206 (which was 100-percent Federal share) for these beneficiaries. We obtained the data for the Medicaid beneficiaries from Colorado's MMIS.

SAMPLE UNIT

The sample unit was a newly eligible Medicaid beneficiary.

SAMPLE DESIGN

We used a simple random sample of all newly eligible Medicaid beneficiaries who received services during our audit period.

SAMPLE SIZE

We selected a sample of 60 beneficiaries.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the Medicaid claims. After generating the random numbers, we selected the corresponding Medicaid beneficiaries in the sampling frame for our sample.

[32] American Indians and Alaska Natives are subject to different eligibility requirements that were not a part of this review.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to calculate the point estimates and 90-percent confidence intervals for the total number of ineligible and potentially ineligible Medicaid beneficiaries in the sampling frame. This software was also used to calculate the point estimates for the total dollar value of payments made for ineligible and potentially ineligible Medicaid beneficiaries. The 90-percent confidence intervals for these latter estimates were calculated using the empirical likelihood approach, which was programmed using Microsoft Excel.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Table 1: Sample Detail and Results for Ineligible Beneficiaries

	Number of Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
Total	579,070	$2,246,254,206	60	$225,351	14	$12,695

Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries

	Number of Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
Total	579,070	$2,246,254,206	60	$225,351	4	$8,991

ESTIMATES

Table 3: Estimated Number of Ineligible Beneficiaries and Value of Improper Payments

(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Ineligible Beneficiaries	Total Value of Payments for Ineligible Beneficiaries
Point Estimate	135,116	$122,523,781
Lower Limit	85,085	$66,525,688
Upper Limit	197,159	$218,704,996

Table 4: Estimated Number of Potentially Ineligible Beneficiaries and Value of Improper Payments

(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Potentially Ineligible Beneficiaries	Total Value of Payments for Ineligible Beneficiaries
Point Estimate	38,605	$86,777,017
Lower Limit	13,372	$26,797,483
Upper Limit	84,598	$212,929,387

APPENDIX E: FEDERAL AND STATE REQUIREMENTS

FEDERAL AND STATE REQUIREMENTS FOR MEDICAID ELIGIBILITY DETERMINATIONS

Federal and State Requirements Pertaining to Eligibility Based on Income

In accordance with the Act and the ACA, State Medicaid agencies claimed Federal Medicaid reimbursement for newly eligible Medicaid beneficiaries at 100-percent FMAP through CY 2016 (the Act § 1905(y)(1) and the ACA § 2001). In addition, individuals who have household income at or below 133 percent of the FPL for the applicable family size may be eligible for Medicaid under the new adult group (42 CFR § 435.119(b)(5)). The ACA allows for a 5-percent income disregard, making the effective income threshold 138 percent of the FPL (the Act § 1902).

Federal regulations require State Medicaid agencies to verify financial information related to wages, net earnings from self-employment, unearned income, and resources from the State Wage Information Collection Agency (SWICA), IRS, SSA, and State unemployment insurance (42 CFR § 435.948(a)(1)). The State agency must request additional information or documentation from the beneficiary if the attested income is not reasonably compatible with electronic sources (42 CFR § 435.952(c)(2)).

The PRWORA includes requirements for determining the eligibility and amount of benefits of an alien for any means-tested public benefits program.[33] Under these provisions, the income and resources of the alien are deemed to include the income and the resources of any person who executed an affidavit of support as provided by section 213A of the Immigration and Nationality Act of behalf of the alien (i.e., an alien sponsor) (PRWORA § 421(a)).

The PRWORA also specifies that a State is authorized to provide that the income and resources of the alien are deemed to include that of the sponsor for any State public benefits (§ 422(a)). Colorado State regulations convey this provision (10 CCR 2505-10 8.100.3.K) but make an exception for aliens who are pregnant or are children.

Further, during Federal Rulemaking, commenters asked whether alien sponsor deeming would still apply under MAGI policies for Medicaid. CMS confirmed that nothing in the ACA changed the requirements, cited above, in PRWORA § 421.[34]

[33] Federal healthcare benefits are generally allowable when provided to a beneficiary who is either a U.S. citizen or a U.S. national or to an alien who is lawfully present in the United States. But when the alien beneficiary is not lawfully present in the United States, Federal healthcare benefits are not allowable (8 U.S.C. § 1611).

[34] 77 Fed. Reg. 17144, 17153 (Mar. 23, 2012).

Federal and State Requirements Pertaining to Enrollment in Correct Medicaid Eligibility Group

If an individual is eligible for Medicaid through any mandatory category, the individual cannot be enrolled in Medicaid as newly eligible (the Act § 1902(a)(10)(A)(i)).

Federal regulations for the new adult group allow parents or caretakers living with a dependent child—and who meet the rest of the eligibility criteria—to be eligible for the new adult group (42 CFR § 435.110). Colorado regulations require the State agency to affirm that parents and caretaker relatives applying for medical assistance have a dependent child in the household (10 CCR 2505-10 8.100.4.G).

Additionally, a dependent child's parent or caretaker is not eligible under the new adult group "unless such child is receiving benefits under Medicaid, [CHIP] . . . or otherwise is enrolled in minimum essential coverage as defined by § 435.4 of this part" (42 CFR § 435.119(c)).

The MAGI adult expansion category includes parents or caretaker relatives aged 19 through 64 with income that ranges from 69 percent to 133 percent of the FPL[35] (10 CCR 2505-10 8.100.4.G and Colorado State Medicaid plan, SPA 13-0045).

Federal Requirements Pertaining to Eligibility Based on Citizenship

To verify citizenship or nationality status of beneficiaries applying for Medicaid, States must confirm that those individuals declaring to be citizens or nationals of the United States have presented satisfactory documentary evidence of citizenship or nationality (the Act § 1903(x)). States may verify citizenship or nationality by electronically verifying status with SSA (42 CFR §§ 435.406 and 435.949). However, if a State is unable to verify citizenship or nationality, there is a 90-day inconsistency (that is, reasonable opportunity) period to resolve a discrepancy (the Act § 1902(ee)), during which time the beneficiary is presumed eligible. In addition, the State agency "must promptly evaluate information received or obtained by it . . . to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled" (42 CFR § 435.952(a)).

Federal Requirements Pertaining to Eligibility for the New Adult Group

The ACA § 2001 authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group. Federal statute states: "The term 'newly eligible' [new adult group] means, with respect to an individual described in [the Act § 1902(a)(10)(A)(i)(VIII)], an individual who is *not* under 19 years of age (or such higher age as the State may have elected)" (the Act § 1396d(y)(2)(A)) (emphasis added).

[35] The Act § 1902 established the FPL income threshold at 133 percent but allows for a 5-percent income disregard (a standard deduction applied to calculate income for Medicaid), making the effective threshold 138 percent of the FPL.

FEDERAL AND STATE REQUIREMENTS FOR VERIFICATION OF CHANGES IN INCOME

Individuals who have household income at or below 133 percent of the FPL for the applicable family size may be eligible for Medicaid under the new adult group (42 CFR § 435.119(b)(5)). The ACA allows for a 5-percent income disregard, making the effective income threshold 138 percent of the FPL (the Act § 1902).

The State agency must verify financial information related to wages, net earnings from self-employment, unearned income, and resources from SWICA, IRS, SSA, and State unemployment insurance (42 CFR § 435.948(a)(1)). Federal regulations also state that income will be verified using electronic sources (42 CFR § 435.948(b)) and add that the State agency must request additional information or documentation from the beneficiary if the information needed cannot be obtained electronically or if the attested income is not reasonably compatible with electronic sources (42 CFR § 435.952(c)(2)). In addition, the State agency "must promptly evaluate information received or obtained by it . . . to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled" (42 CFR § 435.952(a)).

The State agency's verification plan (required under 42 CFR § 435.945(j)) says that the State agency will verify income on a post-eligibility basis using data matches approximately 2 to 4 months after a beneficiary self-attests income and an eligibility determination has been made.[36]

[36] The verification plan is a standalone document, separate from the State Medicaid plan and from any of the SPAs. Although this document is undated, the State agency confirmed to us during our review that its provisions were applicable for our entire audit period.

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

June 12, 2019

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 E. 12th Street, Room 0429
Kansas City, MO 64106

Re: Report Number A-07-16-04228

Dear Mr. Cogley:

Enclosed is the Department of Health Care Policy and Financing's response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries.*

If you have any questions or need additional information, please contact Delora Hughes-Wise at 303-866-4155 or at delora.hughes-wise@state.co.us.

Sincerely,

Donna Kellow
Audits and Compliance Division Director

DK:dhw

Cc: Mary Marchioni, Acting Associate Regional Administrator for
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Center for Medicare & Medicaid Services, Region VIII

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Colorado Department of Health Care Policy and Financing Response to the Department of Health and Human Services Office of Inspector General Audit Report Titled Colorado Medicaid Eligibility for Newly Eligible Beneficiaries Under the Affordable Care Act (A-07-16-04228)

General Comments: OIG Audits Same Timeframe as Other Auditors to Produce Same Findings

The Department appreciates the work of the OIG and other auditors who identify incorrect eligibility determinations and payments. This work is valuable to maintain the credibility of the Medicaid program. In addition, it allows timely corrections to be made when the Department is focused on the interpretation and implementation of complex federal rules. Implementing changes under ACA required a significant redesign of our eligibility operations and systems. Such audits are necessary so that the Department can correct errors going forward. As detailed in the Department's response to the recommendations, the system and coding errors affecting eligibility determination were previously identified and have already been addressed and implemented by the Department.

Review of Eligibility Finds Vast Majority of Clients Eligible

The errors and recommendations provided by Department of Health and Human Services Office of Inspector General (OIG) Audit Report, titled Colorado Medicaid Eligibility for Newly Eligible Beneficiaries Under the Affordable Care Act (A-07-16-04228), is a duplication of previous audits. Because of this duplication, the audit provides recommendations already addressed by the Department. In addition, the Colorado Department of Health Care Policy and Financing (Department) finds that several beneficiaries remain correctly eligible following the resolution of the error identified through the report. Several others have since been redetermined ineligible due to changes in the beneficiaries' circumstances that occurred since the review period (January 1, 2014 through September 30, 2015). Based on this information, the Department find the OIG's estimated number of ineligible beneficiaries identified in the audit to be inaccurate; it also finds the audit's interpretation of the value of improper payments to be an inaccurate reflection of the Department's eligibility determinations during the audit period.

Redundant Findings from Previous Audits

The Department agrees with the OIG's recommendations and has already implemented the necessary changes to correct the errors found in the report. As state, these errors were previously identified through other state and federal reviews. Specifically, the OIG's work is duplicative of: the Department's internal reviews, the Department's Medicaid Eligibility Quality Control (MEQC) reviews, county Medical Eligibility Quality Improvement Program (MEQIP) reviews, Centers for Medicare and Medicaid Services' (CMS) quarterly reviews, and annual Single Statewide eligibility audits performed by the Colorado Office of the State Auditor.

As detailed in the Department's response to the recommendation below, the system and coding errors affecting eligibility determination were previously identified, addressed and implemented by the Department prior to the OIG audit. Therefore, the Department does not need to take additional action based on the system and coding findings in this report.

Federal Government Understood – *and Communicated Its Understanding* – That There Would Be Errors When Implementing Substantial Changes Mandated by the ACA

All of the cases audited by the OIG are related to the Department's implementation of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) ("ACA"). CMS has recognized that the ACA made "significant changes to Medicaid and CHIP eligibility," which "required states to redesign many Medicaid business operations, systems, and interactions with other state and federal partners." (SHO #15-004, p.1, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho15004.pdf.)

Because of the changes in the way that states make eligibility determinations under the ACA, CMS directed states to implement new eligibility review pilots for fiscal years 2014–2017 in place of Medicaid Eligibility Quality Control (MEQC) reviews, performed to comply with section 1903(u) of the Act. (See SHO #15-004, pp. 1–2.) One of CMS' stated goals for the pilots is to "provide more targeted, detailed information on the accuracy of eligibility determinations." (SHO #13-005, pp. 2–3. available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-005.pdf) *To facilitate improvements in state's eligibility determinations under ACA, CMS has suspended recoveries—including payment reductions and disallowances—for errors identified through the MEQC pilot programs. (81 FR 40596, 40602; CMS Medicaid & CHIP Eligibility Review Pilot Guidance, Pilot: 1st Round, Due June 2014, Issued: Oct. 2013, p.6.)*

For Colorado, implementing changes under the ACA required a significant redesign of our eligibility operations and systems. Beginning in 2013, the Department began modifying the Colorado Benefits Management System (CBMS) to make ACA federally mandated eligibility determinations, including the use of MAGI methodologies for income determinations and household composition. The Department then began a process of continually adjusting CBMS and related operations in response to additional federal guidance clarifying eligibility determinations. This process of implementing complex new rules with evolving federal guidance has been reflected in the results of the OIG review. Therefore, the Department agrees with the federal guidance, as provided through the changes to the MEQC reviews, *that it should not be financially penalized for putting forward a good faith effort to implement the ACA and making some eligibility determination errors during the implementation.* This is particularly true since the OIG sample period directly corresponds to the ACA implementation. This outcome is exactly what CMS sought to avoid by implementing the policy of the MEQC pilots – to give states the opportunity to come into compliance with the ACA by overhauling their eligibility systems without the threat of recovery for erroneous payments made during the period. It is also important to note that reimbursements for erroneous payments associated with ineligible individuals can only be recovered if the state's error rate exceeds 3% — a rate which has never been set for Colorado. 42 U.S.C. § 1396b(u)(1)(A). As such the Department should not be penalized for the results of this review, even if it were correct.

Small Sample Size Leads to Overestimated Extrapolation

In the report, the OIG used a sample size of 60 newly eligible Medicaid members, from a population of 579,070 newly eligible members, as its basis for extrapolation. For additional

perspective on common techniques used to determine appropriate sample size, this selection implies a margin of error of 10.6% at a 90% confidence interval. Common practices target closer to a 4-5% margin of error, which would imply a needed sample size between 270 and 423 individuals. The OIG provides a range of estimated dollars associated with its findings, which recognizes the variability inherent in the small sample size. Because of this there is more than a $150 million difference between the lower and upper limits of the estimate. Such an extreme range caused by a small sample size is a factor to why the Department finds the OIG's estimated number of ineligible beneficiaries and value of improper payments to be an inaccurate reflection of the Department's eligibility determinations during the audit period.

Further, the Department questions the OIG's calculations. For additional context related to other credibility thresholds, CMS requires 2,000 average monthly members for historical experience to be deemed 100% credible for Medicare Advantage bids. This guideline is in place to mitigate variability in projected costs from year to year. Additionally, published studies suggest that full credibility for Medicaid populations varies by type of population ranging between 1,000 and 5,000 members. The use of the small sample size by the OIG should be recognized as a limiting factor when interpreting and extrapolating the estimated number of ineligible beneficiaries and value of improper payments in the report.

The OIG report notes that five beneficiaries were determined to be either eligible or enrolled in a traditional Medicaid category. The footnote on page 8 of the report notes the value of expenditures for all 14 of these members is based on 100% of medical expenditures, while five of the 14 beneficiaries would have otherwise been non-newly eligible and the Department could collect the standard Federal Match rate, which was 50% in 2014. Based on this, the OIG's estimated number of ineligible beneficiaries and the calculated value of improper payments is overestimated. In addition, the OIG sample is solely based on individuals enrolled and who had expenditures during the sample period, so any errors would automatically generate a cost that could be extrapolated. However, there may have been instances when errors in eligibility determinations placed beneficiaries in the traditional Medicaid category or had no associated costs. In these cases, the result would have been lower Medicaid expenditures which would offset the financial impact of the findings noted in OIG's report. To accurately estimate the financial implications of eligibility errors, the errors that result in both savings and costs would need to be considered.

Furthermore, the newly eligible Medicaid beneficiaries sampled in the report were subject to several factors during the first two years of their eligibility. For example, the majority of newly eligible members may not have been previously eligible for health insurance, and therefore had pent-up health care needs resulting in higher utilization of services. Additionally, it took several months for many of the eligible members to become aware, apply and enroll in Medicaid. This resulted in a materially different average duration for members depending upon when they were enrolled. For example, within the January 2014 – September 2015 period used in the report, beneficiaries enrolled in January 2014 may have been eligible for Medicaid for the full 21 months, while members who did not enroll until late 2014 may have had 12 or fewer months of eligibility and therefore fewer months available to incur claims. This means there is an inherently different expected cost for individuals along the enrollment spectrum, due to both average duration and a disproportionate level of pent-up demand for services at varied

points within the 21-months. The lack of consideration for member duration as compared between the full newly eligible Medicaid population, the 60-member sample size, and the individuals identified as being ineligible leaves many unknowns as to the validity of extrapolating the results to the entire newly eligible Medicaid population utilizing services. This uncertainty should be considered in any review or action taken based on the estimated in the report.

Based on this information, the Department finds the OIG's estimated number of ineligible beneficiaries and value of improper payments finding do not represent actual dollars or an overpayment. In addition, the estimates are duplicative of other dollar amounts provided through other audits. Therefore, these payments do not represent an actual over-expenditure of state General Fund or federal funds. As such, the federal share of these likely questioned costs cannot be recovered by the federal government. The projected amount is a mathematical calculation of likely questioned costs that does not represent actual money or potential future savings. Further, since the Department has already corrected the findings based on work from previous audit reports, it would expect a corresponding reduction in federal expenditures once the errors had been corrected, which has not been the case.

OIG Recommendations and Department Responses

We recommend that the State agency:

- *Redetermine, as appropriate, the current Medicaid eligibility status of the sampled beneficiaries who did not meet Federal and State eligibility requirements, with specific attention to:*
    - *beneficiaries who did not meet income requirements,*
    - *beneficiaries who were eligible under a mandatory Medicaid eligibility group,*
    - *beneficiaries who did not meet citizenship requirements, and*
    - *beneficiaries who were not eligible for the new adult group but for whom the State agency claimed enhanced Federal Medicaid reimbursement.*

Department Response:

The Department has already implemented the necessary changes as these errors were previously identified through numerous other state and federal reviews. The Department notes that 41% or seven beneficiaries remain correctly eligible following the resolution of the errors identified through the report while ten have since been redetermined ineligible due to changes in the beneficiary's circumstances that occurred since the review period (January 1, 2014 through September 30, 2015). Specifically, to this recommendation:

- Three errors were cited due to a misprint in the correspondence that was corrected in July 2015. Through the redetermination process, two beneficiaries were determined to be approved for the correct Medicaid category.
- One error was cited for the medical eligibility spans not closing timely. This was corrected in October 2014 and the beneficiary's eligibility has since been redetermined.

- One error was cited for incorrectly using the Social Security Income of a child to determine the household's member eligibility. This was corrected in October 2015 and the beneficiary's eligibility has since been redetermined.
- One error was cited for not counting an interfaced income record to determine the beneficiary's eligibility. This was corrected in June 2018 and the beneficiary's eligibility has since been redetermined.
- One error was cited for not meeting income requirements based on the existing calculation of sponsorship income. The Department finds that CBMS is working as designed and any change to the current process requires further federal policy clarification. The Department has requested additional guidance from CMS and is waiting on this guidance. The beneficiary has since been redetermined eligible.
- One error cited for not meeting income requirements was a data entry error where updated income information was received but the case worker failed to enter this information into CBMS. The beneficiary's eligibility has been reassessed, with updated income, and through this reassessment the beneficiary was approved for the correct Medicaid category.
- One error was cited for a mother placed in the incorrect category while her child was pending an enrollment fee – this was corrected April 2015. Through the redetermination process the beneficiary was determined to be approved for the correct Medicaid category.
- One error was cited for incorrectly using the Social Security Income of a child to determine the household's member, eligibility which caused the mother of the child to be placed in the incorrect category. This was corrected in October 2015. Through the redetermination process the beneficiary was determined to be approved for the correct Medicaid category.
- Two errors were cited when beneficiaries were placed in an incorrect category. These were data entry errors where the case workers entered Social Security Income as Social Security Disability Income. Both data entry errors were corrected by the case worker or by an interface shortly after the errors occurred. The beneficiaries' eligibility has been reassessed and through this reassessment both beneficiaries were approved for the correct Medicaid category.
- One error was cited when the beneficiary did not meet the citizenship requirement because of a system-caused error when CBMS did not timely deny the beneficiary for not meeting the citizenship requirement, which was corrected in November 2015. The beneficiary's eligibility has since been redetermined.
- One error was cited when the beneficiary did not meet the MAGI Adult requirement because of a manual process error that was used to create the CMS 64 in the legacy system. Counter to the error in the CMS 64 data, the beneficiary's classification actually matches in the Department's eligibility and claims processing systems.

We recommend that the State agency:

- *Improve the CBMS to ensure that:*
    - *it verifies income and determines eligibility by using available electronic data sources on a timely basis,*
    - *it has system functionality to terminate Medicaid coverage for beneficiaries who do not provide satisfactory documentation to resolve a citizenship discrepancy after the reasonable opportunity period ends,*
    - *the coding errors affecting eligibility determinations are identified and addressed in a timely manner, and*
    - *it has the ability to verify income that is self-attested by beneficiaries on a timely basis and through multiple sources, to include one-to-one employer matches.*

Department Response:

The system and coding errors affecting eligibility determination were previously identified and have already been addressed and implemented by the Department prior to the OIG ACA Eligibility Audit A-07-16-04228. Specifically, to this recommendation:

- Two errors were cited for giving multiple reasonable opportunity periods for the beneficiary to confirm their income. This was corrected in December 2016.
- One error was cited when the beneficiary did not meet the citizenship requirement. This was a system-caused error when the CBMS did not timely deny the beneficiary for not meeting the citizenship requirement. This was corrected in November 2015.
- One error was cited when the beneficiary's income did not include one-to-one employer match on a timely basis and through multiple sources. In this sample the beneficiary reported two jobs, but the electronic source confirmed one job. The income amount of the two jobs reported by the beneficiary was found compatible with the electronic source. It is allowable policy for the total income to match if missing one job and the aggregate amounts of income from two jobs. The Department has determined the CBMS is functioning as designed and as approved by CMS.

We recommend that the State agency:

- *Implement in the CBMS system functions to ensure that:*
    - *benefits of ineligible beneficiaries are terminated in a timely manner and*
    - *income verifications are requested from beneficiaries when electronic verification does not occur within 4 months of application.*

Department Response:

The system errors affecting eligibility determination were previously identified and have already been addressed and implemented by the Department prior to the OIG ACA Eligibility Audit A-07-16-04228. Specifically, to this recommendation:

- Two errors were cited for giving multiple reasonable opportunity periods for the beneficiary to confirm their income. This was corrected in December 2016.
- One error was cited for the income interface failing to update the case. This was corrected in June 2018.
- One error was cited for giving multiple reasonable opportunity periods for the beneficiary to confirm their income. This was corrected in December 2016.

We recommend that the State agency:

- *Improve the accuracy of manually input case actions by:*
    - *providing eligibility caseworkers with clear policies, procedures, and guidance on eligibility determinations that comply with Federal and State requirements and that address, among other things, income calculations and parent and caretaker definitions,*
    - *providing training to and monitoring of caseworkers to improve manual input accuracy, and*
    - *implementing a process to identify and review manually input eligibility data.*

Department Response:

The accuracy errors affecting eligibility determination were previously identified and additional training has already been implemented by the Department prior to the OIG ACA Eligibility Audit A-07-16-04228. Specifically, to this recommendation:

- The Department's Staff Development Center (SDC) is staffed by 14 individuals to train and support more than 4,500 statewide CBMS users, which include 64 County Departments. The SDC is responsible for training on CBMS using a Process-Based Training model that provides consistent CBMS data entry training, policy, eligibility information, timeliness and case file documentation regardless of the program area. The Department has engaged with the SDC to train on the issues identified in this audit.

We recommend that the State agency:

- *Implement a process whereby it resolves discrepancies more promptly by reducing the time between the identification of a discrepancy and the dispatch of a discrepancy letter to the beneficiary.*

Department Response:

The system errors affecting eligibility determination were previously identified and have already been addressed and implemented by the Department prior to the OIG ACA Eligibility Audit A-07-16-04228. Specifically, to this recommendation:

- Two errors were cited for giving multiple reasonable opportunity periods for the beneficiary to confirm their income. This was corrected in December 2016.