Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

UTAH GENERALLY COMPLETED MEDICAID ELIGIBILITY ACTIONS DURING THE UNWINDING PERIOD IN ACCORDANCE WITH FEDERAL AND STATE REQUIREMENTS

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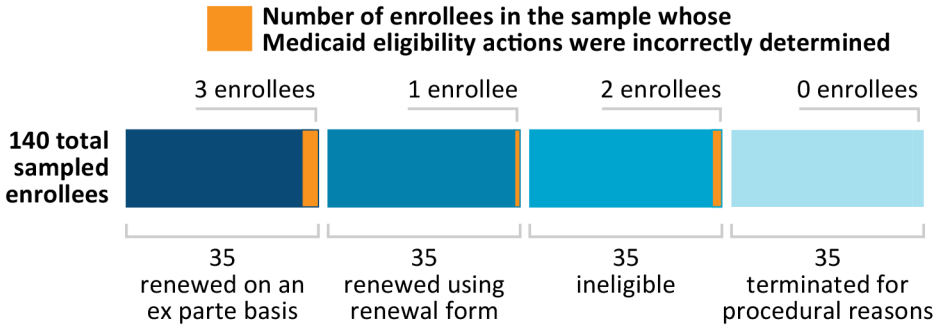
Utah Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

Why OIG Did This Audit

- In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure that most individuals were continuously enrolled for Medicaid benefits (enrollees).
- The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees, including terminating Medicaid enrollment of ineligible individuals.
- This audit of Utah is part of a series of audits examining whether States completed Medicaid eligibility actions during their unwinding periods in accordance with Federal and State requirements.

What OIG Found

Of the 193,009 enrollees who had their Medicaid eligibility renewed or coverage terminated during April 1 through September 30, 2023 (audit period), we sampled 140 enrollees and determined that Utah incorrectly completed Medicaid eligibility actions for 6 enrollees.



On the basis of our sample results, we estimated that Utah incorrectly renewed eligibility or incorrectly terminated Medicaid coverage for 5,233 of the 193,009 enrollees during our audit period. We also estimated that Utah reported 15,269 of the 193,009 enrollees on the incorrect line of Utah's monthly unwinding data reports to CMS during our audit period.

What OIG Recommends

We made four recommendations to Utah, including that it redetermine Medicaid eligibility for the six sampled enrollees identified as having incorrect eligibility determinations, provide periodic training to caseworkers, identify and correct data limitations we identified, and strengthen policies and procedures to provide for greater accuracy in the monthly unwinding data reports. The full recommendations are in the report.

Utah concurred with all our recommendations and described corrective actions it had taken or planned to take.

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INTRODUCTION

WHY WE DID THIS AUDIT

On January 31, 2020, the Department of Health and Human Services (HHS) declared a public health emergency (PHE) for COVID-19.[1] In March 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA) in response to the PHE.[2] The FFCRA provided States with a temporary increase of 6.2 percentage points to their regular Federal medical assistance percentage (FMAP) rates. To receive the increased FMAP, the FFCRA required, among other conditions, States to ensure that most individuals who were enrolled for Medicaid benefits (enrollees) as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ended (continuous enrollment condition). These enrollees should have remained enrolled in Medicaid, unless the enrollee requested a voluntary termination of eligibility, ceased to be a resident of the State, or died.

The Consolidated Appropriations Act, 2023 (CAA), amended the expiration of the continuous enrollment condition to March 31, 2023.[3] As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees. In accordance with guidance issued by the Centers for Medicare & Medicaid Services (CMS), States have up to 12 months to initiate and an additional 2 months to complete Medicaid eligibility actions for all enrollees (unwinding period). States were able to begin their unwinding period as early as February 1, 2023, and could begin terminating Medicaid enrollment on or after April 1, 2023, for individuals who were no longer eligible.[4]

The COVID-19 pandemic created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.[5] This audit of the Utah Department of Health and Human Services (State agency) is one in a series of reports related to States' unwinding periods.

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[1] Administration for Strategic Preparedness & Response, "Determination That A Public Health Emergency Exists." Available online at https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx. Accessed on May 15, 2024. (The PHE ended on May 11, 2023.)

[2] The Families First Coronavirus Response Act (P.L. No. 116-127) (Mar. 18, 2020).

[3] Division FF, § 5131, Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022).

[4] CMS State Health Official (SHO) Letter No. 23-002 (issued Jan. 27, 2023).

[5] OIG's COVID-19 response strategic plan and oversight activities can be accessed at https://oig.hhs.gov/coronavirus/index.asp.

OBJECTIVE

Our objective was to determine whether the State agency completed Medicaid eligibility actions in accordance with Federal and State requirements during its unwinding period following the end of the continuous enrollment condition.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the FMAP, which varies depending on the State's per capita income.[6] Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time.

Federal Requirements and CMS Guidance Related to the Continuous Enrollment Condition and the Unwinding Period

In March 2020, Congress enacted the FFCRA in response to the COVID-19 PHE. Section 6008 of the FFCRA provided a temporary increase of 6.2 percentage points to each qualifying State's FMAP effective January 1, 2020. To qualify for the increased COVID-19 FMAP, States were required to ensure that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ended.

Federal regulations (42 CFR § 433.400, effective November 2, 2020) interpret and implement section 6008(b)(3) of the FFCRA. The regulations outline exceptions to the continuous enrollment condition requirement. A State could terminate an enrollee's Medicaid enrollment during the PHE if:

- the enrollee or the enrollee's representative requests a voluntary termination of eligibility,
- the enrollee ceases to be a resident of the State, or
- the enrollee dies.

[6] The Act § 1905(b).

The CAA, enacted on December 29, 2022, included significant changes to the FFCRA's continuous enrollment condition. The CAA addresses the end of the continuous enrollment condition, the phase down and end of the temporary FMAP increase, and the unwinding process. Under section 5131 of the CAA, the end of the continuous enrollment condition and receipt of the temporary FMAP increase are no longer linked to the end of the PHE. The CAA amended section 6008(b)(3) of the FFCRA to end, on March 31, 2023, continuous Medicaid enrollment as a condition for claiming the temporary FMAP increase. Furthermore, the FFCRA's temporary FMAP increase gradually phased down beginning April 1, 2023, and ended on December 31, 2023. The CAA required States to initiate all eligibility actions for all enrollees when the continuous enrollment condition ended.

In accordance with CMS-issued guidance, in preparation for and at the end of the continuous enrollment condition:

- States could begin their unwinding period as early as February 1, 2023, but were required to begin initiating eligibility actions no later than April 2023.

- For States that initiated renewals before April 1, 2023, terminations of Medicaid eligibility could not be effective earlier than April 1, 2023.

- States must initiate renewals for all individuals enrolled in Medicaid within 12 months of the beginning of the State's unwinding period and must complete renewals for all individuals within 14 months of the beginning of the State's unwinding period.[7]

Monthly Reporting Requirements for States During the Unwinding Period

In March 2022, CMS announced that States would be expected to submit data demonstrating progress in completing the required eligibility and enrollment actions during the unwinding period.[8] Subsequently, the CAA required States to report and CMS to publicly report on a broad set of metrics, including some of the specific metrics described in CMS's monthly *Unwinding Eligibility and Enrollment Data Reporting Template* (unwinding data report).[9, 10] These metrics in the monthly unwinding data reports are designed to demonstrate the State's

[7] CMS SHO Letter No. 23-002 (issued on Jan. 27, 2023).

[8] CMS SHO Letter No. 22-001 (issued on Mar. 3, 2022).

[9] Division FF, § 5131(b), Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022).

[10] As of Dec. 6, 2023, this process is further outlined in 42 CFR §§ 435.927 and 435.928.

progress toward restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and Children's Health Insurance Program (CHIP) enrollees.[11] The categories of metrics that are reported monthly by the States are:

- application processing (e.g., pending applications that were received during the continuous enrollment condition),
- renewals initiated,
- renewals and outcomes, and
- Medicaid fair hearings.

In the unwinding data reports, States must report on the numbers of applications processed, renewals initiated, renewals and outcomes, and Medicaid fair hearings. The numbers of renewals and outcomes are defined as follows:

- enrollees renewed and retained, which includes:
    - enrollees renewed on an ex parte basis[12] and
    - enrollees renewed using a renewal form;
- enrollees determined to be ineligible; and
- enrollees whose coverage was terminated for procedural reasons (i.e., the enrollee failed to respond).

Utah's Medicaid Program

The State agency provides health care coverage for 526,600 Utah enrollees and is responsible for the administration and oversight of the Medicaid program in Utah. The State agency delegates certain tasks, including eligibility determinations, to the Eligibility Division of the

[11] CHIP provides health coverage to eligible children of families with incomes too high to qualify for Medicaid but too low to afford private coverage.

[12] An ex parte renewal is any renewal that is completed without contacting the enrollee for information or verification (42 CFR § 435.916(a)(2)). An ex parte review is therefore a redetermination based on current, reliable information and does not require enrollee participation.

Department of Workforce Services (DWS).[13] The DWS caseworkers review Medicaid applications, complete Medicaid eligibility determinations, and process Medicaid renewals and terminations for enrollees using the Eligibility & Enrollment System, Electronic Resources & Eligibility Product (eREP), which is DWS's system for storing enrollees' eligibility determination information.

Medicaid case records are electronic, and the components of the records are stored in various electronic systems. Paper documents, such as applications, reviews, check stubs, and bank statements, are scanned and the images uploaded to the Content Manager system (Content Navigator), which DWS maintains. These eligibility-related documents are then entered into eREP, which determines eligibility, records case narration, manages notices, creates and manages worker tasks, holds records of benefits issued, and interfaces with other electronic systems.[14]

The *Utah Department of Health and Human Services, Medicaid Policy Manual* (Medicaid Policy Manual) describes the eligibility criteria that apply to Utah's Medicaid program. The DWS *Eligibility Services Division Operations Manual* (ESD Operations Manual) describes the actions that DWS caseworkers must take during the eligibility review process.

State Agency Oversight of Department of Workforce Services Operations for the Unwinding Period

The State agency's Medicaid Division is responsible for overseeing and monitoring eligibility determinations, including providing guidance and technical assistance to DWS caseworkers and developing policy and procedures used in determining eligibility for Medicaid. According to the State agency's unwinding plan, *Returning Medicaid Eligibility to Normal Operations When the Public Health Emergency Ends* (published on February 7, 2023),[15] and to prepare for the end of the unwinding period, the State agency took several steps to ensure that renewal determinations for enrollees were conducted accurately and in a timely manner, including:

[13] The State agency and DWS are separate, co-equal departments within the executive branch of the Utah State government. DWS executes its responsibility for making eligibility determinations through a waiver of the single State agency requirements, as provided for by the Intergovernmental Cooperation Act of 1968, P.L. No. 90-577 (Oct. 16, 1968).

[14] As part of the case record requirements conveyed in the *Utah Department of Health and Human Services, Medicaid Policy Manual* (Medicaid Policy Manual), the case narration must: (a) describe all factors and activities that lead to the eligibility determination and case maintenance; (b) contain client contacts and discussions; (c) contain actions taken by the agency, including corrections, agency conferences, hearings, overpayments, and investigations, among other things; (d) be written in a professional manner; and (e) label all statements of fact, hearsay evidence, employee's professional opinion, or situational judgment.

[15] *Returning Medicaid Eligibility to Normal Operations When the Public Health Emergency Ends* (published Feb. 7, 2023) was revised on Sept. 5, 2023, with the new name of *Unwinding Medicaid Eligibility*. This revision is described as a narrative of Utah's plan for the resumption of normal State Medicaid eligibility upon the conclusion of the Medicaid continuous enrollment requirement.

- requesting eligibility-related flexibilities from CMS, such as using the U. S. Postal Service (USPS) instate forwarding addresses to update enrollees' contact information;[16]

- requesting from CMS policy flexibilities related to individuals with no income and no assets, to allow more individuals to renew on an ex parte basis;[17]

- preparing DWS by issuing policy guidance, assessing staffing levels and training, and providing a communication toolkit;

- reviewing eligibility system functionality and designing system changes to resume normal renewal actions;

- collaborating with a variety of stakeholders, including managed care plans and community organizations, to prepare for the unwinding period;

- creating a reporting dashboard to allow the State agency's Office of Eligibility Policy to monitor eligibility data and provide a source of information to the public; and

- redetermining enrollees' eligibility throughout the PHE, without actually executing any negative actions (e.g., termination, lower benefit level, premium increase), to identify enrollees to prioritize for eligibility redeterminations during the unwinding period.

State Agency's Unwinding Process for Determining Medicaid Eligibility

The State agency directed DWS to begin initiating unwinding-related renewals of Medicaid eligibility in March 2023, one month before the end of the continuous enrollment condition. In May 2023, DWS began processing renewals, including terminations of eligibility. DWS had until February 2024 to initiate all renewals and two additional months to complete renewals during the unwinding period, ending in April 2024.

Utah's eligibility review is designed to begin processing renewals two months before the renewal month.[18] A renewal is considered initiated when DWS attempts to verify an enrollee's eligibility on an ex parte basis. For example, if an enrollee had a June 2023 renewal month,

[16] The State agency received waiver authorities from CMS under section 1902(e)(14)(A) of the Act for obtaining address information from the Medicaid managed care plans and the National Change of Address database (approved Nov. 4, 2022, and Oct. 24, 2022, respectively).

[17] The State agency received waiver authorities from CMS under section 1902(e)(14)(A) of the Act for completing ex parte renewals for individuals with no income and no data returned (approved Oct. 24, 2022). In addition, the State agency received waiver authorities from CMS under section 1902(e)(14)(A) of the Act for facilitating renewals for individuals with no Asset Verification System (AVS) data returned within a reasonable timeframe (approved Oct. 24, 2022).

[18] An enrollee's renewal month is the month in which the redetermination is due. Generally, the renewal month is set 12 months after the application month or previous renewal month.

DWS initiated the renewal process on an ex parte basis in April 2023. This procedure allowed DWS enough time to send a renewal form to the enrollee, if necessary, and to complete Medicaid eligibility actions before the end of the enrollee's renewal month if the renewal on an ex parte basis was unsuccessful. By the beginning of February 2024, DWS should have initiated Medicaid eligibility actions for all enrollees and completed all those actions by the end of April 2024, the end of the 14-month unwinding period.

Figure 1 illustrates the State agency's timeline for initiating and completing all Medicaid eligibility actions for enrollees during its 14-month unwinding period.

Figure 1: State Agency's Unwinding Timeline

To verify the accuracy of eligibility information for an enrollee whose eligibility is determined on the basis of modified adjusted gross income (MAGI), DWS uses information from eREP, including information on the electronic verifications (eVerifs). The eVerifs's function is to gather all electronic verifications into one central location within eREP. In so doing, eVerifs uses data from multiple electronic data sources, including from the Social Security Administration, Department of Homeland Security, and Department of Agriculture, Food and Nutrition Services; and from State-approved data sources. Then, eVerifs compares the data provided by these data sources with the enrollee's information in eREP to determine whether the information is electronically verified. Additionally, eVerifs allows for the electronic verification to be posted automatically into eREP without manual intervention from a DWS caseworker. If eVerifs is able to electronically verify the information, the enrollee's eligibility can be renewed on an ex parte basis.

Before completing an ex parte review or processing any program changes, the caseworker must check the Medical Assistance Eligibility system (which is referred to as "Cascade") to verify that the enrollee is still eligible for a medical assistance program. Cascade is a function in eREP that enables a caseworker to review any medical assistance, as well as any possible future medical assistance, that the household is receiving from all medical assistance programs.

Once eligibility has been determined, the DWS caseworker sends a Medical Review Complete Notice, which specifies the new effective date for Medicaid eligibility, to the enrollee.

As part of the State agency's processes, to verify accuracy of eligibility information for an enrollee whose eligibility is not determined on the basis of MAGI, a DWS caseworker attempts a renewal on an ex parte basis if the enrollee's declared assets are below $1,000.[19] DWS caseworkers use the Asset Verification System (AVS), another electronic data system, to coordinate with financial institutions to verify assets on behalf of medical assistance programs that require an asset test. AVS must be used to verify assets with financial institutions for individuals whose eligibility is determined based on being 65 years old or over, on being blind, or on having a disability based on non-MAGI financial methodologies. Once the AVS search is complete, the caseworker is able to view the results in eVerifs to verify the enrollee's assets based on the enrollee's information in eREP.

If DWS cannot renew an enrollee's eligibility on an ex parte basis, DWS sends a renewal form to the enrollee with some information filled in and requests that the individual: (1) verify the information on the form or provide updated information and (2) return the form and other requested information (e.g., proof of current income, such as pay stubs or the prior year's tax return).[20] The enrollee may provide the information requested on the renewal form through any available means, including by telephone, by mail, or through DWS's online self-service portal.[21]

If the enrollee returns the form and the requested information, the DWS caseworker processes the renewal by entering the information into eREP to determine whether the enrollee is eligible. If the enrollee is determined to be eligible, Medicaid coverage will be renewed. If the enrollee is determined to be ineligible, Medicaid coverage will be terminated.

If DWS does not receive the necessary information by the due date (i.e., the enrollee failed to respond), DWS sends to the enrollee a Notice of Decision at least 10 days before the end of the enrollee's renewal month explaining the reason for the termination of the enrollee's Medicaid coverage (i.e., the enrollee's coverage is terminated for procedural reasons).[22]

Any returned (i.e., undeliverable) mail that DWS receives during the unwinding process that relates to an enrollee's review generally requires that the caseworker attempt to contact the

[19] Enrollees whose eligibility is not determined on the basis of MAGI include individuals aged 65 or older and individuals who are blind. The non-MAGI medical assistance programs include Aged, Blind and Disabled Medicaid; Medicaid Work Incentive; Medicare Cost Sharing Programs; Nursing Home Medicaid; Family Medically Needy Medicaid; and various waiver programs (ESD Operations Manual, "AVS Process" section).

[20] 42 CFR § 435.916(a)(3).

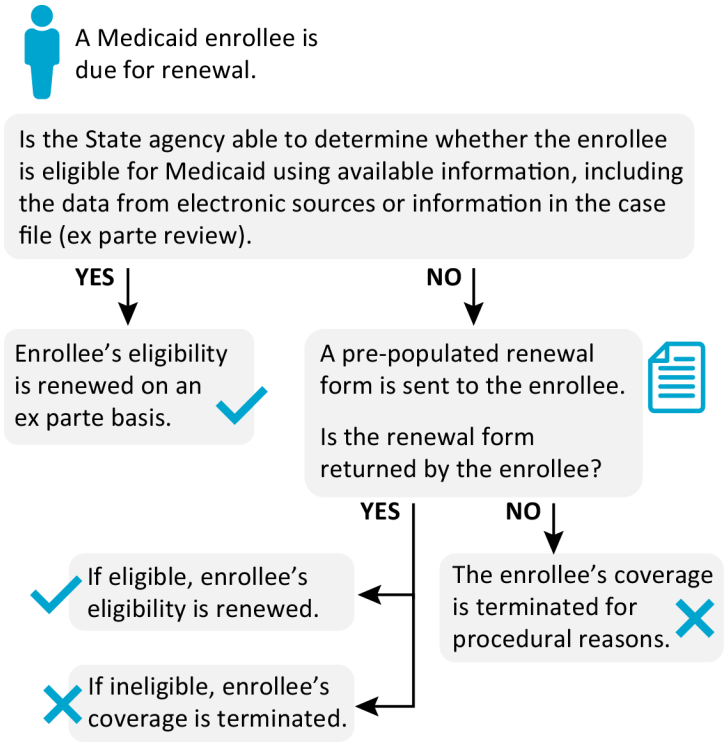
[21] Medicaid Policy Manual, section 721-2, "Reviews Requiring Member Participation."

[22] The enrollee is entitled to a 90-day period to provide the required information if Medicaid coverage is terminated for failing to provide information or verifications. If the enrollee is determined to be eligible during this 90-day period, the State agency grants coverage retroactively to the date of termination so that there is no lapse in Medicaid coverage (42 CFR § 435.916(a)(3)(iii)).

enrollee using two additional modalities (email, phone, text, other). Each contact attempt and method must be documented in the case record.[23]

Figure 2 provides an overview of the State agency's eligibility determination process for enrollees during the unwinding period.

Figure 2: Overview of the State Agency's Medicaid Eligibility Determination Process During the Unwinding Period



HOW WE CONDUCTED THIS AUDIT

Our audit covered 193,009 enrollees who were listed on Utah's monthly unwinding data reports and who had their Medicaid eligibility renewed or coverage terminated during April 1 through September 30, 2023 (audit period), following the end of the continuous enrollment condition.[24] Of the 193,009 enrollees whose Medicaid eligibility was renewed or whose coverage was terminated during the audit period, we identified:

- 44,140 enrollees whose eligibility was renewed on an ex parte basis,

[23] ESD Operations Manual: Returned Mail; CMS SHO Letter No. 23-002 (Jan. 27, 2023). Fewer contact methods are allowed if the State does not have other contact information.

[24] This audit excludes enrollees who had coverage through CHIP before their renewal months.

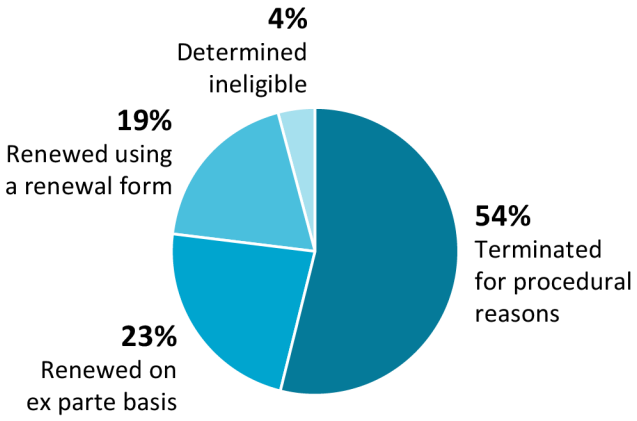
- 37,200 enrollees whose eligibility was renewed using a renewal form,

- 6,768 enrollees who were determined to be ineligible and whose Medicaid coverage was terminated, and

- 104,901 enrollees whose Medicaid coverage was terminated for procedural reasons (i.e., the enrollee failed to respond).

See Figure 3 for the percentage of the 193,009 enrollees who had their Medicaid eligibility renewed, were determined ineligible, or had their coverage terminated for procedural reasons during our audit period.

Figure 3: Percentage of Enrollees Who Had Various Medicaid Eligibility Actions Taken Following the End of the Continuous Enrollment Condition (April Through September 2023)



For a stratified random sample of 140 Medicaid enrollees, we reviewed the Medicaid eligibility actions taken by the State agency. These 140 sampled enrollees consisted of:

- 35 enrollees who were listed on the unwinding data reports as having had their eligibility renewed on an ex parte basis,

- 35 enrollees who were listed on the unwinding data reports as having had their eligibility renewed using a renewal form,

- 35 enrollees who were listed on the unwinding data reports as having been determined to be ineligible and having had their Medicaid coverage terminated, and

- 35 enrollees who were listed on the unwinding data reports as having had their Medicaid coverage terminated for procedural reasons.

For each of the sampled enrollees, we reviewed DWS's documentation from eREP and DWS's Content Navigator that supported the eligibility determinations, including renewal forms,

income support (e.g., pay stubs), notice letters, and caseworker notes. We also reviewed verification results from eVerifs for eligibility factors such as income and asset amounts.[25]

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, and Appendix B contains the details of our statistical sampling methodology.

FINDINGS

The State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period following the end of the continuous enrollment condition. Of the 140 sampled enrollees, the State agency correctly completed eligibility actions for all 35 enrollees whose coverage was terminated for procedural reasons. However, for 6 of the remaining 105 sampled enrollees, the State agency incorrectly completed eligibility actions for enrollees whose eligibility was renewed on either an ex parte basis or by using a renewal form, or who were determined ineligible and had their coverage terminated during our audit period. Specifically:

- Of the 35 sampled enrollees whose eligibility was renewed on an ex parte basis, the Medicaid eligibility actions were incorrectly completed for 3 enrollees.

- Of the 35 sampled enrollees whose eligibility was renewed using a renewal form, the Medicaid eligibility action was incorrectly completed for 1 enrollee.

- Of the 35 sampled enrollees who were determined ineligible and had their coverage terminated, the Medicaid eligibility actions were incorrectly completed for 2 enrollees.

On the basis of our sample results, we estimated that the State agency incorrectly renewed eligibility or incorrectly terminated Medicaid coverage for 5,233 of the 193,009 enrollees during our audit period.[26] Moreover, we estimated that eligibility for 4,846 enrollees was incorrectly renewed on an ex parte basis or was incorrectly renewed using a renewal form.[27] We have chosen not to report the estimated number of incorrect eligibility terminations because of the

[25] We relied on the electronic verification results from eVerifs's comparison of the enrollees' attested information with data received from electronic data sources. We did not review whether the data originally received from the electronic data sources and the result of the comparison were accurate.

[26] The lower and upper limits of the 90-percent confidence interval are 1,310 and 9,156, respectively.

[27] The lower and upper limits of the 90-percent confidence interval are 948 and 8,744, respectively.

low number of enrollees in our sample who were incorrectly determined to be ineligible or who had their coverage incorrectly terminated for procedural reasons.

Furthermore, we found that 15 of the 140 sampled enrollees were included on the incorrect line of the State agency's monthly unwinding data reports. On the basis of our sample results, we estimated that the State agency incorrectly reported 15,269 of the 193,009 enrollees on the monthly unwinding data reports during our audit period.[28] (Appendix C contains our sample results and estimates.)

Additionally, for 9 of the 140 enrollees in our sample, DWS caseworkers made errors while verifying enrollees' income, which resulted in incorrectly calculated income and asset amounts, but which did not affect the sampled enrollees' eligibility determinations. Furthermore, caseworkers did not always use information that was available or did not follow DWS internal policies and procedures when completing the eligibility determinations. Although these actions may not have affected the eligibility determinations of enrollees in our sample, similar actions could adversely impact other enrollees' eligibility determinations.

These deficiencies occurred because DWS caseworkers did not use information that was available to them, made mistakes while completing income calculations, or did not follow DWS internal policies and procedures. As a result, the State agency could not always be assured that Medicaid eligibility actions taken by DWS caseworkers were completed in accordance with Federal and State requirements, and certain enrollees' eligibility was incorrectly renewed or terminated during the unwinding period following the end of the continuous enrollment condition. The findings we identified suggest that although the State agency and DWS generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period, caseworkers may benefit from periodic training that focuses on verifying and documenting information used and steps performed during the eligibility renewal process.

MEDICAID ELIGIBILITY ACTIONS WERE GENERALLY COMPLETED CORRECTLY DURING THE UNWINDING PERIOD

Of the 140 sampled enrollees, the State agency correctly completed eligibility actions for all 35 enrollees whose coverage was terminated for procedural reasons. However, for 6 of the remaining 105 sampled enrollees, the State agency incorrectly completed eligibility actions during our audit period.

[28] The lower and upper limits of the 90-percent confidence interval are 8,320 and 22,218, respectively.

Three Sampled Enrollees' Eligibility Was Incorrectly Renewed on an Ex Parte Basis

The State agency must make a redetermination of eligibility without requiring information from the individual if the State agency is able to do so based on reliable information contained in the enrollee's case file or other more current information available to the agency.[29] During the unwinding period, a renewal is considered initiated when DWS (as overseen and monitored by the State agency) begins the renewal process by attempting to renew eligibility on an ex parte basis. If DWS can electronically verify the enrollee's eligibility using information from eVerifs and eREP case records, the enrollee's eligibility can be renewed on an ex parte basis.[30] As part of the State agency's and DWS's processes, once an ex parte review is completed, DWS sends a Medical Review Complete Notice to the enrollee.

All actions taken on a case must be documented and maintained in that enrollee's case records. The Medicaid Policy Manual requires that the case records include the actions taken and the decisions made during the review process. This manual also requires the case narration (footnote 14) to describe all factors and activities that led to the eligibility determination and to include information on case maintenance, client contacts, and discussions.

Any returned (i.e., undeliverable) mail that DWS receives during the unwinding process that relates to an enrollee's review generally requires that the caseworker attempt to contact the enrollee using two additional modalities (email, phone, text, other). Each contact attempt and method must be documented in the case record (footnote 23).

Of the 35 sampled enrollees whose eligibility was renewed on an ex parte basis, the State agency correctly completed Medicaid eligibility actions for 32 enrollees. However, the State agency incorrectly completed eligibility actions for three enrollees. Specifically, DWS did not verify that the address in eREP that supported Utah residency was current for two of the sampled enrollees who had Medical Review Complete Notices returned to DWS after the enrollees' Medicaid eligibility was approved through an ex parte review. For the third enrollee, DWS had no documentation that an ex parte review had been conducted since August 4, 2022, even though there was a Medical Review Complete Notice dated August 1, 2023. These actions were not in accordance with Federal and State requirements.

The following are examples of enrollees whose eligibility was renewed on an ex parte basis.

Example 1:
Enrollee whose eligibility was correctly renewed on an ex parte basis.

For an adult enrollee in our sample, the State agency listed the enrollee on the July 2023 unwinding data report as having had eligibility renewed. In May 2023,

[29] 42 CFR § 435.916(a)(2).

[30] 42 CFR § 435.916(a)(2); Medicaid Policy Manual, section 721-1, "Ex Parte Reviews."

the enrollee's renewal was initiated through the ex parte process. DWS processed the renewal using the income data in the case record, which stated that the enrollee's income derived from Social Security income. DWS verified the enrollee's monthly income using data obtained from approved electronic sources, and it correctly renewed the enrollee's eligibility.

Example 2:
Enrollee whose eligibility was incorrectly renewed on an ex parte basis.

For an adult enrollee in our sample, the State agency listed the enrollee on the June 2023 unwinding data report as having had eligibility renewed. In May 2023, the enrollee's renewal was initiated through the ex parte process. However, the caseworker did not verify a current address to confirm Utah residency before mailing the Medical Review Complete Notice on May 4, 2023. That letter was returned with no forwarding address. Although the caseworker was required to attempt to contact this enrollee using two additional modalities (footnote 23), the State agency could furnish no documentation supporting that these attempts had been undertaken. This enrollee's Medicaid eligibility was nevertheless renewed on July 1, 2023.

One Sampled Enrollee's Eligibility Was Incorrectly Renewed Using a Renewal Form

When an enrollee's eligibility cannot be renewed on an ex parte basis, DWS (as overseen and monitored by the State agency) must send the enrollee a renewal form to request information and verify the information that the enrollee provides.[31] After DWS has sent an enrollee the renewal form, the enrollee may respond with the requested information by contacting DWS by telephone or in person or by using DWS's online self-service portal. Caseworkers are responsible for documenting the latest information reported by the enrollee in the enrollee's case record, including additional information reported by the enrollee based on followup requests, such as pay stubs, employment verification, or proof-of-residency documentation.[32]

Any returned (i.e., undeliverable) mail that DWS receives during the unwinding process that relates to an enrollee's review generally requires that the caseworker attempt to contact the enrollee using two additional modalities (email, phone, text, other). Each contact attempt and method must be documented in the case record (footnote 23).

Of the 35 sampled enrollees whose eligibility was renewed using a renewal form, the State agency correctly completed Medicaid eligibility actions for 34 enrollees. However, the State agency incorrectly completed an eligibility action for one enrollee.

[31] 42 CFR §§ 435.916(a)(2) and (3).

[32] Caseworkers can access a database of income and employment data from employers across various industries to verify income and employment.

With respect to the incorrectly completed eligibility action, DWS determined that the enrollee was eligible even though it had not verified a current address for that enrollee. Before this enrollee's eligibility was approved through an ex parte review, DWS mailed a renewal form to the unverified address, which was subsequently returned as undeliverable and should have resulted in termination—rather than renewal—of Medicaid eligibility. This action was not in accordance with Federal and State requirements or with related processes that the State agency had in place during the unwinding period.

The following are examples of enrollees whose eligibility was renewed using a renewal form.

Example 3:
Enrollee whose eligibility was correctly renewed using a renewal form.

For an adult enrollee in our sample, the State agency listed the individual on the July 2023 unwinding data report as having had eligibility renewed. In May 2023 and again in June 2023, DWS attempted to initiate the individual's renewal on an ex parte basis; however, the ex parte process failed because the enrollee's income could not be verified. DWS sent the enrollee a renewal form in June 2023 requesting income information; the enrollee subsequently filled out and returned the form. After conducting a review of the renewal form, the caseworker sent out multiple notices in July 2023 requesting pay stubs to verify income, along with a form to verify whether the enrollee's employer was providing health insurance. The enrollee did not return these documents by the due date, and the enrollee's eligibility was not renewed; however, DWS received the documents approximately 1 week later. At that point, the caseworker added the newly verified income to the enrollee's case record, determined that the household remained eligible for Medicaid, and correctly reopened and renewed the enrollee's Medicaid coverage.

Example 4:
Enrollee whose eligibility was incorrectly renewed because the address was unverified.

For an adult enrollee in our sample, the State agency listed the individual on the April 2023 unwinding data report as having had eligibility renewed with a prepopulated renewal form; in fact, the enrollee had been approved because of an ex parte review conducted on March 16, 2023, and was notified via a Medical Review Complete Notice sent the following day. A note in the case file dated April 6, 2023, states: "Received the returned 'Case Review' form with no address correction from USPS," with a return date of March 30, 2023. This note also stated that the DWS caseworker attempted two phone calls to contact the enrollee, both of which were unsuccessful. DWS then sent a "Returned Mail—No Forwarding Address" notice to this enrollee (using the same address that it used for the March 2023 notification—the only address on file for this enrollee)

on April 7, 2023. This notice stated that Medicaid assistance would end on April 17, 2023, if the enrollee did not contact the caseworker. The enrollee did not follow up with the caseworker, but their eligibility was nevertheless renewed.

There were no other actions noted in the case record until May 19, 2023, when DWS mailed to the enrollee a Notice of Decision, which was also returned as undeliverable on May 25, 2023. The enrollee's Medicaid eligibility was terminated effective May 31, 2023.

Two Sampled Enrollees Were Incorrectly Determined Ineligible and Had Their Coverage Terminated

State requirements describe: the criteria that apply to all medical assistance programs; the steps by which DWS, as overseen and monitored by the State agency, verifies eligibility criteria; and the circumstances under which an individual is asked to provide additional verification. DWS caseworkers are responsible for documenting the latest information reported by the enrollee in eREP to determine whether the enrollee is eligible. The State agency must deny an application or Medicaid renewal for an individual who does not meet the conditions of eligibility.[33] A final date of eligibility shall be established when the State agency determines that the enrollee will no longer meet all eligibility requirements. The State agency is required to send an enrollee a Notice of Decision at least 10 days before the date of action, which is defined as "the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective."[34]

Of the 35 sampled enrollees whom the State agency determined to be ineligible and who had their coverage terminated, the State agency correctly completed Medicaid eligibility actions for 33 enrollees. However, the State agency incorrectly completed eligibility actions for two enrollees. Specifically:

- One enrollee was determined ineligible because DWS incorrectly calculated the enrollee's income.[35]

[33] 42 CFR § 435.916(f).

[34] 42 CFR § 431.201; Medicaid Policy Manual, section 811 A-2-b.

[35] Under the provisions of the Medicaid Policy Manual, section 440-4-A-2, child support payments are excluded as income for determinations of MAGI-based household income.

- One enrollee was determined ineligible because they had not responded to a verification request, but we determined, and DWS confirmed, that this request was not necessary for the renewal of the enrollee's benefits.[36]

These actions were not in accordance with Federal and State requirements or with related processes that the State agency had in place during the unwinding period.

The following are examples of enrollees who were determined to be ineligible for Medicaid.

Example 5:
Enrollee who became ineligible for Medicaid and whose coverage was correctly terminated.

For a child enrollee in our sample, the State agency listed the enrollee on the April 2023 unwinding data report as having been determined ineligible and having had coverage terminated. In March 2023, the enrollee's renewal was initiated on an ex parte basis; however, the ex parte renewal process was not completed because the enrollee's household income exceeded the income limit for eligibility. The DWS caseworker sent a renewal form to the enrollee's household. The caseworker subsequently received the enrollee's completed renewal form and determined that the enrollee's household income exceeded the income limit for the enrollee's household size. The enrollee was correctly determined to be ineligible.

Example 6:
Enrollee whose Medicaid coverage was incorrectly terminated because the State agency improperly calculated the enrollee's income.

For a child enrollee in our sample, the State agency listed the enrollee on the May 2023 unwinding data report as having been determined ineligible and having had coverage terminated. DWS determined the enrollee to be ineligible because the enrollee's household income exceeded the Medicaid monthly income limit of $1,072. DWS sent a Notice of Decision to the household on May 19, 2023, stating that coverage would end on May 31, 2023.

However, DWS had incorrectly calculated the enrollee's unearned household income by including a $3,000 cash contribution from an absent parent who was incarcerated. According to State agency officials, the cash contribution was

[36] Under the provisions of the Medicaid Policy Manual, section 348-3.1-F, the Office of Recovery Services (ORS) confirms that the health insurance coverage is still active and that there are no changes in information regarding covered individuals. The ORS confirmed that the insurance details were unchanged; therefore, we concluded that insurance verification was unnecessary for the renewal of the enrollee's benefits.

considered a child support payment and was therefore exempt from being classified as income.

All 35 Sampled Enrollees Had Their Coverage Correctly Terminated for Procedural Reasons

The State agency must make a redetermination of Medicaid eligibility without requiring information from the enrollee if it is able to do so based on reliable information contained in the enrollee's account or other more current information available to the State agency.[37] When an enrollee's eligibility cannot be renewed on an ex parte basis, the State agency must send the enrollee a renewal form to request information and verify the information that the enrollee provides.[38]

If the enrollee does not respond or the State agency does not receive the necessary information by the due date, the State agency sends to the enrollee a Notice of Decision at least 10 days before the end of the enrollee's renewal month, which explains the reason for the termination of the enrollee's Medicaid coverage (i.e., the enrollee's coverage is terminated for procedural reasons).

The State agency correctly completed Medicaid eligibility actions for all 35 sampled enrollees whose eligibility it had terminated for procedural reasons.

The following is an example of an enrollee whose Medicaid coverage was terminated for procedural reasons.

Example 7:
Enrollee whose coverage was correctly terminated for procedural reasons.

For an adult enrollee in our sample, the State agency listed the enrollee on the September 2023 unwinding data report as having had coverage terminated for procedural reasons. A case note dated August 2, 2023, stated that an ex parte review was not completed and that the case could not be completed on an ex parte basis. On August 12, 2023, DWS sent the enrollee a prepopulated renewal form to be completed within 30 days. After not receiving a reply to this communication, DWS sent a Notice of Decision dated September 19, 2023, to the enrollee's household stating that Medicaid benefits would end on September 30, 2023. The caseworker followed State agency procedures to notify the enrollee that coverage would be terminated because DWS had not received the information necessary to complete the enrollee's eligibility redetermination. Accordingly, the enrollee's coverage was correctly terminated.

[37] 42 CFR § 435.916(a)(2).

[38] 42 CFR §§ 435.916(a)(2) and (3).

MEDICAID MONTHLY UNWINDING DATA REPORTS WERE INACCURATE

During the unwinding period, States are required to submit monthly unwinding data reports to CMS that convey specific metrics that demonstrate the extent of the State's progress in initiating and completing renewals of eligibility for all Medicaid enrollees. These reporting activities are designed to allow monitoring of States' progress in meeting timelines and completing required eligibility and enrollment actions. Accordingly, the execution of these activities requires that the monthly unwinding data reports be accurate.[39]

CMS has issued guidance to States on how to prepare the monthly unwinding data reports.[40] This guidance states that enrollees who are reported on line 5a(1) of these data reports represent individuals whose eligibility was renewed on an ex parte basis, while line 5a(2) is used to represent individuals who were renewed and reenrolled in Medicaid using a prepopulated form. Additionally, CMS's guidance specifies that enrollees reported on line 5b are to consist of individuals who were determined ineligible for Medicaid and who in some cases were transferred to the Federal Marketplace for health care coverage. Furthermore, enrollees reported on line 5c are those individuals who were terminated from Medicaid for procedural reasons, a category that includes instances in which enrollees did not provide required information to complete their redeterminations (i.e., failure to respond). Line 5d of these reports represents individuals whose redeterminations were not completed, or those for whom the State agency did not make a final eligibility determination.

For the 140 sampled enrollees who were included in the monthly unwinding data reports, we found that 125 were correctly reported. However, the State agency incorrectly reported 15 enrollees within line 5 of the monthly unwinding data reports. Specifically:

- nine enrollees were reenrolled in Medicaid through an ex parte review (line 5a(1)) but were incorrectly reported as renewed using a renewal form (line 5a(2));

- two enrollees' eligibility determinations were not finalized (line 5d) because the enrollees had been granted a due process month, but the enrollees were incorrectly reported as renewed using a renewal form (line 5a(2));[41]

- three enrollees were terminated from Medicaid because they did not provide required documentation (line 5c) but were incorrectly reported as having been determined ineligible (line 5b); and

[39] CMS SHO Letter No. 22-001 (Mar. 3, 2022).

[40] CMS's Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding (updated December 2022).

[41] Under the provisions of the Medicaid Policy Manual, Glossary A–D, when DWS cannot redetermine eligibility and provide proper notice of its decision, a "due process month" (or months) of extended eligibility is provided to the enrollee.

- one enrollee was reenrolled in Medicaid through a prepopulated renewal form (line 5a(2)) but was incorrectly reported as having been terminated for procedural reasons (line 5c).

The following is an example of an enrollee who was incorrectly reported on the monthly unwinding data reports.

Example 8:
Enrollee whose ex parte renewal was incorrectly reported as renewing with a prepopulated renewal form.

For an adult enrollee in our sample (who had three dependents), the State agency listed the individual on the April 2023 unwinding data report as having their eligibility renewed with a prepopulated renewal form (line 5a(2)). However, this enrollee had been approved on the basis of an ex parte review conducted in March 2023 and was notified of that approval via an ex parte Medical Review Complete Notice sent the following day. The enrollee should have been reported as renewed on an ex parte basis (line 5a(1)).

With respect to the nine enrollees who were renewed on an ex parte basis but who were incorrectly reported on line 5a(2) (as having been renewed using a renewal form), the State agency attributed these errors to eREP data limitations. In accordance with the State's unwinding process, caseworkers would continue to attempt the ex parte renewals even after the prepopulated renewal forms had been sent to the enrollees. Once the prepopulated renewal forms were issued, eREP was not able to identify ex parte renewals that the caseworkers had approved. The renewals would then be incorrectly reported on line 5a(2) of the monthly unwinding data report as prepopulated renewals rather than as successful ex parte renewals.

The State agency was unable to explain how the other 6 enrollees we identified (of the 15 enrollees who were incorrectly reported on line 5) were included on the incorrect lines of the monthly unwinding data reports.

These findings suggest that there are opportunities for the State agency to strengthen its policies and procedures to provide for greater accuracy in the monthly unwinding data reports and any future reports of a similar nature that the State agency submits to CMS.

On the basis of our sample results regarding the 15 sampled enrollees (out of 140) who were included on incorrect lines of the monthly unwinding data reports, we estimated that the State agency incorrectly reported 15,269 of the 193,009 enrollees' Medicaid eligibility actions on those reports during our audit period.[42] Inaccurate data in monthly unwinding data reports can

[42] The lower and upper limits of the 90-percent confidence interval are 8,320 and 22,218, respectively.

greatly affect the State agency's processing or CMS's oversight of Medicaid eligibility determinations.

Consequently, there is a risk that CMS or Federal and State lawmakers might act on the basis of incorrect information when trying to ensure that the high volume of eligibility determinations occurring after the end of the PHE are being appropriately processed.

CASEWORKERS MADE ERRORS THAT DID NOT AFFECT ELIGIBILITY DETERMINATIONS

The State agency must make a redetermination of Medicaid eligibility without requiring information from the enrollee if it is able to do so based on reliable information contained in the enrollee's account or other more current information that is available to the State agency.[43] The State agency verifies the accuracy of this information with eVerifs, which compares the data provided in the electronic sources with the enrollee's information in eREP. Paper documents such as check stubs and bank statements are scanned and the images uploaded to DWS's Content Navigator for access during the State agency's review.

Additionally, any returned (i.e., undeliverable) mail that the State agency receives during the unwinding process that relates to an enrollee's review generally requires that the caseworker attempt to contact the enrollee using two additional modalities (email, phone, text, other). Each contact attempt and method must be documented in the case record (footnote 23). As instructed in the ESD Operations Manual,[44] the caseworker must check the Cascade system to verify that the recipient is still eligible for a medical assistance program.[45]

For 9 of the 140 enrollees in our sample, DWS caseworkers made errors while verifying enrollees' income, which resulted in incorrectly calculated enrollee income and asset amounts, but these errors did not affect the sampled enrollees' eligibility determinations. Caseworkers did not always use current information for enrollees' assets and income, correctly enter the frequency of income, or correctly calculate income when completing the eligibility determinations.

Furthermore, caseworkers did not always use information that was available or did not follow DWS internal policies and procedures, such as processing a Cascade review to identify other medical assistance programs for which these individuals may have been eligible, or attempting to contact the enrollee using two additional modalities when returned mail that related to the enrollee's review had been received (footnote 23).

[43] 42 CFR §§ 435.916(a)(2) and (3).

[44] ESD Operations Manual, "Ex Parte Medical Review," step 12: Check Medical Assistance Eligibility.

[45] 42 CFR § 435.916(f)(1). We discuss Cascade in "State Agency's Unwinding Process for Determining Medicaid Eligibility" earlier in this report.

These findings suggest that caseworkers may benefit from periodic training that focuses on correctly executing and documenting income verification and on following DWS internal policies and procedures. Although these errors did not affect the sampled enrollees' eligibility determinations, errors like these could result in other enrollees having their eligibility incorrectly renewed or having their coverage incorrectly terminated.

The following are examples of errors made by caseworkers during the income verification process that did not affect the eligibility determinations for the sampled enrollees.

Example 9:
Enrollee whose Medicaid eligibility was correctly terminated, but the caseworker did not use the current income amount.

For an adult enrollee in our sample, the State agency listed the enrollee on the May 2023 unwinding data report as having been determined ineligible and having had coverage terminated. While completing the redetermination, a DWS caseworker received pay stubs from this enrollee and posted them into eREP. In so doing, the caseworker used a pay stub from 2022 and incorrectly reported it as having a 2023 date.

Consequently, the caseworker used the 2022 pay stub to calculate the enrollee's income amount instead of using the current income amount that was available in the enrollee's case record. If the caseworker had used the correct income information, the enrollee would still have been ineligible for Medicaid coverage. Therefore, we determined that the caseworker's error did not affect the enrollee's eligibility determination.

Example 10:
Enrollee whose coverage was correctly terminated but whose income frequency was incorrectly entered for the child's household.

For a child enrollee in our sample, the State agency listed the enrollee on the April 2023 unwinding data report as having been determined ineligible and having had coverage terminated. While completing the redetermination, a DWS caseworker applied a pay frequency of every 2 weeks to the income calculation. In fact, the enrollee's household pay stubs showed a weekly pay frequency. If the caseworker had applied the correct frequency with which this enrollee was paid, the enrollee would still have been ineligible for Medicaid coverage. Therefore, we determined that the caseworker's error did not affect the enrollee's eligibility determination.

The following page provides examples of caseworker inactions that could have resulted in incorrect eligibility determinations.

Example 11:
Enrollee who may have been determined to be eligible for coverage if contact was made to obtain the needed information.

For an adult enrollee in our sample, the State agency listed the enrollee on the April 2023 unwinding data report as having been correctly terminated due to incomplete information: not having a Social Security number for their child. On March 11, 2023, DWS sent a renewal form to the enrollee. On April 14, 2023, DWS received a returned mail notice on this mailing, along with notification that USPS did not have a forwarding or correct address for this enrollee. On April 17, 2023, DWS mailed a "Returned Mail—No Forwarding Address" letter to this enrollee at the same (undeliverable) address. On April 20, 2023, DWS mailed a Notice of Decision to this enrollee (again at the same address) informing them that coverage would be terminated effective April 30, 2023, for a missing Social Security number. However, in this case review the State agency confirmed that neither it nor DWS made any subsequent attempts using another modality (email, phone, text, other; footnote 23) to obtain the information needed. Although this case was correctly terminated for a missing Social Security number, DWS should have followed up using another modality and documented the attempt.

Example 12:
Enrollee whose coverage was terminated but who could have been determined eligible for coverage through other medical assistance programs if the caseworker had checked the Medical Assistance Eligibility system (Cascade).

For a child enrollee in our sample, the State agency listed the enrollee on the May 2023 unwinding data report as having been correctly terminated because the enrollee's countable income exceeded the requirements for the enrolled medical assistance program. On May 23, 2023, DWS mailed a Notice of Decision to the enrollee informing them that coverage would terminate effective May 31, 2023, because the enrollee's countable income exceeded the requirements.[46] Based on the income limits for the other medical assistance programs, it appeared that the income of the enrollee as documented in eREP would have disqualified this enrollee for all other medical assistance programs, which is why we did not classify this case as an eligibility error. However, this enrollee's case file showed that a Cascade system check had not been performed since March 17, 2021, which is a procedure that is required by the caseworker.

[46] DWS also mailed a Notice of Decision to the enrollee on May 19, 2023, informing them that coverage would terminate effective May 31, 2023. The details in the May 23, 2023, Notice of Decision were updated for programs outside the scope of our sample items.

CONCLUSION

Although the State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period, the findings in this report demonstrate that the State agency could do more to ensure that Medicaid eligibility determinations are accurate. The State agency incorrectly completed Medicaid eligibility actions for some of the enrollees in our sample, the Medicaid monthly unwinding data reports were inaccurate for some of the report months during our audit period, and DWS caseworkers made errors during the income verification process or did not perform certain actions during the review process for some enrollees. Some of these errors did not affect enrollees' eligibility determinations, but errors like those identified in this report could result in other enrollees having their eligibility incorrectly renewed or having their coverage incorrectly terminated.

State agency officials attributed the deficiencies to various factors, such as technical system limitations and caseworker errors. Specifically, these deficiencies occurred because DWS caseworkers did not use information that was available to them, made mistakes while completing income calculations, or did not follow DWS internal policies and procedures. As a result, the State agency could not always be assured that Medicaid eligibility actions taken by DWS caseworkers were completed in accordance with Federal and State requirements, and certain enrollees' eligibility was incorrectly renewed or terminated during the unwinding period following the end of the continuous enrollment condition.

RECOMMENDATIONS

We recommend that the Utah Department of Health and Human Services:

- redetermine Medicaid eligibility for the six sampled enrollees whom we have identified as having had incorrectly completed eligibility determinations;

- coordinate with DWS to provide periodic training to caseworkers that focuses on verifying and documenting information used and steps performed during the eligibility renewal process, including: (1) verifying income and assets, (2) verifying residency/contact information, and (3) correctly executing case review and reporting;

- identify and correct the eREP data limitations, which in some cases prevented proper reporting classification; and

- strengthen its policies and procedures to provide for greater accuracy in the monthly unwinding data reports and any future reports of a similar nature that the State agency submits to CMS.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all our recommendations and described corrective actions it had taken or planned to take. For our first recommendation, the State agency said that it had corrected the eligibility determinations for the six sampled enrollees whom our draft report had identified as having had incorrectly completed eligibility determinations.

For our second recommendation, the State agency said that DWS had coordinated with it to publish a "Case Maintenance and Processing Refresher" training for all eligibility workers. The State agency said that this training "focused on issuing correct benefits both at application and review" and also included instruction on "verifying income to determine the correct program" for each enrollee. The State agency added that DWS had coordinated with it and would conduct (in November 2024) a mandatory training for workers on "how to properly verify assets utilizing policy and procedures." The State agency also stated that DWS conducts monthly training sessions with supervisors of eligibility staff and annual online training for eligibility workers. The State agency said that it anticipates completing all the corrective actions in response to our second recommendation by November 30, 2024.

For our third recommendation, the State agency said that it had already implemented a solution to identify and correct the eREP data limitations that our draft report had described. Specifically, the State agency stated that it had deployed the initial phase of the automated ex parte process in September of 2023, which included creating a table to better track completed reviews. The State agency also said that with the implementation of automation, it would be able to identify ex parte reviews completed in eREP and track reviews that workers manually complete before the prepopulated reviews are mailed. The State agency added that "[t]hese enhancements reduce the complexity of identifying ex parte from prepopulated review completion."

For our fourth recommendation, the State agency said that it would, in coordination with DWS, establish a standard operating procedure for reporting to CMS. The State agency added that this procedure would include specifications about how requests are created, fulfilled, and reviewed for quality "in a manner that ensures accuracy." Also, the State agency said that it and DWS would "modify the existing unwinding data specification document to improve reporting accuracy." The State agency said that it anticipates completing all the corrective actions in response to our fourth recommendation by October 31, 2024.

CMS also provided written technical comments on the draft report, which we addressed as appropriate.

The State agency's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 193,009 enrollees who were listed on Utah's monthly unwinding data reports and who had their Medicaid eligibility renewed or coverage terminated during April 1 through September 30, 2023, following the end of the continuous enrollment condition.

For a stratified random sample of 140 enrollees, we reviewed the Medicaid eligibility actions taken by the State agency. (See Appendix B.) For each of the sampled enrollees, we reviewed DWS's documentation from eREP and DWS's Content Navigator that supported the eligibility determinations, including renewal forms, income support (e.g., pay stubs), notice letters, and caseworker notes. We also reviewed verification results from eVerifs for eligibility factors such as income and asset amounts.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. As part of our internal control assessment, we reviewed the State agency's and DWS's policies and procedures for processing eligibility actions during the unwinding period. We also performed a virtual walkthrough of some of DWS's systems involved in the eligibility determination process, such as eREP and Content Navigator, to obtain an understanding of how the State agency maintains documentation for eligibility determinations. However, because our review was limited to the processes in place during the unwinding period, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We conducted our audit from October 2023 through June 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

- met with State agency officials to gain an understanding of the electronic systems used in Utah's Medicaid program and the State agency's unwinding process;

- obtained and reviewed the State agency's and DWS's policies and procedures covering the unwinding process;

- obtained Medicaid data supporting what the State agency reported to CMS in its unwinding data reports for April through September 2023;[47]

- identified 193,009 enrollees whose eligibility was renewed or whose coverage was terminated during April 1 through September 30, 2023;

- selected a stratified random sample of 140 enrollees (Appendix B);

- reviewed eligibility documentation associated with the 140 sampled enrollees;

- on the basis of our sample results, estimated:

    - the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form,

    - the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed or whose coverage was incorrectly terminated, and

    - the total number of enrollees in the sampling frame who were incorrectly reported on the unwinding report (Appendix C); and

- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[47] The data provided by the State agency to support these reports included enrollees whose renewal month occurred between May and October 2023 but who also had renewal or termination dates before May 2023. Because the State agency began ex parte actions on Mar. 1, 2023, we included enrollees whose eligibility was renewed or whose coverage was terminated beginning on Apr. 30, 2023.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of an Excel workbook that contained 193,009 Utah Medicaid enrollees whose eligibility was renewed or whose coverage was terminated during April 1 through September 30, 2023, following the end of the continuous enrollment condition.

SAMPLE UNIT

The sample unit was an enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing four strata. Stratum 1 contained enrollees whose eligibility was renewed on an ex parte basis. Stratum 2 contained enrollees whose eligibility was renewed using a renewal form. Stratum 3 contained enrollees who were determined to be ineligible for Medicaid and had their coverage terminated. Stratum 4 contained enrollees whose coverage was terminated for procedural reasons (i.e., the enrollee failed to respond).

Table 1: Sample Design and Size

Stratum	Medicaid Eligibility Actions	Frame Size (Enrollees)	Sample Size
1	Renewals on ex parte basis	44,140	35
2	Renewals using renewal form	37,200	35
3	Coverage terminated based on a determination of ineligibility	6,768	35
4	Coverage terminated for procedural reasons	104,901	35
Total		**193,009**	**140**

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the State agency's Medicaid enrollee identification number (from smallest to largest) and then consecutively numbered the items in each stratum

in the sampling frame. After generating the random numbers for each of these strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate: (1) the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form, (2) the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed or whose coverage was incorrectly terminated, and (3) the total number of enrollees in the sampling frame who were incorrectly reported on the unwinding report. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval for each of these estimates.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

ENROLLEE CHARACTERISTICS FOR ESTIMATION

Incorrect Eligibility Renewals: Enrollee's eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form.

Incorrect Eligibility Terminations: Enrollee was incorrectly determined to be ineligible for Medicaid and coverage was terminated or coverage was incorrectly terminated for procedural reasons.

Incorrect Medicaid Eligibility Actions: Enrollee's eligibility was either incorrectly renewed or coverage was incorrectly terminated.

Reported on the Incorrect Line: Enrollee was incorrectly classified (i.e., on the incorrect line) and reported on the monthly unwinding data reports.

Table 2: Sample Results

Stratum	Frame Size (Enrollees)	Sample Size	Incorrect Eligibility Renewals	Incorrect Eligibility Terminations	Incorrect Medicaid Eligibility Actions	Reported on the Incorrect Line
1	44,140	35	3	N/A	3	0
2	37,200	35	1	N/A	1	11
3	6,768	35	N/A	2	2	3
4	104,901	35	N/A	0	0	1
Total	**193,009**	**140**	**4**	**2**	**6**	**15**

Table 3: Estimates for Each Characteristic in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Attribute	Statistical Estimates		
	Point Estimate	Lower Limit	Upper Limit
Incorrect eligibility renewals	4,846	948	8,744
Incorrect eligibility terminations	N/A	N/A	N/A*
Incorrect Medicaid eligibility actions	5,233	1,310	9,156
Reported on the incorrect line	15,269	8,320	22,218

* We have chosen not to report the estimated number of incorrect eligibility terminations in the sampling frame because of the low number of enrollees in our sample who were incorrectly determined to be ineligible or incorrectly terminated for procedural reasons.

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

July 26, 2024

James Korn
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
1201 Walnut Street, Suite 1338
Kansas City, MO 64106

Dear Mr. Korn:

On behalf of the Utah Department of Health and Human Services (DHHS), thank you for the opportunity to respond to the audit titled *Utah Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements (A-07-24-07013).* I appreciate the effort and professionalism of you and your staff in this review. The final product reflects a significant effort and time of state staff collecting information for HHS OIG review, answering questions, and planning changes to improve the program. This audit and its responses will result in a better, more efficient program.

DHHS concurs with the recommendations in this report. DHHS is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Jennifer Strohecker (Jul 26, 2024 11:06 MDT)

Jennifer Strohecker, PharmD, BCPS
Medicaid Director
Director, Division of Integrated Healthcare

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Response to Recommendations

Recommendation 1

We recommend that the Utah Department of Health and Human Services redetermine Medicaid eligibility for the six sampled enrollees whom we have identified as having had incorrectly completed eligibility determinations.

Department Response:

DHHS concurs with this recommendation.

The Department of Workforce Services has corrected the eligibility determinations for the 6 sampled enrollees that were identified as having incorrect eligibility determinations.

Recommendation 2

We recommend that the Utah Department of Health and Human Services coordinate with DWS to provide periodic training to caseworkers that focuses on verifying and documenting information used and steps performed during the eligibility renewal process, including: (1) verifying income and assets, (2) verifying residency/contact information, and (3) correctly executing case review and reporting.

Department Response:

DHHS concurs with this recommendation.

In January 2024, the Department of Workforce Services in coordination with the Department of Health and Human Services published the training *Case Maintenance and Processing Refresher* for all eligibility workers. This training focused on issuing correct benefits both at application and review. The training also included verifying income to determine the correct program for the customer. A mandatory training on assets will be conducted in November 2024 for all eligibility workers. This training will provide a refresher for workers on how to properly verify assets utilizing policy and procedures. The Asset training will be recorded and available for staff to review as needed.

The Department of Workforce Services conducts monthly training with Supervisors of eligibility staff, topics include policy changes, clarifications, and audit findings. August 2024 topics will include the importance of verifying residency and contact information. These trainings are recorded and available for Supervisors/Managers to view and discuss with eligibility workers. In addition, DWS will publish a training in October 2024 reminding workers of the requirement to narrate on all cases and the importance of accurate narrations.

The department provides annual online training sessions for eligibility staff to reinforce the procedures for verifying and documenting information during the eligibility renewal process. Online training includes an assessment that workers have to complete successfully.

Anticipated Completion Date: November 30, 2024

Recommendation 3

We recommend that the Utah Department of Health and Human Services identify and correct the eREP data limitations, which in some cases prevented proper reporting classification.

Department Response:

DHHS concurs with this recommendation and has already implemented the solution.

Prior to implementation of Utah's automated ex parte process, tracking and data was limited to identifying when eligibility workers sent out the ex parte review complete notice and the date the recertification period was updated, which limited the State's ability to correctly report to CMS.

In September 2023, Utah built and deployed the initial phase of the automated ex parte process. This first phase included creating a table to better track completed reviews. With the implementation of automation, Utah is able to identify any program that eREP completes an ex parte review on. In addition, the State can track reviews that are manually completed by workers prior to the pre- populated review being mailed. The added table allows Utah to identify once the pre-populated review is mailed and report accordingly. These enhancements reduce the complexity of identifying ex parte from pre-populated review completion.

Recommendation 4

We recommend that the Utah Department of Health and Human Services strengthen its policies and procedures to provide for greater accuracy in the monthly unwinding data reports and any future reports of a similar nature that the State agency submits to CMS.

Department Response:

DHHS concurs with this recommendation.

To ensure greater accuracy within data requests and reports, DHHS and DWS will establish a Standard Operating Procedure (SOP) for CMS reporting. The SOP will include specifications about how requests are created, fulfilled, and reviewed for quality in a manner that ensures accuracy. DHHS and DWS will also modify the existing unwinding data specification document to improve reporting accuracy.

Anticipated Completion Date: October 31, 2024