

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**COLORADO CLAIMED UNSUPPORTED
AND INCORRECT FEDERAL MEDICAID
REIMBURSEMENT FOR BENEFICIARIES
ENROLLED IN THE NEW ADULT GROUP**

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Office of Inspector General

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Report in Brief

Date: September 2020
Report No. A-07-19-02822

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



Why OIG Did This Audit

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA). The ACA established enhanced Federal reimbursement rates for services provided to nondisabled, low-income adults without dependent children (new adult group). The enhanced reimbursement rates established under the ACA have raised concerns about the possibility that States could improperly enroll individuals for Medicaid coverage in the new adult group and, as a consequence, the potential for improper payments.

Our objective was to determine whether Colorado complied with Federal and State requirements when claiming Federal Medicaid reimbursement for Medicaid services provided to beneficiaries enrolled in the new adult group.

How OIG Did This Audit

Our audit covered almost 580,000 newly eligible beneficiaries for whom Colorado received \$2.2 billion in enhanced Federal reimbursement during our audit period. To identify discrepancies in beneficiaries' Medicaid eligibility group status, we matched Medicaid claim data from Colorado's Medicaid Management Information System (MMIS) to eligibility span data provided by the State. To identify beneficiaries enrolled in the new adult group who should have been enrolled in the Transitional Medicaid group, we used MMIS data.

Colorado Claimed Unsupported and Incorrect Federal Medicaid Reimbursement for Beneficiaries Enrolled in the New Adult Group

What OIG Found

Colorado did not always comply with Federal and State requirements when claiming Federal Medicaid reimbursement for Medicaid services provided to beneficiaries enrolled in the new adult group. Specifically, Colorado claimed Medicaid payments at the newly eligible Federal Medical Assistance Percentage (FMAP) on behalf of 33,036 beneficiaries, but it did not have adequate supporting documentation to substantiate that these beneficiaries were eligible for the new adult group. Therefore, Colorado may have incorrectly claimed \$4.1 million on behalf of these beneficiaries. In addition, Colorado claimed the incorrect FMAP for Medicaid payments made on behalf of 6,897 beneficiaries whom it enrolled in the new adult group but who, according to supporting documentation, were eligible for the Transitional Medicaid eligibility group. As a result, Colorado incorrectly received an additional \$1.8 million for services that it claimed on behalf of these beneficiaries.

Colorado did not have adequate system controls to ensure that its claims for Federal Medicaid reimbursement were adequately supported and were claimed at the correct FMAP.

What OIG Recommends and Colorado Comments

We recommend that Colorado (1) update its eligibility determination system by implementing an automatically accessible eligibility history to eliminate the need for manual interventions to identify eligibility changes in eligibility status, (2) ensure that the MMIS retains all beneficiary eligibility changes and reconcile the data in the MMIS to the data in its eligibility determination system to determine whether discrepancies in eligibility groups are occurring, and (3) ensure that its systems have automated edits to enroll Transitional Medicaid beneficiaries in the correct eligibility group.

Colorado agreed with all of our recommendations and said that if feasible, it would implement an automatic accessible eligibility history. Colorado also described corrective actions that it said it had already implemented to address the system controls issues related to the findings in this report. Colorado added that therefore, it did not need to take additional action based on these findings. We acknowledge the corrective actions to which Colorado referred. Although Colorado described actions that it said it had implemented to address the system controls, it did not provide any supporting documentation.

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INTRODUCTION

WHY WE DID THIS AUDIT

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 cover nondisabled, low-income adults without dependent children, commonly referred to as the “new adult group.” The ACA also established enhanced Federal reimbursement rates (Federal Medical Assistance Percentage, or FMAP) for services provided to these beneficiaries.²

The enhanced FMAPs established under the ACA have raised concerns about the possibility that States could improperly enroll individuals for Medicaid coverage in the new adult group and, as a consequence, the potential for improper payments.

OBJECTIVE

Our objective was to determine whether the Colorado Department of Health Care Policy and Financing (State agency) complied with Federal and State requirements when claiming Federal Medicaid reimbursement for Medicaid services provided to beneficiaries enrolled in the new adult group.

BACKGROUND

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 United States citizenship. For both newly eligible and Traditional Medicaid eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL).³

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

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 Enhanced Federal reimbursement is defined as a payment made at a higher percentage than the State’s standard FMAP rate.

³ The Social Security Act (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)).

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 73.58 percent.^{6,7}

Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act

The ACA provided States with the option to expand their Medicaid programs to cover more low-income people, including nondisabled adults without dependent children.^{8,9} Effective January 1, 2014, as originally drafted, nearly all individuals under 65 years of age with incomes up to 133 percent of the FPL became eligible for Medicaid;¹⁰ this initiative is known as Medicaid expansion. States that expanded their Medicaid programs under the provisions of the ACA are referred to as “expansion States.” A Medicaid expansion State is one that previously offered health benefits statewide to parents and non-pregnant, childless adults whose income was at least 100 percent of the FPL.¹¹

The ACA § 2001 authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group (footnote 3). This “newly eligible FMAP” was set to remain at 100 percent through calendar year (CY) 2016, gradually decreasing to 90 percent by CY 2020.¹²

⁴ The Act § 1905(b).

⁵ CMS, “Financial Management.” Accessed at <https://www.medicaid.gov/medicaid/financial-management/index.html> on Mar. 5, 2020.

⁶ 77 Fed. Reg. 71420, 71422 (Nov. 30, 2012); 79 Fed. Reg. 3385, 3387 (Jan. 21, 2014).

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 Mar. 5, 2020.

⁸ ACA § 2001(a)(1)(C).

⁹ The ACA required States to expand their Medicaid programs for certain categories of individuals. However, the U.S. Supreme Court found that this expansion violated the Constitution “by threatening existing Medicaid funding.” *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012). The decision allowed States the option to refuse to expand their Medicaid programs and not face any reduction in current Medicaid funding.

¹⁰ The ACA § 2001(a)(3) and the Act § 1902 established the FPL income threshold at 133 percent but allow for a 5-percent income disregard (a standard deduction applied to calculate income for Medicaid), making the effective threshold 138 percent of the FPL.

¹¹ The Act § 1905(z)(3).

¹² 42 CFR § 433.10(c)(6).

Colorado Medicaid and Enhanced Federal Medicaid Reimbursement Rates for the New Adult Group

Colorado met CMS's definition of an expansion State when it expanded its Medicaid program effective January 1, 2014. Therefore, it was entitled to receive the "newly eligible FMAP" reimbursement rate for Medicaid services provided to individuals whom it enrolled under its new adult group category.¹³

In Colorado, the State agency administers the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process payments and maintain beneficiary eligibility and enrollment information.

The State agency is also 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. The MMIS will not process a payment on behalf of a beneficiary who lacks a current Medicaid eligibility determination, so as part of the State agency's adjudication of a Medicaid claim, the system checks eligibility data that transfer from CBMS to verify that the individual in question is Medicaid eligible.

For beneficiaries in certain Medicaid eligibility groups, if changes in eligibility information cause the beneficiary to become ineligible for Medicaid, the beneficiary may be eligible for transitional or extended Medicaid if he or she meets specified requirements. Transitional Medical Assistance (known as Transitional Medicaid) may extend for up to 12 months (10 Code of Colorado Regulations (CCR) 2505-10 8.100.4.I).

Colorado's Process for Assigning the Federal Medical Assistance Percentage

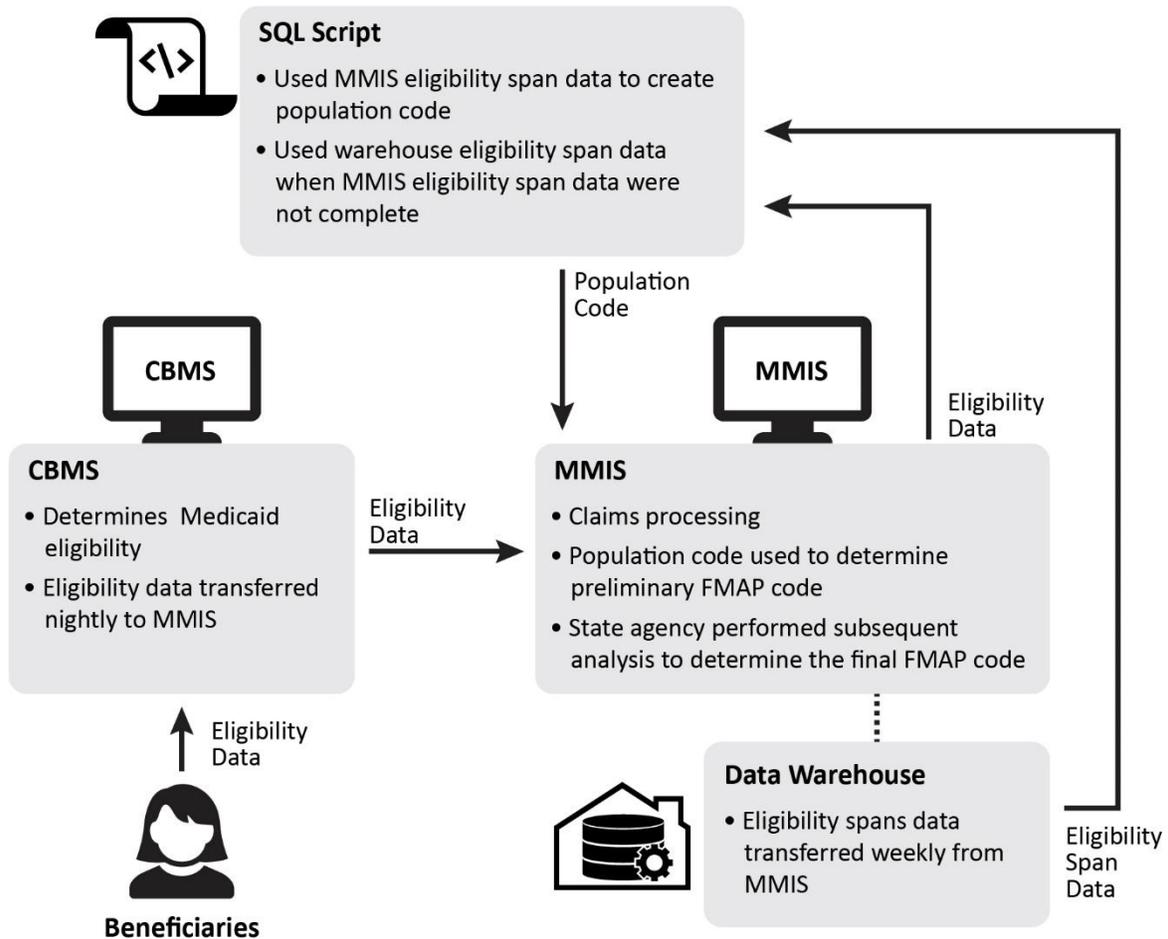
During our audit period (January 1, 2014, through September 30, 2015), the State agency processed claims using a legacy MMIS, which did not have the capability to separately identify distinct Medicaid eligibility groups and assign different FMAP categories (e.g., newly eligible, standard) to claims.¹⁴ Therefore, the State agency developed a Structured Query Language

¹³ Not all beneficiaries enrolled through the new adult group category are eligible for the post-expansion enhanced FMAP of 100 percent. For beneficiaries in the new adult group category who would have been eligible for Medicaid benefits under an existing category as of December 1, 2009, the post-expansion FMAP rates of 75 percent or 80 percent apply because the State already covered those adults. This audit did not review this subgroup; rather, we focused only on newly eligible beneficiaries whose qualified expenditures would have been reimbursed at the 100-percent newly eligible FMAP.

¹⁴ Our audit period is the same as that of a previous report that covered Colorado's newly eligible beneficiaries: *Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (A-07-16-04228, Aug. 30, 2019).

(SQL) script to identify the different Medicaid eligibility groups, including the new adult group, and to assign the applicable FMAP for each of those groups.¹⁵ Figure 1 below depicts the manner in which the SQL script interacts with other systems and functions within the State agency’s administration of the Medicaid program in Colorado.

Figure 1: Interactions of SQL Script With Other State Agency Systems



¹⁵ The Medicaid program identifies a number of Medicaid eligibility groups, which are typically defined by the populations they cover and the financial criteria that apply to them. Thus, Medicaid eligibility groups are differentiated sometimes by income (as a percentage of FPL) and sometimes by other factors. Some other Medicaid eligibility groups, only one of which is related to the scope of this audit, are Transitional Medical Assistance, Qualified Pregnant Women, and Individuals Receiving SSI [Supplemental Security Income]. These Medicaid eligibility groups fall under traditional Medicaid, for which claims are generally reimbursed at the standard FMAP.

The SQL script used both eligibility data that existed in the claim at the time of State agency adjudication and supplemental eligibility span data¹⁶ to create a population code, which the script then assigned to the claims to identify the different Medicaid eligibility groups. The eligibility data that existed in the claim at the time of State agency adjudication transferred directly from the CBMS into the MMIS each night. The State agency used supplemental eligibility span data for any case in which the claim did not capture all of the fields (in the data transferred from the CBMS) necessary to create the population code.

The State agency used the population code to determine the preliminary FMAP code that it then assigned to each claim. After this process, the State agency performed subsequent analysis to determine the final FMAP code that it assigned to a claim. For example, if the population code resulted in a new adult group code, but the State agency's subsequent analysis showed that the beneficiary was eligible for a traditional Medicaid eligibility group, the State agency assigned a standard FMAP code to a claim instead of the newly eligible FMAP code. According to State agency staff, in most cases, the final FMAP code was compatible with the population code originally assigned to the claim.

The State agency assigned population codes to claims using a hierarchy approach.¹⁷ When the eligibility span data matched the given population parameters, the SQL script assigned that population code to the claim. This process ensured that eligibility records associated with beneficiaries who meet the criteria for one eligibility group would never be assigned to a different eligibility group (or, to use the State agency's term, a subsequent population). The SQL script established 54 distinct population codes associated with the different Medicaid eligibility groups to capture all populations of beneficiaries whose medical expenditures are paid by Federal sources, State sources, or both.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 579,925 beneficiaries whom the State agency determined to be newly eligible for Medicaid under the ACA (excluding American Indians and Alaska Natives) for whom the State agency received enhanced Medicaid reimbursement totaling \$2.2 billion (which amount was 100-percent Federal share) for services provided from January 1, 2014, through September 30, 2015.

¹⁶ The supplemental eligibility span data reside in the State agency's data warehouse. MMIS claim data, including eligibility spans, are downloaded from the MMIS to the data warehouse weekly. The State agency also refers to eligibility spans as medical spans. The eligibility span showed the timespan(s) for which each beneficiary was eligible and indicated what Medicaid eligibility group the beneficiary qualified for.

¹⁷ Many Medicaid eligibility groups have specific restrictions that prohibit an individual from being eligible in one group if he or she is eligible for another group. For this reason, CMS guidelines have established a hierarchy for many Medicaid eligibility groups to help States determine which eligibility group (or "population," as the State agency sometimes refers to it) is the correct group to which to assign a beneficiary. (These guidelines appear online as "Reporting PRIMARY-ELIGIBILITY-GROUP-IND (Eligibility)" at <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/47573> (accessed Jun. 18, 2020).

To identify beneficiaries for whom the State agency claimed Medicaid expenditures at the newly eligible FMAP but whose Medicaid eligibility group showed as eligible for the standard FMAP (footnotes 6 and 7) in the eligibility span data, we matched Medicaid claim data from the MMIS to eligibility span data (footnote 16) provided by the State agency. The eligibility span data included eligibility spans that showed the timespan(s) for which each beneficiary was eligible for Medicaid; no eligibility spans would exist for the timespans in which a beneficiary was not eligible. We analyzed MMIS data to identify beneficiaries whom the State agency enrolled in the new adult group but who should have been enrolled in the Transitional Medicaid group. We reviewed only those State agency internal controls directly related to our objective.

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.

FINDINGS

The State agency did not always comply with Federal and State requirements when claiming Federal Medicaid reimbursement for Medicaid services provided to beneficiaries enrolled in the new adult group. Specifically:

- The State agency claimed Medicaid payments at the newly eligible FMAP on behalf of 33,036 beneficiaries, but it did not have adequate supporting documentation to substantiate that these beneficiaries were eligible for the new adult group. Without adequate support, we could not determine whether these individuals were eligible for the new adult group. Therefore, the State agency may have incorrectly claimed Federal Medicaid reimbursement of \$4,086,654 on behalf of these Medicaid beneficiaries.¹⁸
- The State agency claimed the newly eligible FMAP for Medicaid payments made on behalf of 6,897 beneficiaries whom it enrolled in the new adult group but who, according to supporting documentation, were eligible for the Transitional Medicaid eligibility group (footnote 15). As a result, the State agency incorrectly received an

¹⁸ This is the difference between the newly eligible FMAP and the standard FMAP.

- additional \$1,829,564 for services that it claimed on behalf of these beneficiaries.^{19, 20}

The State agency's noncompliance with Federal and State requirements occurred because it did not have adequate system controls to ensure that its claims for Federal Medicaid reimbursement were adequately supported and were claimed at the correct FMAP. The State agency's MMIS had limited system capabilities that prevented documentation of an adequate and complete eligibility history for Medicaid beneficiaries. In addition, the State agency's CBMS lacked effective automated controls to (1) prevent Transitional Medicaid beneficiaries from enrolling in the new adult group before their Transitional 12-month coverage period had ended or (2) detect such incorrect enrollments after they had occurred.

THE STATE AGENCY CLAIMED REIMBURSEMENT FOR SERVICES PROVIDED TO SOME MEDICAID BENEFICIARIES WHO MAY NOT HAVE BEEN ELIGIBLE FOR THE NEW ADULT GROUP

Medicaid Reimbursement Claimed at the Newly Eligible Federal Medical Assistance Percentage but Not Adequately Supported

Federal Requirements

Federal regulations require the State agency to maintain and, if necessary, produce documentation substantiating the allowability of claimed program expenditures. A State plan "must provide that the Medicaid agency and, where applicable, local agencies administering the plan will . . . [m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements" (42 CFR § 433.32(a)). "[I]n all cases, the State has the burden of documenting the allowability of its claims for FFP [Federal financial participation]" (42 CFR § 430.42(b)(2)(ii)).²¹ In addition, the State agency must maintain records that include facts essential to determining initial and continuing Medicaid eligibility (42 CFR § 431.17(b)(1)(iii)).

Unsupported Medicaid Claims

The State agency claimed reimbursement for Medicaid payments made on behalf of 33,036 beneficiaries at the newly eligible FMAP but did not have adequate documentation to

¹⁹ This is the difference between the newly eligible FMAP and the standard FMAP.

²⁰ We are not recommending recovery of the overpayments made to the State agency 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 Medicaid Eligibility Quality Control or Payment Error Rate Measurement reviews. We are issuing a separate report reviewing Colorado's implementation of its eligibility determinations. Payment errors in implementation such as "data processing errors" are disallowable.

²¹ FFP refers to the Federal Government's share of a State's expenditures under the Medicaid program (42 CFR § 400.203).

substantiate that these beneficiaries were newly eligible. The State agency claimed Medicaid payments for these beneficiaries at the newly eligible FMAP, but the associated documentation supported only that the payments were eligible for the standard FMAP. The State agency's MMIS showed these beneficiaries as eligible for and enrolled in the new adult group, but eligibility span data (footnote 16) showed them as eligible for and enrolled in traditional Medicaid, for which claims are generally reimbursed at the standard FMAP (footnote 15).

Inadequate System Controls Prevented Adequate Documentation of a Complete Eligibility History

The State agency did not have adequate documentation to support that the 33,036 beneficiaries were newly eligible Medicaid beneficiaries because the CBMS and MMIS had limited capabilities that prevented documentation of an adequate and complete eligibility history for these beneficiaries.

State agency officials said that the CBMS did not have the capability to automatically provide an accessible eligibility history that would track changes made to a beneficiary's Medicaid case file. These officials said that retroactive changes to a beneficiary's eligibility could cause the beneficiary to move from the new adult group to a Traditional Medicaid eligibility group, which could then create a discrepancy in that beneficiary's Medicaid eligibility group status between the MMIS data and the eligibility span data. These officials added that the CBMS could not generate a report showing retroactive eligibility changes for the 33,036 beneficiaries for whom the eligibility span data did not match the MMIS data, and added that a manual process, which involved a review of paper and electronic documents, was required to identify the retroactive eligibility changes.

State agency officials also stated that another possible reason for the lack of a match between the eligibility span data and the MMIS data was that during our audit period, the MMIS did not have the capability to save all eligibility changes that transferred to it from the CBMS.

Our review of 10 beneficiaries' CBMS case files (which include beneficiaries' eligibility history) found that most of the discrepancies between the MMIS data and the eligibility span data occurred because of retroactive eligibility changes in the CBMS that changed the Medicaid eligibility group status of the beneficiaries after the claims had adjudicated.²² These changes could not be tracked in CBMS without manually reviewing paper and electronic documents, and the MMIS did not retain all the changes in eligibility status.

For a more detailed discussion of these inadequate system controls, see Appendix B.

The lack of an automatically accessible eligibility history in the CBMS and the MMIS's inability to save all eligibility changes were control weaknesses that increased the risk of errors and

²² One of the selected beneficiary case files had access restrictions; therefore, we were not able to access its information in the CBMS.

increased the potential for unsupported payments. Because of (1) the lack of adequate support in cases when the retroactive adjustments that changed an eligibility determination could not be identified without a manual review of the Medicaid case files and (2) the inability of the MMIS to retain all the eligibility changes, we could not determine whether these individuals were eligible for the new adult group. Therefore, the State agency may have incorrectly claimed Federal Medicaid reimbursement of \$4,086,654 on behalf of these Medicaid beneficiaries (footnote 18).

Medicaid Reimbursement Claimed at the Incorrect Federal Medical Assistance Percentage

Federal and State Requirements

The ACA established an enhanced FMAP for medical assistance expenditures for individuals determined eligible under the new adult group in the State and who are considered to be “newly eligible” as defined in section 1905(y)(2)(A) of the Social Security Act (the Act). The enhanced FMAP specified in section 1905(y)(1) of the Act is available for medical assistance expenditures for those individuals who are considered newly eligible (the ACA § 2001(a)(3)).

Federal regulations direct States to apply a threshold methodology to determine the appropriate FMAP for expenditures for individuals enrolled in the new adult group described in 42 CFR § 435.119 and receiving medical assistance (42 CFR § 433.206).²³

Under the threshold methodology, each State must provide that once individuals are determined to be either newly or not newly eligible individuals in accordance with the applicable eligibility criteria, the State will apply that determination until a new determination of income has been made or the individual has been otherwise determined to be not covered under the new adult group (42 CFR §§ 433.206(c)(7) and 435.916).

State regulations provide that eligibility for Transitional Medical Assistance shall be granted for 12 months (beginning with the first month of ineligibility) to individuals who are no longer eligible for the Parent/Caretaker Relative category due to a change in income. Transitional Medicaid Assistance shall discontinue at the end of the month in which the household no longer includes a dependent child (10 CCR 2505-10 8.100.4.I, Transitional Medical Assistance).

Incorrect Federal Medical Assistance Percentage Claimed

The State agency claimed the incorrect FMAP for Medicaid payments made on behalf of 6,897 beneficiaries whom it enrolled in the new adult group but who, according to supporting documentation, were eligible for and should have been enrolled in the Transitional Medicaid eligibility group (footnote 15). The State agency’s MMIS data showed that the State agency

²³ The threshold methodology provides a simple, accurate approach to determining the newly eligible or not newly eligible status of individuals enrolled in the new adult group.

enrolled these beneficiaries under the new adult group during their Transitional 12-month coverage period.

Our review of 10 beneficiaries' CBMS case files found that the State agency enrolled these beneficiaries in Transitional Medicaid and then switched them to the new adult group while they were still in their Transitional 12-month coverage period. After 1 or more months in the new adult group, the State agency placed the beneficiaries back in Transitional Medicaid. For 2 of the 10 beneficiaries, the Transitional 12-month coverage period started again after the CBMS placed the beneficiaries back in the Transitional Medicaid eligibility group. If the State agency had followed its hierarchy approach that assigns distinct population codes to claims (footnote 17), these 10 beneficiaries would have been evaluated and determined eligible for Transitional Medicaid before being evaluated for the new adult group category. Therefore, the State agency should not have enrolled these beneficiaries in the new adult group when they were still in their Transitional 12-month coverage period.

Inadequate System Controls Allowed Transitional Beneficiaries To Enroll in the New Adult Medicaid Eligibility Group

The State agency claimed the incorrect FMAP for Medicaid payments made on behalf of the 6,897 beneficiaries because the State agency's CBMS lacked effective automated controls to (1) prevent Transitional Medicaid beneficiaries from being enrolled in the new adult group before their Transitional 12-month coverage period had ended or (2) detect such incorrect enrollments after they had occurred. In other words, the CBMS allowed Transitional Medicaid beneficiaries to be moved to the new adult group before their Transitional 12-month coverage period had ended.

State agency staff stated that during our audit period, there was an error in the CBMS that permitted Medicaid beneficiaries either to be approved for Transitional Medicaid when they should not have been or to be enrolled in Transitional Medicaid and removed from that status before the end of the Transitional 12-month coverage period. The State agency said that it identified and fixed this error in April 2015 and added that it made additional corrections in 2017 and 2019 after caseworkers reported that beneficiaries eligible for the Transitional Medicaid group were enrolled in the new adult group.

The State agency incorrectly received an additional \$1,829,564 for services that it claimed on behalf of these beneficiaries (footnotes 19 and 20).

RECOMMENDATIONS

We recommend that the Colorado Department of Health Care Policy and Financing:

- update the CBMS by implementing an automatically accessible eligibility history that retains all beneficiary histories when retroactive changes occur, thereby eliminating the need for manual interventions to identify changes in eligibility status;
- ensure that the MMIS retains all beneficiary eligibility changes and reconcile the beneficiaries' data contained in the MMIS to the data in the CBMS to determine whether discrepancies in Medicaid eligibility groups are occurring; and
- ensure that the CBMS has automated edits to enroll Transitional Medicaid beneficiaries in the correct eligibility group.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with all of our recommendations. For our first recommendation, the State agency said that it would review, research, and analyze the ability to implement an automatic accessible eligibility history that retains all beneficiary histories when retroactive changes occur. The State agency added that if feasible, it would implement this feature through a phased approach with a July 2023 planned completion date. For our other two recommendations, the State agency described corrective actions that it said it had already implemented to address the system controls issues related to the findings in this report. The State agency added that therefore, it did not need to take additional action based on these findings.

The State agency also said that the issues affecting eligibility determinations and the resulting claims payments had already been identified by Federal and State agency auditors before our audit. The State agency added that it had updated its eligibility system and implemented system controls.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge the corrective actions to which the State agency referred in its written comments. With respect to the State agency's characterization of our audit as duplicative of other Federal and State reviews, the Office of Inspector General (OIG) (which by statute is independent²⁴) is not bound by the positions taken by any other Federal (or State) agency.

²⁴ The Inspector General Act of 1978, 5 U.S.C. App. § 4(a)(1).

Moreover, even when other reviews might have had identified some of the same issues that we did, our audit did not review the percentage of incorrect newly eligible beneficiaries as some other reviews did. Rather, we identified system control issues that allowed incorrect FMAP claiming.

In addition, although the State agency described actions that it said it had implemented to address the system controls related to two of our recommendations, it did not provide any supporting documentation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 579,925 beneficiaries whom the State agency determined to be newly eligible for Medicaid under the ACA (excluding American Indians and Alaska Natives) for whom the State agency received enhanced Medicaid reimbursement totaling \$2.2 billion (which amount was 100-percent Federal share) for services provided from January 1, 2014, through September 30, 2015.

To identify beneficiaries for whom the State agency claimed Medicaid expenditures at the newly eligible FMAP but whose Medicaid eligibility group showed as eligible for the standard FMAP (footnotes 6 and 7) in the eligibility span data, we matched Medicaid claim data from the MMIS to eligibility span data (footnote 16) provided by the State agency. The eligibility span data included eligibility spans that showed the timespan(s) for which each beneficiary was eligible for Medicaid; no eligibility spans would exist for the timespans in which a beneficiary was not eligible. We reviewed only those State agency internal controls directly related to our objective.

We conducted our audit work from April 2018 to June 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid expansion populations and their associated FMAPs;
- reviewed the Colorado State Plan Amendments and CMS guidance documentation related to implementation of the changes brought about by the ACA;
- interviewed officials from the State agency to gain an understanding of the process for assigning FMAPs to the different Medicaid eligibility groups;
- held discussions with State agency staff members who had taken part in development of the SQL script to gain an understanding of its purpose;
- interviewed State agency staff to gain an understanding of the source data and system interfaces used by the SQL script to create and assign population codes to the different Medicaid eligibility groups;

- obtained MMIS data of all Medicaid paid claim data in Colorado with service dates during our audit period (excluding claims for services provided to American Indians and Alaska Natives, who are already covered at a 100-percent FMAP);
- created a list from the MMIS data of 579,925 newly eligible Medicaid beneficiaries for whom the State agency made Medicaid payments totaling \$2,245,798,183 (which amount was 100-percent Federal share);
- selected, from the list of 579,925 newly eligible Medicaid beneficiaries, a sample of 203,598 beneficiaries totaling \$732,185,053 to match against the Medicaid eligibility data;
- obtained Medicaid eligibility span data (which resides in the State agency's data warehouse) from the State agency for the 203,598 newly eligible Medicaid beneficiaries;
- matched the sample of newly eligible beneficiaries from the MMIS data to the Medicaid eligibility span data and identified 33,036 beneficiaries for whom the State agency claimed Federal Medicaid reimbursement at the newly eligible FMAP but whose eligibility span data showed as eligible for a Traditional Medicaid eligibility group (for which Medicaid services are generally reimbursed at the standard FMAP);
- selected a random sample of 10 Medicaid beneficiaries from the list of 33,036 beneficiaries identified as having a Medicaid eligibility group discrepancy between the MMIS data and the eligibility span data and manually checked the beneficiaries' CBMS case files to try to determine whether the discrepancy occurred because of retroactive adjustments as the State agency believed;
- analyzed the MMIS data associated with all Medicaid paid claim data in Colorado with service dates during our audit period and identified Transitional Medicaid claims, then matched those claims to our list of 579,925 newly eligible beneficiaries from the MMIS data and identified 6,897 beneficiaries whom the State agency enrolled in the new adult group but who should have been enrolled in the Transitional Medicaid group because they were still in their Transitional 12-month coverage period;
- selected a random sample of 10 Medicaid beneficiaries from the list of 6,897 beneficiaries identified as ineligible for the new adult group while they were still in their Transitional 12-month coverage period and manually checked the beneficiaries' CBMS case files to determine whether an error in CBMS was allowing this change in eligibility determination to occur as the State agency believed;
- determined the total amount of Federal Medicaid reimbursement made on behalf of ineligible beneficiaries (footnote 20); and

- discussed the results of our audit with State agency officials on April 9, 2020.

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: INADEQUATE SYSTEM CONTROLS PREVENTED ADEQUATE DOCUMENTATION OF A COMPLETE ELIGIBILITY HISTORY

The State agency did not have adequate support for claims made on behalf of newly eligible Medicaid beneficiaries because the CBMS and MMIS had limited capabilities that prevented documentation of an adequate and complete eligibility history for these beneficiaries.

State agency officials stated that a possible reason for the lack of a match between the eligibility span data and the MMIS data was that the CBMS did not have the capability to automatically provide an accessible eligibility history that would include all changes made to a beneficiary's Medicaid case file. These officials said that retroactive changes to a beneficiary's eligibility could cause the beneficiary to move from the new adult group to a Traditional Medicaid eligibility group, which could then create a discrepancy in Medicaid eligibility group status between the MMIS data and the eligibility span data. However, using these systems it is not possible to identify cases in which a retroactive adjustment has changed a beneficiary's eligibility status. Information that is accessible in the CBMS data and the eligibility span data makes it appear as if the retroactive change was the original eligibility determination. If an accessible eligibility history that included all of the eligibility changes existed, then changes in eligibility could be tracked, and the discrepancy could easily be resolved.

In discussions with us, State agency officials said that the CBMS could not generate a report showing retroactive eligibility changes for the 33,036 beneficiaries for whom the eligibility span data did not match the MMIS data. These officials added that a manual review of paper and electronic documents would be required to identify the retroactive eligibility changes.

State agency officials also stated that another possible reason for the lack of a match between the eligibility span data and the MMIS data was that during our audit period, the MMIS did not have the capability to save all eligibility changes that transferred to it from the CBMS. The CBMS transferred eligibility data to the MMIS on a daily basis, but eligibility data that the MMIS used to assign FMAPs downloaded to the data warehouse (which stores eligibility span data) only on a weekly basis (footnote 16). Because the eligibility data downloaded to the data warehouse at the end of the week, the data warehouse would not have a record of the midweek changes (though they might be reflected on the claim data at adjudication and payment).

The following hypothetical example illustrates how the unsaved eligibility changes could create a mismatch between data in the MMIS and the CBMS:

- The CBMS determined a beneficiary eligible for the new adult group on Monday, and the State agency assigned the new adult group FMAP to the claim, which was adjudicated on Tuesday.
- However, the CBMS redetermined the beneficiary's eligibility on Wednesday and determined that beneficiary to be eligible for a Traditional Medicaid group.

- The Traditional Medicaid eligibility data were transferred from the CBMS to the MMIS, and then to the data warehouse on the following Sunday. The eligibility span data showed only the Traditional group eligibility information, and the new adult group eligibility information was lost.

Therefore, a claim for such a beneficiary could be correctly adjudicated on a Tuesday at the new adult group FMAP, but only the Traditional Medicaid group eligibility information would be reflected in the CBMS and in the eligibility span data.

In an effort to determine why these discrepancies in Medicaid eligibility group statuses between the MMIS data and the eligibility span data had occurred, we reviewed 10 beneficiaries' CBMS case files. Our review showed that most of the discrepancies occurred because of retroactive eligibility changes in the CBMS. We did not identify any cases in which the discrepancy occurred due to the unsaved eligibility changes issue that the State agency described. These retroactive changes changed the Medicaid eligibility group status of the beneficiaries after the claims had been adjudicated; the changes could not be tracked without resorting to individually looking up case files. For example, for one beneficiary, case comments in the CBMS stated that the beneficiary had income and, consequently, the CBMS determined that the beneficiary was eligible for the new adult group. However, a case comment added approximately 5 months after the original eligibility determination stated that the beneficiary's income was lower. At this point, the caseworker retroactively revised the original income back to the date when the beneficiary originally applied for coverage. With this income change, the CBMS retroactively changed the beneficiary's Medicaid eligibility group from new adult to Traditional Medicaid as of that date. Therefore, the beneficiary's eligibility status changed to Traditional Medicaid in the CBMS and the eligibility span data—but did not change in the MMIS.



COLORADO
Department of Health Care
Policy & Financing

1570 Grant Street
Denver, CO 80203

August 11, 2020

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-07-19-02822

Dear Mr. Cogley:

Enclosed is the Department of Health Care Policy and Financing's response to the United States Department of Health and Human Services, Office of Inspector General draft report entitled *Colorado Claimed Unsupported and Incorrect Federal Medicaid Reimbursement for Beneficiaries Enrolled in the New Adult Group*.

If you have any questions or need additional information, please contact Melissa Mull at melissa.mull@state.co.us.

Sincerely,

/s/

Donna Kellow
Division Director
Audits and Compliance

DK:mm

Cc: Ms. Charlie Arnold, Acting Director Audit & Review Branch, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services
James Korn, Assistant Regional Inspector General for Audit Services

Colorado Department of Health Care Policy and Financing Response to
the Department of Health and Human Services Office of Inspector
General (OIG) Audit Report Titled *Colorado Claimed Unsupported
and Incorrect Federal Medicaid Reimbursement for Beneficiaries
Enrolled in the New Adult Group.* (A-07-19-02822)

OIG Audits Same Timeframe as Other Auditors to Produce Same Findings

The Department of Health Care Policy and Financing (Department) appreciates the work of the OIG and other auditors who timely 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 the Affordable Care Act 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 issues impacting eligibility determination and the resulting claims payments were previously identified by the Department and other auditors, including the Department's internal Medicaid Eligibility Quality Control audits, Colorado's Office of the State Auditor, and Centers for Medicare and Medicaid Services (CMS) prior to the OIG audit. In addition, the Department's legacy claims processing system active during the period of the OIG audit has since been sunsetted and replaced. Further, the Department's eligibility system has also been significantly upgraded. The Department has already resolved corrective action plans with CMS related to the findings in the OIG audit report and has implemented the necessary system controls in the Department's current eligibility and claims processing systems.

OIG Recommendations and Department Responses

We recommend that the Colorado Department of Health Care Policy and Financing:

- *update the CBMS by implementing an automatically accessible eligibility history that retains all beneficiary histories when retroactive changes occur, thereby eliminating the need for manual interventions to identify changes in eligibility status;*

Response: Agree that the OIG's recommendation is a best practice to automate the accessibility of the eligibility history in CBMS. It is important to note that this information is available through a manual retrieval process through CBMS or the Department's MMIS. The Department agrees to review, research, and analyze the ability to implement an automatic accessible eligibility history that retains all beneficiary histories when retroactive changes occur, thereby eliminating the need for manual interventions to identify changes in eligibility status. If feasible, the Department will implement it through a phased approach that would be completed by July 2023. If this approach is not feasible, the information will continue to be retrieved manually or through the Department's MMIS.

- *ensure that the MMIS retains all beneficiary eligibility changes and reconcile the beneficiaries' data contained in the MMIS to the data in the CBMS to determine whether discrepancies in Medicaid eligibility groups are occurring; and*

Response: Agree and already completed. Related to the issue identified in the OIG report, the Department made system changes in 2014 to identify spans that were retroactively closed and then in 2016 additional system changes were made to prevent eligibility technicians from incorrectly retroactively closing eligibility spans. The Department's new MMIS, Colorado interChange, which was implemented in 2017, does not delete any CBMS eligibility records, like the legacy MMIS did. In addition, the Colorado interChange has new controls and processes to ensure the member's eligibility records are accepted, processed, and stored in the system which were not available in the legacy MMIS that was in place for the date spans audited by the OIG.

Since the implementation of the Colorado interChange, the Department has enhanced and modified the system to ensure the eligibility information in CBMS is correctly reflected in Colorado interChange. For example, in June 2018, the Department implemented a system enhancement to accept and process retroactive eligibility changes from CBMS, so records of multiple eligibility spans are maintained. Further, starting in October 2019, the Department developed an eligibility reconciliation report that compares beneficiary records with an active eligibility span in the Colorado interChange, and not reported on the CBMS monthly reconciliation file. The reconciliation file is reviewed by MMIS and CBMS teams monthly to identify the beneficiary records that require additional updating in the MMIS. Therefore, the Department finds that it has already implemented adequate systems controls that ensure that eligibility determinations transfer correctly from the CBMS to the MMIS and does not need to take additional action based on the OIG's findings.

- *ensure that the CBMS has automated edits to enroll Transitional Medicaid beneficiaries in the correct eligibility group.*

Response: Agree and already completed. Related to the specific issue identified in the OIG report, the Department identified a defect that was fixed in April 2015 related to Transitional Medicaid (clients were removed before the 12-month guarantee). Since April 2015, the Department has continued to implement improvements related to Transitional Medicaid as issues were identified during various audits. For issues not identified through audits, all eligibility technicians have the ability to report issues through system helpdesk tickets. The Department has a team assigned that specifically handles eligibility helpdesk tickets and works to get these issues fixed timely. Therefore, the Department finds that this recommendation has already implemented and does not need to take additional action based on the OIG's findings.