Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COLORADO IMPROPERLY CLAIMED MILLIONS IN ENHANCED FEDERAL MEDICAID REIMBURSEMENT FOR NEW ADULT GROUP BENEFICIARIES BECAUSE OF A DATA PROCESSING ERROR

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A-07-17-02807

Office of Inspector General

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Report in Brief
Date: October 2020
Report No. A-07-17-02807

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

Colorado Improperly Claimed Millions in Enhanced Federal Medicaid Reimbursement for New Adult Group Beneficiaries Because of a Data Processing Error

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 properly claimed reimbursement for Medicaid services provided from January 1, 2014, through September 30, 2015, to beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage.

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 terminated beneficiaries, we matched Medicaid claim data from Colorado's Medicaid Management Information System (MMIS) to eligibility span data that showed the timespan(s) for which each beneficiary was eligible; no eligibility spans would exist for the timespans in which a beneficiary was not eligible for Medicaid.

What OIG Found

Colorado claimed reimbursement for Medicaid services provided from January 1, 2014, through September 30, 2015, to some beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage. As a result, Colorado improperly claimed and received over $1.9 million in Federal reimbursement for these beneficiaries past the termination dates of their Medicaid eligibility.

Colorado properly terminated 1,543 beneficiaries' eligibility in the Colorado Benefits Management System (CBMS), which determines Medicaid eligibility and interfaces with other automated systems, but erroneously kept them as eligible in the MMIS. The beneficiaries' eligibility was not terminated in the MMIS because of a data processing error in which eligibility data from the CBMS did not always transfer correctly to the MMIS through the normal automated process. Although the CBMS interfaced with the MMIS, for some beneficiaries a change in eligibility determination from eligible to ineligible that occurred in the CBMS did not transfer correctly to the MMIS.

What OIG Recommends and Colorado Comments

We recommend that Colorado (1) refund to the Federal Government the over $1.9 million in improperly claimed Medicaid reimbursement, (2) identify and refund to the Federal Government any payments made on behalf of ineligible beneficiaries for whom services after our audit period were claimed and reimbursed past the termination dates of their eligibility, and (3) establish adequate system controls that ensure that eligibility determinations transfer correctly from the CBMS to the MMIS to prevent payments from being made on behalf of ineligible beneficiaries.

Colorado disagreed with our first two recommendations and agreed with our third recommendation. For all three recommendations, Colorado said that it did not need to take additional action because the issues affecting eligibility determinations and the resulting claims payments had already been identified and addressed before our audit. We maintain that all of our findings and recommendations remain valid. We disagree that Colorado had already identified and addressed the errors we describe in this report. The errors we identified were data processing errors in Colorado's systems, not eligibility errors.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/71702807.asp.

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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 FMAP 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.

OBJECTIVE

Our objective was to determine whether the Colorado Department of Health Care Policy and Financing (State agency) claimed reimbursement for Medicaid services provided from January 1, 2014, through September 30, 2015, to beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage.

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 seeks to provide more Americans with access to affordable healthcare. This legislation addresses gaps in coverage for the poorest Americans by providing States with the option to increase the minimum Medicaid income eligibility level by expanding their Medicaid programs. Effective January 1, 2014, as originally ed, nearly all individuals under 65 years of age with incomes up to 133 percent of the FPL became eligible for Medicaid;[8] this initiative is known as Medicaid expansion. A ruling by the U.S. Supreme Court allowed each State the option to refuse to expand its Medicaid program and not face any reduction in current Medicaid funding (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)). 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.[9]

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.[10]

[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] 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.

[9] The Act § 1905(z)(3).

[10] 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 as newly eligible.[11]

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 the CBMS to verify that the individual in question is Medicaid eligible.

Colorado's Process for Assigning the Federal Medical Assistance Percentage

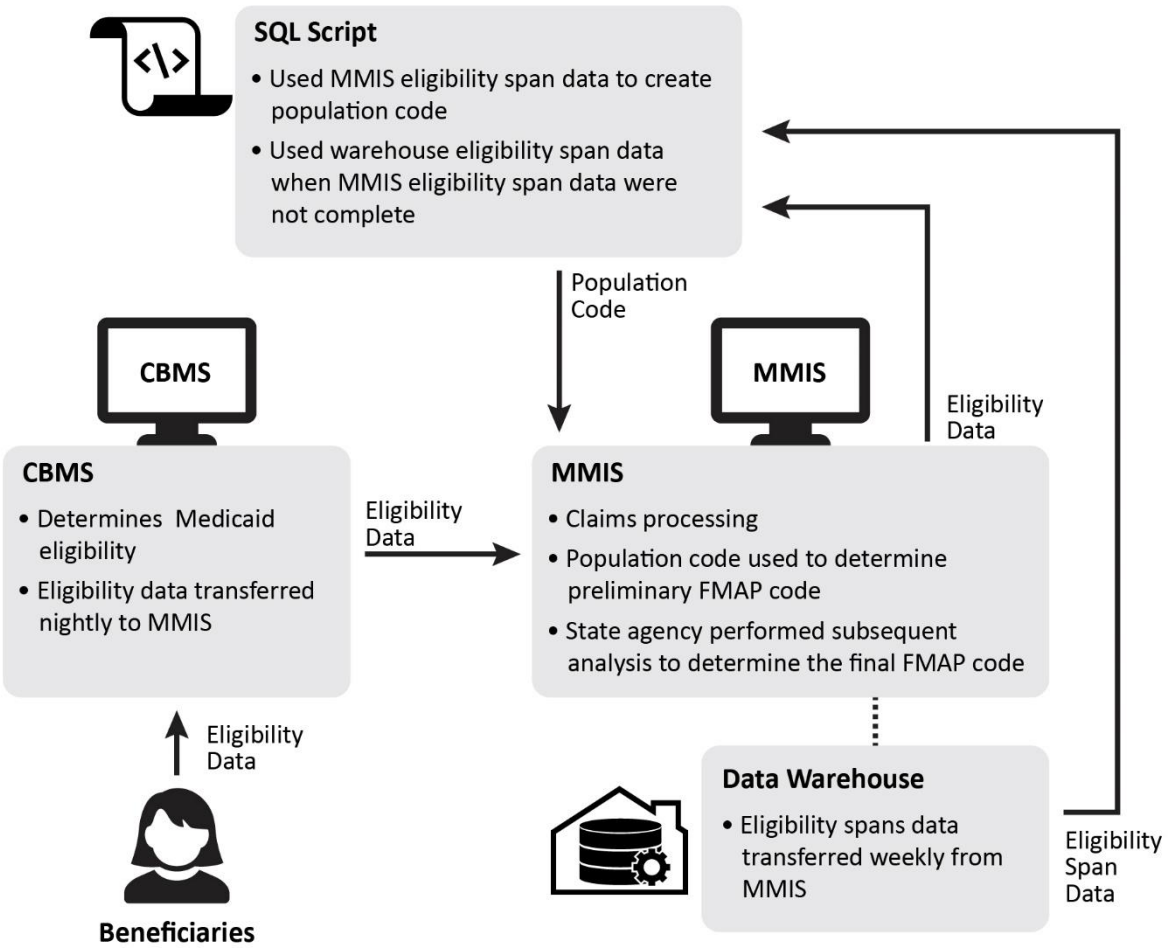
During our audit period (January 1, 2014, through September 30, 2015), the State agency processed claims using a legacy MMIS, which did not have the capability to separately identify distinct Medicaid eligibility groups and assign different FMAP categories (e.g., newly eligible, standard) to claims.[12] Therefore, the State agency developed a Structured Query Language (SQL) script to identify the different Medicaid eligibility groups, including the new adult group,

[11] 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 sub-group; rather, we focused only on newly eligible beneficiaries whose qualified expenditures would have been reimbursed at the 100 percent newly eligible FMAP.

[12] 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).

and to assign the applicable FMAP for each of those groups.[13] 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



The SQL script used both eligibility data that existed in the claim at the time of State agency adjudication and supplemental eligibility span data[14] to create a population code, which the script then assigned to the claims to identify the different Medicaid eligibility groups. The

[13] 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, not directly 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.

[14] 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.

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 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.[15] 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 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 determine whether there were beneficiaries for whom the State agency claimed Medicaid expenditures at the newly eligible FMAP rate but whose eligibility showed as terminated in the eligibility span data, we matched Medicaid claim data from the MMIS to eligibility span data (footnote 14) provided by the State agency. The eligibility span data included eligibility spans that showed the timespan(s) for which each beneficiary was eligible; no eligibility spans would exist for the timespans in which a beneficiary was not eligible for Medicaid. We reviewed only those State agency internal controls directly related to our objective.

[15] 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.

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 claimed reimbursement for Medicaid services provided from January 1, 2014, through September 30, 2015, to some beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage. Specifically, the State agency claimed $1,959,216 in Federal Medicaid reimbursement on behalf of 1,543 newly eligible beneficiaries for Medicaid services that these beneficiaries received after they became ineligible for Medicaid.[16] As a result, the State agency improperly claimed and received Federal reimbursement for these beneficiaries past the termination dates of their Medicaid eligibility.[17]

The State agency properly terminated these beneficiaries' eligibility in the CBMS but erroneously kept them as eligible in the MMIS. The beneficiaries' eligibility was not terminated in the MMIS because of a data processing error in which eligibility data from the CBMS did not always transfer correctly to the MMIS through the normal automated process.[18] Although the CBMS interfaced with the MMIS, for some beneficiaries a change in eligibility determination from eligible to ineligible that occurred in the CBMS did not transfer correctly to the MMIS. Consequently, these individuals were showing as eligible in the MMIS past their termination date.

[16] Because Federal reimbursement under the ACA was at 100-percent FMAP, the amount identified was entirely Federal, not State, dollars.

[17] Prior Office of Inspector General audits of Medicaid eligibility (A-07-16-04228, Aug. 30, 2019; and A-07-18-02812, Mar. 24, 2020) found errors related to individual eligibility determinations, as, for example, a State not correctly determining an individual's income based on available data. Those errors are considered eligibility errors and are not subject to disallowance. In this audit, we found that the State agency made the correct eligibility determinations, but the State agency's systems did not implement those determinations correctly. These are accordingly considered data processing errors, and the associated Medicaid payments made and claimed are therefore disallowable.

[18] Data processing errors include payments that resulted in overpayments due to one or more logic edit errors (42 CFR § 431.960(b)). A logic edit error reflects a situation in which a claim processing system edit was not in place because of State policy, or a system edit was in place but was not working correctly and thus allowed payment (CMS's *Payment Error Rate Measurement Manual*, Version 1.1, Oct. 15, 2013).

THE STATE AGENCY CLAIMED AND RECEIVED REIMBURSEMENT FOR NEWLY ELIGIBLE BENEFICIARIES WHO WERE NOT ELIGIBLE FOR MEDICAID BENEFITS

Federal Requirements

For individuals who are eligible for and enrolled in the new adult group described in the Act § 1902(a)(10)(A)(i)(VIII) and defined in Federal regulations at 42 CFR § 435.119, an increased FMAP matching rate equal to 100 percent, for calendar quarters in CYs 2014 through 2016, is available for medical assistance expenditures (42 CFR § 433.10(c)(6)).

Federal regulations require States to furnish Medicaid benefits to eligible individuals until such time as those individuals are found to be ineligible. Federal regulation directs States to continue to provide benefits until those individuals are found to be no longer eligible for Medicaid (42 CFR § 435.930).

States must return the Federal share of any overpayments resulting from data processing errors in the State's MMIS (42 CFR § 431.1002(a)). A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the MMIS, related systems, or outside sources of provider verification (42 CFR §§ 431.960(b)(1) and (3)) (footnote 18).

The State Agency Improperly Claimed Reimbursement for Ineligible Beneficiaries

For our audit period, the State agency improperly claimed $1,959,216 in Federal Medicaid reimbursement on behalf of 1,543 newly eligible beneficiaries for Medicaid services that these beneficiaries received after they became ineligible for Medicaid (footnote 16). The State agency's MMIS claim data treated these beneficiaries as Medicaid eligible, but the State agency's data warehouse did not include matching eligibility span data to support that the beneficiaries were still eligible for Medicaid during the dates of service. Therefore, the data match between the two systems showed that these beneficiaries were ineligible for Medicaid at the times that they received services.

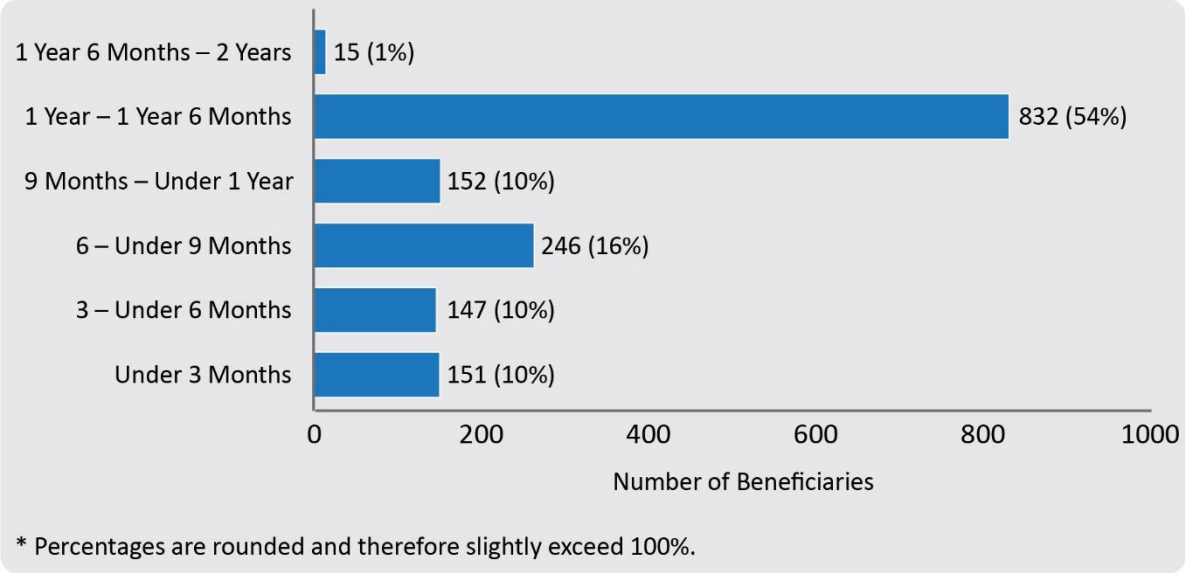
We assessed the reliability of eligibility span data by (1) performing electronic testing for obvious errors in accuracy and completeness, (2) reviewing related documentation, and (3) interviewing agency officials knowledgeable about the data. In addition, we assessed the reliability of the eligibility span data by examining the CBMS case files of 10 randomly selected Medicaid beneficiaries from the 1,543 whom we identified as ineligible. The CBMS showed their eligibility status as terminated after that first month of enrollment. (See Appendix A for details). We determined that the data were sufficiently reliable for the purposes of responding to our objectives.

Relevant MMIS data showed that the State agency claimed these beneficiaries at the newly eligible FMAP months after the beneficiaries were determined to be ineligible and subsequent

termination from Medicaid. The CBMS also showed that these beneficiaries were new applicants who had not received Medicaid services prior to implementation of the ACA.

Figure 2 below depicts, for the 1,543 ineligible beneficiaries whom we identified, the lengths of time after determinations of ineligibility that the MMIS continued to make payments.

Figure 2: Lengths of Time After the Dates of Ineligible Determinations in Which the State Agency Made Improper Payments



* Percentages are rounded and therefore slightly exceed 100%.

A DATA PROCESSING ERROR IN THE STATE AGENCY'S SYSTEMS PREVENTED ELIGIBILITY DATA FROM BEING CORRECTLY TRANSFERRED

The State agency improperly claimed services for these beneficiaries because of a data processing error that prevented eligibility data in the CBMS from transferring correctly to the MMIS. The State agency properly terminated these beneficiaries' eligibility in the CBMS; the eligibility data should have transferred directly from the CBMS into the MMIS each night. However, for these beneficiaries, an eligibility status change that terminated the beneficiaries' Medicaid eligibility in the CBMS did not transfer correctly to the MMIS, which erroneously continued to show these beneficiaries as eligible in the MMIS. For example, the CBMS determined a beneficiary eligible for the new adult group at the beginning of December 2013; later that month, the CBMS determined the beneficiary to be ineligible for Medicaid services for January 2014 and all subsequent months. However, the MMIS continued to show the beneficiary as eligible from January 2014 to February 2015, and the State agency improperly continued to claim reimbursement at the newly eligible FMAP.

State agency officials told us that this issue occurred because of what they referred to as "vanishing" eligibility spans and that the beneficiaries were in fact eligible for Medicaid at the times of service. Our data match of the MMIS data against eligibility span data and our analysis

of CBMS eligibility data did not support the assertion by State agency officials that these beneficiaries were eligible for Medicaid at the times of service. Specifically, these officials stated that when their staff retroactively adjusted a beneficiary's eligibility span to change the individual's status from eligible to ineligible, the CBMS removed the original eligibility span and replaced it with the adjusted eligibility span. When the CBMS transferred the adjusted eligibility span to the MMIS, it replaced the original eligibility span in the CBMS with the new eligibility data (reflecting ineligibility of that beneficiary), and the original (eligible) span "vanished." Therefore, the retroactive adjustment changed the eligibility status to ineligible in the eligibility span data, but at the time that a claim was paid, the MMIS was still seeing only the original span, which showed the beneficiary's status as eligible. State agency officials also said that the CBMS maintains a retroactive adjustments history as well as eligibility records in its case files, which can be used to determine whether an individual is eligible. However, checking the history of the case files in the CBMS requires a review of paper and electronic documents.

The vanishing eligibility spans issue that the State agency described would result in an unsupportable eligibility status without an audit trail of the original eligibility span. However, that does not explain why, for five beneficiaries whom we identified as ineligible,[19] case histories in the CBMS showed that caseworkers changed the eligibility status of these beneficiaries from eligible to ineligible and entered case comments stating that the beneficiaries were determined to be ineligible for Medicaid services. The State agency continued to claim Federal Medicaid reimbursement for services provided to these beneficiaries months after the caseworkers entered those comments in the CBMS. For these five beneficiaries, their case histories in the CBMS did not include any retroactive adjustments that changed their eligibility status. In addition, the State agency did not provide us with any documentation showing that retroactive adjustments caused the change in eligibility status from eligible to ineligible. Consequently, we concluded that the data match between the MMIS, the CBMS, and the information in the five beneficiaries' case files showed that the improper payments occurred not because of vanishing eligibility spans but rather because of a data processing error in which eligibility data from the CBMS did not always correctly transfer to the MMIS.

RECOMMENDATIONS

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

- refund to the Federal Government $1,959,216 in Medicaid payments made and claimed on behalf of beneficiaries for whom services were improperly claimed and reimbursed,

[19] We randomly selected five beneficiaries whom we identified as ineligible and checked their case histories in the CBMS to determine whether their eligibility status changed because of retroactive adjustments. This sample is separate from the 10 beneficiaries selected to assess the reliability of the eligibility span data. See Appendix A for more details of our methodology.

- identify and refund to the Federal Government any payments made on behalf of ineligible beneficiaries for whom services after our audit period were claimed and reimbursed past the termination dates of their eligibility, and

- establish adequate system controls that ensure that eligibility determinations transfer correctly from the CBMS to the MMIS to prevent payments from being made on behalf of ineligible beneficiaries.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first two recommendations and agreed with our third recommendation. For all three recommendations, the State agency said that it did not need to take additional action based on the report's findings. The State agency said that the issues affecting eligibility determinations and the resulting claims payments had already been identified by the State agency and other auditors before our audit. The State agency also stated that it had updated its eligibility system and implemented system controls.

A summary of the State agency's comments and our responses follows. The State agency's comments appear in their entirety as Appendix B.

After reviewing the State agency's comments, we maintain that all of our findings and recommendations remain valid. We disagree with the State agency's characterization of our audit as duplicative of other State and Office of Inspector General eligibility reviews. The objective of this audit was not to determine whether newly eligible beneficiaries were accurately determined to be eligible. Rather, our objective was to determine whether the State agency claimed reimbursement for beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid.

RELATIONSHIP OF ERRORS WE IDENTIFIED TO MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM ELIGIBILITY REVIEW PILOTS

State Agency Comments

The State agency stated that the errors we identified were not subject to disallowance because the services in question were part of the Medicaid and Children's Health Insurance Program (CHIP) pilot programs established as part of implementation of the ACA. In this context, the State agency referred to CMS policy guidance that directed States to implement new eligibility review pilots for FYs 2014 through 2017—a timeframe, the State agency noted, that bracketed

our audit period—in place of the Medicaid Eligibility Quality Control (MEQC) reviews.[20] The State agency cited a Proposed Rule and CMS guidance that stated that CMS had suspended financial recoveries for errors identified through the eligibility pilot programs.[21]

The State agency said that although the CMS policy guidance specifies that errors identified "outside of these pilots" are still "subject to disallowances under the Medicaid recoveries regulation," the errors we identified were not outside of the Medicaid and CHIP eligibility review pilots. The State agency said that these errors were related to some beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage. This population of "some beneficiaries enrolled in the new adult group" was, according to the State agency, one of the "major changes" to Medicaid and CHIP eligibility requirements identified by the U.S. Department of Health and Human Services as the reason for requiring States to engage in the Medicaid and CHIP eligibility review pilots "in the immediate aftermath of ACA implementation." The State agency added that the errors we identified clearly served the purpose behind the pilot programs "in the wake of ACA implementation and the expansion of Medicaid eligibility to new populations." The State agency said that because these errors are part of the eligibility review pilots, it is not required to refund the Federal share for the identified errors.

Office of Inspector General Response

We agree with the State agency's comments that CMS had suspended financial recoveries for errors identified through the Medicaid and CHIP eligibility review pilot programs. For that reason, our audits of Colorado's Medicaid eligibility determinations (A-07-16-04228, Aug. 30, 2019, and A-07-18-02812, Mar. 24, 2020; footnote 17) did not recommend recoveries of the overpayments identified in those eligibility audits.

However, we disagree that the errors identified in the current audit were part of the Medicaid and CHIP eligibility review pilot programs. States were required to participate in the Medicaid and CHIP eligibility review pilots to provide more targeted, detailed information on the accuracy of eligibility determinations under the new ACA-mandated eligibility rules. Although our audit covered the newly eligible adult group, it did not focus on the accuracy of eligibility determinations (which was the purpose of the pilot reviews). Rather, the errors we identified related to newly eligible beneficiaries whom the State agency properly determined to be ineligible for the Medicaid program but erroneously retained as eligible in the MMIS.

[20] CMS and States monitor the accuracy of Medicaid eligibility determinations using the MEQC and Payment Error Rate Measurement (PERM) programs, which are designed to reduce improper payments. In July 2017, CMS modified its MEQC and PERM requirements to incorporate changes mandated by the ACA. 82 Fed. Reg. 31158, 31159 (Jul. 5, 2017).

[21] The State agency cited the Proposed Rule at 81 Fed. Reg. 40598 – 40600 (Jun. 22, 2016) and CMS guidance in *CMS Medicaid & CHIP Eligibility Review Pilot Guidance, Pilot: 1st Round, Due June 2014*, Oct. 2013). We note that the Final Rule was published in 82 Fed. Reg. 31158, 31161 (Jul. 5, 2017).

RELATIONSHIP OF THIS AUDIT TO SECTION 1903(u) OF THE SOCIAL SECURITY ACT

State Agency Comments

The State agency also stated that even if the identified errors were not considered to be part of the Medicaid and CHIP eligibility review pilots, the audit constitutes an eligibility review pursuant to section 1903(u) of the Act. That provision requires the review of Medicaid eligibility to identify erroneous payments, which are defined (in relevant part) as payments for ineligible persons. According to the State agency, the statute does not specify the manner by which such reviews must occur. Thus, our audit was a section 1903(u) eligibility review because we identified "allegedly erroneous payments" based on the eligibility determinations made for some of the "new adult group" under the ACA. The State agency added that because our audit constituted an eligibility review, we must then prove that the State agency exceeded the 3 percent threshold that would subject it to disallowances under section 1903(u) of the Act. According to the State agency, its error rate did not exceed 3 percent and therefore no refund of the Federal share is due.

Office of Inspector General Response

We disagree with the State agency's assertion that our audit constituted an eligibility review pursuant to section 1903(u) of the Act and that therefore, we must prove that the State agency exceeded the 3 percent threshold that would subject it to disallowances under that provision of the Act. The errors we identified were data processing errors in the State agency's systems, not eligibility errors.

Section 1903(u) of the Act sets a 3 percent threshold for eligibility-related improper payments in any FY and generally requires the Federal Government to withhold payments to States equal to the amount of improper payments that exceed that threshold. The errors we identified were not, as the State agency contended, eligibility-related improper payments; rather, the improper payments we identified were related to the data processing error we described earlier in this report. We did not focus on the State agency's eligibility determinations or question the results of those determinations. Instead, we identified errors involving cases in which the State agency had redetermined beneficiaries to be ineligible for Medicaid but then improperly claimed Federal Medicaid reimbursement for services that these beneficiaries received after those eligibility redeterminations. These errors occurred, not because of inaccurate eligibility determinations or redeterminations per se, but rather because eligibility data from the CBMS did not always correctly transfer to the MMIS. This would be considered a data processing error under the provisions of 42 CFR § 431.960(b) rather than an eligibility error.

As a result, in accordance with 42 CFR § 431.1002, the State agency is required to refund to the Federal Government the Federal share of overpayments based on medical and processing errors in accordance with section 1903(d)(2) of the Act and related Federal regulations. In addition, Federal regulation directs States to continue to provide benefits to individuals until they are found to be no longer eligible for Medicaid (42 CFR § 435.930).

OFFICE OF INSPECTOR GENERAL RECOMMENDED REFUNDS

State Agency Comments

With respect to the two recommendations with which the State agency disagreed, the State agency said that our methodology was limited because we selected a sample size of only 5 from the 1,543 beneficiaries that we identified as being in error. The State agency also stated that these 5 beneficiaries fit our identification of Medicaid eligibility spans that were ineligible when claims were paid but added that we would have identified its explanation of "vanishing" eligibility spans if we had reviewed all of the 1,543 beneficiaries. The State agency said that during our audit period, eligibility technicians had the ability to retroactively close eligibility spans in the CBMS. When they did so, a claim would appear to have been paid when the beneficiary was ineligible but in reality, the beneficiary had an open, active eligibility span in the MMIS when the claim was paid. The State agency said that it performed an independent data analysis and believes that almost 50 percent of the 1,543 beneficiaries (or 775 beneficiaries) were affected by these retroactively closed spans. The State agency also described system changes it said it made in 2014 and 2016 that constituted steps taken "over the years to prevent eligibility technicians from retroactively closing eligibility spans."

Office of Inspector General Response

The State agency's critique of our methodology reveals a misunderstanding about how we used the 5 beneficiaries (out of 1,543) whom we randomly sampled. As explained in Appendix A, we selected these five newly eligible beneficiaries to determine whether their eligibility status changed because of retroactive adjustments. This single step in our audit methodology was an aspect of the data match that we performed between (1) Medicaid eligibility data and (2) the MMIS data provided to us by the State agency to try to verify the State agency's explanation of why the processing error was happening. We developed our methodology based on the information we received from State agency staff regarding its process for assigning the FMAP. State agency staff told us during our audit that the State agency transferred data that it used to assign the FMAP from the MMIS to the data warehouse because the MMIS did not have the capability to save these data. Therefore, according to State agency staff, the Medicaid eligibility span data from the data warehouse were the best support for the assignment of FMAP rates to claimed expenditures, and these were the data that the State agency gave to us. We discussed, and provided the State agency with details on, the methodology we used to identify our errors.

We disagree that we needed to review all 1,543 beneficiaries to identify the "vanishing" eligibility spans. We reviewed and performed a reliability assessment of the data that the State agency provided to support the FMAP rates it assigned, and these data showed that these beneficiaries did not have an eligibility span during their times of service. As part of our reliability assessment, we reviewed a judgmental sample of 10 Medicaid beneficiaries from the list of 1,543 whom we identified as ineligible and compared the eligibility information from the eligibility span data to the source data in the CBMS case files. Our review of these case files

verified what the data showed: that none of these beneficiaries were eligible for Medicaid at the time of service.

After we presented details on our findings to the State agency, it said that this error occurred because of retroactive adjustments that caused eligibility spans to vanish and added that it did not have automated data that we could use to determine why and when retroactive adjustments occurred. State agency staff also told us that to acquire this information, we would have to review paper and electronic documents—specifically, the retroactive adjustments in the beneficiaries' files in the CBMS. For this reason, we selected a random sample of five beneficiaries and manually reviewed their eligibility files in the CBMS. The results of this sample did not show that retroactive adjustments changed the eligibility determinations. Instead, we found that the data did not transfer correctly from the CBMS to the MMIS: a result that agreed with our data match.

As mentioned above, our review of the 10 case files in the CBMS during our reliability assessment, as well as our review of the 5 case files in the CBMS that we sampled to determine whether retroactive adjustments changed the beneficiaries' eligibility status, showed that this error occurred due to a data processing error. Therefore, we maintain that our data match accurately identified ineligible beneficiaries who continued to receive Medicaid services after the State agency determined them eligible for Medicaid.

In its comments on our draft report, the State agency said that it performed an independent data analysis and that it believes that almost 50 percent of the 1,543 beneficiaries were affected by these retroactively closed (i.e., "vanishing") eligibility spans. However, the State agency did not discuss this analysis with us during our audit and did not give this data analysis to us with its comments on our draft report.

DATA PROCESSING ERROR IN THE STATE AGENCY'S SYSTEMS

State Agency Comments

With respect to the data processing issue described earlier in this report, the State agency said that it had identified that issue and implemented a system change in November 2014 to identify the eligibility spans. The State agency also stated that, over time, it had corrected the spans within the State agency's legacy MMIS to match the spans with the eligibility system (i.e., the CBMS). The State agency said that when it began to implement Medicaid expansion under the ACA, it allowed ("[d]ue to the need to implement this expansion quickly") individuals to apply for coverage before the January 1, 2014, implementation date. In cases when individuals:

- applied for coverage before that date,
- were initially determined eligible and assigned a prospective eligibility effective date of January 1, 2014, but

- were then determined ineligible before that date,

the legacy MMIS would reject the eligibility end date as "inconsistent" (because that end date preceded the January 1, 2014, effective date). The State agency said that when it identified this issue, it made system changes in November 2014 to identify the eligibility spans by noting them as 1-day spans for the relevant month. "This would provide a record that the [eligibility] span had been retroactively closed." However, other spans that were also, but for different reasons, retroactively closed by eligibility technicians were also noted with 1-day eligibility spans in the MMIS. The State agency described these factors as "easy to confuse . . . the data processing issue that created a mismatch of information between systems (CBMS and MMIS) and the vanishing eligibility spans created by eligibility technicians that incorrectly retroactively backdate[d] eligibility termination dates."

Lastly, the State agency said that the "mismatch" of information between systems was identified by the State agency and through previous audits by CMS. "If CMS desired to recover any federal funds because of this finding it would have been appropriate at that time when the issue was first identified through their own audit. Rather, CMS requested the [State agency] resolve the issue through corrective action plans."

Office of Inspector General Response

We acknowledge the State agency's detailed discussions of both the retroactive closing of eligibility spans and the use of 1-day eligibility spans as what was effectively a workaround. However, these discussions do not align with our own observations and analysis, which we summarized earlier in this report in our explanation of the cause of the errors.

First, if the eligibility spans had been corrected to match in the MMIS and the CBMS, we would not have found this issue and there would not have been a discrepancy. In addition, in January 2020 the State agency published a document (CBMS/interChange Eligibility Issue) that described an issue which, according to the document, occurred between 2013 and 2019. The document stated that Colorado Medicaid and CHIP (called Child Health Care Plan Plus (CHP+) in Colorado) beneficiaries who were no longer eligible for coverage and who had been properly terminated in the eligibility system (CBMS) were erroneously kept open in the claims payment system (Colorado interChange).[22] This is the same error that we describe in this report. According to the State agency's document, then, this same error continued to occur until 2019.

Second, our review of electronic beneficiary case files in the CBMS did not show that the 1-day eligibility spans (in the errors that we identified) provided a record that those spans had been retroactively closed. For all the beneficiary files that we reviewed in this manner, we did not find any retroactive adjustments that changed the eligibility in the CBMS. Rather, the adjustments might have occurred in the data warehouse after the claims were paid, but from

[22] https://www.colorado.gov/pacific/sites/default/files/CBMS%20interChange%20FAQs%20for%20Web%20Posting.pdf (accessed Aug. 4, 2020).

these data it is not possible to determine why or when the retroactive adjustments were made or even that retroactive adjustments occurred.

Third, the evidence we reviewed when doing our review of eligibility files in the CBMS did not show that any of the 1-day eligibility spans were part of the "vanishing" issue that the State agency described both during our audit and in its written comments. In fact, we did a separate review of discrepancies between the CBMS and the MMIS that excluded the 1-day eligibility spans and were able to identify retroactive adjustments that changed the eligibility determinations. We plan to report on the results of that assessment separately.

In addition, during our audit CMS Region VIII officials gave us a report which referred to an analysis performed by the State agency and found that when a valid Medicaid eligibility span in the CBMS was retroactively removed in the CBMS, historical records of the span were also removed from the MMIS. This resulted in the eligibility span "vanishing" retroactively without a record of the original eligibility span. CMS issued this report to the State agency on July 1, 2011, and required it to correct the vanishing spans error by December 31, 2011. Subsequently:

- The State agency replied that its target date to implement corrections to the vanishing eligibility spans was August 2012.

- CMS officials told us that the State agency informed them in 2014 that the vanishing spans issue had been resolved.

- These officials added that in January 2020, the State agency reported to CMS that it had identified Medicaid beneficiaries who had been properly terminated in the eligibility system (CBMS) but who were erroneously kept open in the claims payment system (Colorado interChange). The State agency told CMS that it intended to correct this issue by March 2020.

- However, as of August 2020, CMS had not received information from the State agency on the corrective action taken. CMS officials told us that they believe the issue we identified is the issue that the State agency reported in 2020—not the issue that the State agency reported as resolved in 2014.

Ultimately, CMS, as the cognizant U.S. Department of Health and Human Services Operating Division, will make final determination as to actions taken on our recommendations.

OFFICE OF INSPECTOR GENERAL RECOMMENDATION REGARDING SYSTEM CONTROLS

State Agency Comments

The State agency agreed with our third recommendation and said that it had already taken action to resolve the data processing issue. Specifically, the State agency said that it had identified the error and made system changes in 2014 and that it made additional system changes in 2016 to prevent eligibility technicians from incorrectly closing eligibility spans retroactively. The State agency described further system and procedural changes made in 2017 (implementation of the new MMIS, Colorado interChange), 2018 (system enhancements in the MMIS to accept and process retroactive eligibility changes from the CBMS), and 2019 (development of an eligibility reconciliation report that is reviewed monthly by MMIS and CBMS teams). The State agency stated that with these changes it had already implemented adequate system controls that ensure that eligibility determinations transfer correctly from the CBMS to the MMIS to prevent payments from being made on behalf of ineligible beneficiaries. The State agency added that therefore, it did not need to take additional action based on our findings.

Office of Inspector General Response

We acknowledge the State agency's statements that it had identified and made system and procedural changes in 2014, 2016, 2017, 2018, and 2019 to address data processing errors, but we disagree that these changes resolved the issue and we therefore believe that the State agency still needs to take additional action based on this report's findings. As stated earlier, if the eligibility spans had been corrected to match in the MMIS and the CBMS, we would not have found this discrepancy. In addition, the document published by the State agency (footnote 22) in 2020 identified this same error and stated that the issue occurred between 2013 and 2019. According to the State agency's document, therefore, this same error continued to occur until 2019 even after implementation of its systems upgrades.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 579,925 beneficiaries 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 terminated beneficiaries, we matched Medicaid claims data from the MMIS to eligibility span data (footnote 14) provided by the State agency. The eligibility span data included eligibility spans that showed the timespan(s) for which a beneficiary was eligible; no eligibility spans would exist for the timespans in which a beneficiary was not eligible for Medicaid. We reviewed only those State agency internal controls directly related to our objective.

We conducted our audit work from April 2018 to August 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 the purpose of the SQL script;

- 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);

- obtained Medicaid eligibility span data (that reside in the State agency's data warehouse) from the State agency for the 579,925 newly eligible Medicaid beneficiaries;

- matched the list of newly eligible beneficiaries from the MMIS data to the Medicaid eligibility span data and identified 1,543 ineligible beneficiaries with Medicaid payments totaling $1,959,216, for whom the State agency claimed Federal Medicaid reimbursement at the newly eligible FMAP but for which the eligibility span data had no matching eligibility span covering the service date;

- selected a random sample of 5 newly eligible Medicaid beneficiaries from the list of 1,543 beneficiaries identified as ineligible to determine whether their eligibility status changed because of retroactive adjustments;

- determined the total amount of Federal Medicaid reimbursement made on behalf of ineligible beneficiaries; and

- discussed the results of our audit with State agency officials on November 12, 2019.

We assessed the reliability of the eligibility span data by performing electronic testing for obvious errors in accuracy and completeness, reviewing related documentation, and interviewing agency officials knowledgeable about the data. We verified the completeness and accuracy of the data by performing electronic tests that assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, illogical relationship amongst data elements, data were missing from key fields, or data were outside the time period requested. We also established reasonable assurance of the completeness of the eligibility span data by comparing the data from the MMIS to the eligibility span data obtained from the State agency to confirm that we received all the eligibility information for all the newly eligible beneficiaries in our list of MMIS claims. In addition, we reviewed documentation related to the data to learn about the sources of data, collection process, and the data elements. Furthermore, we interviewed State agency officials knowledgeable about the data to assess the reliability of the data they provided. Finally, we selected a random sample of 10 Medicaid beneficiaries from the list of 1,543 identified as ineligible and compared the eligibility information from the eligibility span data to the source data in the CBMS case files. Based on these steps, we determined that the data were sufficiently reliable for the purposes of responding to our objectives.

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.

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

July 22, 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-07-17-02807

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 Improperly Claimed Millions in Enhanced Federal Medicaid Reimbursement for New Adult Group Beneficiaries Because of a Data Processing Error*.

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 Improperly Claimed Millions in Enhanced Federal Medicaid Reimbursement for New Adult Group Beneficiaries Because of a Data Processing Error* (A-07-17-02807)

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 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. The Department's eligibility system has also been significantly upgraded. The Department has already resolved one corrective action plan 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. Therefore, the Department does not need to take additional action based on this report's findings.

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

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) ("ACA"), required states to make "major changes" to Medicaid and CHIP eligibility requirements. 81 FR 40598. In light of these major changes, HHS required states to halt the Payment Error Rate Measurement program (PERM) and the Medicaid Eligibility Quality Control (MEQC) eligibility reviews and instead participate in Medicaid and CHIP Eligibility Review Pilots from FY2014 – FY2017. 81 FR 40598–40600, citing SHO# 13-005 and SHO# 15-004. And as part of the Medicaid and CHIP Eligibility Review Pilots, "States are not required to refund the FFP for errors identified through these eligibility pilots." *Medicaid and CHIP Eligibility Review Pilot Guidance: Pilot: 1st Round, Due June 2014* at 6 (Oct. 2013)[1] (hereinafter *"1st Round Pilot Guidance"*). Although that guidance

[1] available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/ReviewPilotGuidance.pdf

goes on to state that errors identified "outside of these pilots" are still "subject to disallowances under the Medicaid recoveries regulation," the errors identified by OIG in Report No. A-07-17-02807 were not outside of the Medicaid and CHIP Eligibility Review Pilots. *Id.* The errors identified by OIG are related to "services provided from January 1, 2014, through September 30, 2015, to some beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage." This population of "some beneficiaries enrolled in the new adult group" is one of the "major changes" to Medicaid and CHIP eligibility requirements identified by HHS as the reason for requiring states to engage in the Medicaid and CHIP Eligibility Review Pilots in the immediate aftermath of ACA implementation. *See* 81 FR 40598. The errors identified by OIG, therefore, were not only part of the pilot programs, but also clearly served the purpose behind the pilot programs in the wake of ACA implementation and the expansion of Medicaid eligibility to new populations, which was "to support and encourage states … to address, test, and implement corrective actions that would assist in the improvement of their eligibility determinations." 81 FR 40602. Because the errors are part of the eligibility review pilots, Colorado is not required to refund the FFP for the identified errors. *See 1st Round Pilot Guidance* at 6.

Even if the identified errors were not considered to be part of the Medicaid and CHIP Eligibility Review Pilots, the audit constitutes an eligibility review pursuant to section 1903(u) of the Social Security Act. Section 1903(u) requires the review of Medicaid eligibility to identify erroneous payments, which are defined (in relevant part) as payments for ineligible persons. *See* 42 U.S.C. § 1396b(u). The statute does not specify the manner by which such reviews must occur. Thus, the OIG audit is a section 1903(u) eligibility review because OIG identified allegedly erroneous payments based on the eligibility determinations made for some of the "new adult group" under ACA. Because OIG's audit constitutes an eligibility review, OIG must then prove that the Department exceeded the 3% threshold that would subject the Department to disallowances under section 1903(u) of the Act. *See* 42 U.S.C. § 1396b(u). The Department's position is that its error rate does not exceed 3% and therefore no refund of FFP is due.

OIG Recommendations and Department Responses

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

> • *refund to the Federal Government $1,959,216 in Medicaid payments made and claimed on behalf of beneficiaries for whom services were improperly claimed and reimbursed,*
>
> Response: Disagree. The Department finds that the OIG's methodology was limited since the OIG only selected a sample size of 5 from the 1,543 beneficiaries. These 5 beneficiaries fit the OIG's explanation of Medicaid eligibility spans that were ineligible when claims were paid. The Department's explanation of "vanishing" eligibility spans would have been identified if the OIG had reviewed all of the 1,543 beneficiaries. During the time period covered by OIG audit, eligibility technicians had the ability to retroactively close eligibility spans in the Department's eligibility system (CBMS). When eligibility spans were retroactively closed, it may appear that a claim was paid when the beneficiary was ineligible but in reality, the beneficiary had an open, active eligibility span in the MMIS when the claim was paid. Further, when spans were closed retroactively, the system allowed the span in the MMIS to remain open until it was updated through a separate,

manual update outside of the normal data exchange between CBMS and MMIS. 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. Through the Department's independent data analysis, the Department believes that almost 50% of the 1,543 beneficiaries (or 775 beneficiaries) were impacted by these retroactively closed spans. The Department does not believe that it is appropriate for beneficiaries to have a span closed retroactively. Therefore, the Department has taken steps over the years to prevent eligibility technicians from retroactively closing eligibility spans.

In regards to the data processing issue described by the OIG that did impact the 5 beneficiaries identified in the OIG report, the Department had identified that issue and implemented a system change in November 2014 to identify the spans and then over time corrected the spans within the Department's legacy MMIS to match the spans within the Department's eligibility system. This issue was a direct result of the Department's implementation of the Medicaid ACA expansion that occurred in January 2014. Due to the need to implement this expansion quickly, the Department allowed beneficiaries to apply prior to the January 2014 effective date. When a beneficiary was initially determined eligible for the new ACA expansion eligibility category but then later determined ineligible prior to January 1, 2014, beneficiaries' ineligibility data was not properly transferred to the Department MMIS. For example, if a beneficiary applied in November 2013 and was determined eligible, their Medicaid eligibility effective date was prospectively set for January 1, 2014, the effective date of the ACA expansion. However, if new information was received in December 2013 that made the beneficiary ineligible for the ACA expansion eligibility category, the beneficiary's eligibility was end dated with a date prior to January 1, 2014. When the beneficiary's eligibility end date was prior to their effective date, that date was rejected by the Department's legacy MMIS as being inconsistent. Due to the uniqueness of the ACA expansion, the Department's systems were not designed to allow a beneficiary's eligibility end date to occur prior to their effective date. The Department identified the issue and made system changes in November 2014 to identify the eligibility spans by noting them as 1-day spans for the impacted month. This would provide a record that the span had been retroactively closed. However, other spans that were also retroactively closed by eligibility technicians outside of the description above were also noted with the 1-day eligibility spans in the MMIS. This makes it is easy to confuse the two issues described in the OIG audit: the data processing issue that created a mismatch of information between systems (CBMS and MMIS) and the vanishing eligibility spans created by eligibility technicians that incorrectly retroactively backdate eligibility termination dates.

The mismatch of information between systems was identified by the Department and through previous audits by the Centers for Medicare and Medicaid Services (CMS). If CMS desired to recover any federal funds because of this finding it would have been appropriate at that time when the issue was first identified through their own audit. Rather, CMS requested the Department resolve the issue through corrective action plans. The Department has already implemented changes to the findings in the OIG report though CMS corrective action plans, so no further recovery is appropriate. Further, as described above in the section above of this response (The Federal Government Understood – and

Communicated Its Understanding – That There Would Be Errors When Implementing Substantial Changes Mandated by the ACA) errors identified by the OIG were eligibility errors under section 1903(u) of the Social Security Act and the Department's eligibility error rate does not exceed 3% and therefore no refund of FFP is due.

• *identify and refund to the Federal Government any payments made on behalf of ineligible beneficiaries for whom services after our audit period were claimed and reimbursed past the termination dates of their eligibility, and*

Response: Disagree. As stated in the previous response, the Department has already taken action to resolve the data processing issue that created a mismatch of information between systems (CBMS and MMIS) and the vanishing eligibility spans created by eligibility technicians that incorrectly retroactively backdate eligibility termination dates. The mismatch of information between systems was identified by the Department and through previous audits by CMS. If CMS desired to recover any federal funds because of this finding it would have been appropriate at that time when the issue was first identified through their own audit. Rather, CMS requested the Department resolve the issue through corrective action plans. The Department has already implemented changes to the findings in the OIG report though CMS corrective action plans, so no further recovery is appropriate. Further, as described above in the section above of this response (The Federal Government Understood – and Communicated Its Understanding – That There Would Be Errors When Implementing Substantial Changes Mandated by the ACA) errors identified by the OIG were eligibility errors under section 1903(u) of the Social Security Act and the Department's eligibility error rate does not exceed 3% and therefore no refund of FFP is due.

• *establish adequate system controls that ensure that eligibility determinations transfer correctly from the CBMS to the MMIS to prevent payments from being made on behalf of ineligible beneficiaries.*

Response: Agree. 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 to prevent payments from being made on behalf of ineligible beneficiaries and does not need to take additional action based on this report's findings.