

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MOST OF THE NON-NEWLY ELIGIBLE  
BENEFICIARIES FOR WHOM COLORADO  
MADE MEDICAID PAYMENTS MET  
FEDERAL AND STATE REQUIREMENTS,  
BUT DOCUMENTATION SUPPORTING  
THAT ALL ELIGIBILITY REQUIREMENTS  
WERE VERIFIED PROPERLY WAS NOT  
ALWAYS IN PLACE**

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# *Office of Inspector General*

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## Report in Brief

Date: March 2020

Report No. A-07-18-02812

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



### Why OIG Did This Audit

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid (traditional coverage groups). After the passage of the Patient Protection and Affordable Care Act (ACA), some beneficiaries remained eligible under these traditional coverage groups. We refer to these beneficiaries as “non-newly eligible beneficiaries.” This audit is part of an ongoing series of OIG audits of States’ Medicaid eligibility determinations. We conducted these audits to address the concern that States might have difficulty accurately determining eligibility for Medicaid beneficiaries.

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

### How OIG Did This Audit

We reviewed a stratified random sample of 140 non-newly eligible beneficiaries for whom Medicaid payments were made for services provided from October 2014 through March 2015 (audit period). We reviewed supporting documentation and Colorado’s internal controls to evaluate whether Colorado determined the individuals’ Medicaid eligibility in accordance with Federal and State eligibility requirements (e.g., income and citizenship requirements).

## Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place

### What OIG Found

Most of the Medicaid payments that Colorado made during our audit period were on behalf of non-newly eligible beneficiaries who met Federal and State eligibility requirements. However, Colorado made Medicaid payments on behalf of some non-newly eligible beneficiaries who may not have met Federal and State eligibility requirements. Colorado correctly determined eligibility and, therefore, correctly claimed Federal Medicaid reimbursement, on behalf of 135 of the 140 beneficiaries in our statistical sample. For the remaining five beneficiaries, Colorado had no documentation (specifically, that it had performed annual verifications of resources) to support that all eligibility requirements were verified properly during redeterminations as required by Federal and State regulations and by Colorado’s State Medicaid plan. Although Colorado had policies and procedures in place, it did not always follow them to ensure that redeterminations were properly documented.

On the basis of our sample results, we estimated that Colorado made Medicaid payments of at least \$46.7 million (\$23.8 million Federal share) on behalf of at least 3,603 potentially ineligible beneficiaries.

### What OIG Recommends and Colorado Comments

We recommend that Colorado redetermine, as appropriate, the current Medicaid eligibility of the potentially ineligible sampled beneficiaries and ensure that (1) all eligibility requirements, including those pertaining to resources, are properly verified during annual redeterminations for all non-newly eligible beneficiaries and (2) information is maintained to support that eligibility determinations were performed in accordance with Federal and State requirements.

Colorado agreed with our recommendations and said that it had already implemented the necessary changes to correct the errors we identified. Colorado said that our audit was duplicative of other Federal and State audits. Colorado also said that our sample size was too small and questioned our statistical sampling and projection methodology. After we reviewed Colorado’s comments, we revised our statistical estimates of potentially improper payments and potentially ineligible beneficiaries to remedy imprecision in reporting the results.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA),<sup>1</sup> which included changes to Medicaid eligibility rules, such as requiring that income be calculated on the basis of Modified Adjusted Gross Income (MAGI).<sup>2</sup> The ACA also gave States the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate (Federal Medical Assistance Percentage or FMAP) for services provided to these newly eligible beneficiaries. These changes led to a significantly increased number of applications for Medicaid coverage.

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid (traditional coverage groups). After the passage of the ACA, many beneficiaries remained eligible under these traditional coverage groups. We refer to these beneficiaries as “non-newly eligible beneficiaries.”

This audit is part of an ongoing series of Office of Inspector General (OIG) audits of States’ Medicaid eligibility determinations. We conducted these audits to address the concern that State agencies might have difficulty accurately determining eligibility for Medicaid beneficiaries.

We selected Colorado to ensure that our audits covered States in different parts of the country.<sup>3</sup> (See Appendix B for a list of related OIG reports.)

### OBJECTIVE

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

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<sup>1</sup> 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.”

<sup>2</sup> The Social Security Act (the Act) §§ 1902(e)(14)(A)—(D); 26 U.S.C. § 36B(d)(2)(B). This methodology for determining a person’s income is based on Internal Revenue Service rules.

<sup>3</sup> A previous OIG report covered Colorado’s newly eligible beneficiaries: *Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (A-07-16-04228), issued August 30, 2019.

## **BACKGROUND**

### **The Medicaid Program**

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

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses States for a specified percentage of program expenditures—the FMAP—which is developed from criteria such as the State’s per capita income.<sup>4, 5</sup> The standard FMAP varies by State and ranges from 50 to 75 percent.<sup>6, 7</sup> In addition, a State must receive CMS’s approval of a State plan. The State plan is a comprehensive document that defines how each State will operate its Medicaid program, including program administration, eligibility criteria, service coverage, and provider reimbursement.<sup>8</sup>

CMS and States monitor the accuracy of Medicaid eligibility determinations using the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs, which are designed to reduce improper payments. In July 2017, CMS modified its MEQC and PERM requirements to incorporate changes mandated by the ACA.<sup>9</sup>

### **Medicaid Coverage and Changes to Medicaid Eligibility Under the Affordable Care Act**

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These traditional coverage groups included low-income

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<sup>4</sup> The Act § 1905(b).

<sup>5</sup> CMS, “Financial Management.” Accessed at <https://www.medicaid.gov/medicaid/finance> on May 7, 2019.

<sup>6</sup> 79 Fed. Reg. 3385 (Jan. 21, 2014).

<sup>7</sup> 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 May 7, 2019.

<sup>8</sup> When a State is planning to make a change to its program policies or operational approach, it sends a State plan amendment (SPA) to CMS for review and approval. A State must also submit an SPA to request permissible program changes, make corrections, or update its Medicaid or Children’s Health Insurance Program (CHIP) State plan with new information.

<sup>9</sup> 82 Fed. Reg. 31158, 31159 (Jul. 5, 2017).

parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly. A State had the option, under its State plan, to provide Medicaid coverage to other groups, such as individuals presumed to be eligible before the State had made a formal eligibility determination. The ACA expanded coverage to childless, low-income individuals from the ages of 19 to 64 (i.e., newly eligible beneficiaries).

The ACA also required States to make a number of changes to their Medicaid application, enrollment, and eligibility determination processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual's eligibility for all potential health coverage options, including Medicaid, CHIP, and qualified health plans available through the health insurance marketplaces.<sup>10</sup> In most cases, the ACA required States to use MAGI to determine an individual's income.<sup>11</sup>

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

Federal regulations provide standards under which income information obtained through electronic data sources is considered reasonably compatible with income information provided by or on behalf of an individual (42 CFR § 435.952).<sup>12</sup>

### **Colorado Medicaid Eligibility Determination and Verification**

In Colorado, the State agency is responsible for ensuring that eligibility determinations are performed in accordance with all Federal and State Medicaid requirements. The State agency

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<sup>10</sup> ACA § 1413(b).

<sup>11</sup> See footnote 2. The use of MAGI to determine Medicaid eligibility does not apply to certain groups of beneficiaries, such as seniors who are 65 years of age or older and medically needy individuals.

<sup>12</sup> The term "reasonable compatibility" refers to a Federal requirement (effective January 1, 2014) that prohibits States from requiring Medicaid applicants to provide documentation except in cases in which applicants' self-reported documentation was not reasonably compatible with information in government databases (42 CFR § 435.952(c)). In accordance with this requirement, the State agency established its reasonable compatibility threshold at a 10-percent discrepancy between the applicant's self-attested income and the same individual's income as subsequently reported by his or her employer. The State agency also established a 90-day reasonable opportunity period (discussed later in this report) for an applicant to respond to the State agency regarding income discrepancies.

supervises the County departments of human or social services (County agencies), which actually perform Medicaid eligibility determinations.<sup>13</sup> To perform these functions, the County agencies use the Colorado Benefits Management System (CBMS), which determines Medicaid eligibility and interfaces with other automated systems to verify application information. These interfaces include the Income Eligibility Verification System (IEVS), which is an electronic interface that the State agency uses to verify income.

### *Medicaid Application Process*

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

### *Eligibility Verification Process*

The CBMS uses electronic interfaces with other data sources to conduct automated verifications of information needed to determine applicants' eligibility for Medicaid.<sup>14</sup> For example, the CBMS verifies income, citizenship, immigration status, and identity using electronic interfaces. In some cases, paper documentation is used to verify these eligibility requirements. Information about the documents used for verification is entered into the CBMS by County agencies. The State agency accepts self-attestation for other factors of eligibility.

According to the State agency's MAGI-Based Eligibility Verification Plan (verification plan),<sup>15</sup> a beneficiary's income from a job can be self-attested at application (after which the relevant County agency makes its initial eligibility determination) and is then verified 2 to 4 months after that initial determination through the IEVS electronic interface. The IEVS runs on a monthly basis, and once every 3 months, it receives information about income that beneficiaries' employers report to the Colorado Department of Labor and Employment (CDLE) and passes this information through an electronic interface to the CBMS. Then, the CBMS compares self-attested income to the income reported to the IEVS. If there is a discrepancy of greater than

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<sup>13</sup> Colorado SPA # 13-048 (approved Nov. 18, 2013; effective date Jan. 1, 2014) formalizes the State agency's oversight of the County agencies.

<sup>14</sup> For this report, we use "applicant" to refer to an individual who has applied or is applying for Medicaid and "beneficiary" to refer to that same individual once he or she has received an initial determination of eligibility from the State agency.

<sup>15</sup> The verification plan is a standalone document, separate from the State Medicaid plan and from any of the SPAs. Although the verification plan is undated, the State agency confirmed to us during our audit that its provisions were applicable for our entire audit period.

10 percent between a beneficiary’s self-attested income and the income as reported to CDLE and if the interfaced income amount exceeds the applicable income threshold, then the CBMS determines that the beneficiary’s income is not reasonably compatible.

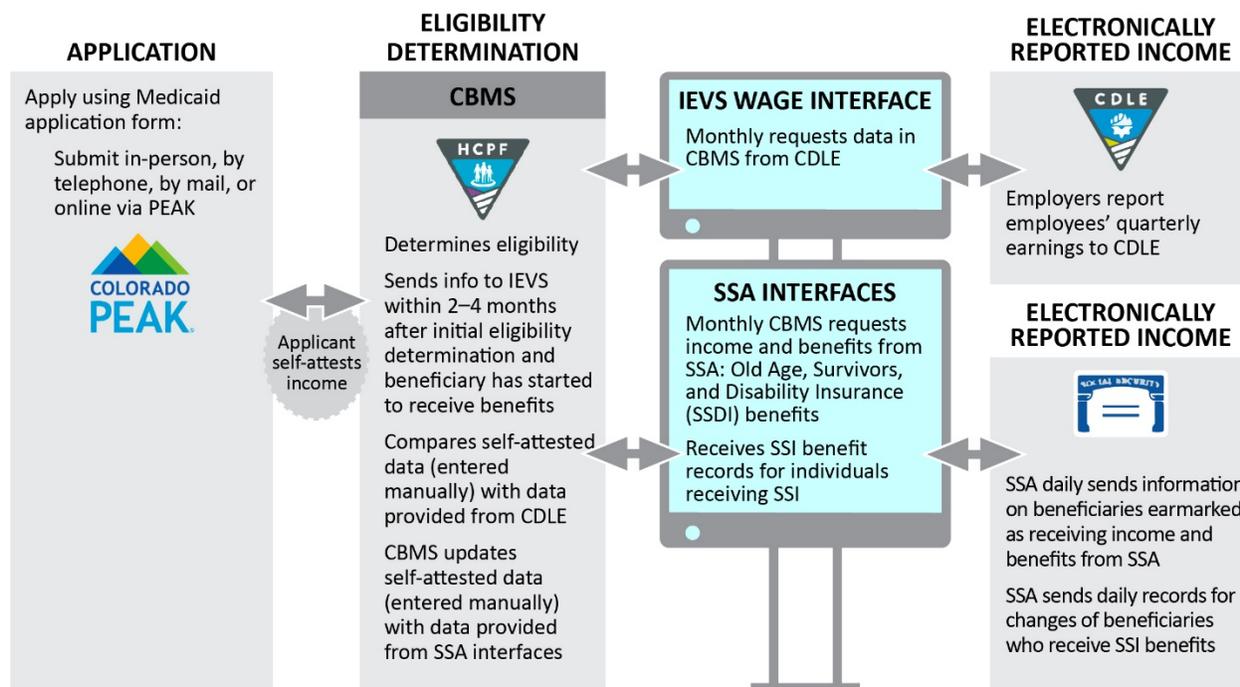
*Post-Eligibility Determination Process*

After a beneficiary is determined to be eligible, the relevant County agency uses the CBMS and its electronic interfaces with other data sources to identify changes that affect beneficiaries’ eligibility. For example, the CBMS checks the IEVS each month for changes in beneficiaries’ incomes. Similarly, each month the CBMS uses an electronic interface to compare its data with data on income and benefits from the Social Security Administration (SSA). In the context of the State agency’s oversight of the County agencies, controls and procedures of this nature constitute the State agency’s eligibility redetermination process.

Generally, the County agencies must also redetermine the eligibility of beneficiaries once every 12 months and must promptly redetermine eligibility when they receive information about a change in a beneficiary’s circumstances that may affect eligibility (42 CFR §§ 435.916 and 435.952(a)).

The Figure below depicts Colorado’s Medicaid application and income verification process.

**Figure: Colorado Medicaid Application and Electronic Income Verification Process**



## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 979,496 non-newly eligible beneficiaries in Colorado for whom the State agency made Medicaid payments from October 1, 2014, through March 31, 2015 (audit period), for services provided during that period. We reviewed the Medicaid eligibility determinations made by the County agencies, as overseen by the State agency, for a stratified random sample of 140 beneficiaries classified as non-newly eligible.

We reviewed the internal controls for eligibility determinations, verifications, and redeterminations that the State agency had in place during our audit period.

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

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

## **FINDINGS**

Most of the Medicaid payments that the State agency made during our audit period were on behalf of non-newly eligible beneficiaries who met Federal and State eligibility requirements. However, the State agency made Medicaid payments on behalf of some non-newly eligible beneficiaries who may not have met Federal and State eligibility requirements. The State agency correctly determined eligibility and, therefore, correctly claimed Federal Medicaid reimbursement, on behalf of 135 of the 140 beneficiaries in our statistical sample. For the remaining five beneficiaries, the State agency had no documentation (specifically, that it had performed the annual verifications of resources) to support that all eligibility requirements were verified properly during redeterminations as required by Federal and State regulations and by the State plan.

The State agency made potentially improper payments because, although the State agency had eligibility determination policies and procedures in place, it did not always follow them to ensure that documentation of redetermination verifications at the County-agency level was properly prepared and maintained.

On the basis of our sample results, we estimated that the State agency made Medicaid payments of at least \$46.7 million (\$23.8 million Federal share)<sup>16</sup> on behalf of at least 3,603 potentially ineligible beneficiaries.<sup>17</sup>

## **THE STATE AGENCY MADE MEDICAID PAYMENTS ON BEHALF OF BENEFICIARIES WHO MAY NOT HAVE MET ELIGIBILITY REQUIREMENTS**

### **Federal and State Requirements**

The State agency must maintain individual records on each applicant and beneficiary, including (1) information on income and eligibility verifications and (2) facts essential to determination of initial and continuing eligibility (42 CFR § 431.17 and State plan § 4.7, effective Jul. 1, 1978).

The State agency must redetermine eligibility of beneficiaries once every 12 months and also promptly redetermine eligibility when it receives information about a change in a beneficiary's circumstances that may affect eligibility (42 CFR §§ 435.916 and 435.952(a)).

Colorado Revised Statutes (CRS) state that the State agency "may review any decision of a county department and may consider any application upon which a decision has not been made by the county department within a reasonable time to determine the propriety of the action or failure to take timely action on an application for medical assistance" (CRS 2016 § 25.5-4-104(2)).

Beneficiaries qualifying for Medicaid on the basis of belonging to the Aged, Blind, or Disabled category of medical assistance are subject to a consideration of resources<sup>18</sup> (10 CCR 2505-10 8.100.3.L).

Colorado SPA # 13-048 (approved November 18, 2013, with an effective date of January 1, 2014) formalizes the State agency's oversight of the County agencies.

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<sup>16</sup> Specifically, we estimated that the State agency made Medicaid payments of at least \$46,734,147 (\$23,839,146 Federal share).

<sup>17</sup> We used the conservative lower limit to remedy any imprecision in reporting our results. We calculated the point estimate to be \$109,192,762 (\$55,699,358 Federal share). See Appendix D for details.

<sup>18</sup> State regulations define "resources" as cash or other assets or any real or personal property that an individual or the individual's spouse owns (10 Code of Colorado Regulations (CCR) 2505-10 8.100.5.M). These regulations list the kinds of assets that qualify as "resources;" but "income" as it is generally understood is not, in terms of these regulatory definitions, a "resource."

## **The State Agency Made Payments on Behalf of Beneficiaries for Whom There Was No Documentation Supporting That All Eligibility Requirements Were Verified Properly During Redeterminations**

The State agency correctly determined eligibility and, therefore, correctly claimed Federal Medicaid reimbursement on behalf of 135 of the 140 beneficiaries in our statistical sample. However, the State agency made Medicaid payments and claimed Federal reimbursement on behalf of five sampled beneficiaries who may not have met eligibility requirements.

Specifically, the State agency could not provide documentation supporting that, during the annual redetermination for five of the sampled beneficiaries, the relevant County agencies had verified the beneficiaries' resources.<sup>19</sup>

Because the State agency did not have supporting documentation that it verified eligibility in accordance with Federal and State requirements, we could not conclusively determine whether the beneficiaries were eligible for Medicaid.

The State agency made potentially improper payments because, although the State agency had eligibility determination policies and procedures in place, it did not always follow them to ensure that documentation of all redetermination verifications at the County-agency level was properly prepared and maintained. State agency officials were unable to clarify whether the necessary documentation was not prepared for these five beneficiaries or whether the documentation was prepared but was not properly maintained.

The State agency made payments of \$95,000 (\$49,000 Federal share)<sup>20</sup> on behalf of these five beneficiaries. On the basis of our sample results, we estimated that the State agency made Medicaid payments of at least \$46.7 million (\$23.8 million Federal share) on behalf of at least 3,603 potentially ineligible beneficiaries.

### **RECOMMENDATIONS**

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

- redetermine, as appropriate, the current Medicaid eligibility of the sampled beneficiaries who may not have met Federal and State eligibility requirements and

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<sup>19</sup> The State agency had determined that 49 of the 140 sampled beneficiaries qualified for Medicaid on the basis of belonging to the Aged, Blind, or Disabled subset of the Non-MAGI eligibility category. (See Appendix A for a list of the eligibility categories from which we sampled.) All five of the beneficiaries for whom documentation was lacking belonged to the Aged, Blind, or Disabled eligibility category.

<sup>20</sup> Specifically, the State agency made payments of \$95,188 (\$48,556 Federal share) on behalf of these five beneficiaries.

- ensure that:
  - all eligibility requirements, including those pertaining to resources, are properly verified during annual redeterminations for all non-newly eligible beneficiaries and
  - information is maintained in case files to support that eligibility determinations were performed in accordance with Federal and State requirements.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency agreed with our recommendations and said that it had already implemented necessary changes to correct the errors we identified. The State agency said that our audit was duplicative of other Federal and State audits. The State agency added that because the errors affecting eligibility determination had been identified, addressed, and implemented “prior to the [Office of Inspector General] audit,” it did not need to take additional action based on our report.

The State agency also said that two beneficiaries (of the five potentially ineligible beneficiaries we identified) remained “correctly eligible” following the resolution of the errors we had identified; the three other beneficiaries, it said, have passed away since our audit period.

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

The State agency’s comments appear in their entirety as Appendix E.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the State agency’s comments, we revised our statistical estimates of potentially improper payments and potentially ineligible beneficiaries by reporting the estimates at the lower limits rather than (as our draft report had done) at the point estimates. With respect to the State agency’s characterization of our audit as duplicative of other Federal and State audits, the fact that our audit identified similar issues as the other audits strengthens the validity of our findings. These findings and the associated procedural recommendations, taken together, demonstrate the need for the State agency to improve the accuracy of Medicaid eligibility determinations and to pursue corrective actions that will prevent a recurrence of similar issues.

Although the State agency said that it found that several beneficiaries remained eligible following the resolution of the errors we identified, it did not provide any additional

documentation to support these redeterminations. Nor did the State agency explain whether the timeframes for which it had determined that these beneficiaries were eligible coincided with or followed the timeframes for which we had identified these beneficiaries as potentially ineligible.

We disagree that our sample size was too small to provide reliable information about the amount of potential improper payments. We used the results of our statistical sample to calculate a two-sided 90-percent confidence interval. The lower limit of this interval, which is included in our report, is designed to be less than the actual value 95 percent of the time. The lower limit accounts for the sampling method, the sample size, the number of items in the sampling frame, and the variability in sample in a manner that is generally favorable to the auditee. Although it is true that we do not know the exact amount of potentially improper payments in the frame, we can state with reasonable level of assurance that the total is above \$46,734,147 (\$23,839,146 Federal share).

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 979,496 non-newly eligible beneficiaries in Colorado for whom the State agency made Medicaid payments for services provided from October 1, 2014, through March 31, 2015 (audit period). We reviewed the Medicaid eligibility determinations made by the County agencies, as overseen by the State agency, for a stratified random sample of 140 beneficiaries classified as non-newly eligible to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

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

We conducted our audit work from November 2017 to May 2019.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to Medicaid eligibility and to the delineation of responsibilities between the State agency and the County agencies;
- reviewed the Colorado State plan and the State agency's verification plan (which describes the State agency's policies and procedures related to verifying an applicant's citizenship and lawful presence status, income, entitlement to and enrollment in Medicare, and other requirements for determining and redetermining Medicaid eligibility);
- held discussions with State agency officials to obtain an understanding of policies, procedures, and guidance for determining and redetermining Medicaid eligibility and then reviewed those policies, procedures, and guidance;
- obtained a database of all Medicaid paid claims data in Colorado with service dates during the audit period (excluding claims for services provided to American Indians and Alaska Natives);<sup>21</sup>

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<sup>21</sup> American Indians and Native Alaskans are subject to different eligibility requirements that were not a part of this audit.

- created a sampling frame of 979,496 non-newly eligible Medicaid beneficiaries for whom the State agency made Medicaid payments totaling \$2,148,608,419 (\$1,114,319,044 Federal share) (Appendix C);
- selected a stratified random sample of 140 Medicaid beneficiaries receiving services in Colorado during the audit period; and
- for each sampled beneficiary, obtained (where possible) application data and documentation to support the eligibility determination that the relevant County agency made and determined whether the State agency followed Federal and State requirements and its own procedures to verify eligibility documentation when making the eligibility determinations for the following categories:
  - MAGI children,
  - non-MAGI (including Aged, Blind, or Disabled; footnote 19),
  - MAGI parents and caretakers,
  - MAGI pregnant women,
  - MAGI adults,
  - Child Health Plan Plus,<sup>22</sup> and
  - Emergency Services Only;<sup>23</sup>
- estimated the total number of potentially<sup>24</sup> ineligible beneficiaries and the total amount of Federal Medicaid reimbursement made on behalf of beneficiaries who were potentially ineligible during our audit period (Appendix D); and
- discussed the results of our audit with State agency officials on May 20, 2019.

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

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<sup>22</sup> The Child Health Plan Plus eligibility category is public low-cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Colorado's Medicaid Program.

<sup>23</sup> The Emergency Services Only eligibility category consists of transportation, emergency room, and urgent care outpatient services.

<sup>24</sup> Because the State agency did not have documentation supporting that all eligibility requirements were verified properly in accordance with Federal and State requirements, we could not conclusively determine whether the beneficiaries were eligible for Medicaid.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<a href="#"><u>A-07-16-04228</u></a>	8/30/2019
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries</i>	<a href="#"><u>A-02-16-01005</u></a>	7/17/2019
<i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<a href="#"><u>A-09-17-02002</u></a>	12/11/2018
<i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<a href="#"><u>A-09-16-02023</u></a>	2/20/2018
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<a href="#"><u>A-02-15-01015</u></a>	1/5/2018
<i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements</i>	<a href="#"><u>A-04-16-08047</u></a>	8/17/2017
<i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<a href="#"><u>A-04-15-08044</u></a>	5/10/2017

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

The population consisted of all beneficiaries, excluding those under the new adult eligibility group established by the ACA, American Indians, and Alaskan Natives (footnote 21), for whom the State agency made Medicaid payments for services provided during our audit period (October 1, 2014, through March 31, 2015).

### SAMPLING FRAME

The sampling frame consisted of 979,496 Medicaid beneficiaries in Colorado, for whom the State agency made Medicaid payments for services provided totaling \$2,148,608,419 (\$1,114,319,044 Federal share) during the period October 1, 2014, through March 31, 2015. The data for the Medicaid beneficiaries were obtained from the State agency's Medicaid Management Information System (MMIS).<sup>25</sup>

The sampling frame did not include 336,172 beneficiaries each of whose total payments was below \$20.01.

### SAMPLE UNIT

The sample unit was a non-newly eligible Medicaid beneficiary.

### SAMPLE DESIGN

We used a stratified random sample consisting of four strata, as shown in Table 1:

**Table 1: Strata in Sample Design**

<b>Stratum</b>	<b>Range of Payment Amounts Used To Define Each Stratum</b>	<b>Number of Beneficiaries</b>	<b>Total Payments</b>	<b>Federal Share of Total Payments</b>
1	≥ \$20.01 and ≤ \$2,156.20	834,966	\$536,474,549	\$287,080,066
2	≥ 2,156.21 and ≤ 11,231.69	105,473	537,371,088	277,524,126
3	≥ 11,231.70 and ≤ 29,849.89	27,639	537,408,832	274,795,041
4	≥ 29,849.90	11,418	537,353,951	274,919,812

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

## **SAMPLE SIZE**

We selected 140 Medicaid beneficiaries: 70 beneficiaries from stratum 1, 30 beneficiaries from stratum 2, 20 beneficiaries from stratum 3, and 20 beneficiaries from stratum 4.

## **SOURCE OF RANDOM NUMBERS**

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

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the Medicaid beneficiaries within strata 1 through 4. After generating the random numbers for all four strata, we selected the corresponding Medicaid beneficiaries in the sampling frame for our sample.

## **ESTIMATION METHODOLOGY**

We used the OIG, OAS, statistical software to estimate the total number of potentially ineligible Medicaid beneficiaries in the sampling frame. This software was also used to estimate the total amount of Federal Medicaid reimbursement made on behalf of these potentially ineligible beneficiaries. The 90-percent confidence intervals for each of these estimates was calculated using the empirical likelihood approach, which we programmed using Microsoft Excel software.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

**Table 2: Sample Detail and Results for Potentially Ineligible Beneficiaries**

<b>Stratum</b>	<b>Number of Beneficiaries in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Potentially Ineligible Beneficiaries</b>	<b>Value of Potentially Improper Payments</b>
1	834,966	\$536,474,549	70	\$50,716	0	\$0
2	105,473	537,371,088	30	157,022	2	14,606
3	27,639	537,408,832	20	390,879	1	14,594
4	11,418	537,353,951	20	743,502	2	65,988
<b>Total</b>	<b>979,496</b>	<b>\$2,148,608,419<sup>26</sup></b>	<b>140</b>	<b>\$1,342,119</b>	<b>5</b>	<b>\$95,188</b>

**ESTIMATES**

**Table 3: Estimated Number of Potentially Ineligible Beneficiaries and Value of Potentially Improper Payments**  
*(Limits Calculated at the 90-Percent Confidence Level)*

	<b>Total Number of Potentially Ineligible Beneficiaries</b>	<b>Total Value of Potentially Improper Payments</b>	<b>Total Value of Potentially Improper Payments (Federal Share)</b>
Point Estimate	9,555	\$109,192,762	\$55,699,358
Lower Limit	3,603	\$46,734,147	\$23,839,146
Upper Limit	20,448	\$216,153,900	\$110,260,315

<sup>26</sup> Numbers do not add to total due to rounding.



**COLORADO**  
Department of Health Care  
Policy & Financing

1570 Grant Street  
Denver, CO 80203

December 10, 2019

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

Re: Report Number A-07-18-02812

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 *Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place.*

If you have any questions or need additional information, please contact Christine Bickers at 303-866-3259 or at [christine.bickers@state.co.us](mailto:christine.bickers@state.co.us).

Sincerely,

/s/

Donna Kellow  
Division Director  
Audits and Compliance

DK: cb

Cc: Richard Allen, Associate Regional Administrator for Medicaid and Children's Health Operations  
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 Audit Report Titled *Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place* (A-07-18-02812)

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

The Department appreciates the work of the OIG and other auditors who identify incorrect eligibility determinations and payments. This work is valuable to maintain the credibility of the Medicaid program. In addition, it allows timely corrections to be made when the Department is focused on the interpretation and implementation of complex federal rules. As detailed in the Department's response to the recommendations, the errors affecting eligibility determination were previously identified and have already been addressed and implemented by the Department.

Review of Eligibility Finds Vast Majority of Clients Eligible

The errors and recommendations provided by Department of Health and Human Services Office of Inspector General (OIG) Audit Report, *Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place* (A-07-18-02812) is a duplication of previous audits. Because of this duplication, the audit provides recommendations already addressed by the Department. In addition, the Colorado Department of Health Care Policy and Financing (Department) finds that several beneficiaries remain correctly eligible following the resolution of the error identified through the report. Several others have passed away since the review period (October 1, 2014 through March 31, 2015). Based on this information, the Department find the OIG's estimated number of ineligible beneficiaries identified in the audit to be inaccurate; it also finds the audit's interpretation of the value of improper payments to be an inaccurate reflection of the Department's eligibility determinations during the audit period.

Redundant Findings from Previous Audits

The Department agrees with the OIG's recommendations and has already implemented the necessary changes to correct the errors found in the report.

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

### Small Sample Size Leads to Overestimated Extrapolation

In the report, the OIG used a sample size of 140 non-newly eligible members, from a population of 979,496 non-newly eligible members, as its basis for extrapolation. The OIG provided an estimated dollar associated with its findings, which recognizes the variability inherent in the small sample size. Because of this there is more than a \$169 million difference between the lower and upper limits of the estimate. Such an extreme range caused by a small sample size is a factor to why the Department finds the OIG's estimated number of ineligible beneficiaries and value of improper payments to be an inaccurate reflection of the Department's eligibility determinations during the audit period.

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

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

### **OIG Recommendations and Department Responses**

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

- *Redetermine, as appropriate, the current Medicaid eligibility of the sampled beneficiaries who did not meet Federal and State eligibility requirements, and ensure:*
  - *All eligibility requirements, including those pertaining to resources, are properly verified during annual redetermination for all non-newly eligible beneficiaries and*
  - *Information is maintained in the case files to support that eligibility determinations were performed in accordance with Federal and State requirements.*

#### Department Response:

The Department has already implemented the necessary changes as these errors were previously identified through numerous other state and federal reviews. These changes include automating the eligibility system in March 2017 to identify and request all eligibility requirements, including those pertaining to resources used in eligibility determinations, during the redetermination period for all beneficiaries, including the non-newly eligible. In addition, an interface was implemented in December 2017 to obtain verification of resources through a reliable database of financial institutions.

The Department notes that 40% or two beneficiaries remain correctly eligible following the resolution of the errors identified through the report while 60% or three beneficiaries have since been redetermined ineligible due to changes in the beneficiary's circumstances that occurred since the review period (October 1, 2014 through March 31, 2015). Specifically, to this recommendation:

- Five errors cited due to resources not properly verified during the annual redetermination were corrected in March 2017 and December 2017. Two of the beneficiary's eligibility has been reassessed, with updated resources, and through this reassessment the beneficiaries were approved for the correct Medicaid category. Three of the beneficiaries have passed away.