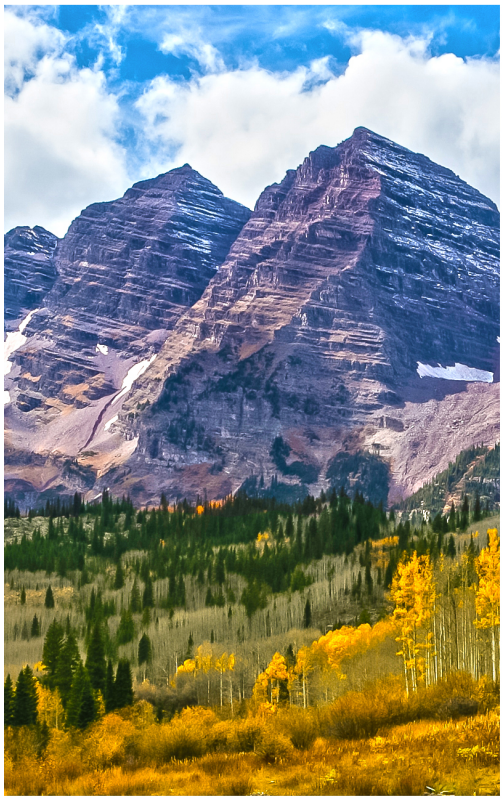
COLORADO OFFICE OF THE STATE AUDITOR

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO MEDICAID: THE PEAK APPLICATION AND ELIGIBILITY VERIFICATION



JULY 2016

PERFORMANCE AUDIT

THE MISSION OF THE OFFICE OF THE STATE AUDITOR
IS TO IMPROVE GOVERNMENT
FOR THE PEOPLE OF COLORADO

LEGISLATIVE AUDIT COMMITTEE

Representative Dan Nordberg – Chair
Representative Dianne Primavera – Vice-Chair

Senator Morgan Carroll
Senator Chris Holbert
Senator Cheri Jahn
Representative Tracy Kraft-Tharp
Senator Tim Neville
Representative Lori Saine

OFFICE OF THE STATE AUDITOR

Dianne E. Ray — State Auditor

Matt Devlin — Deputy State Auditor

Jenny Page — Audit Manager
Derek Johnson — Team Leader
Sarah Grider
Amber Spencer — Staff Auditors

AN ELECTRONIC VERSION OF THIS REPORT IS AVAILABLE AT
WWW.STATE.CO.US/AUDITOR

A BOUND REPORT MAY BE OBTAINED BY CALLING THE
OFFICE OF THE STATE AUDITOR
303.869.2800

PLEASE REFER TO REPORT NUMBER 1555P WHEN REQUESTING THIS REPORT

OFFICE
OF THE STATE AUDITOR

We Set the Standard for Good Government

DIANNE E. RAY, CPA

STATE AUDITOR

July 26, 2016

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of Colorado's Medicaid program within the Department of Health Care Policy and Financing. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

OFFICE OF THE STATE AUDITOR
1525 SHERMAN STREET
7TH FLOOR
DENVER, COLORADO
80203

303.869.2800

STATE · OF · COLORADO
UNION
AND
CONSTITUTION
NIL SINE NUMINE
1876

CONTENTS

Report Highlights 1

CHAPTER 1
OVERVIEW OF MEDICAID 3

Health Insurance Requirements 4
Colorado Medicaid 4
Colorado Health Exchange 6
Colorado's Shared Eligibility System 6
Medicaid Application Process 7
Audit Purpose, Scope, and Methodology 9

CHAPTER 2
MEDICAID ENROLLMENT AND DISENROLLMENT 13

Eligibility Determinations and Verifications for PEAK Applicants 15

Improve Monitoring of Disenrollments 22
RECOMMENDATION 1 31

STATE · OF · COLORADO
UNION
AND
CONSTITUTION
NIL SINE NUMINE
1876

REPORT HIGHLIGHTS

COLORADO MEDICAID: THE PEAK APPLICATION AND ELIGIBILITY VERIFICATION

PERFORMANCE AUDIT, JULY 2016

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

CONCERN

We found that the Department of Health Care Policy and Financing (Department) should improve its data and monitoring related to Colorado's Medicaid program (Medicaid) to ensure the State disenrolls recipients from Medicaid in a timely manner after the program has verified that they are no longer eligible for benefits.

KEY FINDINGS

- When we reviewed how Medicaid processes online applications through the PEAK website, we found that it has adequate procedures for ensuring the eligibility determinations are accurate and timely.
- The Colorado Benefits Management System (CBMS) uses electronic interfaces with other data sources, such as federal systems, to conduct automated verifications of information needed to determine applicants' eligibility for Medicaid. For example, CBMS verifies each applicant's income, identity, citizenship, and immigration status.
- Between October 2013 and December 2015, the audit period reviewed, the Department met its strategic goal to process at least 95 percent of eligibility determinations within required federal timeframes. On average, applicants who applied online through the Department's PEAK website received determinations within 21 days, and all other applicants received determinations within 27 days.
- Between October 2013 and December 2015, the Department conducted annual redeterminations of eligibility, as required by federal regulations, for about 99 percent of Medicaid recipients.
- The Department reported that, between Fiscal Years 2013 and 2016, Colorado counties recovered $835,400 from Medicaid recipients who were not eligible for the benefits they received.
- The Department does not have mechanisms for ensuring that all recipients who become ineligible for Medicaid due to changes in their circumstances are disenrolled from the program in a timely manner so that the State does not continue to pay for their medical costs. The Department's Fiscal Year 2016 SMART Government Act performance plan includes strategic initiatives to ensure sound stewardship of Medicaid funds and ensure efficiency and effectiveness through process improvement.

BACKGROUND

- Medicaid is a federal-state program that provides health care coverage and services to eligible low-income individuals and families with children. As of June 2016, 1.3 million Coloradans were enrolled in Medicaid.
- In Calendar Year 2015, the Department received over 555,000 applications for Medicaid, of which about 62 percent were submitted through the Department's PEAK website; 38 percent were submitted in-person, by mail, or by telephone.
- Eligibility for Medicaid is determined and periodically re-verified by CBMS.
- In Fiscal Year 2016, about $6.8 billion was appropriated to Medicaid in Colorado, of which about $2.6 billion were State funds.

KEY RECOMMENDATION

The Department of Health Care Policy and Financing should conduct monitoring to ensure that Medicaid recipients who become ineligible are disenrolled from the program in a timely manner. This should include tracking the data needed to monitor disenrollments and providing counties clear guidance on disenrolling ineligible recipients.

The Department agreed with the audit recommendation.

STATE · OF · COLORADO
UNION
AND
CONSTITUTION
NIL SINE NUMINE
1876

CHAPTER 1
OVERVIEW OF MEDICAID

Medicaid is a federal-state program that provides health care coverage and services to eligible low-income families. Medicaid is administered at the federal level by the Centers for Medicare and Medicaid Services (CMS) under Title XIX of the Federal Social Security Act, and administered at the state level by Colorado's Department of Health Care Policy and Financing (Department) under Section 25.5-4-105, C.R.S. The Department is responsible for ensuring that the State complies with all federal and state Medicaid requirements. Federal regulations [42 C.F.R., 440] require states' Medicaid programs to provide all eligible recipients certain basic services, including but not limited to inpatient and outpatient hospitalization, physician and rural health clinic services, and nursing facility services for recipients aged 21 and older.

HEALTH INSURANCE REQUIREMENTS

In 2010, the federal government enacted the Patient Protection and Affordable Care Act (Affordable Care Act, or Act), which aimed to reduce the number of uninsured Americans by making healthcare and health insurance more affordable. A key requirement of the Act is that all individuals obtain public or private health insurance or pay an annual tax penalty [26 USC 5000A]. To help accomplish this requirement, the Act provided states the option to expand Medicaid eligibility to adults from ages 19 through 64 with an income at or below 133 percent of the federal poverty level. This option began in 2014, with the federal government fully funding the newly eligible population until Federal Fiscal Year 2017. Colorado is among the 31 states that chose to expand Medicaid under the Act.

COLORADO MEDICAID

Colorado Senate Bill 13-200 expanded eligibility for low-income adults without dependent children and for low-income parents and caretaker relatives with dependent children, effective January 2014. In accordance with federal regulations [42 C.F.R., 435], Colorado currently provides Medicaid benefits and services to the following low-income populations:

- Adults with an income at or below 133 percent of the federal poverty level.
- Children in families with a household income at or below 142 percent of the federal poverty level.
- Pregnant women with an income at or below 195 percent of the federal poverty level.
- Individuals receiving Supplemental Security Income (SSI) for the Aged, Blind, and Disabled.
- Individuals qualified for adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.
- Some dual-eligible Medicare beneficiaries who are over age 65. For this population, Medicaid is the payer of last resort.

- Individuals who are not U.S. citizens, but who meet specific requirements under federal law [8 USC 1612] related to income, work, child support enforcement, and U.S. residency.

According to the most recent Department data available at the time of the audit, about 1,330,000 individuals were enrolled in Medicaid in Colorado as of June 2016, which is about 24 percent of Colorado's population.

Medicaid is funded jointly with state and federal funds. In Colorado, the federal matching rate for most Medicaid expenditures for State Fiscal Year 2016 is 51 percent, meaning that the State was reimbursed 51 cents for each $1 that it spent on Medicaid services, excluding the newly eligible adult population in Medicaid. From Calendar Year 2014 through 2016, the federal government funds 100 percent of states' Medicaid costs for low income adults who are newly eligible under the 2014 expansion; from Calendar Year 2017 through 2020, this federal match will be gradually reduced to 90 percent.

EXHIBIT 1.1 shows Medicaid expenditures in Fiscal Years 2013 through 2016, which include fee for service payments for individual services that recipients received as well as capitation payments to providers.

EXHIBIT 1.1. MEDICAID EXPENDITURES [1] (IN MILLIONS)
STATE FISCAL YEARS 2013 THROUGH 2016

EXPENDITURES BY FUNDING SOURCE	2013	2014	2015	2016 [2]
Federal Funds	$2,172.5	$2,752.2	$3,558.1	$4,208.4
State Funding	$2,215.7	$2,374.2	$2,324.8	$2,592.7
TOTAL	$4,388.2	$5,126.4	$5,882.9	$6,801.1

SOURCE: The Office of the State Auditor's analysis of Joint Budget Committee documents.
[1] Includes Medicaid expenditures for acute medical services and long term care provided to Medicaid recipients, Medicaid-funded programs at the Department of Human Services, and Medicaid-related information technology costs.
[2] Fiscal Year 2016 figures are appropriations.

COLORADO HEALTH EXCHANGE

The Affordable Care Act requires states to either set up a state-run health insurance exchange or use the federal health exchange to help people obtain private health insurance if they are not eligible for public health coverage, such as Medicaid. A health insurance exchange is a competitive marketplace that helps consumers compare available private health plan options, benefits, and prices, and purchase a plan. Colorado was among the 11 states that were operating a state health exchange as of May 2016.

Colorado's health benefit exchange, a non-profit entity known as Connect for Health Colorado (Connect for Health), was created in 2011. Connect for Health administers customer service centers and a website that allow Coloradans to shop for health insurance and purchase a health plan. Connect for Health also helps consumers determine if they are eligible for an advanced premium tax credit (tax credit), which is federal financial assistance meant to reduce consumers' insurance costs.

According to federal regulations [45 C.F.R., 155.320(b)], a consumer may not enroll in a private health plan at a health exchange if the consumer is eligible for public health insurance, such as Medicaid. Individuals wishing to purchase private insurance through Connect for Health, or obtain a tax credit, must first demonstrate that they are not eligible for Medicaid by applying for Medicaid and receiving a denial.

COLORADO'S SHARED ELIGIBILITY SYSTEM

To streamline the application process for Medicaid and tax credits, the Affordable Care Act requires state Medicaid programs and health exchanges to have a shared application and eligibility process. In Colorado, the Department's PEAK website, also known as the Program Eligibility and Application Kit, serves to provide a streamlined shared eligibility process for Medicaid and tax credits.

The Department's PEAK website was implemented in 2010 to allow Coloradans to apply for Medicaid online. The Department implemented PEAK in collaboration with the Governor's Office of Information Technology (OIT), the Department of Human Services (DHS), and the private contractor Deloitte Consulting, LLC (Deloitte). PEAK interfaces with the Colorado Benefits Management System (CBMS), which is the State's system that processes applications and makes eligibility determinations for public benefits such as for food, cash, and medical assistance. The State has contracted with Deloitte to maintain CBMS for the use and benefit of the Department, DHS, and OIT. The eligibility data in CBMS feeds into the Medicaid Management Information System (MMIS), which pays providers for the services Medicaid recipients receive.

In November 2014, the Department improved its PEAK website, with feedback from Connect for Health, to provide a single online process for consumers to apply for Medicaid or tax credits, and improved CBMS to determine eligibility for Medicaid and tax credits. Connect for Health's website includes a link to the PEAK website so consumers wishing to purchase private health insurance can access PEAK to confirm that they are not eligible for Medicaid and determine if they qualify for a tax credit.

MEDICAID APPLICATION PROCESS

Low-income individuals with a significant disability who are receiving Supplemental Security Income (SSI) are automatically eligible for Medicaid. All other Medicaid applicants must complete the Department's standard Medicaid application form and submit it using one of the following methods:

- **ONLINE THROUGH PEAK.** Applicants who are low-income and do not have a disability or need long term care, can apply for Medicaid through the Department's PEAK website or via the PEAK website link on Connect for Health's website. PEAK guides applicants through the Medicaid application process by prompting

them to enter information into an electronic application form. PEAK transfers this information to CBMS, which determines eligibility. When applicants who have a disability or need long term care attempt to apply through PEAK, their application is forwarded to their local county social services office or a Medical Assistance Site (MA Site) for processing. MA Sites are locations certified by the Department to accept and process Medicaid applications.

- **IN-PERSON.** Any applicant can apply in-person at one of the 90 county offices and MA Sites in Colorado which accept Medicaid applications. Caseworkers at these locations guide applicants through the application process by collecting their information and entering it into CBMS, which maintains the case files and determines eligibility. Caseworkers assisting recipients who are enrolled in other public benefits programs, such as the Supplemental Nutrition Assistance Program (SNAP), also help these individuals apply for Medicaid.

- **BY TELEPHONE.** Applicants can apply by calling the Colorado Medical Assistance Program, which is administered by the Department contractor, Denver Health. The information that applicants provide over the phone is entered directly into CBMS by Colorado Medical Assistance Program staff.

- **BY MAIL.** Applicants can apply by mail by sending their completed application either to (1) the Colorado Medical Assistance Program whose staff enter the applicant's information into CBMS, (2) Connect for Health whose staff use the PEAK website to help the applicant complete the application, or (3) their local county department of human services office.

Applicants can also obtain assistance completing and submitting their Medicaid application at 278 Certified Application Assistance Sites, which are Department-authorized volunteer organizations and individuals who agree to be a community resource for applicants.

According to CBMS data, most Medicaid applicants (62 percent) submitted their applications online through the PEAK website during Calendar Year 2015, as shown in EXHIBIT 1.2.

EXHIBIT 1.2. SUMMARY OF MEDICAID APPLICATION METHODS CALENDAR YEAR 2015

APPLICATION METHOD	NUMBER OF APPLICATIONS	PERCENTAGE OF TOTAL
Department's PEAK Website	344,123	62%
In-Person	113,474	20%
Medical Assistance Site	54,854	10%
Mail-In	14,491	3%
Through Another Public Assistance Program	9,467	2%
Telephone	6,458	1%
Other [1]	12,452	2%
TOTAL	555,319	100%

SOURCE: The Office of the State Auditor's analysis of CBMS data.
[1] According to the Department of Health Care Policy and Financing, "Other" includes applicants who applied through some type of special action, such as a Medicaid application that was created for a family after it applied for Child Health Plan Plus in order to determine the family's eligibility for both programs.

If an applicant is determined to be ineligible for Medicaid, but eligible for a tax credit, either the PEAK website, county, MA Site, or Connect for Health informs the applicant of the estimated tax credit for which he or she qualifies and directs the applicant to Connect for Health's website along with the application information so that the applicant can shop for a private health plan.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this performance audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of the state government. The audit was conducted in response to a legislative request. The purpose of the audit was to assess whether the Department has sufficient controls to (1) ensure that only eligible individuals enroll in Medicaid using the PEAK website, (2) detect and disenroll individuals who are improperly enrolled in Medicaid, and (3) recover claims improperly paid on behalf of ineligible recipients. The audit focused on the

individuals who applied for Medicaid through PEAK between October 2013 and December 2015. This audit did not redetermine the eligibility of Medicaid recipients or check that case file documentation supported eligibility, as that work is conducted by our annual Statewide financial audit. Work on this performance audit was conducted from August 2015 through July 2016.

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.

The key objectives of the audit were to determine:

- Whether the Department has effective controls over the eligibility determinations that are issued through PEAK to ensure that determinations are accurate and timely.

- Whether the Department has effective controls to identify Medicaid recipients who are ineligible and to disenroll them from the program in a timely manner.

- The extent to which Medicaid payments for health care services are made on behalf of ineligible individuals.

The audit also reviewed the Department's compliance with the SMART Government Act with respect to Department performance measures and goals for processing Medicaid applications and determining eligibility when applicants applied through PEAK.

To accomplish the objectives, we performed the following audit work:

- Analyzed electronic application data from CBMS for all of the approximately 1.4 million Medicaid applications submitted

October 2013 through December 2015 (the most recent data available at the time of audit testing), showing information such as the timeliness of application processing and eligibility determinations, the verifications the Medicaid program conducted to determine eligibility, and the reasons applicants were determined ineligible.

- Examined electronic benefits data from MMIS showing the benefits paid on behalf of Medicaid recipients.

- Reviewed various information reports and documentation showing the configuration of CBMS and the system controls for determining eligibility.

- Analyzed trends in applications and enrollment for Colorado's Medicaid program using Department and CMS reports.

- Analyzed the Department's Fiscal Years 2014 and 2015 Annual Reports and its Fiscal Year 2016 SMART Government Act Performance Plan.

- Interviewed Department and OIT management and staff, the Deloitte contractors responsible for making changes to CBMS and PEAK, federal CMS staff, Connect for Health management, and county caseworkers.

We relied on sampling to support some of our audit work. Specifically, we selected a judgmental sample of 30 of the 8,815 Medicaid recipients for whom CBMS data indicated may have been disenrolled in an untimely manner from Medicaid in Calendar Year 2015. We reviewed the detailed Medicaid case files for the sampled recipients to determine if the CBMS timeliness data was accurate. We designed our sample to provide sufficient and appropriate evidence for the purpose of evaluating the Department's CBMS data related to disenrollments.

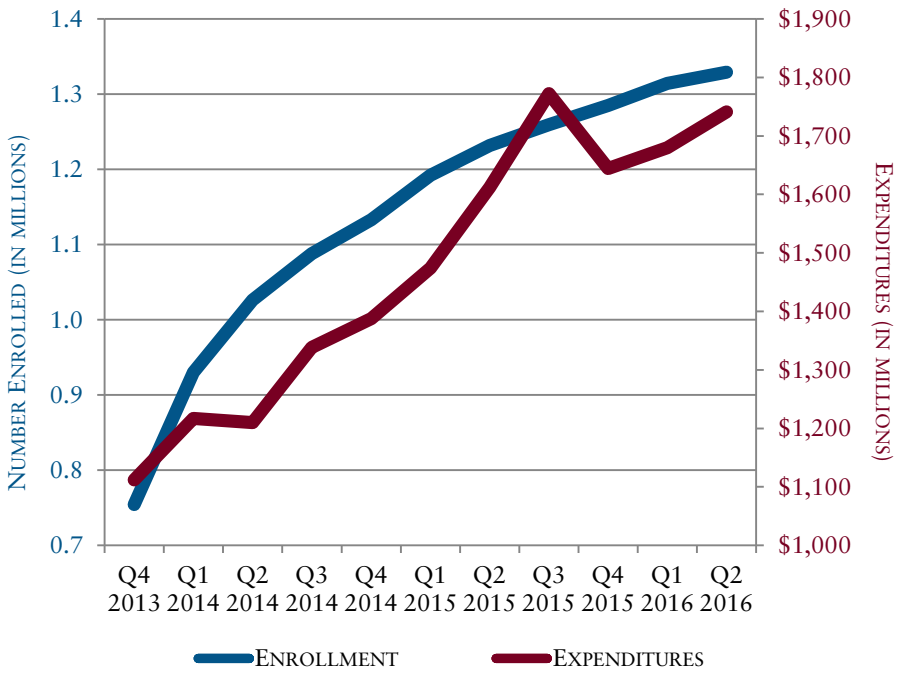
We planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Our conclusions on the effectiveness of those controls, as well as specific details about the audit work supporting our findings, conclusions, and recommendations, are described in CHAPTER 2 of this report.

CHAPTER 2

MEDICAID ENROLLMENT AND DISENROLLMENT

Following the enactment of the federal Patient Protection and Affordable Care Act (Affordable Care Act, or Act), there was an increase in the number of applications for Colorado's Medicaid program (Medicaid) and an increase in enrollment in the program. The increases were primarily due to (1) the requirement in the Act that all Americans obtain health insurance, and (2) the expansion of Medicaid eligibility in the State. From October 2013 (the first month that the Act required enrollment in health insurance) through June 2016 (the most recent data available at the time of the audit), the number of recipients who were enrolled in Medicaid increased by about 595,000 or 81 percent, while monthly Medicaid costs in Colorado increased by about $81 million or 20 percent. These Medicaid trends are shown in EXHIBIT 2.1.

EXHIBIT 2.1. TRENDS IN COLORADO MEDICAID ENROLLMENT AND COSTS OCTOBER 2013 THROUGH JUNE 2016 (BY QUARTER)



SOURCE: The Office of the State Auditor's analysis of the Department of Health Care Policy and Financing's monthly reports to the Joint Budget Committee.

To respond to the increase in Medicaid applications, the Department of Health Care Policy and Financing (Department) improved the Program Eligibility and Application Kit website known as PEAK, as discussed in CHAPTER 1, to provide a more streamlined application process for Medicaid. To respond to expanded Medicaid eligibility and increased enrollment, the Department improved the Colorado Benefits Management System (CBMS) to allow it to determine applicants' eligibility based on the revised eligibility requirements and to improve the timeliness of eligibility determinations. Additionally, the Department has implemented internal controls, processes, and systems for ensuring that individuals who enroll in Medicaid through the PEAK website are eligible and remain eligible, as described in the following section.

ELIGIBILITY DETERMINATIONS AND VERIFICATIONS FOR PEAK APPLICANTS

Federal regulations [42 C.F.R., 435.930] require states to furnish Medicaid benefits to recipients promptly, without any delay caused by the agency's administrative procedures, and to continue to furnish Medicaid to eligible individuals until they are found to be ineligible. During the audit, we evaluated the internal controls and procedures in Colorado's Medicaid program for ensuring the Medicaid application process and eligibility notifications using PEAK are prompt, the eligibility determinations are accurate, and recipients who are ineligible are identified and disenrolled from Medicaid in a timely manner to reduce unnecessary costs to the State.

Overall, we found that the Department and Medicaid program have adequate procedures and internal controls for processing applications through PEAK, ensuring the eligibility determinations of online applicants are accurate and timely, detecting changes in recipients' circumstances that could affect their eligibility, and recovering improperly paid claims, as required by federal and state laws and regulations. These procedures and controls are described below.

VERIFICATIONS OF APPLICANTS' ELIGIBILITY INFORMATION. Federal regulations require states to determine whether an applicant is eligible for Medicaid based on the applicant's income, state residency, age, citizenship, immigration status, household composition, and pregnancy status [42 C.F.R., 435 et. seq.]. When applicants apply through PEAK, CBMS is automated to conduct real-time verifications of each applicant's identity, Social Security number, citizenship, and immigration status through electronic interfaces with other data sources. Medicaid may accept an applicant's self-attestation of other information needed to determine eligibility [42 C.F.R., 435.945]. For example, federal regulations [42 C.F.R., 435.956(e)] require the State to accept applicant's self-attestations for pregnancy, unless the State has information that is not compatible with the applicant's attestation. Department staff reported to us that if application information is

missing, questionable, or does not match the data from the appropriate interface, the applicant is given a pending status in CBMS, and PEAK forwards the application to county caseworkers for manual processing.

Colorado's methods for verifying applicants' information are outlined in the Department's Medicaid and Child Health Plan Plus (CHP+) Verification Plan (Verification Plan), and were approved by the U.S. Secretary of Health and Human Services [42 C.F.R., 435.945(j)]. EXHIBIT 2.2 summarizes the methods Medicaid uses to verify application information and determine eligibility for applicants who apply online through PEAK. Most of the electronic verifications occur within 24 hours of application completion and CBMS tracks the verifications conducted.

EXHIBIT 2.2. COLORADO MEDICAID METHODS FOR VERIFYING APPLICANTS' ELIGIBILITY INFORMATION

ELIGIBILITY FACTOR	INITIAL SELF-ATTESTATION	ELECTRONIC SYSTEM VERIFICATIONS	WHEN DOCUMENTATION IS OBTAINED TO VERIFY ELIGIBILITY
Residency Age Pregnancy	Yes	None	Obtained if applicant provides questionable information.
Income	Yes	Income and Eligibility Verification System (IEVS)	Obtained if there is a discrepancy of 10% or more between the application and IEVS data, and applicant does not provide a reasonable explanation.
Citizenship	None	State Verification Exchange System (SVES)	Obtained if CBMS does not find the applicant in the SVES System.
Identity	None	Social Security Administration Interface or Department of Motor Vehicles Interface	Obtained if CBMS does not find the applicant through the Social Security Administration Interface or Department of Motor Vehicles Interface.
Social Security Number	Yes	Social Security Administration Interface	Obtained if applicant provides questionable information.
Immigration Status	None	Verify Lawful Presence Interface	Obtained if an electronic verification is not received.

SOURCE: Office of the State Auditor's summary of the Department of Health Care Policy and Financing's documentation.

In addition to the verifications listed in EXHIBIT 2.2, CBMS interfaces with the federal Public Assistance Reporting Information System

(PARIS) to search for any benefits a recipient may be receiving in another state or another federal program, such as veteran's benefits. CBMS also checks information the applicant provided to other public assistance programs, such as Colorado's Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF), to determine in real-time whether the recipient provided those programs with any information that conflicts with the information provided on their Medicaid application.

We reviewed CBMS data for the approximately 1.4 million Medicaid applications that the program received between October 2013 and December 2015, which included the eligibility verifications that CBMS conducted. According to the data, 48 percent of these Medicaid applicants were determined eligible during this period. Based on our review of the data and Department documentation, the Department has adequate controls for conducting verifications and obtaining supporting documentation to ensure that only eligible individuals enroll in Medicaid through PEAK.

PEAK NOTIFICATION OF POTENTIAL ELIGIBILITY BEFORE APPLICATION IS COMPLETED. In the legislative request that precipitated this audit, legislators had concerns that some individuals had applied for tax credits through PEAK, and were enrolled in Medicaid although they believed that they were ineligible. During audit interviews, we learned that there were some applicants who applied through PEAK in 2013 and entered incorrect information, such as $0 income, into their online Medicaid application to speed up the application process and obtain the denial needed to purchase a health plan through Connect for Health Colorado (Connect for Health).

To help ensure applicants provide accurate information when applying online, beginning with the November 2014 open enrollment period, PEAK provides applicants with an immediate notification of their eligibility and a reminder to check the information inputted into the application prior to finalizing their application. If someone who applies does not believe they are eligible, but receives the notification that they are eligible, he or she has an opportunity to check their

application and correct any errors that might lead to an incorrect eligibility determination.

TIMELINESS OF ELIGIBILITY DETERMINATIONS. Beginning in 2013, the Department was required by a court settlement agreement to process at least 95 percent of all applications and determine applicants' eligibility within federally required timeframes—90 days for applicants who are applying based on disability, including long-term disability, and 45 days for all other applicants [42 C.F.R., 435.912]. For the Medicaid applications submitted between October 2013 and December 2015, CBMS data showed that the Department met the timeliness requirements. Specifically, about 96 percent of all Medicaid eligibility determinations were completed within required federal timeframes—the average timeframe for determining eligibility for applications submitted through PEAK was 21 days, while the average timeframe for all other applications (e.g., in-person, mail, and telephone applications) was 27 days. The eligibility determinations that did not meet federal timeframes were delayed because Medicaid caseworkers needed to obtain documentation from applicants to verify their eligibility or the applicants filed an appeal to dispute their eligibility determination.

Further, the legislative request that precipitated this audit had concerns that some individuals who applied for Medicaid through PEAK had been initially determined ineligible, but the Department had a mechanism that determined the individuals eligible at a later date, after they had purchased a private health plan through Connect for Health. According to our interviews with Department staff and analysis of CBMS, the Department has no such mechanism. The only way an individual can be determined eligible for Medicaid after being denied is if he or she files an appeal with the Office of Administrative Courts to overturn the denial, or if the individual's circumstances change and they submit a new Medicaid application.

CONTROLS TO DETECT CHANGES IN RECIPIENTS' ELIGIBILITY. Federal regulations [42 C.F.R., 435.916(d)] require the State to redetermine a Medicaid recipient's eligibility promptly when the program receives

information about a change in a recipient's circumstances, such as changes in income, residency, and age, which may affect eligibility. Additionally, federal regulations require the Department to have procedures designed to ensure that recipients report changes in their circumstances accurately and in a timely manner, such as a change in income, which may affect their eligibility [42 C.F.R., 435.916(c)]. Medicaid uses the following methods to monitor changes in recipients' circumstances and detect when recipients are no longer eligible:

- **AUTOMATED MONITORING.** After an applicant is determined eligible, CBMS and its automated interfaces with other systems are used to identify changes that affect recipients' eligibility. For example, on a monthly basis CBMS checks IEVS for changes in recipients' incomes, and checks PARIS to search for any benefits a recipient may be receiving in another state or another federal program. When reviewing CBMS data, we confirmed that the IEVS and PARIS checks were occurring on a regularly scheduled basis. CBMS also automatically checks the recipient information that has been updated by other public assistance programs, such as SNAP and TANF. When CBMS identifies a change in a recipient's eligibility information for another assistance program that may affect his or her eligibility for Medicaid, it triggers CBMS to redetermine the recipient's Medicaid eligibility.

  We reviewed Department and Governor's Office of Information Technology (OIT) documentation, such as the CBMS system architecture and eligibility determination process flow diagrams, to confirm that CBMS is designed to detect changes in the data that it maintains on applicants who are receiving public assistance and the system redetermines their eligibility when changes occur. We also reviewed CBMS data to confirm that redeterminations were occurring between October 2013 and December 2015.

- **SELF-REPORTED CHANGES.** Colorado's Medicaid application requires applicants to sign the application form, in part to acknowledge their responsibility to report changes in their circumstances, such as income changes, to their county Medicaid

office within 10 calendar days of the change. The Department also sends recipients annual letters that instruct them to report changes in their circumstances that can affect their eligibility. Medicaid recipients are able to update their information online through PEAK or in person, by mail, or by calling their county office. When an applicant provides Medicaid with updated information used to determine eligibility, CBMS automatically redetermines his or her eligibility.

When analyzing the CBMS data, we confirmed that Medicaid had issued approximately 764,000 of these annual letters to recipients between October 2013 and December 2015, which represents over 99 percent of recipients who should have received a letter. We also reviewed Department and OIT documentation regarding CBMS to confirm that CBMS automatically redetermined eligibility when changes occurred.

In addition, Connect for Health management informed us that in October 2014, it implemented an automated process that sends an electronic report of private health plan holders to CBMS on a monthly basis, which CBMS checks to determine if the plan holders are Medicaid eligible, and therefore, no longer eligible for a tax credit. After CBMS conducts these checks, the Department provides Connect for Health a listing of the plan holders who were enrolled in Medicaid after purchasing a private health plan. Connect for Health staff attempt to contact each of these plan holders up to three times to inform them that, under federal law, they lose the tax credit when Medicaid eligible. If Connect for Health does not receive a response, the plan holders remain enrolled in their health plans, but will lose their tax credit.

We reviewed the monthly reports that Connect for Health submitted to CBMS for January through May 2016 to confirm that this automated process was in place. Connect for Health management estimated that, since October 2014, these CBMS checks have identified a total of about 90 Coloradans who qualified for Medicaid but who chose to keep their health plan and forego their tax credit.

ONGOING ELIGIBILITY REDETERMINATIONS. According to federal regulations [42 C.F.R., 435.916], the adult Medicaid recipients must have a redetermination of eligibility every 12 months. Regulations [42 C.F.R., 435.916(a)(2)] specify that if Medicaid is able to redetermine eligibility based on reliable information contained in the recipient's case file or other current information available, the redetermination must be made without requiring additional information from the individual. We found that the Department had sufficient controls in place to conduct redeterminations, and over 99 percent of the 764,000 redeterminations conducted in the period we reviewed complied with federal requirements.

RECOVERY PROCESSES. State regulations make it the responsibility of the county to take action against any person suspected of obtaining Medicaid benefits for which they are not entitled [Section 8.070.01, 10 C.C.R., 2505-10]. State regulations [Section 8.065.1, 10 C.C.R., 2505-10] define an "overpayment" as any medical assistance paid on behalf of a recipient who was not lawfully entitled to receive benefits, but statute [Section 25.5-4-301(2)(a)(II), C.R.S.] specifies that funds are not recovered from the recipient if the overpayment was made through no fault of the recipient. According to Department staff, the State pursues recovery from recipients if fraud is suspected, the suspected fraud is investigated by the county in which the recipient lives, and the local district attorney determines whether to prosecute.

We reviewed the mechanisms Medicaid has in place to recover the costs of claims improperly paid on behalf of ineligible recipients and found that the program complies with federal and state regulations. While it is more common for Medicaid to recover overpayments from providers than to recover from recipients, according to Department reports, between Fiscal Years 2013 and 2016, the counties recovered $835,400 from Medicaid recipients who were suspected of fraud and were not eligible for the benefits they received.

Although we found that the Department has sufficient internal controls for processing applications submitted through PEAK, determining eligibility, and conducting redeterminations and cost

recoveries, we found that the Department could improve its oversight related to disenrolling Medicaid recipients when they are determined ineligible. Specifically, we found that the Department can improve its processes, internal controls, and information systems to monitor disenrollments and ensure that the Medicaid program is ending benefits for ineligible recipients in a timely manner. The remainder of CHAPTER 2 describes our finding and recommendations in this area.

IMPROVE MONITORING OF DISENROLLMENTS

The Department is responsible for disenrolling recipients from Medicaid and ending their benefits when they are no longer eligible. A Medicaid recipient's disenrollment can be triggered at any time due to a change in his or her circumstances that makes him or her ineligible. According to the Department's Medicaid data, the primary reason recipients become ineligible is an increase in their income above the Medicaid eligibility limit; other reasons include, but are not limited to, recipients' moving out of state, death, incarceration, and failure to provide Medicaid verification that they are in the United States lawfully.

As discussed previously, the Department is made aware of changes in a Medicaid recipient's circumstances that affect his or her eligibility through CBMS interfaces with other databases and when recipients provide the program with information on changes. When the Department learns of a change in a recipient's circumstances the new information is added to the recipient's record in CBMS, which determines whether the recipient remains Medicaid-eligible. If CBMS determines that the recipient is ineligible, the Department notifies the recipient that they will be disenrolled from Medicaid unless he or she submits documentation to refute the determination within 10 days, as required by federal regulations [42 C.F.R., 431.211]. If the Medicaid program does not receive a response from the recipient, the program's policy is to disenroll the recipient from Medicaid.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of the audit work was to determine whether the Department disenrolls ineligible recipients from Medicaid in a timely manner and in accordance with federal, state, and Department requirements.

Our audit work included analyzing the Department's CBMS electronic data for the approximately 1.13 million individuals who applied for Medicaid between October 2013 and December 2015. According to the Medicaid data, 8,815 recipients received a notification from the Department that they would be disenrolled due to a change in their circumstances in Calendar Year 2015, and the data indicated that these recipients may not have been disenrolled from Medicaid in a timely manner. We reviewed the Department's detailed electronic case file information for a sample of 30 of the 8,815 recipients to determine whether the aggregate data were reliable for determining the timeliness of the recipients' disenrollment. We also analyzed data from the Medicaid Management Information System (MMIS) to determine whether the sampled recipients received benefits after they should have been disenrolled.

We interviewed county caseworkers and management and staff from the Department, OIT, Deloitte Consulting LLC (Deloitte), and the Federal Centers for Medicare and Medicaid Services (CMS) to understand requirements and processes for identifying ineligible recipients and disenrolling them from Medicaid, and to determine how the Department monitors the timeliness of disenrollments to help detect and prevent waste in Medicaid.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Federal regulations [42 C.F.R., 435.930] require the state to furnish Medicaid benefits to eligible individuals until they are found to be ineligible. This federal regulation implies that the State should disenroll recipients from Medicaid and terminate their benefits when they are found to be no longer eligible for Medicaid.

Federal and state regulations provide the Medicaid program with some flexibility on when to terminate an ineligible recipient's benefits. According to CMS, a recipient's Medicaid benefits generally stop at the end of the month in which the person no longer meets the eligibility requirements. However, Department policy and guidance that it has received from CMS allow for ineligible recipients to receive Medicaid benefits up to 41 days, and sometimes longer if the recipient disputes the ineligibility determination. Specifically, federal regulations [42 C.F.R., 431.211] require the Department to notify ineligible recipients that they will be disenrolled from Medicaid at least 10 days prior to terminating their benefits. Department policy further specifies that if the ineligible recipient is notified of their ineligibility within 10 days of the end of the month, their Medicaid benefits should be terminated at the end of the following month. For example, if a recipient is notified of their ineligibility on December 28, he or she would receive Medicaid benefits through January 31; on February 1 the recipient's benefits should end and he or she should be disenrolled from Medicaid.

In addition, regulations [Section 8.100.3.H(10), 10 C.C.R., 2505-10] and Department policy allow county case workers the discretion to provide ineligible recipients benefits for extended periods while the recipients dispute the determination that they are no longer eligible and provide documentation of their eligibility. CBMS is programmed to automatically discontinue an ineligible recipient's benefits after a 90-day reasonable opportunity period, but the Department has

established what it calls a good faith policy, whereby counties can provide recipients extensions beyond this timeframe.

The Department should have mechanisms to ensure that recipients who become ineligible due to a change in their circumstances are disenrolled in a timely manner so that the Medicaid program is not paying for the medical costs of ineligible individuals. To help comply with federal requirements, the Department included a strategic initiative in its Fiscal Year 2016 SMART Government Act performance plan to ensure sound stewardship of Medicaid funds and financial resources through costs containment, and an initiative to enhance efficiency and effectiveness through process improvement.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

Overall, we were unable to determine whether the Department consistently disenrolls all ineligible recipients from Medicaid and ends their benefits in a timely manner. While Department policies comply with state and federal regulations, the Department does not track the timeliness of all disenrollments for Colorado's Medicaid program.

When we attempted to obtain this disenrollment information by analyzing the CBMS data that the Department provided, we found that the data were unreliable for determining the timeliness of disenrollments and the number of recipients who should have been disenrolled. For example, the Department's data indicated that 8,815 ineligible recipients had not been disenrolled from Medicaid within 41 days during Calendar Year 2015. However, when we reviewed the case files for a sample of 30 of the 8,815 recipients, we identified problems with the reliability of the aggregate data for all 30 recipients. The CBMS aggregate data showed that the 30 recipients had been found ineligible and had not been disenrolled from Medicaid in a timely manner, but the details in the case files accurately showed that these recipients either remained eligible and enrolled in Medicaid, or

were disenrolled in a timely manner. Specifically, we identified the following problems with the CBMS data. The data did not:

- **Distinguish between recipients disenrolled from Medicaid and recipients transferring between different Medicaid eligibility groups.** The aggregate CBMS data showed that 20 of the 30 sampled recipients were ineligible and should have been disenrolled, but the case files showed that the recipients were actually disenrolled from one Medicaid eligibility group and enrolled in another group, such as from the "Aid to Families with Dependent Children" group to the Child Health Plan Plus or CHP+ group. The aggregate CBMS data was also misleading because it showed that these 20 recipients had been notified that they were being disenrolled for ineligibility and showed the reasons that they were being disenrolled. For example, the data indicated that one sampled recipient was determined ineligible in October 2015 for a lack of documentation to verify eligibility, and was disenrolled in January 2016, which would have been untimely. However, the recipient's case file showed that she had become ineligible for the "Aid to Needy Disabled" Medicaid group and was disenrolled from that group on September 30, 2015, and had been enrolled in the "Old Age Pension for those aged 60-64" Medicaid group on October 1, 2015.

- **Indicate when ineligibility determinations and notifications had been found to be inaccurate.** The aggregate CBMS data showed that 5 of the 30 sampled recipients were determined ineligible because they had died, but the case files showed that the recipients had provided evidence to the county that they were alive and remained eligible and enrolled. For example, the data indicated that one sampled recipient was determined ineligible in October 2014 due to "death" and had not been disenrolled from Medicaid. However, the recipient's case file showed that she had contacted her county caseworker, was not deceased, and remained enrolled in Medicaid.

- **ALWAYS INCLUDE ACCURATE DATES NEEDED TO DETERMINE THE TIMELINESS OF DISENROLLMENT.** The aggregate CBMS data showed that the remaining 5 of the 30 sampled recipients were disenrolled from Medicaid in an untimely manner, but the case files showed different disenrollment dates than the aggregate data and showed that the disenrollments were timely. For example, the data indicated that one sampled recipient was determined ineligible for "not being a Colorado resident" on October 1, 2015 and was disenrolled on November 30, 2015, which would have been untimely. However, the recipient's case file showed that the recipient was disenrolled on October 31, 2015 and MMIS data showed that the recipient had not received any Medicaid services after October 1, 2015.

WHY DID THESE PROBLEMS OCCUR?

Overall, the Department's focus is on ensuring that Medicaid application and eligibility processes are timely because there are numerous federal requirements and federal monitoring related to the timeliness of these processes. The Department does not have processes or mechanisms, such as data tracking, reporting, and monitoring, to check that all Medicaid recipients who become ineligible are consistently disenrolled in a timely manner.

We identified the following areas where the Department could improve its oversight over disenrollments:

- **TRACK DATA.** The Department needs to track the data in a way to accurately identify disenrollments and analyze disenrollment timeliness for the entire Medicaid program. Based on our interviews with Department, OIT, and Deloitte staff, CBMS is not currently designed to capture the data needed to reliably determine the timeliness of disenrollments for Medicaid. For example, CBMS has codes to track the reasons why a recipient is disenrolled, but the codes do not clearly indicate when a recipient moves from one eligibility group to another—such as when an individual becomes too old to be eligible for CHP+ coverage, is disenrolled from that group, and is enrolled into an adult eligibility group. CBMS also

does not allow for efficient analysis of changes to ineligibility determinations, such as when a recipient is notified of their disenrollment but later found eligible because the recipient provided documentation of their eligibility. Lastly, CBMS does not currently allow for efficient analysis of timeliness, such as analyzing the dates shown in the case files and calculating the number of days that have elapsed from the notification of disenrollment to the date that the recipient was actually disenrolled from Medicaid.

- **Implement automated ways to monitor disenrollments and disenrollment timeliness.** After we reported the problems that we found to the Department, its staff informed us that there was no efficient way for it to assess the timeliness of disenrollments for the entire Medicaid program; the only way to determine if an ineligible recipient was disenrolled in a timely manner would be to review his or her case file. The Department has not established a process for monitoring or measuring the timeliness of disenrollments for all recipients who should be disenrolled from Medicaid. For example, the Department has not established CBMS reports or automated system controls to check whether ineligible individuals are disenrolled in accordance with Department policy or within reasonable time periods, nor does it have automated methods to check how long Medicaid recipients are receiving benefits after being notified of ineligibility.

  Without automated monitoring, the Department cannot efficiently investigate, or alert counties to investigate, the highest risk cases of ineligible recipients continuing to receive Medicaid benefits, such as the ineligible recipients who receive high dollar benefits or receive benefits for the longest periods. According to Department staff, the Department relies on the counties to manage Medicaid cases. However, the Department has not provided the counties with guidance or tools for monitoring the timeliness of disenrollments or reporting disenrollment timeliness to the Department.

- **Establish ways to identify and limit extensions of benefits for recipients who are found ineligible.** During our interviews,

we learned that county case workers can provide recipients with multiple extensions to dispute an ineligibility determination or provide eligibility documentation, during which time the recipients remain enrolled in Medicaid. The Department does not monitor these extensions and has not established a policy, rule, or guidance for counties on limiting the number or length of extensions that the counties provide an ineligible recipient. The Department also does not have a risk-based process to investigate or alert counties to investigate these extensions, such as follow-up on cases when the counties provide ineligible recipients multiple extensions for long periods of time, such as 6 months or more.

WHY DO THESE PROBLEMS MATTER?

During Fiscal Year 2016 through May, approximately 205,000 individuals, or about 13 percent of the total number of Colorado Medicaid recipients, were disenrolled from Medicaid because they were no longer eligible. Without methods for ensuring timely disenrollments, the Department risks wasting public funds and limits its ability to safeguard the State's financial investment in the Medicaid program. First, when the Department does not have a method to ensure ineligible recipients are disenrolled from Medicaid in a timely manner, the State could pay for the medical costs of ineligible individuals. When ineligible individuals use Medicaid providers' time and services, it can affect the timeliness and quality of service for legitimately eligible recipients. By receiving benefits after being determined ineligible, ineligible recipients can put a strain on providers' time and services.

Second, without adequate monitoring of disenrollments, the Department cannot ensure that the State is paying the accurate state share for Medicaid recipients' medical claims. Currently the federal government funds 100 percent of Colorado's Medicaid costs for low income adults who were newly eligible under the 2014 expansion of Medicaid. However, the federal government generally requires the state to pay for 50 percent of the costs of other eligible Medicaid populations. When the Department does not have reliable ways to

monitor disenrollments and the movement of recipients among different Medicaid eligibility groups, it is difficult for it to ensure that it is paying the correct state share amounts for each recipient and not overpaying the federal government.

Third, the implementation of the Affordable Care Act resulted in the expansion of Medicaid enrollment and new costs, and the monitoring of disenrollments will be increasingly important to the State when it will be required to cover a greater percentage of recipients' Medicaid costs in future years. From State Fiscal Year 2017 through Fiscal Year 2020, the federal match for the low income adults who were newly eligible under the expansion will be gradually reduced from 100 percent to 90 percent, so Colorado will pay a greater percentage of these recipients' Medicaid costs. The Department has projected that the Medicaid costs for this new adult population alone will total $1.44 billion in Fiscal Year 2017, of which the State will cover about $36 million, or 2.5 percent, and the federal government will cover the remaining 97.5 percent. The State's share of these costs will continue to increase annually as the federal match is reduced to 90 percent, making it important for the Department to take steps to find ways to ensure that ineligible recipients are disenrolled from Medicaid in a timely manner.

RECOMMENDATION 1

The Department of Health Care Policy and Financing should implement processes for ensuring that Medicaid recipients who become ineligible are consistently disenrolled from the program in a timely manner. These processes should include, but should not be limited to the following:

A Tracking the data needed to report on the timeliness of all Medicaid disenrollments.

B Establishing automated monitoring to check that ineligible recipients are disenrolled in a timely manner, within reasonable timeframes determined by the Department.

C Developing risk-based monitoring to ensure that the benefits of ineligible recipients are terminated within reasonable timeframes determined by the Department.

D Providing counties clear guidance for completing disenrollments in a timely manner and limiting extensions of benefits for recipients who are determined to be ineligible.

RESPONSE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

AGREE. IMPLEMENTATION DATE: JULY 2017.

A While the audit did not find that benefits were incorrectly extended to Medicaid recipients that should have been disenrolled, the Department does agree with the audit recommendation to provide automated monitoring. The Department will work with our county partners and CBMS vendor to develop and implement a new

CBMS automated report that can be used to monitor and track all Medicaid disenrollments, including Medicaid recipients who move from one eligibility category separately from those who become ineligible and should be disenrolled from the program in a timely manner as defined by the Department. The Department will need until July 2017 to implement the recommendation since the CBMS changes typically need approximately eight months to be designed, developed, and implemented and as such, will be scheduled on the June 2017 CBMS release schedule.

B The Department will update the Medicaid Eligibility Quality Improvement Plan (MEQIP) manual to indicate that the sample of each county's internal review should include those from the new CBMS automated report that monitors that Medicaid recipients who become ineligible are disenrolled from the program in a timely manner as defined by the Department. The MEQIP was established as the framework to communicate the Department's vision, objectives and strategies to improve the eligibility determination process. An essential component of MEQIP is to provide a formal ongoing process by which eligibility sites monitor and evaluate the quality of administrative eligibility activities. Through this process, supervisory case reviews must be completed to evaluate timely processing, data entry accuracy and supporting case file documentation.

C The Department will update the MEQIP manual to indicate that the sample of each county's internal review should target high risk clients (as defined by the Department) on the new CBMS automated report that monitors that Medicaid recipients who become ineligible are disenrolled from the program in a timely manner as defined by the Department.

D The Department will work with stakeholders and county partners to refine the guidance regarding the reasonable opportunity period and good faith policy (i.e., extensions) for clients to dispute an ineligibility determination or provide eligibility documentation.