



MEMORANDUM

Date: August 8, 2011  
To: Members of the Legislative Audit Committee  
From: Dianne E. Ray, CPA, State Auditor  
Re: Federal Colorado Eligibility and Enrollment Review

The Centers for Medicare & Medicaid Services (CMS) Denver Regional Office performed a review of proposed remediation efforts implemented by the State of Colorado in response to issues identified with Medicaid eligibility determinations and redeterminations. The review was conducted from July 1, 2010, through December 7, 2010. CMS' review was performed to determine the State's compliance with applicable Federal law and regulations as related to Medicaid eligibility determination and redetermination. The Colorado Benefits Management System (CBMS) functionality and the State's administration of the Medicaid program were also the focus of the review.

CMS identified several substantial findings as a result of the review and has threatened Federal Financial Participation sanctions against the State, including disallowing Federal Funds for CBMS, unless immediate corrective actions are taken by the Colorado Department of Health Care Policy and Financing (Department) and the Governor's Office of Information Technology (OIT). CMS findings include:

- The State is out of compliance with the federal rules for timeliness of Medicaid eligibility determinations and redeterminations.
- The State is out of compliance with federal rules requiring that the Single State Agency maintain control over the operations of the Medicaid program.
- The State is out of compliance with federal rules requiring a reasonable period of time be allowed for applicants to present satisfactory documentary evidence of citizenship.
- The State is out of compliance with the federal rules for citizenship and alienage.
- The State is out of compliance with the federal rules regarding the termination of eligibility.



We Set the Standard for Good Government

- The State is out of compliance with federal rules regarding periodic redeterminations of Medicaid eligibility.
- The State is out of compliance with the federal rules for client notices.
- The State is out of compliance with the federal rules for documentation and maintenance of an adequate and complete eligibility history of Medicaid individuals.

Due to the serious nature of the findings contained in the review and the threat of federal sanctions against the State, we have asked representatives from the Department and OIT to be present at the August 23, 2011, hearing to further discuss the findings and their corrective action plans.

Attached to this memo is a copy of the federal Colorado Eligibility and Enrollment Review, Final Report, dated July 1, 2011, and a matrix prepared by the Office of the State Auditor containing our recommendations related to problems with the Department's Medicaid eligibility determinations and redeterminations.

# COLORADO ELIGIBILITY AND ENROLLMENT REVIEW

## TABLE OF CONTENTS

EXECUTIVE SUMMARY.....	3
BACKGROUND.....	4-6
OBJECTIVE/SCOPE/METHODOLOGY.....	6-9
FINDINGS/RECOMMENDATIONS/OBSERVATIONS.....	9-33
<i>Finding #1: Timely determination of eligibility.....</i>	9
<i>Finding #2: State Control.....</i>	18
<i>Finding #3: Citizenship and Identity Documentation.....</i>	22
<i>Finding #4: Citizenship and Alienage.....</i>	23
<i>Finding #5: CBMS Redeterminations of Medicaid eligibility.....</i>	24
<i>Finding #6: Periodic Redeterminations.....</i>	26
<i>Finding #7: Client Notifications.....</i>	28
<i>Finding #8: Vanishing Eligibility Spans.....</i>	30
PROMISING PRACTICES.....	34

REVIEW AT COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DRAFT REPORT

**EXECUTIVE SUMMARY**

The Centers for Medicare & Medicaid Services (CMS) Denver Regional Office (RO) performed a review of proposed remediation efforts implemented by the State of Colorado in response to issues identified with Medicaid eligibility determinations and redeterminations. The review was conducted beginning July 1, 2010 through December 7, 2010.

CMS examined State policies, procedures and actions taken to improve Medicaid eligibility and enrollment processes from 2007 to the current day. CMS' review was conducted in accordance with Federal regulations at 42 CFR 430.32 and 45 CFR Parts 92 and 95 and performed to determine the State's compliance with applicable Federal law and regulations as related to the Medicaid eligibility determination and redetermination. The Colorado Benefits Management System functionality and the State's administration of the Medicaid program were also a focus of the review. CMS identified several substantial findings as a result of the review, and is requiring that the State Medicaid Agency take corrective actions. The CMS findings include:

- The State is out of compliance with the federal rules for timeliness of Medicaid eligibility determinations and re-determinations;
- The State is out of compliance with federal rules requiring that the Single State Agency maintain control over the operations of the Medicaid program;
- The State is out of compliance with federal rules requiring a reasonable period of time be allowed for applicants to present satisfactory documentary evidence of citizenship;
- The State is out of compliance with the federal rules for citizenship and alienage;
- The State is out of compliance with the federal rules regarding the termination of eligibility;
- The State is out of compliance for federal rules regarding periodic redeterminations of Medicaid eligibility;
- The State is out of compliance with the federal rules for client notices; and
- The State is out of compliance with the federal rules for documentation and maintenance of an adequate and complete eligibility history of the Medicaid individuals.

The State concurred with the CMS findings, and agreed to implement corrective actions by date certain. The State concurrence with corrective actions was contingent on available funding. However, the State must comply with the federal rules without exception or condition related to funding.

**Administrative Renewals.** The HRSA grant is providing funding critical to creating an infrastructure that will support our increasing capacity needs. The Department is implementing Administrative Renewals to simplify an individual's redetermination process and lessen the workload of the eligibility site worker. Administrative renewals will automate the ex parte process, by utilizing current information available from other programs within CBMS as well as the interfaces targeted for implementation in the summer of 2011. Individuals who are found eligible through the automated process will continue to receive benefits without worker intervention. Individuals who are found ineligible through the automated process will receive a preprinted form of their eligibility information requesting that it be reviewed, updated and returned. Eligibility site workers will then enter the information into CBMS and redetermine eligibility. Individuals whose information is correct on the preprinted form do not need to return the form and eligibility will be redetermined automatically with the existing information on file. All individuals who receive the preprinted form will also receive the 10-day noticing if their eligibility will be terminated. This new functionality will continue Medicaid eligibility to individuals until they are determined ineligible.

**CMS Response:**

We recognize the State's response is contingent on obtaining necessary funding for the Electronic Document Management System. However, CMS holds the State responsible for compliance with Federal rules regardless of the availability of funding. Additionally, the State may face Federal Financial Participation sanctions if the corrective actions are not completed by the agreed upon dates. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15<sup>th</sup> of each month (for the previous month) until the compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

**Client Notification Issued by CBMS**

**Finding #7: HCPF is not in compliance with Federal Regulations at 42 CFR 431.211, which requires that the State or local agency must mail a notice at least 10 days before the date of action.**

CMS reviewed various reports which identified proper noticing as an issue within the State's delivery of the Medicaid program. The reports reviewed were the CMS CBMS P-I Report, the 2005 Family and Children Active MEQC Pilot Project, the 2005 Nursing Family Active Pilot Project, and the 2008 Public Knowledge Report.

These reports cite various problems such as proper noticing, content, unnecessary repetitive volume of notices and contradictory notices. Also, CMS interviewed advocacy groups and information they provided indicating that clients will often receive numerous notices within the same week which indicate different 'actions'. Some of the notices indicate that Medicaid has been discontinued and others indicate the client has been found eligible for Medicaid. Federal Regulations at 42 CFR 435.912 require that the agency

must send each applicant a written notice of the agency's decision on his or her application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his or her right to request a hearing.

Also, Federal Regulations at 42 CFR 431.210 establish that notices must contain the following elements: "(a) a statement of what action the State intends to take; (b) the reasons for the intended action; (c) the specific regulations that support, or the change in Federal or State law that requires the action; (d) an explanation of: (1) the individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or (2) in cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) an explanation of the circumstances under which Medicaid is continued if a hearing is requested."

CMS noted that CBMS-generated notices denying Medicaid applications due to incomplete applications and missing required documentation did not specify which portions of the application were incomplete or which documents were missing.

CMS has also reviewed reports regarding notices and notes the following issues:

- Notices contain incorrect spans of Medicaid eligibility and continue to reflect older dates for new spans (sometimes going back to three and four years).
- Notices continue to have contradictory information such as "you are eligible for Medicaid" and in the same notice "your Medicaid benefits have been terminated."
- Clients continue to receive multiple contradictory notices at the same time.
- Many of the legal citations in the notices are incorrect or do not apply to the action being taken. Since the noticing is tied to the integrated nature of the system, one system that implements several programs with different definitions of income results in a complex set of programming instructions that often must compete with each other. This complexity may also extend to the county workers who have to keep in mind all the competing definition of the various programs and causes for a longer eligibility review time.
- The use of county-generated notices rather than CBMS notices.

### **Requirement**

CMS requires that, within sixty days of the final issuance of this report, develop a corrective action plan addressing the notification issues cited above and identifying activities that it will take to improve the CBMS notification process and bring it into compliance with Federal regulations at 42 CFR 431.210-211. Please note, if the corrective actions are not completed within twelve months from the date of this report being issued, CMS will consider deferring funding for CBMS.

### **Recommendations**

CMS recommends that, with regard to terminations without proper advance notice to clients and notifications content, the State assess whether these are system-generated

problems that need to be resolved through system remediation or whether they are problems arising from user error and need to be addressed through training.

With regard to the use of county-generated notices rather than CBMS notices, CMS recommends that HCPF work with the counties to enhance CBMS notices to capture the information that the counties feel is lacking and needs to be represented in their notices.

**State Response:**

The Department agrees with both the Requirements and Recommendations and agrees to comply with all of the Requirements and Recommendations of Finding 7. The following initiatives address client noticing.

**CBMS Change Request 2135.** The CBMS Change Request #2135 was implemented on January 31, 2011. This change generates a verification checklist for required verifications based on the eligibility site worker's data entry, thus eliminating the need for eligibility site workers to create their own notices.

**Citations and Language.** Over the past year, the Department has reviewed all of the medical correspondence notices, updated legal citations, and revised language, and submitted these changes to the Governor's Office of Information Technology (OIT) in March 2011. OIT is in the process of updating CBMS with the new notices.

**CMS Response:**

CMS concurs with the State's plan for corrective actions. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15<sup>th</sup> of each month (for the previous month) until the compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

**Vanishing Medicaid Eligibility Spans**

**Finding #8:** CMS found that, in an analysis performed by HCPF, when a valid eligibility span in CBMS is retroactively removed, historical records of the span are also removed from the Medicaid Management Information System (MMIS) in a majority of the vanishing cases. Clients in these cases are defined as having "uncertain eligibility history", because there is uncertainty around the past eligibility status of the clients.

CBMS functionality currently permits county and medical assistance site workers to change data to an existing medical eligibility span within the system. This change may result in the medical eligibility span "vanishing" retroactively without an audit trail or a record of the original medical eligibility span.

As a result of the Vanishing Medical Span (VMS) there are various problems and risks for Medicaid clients that include but are not limited to:

- When a medical eligibility span is eliminated, resulting medical services are denied to clients;
- The eligibility status of affected clients is determined to be unjustifiably uncertain;
- An estimated tens of millions of dollars in capitations where clients 'look' ineligible in CBMS yet could be actually eligible; and
- Reconciliations in the capitated programs that have not been completed could result in several million dollars outstanding which could be owed the State/CMS.

### **Requirement**

CMS requires that, within sixty days of the final issuance of this report, the State will submit a project plan with specific timeline for correcting the VMS by December 31, 2011 and which will ensure the elimination of the VMS problem by that date.

### **Recommendation**

CBMS recommends that HCPF perform system changes within CBMS to eliminate the VMS Problem.

### **State Response:**

The Department agrees with the Requirements and the Recommendations of Finding 8. The Department agrees to comply with the Requirements and Recommendations of Finding 8, however is unable to meet the required timeline of December 31, 2011.

The Department maintains paper or electronic application files for all eligible individuals, which can be used to determine if the individual is eligible. The Department also provides ongoing training and technical support to county departments of human/social services on how to correctly enter medical applications into CBMS. To prevent the electronic records from being deleted retrospectively, the Department, in coordination with the Governor's Office of Information Technology, developed a project plan in October 2009 to implement changes into the CBMS system. The Department is targeting the implementation to correct the Vanishing Medicaid Eligibility Spans in August 2012.

### **CMS Response:**

CMS concurs with the State's plan for corrective actions. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15<sup>th</sup> of each month. The progress reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.