STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

September 22, 2022

Rick Lowe, Chief Internal Auditor
Office of Internal Audit Services
111 South Capitol Avenue
8th Floor, Romney Building
Lansing, Michigan 48933

Dear Mr. Lowe:

In accordance with the State of Michigan, Financial Management Guide, Part VII, attached are the summary table identifying our responses and corrective action plans to address recommendations contained within the Office of the Auditor General's Performance Audit of Medicaid and Children's Health Insurance Program Client Eligibility Determinations.

Questions regarding the summary table or corrective action plans should be directed to me at 517-241-4237 or MyersP3@michigan.gov.

Sincerely,

Pam Myers

Pam Myers, Director
Bureau of Audit

PM:wb

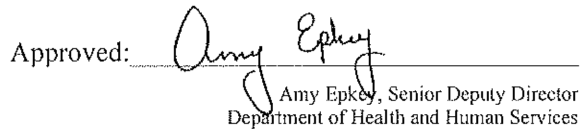
Enclosure (1)

c: Office of the Auditor General
House Fiscal Agency
Senate Fiscal Agency
Executive Office
DHHS, David Knezek
DHHS, Amy Epkey
House Appropriations Committee
House Standing Committee
Senate Appropriations Committee
Senate Standing Committee
DHHS, Farah Hanley
DHHS, Lewis Roubal

MEDICAID AND CHILDREN'S HEALTH
INSURANCE PROGRAM CLIENT
ELIGIBILITY DETERMINATIONS

DEPARTMENT OF HEALTH AND HUMAN
SERVICES

AUDIT RESPONSE

Approved: 

Amy Epkey, Senior Deputy Director
Department of Health and Human Services

Date: September 12, 2022

AUDIT REPORT SUMMARY

DEPARTMENT: Behavioral and Physical Health & Aging Services Administration

AUDIT PERIOD: October 1, 2018 through May 31, 2020

REPORT DATED: March 11, 2022

DISPOSITION OF AUDIT RECOMMENDATIONS

CITATIONS COMPLIED WITH	CITATIONS TO BE COMPLIED WITH	CITATIONS DHHS DID NOT AGREE WITH
		Finding 1
		Finding 2
	Finding 3	
		Finding 4
		Finding 5
		Finding 6
Finding 7 (December 2021)		
		Finding 8
		Finding 9
		Finding 10
		Finding 11
	Finding 12	
		Finding 13

Audit Response
Performance Audit
2019 OAG Medicaid Eligibility Audit
Department of Health and Human Services
October 1, 2018 through May 31, 2020

Recommendation 1: Improvements needed to ensure MDHHS completes accurate eligibility determinations and maintains documentation

We recommend that MDHHS accurately determine beneficiary eligibility and maintain documentation that eligibility was processed in accordance with eligibility requirements.

Response

MDHHS disagrees with the finding.

MDHHS strongly disagrees that the estimated improper payments are an accurate depiction of payments in error. MDHHS requested an audit conference to discuss this significant disagreement, during which MDHHS provided additional policy and regulatory background. Additional details were also provided for a subset of the cases wherein the OAG cited the accuracy of MDHHS' eligibility determination despite policy and case documentation that supported the determination made by the caseworker. Given the complexity of Medicaid eligibility, MDHHS took this
additional step to partner with the OAG to help educate them on state and federal policy, operations and technology and resolve concerns with incorrect audit findings to ensure an accurate and representative audit product.

MDHHS does not agree with the methodology utilized by the OAG in this audit. The OAG methodology results in a grossly inflated estimate and an inaccurate representation of potential payments made in error. The calculation of improper payments used as the basis for the extrapolation failed to differentiate cases that lacked eligibility from those that were eligible but placed in a misclassified type of assistance or different benefit category and included cases that MDHHS disagrees were in error. As noted, this resulted in a significantly inflated estimate which exacerbated the estimate made through the OAG's extrapolation methodology. Despite the detailed discussion of these disagreements and the concerns noted in more detail below, the OAG made minimal changes to their findings or methodology.

MDHHS's Concerns:

Inclusion of Permissible Payments: The OAG deemed payments to be improper when CMS would not have made the same determination.

MDHHS reviewed the cases and determined that many of these beneficiaries were eligible under other aid categories. Given that these individuals were in fact eligible for Medicaid, there was no improper payment. The improper payment calculation should be limited to those cases truly ineligible for Federal reimbursement. Any other methodological approach grossly misrepresents financial risk to the program and the state.

The federal government's audit process supports MDHHS' conclusion above. As part of the federal Payment and Error Rate Measurement (PERM) audits, CMS first determines if the beneficiary is eligible in other aid categories, before determining "inaccuracies." Had the scope of the OAG's audit taken these factors into account and noted them as part of its extrapolation, the dollar amount would be significantly lower.

Lack of Recognition for Federal Medical Assistance Percentage (FMAP) Differentials: The OAG deemed full payment amounts to be improper when CMS would have only recognized the

difference in federal match rates. CMS is interested in the validity of the federal payment, which is defined by the PERM Manual as the difference between what was paid and what should have been paid.

When beneficiaries were eligible under different Medicaid benefit categories than audited, the OAG reported the total payment as improper. However, several of these individuals were eligible under another type of assistance with a different FMAP. In such instances, the payment amount is accurate; only the amount of federal and state share requires adjustment and the potential amount of the improper federal reimbursement should have been limited to the difference

For example, a $1,000 payment was made on behalf of a child who was determined eligible for MI Child (CHIP: matched at 98.12% federal) but should have been in a Low- Income Family (Medicaid: matched at 64.45% federal) group. The OAG deemed the full $1,000 payment to be in error, whereas CMS would have only cited the difference in the federal match for which the payment qualified vs. the amount originally drawn, which was $336.70. The $336.70 figure would have then been used in the base amount used by the federal government to extrapolate rather than the $1,000 amount used by the OAG.

Misapplication of MDHHS/CMS Policy: The federal government establishes clear policy for states when they determine or redetermine eligibility. The OAG has assessed cases that they deem improper based on an incorrect interpretation of federal policy.

There were a number of state and federal policies that were misinterpreted or misapplied by the OAG these are represented below.

MAGI Determinations:
Federal regulations (42 CFR 435.907 in conjunction with supporting regulations 435.945, 435.948, 435.949, and 435.952) allow MDHHS to consider the case complete when a case is auto certified. IRS data is the most accurate, up to date information, at the time of auto certification. Therefore, the determination was accurate at the time of the MAGI run and auto certification. Relatedly, the exclusion of numerous MAGI certified cases incorrectly exaggerated the improper payment calculation.

In sample 89 the application was submitted via MI Bridges and the income reported in the application was correctly used in the eligibility determination. Additionally, income is not required to be verified for this eligibility category (U19).

Other Eligibility Determinations:
Case workers must adhere to policy and system guidelines that instruct them to make a "point in time" assessment even if income varies after the initial assessment.

In Sample 52, a 'point in time' assessment was made using the father's earned income. He was not receiving RSDI at that time but began receiving it later. The original OHK U19 determination was correct and would continue for 12 months.

In sample 89 a 'point in time' assessment was made when the application was submitted via MI Bridges. Income was further verified during an interview and updated in the eligibility system; however, it did not result in a change to the Medicaid category.

In sample 88, a 'point in time' assessment was made when the client reported increased earned income which MAGI confirmed was over the income limit for LIF. CI from the previous quarter verified earned income had increased since the previous determination. Check stubs were then received further confirming TMA was the correct TOA

Continuous eligibility Requirements:
As stated in BEM 131, Children under 19 (U-19) beneficiaries remain eligible for 12 months of continuous eligibility, unless the beneficiary: Reaches age 19; moves out of state; is ineligible due to Institutional Status; is eligible for Foster Care Department Ward (FCDW) coverage; or dies. Further, BEM 500 (pg.13) Verification Requirements states that this applies for all programs except children under 19.

In Sample 13, the beneficiary was determined eligible for MiChild for the retro month of April using check stubs. MiChild is a continuous eligibility program and subsequent income changes would not impact the Medicaid Benefits.

In Sample 52, the application was correctly certified for OHK which is a continuous eligibility category and subsequent income changes would not impact the Medicaid benefits.

In sample 89, the application was auto certified approved for OHK, which is a 12 month continuous eligibility category, and subsequent income changes would not impact the Medicaid benefits.

Notwithstanding the above noted disagreements, MDHHS is always looking for opportunities for improving its programs and how they are operated. This includes exploring the use of additional data sources to assist with income verification as well as enhanced case worker training. The fact that these efforts to improve policies, programs and oversight activities are underway does not necessarily mean these were done as a result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Recommendation 2: System improvements needed to ensure the correct classification of Medicaid and CHIP expenditures

We recommend that MDHHS ensure Bridges and CHAMPS contain the correct Medicaid and CHIP eligibility information for recording expenditures to the appropriate program at the time of payment.

Response

MDHHS disagrees with the finding.

MDHHS does not agree that the entire amount cited is inappropriate federal reimbursement. All of these beneficiaries were Medicaid eligible, and all payments would have been eligible for regular FMAP. Therefore, the amount cited above is significantly overstated.

MDHHS is always looking for opportunities to improve its programs and how they are operated. MDHHS has been working since 2018 to ensure correct eligibility classifications in Bridges at the time of payment and a solution was implemented in April 2021. All new cases are correctly routed and MDHHS expects that all existing cases will be updated during a 12-month period following the end of the public health emergency. The efforts we have underway to improve this program and its activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Until full implementation is completed, MDHHS will continue its manual process of transferring expenditures from the Medicaid Cluster to CHIP on a quarterly basis. In the interim, MDHHS has made

several changes to its quarterly process and will continue to review its methodologies and make adjustments if warranted, until all cases are systematically corrected.

Recommendation 3: Improvements needed in processing TMA

We recommend that MDHHS accurately and timely process eligibility determinations for beneficiaries receiving healthcare coverage from the TMA eligibility category.

Response

MDHHS agrees with the finding.

TMA is a 12-month program, however due to overlapping statutory requirements regarding negative action and timely notice rules, cases can legitimately extend to 13 months. A process has been developed for implementation that will be used to determine appropriate actions following the end of the Public Health Emergency.

MDHHS is always looking for opportunities for improving its programs and how they are operated. A system change was implemented in August 2021 to address beneficiaries that received TMA but none of their group members had been eligible for and received LIF for three of the six calendar months immediately preceding the month of LIF denial. MDHHS is working on a system enhancement that will generate redetermination requests 2 months in advance, addressing the issue of beneficiaries receiving TMA for more than 12 months without violating existing rules or statutory requirements. If necessary, further system enhancements will be initiated to resolve underlying issues as identified following the end of the Public Health Emergency.

Recommendation 4: Improvements needed to ensure required SSN verifications are completed

We recommend that MDHHS complete the required SSN verifications for Medicaid and CHIP beneficiaries.

Response

MDHHS disagrees with this finding.

MDHHS disagrees with the methodology applied to determine inappropriate payments. MDHHS acknowledges that there were cases that lacked verification in the case file, however there can be a delay in verification if the beneficiary had applied for and not yet received an SSN.

Federal regulation 42 CFR 435.910 delineates that a State cannot delay an eligibility determination for those who do not or cannot obtain an SSN and must accommodate those who do not qualify for or refuse to get one based on religious declarations and those who have applied for and not yet received an SSN. MDHHS is always looking for opportunities to improve its programs and how they are operated, therefore, MDHHS has requested specific guidance from CMS to determine SSN-requirements related to closure and will make appropriate adjustments if so required. MDHHS has been involved in ongoing communication with CMS and will modify processes as necessary once final guidance is received. The efforts we have underway to improve policies, programs and oversight activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Recommendation 5: Improvement needed in alien status verification

We recommend that MDHHS ensure all Medicaid and CHIP beneficiaries have an acceptable alien status to receive full healthcare coverage.

Response

MDHHS disagrees with this finding.

MDHHS disagrees that all cases cited in this finding were ineligible for full Medicaid coverage due to immigration status. Initial eligibility is based on client attestation per Section 1137(d)(4) of the Social Security Act (the Act) and regulations at 42 CFR 435.956 which require MDHHS to provide full Medicaid to individuals who have attested to having satisfactory immigration status during a reasonable opportunity period while their immigration status is being verified if they are otherwise eligible for Medicaid. The reasonable opportunity period is 90 days from the date of the notice. This means that the individual has 90 days to provide documents to prove their attested satisfactory immigration status. MDHHS has identified numerous cases cited as error in which beneficiaries were correctly receiving full Medicaid coverage based on documentation in the electronic case file or were within the 90-day period.

MDHHS is always looking for opportunities to improve its programs and how they are operated. MDHHS has identified systems issues resulting in incorrect full coverage for a limited number of beneficiaries. MDHHS has initiated a project to identify and address the systems issues related to this finding. MDHHS is assessing the available FY22 information technology resources to address the findings in this audit. A supplemental funding request will be evaluated for any systems issues that cannot be resolved with existing appropriations. The efforts we have underway to improve programs, oversight, and IT functionalities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Recommendation 6: Improvements needed in determining eligibility for HMP beneficiaries concurrently enrolled in Medicare

We recommend that MDHHS accurately determine beneficiary eligibility in accordance with federal eligibility requirements for HMP beneficiaries concurrently enrolled in Medicare.

Response

MDHHS disagrees with the finding.

MDHHS is required to follow The Patient Protection and Affordable Care Act ("ACA"; Public Law 111–148), which requires states to accept self-attestation of all eligibility factors except income and to auto-certify individuals based on this attestation. MDHHS auto-certified many applications cited within this audit based on self-attestation as required. MDHHS is always looking for opportunities to improve its programs and how they are operated. In addition to maintaining compliance with federal regulations, MDHHS implemented several system enhancements prior to the audit that go beyond the requirements established in the ACA to ensure accurate eligibility. Errors flagged by this audit were identified prior to the implementation of system enhancements and field staff have been provided with guidance to address any remaining cases following the end of the public health emergency. These enhancements include no longer autocertifying individuals who have Medicare coverage on file from a previous application, checking additional areas of the application for evidence of Medicare coverage, and

requests listed on applications for the Medicare Savings Program. The efforts we have underway to improve policies, programs and oversight activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Recommendation 7: Improved controls needed to prevent or recover healthcare payments issued on behalf of incarcerated individuals

We recommend that MDHHS enhance its controls to prevent or recover Medicaid and CHIP healthcare coverage payments issued on behalf of incarcerated individuals who no longer meet eligibility requirements.

Response

MDHHS agrees that improper payments were not always timely recouped.

MDHHS healthcare coverage is updated when the file is received from MDOC indicating the incarceration status. MDHHS is not always made aware of the incarceration status prior to payment; however, once incarceration is identified and coverage updated, recoupment is initiated.

During the audit period there was a flaw in the criteria utilized to process recoupments for some health coverage. As a result, capitation payments were not being recouped for some individuals with incarcerations beginning more than 24 months ago. The system issue was fixed, and the recoupments subsequently processed as of December 2021.

Recommendation 8: Improvements needed to ensure accurate information for SSI-related Medicaid beneficiaries

We recommend that MDHHS ensure Medicaid beneficiaries who automatically receive full healthcare coverage because of their SSI status have current and accurate beneficiary information documented in Bridges.

Response

MDHHS disagrees with the finding.

Current Bridges functionality ensures that SSI Medicaid cases are properly opened and closed. The audit improperly makes an assumption that each beneficiary converted in 2008 is ineligible.
To accurately quantify the duration of the ineligible periods for the identified cases, additional information would have to be obtained from the Social Security Administration for each individual case. The audit period for this objective and finding was October 2018 through September 2019, however healthcare coverage payment are presumed to be ineligible for all of 2019 without validation. MDHHS agrees that there were cases that required manual intervention due to a historic system conversion error.

Recommendation 9: Enhancements needed in MDHHS's monitoring of beneficiary eligibility for Medicaid and CHIP

We recommend that MDHHS implement a sufficient monitoring process to help ensure accurate Medicaid and CHIP eligibility determinations.

Response

MDHHS disagrees with this finding.

MDHHS was compliant with CMS MEQC and PERM monitoring requirements. MDHHS relies on its CMS mandated MEQC and PERM processes to supplement any monitoring conducted at the local level. The federally required audits cited in MDHHS's BAM 320 are the MEQC audits which were suspended during the pandemic. MDHHS completed the required MEQC case review activities between April 2019 and February 2020. However, the MEQC findings and corrective action plans had not been submitted during the audit period because CMS put a pause on MEQC reporting requirements due to the COVID-19 pandemic.

BAM 301 allows flexibility in the implementation of case monitoring at the local office level and MDHHS local office management staff have chosen to complete Medicaid case reads on probationary staff, as well as staff who are not meeting department expectations to fulfill BAM 301 requirements. Effective October 2020, BAM 320 Medicaid monitoring requirements were removed from policy since this is covered under current CMS requirements and part of the PERM and MEQC audit parameters.

MDHHS recognizes the importance of robust monitoring procedures and continuously looks for opportunities to improve on ways to administer its Medicaid program. Therefore, as a result of the previously conducted PERM cycle, the Eligibility Quality Assurance Section is developing an ongoing Medicaid Eligibility Quality Assurance case review process that will help to further identify areas within eligibility that need attention, with the goal of continuous quality improvement in Medicaid eligibility determinations. These efforts will supplement ongoing PERM and MEQC monitoring, which will sufficiently meet the definition of timely monitoring. Once this process is fully developed, policy changes will be made as necessary and new guidance will be developed and distributed to local office staff.

Recommendation 10: Improvements needed to ensure MDHHS timely completes Bridges tasks and reminders

We recommend that MDHHS establish an effective process to monitor the eligibility specialists' completion of the Bridges non- UCL tasks and reminders.

Response

MDHHS disagrees with the finding.

Many Tasks and Reminders (T&Rs) are informational or remain active despite action by caseworkers to resolve the issue. Further, not all tasks or reminders are directly linked to a correct eligibility determination. It is inappropriate to assume that all T&Rs that remain on the report result in incorrect cases. Dependent on workload capacity and staffing limitations, local office management is given the latitude to prioritize casework based on the nature of the T&R. Additional monitoring would not address workload saturation which prevents completion of additional T&R's.

MDHHS continues to plan for the Universal Caseload (UCL) expansion. In the interim until UCL is fully functional across Michigan, MDHHS will reiterate T&R policy requirements to staff.

Recommendation 11: Improvements needed in MDHHS's monitoring of the timely completion of eligibility redeterminations

We recommend that MDHHS sufficiently monitor the timeliness of Medicaid and CHIP eligibility

redeterminations to help prevent MDHHS from issuing payments on behalf of ineligible beneficiaries.

Response

MDHHS disagrees with this finding.

MDHHS reviewed some of the cases cited by the audit and found examples that were not overdue. The audit also fails to account for business processes and policies that provide extensions to beneficiaries, such as BAM 130 which allows beneficiaries two 10-day extensions to provide required documentation. Further, state policy allows for the processing of overdue redeterminations. Many of these nuances are not reflected in the reports used by the audit. As noted in the finding, the necessary Bridges reports were not always available for distribution during the audit period due to various technical issues. MDHHS is always looking for opportunities to improve its programs and how they are operated. MDHHS acknowledges that sufficient monitoring of reports is a critical function, however, without sufficient resources to reduce worker caseload current monitoring capabilities are limited to the most critical. MDHHS will determine what, if any additional measures can be put in place until adequate funding can be allocated for Bridges enhancements and additional staffing resources. The efforts we have underway to improve policies, programs and oversight activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Recommendation 12: Improvements needed in MDHHS's training program for Medicaid and CHIP eligibility determinations

We recommend that MDHHS improve its training program and consider instituting continuous education requirements for its eligibility specialists and supervisors.

Response

MDHHS is continually working to invest in staff, improve processes, and analyze underlying issues occurring at the local and state level. MDHHS offers new hire training for all employees, as well as on-the-job training in local offices provided by managers and experienced caseworkers. MDHHS' new hire staff training is designed to cover all types of payment assistance programs in Bridges. MDHHS has designed the Medicaid portion of the training to focus on MAGI Medicaid, which makes up over 80 percent of all active Medicaid cases. Due to the volume of information delivered during new hire training, MDHHS is not able to provide individual trainings for each type of Medicaid eligibility category. With additional resources, training and business processes could be improved.

MDHHS supports a continuing education program but does not have the resources to implement a program and ensure appropriate tracking for completion and effectiveness. Based on competing priorities in local offices, as well as the increase in worker caseload demands, caseworkers are challenged by the volume of casework. MDHHS is implementing an ongoing annual training expectation for local office staff involved in determining Medicaid eligibility. The specific requirements of this expectation will be disseminated to the field offices by June 2022. Additionally, MDHHS has initiated a supplemental staffing request for fiscal year 2023.

Recommendation 13: Improvements needed in MDHHS's process to address policy questions and clarifications

We recommend that MDHHS consider making improvements to its process for tracking, reviewing, and sharing policy questions and clarifications.

Response

MDHHS disagrees with this finding.

MDHHS does not agree that it would be efficient to formally track and share the specific case questions from MDHHS field office staff that are sent to the policy mailbox. These questions are typically due to a unique set of circumstances and if the field staff believe that a BEM/BAM needs further clarification, they are directed to notify field supervisors of the policy concerns. Field supervisors are then required to communicate policy concerns and suggested policy clarifications as needed to central ESA staff and HASA policy staff. Based on feedback from the field and changes to federal guidance, HASA policy staff evaluate the need for revisions to the BEM/BAM language and continuously update policy to provide clarification and examples as necessary. ESA will reiterate this process to field staff and their managers.

MDHHS communicates all policy changes to the field staff for review and comment via email reminders, memos, and website alerts.