October 16, 2024

Lina M. Khan, Chair
Rebecca Kelly Slaughter, Commissioner
Alvaro Bedoya, Commissioner
Melissa Holyoak, Commissioner
Andrew N. Ferguson, Commissioner
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Supplemental information concerning In re: Deloitte Consulting LLP

Dear Chair Khan and Commissioners Slaughter, Bedoya, Holyoak, and Ferguson;

The National Health Law Program (NHeLP), Electronic Privacy Information Center (EPIC) and Upturn, Inc. write to alert the FTC to further information to supplement and support the complaint filed on January 31, 2024 regarding Deloitte Consulting LLP. As noted in the complaint, its operation of Medicaid eligibility systems is resulting in serious financial and health harms to consumers who rely on Medicaid in Texas and across the country.

As described in our initial complaint, Deloitte engages in unfair trade practices when it (1) knows or should know of errors in its automated Medicaid eligibility systems that result in loss of critical health coverage, but does not take prompt, meaningful steps to mitigate the harms flowing from those errors in the state where the error is discovered and (2) fails to take steps to detect errors and prevent foreseeable harms in other states that rely on similar technology and are experiencing strikingly similar problems. As a consequence of Deloitte's inaction, consumers in Texas and across the country, are losing critical health coverage and have no way to avoid these harms because they must rely on Deloitte's eligibility systems in order to maintain their Medicaid coverage.

Deloitte's practice of non-response to known issues offers no countervailing benefits to consumers or competition. As described in our initial complaint, there is simply no benefit to consumers from erroneous loss of health coverage. Further, errors in the automated eligibility systems often impose additional burdens on state eligibility workers, who must perform

additional manual tasks or complete complicated workarounds when the automated system does not produce the correct result. The resulting increase in workload can exacerbate delays in processing benefits applications and result in more errors in eligibility decisions. Nor does Deloitte's practice benefit competition. Instead, it accrues to Deloitte's benefit: Deloitte routinely charges state Medicaid programs additional, often significant fees before making necessary changes to protect health care coverage, costs which often lead to long delays in correcting known issues. Meanwhile, low-income consumers continue to lose vital health coverage that they must have to obtain medically necessary care, leading to significant and often irreversible harm. Finally, these practices run counter to established public policies regarding automated systems, including basic AI risk management practices as outlined in the parties' original complaint.

This supplement presents the following additional evidence of Deloitte's unfair trade practices for your consideration:

1. evidence from two federal trials, including testimony from a Deloitte manager;
2. a recent report from the United States Government Accountability Office (GAO); and
3. new information and case examples from attorneys in Texas and Colorado working directly with Medicaid enrollees. These attorneys are available and willing to speak with FTC investigators and can supply additional case examples.

As described in detail below, the supplemental evidence shows that Deloitte's Medicaid eligibility systems are failing to:

- Accurately calculate postpartum coverage for Medicaid enrollees, with similar problems documented in Texas and Florida;
- Recognize when Medicaid enrollees submit documents through the online portal, causing individuals to lose coverage for failing to return documents that have, in fact, been returned, with similar problems in Texas and Colorado; and
- Accurately determine eligibility for individuals with disabilities whose eligibility hinges on prior receipt of Supplemental Security Income (SSI), with similar problems in Tennessee and Michigan.

Finally, recent evidence confirms that this is a consistent pattern for Deloitte. As explained in recent in-depth reporting from KFF Health News: "[E]ven though Deloitte isn't reinventing the wheel for each eligibility system it builds or runs, the company addresses problems state by state rather than patching through fixes for systems across states."[1] In other words, when Deloitte does take steps to remedy consumer harms in its systems, it chooses to pursue the least remedial option available, allowing consumer harms in other states to continue. And a Deloitte employee who testified in a federal trial in Florida concerning Medicaid notices confirmed that Deloitte

[1] Samantha Liss & Rachana Pradhan, *Errors in Deloitte-Run Medicaid Systems Can Cost Millions and Take Years to Fix*, KFF Health News (Sept. 5, 2024), https://kffhealthnews.org/news/article/deloitte-run-medicaid-systems-errors-cost-millions-take-years-to-fix/.

teams who work across different state Medicaid programs do not routinely share information about ongoing projects or issues:

> Q. How many states does Deloitte help generate notices for?
>
> A. I don't know exactly how many, but I know it's more than 20.
>
> Q. More than 20?
>
> A. Yeah.
>
> Q. Okay. So Deloitte must be pretty familiar with the various technologies for generating Medicaid notices, right?
>
> A. I mean, when you say 'Deloitte,' we are talking about projects, people. I am focused on Florida DCF. I know what and my team knows what DCF has and what DCF needs. But I don't have information on what other Deloitte projects there are for notices of eligibility. I know that we do support eligibility systems in other states. That's – that's common knowledge. But I don't have any specifics on what other states do, what tools they use, any of that.
>
> . . .
>
> Q. But isn't it true that [Florida] expects and requires its vendors to bring forth best practices from other states?
>
> A. We do bring best practices in the sense of project management. For example, estimation is one of them, how we run projects, how we do quality control, how we do testing, how we do designs. But we are not asked to bring, like, how other states do notices.
>
> . . .
>
> Q. Okay. But Deloitte hasn't investigated what your own company is doing with respect to Medicaid notices in other states?
>
> A. No. The Oregon project is not under my control. I do not oversee that. I only deal with Florida's project.[2]

[2] Ex. E, Trial Transcript, Vol. 6, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 166 at 59:1-62-24.

Texas

In the months since we filed our initial complaint a GAO report confirmed that computer system errors in Texas caused Medicaid enrollees to lose their health coverage entitlement. As described in the report:

> After stakeholders notified CMS of potentially erroneous disenrollments in Texas, CMS told us they found that about 100,000 eligible individuals had been disenrolled due to eligibility system errors. For example, the system had disenrolled some individuals without processing their returned renewal forms, and disenrolled some women after miscalculating the length of their postpartum Medicaid coverage.[3]

We have been contacted by attorneys from legal services offices in Texas—Texas RioGrande Legal Aid, Lone Star Legal Aid, and Disability Rights Texas—who have offered additional information regarding errors in Deloitte's TIERS system and the Deloitte-affiliated consumer-facing online portal, YourTexasBenefits. These attorneys are available and willing to speak with FTC investigators regarding their experiences.

A. Portal Problems with YourTexasBenefits

As referenced in the recent GAO report, individuals in Texas had their Medicaid benefits terminated for failing to submit documents and renewal forms because the state's Deloitte-operated eligibility system automatically terminates coverage at the end of the eligibility period if their documents are not "processed." These system errors are similar to those documented in other states with Deloitte systems, including as described below in Colorado, and as previously experienced in Rhode Island (as described in paragraph 67 of the initial complaint) and Kentucky (as described in paragraph 80 of the initial complaint).

Legal services attorneys in Texas report that these problems are ongoing, particularly when documents are uploaded through the Deloitte-built online portal, YourTexasBenefits. Medicaid enrollees who attempt to submit requested documents are either unable to actually upload those documents, or even when the portal suggests they have been uploaded, the documents cannot be found by the case worker to process them.[4]

---

[3] U.S. Gov't Accountability Office, *GAO-24-106883, Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19*, 6 (July 18, 2024), https://www.gao.gov/assets/gao-24-106883.pdf.

[4] News reports reiterate these problems. *See* Nicole Villalpando, *Texas congressional Democrats call for federal intervention for states' Medicaid problems*, AUSTIN AMERICAN-STATESMAN, (Oct. 17, 2023), https://www.statesman.com/story/news/healthcare/2023/10/17/texas-medicaidproblems-healthhuman-services-federal-intervention-kaiser-family-foundationreport/70991827007/ (Texans describe the online portal provide false information and not accepting documentation); Nicole Villalpando, *Austin Families talk about being stuck in Medicaid red tape and living without coverage*, AUSTIN AMERICAN-STATESMAN (Nov. 7, 2023),

As a consequence, individuals regularly receive multiple redundant requests for information and can lose Medicaid due to procedural terminations. As described by an attorney at Texas RioGrande Legal Aid, the consequences can be significant. The attorney reports multiple clients who have suffered significant financial and health harms because of the portal's failure to reliably recognize documents, including:

- Several clients who rely on long term care services to provide help with activities of daily living in the home, including things like bathing, feeding, and cleaning, but lost those services due to difficulties with the portal. For instance, one client lost Medicaid coverage for failure to submit documents, even though she tried repeatedly over multiple months to submit the documents. The consequences were dramatic. The individual has severe mobility limitations and therefore relied on attendant services to support her ability to live independently at home. Without Medicaid, she lost services and was left on her own; her health and the conditions in her home deteriorated significantly.

- Another client submitted a request to continue long term care services in September 2023. The Texas Medicaid agency reported that this request was never received. As a result, she was sent a notice, dated November 11, 2023, denying her Medicaid coverage—which included both long term care services and coverage of her Medicare costs. Although Medicaid regulations require *advance* notice, the notice indicated a denial *retroactive* to September 2023. The client attempted to submit new applications, but those were also lost. As a consequence, she went without necessary Medicaid services for almost a year. She lost in home services to clean. Her home became infested with vermin. She did not attend doctor visits because she could not pay out of pocket Medicare costs.

- Another client relies on Medicaid to pay for nursing facility care. When they lost coverage for failure to submit documents the nursing facility began eviction proceedings against them. It was only with the intervention of the attorney and the Long-Term Care Ombudsman that eviction was ultimately avoided.

- A single father and veteran was forced to reapply for food assistance and Medicaid for his children at least four times because his application submitted through the online portal was lost. Once the application was recognized, he also had to repeatedly submit verification documents. He began the application process in August 2023 and only received food assistance benefits in September 2024 following a fair hearing.

---

https://www.statesman.com/story/news/healthcare/2023/11/07/medicaid-enrollmentaustin-texasfamilies-living-without-coverage/71256001007/ ("the website or app gives them errors or conflicting information, such as the date their Medicaid coverage ends.").

B. Inability to Reinstate Following Inaccurate Termination of Qualified Medicare Beneficiary (QMB) Coverage

The TIERS computer system contains other processes that automatically terminate coverage for Texans. An attorney now at Lone Star Legal Aid reported that while at Legal Aid of NorthWest Texas, she helped a client with disabilities whose QMB coverage was terminated automatically due to a "system update" of federal poverty income levels in TIERS. The client received a notice in February 2023 that her coverage would switch from QMB to a program called the Specified Low-Income Medicare Beneficiary program, which meant she would have to begin making co-pays. During the appeal, state Medicaid agency staff confirmed to the attorney that the automatic update wrongfully terminated the client while the continuous Medicaid enrollment requirement was still in effect due to the COVID-19 public health emergency. An agency staffer asked the attorney to proceed to a fair hearing, because the IT ticket the staff member had submitted to restore coverage was "still in process."

In June 2023, agency staff conceded the error in the fair hearing. The Hearings Officer's order gave the agency 10 days to restore coverage to the client. Yet coverage was not restored: the legal aid attorney spent months calling and emailing to ask why coverage had not been restored. Various agency staff consistently said that "computer problems" prevented the restoration and "IT repair tickets" had been made but not yet implemented.

Meanwhile, the client paid some co-pays herself. Unable to afford all the required co-pays, she postponed a surgical consult and treatment and suffered additional health problems.

Her QMB coverage was not restored until November 2023. Then, in January 2024, the client received a notice from the federal Centers for Medicare & Medicaid Services (CMS) that her Medicare Part B premium was not paid. The attorney investigated again. A Texas Medicaid agency attorney confirmed that due to another "automatic system update," the client had again been wrongfully terminated from QMB for January. The agency attorney said this occurs when "Medicare sends information to HHSC [the Texas Medicaid agency] about recipients and cases are updated automatically."

Tennessee

As described in paragraph 75 of our initial complaint, the Deloitte-built system in Tennessee had errors in how it loaded data from the Social Security Administration's State Data Exchange (SDX) database. As a result, individuals with disabilities who should have been found eligible for Medicaid based on current or prior receipt of SSI were incorrectly found ineligible.

Recently, the United States District Court for the Middle District of Tennessee confirmed those findings following a bench trial in the case *A.M.C. v. Smith*, No. 3:20-CV-00240, 2024 WL 3956315 (M.D. Tenn. Aug. 26, 2024), concluding that "systemic errors" in Tennessee's Deloitte-built Medicaid eligibility system, which in Tennessee is called TEDS, "blocked those with disabilities from accessing benefits to which they were legally entitled." *Id.* at *47.

While the named defendant was the state official in charge of Tennessee's Medicaid program, TennCare, the opinion nonetheless describes significant problems with the Deloitte-built eligibility system, TEDS. TEDS was not designed from scratch for Tennessee, but rather was

built off a "base system" from another the Deloitte Medicaid eligibility system, specifically from Georgia, because at the time, that was the "latest rollout" of a Deloitte Medicaid eligibility system.[5] A TennCare official testified that TEDS used both the overall "framework" and the "baseline rules engine" from the Georgia system.[6]

As described in the opinion, TEDS had significant problems when it was launched, including with its business rules:

> [TEDS] relies on a series of business rules converted into an algorithm to make eligibility determinations. Since TEDS's launch, TennCare and Deloitte have had to address several defects in those business rules and, in turn, the algorithm, so that TEDS might function as intended. When TEDS makes a wrong eligibility determination about someone entitled to TennCare, that enrollee is deemed ineligible and placed at risk of losing their healthcare coverage
>
> When TEDS launched, ingrained systemic errors pervaded eligibility considerations of enrollees whose eligibility hinged on prior or ongoing receipt of SSI. Whether enrollees were considered for [the Medicaid eligibility category] Pickle depended on certain criteria that would prompt a specific review for eligibility. But, for several months, TEDS did not consistently load and consider those criteria. Likewise, TennCare did not properly load the indicators corresponding to the [Disabled Adult Child] DAC and Widow/Widower categories. Because of this, workers would have to go into the interface data to find the relevant indicators until 2020, which they did not consistently do.

Id. at *10. The Court found that these errors harmed numerous individuals with disabilities including plaintiffs in the case, Carlissa Caudill, Johnny Walker, and Kerry Vaughn, concluding:

> Plaintiffs argue and presented persuasive evidence that TennCare's systems and policies, primarily TEDS, were flawed in myriad ways that resulted in TennCare functionally ignoring categories of eligibility. Specifically, Plaintiffs rely on to [sic] TennCare's inability to load special indicators for DAC and Widow/er data into TEDS (an error that TennCare did not correct until 2023), which led to missed screenings for these categories. Plaintiffs further highlight TennCare's failure to reliably load data that affected consideration of three SSI-related categories: DAC, Widow/er, and Pickle. This latter error caused TennCare to wrongly terminate the benefits of enrollees including **Walker**, **Caudill**, and **Vaughn** on account of TEDS's failure to recognize their ongoing receipt of SSI.

Id. at *45 (emphasis in original). The Court also noted how TEDS errors harmed plaintiff Michael Hill:

> Mr. Hill qualified for TennCare as a DAC. However, when TennCare converted Mr. Hill's data into TEDS on January 19, 2019, TEDS erroneously placed him in

[5] Ex. I, Excerpts of Deposition Transcript of Kimberly Hagan at 52:1-18.
[6] *Id.* at 53:5-19.

> the Pickle category instead. Pickle and DAC have different rules for what income is considered, and because it placed him in the Pickle category, TEDS disregarded too little of Mr. Hill's income. TEDS then determined Mr. Hill was over income—and therefore ineligible—for Pickle and began its processes for terminating TennCare coverage. While Mr. Hill was over income for Pickle, TEDS should have recognized that he remained eligible for coverage in the DAC category.

Id. at *11. Finally, the Court confirmed that, despite knowledge of the errors in TEDS, neither TennCare nor Deloitte took meaningful steps to prevent erroneous terminations of coverage.

> During the class period, TennCare had various systemwide defects that rendered it unable to reliably load data it used to consider individuals' eligibility. TennCare did not properly load special indicators for DAC and Widow/er data into TEDS until April 2023. It also struggled to reliably load data that showed members' prior receipt of SSI, affecting consideration of three of TennCare's SSI related categories. Although TennCare was aware of these systemic issues, it was lethargic in its response and attempts to reprogram TEDS.

Id. at *46.

As described in paragraph 76 of the original complaint, the Deloitte-built system in Tennessee also inappropriately found children ineligible for coverage during 2019 for failure to return verifications, even when it found parents in the same household eligible. The problem was not corrected until February 23, 2020. This type of coverage is referred to as "Transitional Medicaid" In *A.M.C. v. Smith*, the Court affirmed that finding and concluded that it harmed multiple named plaintiffs in the case. 2024 WL 3956315, at *26 (Turner children denied Transitional Medicaid); *id.* at *36 (Skai Anders also denied Transitional Medicaid due to "a computer error in TEDS").

Furthermore, as described in the original complaint (¶¶ 41-47, 67, 100-02, 151), Deloitte-built portals often present inaccurate information. The Court in *A.M.C. v. Smith* found similar problems with Tennessee's portal. 2024 WL 3956315, at *12 (describing experiences of Andrea Riley).

Florida

In a recent trial in the United States District Court for the Middle District of Florida, Florida Medicaid officials from the Department of Children and Families (DCF) and a Deloitte employee testified about known errors in the automated computer system that determines Medicaid eligibility, which is operated and maintained by Deloitte. Specifically, the witnesses identified two different errors that caused pregnant and postpartum Medicaid enrollees to lose coverage.

In Florida, once an individual meets the eligibility requirements for pregnancy-related Medicaid, they are automatically entitled to Medicaid coverage during their pregnancy and for 12 months

postpartum.[7] Prior to 2022, the postpartum period only lasted two months. When Florida first extended postpartum coverage from two to 12 months, Deloitte attempted to re-program the computer system to ensure that full, 12 month postpartum coverage was automatically provided.[8] DCF then issued a policy transmittal describing the change, which stated its belief that "[p]ostpartum coverage will build [in the computer system] for 12 months instead of 2 months from the PREGNANCY END DATE entered on AIIM."[9] AIIM is the name of a particular screen within the automated computer system in Florida.

William Roberts, a state official with DCF, testified that the agency became aware of a computer "glitch" that reverted back to only giving two months post-partum, rather than 12.[10] Hari Kallumkal, the Deloitte project manager for Florida's Medicaid eligibility system, confirmed that Deloitte was also aware of the issue.[11] The error was discovered no later than April 2023.[12] At that time, DCF issued a document describing certain "SYSTEM PROGRAMMING ISSUES" which stated "[i]n some instances, the system is not recognizing to keep MM P open for 12-months post-partum coverage from the end date of pregnancy."[13] MM P is the code given to pregnancy and postpartum coverage in Florida's computer system.

Though it was discovered in April 2023, Mr. Kallumkal testified that this issue was not addressed by Deloitte until a year later, in April or May 2024.[14] Even then, the solution implemented was only to support a manual work around for case processors. The change simply displayed the pregnancy end date so that case processors could, hopefully, remember to go back and manually ensure that 12 months of coverage was provided.[15]

Because of the computer's failure to automatically provide 12-months of coverage, case workers continue to make mistakes to this day. One Medicaid enrollee who testified at trial recounted a conversation she had with a supervisor working at the DCF call center, who explained to her that:

---

[7] Ex. A, Fla. Dep't of Children & Families, Policy Transmittal No. P-22-03-0003, "Postpartum Coverage Extension to 12 Months," (Mar. 3, 2022), Plaintiffs' Trial Exhibit 143, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.) (attached).
[8] Ex. E, Trial Transcript, Vol. 6, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 166 at 6:19-7:1.
9 Ex. A, Policy Transmittal, at 2.
[10] Ex. C, Trial Transcript, Vol. 2, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 162 at 147:1-148:18.
[11] Ex. E, *Chianne D. v. Weida*, Tr. Vol. 6 at 12:4-14:13.
[12] Ex. C, *Chianne D. v. Weida*, Tr. Vol. 2 at 147:17-148:12; Ex. F, Fla. Dep't of Children & Families, Medicaid Unwinding Updates & FAQs (Apr. 2023), Plaintiffs' Trial Exhibit 161, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.)
[13] Ex. F, Unwinding Updates & FAQs at 2.
[14] Ex. E, *Chianne D. v. Weida*, Tr. Vol. 6 at 12:4-14:3.
[15] *Id.* at 12:4-14:3, 15:11-13 ("workers were supposed to handle that situation"); *see also* Ex. F at 2 (directing case workers 'If post-partum coverage does not build, re-enter the pregnancy with the same pregnancy dates on AIIM to maintain coverage").

> their system doesn't have a way to automatically renew the pregnancy Medicaid when I submit applications and that the person reviewing the case has to manually make it so that I can continue my coverage, but the person that did that -- that reviewed my case didn't do that and that's why it was being taken away again. And she also told me that if I renewed for Food Assistance again the same thing would probably happen with the Medicaid and to maybe not do -- not renew for Food Assistance if I wanted to keep my Medicaid.[16]

As a consequence, this witness is considering foregoing food assistance in order to maintain her Medicaid coverage.[17]

Separate and apart from the postpartum error, Mr. Kallumkal identified a second error related to the computer system's inability to load more than 24 rows of historical data.[18] This error could impact individuals even before the two-month postpartum period expired, and testimony at trial included testimony from one witness who lost coverage while pregnant—and was without coverage when she went into preterm labor—and another who lost coverage when her first child was less than one month old.[19] Mr. Kallumkal testified that this error was not fixed until November 2023—nearly eight months after Medicaid terminations restarted due to the Medicaid unwinding.[20] Deloitte apparently has not investigated how many individuals were impacted by this error: Mr. Kallumkal was not sure how many people lost coverage due to this error or whether this historical data error could impact other Medicaid eligibility groups.

Colorado

Since submitting the initial complaint, we have obtained copies of Deloitte's contract with Colorado's Medicaid agency, the Colorado Department of Health Care Policy & Financing (HCPF). Those contracts establish that Deloitte is responsible for the maintenance and operation of both the Colorado Benefits Management System (CBMS) and Program Eligibility and Application Kit (PEAK) systems in Colorado.[21] CBMS is the back-end computer system that makes Medicaid eligibility determinations and generates notices to clients regarding their Medicaid eligibility. PEAK is the online portal used by Medicaid enrollees to submit applications and documents necessary to maintain Medicaid coverage. Deloitte is also obligated, under the contract, to "participate with the state in problem identification and error resolution"

[16] Ex. D, Trial Transcript, Vol. 3, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 163 at 153:5-10.
[17] *Id.* at 153:21-154:2.
[18] Ex. E, *Chianne D. v. Weida*, Tr. Vol. 6 at 9:9-11:8.
[19] *Id.* at 15:1-8; Ex. B, Trial Transcript, Vol. 1, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.) at 27:14-24 (Taylor testimony); Ex. D, Tr. Vol. 3 (Mezquita testimony).
[20] Ex. E, *Chianne D. v. Weida*, Tr. Vol. 6 at 14:9-13.
[21] Ex. G, Contract No. 98342, at §3.C ("The purpose of this Contract is to procure a system or systems which operate, maintain and enhance functionality of the Colorado Benefits Management System (CBMS), the Program Eligibility and Application Kit (PEAK), and related systems and applications as outlined in the statement of work"); Ex. H, Contract No. 169723 (extending and amending Contract No. 98342).

within these systems.[22] In addition to the maintenance and operations contracts, the state has consistently executed separate contracts for tens-of-thousands of "enhancement" hours, which have been needed to make changes to these systems.

Furthermore, we have received further information from advocates working directly with Colorado Medicaid enrollees about additional problems with both CBMS and PEAK in Colorado.

Advocates from the Colorado Center on Law and Policy are willing and available to speak with the FTC investigators about each of the issues described below, including providing specific case examples.

A. Notices

As described in paragraph 79 of the initial complaint, "problems with inaccurate and missing system-generated dates and deadlines [in Medicaid notices sent to enrollees] have also been noted in Colorado."

Notices in Colorado are generated by CBMS. "CBMS is programmed to generate correspondence based on specific schedules and triggers," including that certain fields are "populated by CBMS and contain[] member-specific information through dynamic fields, which include information such as the effective date of the member's eligibility."[23]

The contracts we obtained confirm that Deloitte is responsible for CBMS's creation of notices that are sent to Medicaid enrollees.[24] While the State provides the text that should appear in the notices, Deloitte is responsible for ensuring that CBMS generates correctly formatted correspondence that includes all relevant text and information for a particular case.[25] The contract also requires Deloitte to make recommendations for enhancements that may be needed for CBMS, which may include "ways to . . . reduce contradictory and overlapping notices, [and] increase accuracy in eligibility determinations."[26]

Yet, despite Deloitte's responsibility for notices, state audits completed in 2020 and 2023 documented widespread problems. The 2023 audit concluded that "[p]revious work conducted

[22] Ex. G, Contract No. 98342 at § 1.1.1(I).
[23] Co. Office of the State Auditor, Medicaid Correspondence 13 (Sept. 2023) https://leg.colorado.gov/sites/default/files/documents/audits/2261p_medicaid_correspondence.pdf.
[24] *See* Ex. G, Contract No. 98342, § 11.1.7 ("Update Client Correspondence notifications as required"), § 15.1.7 ("Maintain the interfaces and integration between CBMS and related applications and Connect for Health Colorado including responsibilities for maintaining . . . . eligibility, benefit calculations and client correspondence").
[25] Ex. H, Contract No. 169723 at F-1-4 (Section 4.1.1).
[26] Ex. H, Contract No. 169723 at 11 (Para N, adding § 7.8 to the initial contract).

by the Department's communications contractor in 2016 and our contractor in 2020 identified many of the same issues we continued to see in this audit."[27]

The audit further specified that

> [i]n 2020, we made a recommendation that the Department make necessary CBMS programming changes to address date fields. While the Department agreed to the 2020 recommendation, this problem is still occurring and this design issue continues to impact the quality of Medicaid correspondence. Additionally, the Department says that the CBMS design prevents caseworkers from editing or consolidating standard messages used in Notices, which results in contradictory and repeated messages.[28]

Thus, caseworkers could not assist applicants and enrollees in avoiding these harms from the Deloitte system, even if help was requested.

Among the problems identified by the audit are:

1. "[C]ontradictory messages in the same letter" including informing the same person that they both qualified for and did not qualify for Medicaid;
2. "[F]amilies who received multiple and confusing messages letter-to-letter;"
3. "[L]etters that did not directly state eligibility status;"
4. "[N]oncompliant dates for listed deadlines;"
5. "[I]nconsistent response timeframes listed for the same type of information requests;" and
6. "[N]otices that were missing information on the reasons for the denial or the member status."[29]

With respect to contradictory messages about an individual's eligibility status, the audit found "more than 15,000 additional members who might have received a contradictory message."[30]

The audit also noted that the system did not reliably send "Information Request" letters. Such letters alert an individual that HCPF needs more information to determine Medicaid eligibility. If such information is not returned, an individual can lose Medicaid coverage for failing to provide information—rather than because they are substantively ineligible. These are often referred to as "procedural terminations." The 2023 audit found "more than 16,000 people who were denied benefits because they had not provided all requested information during the 2 months we reviewed. Of these, more than 13,600 (85 percent) did not receive an Information Request Letter during the same time frame to specify what information they were missing."[31]

---

[27] Co. Office of the State Auditor, Medicaid Correspondence 42 (Sept. 2023) https://leg.colorado.gov/sites/default/files/documents/audits/2261p_medicaid_correspondence.pdf
[28] *Id.* at 42.
[29] *Id.* at 21, 27-28.
[30] *Id.* at 29.
[31] *Id.* at 32.

Finally, when someone is found substantively ineligible for Medicaid, notices must provide a reason why. This enables the Medicaid enrollee to determine whether a mistake was made and whether to challenge the termination through an appeal. The audit found that notices generated by CBMS did not reliably include a reason for the denial, instead leaving the placeholder blank.[32]

Because of these numerous errors, the notices generated by Deloitte's software present deceptive statements to Medicaid enrollees about their eligibility status and what steps must be taken to maintain eligibility.

In a video created by eligibility workers in Colorado, and played during a hearing of the Colorado legislature's Joint Technology Committee on September 24, 2024, workers described the burdens that the flaws in CBMS impose on them and cited specific examples of the problems with the CBMS system, including:

- Michelle, a client who applied in August 2024 for Medicaid coverage during a high-risk pregnancy, could not have her coverage approved. When the case worker initially processed the case, even though the eligibility was denied, no reason code was populated to explain why there was a denial. After troubleshooting the issue to figure out the underlying reason for the ineligibility decision and submitting a Help Desk ticket, the case worker was told that the denial (and absence of a reason code) was due to a "known system issue" that was not scheduled to be implemented until October – leaving Michelle without coverage and without access to her specialists during her high-risk pregnancy.[33]

One Colorado state official reportedly quit over Deloitte's refusal to implement fixes to the notices. Jamie Perkins is quoted in the recent in-depth reporting on Deloitte as saying, "It feels like a really perverse reward system, frankly, for Deloitte. . . . When Deloitte is themselves making a problem that did not originate with the department, the department is still paying them to fix those problems."[34]

B. Failure to recognize uploaded documents

As described above, Medicaid enrollees can be required to supply documents verifying their eligibility for Medicaid. This can include information such as pay stubs to verify income or medical records to verify disability. When the state requests information but it is not returned, individuals lose coverage for failing to provide the necessary information. These are referred to as procedural terminations.

On the other hand, once documents have been returned, state Medicaid agencies "must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested

[32] *Id.* at 37-38.
[33] WC DHS CMBS Discussion Video, https://www.youtube.com/watch?v=2b9qN5qo9Nk (0:00 to 4:58); Joint Technology Committee Hearing Audio (Sept. 24, 2024), https://sg001-harmony.sliq.net/00327/Harmony/en/PowerBrowser/PowerBrowserV2/20220216/-1/16224.
[34] Liss & Pradhan, *Errors in Deloitte-Run Medicaid Systems*, *supra* note 1.

documentation unless and until they are determined to be ineligible."[35] "[T]his requirement also applies in cases when processing the renewal form/requested information will need to occur after the eligibility period has ended."[36]

Advocates in Colorado report that PEAK and CBMS do not reliably recognize when documents are submitted. For instance, Jan Taylor, who attempted to renew her daughter's Medicaid coverage, reported that "I had to keep submitting the paperwork over and over again because the PEAK app is not an ideal situation, it won't acknowledge that things have been uploaded into it, and I get asked for the same paperwork three, four, six, 12 times."[37]

Furthermore, CBMS requires not only that a document be uploaded, but that an eligibility technician actually review the document and "process" it. Where a document has merely been submitted, but not yet processed, CBMS is still programmed to terminate coverage when the eligibility period ends. As a result, individuals who have returned the requested information are nonetheless being procedurally terminated, contrary to federal requirements.

The Colorado Center for Law and Policy reports the following specific case examples and can provide additional information regarding these cases and others if it would be helpful to the FTC's investigation:

- S.S. is a child with disabilities who was enrolled in Medicaid during the pandemic. The family received a renewal packet and returned it before it was due on May 10, 2024, specifically noting on the renewal form that the child had disabilities. The family called their county office several times to confirm the renewal form had been received. Nonetheless, on May 14, 2024, CBMS generated a notice regarding S.S. The notice did not mention S.S.'s Medicaid eligibility. Instead, it stated that S.S. had been denied a different health insurance program—CHIP— because "you did not give all the information we need to decide if you qualify for benefits." No date of action was included in the letter, and the specific information missing was not identified. S.S.'s parent later learned from a provider that the child's Medicaid coverage had ended as of May 30, 2024.

- T.C. is an 81-year-old veteran who lives in Jefferson County and who relies on the Qualified Medicare Beneficiary (QMB) program, which provides Medicaid coverage for Medicare Part A and B premiums and cost-sharing. He was sent a renewal packet in

[35] Ctrs. for Medicare & Medicaid Servs., Ensuring Continuity of Coverage for Individuals Receiving Home and Community-Based Services (HCBS) 3 (Aug. 19, 2024), https://www.medicaid.gov/federal-policy-guidance/downloads/cib081924.pdf.
[36] Ctrs. for Medicare & Medicaid Servs., Overview: Medicaid and CHIP Eligibility Renewals 13 (Sept. 2024), https://medicaid.gov/resources-for-states/downloads/eligibility-renewals-overview.pdf.
[37] Katie Weis, *Medicaid mayhem: Tech problems with Colorado's Medicaid delay critical money for tens of thousands with disabilities*, CBS News (Apr. 25, 2024), https://www.cbsnews.com/colorado/news/medicaid-mayhem-tech-problems-colorados-medicaid-delay-critical-money-disabilities/.

spring of 2024 and timely submitted his renewal paperwork and verifications *twice*: once in April and again in June. There were no major changes to his circumstances (same fixed income, living in same county, etc.). T.C. also visited his local county office to confirm that they had received his renewal paperwork. However, due to workload challenges and insufficient staffing, eligibility specialists were delayed in processing his materials. Without this processing, CBMS terminated T.C.'s QMB coverage at the end of June 2024. It was not until his materials were finally processed in August 2024 that his coverage was reinstated. Without QMB coverage, the Medicare Part B monthly premiums were withheld from T.C.'s monthly benefits, he received medical bills that should have been covered by QMB, and he risked losing his Medicare Advantage plan.

C. Inability to Pause Terminations

Colorado advocates have reported other problems with CBMS. Starting in the summer of 2023, HCPF has been confronted with concerns about improper termination of Medicaid coverage for individuals with disabilities who utilize Long Term Services and Supports. The terminations are due to failures in timely processing of necessary application materials.[38]

Advocates repeatedly requested that HCPF pause Medicaid terminations for this population to prevent ongoing harm.[39] HCPF's response in public meetings with the advocates was that CBMS lacked that functionality and that it would take months to change the system to implement that functionality.[40] For instance, on February 27, 2024 when asked about a pause, Marivel Klueckman, Eligibility Division Director, responded that there "isn't the system capability to pause terminations for this population," and that it would take a "significant ramp up to do this, to make this system change." A few months later, HCPF reported at a Joint Technology Committee Briefing that it already had an estimated 57 CBMS projects in a backlog which Deloitte estimated would take 175,000 to 250,000 hours over two years to complete.[41]

---

[38] *See* Complaint to the Office for Civil Rights, U.S. Dep't of Health & Hum. Servs., RE: Discriminatory provision of case management services to people with disabilities and request for immediate action by the federal agencies, Ref. No. 414820-FJQ. (Feb. 21, 2024), *available at* https://healthlaw.org/resource/ocr-complaint-advocates-urge-hhs-office-for-civil-rights-to-stop-colorado-medicaid-cuts-citing-disabilities-act-violations/.

[39] *See, e.g.*, Second Supplemental Filing to Complaint to the Office of Civil Rights Compliance, at 5-7 (Mar. 12, 2024), https://healthlaw.org/wp-content/uploads/2024/03/2d-Suppl-Filing-CO-CM-Admin-Comp.final_.docx-2.pdf.

[40] *See, e.g.*, Supplemental Filing to Complaint to the Office of Civil Rights Compliance, 3 (Feb. 27, 2024) https://healthlaw.org/wp-content/uploads/2024/02/Supplemental-Filing-with-attachments.FINAL_.pdf ("HCPF said they lacked system capability to stop terminations for only that group; thus, advocates asked that HCPF pause terminations for all populations, if necessary to protect the LTSS population, until the serious and growing problems with the case management system are resolved.").

[41] HCPF, *CBMS 2024: Joint Technology Committee Briefing*, 9-10 (July 2024), https://leg.colorado.gov/sites/default/files/images/hcpf_dhs-cbms_presentation.pdf/

As a consequence of Deloitte's inability to promptly re-program CBMS (or the absence of a pre-existing pause functionality) improper terminations continued for many more months.

Eventually, after substantial pressure from advocates, HCPF attempted to implement a work-around to address the improper terminations.[42] In the first few months of that work-around process, CBMS still could not stop sending out Medicaid termination notices. Specifically, on February 28, 2024 HCPF, sent an email alert stating that the agency "recently became aware of an unintended occurrence specifically impacting Long-Term Services and Supports (LTSS) members that resulted from a system update. The occurrence resulted in a subset of LTSS members being scheduled to have their coverage terminated as of February 29, 2024."[43] HCPF later confirmed that approximately 6,000 individuals were terminated from Medicaid at the end of February 2024 and another roughly 6,000 were terminated at the end of March.

As mentioned above, if it would aid your investigation, we can connect you to advocates at the Colorado Center for Law and Policy to discuss these issues and provide additional case examples.

Other States

In addition, recent in-depth reporting from KFF Health News has collected examples of yet more Deloitte system errors causing loss of coverage in other states. As the reporting reveals, individuals continue to lose coverage and vital benefits months after the errors are discovered, and errors are strikingly similar from one state to the next.

The articles describe:

- Problems in Michigan recognizing eligibility for individuals with disability that mirror those documented in Tennessee: "The computer system routinely fails to recognize when certain adults with disabilities should receive Medicaid benefits."[44] As described by The Arc of Oakland County, a group working directly with Medicaid enrollees in Michigan, "nearly every single person that called had the same story: they are currently receiving SSDI but previously received SSI," and thus "should have continued to qualify for Medicaid" in the Disabled Adult Child (DAC) category.[45]

---

[42] *See* Katie Weis, *Medicaid mayhem: Tech problems with Colorado's Medicaid delay critical money for tens of thousands with disabilities*, CBS News (Apr. 25, 2024), https://www.cbsnews.com/colorado/news/medicaid-mayhem-tech-problems-colorados-medicaid-delay-critical-money-disabilities/.

[43] Colordao HCPF, email (Feb. 28, 2024), https://myemail-api.constantcontact.com/IMPORTANT-COMMUNICATION-Reinstatement-of-LTSS-members-scheduled-to-lose-eligibility-effective-2-29-2024-due-to-an-unintended-sys.html?soid=1120776134797&aid=TZQ0vRcYp6A; *See* Second Supplemental Filing to Complaint to the Office of Civil Rights Compliance, 4 (Mar. 12, 2024), https://healthlaw.org/wp-content/uploads/2024/03/2d-Suppl-Filing-CO-CM-Admin-Comp.final_.docx-2.pdf;

[44] Liss & Pradhan, *Errors in Deloitte-Run Medicaid Systems*, *supra* note 1.

[45] The Arc, Oakland County, *Profiles*, Vol. 49, No. 4-6, at 2 (2024), https://www.thearcoakland.org/wp-content/uploads/2024-Q2-PROFILES.pdf.

- Kentucky resident Beverly Likens lost Medicaid coverage in June 2023 and was unable to submit a new application due to a flaw in the Deloitte-run system. Although a change request was submitted by September 2023, the change was not implemented until April 2024.[46]

- In Georgia, "[a] defect affected potentially tens of thousands of "cases/claims" for families in the Supplemental Nutrition Assistance Program, known as SNAP, and the Temporary Assistance for Needy Families program that, among other problems, led the state to recoup some residents' entire benefit, according to state documents"[47] Yet the fix for that defect was not implemented for nearly two years after it was identified. Georgia also has a backlog of 35 change requests which Deloitte said would take over 104,000 hours to complete.[48]

- A program eligibility specialist in Arkansas reported that the Deloitte-built system was full of "bugs" which caused Medicaid enrollees to lose coverage. For instance, "they wouldn't receive the state's request for information because of glitches," and even though the enrollees "were doing their part. . . the system just failed."[49]

- Following a data conversion error, children in Pennsylvania were unable to use their insurance through the CHIP, impacting 9,269 children last June and 2,422 in October [2023].[50]

These are not isolated incidents. As quoted in the article, a Deloitte spokesperson Karen Walsh confirmed that "in all of [the systems], you're going to be able to find a point in time where there was an issue that needed to be fixed."[51]

Conclusion

Given this additional information and apparent ongoing pattern of harm to Medicaid enrollees stemming from Deloitte's automated Medicaid eligibility systems, we once again, urge the FTC to investigate and take action to address Deloitte's practices as described in our initial complaint.

Please do not hesitate to reach out to us for additional information.

---

[46] Liss & Pradhan, *Errors in Deloitte-Run Medicaid Systems*, *supra* note 1.
[47] *Id.*
[48] *Id.*
[49] Samantha Liss & Rachana Pradhan, *Medicaid for Millions in America Hinges on Deloitte-Run Systems Plagued by Errors*, KFF Health News (June 24, 2024), https://kffhealthnews.org/news/article/medicaid-deloitte-run-eligibility-systems-plagued-by-errors/.
[50] *Id.*
[51] Liss & Pradhan, *Errors in Deloitte-Run Medicaid Systems*, *supra* note 1.

NATIONAL HEALTH LAW PROGRAM

/s/ Sarah Grusin
Senior Attorney
grusin@healthlaw.org

/s/ Elizabeth Edwards
Senior Attorney
edwards@healthlaw.org

/s/ Jane Perkins
Litigation Director
perkins@healthlaw.org

1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
Phone: (919) 968-6308

UPTURN, INC.

/s/ Emily Paul
Project Director
emily@upturn.org

/s/ Emma Weil
Senior Policy Analyst
emma@upturn.org

1015 15th St NW, Suite 600
Washington, DC 20005

ELECTRONIC PRIVACY INFORMATION CENTER (EPIC)

/s/ John Davisson
Director of Litigation
davisson@epic.org

/s/ Grant Fergusson
EPIC Counsel
fergusson@epic.org

1519 New Hampshire Ave. NW
Washington, DC 20036
202-483-1140 (tel)
202-483-1248 (fax)

Exhibit Index

Florida Documents

Ex. A, Fl. Dep't of Children & Families, Policy Transmittal No. P-22-03-0003, "Postpartum Coverage Extension to 12 Months," (Mar. 3, 2022), Plaintiffs' Trial Exhibit 143, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.)

Ex. B, Trial Transcript, Vol. 1, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.).

Ex. C, Trial Transcript, Vol. 2, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 162

Ex. D, Trial Transcript, Vol. 3, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 163

Ex. E, Trial Transcript, Vol. 6, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.), ECF No. 166

Ex. F, Fl. Dep't of Children & Families, Medicaid Unwinding Updates & FAQs (Apr. 2023), Plaintiffs' Trial Exhibit 161, *Chianne D. v. Weida*, No. 3:23-cv-985-MMH-LLL (M.D. Fla.)

Colorado Documents

Ex. G., Contract No. 98342

Ex. H, Contract No. 169723

Tennessee Documents

Ex. I, Deposition Transcript of Kimberly Hagan