Department of Health and Human Services

Centers for Medicare & Medicaid Services
Center for Program Integrity

Connecticut Medicaid and CHIP Eligibility Determinations Audit

Audit Period: September 2019 through February 2020

Final Report

August 2023

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) conducted an audit of the Connecticut Department of Social Services' (hereinafter referred to as Connecticut) eligibility determination process. CMS' primary audit objective was to identify whether the State determined Medicaid and Children's Health Insurance Program (CHIP) eligibility at the point of application or re-determination in accordance with federal and state eligibility requirements and claimed the appropriate Federal Medical Assistance Percentage (FMAP) on behalf of these beneficiaries.

To meet the objectives of this beneficiary eligibility audit, CMS conducted in-depth reviews of eligibility determinations made by the State by examining individual cases, selected from samples, for compliance with federal and state rules and regulations. The audit period was September 2019 - February 2020. This report includes CMS' findings and recommendations, as well as observations, that were identified during the beneficiary eligibility audit.

Findings and Recommendations

Based on the results of this audit, Connecticut correctly determined general Medicaid, adult expansion, and CHIP eligibility in accordance with federal and state requirements for 97.34 percent, 98.39 percent, and 97.75 percent of the sampled beneficiaries, respectively. This audit also determined that, during the audit period, Connecticut's extrapolated improper payments totaled $50,570,431 (federal and state share)[1] for the ineligible Medicaid beneficiaries reviewed. Connecticut also made one payment of $308,658 for a potentially ineligible Medicaid beneficiary.[2] During the audit period, extrapolated improper payments for the adult expansion program totaled $9,881,675 (federal and state share) for the ineligible Medicaid beneficiaries reviewed. Finally, during the audit period, extrapolated improper payments for the CHIP population totaled $1,073,357 (federal and state share) in improper and potentially improper payments. CMS' current statutory authority[3] only allows overpayments to be recovered through the Payment Error Rate Measurement Program (PERM), thus CMS is unable to recover the federal payments associated with the ineligible beneficiaries identified as a result of this audit.[4]

For most eligibility determinations in the samples, Connecticut verified financial information related to wages, net earnings from self-employment, and unearned income from a combination of the following data sources: the State Wage Information Collection Agency (SWICA), Internal Revenue Service (IRS), Social Security Administration (SSA), and state unemployment insurance (42 CFR 435.948(a)(1)). In general, Connecticut requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably

[1] CMS made several attempts to have Connecticut provide the breakout between federal and state dollars. Connecticut stated that this information was 'difficult' to provide and did not respond to CMS' requests.
[2] Appendix C:1 – Potentially Ineligible Beneficiary. There was only one potentially ineligible beneficiary identified in the audit, therefore, the value of the payment ($308,658.22) could not be extrapolated over the entire sample and remains a standalone error.
[3] Section 1903(u) of the Social Security Act
[4] Appendix C includes additional information on the improper payment calculations.

compatible[5] with electronic sources in accordance with the State's verification plan (§ 435.952(c)(2)). Additionally, this audit found that Connecticut verified citizenship or immigration status by electronically verifying citizenship status with the SSA or immigration status with the Department of Homeland Security (DHS).[6]

CMS identified four recommendations for improvement as a result of this audit:

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

Recommendation #2: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[7] CMS recommends Connecticut perform an annual renewal of Medicaid, including adult expansion services, and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility.

Recommendation #3: In accordance with § 435.119(b)(3), CMS recommends that Connecticut ensure timely actions are taken to close cases once the beneficiary is eligible for or enrolled in Medicare.

Recommendation #4: In accordance with § 435.912, CMS recommends that Connecticut ensure timely actions are taken to close cases no longer requiring services to reduce the risk that inappropriate or fraudulent claims could be billed for Medicaid or CHIP services using those beneficiaries' active case numbers.

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[5] The term "reasonably compatible" refers to a federal requirement that prohibits states from requiring Medicaid applicants applying under Modified Adjusted Gross Income (MAGI) to provide documentation except in cases in which applicants' self-reported documentation was not reasonably compatible (a threshold determined by the state) with information in Government databases (§ 435.952(c)). In accordance with this requirement, if (a) an applicant attests to income above the applicable income standard and a data source shows it to be below the standard or (b) an applicant's attestation and electronic verification are both below the applicable standard, the state agency accepts the applicant's attestation. However, if an applicant attests to income below the applicable income standard and a data source shows it to be above the standard, the state applies its reasonable compatibility standard and potentially requests additional documentation. In Connecticut, an applicant's attestation of income is considered reasonably compatible if the difference between the attested income and electronic data verifications is within an amount no more than 20 percent of 100 percent Federal Poverty Level (FPL) for a family of one. If the difference exceeds that threshold, the state agency requests manual verifications. (Connecticut Based Eligibility Verification Plan).

[6] §§ 435.406 and 435.949. Citizenship and non-citizen eligibility, Verification of information through an electronic service. Retrieved August 10, 2021, from https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.4.435&rgn=div5

[7] *Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023* (SHO# 23-002), available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

Connecticut's Medicaid and CHIP Beneficiary Eligibility Determinations Audit

Background

The Comprehensive Medicaid Program Integrity Plan (CMIP) for Fiscal Years (FYs) 2019-2023 describes CMS' 5-year Medicaid program integrity strategy that aims to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools.[8] A key component of this strategy is conducting audits of Medicaid and CHIP beneficiary eligibility determinations.

CMS conducts in-depth reviews of eligibility determinations made by the State by examining individual cases, selected from samples, for compliance with federal and state rules and regulations during an established audit period. CMS identifies states for beneficiary eligibility audits by conducting a risk-based analysis informed by the review of State Plan Amendments proposing Medicaid and CHIP eligibility expansions; findings from other review programs; audits conducted by other entities, such as the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), Government Accountability Office (GAO), and/or state auditors; and other sources. Through these audits, CMS identifies findings and related recommendations that will help states make proper eligibility determinations in the future. CMS also provides states with feedback and promising practices that may be used to enhance program integrity within the Medicaid and CHIP beneficiary eligibility determination process.

Overview of the Medicaid and CHIP Programs

Medicaid is a joint Federal and state program that, together with CHIP, provides health coverage to over 77 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.[9]

Federal law requires states to cover certain groups of individuals under the state's Medicaid program. Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of individuals who are eligible under mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.[10]

CHIP builds on Medicaid's success, providing health coverage to uninsured children. States can use their federal CHIP funds to finance coverage for children whose family incomes are too high

[8] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[9] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2022, from https://www.medicaid.gov/medicaid/eligibility/index.html
[10] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2022, from https://www.medicaid.gov/medicaid/eligibility/index.html

to qualify for Medicaid. States may opt to use CHIP funds to expand Medicaid for children, cover children through a separate CHIP program, or combine the two approaches.

States operate and fund Medicaid and CHIP in partnership with the Federal Government.[11] CMS reimburses states for a specified percentage of program expenditures, called the FMAP, which is developed from criteria such as the state's per capita income. The regular program FMAP varies by state and ranges from 50 to about 75 percent. Connecticut's regular Medicaid and CHIP FMAPs for the audit period (September 2019 through February 2020) were 50 percent and 76.50 percent, respectively. Congress authorized an enhancement to the regular FMAPs due to the COVID-19 Public Health Emergency, which increased Connecticut Medicaid and CHIP FMAPs to 56.20 percent and 80.84 percent, respectively, for the portion of the audit period for January and February 2020.[12]

Medicaid and CHIP Coverage under the Affordable Care Act (ACA)

As of May 2023, 40 states, including the District of Columbia, elected to expand Medicaid coverage under the ACA to low-income adults.[13] Prior to the ACA, low-income, non-disabled, non-pregnant adults without dependent children generally were not eligible for Medicaid, regardless of income. Section 2001 of the ACA established a new eligibility group providing health care coverage to previously ineligible adults under Section 1902(a)(10)(A)(i)(VII) of the Social Security Act (subsequently codified in regulation at 42 CFR § 435.119). These changes allowed states to receive federal Medicaid funds, without a waiver, to provide coverage to low-income individuals without regard to disability, parental status, or most other categorical limitations. The ACA's changes to Medicaid eligibility criteria expanded coverage to nearly all non-elderly adults with incomes at or below 138 percent of the Federal Poverty Level (FPL).[14]

The ACA established a new methodology for determining income eligibility for Medicaid and CHIP based on the applicant's modified adjusted gross income (MAGI). MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents, and adults.

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[11] HUSKY Health is the State of Connecticut's public health coverage program for eligible children, parents, relative caregivers, elders, individuals with disabilities, adults without dependent children, and pregnant women. HUSKY Health encompasses Medicaid and the Children's Health Insurance Program: HUSKY A—Medicaid for children, teens, parents, relative caregivers and pregnant women; HUSKY B—Children's Health Insurance Program for children and teens up to age 19; HUSKY C—Medicaid for adults 65 and older and adults with disabilities, including long-term services and supports; and HUSKY D—Medicaid for low-income adults without dependent children. For most families and individuals, HUSKY Health coverage is cost-free or low-cost. For beneficiaries who do have a cost, the monthly cost is a sliding scale based on income. Beneficiaries are placed into bands based on their income which dictate the premium owed.

[12] MACPAC FMAPS for Medicaid. Retrieved August 15, 2021, from https://www.macpac.gov/wp-content/uploads/2022/08/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-FMAPs-by-State-FYs-2020-2023-1.pdf

[13] Medicaid.gov. Adult Coverage Expansion Map as of July 2021. Retrieved August 11, 2021, from https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map-07-2021.pdf

[14] Section 1902(a)(10)(A)(i)(VII) of the Social Security Act and 42 CFR § 435.119 define the income standard for the group at 133 percent of the FPL; however, the income counting methodology allows for an income disregard equivalent to five percentage points of the FPL when a household is on the edge of eligibility for Medicaid or CHIP. As a result, the effective income standard for the adult group is 138 percent of FPL.

The MAGI-based methodology generally considers taxable income and tax filing relationships to determine financial eligibility for Medicaid.[15] States must complete renewals once every 12 months and no more frequently than once every 12 months for groups eligible based on MAGI.[16] The ACA also provided enhanced FMAP for the adult expansion population. Beginning in 2020, the Federal Government funded 90 percent of allowable health care costs for the newly eligible adult population.[17] The ACA also provided enhanced FMAP (75 to 90 percent) to support states in the replacement or upgrade of outdated eligibility systems and to establish links to other data sources to implement new streamlined processes.

To promote program integrity when verifying eligibility while also minimizing the amount of paper documentation that applicants and beneficiaries need to provide, the ACA also required states to primarily rely on available electronic data sources to verify information included on the application (or conduct the renewal process), such as data from the SSA, the DHS, and the state Department of Labor.[18] Documentation or other information is requested when electronic data is unavailable or not reasonably compatible (i.e., consistent with electronic data) in accordance with a state's verification plan.[19] States are also able to accept self-attestation of some elements of eligibility when making determinations where the statute does not require other verification processes. States must also seek to renew coverage based on information from the beneficiary's account and available data sources before requesting information from the individual (these renewals are known as *ex parte* renewals[20]).

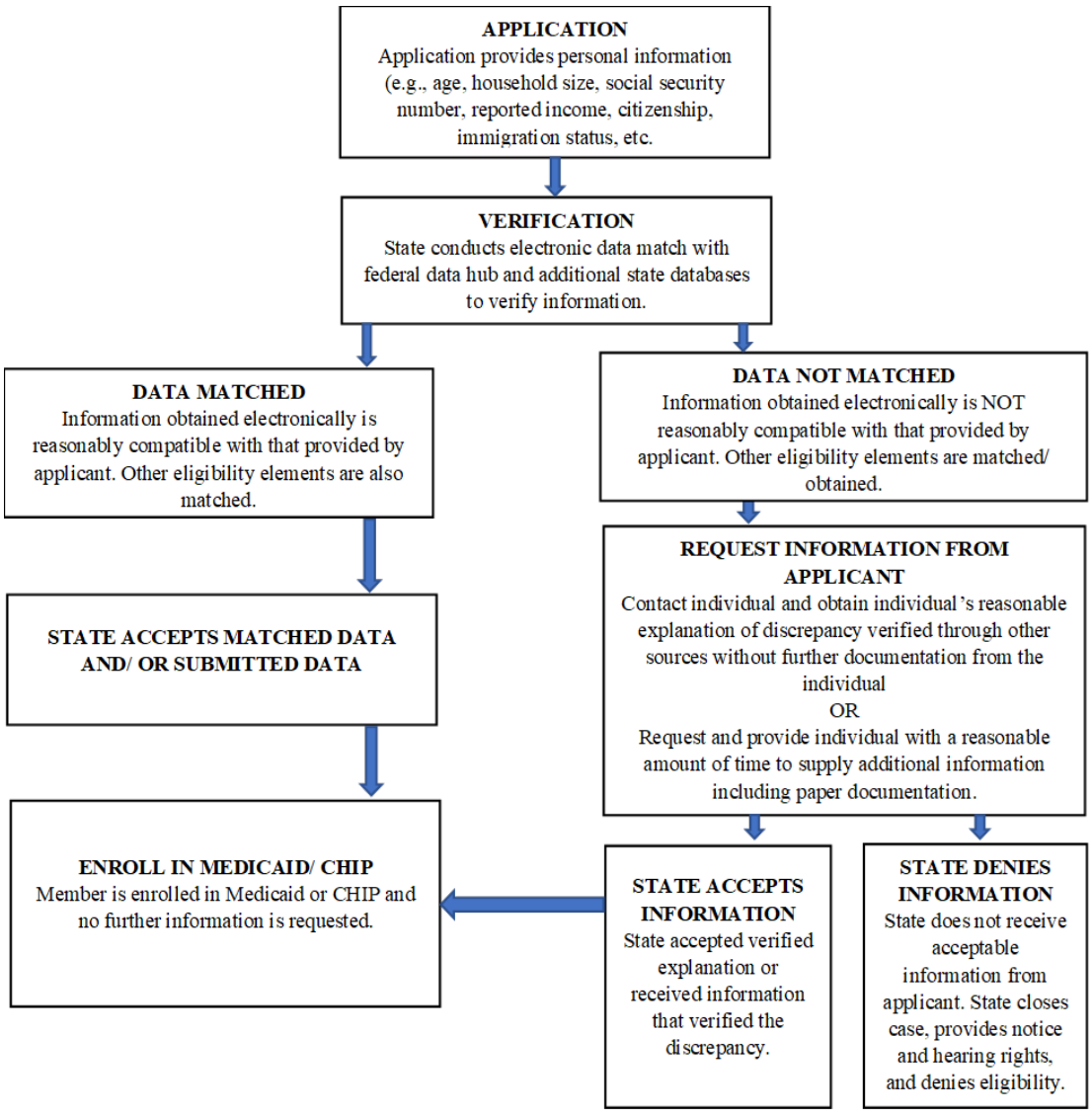
Regulations at §§ 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state. States must submit their verification plans to CMS upon request and provide updated versions of the plans to CMS if the state subsequently changes verification policies and procedures.

[15] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2021, from https://www.medicaid.gov/medicaid/eligibility/index.html
[16] Regulations at 42 CFR § 435.916 describe the periodic renewal of Medicaid eligibility.
[17] 42 CFR § 433.10(c)(6).
[18] Regulations at 42 CFR §§§ 435.945, 435.948, and 435.956 describe income and eligibility verification requirement.
[19] Medicaid .gov. Keeping America Healthy. Medicaid / CHIP Eligibility Verification Plans. Retrieved August 11, 2021, from https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html
[20] An ex parte renewal is a redetermination of eligibility that can be made based on reliable information available to the agency, including information accessed through electronic data sources, without requiring information from the individual. This is also referred to as a passive renewal.

Overview of Connecticut's Medicaid and CHIP Eligibility Processes

Individuals seeking coverage may apply on-line, through a phone call, in person, or by mail. To verify eligibility for individuals who apply for coverage, the state uses multiple electronic data sources available through the Federal Data Services Hub (Data Hub).[21] The data sources used by Connecticut through the Data Hub are provided by HHS, the SSA, the DHS, and the IRS, among others. Connecticut also uses data sources maintained by the State, such as the SWICA.

Figure 1: Connecticut's Medicaid and CHIP MAGI Eligibility Process



[21] Connecticut MAGI-Based Eligibility Verification Plan. Retrieved January 21, 2023, from https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html

Overview of the Connecticut Medicaid and CHIP Eligibility Determinations Audit

In February 2022, CMS conducted an audit of Connecticut's general Medicaid, adult expansion, and CHIP eligibility determinations for the audit period of September 2019 through February 2020.[22] During the audit, CMS identified a total of four recommendations and eight observations. This audit assessed how well Connecticut complied with its MAGI verification plan as well as other federal regulatory requirements.

The Connecticut's response to CMS' report can be found in Appendix D, and the final report reflects changes CMS made based on the Connecticut's response.

The audit encompassed the following four areas:

A. <u>State Oversight of Eligibility Determinations.</u> CMS established requirements at § 431.10(c) that require the SMA to exercise appropriate oversight over the eligibility determinations and appeals decisions to ensure compliance with all relevant federal and state laws, regulations, and policies related to eligibility. Oversight includes but is not limited to maintenance and content of eligibility records, such as those found under § 431.17, as well as any reporting requirements needed to facilitate such control and oversight. Additionally, §§ 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state.

B. <u>Utilization of the Data Hub to Determine Financial Eligibility.</u> The Data Hub was created to verify financial information related to wages, net earnings from self-employment, and unearned income from the IRS and SSA. States use state databases related to wages and unemployment compensation from SWICA and state unemployment insurance to verify more recent wage records or wage information, if necessary. The state may also request additional information or documentation from beneficiaries for a variety of reasons, including but not limited to attested income did not closely match verified income, verified assets exceeded what was attested, attested income was not reasonably compatible with electronic sources in accordance with the state's verification plan (§ 435.952(c)(2)).

C. <u>Non-Financial Elements of Eligibility.</u> The Data Hub also assists states in collecting non-financial eligibility criteria. Medicaid beneficiaries generally must be residents of the state in which they are receiving Medicaid. They must be either citizens of the United States or certain qualified non-citizens, such as lawful permanent residents (LPR) who have met the five-year bar. In addition, some eligibility groups are limited by age, or by pregnancy or parenting status. If the Data Hub does not provide sufficient information, the state must seek information from the beneficiary.

[22] The Audit Scope and Methodology can be found in Appendix A, the Statistical Sampling Methodology can be found in Appendix B, and the Medicaid and CHIP Sample Results and Estimates can be found in Appendix C.

D. Required Annual Renewals of Medicaid and CHIP Beneficiaries. In accordance with § 435.916, periodic renewal of Medicaid eligibility, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, must be renewed once every 12 months and no more frequently than once every 12 months. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under §§§ 435.948, 435.949, and 435.956.

Results of the Audit

Medicaid

General Population
Connecticut correctly determined general Medicaid eligibility in accordance with federal and state requirements for 97.34 percent of the sampled Medicaid beneficiaries (221 of 226 Medicaid beneficiaries sampled). CMS identified findings for four improper eligibility determinations in which Connecticut did not always verify resources or correctly calculate income when determining eligibility. In addition, Connecticut did not provide sufficient documentation to support the eligibility determination for one potentially ineligible beneficiary. Because of a lack of supporting documentation, CMS could not definitively determine whether this one beneficiary was eligible for Medicaid. CMS also identified one observation in which eligibility was determined correctly; however, federally required renewal documentation was absent for two months.

Of the universe of federal and state Medicaid payments totaling $2,922,041,774 made on behalf of 585,147 beneficiaries during the audit period, CMS' sample of 226 beneficiaries represented $32,494,294 in Medicaid (federal and state share) payments. Based on the results of this audit, Connecticut made improper or potentially improper payments totaling $643,672 for the five sampled ineligible and potentially ineligible beneficiaries.[23] Extrapolating these errors to the entire Connecticut general Medicaid population, CMS estimates that during the audit period, Connecticut made federal and state Medicaid payments on behalf of an estimated 15,537 ineligible beneficiaries, totaling an estimated $50,570,430.89 (federal and state share) in improper payments.

Adult Expansion Population
Connecticut correctly determined eligibility in accordance with federal and state requirements for 98.39 percent of the sampled beneficiaries enrolled in the adult expansion program (222 of the 225 Medicaid beneficiaries sampled). CMS identified findings for three improper eligibility determinations in which Connecticut did not always correctly calculate income when determining eligibility. CMS also identified two observations in which eligibility was extended

[23] Appendix C included additional information on the improper payment calculations.

beyond the beneficiaries dates of death. Payments were not made in these cases; however, instances such as these increase the risk of improper payments.

Of the universe of federal and state Medicaid payments totaling $1,102,348,018 made on behalf of 301,101 beneficiaries during the audit period, CMS' sample of 225 beneficiaries represented $17,401,870 in Medicaid (federal and state share) payments. Based on the results of this audit, Connecticut made estimated improper payments totaling $178,476.97 based the three sampled ineligible beneficiaries.[24] Extrapolating these errors to the entire Connecticut adult expansion population, CMS estimates that during the audit period, Connecticut made federal and state Medicaid payments on behalf of an estimated 4,852 ineligible beneficiaries, totaling an estimated $9,881,675 (federal and state share) in improper payments.

CHIP

Connecticut correctly determined CHIP eligibility in accordance with federal and state requirements for 97.75 percent of the sampled CHIP beneficiaries (169 175 CHIP beneficiaries sampled). CMS identified findings for six improper eligibility determinations in which Connecticut did not always include or calculate all applicable income correctly. CMS also identified several observations in which eligibility was determined correctly for five cases, but the monthly premium was assessed incorrectly.

Of the universe of federal and state CHIP payments totaling $47,800,372 made on behalf of 26,652 beneficiaries during the audit period, CMS' sample of 175 beneficiaries represented $8,019,144 in CHIP payments. Based on the results of this audit, Connecticut made improper payments totaling $416,041 for the six sampled ineligible beneficiaries. Extrapolating these errors to the entire Connecticut CHIP population, CMS estimates that, during the audit period, Connecticut made federal and state share CHIP payments on behalf of an estimated 336 ineligible CHIP beneficiaries, totaling an estimated $1,073,357 (federal and state share) in improper payments.

Medicaid Findings

Findings are those errors where the State did not make an accurate eligibility determination based on eligibility application or renewal data for the case, consistent with federal requirements and the State's verification plan. The findings were largely caused by human and/or system errors. Findings result in recommendations that will ensure the State comes into compliance with Federal requirements and the State's verification plan. Findings and recommendations for the four ineligible beneficiaries are described below.

1. The beneficiaries appeared to be ineligible for Medicaid services due to having resources over the allowable limits.

1.A) The beneficiary, date of birth of August 30, 1996, had been in the foster care program through October 20, 2018. Subsequent to the foster care program, it appears the beneficiary was deemed eligible for the Home and Community-Based Waiver (HCBW)

[24] Appendix C included additional information on the improper payment calculations.

program. The beneficiary submitted an application for the HCBW program on August 24, 2018, for the period of December 1, 2018, through November 30, 2019. Another renewal date of November 5, 2019, for the period of December 1, 2019, through December 31, 2021, was also on file.

Connecticut's case notes reflected that the beneficiary was over the limit for assets, rendering them ineligible for Medicaid yet Connecticut made the beneficiary eligible for Medicaid regardless. Connecticut noted that the beneficiary's assets on August 24, 2018, consisted of three bank accounts ($2,162.04, $678.94, and $4,936) totaling $7,776.98. The asset limit for an individual receiving waiver services was $1,600.00. There did not appear to be updates to the resources for the second renewal period which began on December 1, 2019.

Connecticut did not concur with the finding, stating that one bank account with a balance of $643.94 was closed on December 18, 2019, and a conservator account had a zero balance until November 1, 2021. Connecticut did not address the third account. Connecticut stated the assets verified for the audit period were within limits; however, it did not provide CMS with adequate closure verification information such as bank account balances for all three accounts for each renewal period, specific dates that each account was closed or zeroed out, and what happened to the balances of each account. Without reliable resource information, eligibility cannot be reasonably determined.

Based on this error, total payments of $117,448.88 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.[25]

1.B) The beneficiary, a household of one, applied for long-term care (LTC) institutional services on January 2, 2019, for the coverage period of January 1, 2019, through December 31, 2019. The beneficiary attested, via paper, to an income of $4,978.86 per month. The beneficiary submitted a renewal on December 9, 2019, for the period of January 1, 2020, through December 31, 2020, attesting, via paper, to income of $5,433.10 per month. The income limit for these services was $2,523 monthly.

For the 2019 application period, the beneficiary received monthly income from Social Security Disability Insurance (SSDI) of $2,914.50 and long-term disability benefits of $1,235.75 twice per month. At the time of the December 2019 renewal, the beneficiary received monthly SSDI income of $2,961.60 and long-term disability benefits of $1,235.75 twice per month.

The beneficiary had assets totaling $227,872.79 at the time of the January 2019 application. The beneficiary's overall reported resources as of December 2019 had grown

[25] HUSKY Health for Connecticut Children & Adults. How to Qualify. Retrieved January 3, 2023, from https://portal.ct.gov/HUSKY/How-to-Qualify

to $961,878.37. Funds in both checking accounts were almost depleted while listed investments increased by $753,705.39 (79.3 percent).

CMS reviewers questioned the beneficiary's eligibility status, considering the large volume of resources documented in the beneficiary's case file. Connecticut's Subject Matter Expert (SME) stated the beneficiary was on the State's high deductible program and was placed on a "L99 spenddown" (L99 is Husky C, Medically Needy, Long-Term Care Facility residence) with a pickup date of January 1, 2019.

Connecticut did not concur with this finding. It stated the beneficiary had assets held in a special needs trust, which their legal department deemed unavailable/inaccessible and therefore did not count towards the $1,600.00 asset limit.[26] However, when asked, Connecticut did not provide an explanation of the L99 spend down program. Furthermore, Connecticut's response did not include a copy of the trust document nor any type of documentation from their legal department describing in detail how the high deductible, special needs trust worked and what the parameters of the trust were. Additionally, Connecticut did not delineate what funds, if any, operated outside the trust and how those were to be used and monitored.

Based on this error, total payments of $102,491.94 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

1.C) The beneficiary submitted a renewal for services in the HCBW program on October 31, 2018, for the coverage period of October 1, 2018, through September 30, 2019. The household of one attested, via paper, to SSI of $750.00 per month (72 percent of FPL).

The beneficiary submitted another renewal for HCBW services on October 15, 2019, for the coverage period of October 1, 2019, through January 31, 2021. The household of one attested, via paper, to SSI of $771.00 per month (74 percent of FPL).

The beneficiary was originally in a case with the parent but was removed effective October 31, 2018. The case notes of October 31, 2018, did not address anything related to medical coverage, only Supplemental Nutrition Assistance Program (SNAP) renewal. The beneficiary's mother oversaw a special needs trust for the period of September 29, 2018, through September 30, 2019, with a reported balance of $112,530.26. At the time, there were monthly deposits into this account of $2,360.48. There were also external withdrawals from this account of $350.00 per month. On October 15, 2019, there was a five-year lookback on the case. Shortly after the lookback, the bank account related to the trust was closed on October 15, 2019.

CMS reviewers questioned the beneficiary's eligibility status considering the large, reported balance of resources documented in the beneficiary's case file. Connecticut's

[26] HUSKY Health for Connecticut Children and Adults. How to Qualify. Retrieved January 3, 2023, from https://portal.ct.gov/HUSKY/How-to-qualify.

SME stated the beneficiary was placed on a "W01 spenddown" (W01 is for Husky C, Medically Needy for Eighteen or over and enrolled in a waiver).

Connecticut did not concur with this finding. Connecticut stated the beneficiary had assets held in a special needs trust, which their legal department deemed unavailable/inaccessible and therefore did not count towards the $1,600 asset limit. However, when asked, Connecticut did not supply an explanation of the W01 spend down program. Furthermore, Connecticut's response did not include a copy of the trust document nor any type of documentation from their legal department describing in detail how the special needs trust worked and what the parameters of the trust were. Additionally, Connecticut did not delineate what funds, if any, operated outside the trust and how those were to be used and monitored.

More specifically, Connecticut did not respond with any answers to account for the final resolution of the September 30, 2019, trust balance held by the beneficiary's parent of $112,530.26 or the monthly deposits of $2,360.48.

Based on this error, total payments of $114,057.11 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

2. The beneficiary was ineligible for Medicaid resulting from inappropriate household attestation of income and the Data Hub's failure to deny eligibility based on reliable financial data.

The beneficiary was auto renewed into low-income families' coverage on December 17, 2018, for the period of January 1, 2019, through December 31, 2019. A household of five, the Wage Earner and four children, attested to no income.

The beneficiary was auto-renewed again into low-income families' coverage on December 17, 2019, for the period of January 1, 2020, through December 31, 2020. The household of five again attested to no income. This case has been auto renewed since 2015 with no income.

CMS reviewed Department of Labor (DOL) records. There were DOL wage results for the Wage Earner over the course of April 2019 through March 2020. The Wage Earner had DOL wages indicating earnings of $33,000.00 per quarter, or $11,000 per month (438 percent of FPL). CMS also reviewed Equifax. Equifax reported the Wage Earner had been employed with the same company since October 31, 2016. Based on the combined wage reports from Equifax and DOL, the Wage Earner's annual income amounts for 2018 through 2022 were $135,000.08, $150,633.36, and $159,593.86, respectively.

This appears to be both a beneficiary issue and a Data Hub issue. The beneficiary's household should have updated the renewal form with appropriate income information when they received it each year; however, the Data Hub should have had this updated income populated within its system as it became available. The Data Hub should have alerted Connecticut to deny the beneficiary's eligibility based on this income upon their new renewals.

Connecticut concurred with the finding, stating there was a possible Data Hub/interface issue. Connecticut responded that the workers do not have access to current DOL files, the files are three to six months old when the worker has access to them. However, according to Equifax, the Wage Earner had worked with the same employer since October 2016. The Data Hub should have alerted Connecticut of the Wage Earner's employment status prior to this audit.

Based on this error, total payments of $1,015.40 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

Potential Medicaid Findings

Potential findings represent the class of errors in which the State could not provide enough supporting documentation to determine whether the beneficiary was eligible. Potential findings result in potentially ineligible beneficiaries and potential improper payments. Potential findings result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. The potential finding and recommendation for the one potentially ineligible beneficiary is described below.

1. The beneficiary's renewal for the HCBW program was missing from September through December 2019.

The beneficiary submitted a renewal for the HCBW program on July 22, 2019, for the coverage period of July 1, 2019, through June 30, 2020. The household of one attested, via paper, to no income. The beneficiary's only income was from state administered general assistance (SAGA). Connecticut's eligibility dashboard indicated that there had been a renewal for that period; however, CMS was unable to locate the actual renewal, dated July 22, 2019, for review.

On January 1, 2020, a new application, with a new coverage period from January 2020 through December 2020, was submitted to move the beneficiary from one waiver to another. The CMS reviewers were able to satisfactorily review this application.

Connecticut did not concur with the finding, responding that "[t]his was a November 2018 renewal received timely on November 27, 2018. The Department did not review the form, although coverage remained active, until July 22, 2019." This statement discusses a renewal period prior to the audit period of September 2019 through February 2020 which was not in question. The months in question are September 2019 through December 2019.

Based on this error, total payments of $308,658.22 (federal and state dollars) were potentially inappropriately paid for the months of September through December of 2019 for the sampled individual in the audit period.

Recommendation #2: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, CMS recommends Connecticut perform an annual renewal of Medicaid, including adult expansion services, and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility.

Medicaid Observations

During the course of the audit, other issues were identified in the sampled cases that do not represent an error to the State because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Observations and recommendations for the one beneficiary is described below.

1. The income of all members in the household was not captured to determine eligibility.

The beneficiary applied for coverage in the Mandatory Poverty Level Related, Infants category of service coverage group on September 17, 2019, for the coverage period of September 1, 2019, through September 30, 2020. The household of four attested to no income. However, only Wage Earner #1 and two children, were included in the financial eligibility calculation. Wage Earner #2's income was not included.

CMS reviewers reviewed the DOL records and found that Wage Earner #2 did indeed have earnings as of the second quarter of 2019 totaling $11,903.70 or $3,967.90 per month (185 percent of FPL). The beneficiary would have remained eligible for services even if Wage Earner #2's income had been appropriately included. The upper limit for Medicaid coverage for an infant in a family of four was $4,206.16 per month (196 percent of FPL) during the audit period. Although this did not cause the beneficiary to be ineligible in this case, state worker errors like this could cause eligibility determination errors in other cases. Connecticut should practice due diligence and include all applicable incomes from all household members when determining the financial eligibility of a beneficiary.

Connecticut concurred with this observation and agreed Wage Earner #1 was listed as "married living apart" and that both children were claimed as tax dependents by someone

outside of the household. Wage Earner #2 should have been listed on this case as not requesting coverage; however, their income should have been included.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

Adult Expansion Population Findings

Findings are those errors where the State did not make an accurate eligibility determination based on eligibility application or renewal data for the case, consistent with federal requirements and the state's verification plan. The findings were largely caused by human and/or system errors. Findings result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Findings and recommendations for the three ineligible beneficiaries are described below.

1. The beneficiaries were ineligible for adult expansion coverage once they began receiving Medicare coverage.

1.A) The beneficiary's date of birth was February 29, 1964. The beneficiary submitted a renewal for services in the adult expansion program on April 25, 2019, for the coverage period of May 1, 2019, through October 31, 2020. The household of one attested, via mail, to no income. The beneficiary began receiving Medicare Part A as of August 1, 2019, and then also began receiving Medicare Part D as of November 1, 2019, which overlapped with the adult expansion coverage. The beneficiary was not eligible for adult expansion coverage at the higher FMAP because they were receiving coverage under Medicare.

Connecticut concurred with this finding. Connecticut agreed that Medicare Part A coverage began on August 1, 2019, and that Connecticut's case was not closed until February 28, 2022.

Based on this error, total payments of $178,231.84 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

1.B) The beneficiary's date of birth was March 9, 1967. The beneficiary submitted a renewal for adult expansion coverage on January 22, 2019, for the coverage period of March 1, 2019, through February 29, 2020. The household of one received income of $1,217.00 per month of SSDI. The beneficiary had Medicare Parts A, B, and D coverage effective February 1, 2020, which overlapped with the adult expansion coverage for the month of February 2020. Adult expansion coverage ended February 29, 2020.

Connecticut concurred with this finding. Connecticut agreed that Medicare coverage began on February 1, 2020, interfaced in the Health Insurance Exchange (HIX) system the same month, and that Connecticut's case was not closed until February 29, 2020.

Based on this error, total payments of $245.13 (federal and state dollars) were inappropriately paid for the sampled individual during February 2020 of the audit period.

Recommendation #3: In accordance with § 435.119(b)(3), CMS recommends that Connecticut ensure timely actions are taken to close cases once the beneficiary is eligible for or enrolled in Medicare.

2. The beneficiary was ineligible because they were over the income threshold for adult expansion.

The beneficiary's date of birth was May 19, 2000. The beneficiary aged out from Medicaid coverage, children, ages 6-18, and was transitioned to adult expansion coverage on June 10, 2019, for the period of July 1, 2019, through December 31, 2019. The household of two attested to income of $2,231.17 per month (158 percent of FPL) for the Wage Earner. The monthly income limit for a household of two was $1,945.80. The beneficiary, based on this income, was not eligible for adult expansion coverage for the eligibility period of July 2019 through December 2019.

The beneficiary submitted a renewal for adult expansion coverage on November 20, 2019, for the coverage period of January 1, 2020, through December 31, 2020. The household of two attested online to income of $3,778.15 per month (268 percent of FPL) for the Wage Earner and beneficiary. The beneficiary continued to be over the income limit; however, Connecticut continued to approve eligibility throughout the next coverage period.

Connecticut concurred with this finding. Connecticut agreed that the beneficiary was over the income standard for a household of two.

Based on this error, total payments of $0.00 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

Adult Expansion Population Observations

During the course of the audit, other issues were identified in the sampled cases because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Observations and recommendations for the two beneficiaries are described below.

1. The beneficiaries passed away, however, the case remained open for several months after the beneficiary's death.

1.A) The beneficiary was enrolled in adult expansion coverage that was renewed on November 15, 2019, for the coverage period of December 1, 2019, through November 30, 2020. The beneficiary passed away on May 27, 2021 (after the audit period); however, the case remained open. Although no payments were made after this beneficiary's death, this creates a risk in the control environment for Connecticut. There appears to be no controls in place that would protect Connecticut from improper payments being made after this beneficiary's date of death. On April 30, 2022, Connecticut's SME closed the case upon realizing it was still active during the audit.

Connecticut concurred there were no payments made after the date of death.

1.B) The beneficiary applied for adult expansion services on July 11, 2019, for the period of June 1, 2019, through May 31, 2020. The beneficiary passed away on June 20, 2020 (after the audit period); however, the case remained open. Although no payments were made after this beneficiary's death, this creates a risk in the control environment for Connecticut. There appears to be no controls in place that would protect Connecticut from improper payments being made after this beneficiary's date of death. On April 30, 2022, Connecticut's SME closed the case upon realizing it was still active during the audit.

Connecticut concurred there were no payments made after the date of death.

Recommendation #4: In accordance with § 435.912, CMS recommends that Connecticut ensure timely actions are taken to close cases no longer requiring services to reduce the risk that inappropriate or fraudulent claims could be billed for Medicaid or CHIP services using those beneficiaries' active case numbers.

CHIP Findings

Findings are those errors where the State did not make an accurate eligibility determination based on eligibility application or renewal data for the case, consistent with federal requirements and the State's verification plan. The CHIP findings identified during this audit were largely caused by human and/or system errors. Findings result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Findings and recommendations for the six ineligible beneficiaries are described below.

1. **The beneficiary was not eligible for CHIP and should have been covered under Medicaid instead because of income limits.**
   1.A) The beneficiary completed a paper renewal on January 3, 2019, for the coverage period of February 1, 2019, to January 31, 2020. The household of five attested to monthly income of $4,966.50 (197 percent of FPL).

   The beneficiary submitted a renewal on January 6, 2020, for the coverage period of February 1, 2020, through January 31, 2021. The household of five attested online to monthly income of $4,687 (183 percent of FPL).

   The Wage Earners were undocumented citizens without social security numbers. CMS reviewers were unable to determine how Connecticut verified income for both coverage periods. Additionally, based on declared income used by Connecticut, the beneficiary should have qualified for Medicaid coverage for the first and second renewal periods rather than CHIP coverage.

   Connecticut concurred with the finding that the beneficiary was eligible for Medicaid services but was granted CHIP services in error. Connecticut indicated that the acceptable income verification documents were received in the HIX system on December 5, 2018, and December 28, 2018; however, the incorrect eligibility determination was made. The verifications included a current employer letter/paystub and a current letter from the DOL verifying unemployment benefits. Connecticut has submitted a ticket to their Business Systems in an attempt to resolve the error.

   Based on this error, total payments of $3,007.72 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

   1.B) The beneficiary was transitioned from Medicaid (October 1, 2018, through September 30, 2019) to CHIP Band Two (October 1, 2019, through January 31, 2020) and then transitioned to CHIP Band One (February 1, 2020, through September 30, 2020). Connecticut's SME believed this change was due to multiple reported changes in income. The beneficiary received one year of extended coverage when the income change was reported.

   A renewal was submitted on September 24, 2019, for the coverage period of October 1, 2019, through January 31, 2020. The same day, a call center representative called the family of four to verify income. The household reported income amounts from both Wage Earners: $3,225 monthly and $4,730 monthly, less alimony deduction of $1,075, for a total monthly income in the amount of $6,880.00. The household was eligible for CHIP Band Two.

   A renewal was completed on January 6, 2020, for the coverage period of February 1, 2020, through September 30, 2020. Wage Earner #1 called to report a change in income and only reported income for himself in the amount of $4,730, with a reported alimony deduction of $430, for a net income of $4,300. The beneficiary was transitioned into CHIP Band One. However, based on this attested income, the beneficiary should have

been placed into Medicaid as the highest allowable monthly income limit for Medicaid for a household of four was $4,313.46 (201 percent of FPL).

On the first renewal from September 2019, Connecticut responded that the deduction regarding alimony was all self-attested and the deduction was not required to be verified. Connecticut also responded that on the renewal from January 6, 2020, the beneficiary was transitioned into CHIP Band One with no premium. However, using the income provided by Connecticut for this period, $4,300, the beneficiary should have been placed into Medicaid.

Based on this error, total payments of $51,362.82 (federal and state dollars) were inappropriately paid for the sampled individual during February 2020 of this audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

2. **The beneficiary was not eligible for CHIP because income exceeded the limit for CHIP.**

   The beneficiary applied for CHIP services on September 30, 2019, for the coverage period of September 1, 2019, through January 31, 2020. The four-person household attested by telephone to wages of $6,160 per month (287 percent of FPL). Annual income was electronically verified for the household. The beneficiary was correctly placed in CHIP Band Two with a monthly premium of $50.

   The beneficiary applied for a renewal for CHIP services on January 6, 2020. The four-person household attested by telephone to wages of $6,428.16 per month (294 percent of FPL). The beneficiary remained in CHIP Band Two with a monthly premium of $50 for the period of February 1, 2020, through January 31, 2021. Connecticut attested that income was verified appropriately by the Data Hub at the time of renewal. Although not required, a notice for additional information was sent to the beneficiary on January 6, 2020. No additional information was on file to indicate the beneficiary responded to the notice.

   Because the beneficiary did not respond to the notice, CMS reviewed information that should have been available to Connecticut at the time of determination from the DOL. DOL records from the second quarter of 2019 verified income for Wage Earner #1 was $11,777.01 and for Wage Earner #2 was $10,961.52. This gave the family a total monthly household income of $7,579.51 (347 percent of FPL). The highest allowable monthly income limit for a household of four was $7,052.17 (323 percent of FPL). The beneficiary exceeded the income threshold for CHIP.

Connecticut did not concur with the finding. Connecticut responded that a call center agent was responsible for the renewal on January 6, 2020, and the agent did not have a direct source for looking at any data sources for income. Connecticut responded that although the household did not respond to the request to verify income, the PHE rules were in effect and the household remained in continuous enrollment until they stopped paying the premium.

Connecticut responded reported that wages from the second quarter of 2019 were within the ten percent reasonable compatibility threshold. The ten percent reasonable compatibility threshold is used to compare attested income to actual income, not to be used as a discount on actual verified income.

The income exceeded the limit for CHIP and should have been verified. The PHE was not in effect until March 11, 2020, before the date of this audit.

Based on this error, total payments of $2,058.52 (federal and state dollars) were inappropriately paid for the sampled individual during February 2020 of this audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

3. **CMS was unable to determine eligibility due to lack of income verification.**
3.A) The family of five called in a renewal on August 15, 2019, for the coverage period of September 1, 2019, through December 31, 2020. Wage Earner #1 declared income of $1,080 per week or $4,644 monthly. Wage Earner #2 declared income of $540 biweekly or $1,161 monthly. This was a total household income of $5,805 per month. There was no notation in the case notes to indicate what was used for income verification for the August 15, 2019, renewal. With no income verification in the case, eligibility cannot be determined.

Connecticut concurred with this finding. Connecticut agreed that there should be a notation in the case comments to indicate what was used for income verification after the ninety-day reasonable opportunity period to verify attested income.

Based on this error, total payments of $357,230.42 (federal and state dollars) were inappropriately paid for the sampled individual during the audit period.

3.B) A paper renewal was received on November 19, 2018, for the coverage period of January 1, 2019, to December 31, 2019. The household consisted of Wage Earner #1, Wage Earner #2, and two children. CMS reviewers could not determine how Connecticut verified income on Wage Earner #1 and #2, as both were undocumented and without Social Security numbers. No income was declared for Wage Earner #1. On December 6, 2018, Connecticut requested income verification due to non-sequential check stubs,

which were not received. The beneficiary was placed into CHIP Band Two based on Wage Earner #2's declared monthly income of $5,484.56; however, this income was not verified by Connecticut.

The second renewal was by telephone on November 19, 2019, for the coverage period of January 1, 2020, to February 29, 2020. Household composition remained the same. The income for Wage Earner #2 was verified by pay stubs, a monthly income of $5,540.18. No income was declared for Wage Earner #1. The beneficiary correctly remained in CHIP Band Two.

Connecticut concurred with the finding that the Wage Earners' income was not verified for the November 2018 renewal. The income for the household was verified for the November 2019 renewal and the beneficiary was in the correct CHIP category.

Based on this error, total payments of $2,381.02 (federal and state dollars) were inappropriately paid for the sampled individual during September 2019 through December 2019 of the audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

4. **Income was incorrectly calculated resulting in the beneficiary receiving Medicaid when they should have been placed into CHIP.**
A renewal for the beneficiary was hand-carried into the DSS office on July 5, 2019, for the coverage period of August 1, 2019, to October 31, 2019. The Wage Earner reported that they had been married in the previous year. The household consisted of Wage Earner #1, Wage Earner #2, and the beneficiary. The household declared monthly income of $3,782.72 (213 percent of FPL). Connecticut attested that it appropriately verified the declared income against the Data Hub. The beneficiary received SSI and was in transitional medical assistance (TMA) from August 1, 2019, to October 31, 2019. In a case note from November 22, 2019, the system showed the beneficiary as the head of household and working full time; this was a system error, as the beneficiary was a minor. The case was updated to make Wage Earner #1 Head of Household.

On October 29, 2019, Wage Earner #1 applied online for the beneficiary's coverage. The beneficiary was placed into Medicaid for two months (November 2019 and December 2019). The monthly income exceeded the limit for Medicaid of $3,573.78 (201 percent of FPL). The beneficiary should have been placed into CHIP Band One instead of Medicaid.

The second renewal was on November 20, 2019, by telephone, for the coverage period of January 1, 2020, to December 31, 2020. Also, on November 20, 2019, a supervisor saw the case and instructed the case worker to place the beneficiary into CHIP Band One. The

household of three declared monthly income of $4,413.40 (244 percent of FPL). Connecticut verified monthly income in the amount of $4,555.44 (252 percent of FPL) with pay stubs and an employer statement. The beneficiary was correctly placed into CHIP Band One.

Connecticut concurred with the finding, responding that the income was incorrectly zeroed out after an online change was reported on October 31, 2019. Connecticut stated there were no case comments to substantiate the change in income in their eligibility systems.

Connecticut also responded that the system error of the beneficiary being the head of household had no effect on program eligibility. However, when the beneficiary was made head of household, the beneficiary went from CHIP Band One to Medicaid. The beneficiary should have remained in the CHIP Band One category.

Based on this error, total payments of $0.00 (federal and state dollars) were inappropriately paid for the sampled individual during November 2019 and December 2019 of this audit period.

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

CHIP Observations

During the course of the audit, other issues were identified in the sampled cases because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the State's verification plan. Observations and recommendations for the five beneficiaries are described below.

1. **The beneficiary was potentially charged the incorrect premium amount because Connecticut did not always verify and/or use the correct income amount when calculating the premium.**

   1.A) A passive renewal was performed online for a household of four on November 16, 2018, for the coverage period of January 1, 2019, through December 31, 2019. Wage Earner #1 declared monthly self-employment income of $4,113.58. Wage Earner #2 declared monthly income of $2,500.00. Connecticut attested that it appropriately verified the income during the determination process. The income was electronically verified by the Data Hub. The household's total monthly declared income was $6,613.58. The beneficiary was correctly placed into CHIP Band Two with a $50 premium.

   The second renewal was received by Connecticut on November 26, 2019, for the coverage period of January 1, 2020, through December 31, 2020. Wage Earner #1

declared monthly self-employment income of $5,000.00 and Wage Earner #2 declared no income. The beneficiary remained in CHIP Band Two although they should have been placed into CHIP Band One.

Connecticut concurred with this observation. Connecticut stated a system ticket has been created to analyze why CHIP Band Two was granted as the beneficiary was eligible for CHIP Band One.

1.B) A renewal for a household of five was completed via telephone on May 17, 2019, for the coverage period of July 1, 2019, through June 30, 2020. The Wage Earner declared monthly income of $5,805.00 with a $86.00 student loan interest deduction; the monthly income total was $5,719.00 (227 percent of FPL). The beneficiary was renewed under CHIP Band Two but qualified under CHIP Band One at the time of the May 2019, renewal.

Connecticut concurred with this observation. Connecticut stated a system ticket has been created to analyze why CHIP Band Two was granted as the client was eligible for CHIP Band One.

1.C) The renewal on August 14, 2019, was received in paper form for the coverage period of November 1, 2019, to April 30, 2020. Wage Earner #1 declared monthly self-employment income of $2,150 less student loan interest of $208.33 for a net monthly income of $1,941.67. Wage Earner #2 declared monthly income of $5,115.40 monthly. Equifax verified monthly income of $6,463.22. Using the attested income and deductions from Wage Earner #1 and Equifax for Wage Earner #2, provided a total monthly income of $8,404.89 (292 percent of FPL). The beneficiary should have been placed in CHIP Band Two with a $50 premium instead of CHIP Band One.

Connecticut concurred that once the income verification was received the beneficiary should have been placed into CHIP Band Two with a premium. This appeared to be a system error.

1.D) A renewal was submitted online on August 16, 2019, for the coverage period of September 1, 2019, to August 31, 2020. The system incorrectly processed the renewal without questioning unusual student loan interest ($600 per month) for the adult child in home, as well as $185 per month for student loan interest for the Wage Earner. The maximum student loan interest deduction allowed by the IRS annually is $2,500 ($208.33 per month). Amounts allowed on this case were $7,200 and $2,220, respectively. The household of three declared monthly income before the deductions was $5,011.20 (282 percent of FPL). The monthly income limit for a household of three in CHIP Band One was $4,516.12.

Connecticut concurred with this observation. It agreed that there was neither a verification checklist nor any case note requesting any verification located in the case record. It stated that the beneficiary should have been placed into CHIP Band Two instead of CHIP Band One. Connecticut is analyzing why the system placed the

beneficiary in CHIP Band One when the beneficiary was eligible for CHIP Band Two. While it agreed the student loan interest was unusual, it stated that the Department allowed the maximum deduction of $2,500 annually. This appears to be a system error.

1.E) The household of four submitted a renewal on November 1, 2018, for the coverage period of December 1, 2018, through November 30, 2019. Wage Earner #1 attested to yearly self-employment income of $62,682.00, or a monthly income of $5,223.50 (250 percent of FPL). Wage Earner #2 declared no income. At the time of the renewal, a proof of income letter, dated January 16, 2018, was provided for Wage Earner #1 verifying annual self-employment income of $75,298.00, or monthly income of $6,274.83 (300 percent of FPL) in 2017, the latest tax year for which a tax return had been filed. However, because there was more difference than the 10 percent reasonable consideration stated in Connecticut's verification eligibility plan, Connecticut should have asked the household for an explanation of the difference, or better documentation of the self-attested, self-employment income as of November 1, 2018, such as a profit/loss statement.

Annual and self-employment income was electronically verified for both Wage Earners. The beneficiary was placed into CHIP Band One with no premium. The monthly income limit exceeds the limit of $5,313.68 (254 percent of FPL) for CHIP Band One. The beneficiary should have been placed into CHIP Band Two with a $50 premium.

The beneficiary applied again for a renewal into CHIP Band One with no premium on January 14, 2020, for the coverage period of December 1, 2019, through November 30, 2020. Wage Earner #1 reported yearly wages of $62,682.00 of self-employment and Wage Earner #2 reported yearly wages of $10,000.00 of self-employment. The four-person household attested to monthly income of $6,056.83 (277 percent of FPL). Annual and self-employment income was electronically verified for both Wage Earners. However, the household's attested income exceeded the monthly limit for CHIP Band One for a household of four which was $5,545.67 (254 percent of FPL). The beneficiary was incorrectly placed into CHIP Band One with no premium. The beneficiary should have been placed into CHIP Band Two with a $50 premium.

Subsequently, there were several failed income verifications per the case notes. There were no documents on file to verify income for 2019 at the time of the January 2020 renewal. Per case notes on January 14, 2020, there was a system issue in which the case worker had to do a system override to prevent a lapse in coverage resulting in the coverage period changing from January 1, 2020, through December 31, 2020, to December 1, 2019, through November 30, 2020.

Connecticut did not concur that the beneficiary was incorrectly placed in CHIP Band One with no premium. Connecticut responded the renewal period of December 1, 2019, through November 30, 2020, did not have an eligibility determination of HUSKY B Band Two due to the extension of previous Medicaid coverage group eligibility at the start of the PHE.

(However, the PHE was not in effect until March of 2020. Therefore, the income, self-attested and electronically verified in January 2020 placed the beneficiary into HUSKY B Band Two with a $50 premium.)

Recommendation #1: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

Appendix A: Audit Scope and Methodology

Scope

CMS' audit covered Medicaid and CHIP beneficiaries who received services from Connecticut for the period of September 1, 2019, through February 28, 2020 (audit period). While all CHIP beneficiaries were in the population, Medicaid enrollees in the following Medicaid eligibility categories were included in the audit population:

Program or Category of Service	Basis of Eligibility
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules	Non-MAGI
Individuals in Institutions Eligible under a Special Income Level	Non-MAGI
Independent Foster Care Adolescent	Non-MAGI
Medically Needy Populations based on Age, Blindness, or Disability	Non-MAGI
Low Income Families	MAGI
Mandatory Poverty Level Related Pregnant Woman	MAGI
Mandatory Poverty Level Related Children Infants	MAGI
Mandatory Poverty Level Related Children 1-5	MAGI
Adult Expansion	MAGI

CMS limited the review of internal controls to those surrounding the determinations and/or redeterminations of applicant eligibility for Medicaid and CHIP beneficiaries. The testing of controls included a review of supporting documentation at the State to evaluate whether the State determined the applicants' eligibility in accordance with federal and state requirements.

CMS performed fieldwork remotely through secure, online data reviews of eligibility information from the State with the assistance of the Connecticut Department of Social Service employees.

Methodology

To accomplish the objective, CMS:

- Reviewed applicable federal and state laws, regulations, and other requirements related to Medicaid and CHIP eligibility, including Connecticut's Medicaid eligibility verification plan
- Selected a stratified random sample of 226 Medicaid beneficiaries, 225 adult expansion, and 175 CHIP beneficiaries from a total of 585,147, 301,101 and 26,652 beneficiaries, respectively, who were determined or redetermined to be eligible during the audit period
- Obtained application data and documentation to verify the Medicaid or CHIP eligibility of each sampled beneficiary
- Analyzed the State's documentation supporting beneficiaries' eligibility
- Estimated the total number of payments made during the audit period on behalf of actual and potentially ineligible beneficiaries and the dollars associated with those payments,

and

- Calculated an eligibility error rate for both the number of payments and the dollar amounts for both actual and potentially ineligible beneficiaries.

Appendix B: Statistical Sampling Methodology

Target Population

The target population consisted of beneficiaries determined eligible and enrolled in the general Medicaid, adult expansion, and CHIP populations, excluding American Indians and Alaskan Natives, for whom the State made general Medicaid, adult expansion, or CHIP payments for services provided during the audit period.

Sampling Frame

The general Medicaid sampling frame consisted of a database containing 585,147 general Medicaid beneficiaries in Connecticut for whom the State made general Medicaid payments totaling $2,922,041,774 for services provided during the audit period. The adult expansion sampling frame consisted of a database containing 301,101 beneficiaries for whom the State made federal and state Medicaid payments of $1,102,348,018. The CHIP sampling frame consisted of a database containing 26,652 CHIP beneficiaries in Connecticut for whom the State made federal and state CHIP payments totaling $47,800,372 for services provided during the audit period. CMS obtained the data for the general Medicaid, adult expansion, and CHIP beneficiaries from Connecticut's Medicaid Management Information System (MMIS). CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frames.

Sample Unit

The sample unit was a general Medicaid, adult expansion, or CHIP beneficiary.

Sample Size

CMS selected 226 general Medicaid beneficiaries. 225 adult expansion beneficiaries and 175 CHIP beneficiaries

Source of Random Numbers

CMS generated the random numbers using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software called RAT-STATS 2019, their most recent version.[27]

Method for Selecting Sample Units

CMS consecutively numbered the populations of beneficiaries within strata 1 through 7 for general Medicaid and adult expansion; CHIP was numbered within strata 1 through 6. After generating the random numbers for all random strata, CMS selected the corresponding general Medicaid, adult expansion, and CHIP beneficiaries in the sample frame for the sample.

[27] https://oig.hhs.gov/compliance/rat-stats/index.asp

Estimation Methodology

CMS used the OIG/OAS statistical software to estimate the total number of ineligible beneficiaries and potentially ineligible beneficiaries and the total amount of federal and state payments for the ineligible beneficiaries and potentially ineligible beneficiaries for whom the State claimed federal reimbursement.

In addition, CMS determined the percentage of ineligible beneficiaries and potentially ineligible beneficiaries by dividing the estimated number of ineligible beneficiaries and potentially ineligible beneficiaries by the total number of beneficiaries in the sampling frame. CMS also determined the percentage of total dollars expended for ineligible beneficiaries and potentially ineligible beneficiaries by dividing the estimated amount of total dollars expended in error by the total amount of total dollars in the sampling frame.

Appendix C: Medicaid and CHIP Sample Results and Estimates

Sample Results

Table 1.1: Medicaid Sample Details and Results for Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	46	46	$24,023,998.95	0	0
2	3,154	30	$4,450,763.24	3	$333,997.93
3	8,190	30	$2,014,870.57	0	0
4	15,240	30	$1,153,108.83	0	0
5	26,118	30	$647,426.00	0	0
6	75,748	30	$183,658.22	0	0
7	456,651	30	$20,468.44	1	$1,015.40
Totals	**585,147**	**226**	**$32,494,294.25**	**4**	**$335,013.33**

Table 1.2: Medicaid Sample Details and Results for Potentially Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	46	46	$24,023,998.95	1	$308,658.22
2	3,154	30	$4,450,763.24	0	0
3	8,190	30	$2,014,870.57	0	0
4	15,240	30	$1,153,108.83	0	0
5	26,118	30	$647,426.00	0	0
6	75,748	30	$183,658.22	0	0
7	456,651	30	$20,468.44	0	0
Totals	**585,147**	**226**	**$32,494,294.25**	**1**	**$308,658.22**

Table 2.1: Adult Expansion Sample Detail and Results for Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	26	26	$11,932,603.31	0	0
2	1,661	30	$3,049,344.10	2	$178,476.97
3	4,619	30	$1,287,853.13	0	0
4	9,569	30	$647,085.56	0	0
5	18,945	30	$320,802.75	0	0
6	43,436	32	$139,195.52	0	0
7	222,845	47	$24,985.452	1	$00.00
Totals	**301,101**	**225**	**$17,401,870.12**	**3**	**$178,476.97**

Table 3.1: CHIP Sample Detail and Results for Ineligible Beneficiaries

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	23	23	$6,279,694.96	2	$408,593.24
2	193	30	$1,182,838.40	0	0
3	734	30	$359,524.57	1	$2,058.52
4	2,079	30	$132,105.68	2	$3,007.72
5	5,115	30	$53,168.03	1	$2,381.02
6	18,508	32	$11,811.97	0	0
Totals	**26,652**	**175**	**$8,019,143.61**	**6**	**$416,040.50**

Estimates

Table 4.1: Medicaid Estimated Number of Ineligible Beneficiaries and Value of Improper Payments
(Limits Calculated at the 90-Percent Confidence Level)

	Estimated Total Number of Ineligible Beneficiaries	**Estimated Total Value of Payments for Ineligible Beneficiaries**
Point estimate	15,537	$50,570,430.89
Lower limit	-9,501	$9,637,402.37
Upper limit	40,575	$91,503,457.51

Table 4.2: Medicaid Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Ineligible Beneficiaries	15,537
	Total Number of Medicaid Beneficiaries in Sample Frame	2.66% 585,147
Dollar Value of Payments	Estimated Total Dollars Associated With Ineligible Beneficiaries	$50,570,430.89
	Total Dollars in Sample Frame	1.73% $2,922,041,774.40

Table 5.1: Medicaid Estimated Number of Potentially Ineligible Beneficiaries and Value of Potentially Improper payments
(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Potentially Ineligible Beneficiaries	**Total Value of Potentially Improper Payments**
Point estimate	1	$308,658.22
Lower limit	1	$308,658.22
Upper limit	1	$308,658.22

Table 5.2: Medicaid Calculation of Overall Rate of Potentially Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Potentially Ineligible Beneficiaries	1
		2.17%
	Total Number of Beneficiaries in Sample Frame	46
Dollar Value of Payments	Estimated Total Dollars Associated with Potentially Ineligible Beneficiaries	$308,658.22
		1.28%
	Total Dollars in Sample Frame	$24,023,998.95

Table 6.1: Adult Expansion Estimated Number of Ineligible Beneficiaries and Value of Improper Payments
(Limits Calculated at the 90-Percent Confidence Level)

	Estimated Total Number of Ineligible Beneficiaries	**Estimated Total Value of Payments for Ineligible Beneficiaries**
Point Estimate	4,852	$9,881,674.91
Lower Limit	-2,947	$-6,201,911.72
Upper Limit	12,651	$25,965,261.53

Table 6.2: Adult Expansion Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Ineligible Beneficiaries	4,852
		1.61%
	Total Number of Medicaid Beneficiaries in Sample Frame	301,101
Dollar Value of Payments	Estimated Total Dollars Associated With Ineligible Beneficiaries	$9,881,674.91
		0.90%
	Total Dollars in Sample Frame	$1,102,348,018.49

Table 7.1: CHIP Expansion Estimated Number of Ineligible Beneficiaries and Value of Improper Payments
(Limits Calculated at the 90-Percent Confidence Level)

	Estimated Total Number of Ineligible Beneficiaries	**Estimated Total Value of Payments for Ineligible Beneficiaries**
Point estimate	336	$1,073,357.27
Lower limit	12	$321,223.26
Upper limit	659	$1,825,491.28

Table 7.2: CHIP Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of Ineligible Beneficiaries	336
		1.26%
	Total Number of Medicaid Beneficiaries in Sample Frame	26,652
Dollar Value of Payments	Estimated Total Dollars Associated With Ineligible Beneficiaries	$1,073,357.27
		2.25%
	Total Dollars in Sample Frame	$47,800,372.03

Appendix D: Beneficiary Eligibility Audit Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Connecticut ensure that income and resources are identified, verified, and calculated correctly. Additionally, in accordance with §§ 435.1200(b)(3)(iii) and 435.912, CMS recommends that Connecticut ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.	**X**	
Recommendation #2	In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, Connecticut should perform an annual renewal of Medicaid, including adult expansion services, and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility.	**X**	
Recommendation #3	In accordance with § 435.119(b)(3), CMS recommends that Connecticut ensure timely actions are taken to close cases once the beneficiary is eligible for or enrolled in Medicare.	**X**	
Recommendation #4	In accordance with § 435.912, CMS recommends that Connecticut ensure timely actions are taken to close cases no longer requiring services to reduce the risk that inappropriate or fraudulent claims could be billed for Medicaid or CHIP services using those beneficiaries' active case numbers.	**X**	

Acknowledged by:

Derrick Perry, Public Assistance Consultant

[Name], [Title]

07/05/2023

Date (MM/DD/YYYY)