Department of Health and Human Services

Centers for Medicare & Medicaid Services
Center for Program Integrity

Missouri Medicaid and CHIP Beneficiary Eligibility Determinations Audit

Audit period: September 2019 through February 2020

Final Report

October 2023

Table of Contents

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) conducted an audit of the Missouri Department of Social Services' (hereinafter referred to as Missouri) 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 to 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, Missouri correctly determined Medicaid and CHIP eligibility in accordance with federal and state requirements for 95.29 percent and 77.7 percent of the sampled beneficiaries, respectively. This audit also determined that, during the audit period, Missouri made improper or potentially improper Medicaid payments totaling $688,913.97 (federal share) for the 8 sampled ineligible or potentially ineligible beneficiaries. During the audit period, Missouri also made improper or potentially improper CHIP payments totaling $1,343,735.03 (federal share) for the 39 sampled ineligible or potentially ineligible beneficiaries.[1] CMS' current authority[2] allows overpayments to be recovered only through the Payment Error Rate Measurement Program (PERM), thus CMS will not recover the federal payments associated with the ineligible beneficiaries identified as a result of this audit.[3]

For most eligibility determinations in the samples, Missouri 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, Missouri requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible[4] with electronic sources in accordance with the State's verification plan (§

[1] Extrapolation was not performed on the results of the review to determine the estimated number of ineligible or potentially ineligible beneficiaries, or the estimated overpayments based on the samples' findings. The accuracy rates for Medicaid and CHIP were calculated by dividing the estimated number of ineligible and potentially ineligible beneficiaries by the total number of beneficiaries in the sampling frame (175) to arrive at the percent of overall accuracy, 95.29 and 77.7 percent, respectively.
[2] Section 1903(u) of the Social Security Act
[3] Appendix C includes additional information on the improper payment calculations.
[4] 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)

435.952(c)(2)). Additionally, this audit found that Missouri verified citizenship or immigration status by electronically verifying citizenship status with the SSA or immigration status with the Department of Homeland Security (DHS).[5]

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

Recommendation #1: In accordance with §§ 435.912 and 447.10, CMS recommends that Missouri ensure timely actions are taken to close cases in both the eligibility system and the Medicaid Management Information System (MMIS), when beneficiaries are found to be ineligible. When Missouri takes an action to close a case, Missouri must also close the beneficiary's case within the claims payment system to ensure payments are only made for eligible Medicaid or CHIP beneficiaries.

Recommendation #2: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Missouri 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 Missouri ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

Recommendation #3: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[6] Missouri should perform an annual renewal of Medicaid and CHIP eligibility every 12 months, and no more frequently than once every 12 months, to ensure beneficiaries maintain their eligibility.

Recommendation #4: In accordance with § 457.320(a)(2), CMS recommends that Missouri consider implementing system fixes, to ensure capitated payments and other health related payments do not continue to be made on behalf on beneficiaries after they have reached the age of 19.[7] (Since this audit was conducted, Missouri has implemented the recommendation; however, this recommendation will remain for purposes of this report, as it was accurate at the time of this audit).

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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 Missouri, 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 10 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. (Missouri Based Eligibility Verification Plan).

[5] §§ 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

[6] Keeping People Covered As States Restart Routine Medicaid Renewals. Retrieved September 11, 2023, from https://www.medicaid.gov/sites/default/files/2023-06/renewals-all-hands-on-deck-fact-sheet_0.pdf

[7] § 457.320. Other eligibility standards. To the extent consistent with title XXI of the Act, the State plan may adopt eligibility standards of Age (up to, but not including age 19). Retrieved January 31, 2023, from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-C/section-457.320

Missouri'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 72.5 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 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.

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[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 September 11, 2023, from https://www.medicaid.gov/medicaid/eligibility/index.html

States operate and fund Medicaid and CHIP in partnership with the Federal Government. 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. Missouri's regular Medicaid and CHIP FMAPs for the audit period (September 2019 through February 2020) were 65.65 percent and 87.46 percent, respectively. Congress authorized an enhancement to the regular FMAPs due to the COVID-19 Public Health Emergency, which increased Missouri Medicaid and CHIP FMAPs to 71.85 percent and 91.80 percent, respectively, for the portion of the audit period for January and February 2020.[11]

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.[12] 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).[13]

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. The MAGI-based methodology generally considers taxable income and tax filing relationships to determine financial eligibility for Medicaid.[14] States must complete renewals once every 12 months and no more frequently than once every 12 months for groups eligible based on MAGI.[15] 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.[16] At the time of the audit period, Missouri was not participating in the Adult Expansion program. Missouri has since implemented the Adult Expansion program. The ACA

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

[12] Medicaid.gov. Adult Coverage Expansion Map as of July 2021. Retrieved August 11, 2021, from www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map-10-2021.pdf.

[13] 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.

[14] Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved August 11, 2021, from https://www.medicaid.gov/medicaid/eligibility/index.html

[15] Regulations at 42 CFR § 435.916 describe the periodic renewal of Medicaid eligibility.

[16] 42 CFR § 433.10(c)(6).

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.[17] 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.[18] 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[19]).

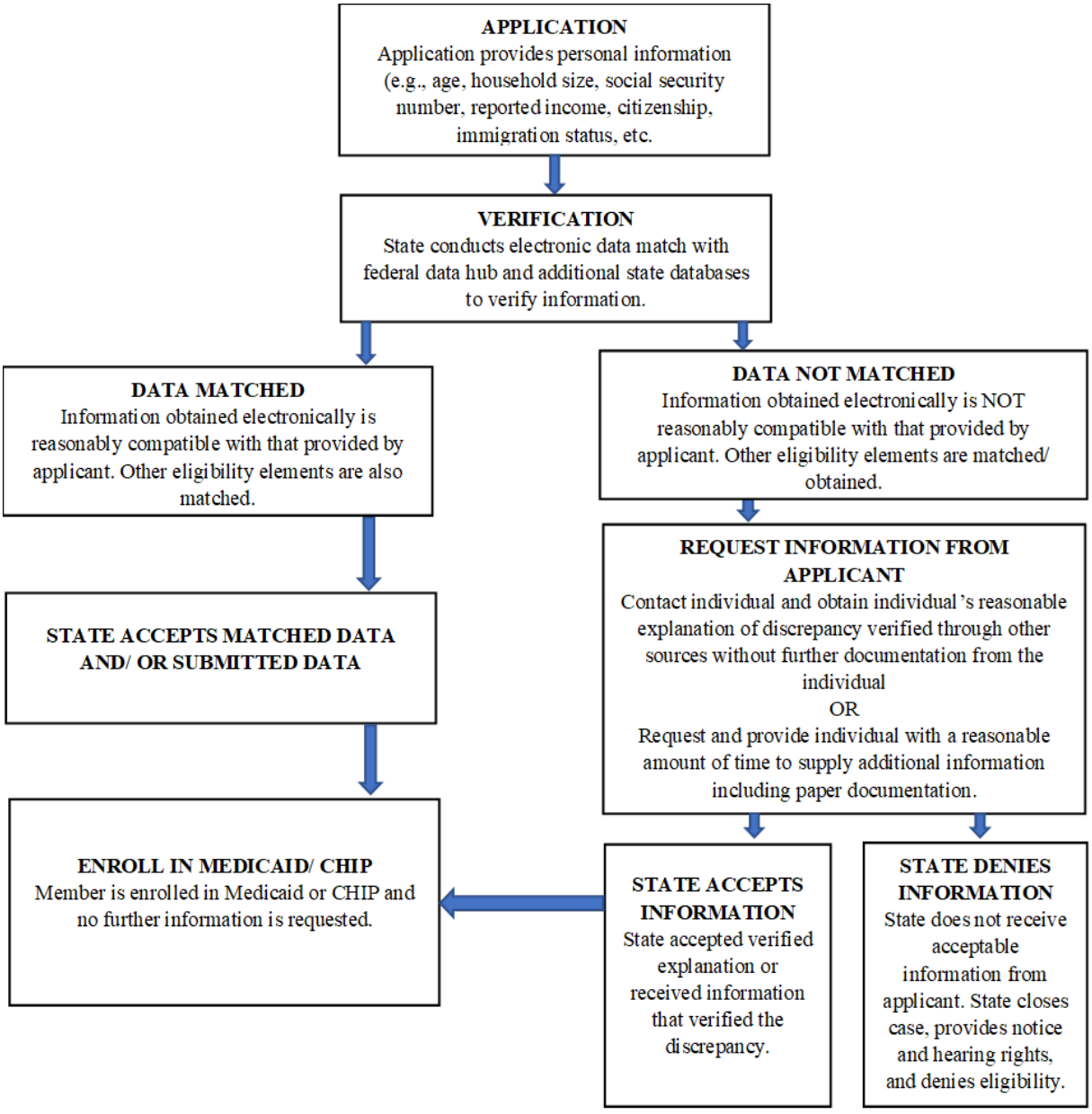
Regulations at §§ 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state. States must submit their verification plans to CMS upon request and provide updated versions of the plans to CMS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

[17] Regulations at 42 CFR §§§ 435.945, 435.948, and 435.956 describe income and eligibility verification requirement.
[18] 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
[19] 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 Missouri's Medicaid and CHIP Eligibility Processes

Individuals seeking coverage may apply online, 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).[20] The data sources used by Missouri through the Data Hub are provided by HHS, the SSA, the DHS, and the IRS, among others. Missouri also uses data sources maintained by the State, such as the SWICA.

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



[20] Missouri 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 Missouri's Medicaid and CHIP Eligibility Determinations Audit

In July 2021, CMS conducted an audit of Missouri's Medicaid and CHIP eligibility determinations for the audit period of September 2019 through February 2020.[21] During the audit, CMS identified four recommendations and three observations. This audit assessed how well Missouri complied with Missouri's MAGI verification plan as well as other federal regulatory requirements.

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

The audit encompassed the following four areas:

A. State Oversight of Eligibility Determinations. 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. Utilization of the Data Hub to Determine Financial Eligibility. 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 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. Non-Financial Elements of Eligibility. 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.[22] 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.

D. Required Annual Renewals of Medicaid and CHIP Beneficiaries. In accordance with § 435.916, periodic renewal of Medicaid eligibility, the eligibility of Medicaid beneficiaries

[21] 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.
[22] https://www.ecfr.gov/current/title-42/section-435.406 Citizenship and non-citizen eligibility.

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

Missouri correctly determined Medicaid eligibility in accordance with federal and state requirements for 95.29 percent of the sampled Medicaid beneficiaries (167 of 175 Medicaid beneficiaries sampled). CMS identified three findings in which Missouri's MMIS continued to generate capitated payments and other health-care related payments after the cases were closed. In addition, CMS identified one finding in which Missouri did not correctly calculate income when determining eligibility. CMS also identified four potentially improper eligibility determinations in which there was no required renewals conducted for the audit period.

Based on the results of this audit, Missouri made improper or potentially improper payments totaling $688,913.97 for the 8 sampled ineligible and potentially ineligible beneficiaries.

CHIP

Missouri correctly determined CHIP eligibility in accordance with federal and state requirements for 77.7 percent of the sampled CHIP beneficiaries (136 of 175 CHIP beneficiaries sampled). CMS identified findings for 39 improper eligibility determinations in which Missouri did not always include or calculate all applicable income correctly. CMS also identified observations in which eligibility was determined correctly for three cases, but the monthly premium was assessed incorrectly.

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. Beneficiary cases were closed through Missouri's eligibility and enrollment system; however, capitated payments and other health-care related payments for the beneficiaries continued to be made through Missouri's MMIS throughout the audit period.

1.A) Missouri determined the Aged, Blind and Disabled (ABD)-209(b) beneficiary was ineligible and closed the case on January 14, 2019; however, the MMIS continued to pay claims throughout the audit period.

Based on this error, total payments of $610,672.40 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.B) On July 5, 2019, Missouri mailed a renewal to the ABD-209(b) beneficiary for the next renewal period of July 1, 2019, through June 30, 2020. The beneficiary declined to submit the renewal stating they had too many assets to qualify for a household of one. The case was closed on February 7, 2019; however, the MMIS continued to pay claims throughout the audit period.

Based on this error, total payments of $24,045.78 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.C) A renewal was received in the mail on September 7, 2018 for the coverage period of September 1, 2018 through August 31, 2019. The beneficiary was enrolled in the mandatory poverty level related (MPLR) Children, Aged 6-18 group. Missouri closed the case on February 10, 2019; however, the MMIS continued to pay claims throughout the audit period.

Based on this error, total payments of $995.53 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #1: In accordance with §§ and 435.912 and 447.10, CMS recommends that Missouri ensure timely actions are taken to close cases in both the eligibility system and the MMIS when beneficiaries are found to be ineligible. When Missouri takes an action to close a case, Missouri must also close the beneficiary's case within the claims payment system to ensure payments are only made for eligible Medicaid or CHIP beneficiaries.

2. Missouri did not verify incomes, either through data matches or requests for documentation, when determining eligibility for this beneficiary.
The beneficiary, belonging to a household of four, was enrolled in the MPLR Children, Aged 6-18 category of service. The beneficiary's renewal was received in the mail on April 3, 2019, for the coverage period of April 1, 2019 through March 31, 2020. The Wage Earner had a bi-weekly income of $608.68 and a monthly contribution of $866.60, which were last verified in 2016. Missouri should have verified income, either through data matches or requests for documentation, when determining eligibility for this beneficiary for renewal covering the audit period.

Based on this error, total payments of $3.123.59 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #2: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Missouri 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 Missouri 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 findings and recommendations for the four potentially ineligible beneficiaries are described below.

1. CMS was unable to verify Medicaid eligibility due to a failure to conduct an annual renewal covering the audit period.

1.A) CMS reviewers were unable to verify Medicaid eligibility because there was not an annual renewal covering the sample audit period. On August 3, 2018, an auto renewal was mailed out for the eligibility period of September 2018 through August 2019. The beneficiary was in the Low-Income Families' categories of service group. In December 2018, a household member aged out, causing a systematic renewal for December 2018, through December 2019.

Missouri failed to redetermine eligibility beyond December 2018. There was no verification of income as required when there was a change in household circumstances such as a change in household composition.

In February 2020, the beneficiary became a Parent/Caretaker, and in March 2020, the system was identified as having a certification period that ended in the past. The system extended the certification period two years from the last certification end date without verifying household size or income as required when changing category of service groups (a change from Low-Income Families to Parent/Caretaker). The extended certification period was from December 2019 to December 2021.

Based on this error, total payments of $42,110.53 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.B) CMS reviewers were unable to verify Medicaid eligibility for this sampled beneficiary who appeared to have current eligibility status in the MPLR Children, Aged 6-18 category of service group; however, there was not a required annual renewal covering the audit period. An application for the household of four was received September 14, 2017, for the coverage period of September 1, 2017, through September 30, 2019. Pursuant federal regulations, coverage periods are 12 months rather than two years.

The second renewal was received on October 24, 2019. This was for the coverage period of October 1, 2019, through September 30, 2020. The beneficiary was in the MPLR Children, Aged 6-18 category of service, when income was reported for this period.

Updates were reported between 2017-2019, but the next renewal was not received until October 24, 2019. Reported income ended February 28, 2017, and therefore, no earnings were considered during 2017-2019. CMS was unable to verify if the household had income until the next renewal was received in October 2019.

The Wage Earner reported monthly income of $947.50, based on provided paystubs at the October 2019 renewal. Based on the Wage Earner's income, the beneficiary should have qualified as MPLR, Aged 6-18 category of service for September 2019 and had a renewal done prior to October 2019.

Based on this error, total payments of $5,588.74 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.C) CMS was unable to verify Medicaid eligibility for this beneficiary residing in the MPLR Children, Aged 1-5 category of service, because there was not an annual renewal covering the sample audit period. The beneficiary's date of birth February 13, 2014, eligibility began as a deemed newborn in Missouri's legacy system. Per Missouri's SME (Subject Matter Expert), this was a protected case and general staff could not view the case or any of its details. This was considered a bypass case and was on a waiting list to be entered into Missouri's new system; there was no documentation available for the case review.

Based on this error, total payments of $1,359.13 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.D) CMS was unable to verify Medicaid eligibility in the MPLR Children, Aged 6-18 category of service group because there was not an annual renewal covering the sample audit period. There was a renewal performed in February 2018, covering the period of February 1, 2018, through January 31, 2019, but there were no renewals after that period. The case was closed in February 2020, more than a year after the end of the last renewal, because Missouri became aware that the beneficiary had moved out of state. Although Missouri closed the case in February 2020, payments for health-related services continued.

Based on this error, total payments of $1,017.27 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

Recommendation #3: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, CMS recommends Missouri perform an annual renewal of Medicaid and CHIP eligibility every 12 months, and no more frequently than once every 12 months, to ensure beneficiaries maintain their eligibility.

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 27 ineligible beneficiaries are described below.

1. The beneficiaries were not eligible for CHIP coverage and should have been covered under Medicaid.

1.A) The household of two originally applied for health care through the Marketplace on July 18, 2016. There were no reviews or other applicable program applications noted until a SNAP (Supplemental Nutrition Assistance Program) application, dated July 26, 2019. The SNAP application was used for the coverage period of July 1, 2019, through July 31, 2020. Annual income of $5,324 was used by Missouri, an FPL of 31 percent. The beneficiary should have been placed into Medicaid rather than CHIP.

Based on this error, total payments of $422,597.01 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.B) A renewal was received in the mail in June 2019 for the coverage period of June 1, 2019, through July 31, 2020. Missouri certified the renewal with income from the previous certification rather than use the household's current declaration of no income. The Wage Earner marked that the household was unemployed and had no income. Missouri should have verified the unemployment and ultimately used no income if the verification came back correctly. In no instance should income from the prior period be used as current year income. The beneficiary should have been placed in Medicaid.

Based on this error, total payments of $193,864.92 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.C) A renewal was received in the mail on October 1, 2018, for the household of five. The renewal was not processed until March 6, 2019, five months later, for a coverage period of March 1, 2019, through February 29, 2020. Income declared was $29,693, which was verified by the State Wage file. This was an FPL of 98 percent for the household. The beneficiary should have been placed in Medicaid.

Based on this error, total payments of $123,412.80 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.D) An application was received in the mail on August 19, 2019, for the coverage period of August 1, 2019, through July 31, 2020. The household of four declared monthly income of $2,093 verified by paystubs. This was an FPL of 98 percent. The beneficiary should have been placed into Medicaid rather than CHIP.

Based on this error, total payments of $78,848.30 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.E) Missouri received the renewal by mail on July 16, 2019, for the household of seven for the coverage period of July 1, 2019, through June 30, 2020. The household declared monthly income of $3,374.21, an FPL of 104 percent. The Wage Earner provided three paystubs, one of which was not sequential. Using the two sequential paystubs, the monthly income was $2,401.88, an FPL of 74 percent. Missouri continued to use the household's declared income rather than use the independence and validity of the provided paystubs. Using the provided paystubs, the beneficiary should have been placed into Medicaid rather than CHIP.

Based on this error, total payments of $8,072.54 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.F) A renewal received on August 26, 2019, was not processed until June 17, 2020, for the coverage period of August 1, 2019, through July 31, 2020. Wage Earner #1 had a monthly income of $2,305 which was verified by a telephone call to the employer on June 17, 2020. The employer also verified the income ended in May of 2020.

According to the Income Maintenance and Employment Security Interface (IMES) the last quarter the Wage Earner #2 had income was the third quarter of 2018. This terminated income from Wage Earner #2 continued to be coded on the case throughout the sample audit period. The household of six had a CHIP premium of $115. Without the Wage Earner #2's income, the case would have been Medicaid as their FPL was 76 percent.

Based on this error, total payments of $1,194.03 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.G) The beneficiary's household of five turned in a renewal in February 2019; however, the renewal was not reviewed by Missouri until June 2019 for a coverage period of June 1, 2019, through May 31, 2020. Non-sequential check stubs were used for determining income without any explanation. Two checks stubs were from December 2018 and the other two used were from February 2019. Additionally, Missouri used net income instead of gross income on one of the check stubs in their calculation of income. Using only the two sequential check stubs from February 2019, the household's monthly income was $1,806.21 with an FPL of 72 percent. The beneficiary should have been placed in Medicaid rather than CHIP.

Based on this error, total payments of $896.99 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.H) The case was closed on July 8, 2019. The household of four reapplied for coverage on August 22, 2019. The household requested coverage for June 2019, but they had already received coverage through all of June 2019. The household income was $1,908 monthly, an FPL of 88.95 percent. The beneficiary should have been placed in Medicaid rather than CHIP.

Based on this error, total payments of $709.38 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #2: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Missouri 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 Missouri ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

2. Missouri did not verify incomes, either through data matches or requests for documentation, when determining eligibility for the beneficiaries.

2.A) A mailed in renewal was received by Missouri on April 8, 2019, for the household of seven. Income of $5,002 was declared by the household for the coverage period of April 1, 2019, through March 31, 2020. Wage Earner #1 reported weekly income of $705, for a monthly income of $3,031.50 and Wage Earner #2 reported $1,947.45 monthly for a total monthly income of $4,978.95. There were no supporting documents or comments found to verify the income and Missouri attested that the data was not matched against the Data Hub.

Based on this error, total payments of $2,547.19 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

2.B) Missouri received the mailed renewal on April 2, 2019, for the coverage period of April 1, 2019, through March 31, 2020. The review was not completed until April 16, 2020. The beneficiary declared monthly income of $6,500 or 359 percent FPL and was over income; however, the beneficiary retained eligibility. Cases that were backlogged due to a lack of resources, were to be screened for eligibility as they were received. It does not appear that this case was screened.

When this case was processed in April 2020 Missouri applied CMS' COVID-19 rules.[23] This case should have been processed and coverage terminated by Missouri one year earlier in April 2019, prior to the release of the COVID-19 rules. At this time, the beneficiary's household was over income for CHIP with an FPL of 359 percent.

Based on this error, total payments of $2,194.01 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

2.C) A renewal for the household of four was received in February 2019, but not processed until August 2019 for the coverage period of August 1, 2019, through July 31, 2020. The financial eligibility was completed with incomplete and outdated self-employment and rental income information. Missouri attested that they used a tax return from 2014 to verify self-employment and rental income rather than requesting a more up-to-date tax return.

Based on this error, total payments of $1,017.27 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

2.D) The beneficiary's renewal was received by Missouri on July 17, 2019, for the coverage period of August 1, 2019, through June 30, 2020. The renewal for the household of two was

[23] 42 CFR § 433.400. Continued enrollment for temporary FMAP increase.

certified using income from June 17, 2018, $2,399.97 monthly, which was from the prior period renewal. Missouri should review and verify recent income, as well as other changes with each new renewal.

The IMES ran again on July 26, 2021, and verified the Wage Earner had earnings the entire year of 2019 and in the first quarter of 2020.

Based on this error, total payments of $304.93 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #2: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Missouri 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 Missouri ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

3. The beneficiary's case was closed through Missouri's eligibility and enrollment system; however, capitated payments and other health-care related payments continued to be made through Missouri's MMIS on behalf of the beneficiary throughout the audit period.

An application was received in May 2014. There were no renewals since 2014 for the household of three. A closing notice was sent to the household on June 6, 2019, for failure to renew. MEDES (Missouri Eligibility and Enrollment System) shows the case closed in June 2019; however, the MMIS shows case was open at the time of the audit. The MMIS continued to make health-care related payments on behalf of the beneficiary during the audit period.

Based on this error, total payments of $13,927.18 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

Recommendation #1: In accordance with §§ and 435.912 and 447.10, CMS recommends that Missouri ensure timely actions are taken to close cases in both the eligibility system and the MMIS, when beneficiaries are found to be ineligible. When Missouri takes an action to close a case, Missouri must also close the beneficiary's case within the claims payment system to ensure payments are only made for eligible Medicaid or CHIP beneficiaries.

4. Under federal law beneficiaries are eligible for CHIP up to age 19. However, these cases remained open and capitated and other health care related payments continued to be made for several months after the beneficiaries' 19th birthdays.

4.A) The household submitted a renewal by mail on August 1, 2019, for the coverage period of August 2019 through July 2020. The renewal was approved by Missouri after the beneficiary turned 19 on June 1, 2019, prior to the beginning of the audit period (September 2019 through February 2020). The case was not closed until August 20, 2020.

Based on this error, total payments of $994.12 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.B) Missouri received a mailed in renewal on June 18, 2018. A system issue caused the case not to process appropriately and arrive at a final determination of eligibility until September 17, 2019.

The beneficiary turned 19 on December 24, 2018, and should have been removed from the case. Missouri should have removed the beneficiary in December 2018.

Based on this error, total payments of $669.09 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.C) The last manual review performed on this case was for the coverage period ending November 30, 2018. The beneficiary turned 19 on May 2, 2019, prior to the beginning of our sample audit period (September 2019 through February 2020). The beneficiary should have been removed from the case. The beneficiary remained on the open case until September 30, 2020.

Based on this error, total payments of $568.55 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.D) The household of four mailed in a renewal received by Missouri on February 12, 2019. The coverage period was from February 1, 2019, through August 31, 2020. The beneficiary turned 19 on July 11, 2019, prior to the beginning of our sample audit period (September 2019 through February 2020). The beneficiary should have been removed from the case.

Based on this error, total payments of $554.79 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.E) There were no renewals or applications since the beneficiary's original application from August 29, 2014. On this original application the family of four had an FPL of 216 percent with a premium of $195. Coverage and premiums remained the same until the case was closed on September 14, 2020. The beneficiary turned 19 on May 4, 2019, and should have been removed from the case.

Based on this error, total payments of $447.47 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.F) The beneficiary turned 19 on May 11, 2019, prior to the beginning of the sample audit period (September 2019 through February 2020). The case was not closed until August 2020. The beneficiary's payment coverage continued until February 9, 2021.

Based on this error, total payments of $331.23 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.G) In April 2019 the household reported that the beneficiary was turning 19 on July 2, 2019. Rather than remove the beneficiary from the case, the reported change caused the case

to reset the end date of the coverage period to April 30, 2020. The beneficiary was not removed from the case until September 25, 2020.

A renewal for the household of four was received September 17, 2018, for the coverage period of September 1, 2018, through October 31, 2019. No review of the case was conducted after 2018, and the 2017 income remained on the case. In 2017 the FPL was calculated to be 186 percent with a monthly premium of $29. The household continued to pay this premium throughout the sample audit period.

Based on this error, total payments of $295.06 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.H) Missouri received the mailed application for the household of three on July 17, 2019, for the coverage period of July 1, 2019, through December 31, 2020. The beneficiary turned 19 on July 21, 2019, prior to the beginning of the sample audit period (September 2019 through February 2020). The beneficiary should have been removed from the case.

Based on this error, total payments of $276.22 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.I) The household of seven's renewal was received by Missouri on September 27, 2018, for the coverage period of November 1, 2018, through October 31, 2019. A system issue caused the system not to recognize the certification end date and the period was extended to October 31, 2020. The beneficiary turned 19 on April 12, 2019, and should have been removed from the case.

Based on this error, total payments of $ 226.59 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.J) Missouri received a mailed in application on September 25, 2019, for the coverage period of September 1, 2019, through September 30, 2020. The household of four declared monthly income of $1,022, or 58 percent of FPL, which Missouri attested to being verified by the Data Hub.

The renewal was approved by Missouri after the beneficiary had turned 19 in September 2018, prior to the beginning of the sample audit period (September 2019 through February 2020). The case was not closed until August 7, 2020.

Based on this error, total payments of $215.41 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.K**)** The beneficiary turned 19 on April 4, 2019, prior to the beginning of the sample audit period (September 2019 through February 2020). The case was not closed until August 8, 2020. The case was closed when Missouri did a sweep of all beneficiaries past the age of 18.

Based on this error, total payments of $137.87 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.L) The beneficiary had two distinct DCNs (department client number)[24]. One was closed appropriately when the beneficiary reached the age limit for the program. The other DCN inappropriately remained open; the beneficiary continued to receive coverage with no premium. This DCN was closed in August 2019. By federal regulation, the beneficiary should have been removed from the case in 2016 when they turned 19 years old. The beneficiary aged out prior to the beginning of the sample audit period (September 2019 through February 2020).

Based on this error, total payments of $31.40 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

4.M) The beneficiary turned 19 on April 15, 2018. Missouri received a mailed in renewal on February 13, 2019, for the household of four. It was certified for the coverage period of February 1, 2019, through February 29, 2020. By federal regulation, the beneficiary should have been removed from the CHIP case when the beneficiary turned 19 years old in April 2018. The beneficiary aged out prior to the beginning of the audit period (September 2019 through February 2020) but was not removed from CHIP coverage until October 2019.

Based on this error, total payments of $22.12 (federal dollars) were inappropriately paid for the months of September and October 2019, for the sampled individual during the audit period.

Recommendation #4: In accordance with § 457.320(a)(2), CMS recommends that Missouri consider implementing system fixes, to ensure capitated payments and other health related payments do not continue to be made on behalf on beneficiaries after they have reached the age of 19. Since this audit was conducted, Missouri has implemented this recommendation.

5. The beneficiary was certified as Medicaid during the audit period. The beneficiary's previous certification was in M-CHIP. Missouri erroneously continued to pay claims using CHIP's higher FMAP rather than the Medicaid FMAP the beneficiary was entitled to receive.

The household of two's renewal was received in the mail on March 12, 2019. The renewal was not processed until December 6, 2019, resulting in a new coverage period of April 1, 2019, to December 31, 2020. The renewal was appropriately processed as a Medicaid Low-Income Families' category of service case. The beneficiary had been in a M-CHIP category of service case through March 31, 2019. After the renewal was processed placing the beneficiary into a Low-Income Families' case, it appears that the MMIS continued to have this case coded as a CHIP case. Claims were inappropriately paid at CHIP's higher FMAP rather than the Medicaid FMAP the beneficiary was entitled to receive.

Based on this error, total payments of $259,893.57 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

[24] DCN stands for department client number in Missouri, also known as document control number.

Recommendation #1: In accordance with §§ 435.912 and 447.10, CMS recommends that Missouri ensure timely actions are taken to close cases in both the eligibility system and the MMIS, when beneficiaries are found to be ineligible. When Missouri takes an action to close a case, Missouri must also close the beneficiary's case within the claims payment system to ensure payments are only made for eligible Medicaid or CHIP beneficiaries.

Potential CHIP 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 findings and recommendations for the twelve potentially ineligible beneficiaries are described below.

1. CMS was unable to verify CHIP eligibility due to a failure to conduct an annual renewal covering the audit period.

1.A) The last renewal conducted on this beneficiary was in December 2013. System issues caused the eligibility to be held over year after year without a renewal. Missouri was aware of the system issues. The beneficiary was not covered by any renewal during the sample audit period.

Based on this error, total payments of $195,232.19 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.B) No renewal had been completed on this case since 2016 for this household of two. A renewal was received in the mail on June 15, 2019, for the coverage period for June 1, 2019, through May 31, 2020. As of the time of this audit, this renewal had not been completed.

Based on this error, total payments of $8,407.57 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.C) The original application was received in April 2016 for the coverage period of February 1, 2016, through January 31, 2017. There were no renewals or subsequent applications since the February 2016 coverage period, but the case was never closed.

Based on this error, total payments of $5,034.10 (federal dollars) were inappropriately paid for the sampled individual during the audit period.

1.D) The household of four submitted a renewal by mail on January 7, 2019, for the coverage period of January 1, 2019, through December 31, 2019. No required renewal, *ex parte* or otherwise, was conducted after the coverage period ended, however, eligibility continued.

Based on this error, total payments of $2,265.35 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.E) No renewal was found in the case record for the sampled beneficiary after the coverage period of January 1, 2019, through December 31, 2019. There was no active renewal; however, the beneficiary continued to remain covered.

Based on this error, total payments of $1,815.20 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.F) A renewal for the family of four was received on October 8, 2019, for the coverage period of October 1, 2019, through September 30, 2020. The renewal was not processed until June 26, 2020, eight months later, due to a backlog of reviews.

Based on this error, total payments of $1,772.21 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.G) The household of four submitted a renewal by mail on January 7, 2019, for the coverage period of January 1, 2019, through December 31, 2019. No renewal was conducted after the coverage period ended; however, coverage continued.

Based on this error, total payments of $1,412.45 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.H) The SME stated there was an error in the system causing the case to be bypassed. Bypass cases are maintained in Missouri's legacy system. The bypass process is managed separately, and the SME could not access information concerning renewals, updated FPL, or income information. Information available was from a 2015 application. Missouri has been working to get the bypass cases from the legacy system into the main system so that annual renewals are conducted automatically.

Based on this error, total payments of $1,244.00 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.I) The household of four mailed in a renewal to add a child, which caused Missouri to conduct a "floating" renewal on February 2, 2018. Missouri should have followed up with a complete eligibility renewal. Income from 2016 of $44,313 annually, an FPL of 167 percent remained on the case record with a premium of $29 at the time of this review, July 2021.

Based on this error, total payments of $931.36 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.J) A telephone application was received by Missouri on January 23, 2017, for the coverage period of January 1, 2017, through December 31, 2017, for the household of two. No review of the case was conducted in 2018 or 2019. On November 11, 2019, a renewal notice was sent out but not returned. The case closed in December 2019.

Based on this error, total payments of $589.08 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.K) The renewal for the household of one was received in the mail on March 19, 2019, for the coverage period of March 2019 through February 2020. The renewal was not processed until April 2020.

Based on this error, total payments of $9,754.57 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

1.L) Missouri received the renewal for the beneficiary on April 25, 2019, but it was not processed until January 8, 2020. The coverage period began on June 1, 2019, and was extended through January 31, 2021.

Based on this error, total payments of $1,062.89 (federal dollars) were potentially inappropriately paid for the sampled individual during the audit period.

Recommendation #3: In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, CMS recommends Missouri perform an annual renewal of Medicaid and CHIP eligibility every 12 months, and no more frequently than once every 12 months, to ensure beneficiaries maintain their eligibility.

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 three beneficiaries are described below.

1. The CHIP beneficiaries were charged the incorrect premium amounts because Missouri did not always verify and/or use the correct income amounts when calculating premiums.

1.A) A renewal was received July 24, 2019, for the coverage period of July 1, 2019, to June 30, 2020, for the household of five. Beginning August 1, 2019, through November 30, 2019, a system error changed the household composition from five to two, leaving only Wage Earner #1 and the beneficiary in the case. This changed the premium to $159 monthly.

Eligibility ended December 31, 2019, with both the correction of the system error and when wage earner two reported monthly income of $2,900. Wage Earner #2's employment ended in January 2020, and the beneficiary regained CHIP eligibility with $0 premiums.

1.B) The household of six's renewal was received by mail on March 26, 2019, for the coverage period of March 1, 2019, through February 29, 2020. Income from 2014 of $3,689.00 (FPL 128 percent) for the Wage Earners was used by Missouri.

Both Wage Earners provided check stubs to verify monthly income; for Wage Earner #1, $1,132.02 and Wage Earner #2 $3,662.42. This was a total monthly household income of $4,797.49 (FPL 166 percent). The beneficiary's premium should have been $40 monthly rather than zero.

1.C) The household of three reported a change of income on March 18, 2019, and provided their 2017 1040 income tax return to Missouri.

The monthly income provided by the beneficiary totaled $3,773.90, an FPL of 212 percent.

Missouri failed to change the reported income for the coverage period for the two years ending December 31, 2019, and December 31, 2020. Missouri continued to count monthly income from prior certifications of $2,068 (127 percent of FPL). This caused the beneficiary to be in the incorrect CHIP band. The beneficiary's premium should have been zero rather than $82 monthly.

Recommendation #2: In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Missouri 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 Missouri 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 Missouri 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

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 Missouri 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 Missouri's Medicaid eligibility verification plan.
- Selected a stratified random sample of 175 Medicaid beneficiaries and 175 CHIP beneficiaries from a total of 961,370 Medicaid and CHIP beneficiaries 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 agency's documentation supporting beneficiaries' eligibility.
- Calculated an eligibility accuracy rate for both Medicaid and CHIP populations.

Appendix B: Statistical Sampling Methodology

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

Sampling Frame
The Medicaid and CHIP sampling frames consisted of a database containing 961,370 beneficiaries in Missouri for whom the state agency made payments totaling $4,010,532,460.79 for services provided during the audit period. CMS obtained the data for the Medicaid and CHIP beneficiaries from Missouri's MMIS. CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frames.

Sample Unit
The sample unit was a Medicaid or CHIP beneficiary.

Sample Size
CMS selected 175 Medicaid 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.[25]

Method for Selecting Sample Units
CMS consecutively numbered both populations of beneficiaries within strata 1 through 5 for Medicaid; CHIP was numbered within strata 1 through 5. After generating the random numbers for all random strata, CMS selected the corresponding Medicaid and CHIP beneficiaries in the sample frame for the sample.

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

Appendix C: Medicaid and CHIP Sample Results

Sample Results

Table 1.1: Medicaid Sample Details and Results for Ineligible Beneficiaries

Stratum	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	21	$18,113,940.28	1	$610,672.40
2	38	2,612,985.08	0	0
3	38	871,090.98	1	24,045.78
4	39	279,145.15	0	0
5	39	40,006.39	2	4,119.12
Totals	**175**	**$21,917,167.88**	**4**	**$638,837.30**

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

Stratum	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	21	$18,113,940.28	0	0
2	38	2,612,985.08	1	$42,110.53
3	38	871,090.98	0	0
4	39	279,145.15	1	5,588.74
5	39	40,006.39	2	2,376.40
Totals	**175**	**$21,917,167.88**	**4**	**$50,076.67**

Table 2.1: CHIP Sample Detail and Results for Ineligible Beneficiaries

Stratum	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	40	$4,216,428.62	18	$1,083,386.52
2	34	516,810.17	3	22,304.65
3	34	74,647.51	2	4,741.20

4	34	42,810.91	1	851.37
5	33	27,420.78	3	2,930.30
Totals	**175**	**$4,878,117.99**	**27**	**$1,114,214.06**

Table 2.2: CHIP Sample Details and Results for Potentially Ineligible Beneficiaries

Stratum	Sample Size	Value of Sample (Total Payments Associated with Sampled Beneficiaries)	Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	40	$4,216,428.62	2	$200,266.29
2	34	516,810.17	3	19,934.35
3	34	74,647.51	3	4,921.80
4	34	42,810.91	2	2,878.09
5	33	27,420.78	2	1,520.44
Totals	**175**	**$4,878,117.99**	**12**	**$229,520.97**

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 §§ and 435.912 and 447.10, CMS recommends that Missouri ensure timely actions are taken to close cases in both the eligibility system and the MMIS, when beneficiaries are found to be ineligible. When Missouri takes an action to close a case, Missouri must also close the beneficiary's case within the claims payment system to ensure payments are only made for eligible Medicaid or CHIP beneficiaries.	**X Please see comments below.**	
Recommendation #2	In accordance with §§ 435.603, 435.945, 435.948, 435.952, and 457.380(d), CMS recommends that Missouri 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 Missouri ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.		**X Please see comments below.**
Recommendation #3	In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, Missouri should perform an annual renewal of Medicaid and CHIP eligibility every 12 months, and no more frequently than once every 12 months, to ensure beneficiaries maintain their eligibility.	**X Please see comments below.**	
Recommendation #4	In accordance with CFR 42 § 457.320 (a) (2) Missouri should consider implementing system fixes, to ensure capitated payments and other health related payments do not continue to be		**X Please see comments below.**

Classification	Issue Description	Agree	Disagree
	made on behalf on beneficiaries after they have reached the age of 19. Since this audit was conducted, Missouri has implemented this recommendation.		

DSS Comments by recommendation number:

1. The Missouri Department of Social Services (DSS) notes that there was a system issue during the audit time frame which caused future end dates from FAMIS to not cross over to the eMMIS if the period was also known to MEDES. The fix was moved to production on February 6, 2021.

2. While Missouri DSS recognizes that some of the identified beneficiaries in the draft report were claimed as CHIP incorrectly, Missouri DSS disagrees that all of the identified beneficiaries in this draft report were placed in the incorrect category. Beneficiaries 1.C, 1.D, 1.G, and 1.J are beneficiaries between the age of 6-18 with household income over 110% FPL and were correctly claimed for enhanced match.

3. The DSS has no further comments.

4. Missouri DSS acknowledges that capitated or other health related payments were made for beneficiaries after they reached the age of 19. However, the error was not due to proper controls being in place. Missouri verifies the age of all beneficiaries at application as required and the eligibility system properly identified when they reached age 19. Due to system issues, the eligibility did not properly end for these beneficiaries upon turning age 19. Missouri has implemented system upgrades since the review period and the eligibility system now appropriately completes an ex-parte review for beneficiaries turning 19 to explore eligibility for other Medicaid categories, including the Adult Expansion Group (AEG) and if found eligible, eligibility ends upon turning 19 years of age.

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)