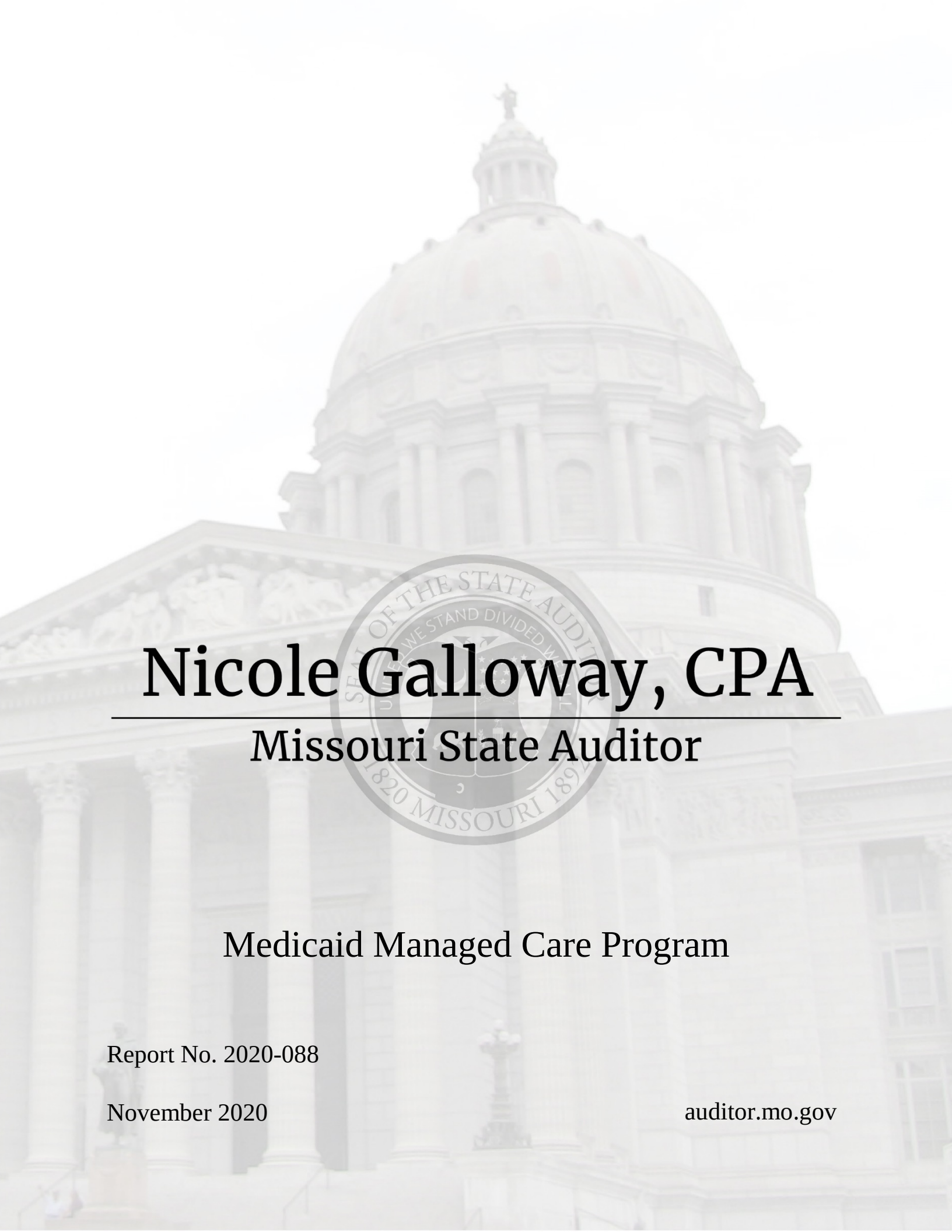


Nicole Galloway, CPA

Missouri State Auditor

Medicaid Managed Care Program

Report No. 2020-088

November 2020

auditor.mo.gov

Nicole Galloway, CPA
Missouri State Auditor

CITIZENS SUMMARY

Findings in the audit of the Medicaid Managed Care Program

Eligibility Bypass	The Department of Social Services (DSS) improperly issued capitation payments on behalf of participants whose eligibility was previously activated (and remained active) in the Missouri Eligibility Determination and Enrollment System (MEDES) through a manual bypass process. This bypass state prevented MEDES controls from deactivating eligibility (and, in turn, discontinuing payments) when these participants later became ineligible.
Indicator Control	The DSS improperly issued capitation overpayments on behalf of some participants, and issued potentially preventable capitation payments (not considered overpayments) on behalf of other participants. This occurred because of weaknesses in an "indicator" control (i.e., system flag) in the MEDES and the related manual tracking processes.
Out-State-Participants	The DSS improperly issued capitation payments on behalf of participants who were ineligible due to no longer residing in Missouri. Automatic and manual attempts to deactivate eligibility were not always successful due to MEDES control limitations.
Incarcerated Participants	The DSS is not performing effective incarceration matches, or the results are not always used effectively, to detect, discontinue, and recoup capitation payments issued on behalf of participants who are incarcerated.

In the areas audited, the overall performance of this entity was **Good**.*

*****The rating(s) cover only audited areas and do not reflect an opinion on the overall operation of the entity. Within that context, the rating scale indicates the following:

Excellent: The audit results indicate this entity is very well managed. The report contains no findings. In addition, if applicable, prior recommendations have been implemented.

Good: The audit results indicate this entity is well managed. The report contains few findings, and the entity has indicated most or all recommendations have already been, or will be, implemented. In addition, if applicable, many of the prior recommendations have been implemented.

Fair: The audit results indicate this entity needs to improve operations in several areas. The report contains several findings, or one or more findings that require management's immediate attention, and/or the entity has indicated several recommendations will not be implemented. In addition, if applicable, several prior recommendations have not been implemented.

Poor: The audit results indicate this entity needs to significantly improve operations. The report contains numerous findings that require management's immediate attention, and/or the entity has indicated most recommendations will not be implemented. In addition, if applicable, most prior recommendations have not been implemented.

Medicaid Managed Care Program
Table of Contents

NICOLE GALLOWAY, CPA
Missouri State Auditor

Honorable Michael L. Parson, Governor
and
Jennifer Tidball, Acting Director
Department of Social Services
Jefferson City, Missouri

We have audited certain operations of the Department of Social Services, Medicaid Managed Care program. This audit was conducted in fulfillment of our duties under Chapter 29, RSMo. The objectives of our audit were to:

1. Evaluate the effectiveness of procedures for ensuring the reliability of submitted and reported managed care encounter data.

2. Evaluate the use and effectiveness of data management, monitoring, and analytic techniques for providing oversight of the program.

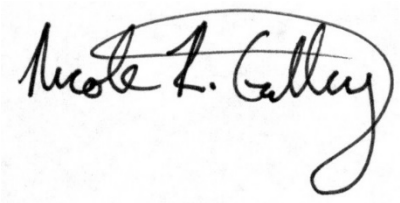
3. Evaluate compliance with certain legal provisions.

4. Evaluate the economy and efficiency of certain management practices and information system control activities.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

For the areas audited, we identified (1) no significant deficiencies in procedures for ensuring the reliability of encounter data, (2) the need for improvement of data analytic techniques utilized by the department for overseeing the program, (3) noncompliance with state and federal laws, and (4) the need for improvement in management practices and information system control activities.

The accompanying Management Advisory Report presents our findings arising from our audit of the Medicaid Managed Care Program.



Nicole R. Galloway, CPA
State Auditor

The following auditors participated in the preparation of this report:

Director of Audits:	Jon Halwes, CPA, CGFM
Audit Manager:	Jeffrey Thelen, CPA, CISA
	Alex R. Prenger, M.S.Acct., CPA, CISA, CFE, CGAP
In-Charge Auditor:	Anh Nguyen, CPA
Audit Staff:	Zachery L. Harris
	Devin Jackson

Medicaid Managed Care Program
Introduction

Background

The Medicaid program was created in 1965, under Title XIX of the Social Security Act, to provide health coverage to individuals with low income and/or disabilities. The Medicaid program, called MO HealthNet in Missouri, is jointly administered and funded by the federal government (Centers for Medicare & Medicaid Services [CMS]) and state governments. In Missouri, the Department of Social Services (DSS) MO HealthNet Division (MHD) administers the Medicaid program, with the assistance of the Family Support Division (FSD) for participant eligibility determinations.

Missouri's Medicaid Managed Care (MC) program was established in September 1995. According to the CMS,[1] "Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services."

Since May 2017, Missouri has contracted with three MCOs: Home State Health, Missouri Care, and UnitedHealthcare. The MCOs do not directly serve program participants, but act as health management organizations administering networks of providers, such as hospitals, doctors, and subcontractors. In Missouri, providers serve participants with doctor visits, hospital stays, emergency care, specialist referrals, behavioral health and substance/tobacco abuse services, and other services such as dental, eye care, medical equipment, and family planning.

The CMS also indicates,[1] "By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care." The state's collection, use, and submission of encounter data (records of services provided to MC program participants) are critical to achieving these objectives.

The MHD administers the Medicaid Management Information System (MMIS) to issue capitation payments to, and collect encounter data from, MCOs. The MMIS receives and relies on participant eligibility and enrollment data from other DSS systems to issue capitation payments and determine if received encounter data are valid. For the majority of MC program participants, eligibility data comes from the Missouri Eligibility

[1] Centers for Medicare & Medicaid Services, Managed Care, <https://www.medicaid.gov/medicaid/managed-care/index.html>, accessed December 30, 2019.

Determination and Enrollment System (MEDES), which the FSD administers to activate, adjust, and deactivate participant eligibility. Therefore, coordination between the MHD and FSD through the MMIS and MEDES is crucial.

Table 1 summarizes the basic (non-exhaustive) relationship and responsibilities between various entities under Missouri's MC program.

Table 1: MC program entity relationship and responsibilities

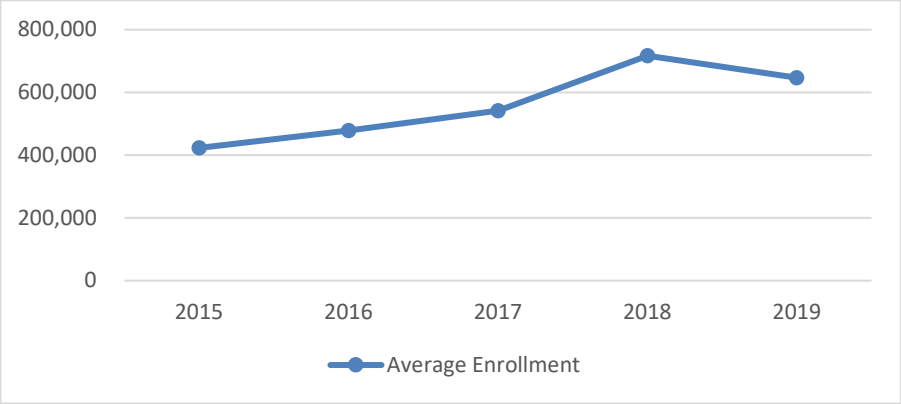
Responsibility	The DSS	MCOs	Providers	Participants
General	Administers the state's MC program and related systems.	Act as a health management organization between the DSS, providers, and participants.	Provide medical services to participants.	Receive medical services from providers.
Participant eligibility and enrollment	Uses systems, primarily the MEDES, to administer participant eligibility. Uses systems to administer participant enrollment with a given MCO.	Receive periodic participant eligibility and enrollment data from the DSS.	Use DSS and/or MCO resources to confirm participants are eligible and enrolled before performing services.	Provide the DSS with necessary eligibility information. Enroll with an MCO, and select a provider networked with that MCO.
Capitation payments	Uses the MMIS to issue monthly capitation payments to MCOs on behalf of all eligible and enrolled participants.	Receive capitation payments from the DSS.	No involvement; providers do not receive capitation payments from the DSS or MCOs.	No involvement; participants do not receive capitation payments from the DSS or MCOs.
Encounter data	Uses the MMIS to receive and process encounter data from MCOs, generally at a real-time basis. Submits encounter data to the federal government.	Receive and process encounter data from providers. Submit encounter data to the DSS.	Create encounter data from services provided to participants. Submit encounter data to MCOs.	No involvement; participants do not have any encounter data responsibilities.

Source: SAO observations of the MC program and discussions with DSS officials

During the 3 state fiscal years ending June 30, 2019, the state's MC program covered approximately 1 million unique participants. The MMIS received records for approximately 21 million encounters (instances of services provided), and issued approximately $5.58 billion in MC benefits.

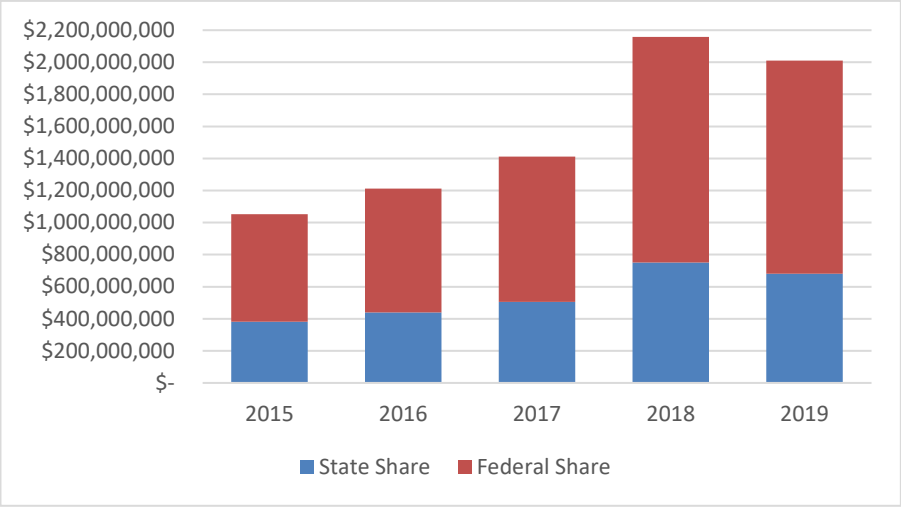
Figures 1 and 2 show the average MC participant counts and total benefit issuances for each of the 5 state fiscal years ending June 30, 2019. In May 2017, the DSS completed a statewide MC program expansion that increased MCO coverage from 54 counties to all 114 counties in the state. During this expansion, individuals in uncovered counties who were participating in the existing Medicaid fee-for-service (FFS) program were generally moved to the MC program. Exceptions included individuals who either opted out, or were elderly (age 65 or older), blind or disabled. This change resulted in a significant increase in MC participants and benefits issued, which is reflected in state fiscal year 2018 data. In state fiscal year 2019, the state had an average of approximately 650,000 participants in the MC program, and issued approximately $2 billion in benefits.

Figure 1: Average MC program participants by state fiscal year



Source: SAO analysis of FSD monthly data reports

Figure 2: MC program benefit issuance by state fiscal year



Source: SAO analysis of FSD monthly data reports

Eligibility and enrollment

Initial eligibility determinations and periodic redeterminations are regulated by complex factors that are beyond the scope of this audit. However, certain basic factors facilitate understanding the topics discussed in this report.

Upon applying for assistance, initial eligibility is determined individually for all members of a household, but considers factors such as family composition, income level, and insurance status. Federal law[2] requires the individual to be a Missouri resident and U.S. citizen or qualified alien. In addition, the individual must be within one of the following eligibility groups:

- MO HealthNet for Families
- MO HealthNet for Pregnant Women
- MO HealthNet for Kids
- Children's Health Insurance Program (CHIP)
- Children in care and custody of the state
- Children receiving adoption subsidy
- Individuals in the refugee assistance program (program ended May 2018)

Eligibility groups for the elderly (age 65 or older), blind and disabled are not listed above because such individuals receive Medicaid services under the FFS program instead of the MC program.

After an individual is determined to be eligible, he/she is formally enrolled with (assigned to) an MCO. This process generally begins both the participant's coverage under the MCO (and providers), as well as the capitation payments to the MCO.

Eligible participants are subject to annual redeterminations, in which the DSS reviews participants for changes in circumstances to continue, adjust, or deactivate eligibility. Participants are required to report changes in their circumstances that potentially affect eligibility (such as residency, income, employment, household composition, and other factors) to the DSS within 10 calendar days. However, as observed during audit reviews and explained by DSS personnel, participants do not always report, or timely report, such changes to the department.

Capitation payments

MC program benefit payments most frequently occur as capitation payments, or "per member per month" payments. As long as a participant remains both eligible and enrolled, the DSS automatically issues monthly capitation payments on his/her behalf. Capitation payments are issued to MCOs and never issued directly to the participants or providers.

[2] Section 42 USC Section 1396b(x) and 42 CFR Section 435.403.

According to 42 CFR Section 438.2, "The State makes the [capitation] payment regardless of whether the particular beneficiary [participant] receives services during the period covered by the payment." For example, even if a participant does not receive services for a consecutive year, capitation payments will continue as long as the participant remains eligible and enrolled.

If services are provided, capitation payments are not reimbursements of the provider's service cost. According to the GAO,[3] "…capitated payments generally reflect the average cost to provide covered services to enrollees, rather than a specific service. Federal law requires capitation rates to be actuarially sound, meaning that, among other things, they must be reasonably calculated for the populations expected to be covered and for the services expected to be furnished under contract."

The capitation payment amount issued on a participant's behalf depends on the person's age, eligibility group, income, county of residence, and the MCO. In general, capitation payments are approximately $200 to $400 per month for most children and adults, but typically exceed $1,000 per month for newborns (individuals younger than one year old). Participants eligible under CHIP may be required to pay monthly premiums. Capitation payments can be pro-rated, for example, if a participant is only eligible and enrolled for a portion of a given month.

The state's MC program costs are partially reimbursed by the federal government. During the 3 years ending June 30, 2019, the federal share was approximately 65 percent of MC program costs.

Encounter data

According to the GAO,[4] "Encounter data are the primary record of services provided to beneficiaries in managed care, and these data are used for several critical purposes, including program oversight, expenditure forecasting, and policy analysis." The GAO also indicates "Reliable encounter data—which . . . we have defined to mean data that are complete, accurate, and submitted in a timely manner, as required by regulation—are central to CMS's and the states' abilities to effectively oversee the Medicaid managed care program."

Encounter data are continuously created and transmitted, beginning with providers and ultimately flowing to the federal government. Upon completing a service, a provider creates and sends encounter data to its associated MCO;

[3] Report GAO-18-291, *Medicaid - CMS Should Take Steps to Mitigate Program Risks in Managed Care*, May 2018, <https://www.gao.gov/assets/700/691619.pdf>, page 8, accessed January 6, 2020.

[4] Report GAO-19-10, *Medicaid Managed Care - Additional CMS Actions Needed to Help Ensure Data Reliability*, October 2018, <https://www.gao.gov/assets/700/695069.pdf>, pages 1-2, accessed January 6, 2020.

each MCO sends data collected from all contracted providers to the DSS; and the DSS sends data collected from each MCO to the CMS.

Encounter data include detailed information for a given service, including basic concepts such as the participant, provider, and MCO involved in the service; the medical procedure completed; when the service occurred; and when the MCO submitted the data to the DSS.

A given service, once generated into encounter data, is also known as an "encounter claim." Despite this label, encounter data do not represent claims for payment, and do not result in the DSS reimbursing service costs to MCOs or providers. The DSS only issues capitation payments to MCOs.

MCO contracts indicate the department "collects and uses encounter data for many purposes such as federal reporting, rate setting and risk adjustment, payment indication of [newborn] delivery and NICU [neonatal intensive care unit] supplemental payments, services verification, managed care quality improvement activities, utilization patterns and access to care, hospital rate setting, and research studies."

Federal law[5] requires states to conduct at least once every 3 years an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by MCOs. The department's first deadline for this audit is June 30, 2021.

Overpayments

Improper payments, including overpayments, may occur in the MC program. Under 42 CFR Section 431.958, improper payments are defined as "any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary…"

If a participant's eligibility is not deactivated in the MEDES (or if enrollment is not deactivated through other systems) when appropriate, capitation payments will continue automatically (as overpayments) because the MMIS will not receive an update to discontinue such payments.

When overpayments begin, they can continue indefinitely without further DSS intervention. Among other system control factors, this depends on if the DSS sets the participant's eligibility and/or enrollment to remain active (1) for a definite period (for example, a specific deactivation date, such as one year in the future, was preemptively entered) or (2) indefinitely (MEDES and MMIS recognize the deactivation date as December 31, 9999). The practice

[5] 42 CFR 438.602(e).

of setting a participant's eligibility and/or enrollment to remain active indefinitely is not necessarily unusual. While some eligibility groups have pre-defined time limits that allow the DSS to preemptively set a definite deactivation date (for example, MO HealthNet for Pregnant Women participants have an initial 60-day limit for postpartum benefits), most do not.

Overpayments can occur due to timing delays between when (1) a participant change in circumstance occurs; (2) the participant informs the DSS of the change, or when the DSS directly detects the change; and (3) the DSS acts on the change to deactivate the participant's eligibility and/or enrollment. For example, if a participant moved out-of-state on January 1, but capitation payments continued until the DSS detected the move on March 31, the participant becomes ineligible going forward, but the capitation payments issued during that 3-month period would be overpayments. Such timing delays are not unusual, and are not unique to the MC program.

However, overpayments can also occur due to significant MEDES control limitations that are unique to the MC program. When the MEDES was implemented in January 2014, control limitations prevented the DSS from activating, adjusting, and deactivating a participant's eligibility using standard processes intended by the system. In addition, the MEDES was designed to perform automatic redeterminations (annual reviews for changes in circumstances to continue, adjust, or deactivate a participant's eligibility). However, control limitations caused eligibility for some participants to be inappropriately deactivated either before a redetermination could occur, or as a result of the redetermination. To protect participant eligibility until development of MEDES updates, (1) automatic redeterminations were disabled until June 2018, and (2) all participants were put in a "blocked" state until October 2018 to further prevent eligibility deactivation. These actions significantly increased the number of manual redeterminations required of DSS personnel, and disabled controls that counteract risks associated with setting a participant's eligibility to remain active indefinitely (deactivation date of December 31, 9999). In addition, while automatic redeterminations were re-enabled in June 2018, the DSS has not performed an expected annual redetermination within MEDES for some current participants due to remaining MEDES control limitations or complexities arising from the DSS's long-term resolution efforts in the MEDES.[6] We noted this problem in the state's single audit report for the year ended June 30, 2019.[7]

[6] These MEDES control limitations and complexities are discussed in the Management Advisory Report (MAR) section.

[7] SAO, Report No. 2020-014, *State of Missouri Single Audit Year Ended June 30, 2019*, finding 2019-005, page 44, issued March 2020.

The DSS has contractual authority to recoup overpayments from MCOs. If the DSS elects to recoup overpayments, the MCO repays the capitation payments (state and federal shares) to the DSS. The department repays the federal share to the CMS.

However, the DSS generally only recoups overpayments associated with deceased or incarcerated participants, because it is physically impossible for such participants to receive services. In contrast, the DSS will generally not recoup overpayments associated with ineligible participants in other scenarios because it is still physically possible for such participants to receive services and they were listed as eligible in the MEDES when the MCO checked eligibility. In such other scenarios, DSS officials indicated, "the health plan [MCO] has exercised their due diligence if they have checked [the participant's] eligibility prior to authorizing services, therefore it would be inappropriate to penalize them by recouping the capitated payment." Also, the "DSS does not recoup capitation payments from a participant when eligibility is granted due to an agency error."

Because the DSS only recoups capitation payments in limited situations, it is unlikely that overpayments identified in this report will be recovered (with the exception of MAR finding number 4 that concerns incarcerated participants). Overall, the overpayments identified emphasize the need for the DSS to prevent overpayments from occurring.

The MEDES has been periodically updated since January 2014 to resolve system weaknesses. While these updates improved functionality going forward (for new participants), given the nature of the MEDES control limitations and complexities arising from the DSS's long-term resolution efforts in the MEDES, the updates do not necessarily automatically correct all previously impacted participants. As a result, there remains a need for significant effort by the DSS to identify participants with active eligibility who are truly ineligible, and to deactivate their eligibility to discontinue overpayments.

Public health emergency and restrictions on deactivating eligibility

On January 31, 2020, the federal Department of Health and Human Services declared a public health emergency for COVID-19. On March 18, 2020, the Families First Coronavirus Response Act was signed into law.

The act temporarily increases the federal share of MC program costs. Specifically, it provides Missouri a 6.2 percent Federal Medical Assistance Percentage (FMAP) increase beginning January 1, 2020, for the MO HealthNet program. The state's FMAP percentage was approximately 66

percent prior to this act.[8] The increased FMAP is available for qualifying expenditures incurred on or after that date and through the end of the quarter in which the public health emergency, including any extensions, ends.

To receive the temporary increase in federal share, among other requirements, states may not deactivate participants' eligibility from Medicaid if such participants were already enrolled (or become enrolled) during the emergency period. Limited exceptions only allow states to deactivate eligibility if the participant (1) voluntarily requests closure of his/her case, (2) is no longer a resident of the state, (3) becomes deceased, or (4) is a child eligible under CHIP who ages out when he/she turns age 19. While there is no exception for incarcerated participants, one is not specifically needed because the act does not supersede existing federal law prohibiting states from obtaining federal share reimbursements for benefits issued on behalf of incarcerated participants.

As discussed in the report's MAR findings, MEDES system control limitations and complexities arising from the DSS's long-term resolution efforts in the MEDES cause situations in which participants who are truly ineligible remain actively eligible, and therefore, their eligibility should be deactivated. However, if such situations do not meet an exception, the DSS cannot deactivate such participants' eligibility during the emergency period. As a result, any future overpayments set to continue for such participants cannot be immediately discontinued. This requires the DSS to continue identifying truly ineligible participants during the public emergency, to enable timely deactivation once the public emergency ends.

Scope and Methodology

The scope of our audit included evaluating (1) DSS management's procedures to ensure reliable MC encounter data, (2) DSS management's techniques to provide oversight of the program, (3) policies and procedures, and (4) other management functions and compliance requirements in place during the period July 2016 to June 2019. Due to MEDES system control limitations and complexities rising from the DSS's long-term resolution efforts in the MEDES, we also observed activity beyond June 2019 for further comprehension and to assess significance.

Our methodology included reviewing written policies and procedures, and interviewing various DSS personnel. We obtained an understanding of the applicable controls that are significant within the context of the audit

[8] The FMAP is used as a base for the Enhanced FMAP (EFMAP) for the state's Children's Health Insurance Program (CHIP). CHIP represents one of the MC program's eligibility groups available to participants. Therefore, the increase in FMAP will also result in an increase in EFMAP, but not necessarily by 6.2 percent. The state's EFMAP rate was approximately 87 percent prior to this act. The state's FMAP and EFMAP collectively affect federal share coverage of MC program costs.

objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of these controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violation of contract or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

We obtained data files of MC program participant records, capitation payments, and encounter data from the MMIS for the period July 2016 through June 2019 from the DSS. We also obtained data files of additional MC program participant records from the MEDES. Such data generally covered the same July 2016 through June 2019 period. However, because our requests were made after June 2019, and also because the MEDES could not generate snapshot (point-in-time) reports as of June 30, 2019, the data received also contained up-to-date (at the time of DSS fulfillment) information for periods beyond June 2019. Such information generally enhanced our ability to assess other details and analyze the flow of information from the MEDES to the MMIS. While the DSS owns MMIS and MEDES data, such data are collected and managed by separate contractors on the department's behalf. To determine the reliability of the MC program data, we evaluated the materiality of the data to our audit objectives and assessed the data by various means, including (1) interviewing knowledgeable DSS officials, (2) reviewing existing information about the data and the systems that produced them, (3) performing certain analytic techniques, and (4) reviewing internal controls. Based on this evaluation, we determined the data and information were sufficiently reliable for the purposes of the audit.

We obtained a listing of deaths recorded in the state for the period 1995 to 2018 from the Missouri Department of Health and Senior Services (DHSS). We matched these records to MC participant records to determine if any deceased participant cases continued to have capitation payments made on behalf of the participant after death.[9] Although we used computer-processed data from the DHSS for our audit work, we did not rely on the results of any processes performed by the DHSS system in arriving at our conclusions. Our conclusions were based on our review of the issues specific to the audit objectives.

[9] Acknowledgement: The data used in this document/presentation was acquired from the Missouri DHSS. The contents of this document including data analysis, interpretation or conclusions are solely the responsibility of the authors and do not represent the official views of DHSS.

We obtained a listing of individuals incarcerated by the state during the period July 2016 through June 2019 from the Missouri Department of Corrections (DOC). We matched those records to MC participant records to determine if incarcerated participant cases continued to have capitation payments made on behalf of the participants after incarceration. Although we used computer-processed data from the DOC for our audit work, we did not rely on the results of any processes performed by the DOC system in arriving at our conclusions. Our conclusions were based on our review of the issues specific to the audit objectives.

We based our evaluation on accepted state, federal and international standards and best practices related to information technology security controls from the following sources:

- National Institute of Standards and Technology (NIST)
- U.S. Government Accountability Office (GAO)
- ISACA

1. Eligibility Bypass

The Department of Social Services (DSS) improperly issued capitation payments on behalf of participants whose eligibility was previously activated (and remained active) in the Missouri Eligibility Determination and Enrollment System (MEDES) through a manual bypass process. This bypass state prevented MEDES controls from deactivating eligibility (and, in turn, the Medicaid Management Information System [MMIS] from discontinuing payments) when these participants later became ineligible. We identified 18,248 participants in a bypass state. For 23 of 45 participants we reviewed, actual and potential overpayments totaled $87,185 during the 3 years ended June 30, 2019, with an additional $44,211 through the 8 months ending February 28, 2020.

Bypass process

When the MEDES was implemented in January 2014, significant control limitations impeded the department's ability to properly administer participant eligibility. The DSS could not always activate, adjust, and deactivate participants' eligibility using standard processes intended by the system. According to DSS officials:

- MEDES functionality only allowed applications to be taken and did not allow changes in cases or annual reviews to be completed in the system. When implemented, MEDES accepted an initial application to create a household and associated participant eligibility, but it prevented future adjustments that could impact eligibility, such as adding or removing household members, or adjusting a participant's details following a change in circumstance. These limitations meant automatic annual redeterminations of participant eligibility could not be completed. MEDES updates resolved these limitations by August 22, 2016; however, automatic redeterminations remained disabled until June 2018.

- MEDES did not systematically approve newborn eligibility. Initially, newborns of women eligible for MO HealthNet (participants younger than 1 year old), who by federal law are automatically provided Medicaid eligibility, could not be directly added to their existing household to allow MEDES to activate their eligibility. MEDES updates resolved this limitation by December 2016.

Before the MEDES updates resolved these control limitations, the DSS established a bypass process as a labor-intensive workaround to manually activate, adjust, and deactivate eligibility. This process was necessary to activate and/or maintain the eligibility of applicants and participants meeting program requirements. Otherwise, such applicants and participants would have been at risk of being unable to obtain program services, because MEDES (and, in turn, providers) could not formally confirm their active eligibility.

The MEDES updates improved functionality going forward for new participants and households. However, these updates could not automatically

correct the state of previously bypassed participants. While the department's need to continue bypass processes has declined considerably since 2016, some participants still remain in that state, with eligibility set to remain active indefinitely (deactivation date of December 31, 9999).

Participants who remain in a bypass state are not subject to MEDES controls, including the system's June 2018 update to complete automatic annual redeterminations. Because MEDES controls cannot deactivate such participants' eligibility, DSS personnel must use the same bypass process to manually deactivate the participant's eligibility. Therefore, these participants are generally at increased risk of improper capitation payments over time.

Review

We reviewed MEDES eligibility records generated around December 31, 2019, to identify participants who, at that time, remained in a bypass state because their eligibility was (1) previously activated manually via the bypass process during (or preceding) the 3 years ended June 30, 2019, and (2) set to remain active indefinitely. Participants meeting these conditions remain in a bypass state until manually removed by DSS personnel. We identified 18,248 participants in this state, for whom the DSS paid approximately $101 million in capitation payments during the 3 years ended June 30, 2019. These participants and payments do not all necessarily reflect ineligible participants or overpayments; it is possible for a participant's eligibility to remain valid despite being in a bypass state.

In a separate analysis, we also determined 1,633 of these 18,248 participants maintained MC program eligibility during the entire 3 year period ended June 30, 2019, but did not have any encounter claims reported during that time.[10] There is no requirement for a participant to periodically obtain medical services, as a condition to maintain eligibility; however, not obtaining any medical services for an extended period of time may indicate a participant is no longer a state resident or some other situation that would question further program eligibility.

We reviewed 45 of the 18,248 participants. The DSS paid $337,734 in capitation payments associated with these participants during the 3 years ended June 30, 2019. When we began our review in late February 2020, capitation payments were still being issued on behalf of 44 of the 45 participants.

As shown in Table 2, our review found that actual and potential overpayments totaling $87,185 (approximately 26 percent of the $337,734) during the 3 years ended June 30, 2019, occurred for 23 of the 45 participants. In addition,

[10] This analysis identified, in total, 6,654 participants. We provided department officials with a listing of all of these participants for further review.

actual and potential overpayments totaling $44,211 during the 8 months ended February 28, 2020, continued to occur for each of them.

Table 2: Review of actual and potential overpayments for participants in bypass state

		Capitation Payments			Count of Capitation Months		
Participant	Issue	36 months ending 6/30/19	8 months ending 2/28/20	Total	36 months ending 6/30/19	8 months ending 2/28/20	Total
01	Failed to close	$ 11,292	2,090	13,382	36	7	43
02	Failed to close	2,180	1,818	3,998	11	8	19
03	Failed to close	1,555	1,195	2,750	11	8	19
04	Failed to close	8,059	2,853	10,912	22	8	30
05	Failed to close	6,747	3,029	9,776	19	8	27
06	Failed to close	2,181	2,882	5,063	6	8	14
07	Failed to close	3,113	2,774	5,887	9	8	17
08	Failed to close	799	3,205	4,004	2	8	10
09	Failed to close	2,627	1,413	4,040	16	8	24
10	Failed to close	973	1,381	2,354	6	8	14
11	No redetermination[1]	5,828	2,859	8,687	16	8	24
12	No redetermination	3,211	1,189	4,400	22	8	30
13	No redetermination	4,478	1,543	6,021	23	8	31
14	No redetermination	4,488	1,818	6,306	22	8	30
15	No redetermination	615	1,848	2,463	3	8	11
16	No redetermination	4,263	1,413	5,676	26	8	34
17	No redetermination	3,626	2,853	6,479	10	8	18
18	No redetermination	3,387	1,091	4,478	26	8	34
19	No redetermination	5,326	1,348	6,674	36	8	44
20	No redetermination	3,211	1,189	4,400	22	8	30
21	No redetermination	4,488	1,818	6,306	22	8	30
22	No redetermination	2,604	1,189	3,793	18	8	26
23	No redetermination	2,134	1,413	3,547	13	8	21
	Totals	$ 87,185	44,211	131,396	397	183	580

[1] Capitation payments listed for participants with no redetermination are considered potential overpayments.

Source: SAO analysis of MMIS capitation payment data. All capitation payment figures represent state and federal shares combined.

Further explanation of the information in Table 2 follows:

- Failed to close (10 of 23 participants): Review of the case information in MEDES for these participants indicated their eligibility was previously intended to be deactivated. Participants were known to be ineligible for various reasons, such as not responding to an annual review notice to redetermine eligibility, or because the department's attempts to mail communications to the participant were returned as unable to locate. DSS

personnel attempted to deactivate eligibility; however, such attempts were unsuccessful due to the participant's bypass state.

- No redetermination (13 of 23 participants): Review of the case information in MEDES for these participants found nothing to indicate their eligibility was previously intended to be deactivated. However, the bypass state prevented an annual redetermination from occurring in MEDES at least once every 12 months as required, even after this control was reestablished in June 2018. The DSS may also complete redeterminations within other programs, and outside of the MEDES, to satisfy the participant's MC program redeterminations. However, none occurred for these participants.

  Capitation payments listed for these participants are considered potential overpayments. To confirm if actual overpayments occurred for a given participant, the DSS must complete a current redetermination, and its outcome must find the participant is ineligible for the MC program. We requested DSS personnel perform current redeterminations for these participants; however, they could not complete them prior to completion of our audit.

When our review of this area was substantially completed, the DSS had not deactivated eligibility for 22 of 23 participants. Therefore, these 22 participants are at increased risk of continued actual and potential overpayments.

For the 22 of 45 participants reviewed but not listed in Table 2, we did not identify overpayments within the 3 years ending June 30, 2019. However, for 5 of the 22 participants, our review observed similar concerns after June 30, 2019: 2 participants' cases failed to close and 3 participants had late or outstanding redeterminations. This shows that participants remaining in the bypass state is an ongoing problem.

We provided the DSS with the list of all 18,248 participants identified. While we only formally reviewed 45 participants, we analyzed the remaining 18,203 participants. Of these, 17,634 appear at greatest risk of continued actual and potential overpayments, and need further investigation. Capitation payments for the full month of June 2019 were issued on behalf of all 17,634 participants, and nearly all were still actively eligible as of January 2020.

Under 42 CFR Section 431.958, improper payments are defined as "any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary…" 42 CFR Section

435.916(a) requires a redetermination of eligibility once every 12 months, or when criteria affecting a participant's eligibility changes.

Without effective controls to identify and discontinue capitation payments issued on behalf of ineligible participants who remain in a bypass state, the DSS is at increased risk of making actual and potential overpayments.

The DSS may be unable to deactivate eligibility when applicable for participants reported to the department in this finding until after the public health emergency ends, to remain compliant with the requirements for the temporary increase in the federal share of Medicaid program costs.

Recommendation

The DSS continue resolving MEDES control limitations as applicable, to prevent issuing capitation payments on behalf of ineligible participants who remain in a bypass state. In addition, the DSS should perform redeterminations on the 13 identified participants without a current redetermination and deactivate eligibility (as soon as possible, permitting the public health emergency) for applicable participants and the other 9 participants whose cases did not close properly. Also, the DSS should review the provided participant listing to determine if further action is needed.

Auditee's Response

The Missouri Eligibility Determination and Enrollment System (MEDES) development began in calendar year 2013 and was implemented in January 2014. Due to development issues, the bypass process was necessary to activate and/or maintain the eligibility of applicants and participants meeting program requirements. In 2018 the DSS completed the functionality for MO HealthNet MAGI processes in MEDES. Since the final functionality to complete systemic annual reviews was implemented in June 2018, the DSS has continued resolving MEDES control limitations for participants in a bypass state during the period under review, July 1, 2016 through June 30, 2019. The DSS has continued to move the individuals with manual eligibility determinations into MEDES and complete eligibility reviews. After the MEDES eligibility review, the DSS ends eligibility if the individual is determined ineligible. This audit confirms that the DSS' action to implement annual renewals in 2018 and 2019 to verify continued eligibility was the correct action.

Additionally, the DSS is reviewing the provided participant listing to determine if further action is needed.

Auditor's Comment

The audit shows many cases in bypass status have not been reviewed or resolved timely. It is not clear why the department mentions actions taken to implement annual reviews in 2018 as noteworthy when such annual reviews have been a federal requirement for many years. For any cases in which the participant is no longer eligible, each additional monthly capitation payment results in unnecessary costs to the state and federal government.

2. Indicator Control

The DSS improperly issued capitation overpayments on behalf of some participants, and issued potentially preventable capitation payments (not considered overpayments) on behalf of other participants. This occurred because of weaknesses in an "indicator" control in the MEDES and the related manual tracking processes. For all participants reporting a disability, if MEDES attempts to deactivate MC program eligibility for any reason, the indicator triggers and instead maintains the participant's eligibility indefinitely. The indicator's intended purpose is to allow the DSS to maintain eligibility for some participants, as legally required, until department personnel can manually review whether the participant is eligible for the separate MO HealthNet Aged, Blind and Disabled (MHABD) program. However, the indicator can trigger unnecessarily (i.e., when a participant's circumstances make MHABD program eligibility impossible). In addition, DSS personnel did not always effectively track all triggered indicators to ensure timely completion of the review. This weakness allowed overpayments and potentially preventable capitation payments to continue for extended periods.

We identified 2,810 participants with outstanding triggered indicators. Our review of 20 participants identified concerns with 17. We separated the results into two groups.

- In Group 1, covering 10 participants reviewed, overpayments occurred because the indicator triggered unnecessarily. Overpayments totaled $45,431 during the 3 years ended June 30, 2019, with an additional $25,038 through the 9 months ending March 31, 2020.

- In Group 2, covering 7 participants reviewed, overpayments did not occur because the indicator triggered appropriately, and the DSS was required to maintain MC program eligibility until its review for MHABD program eligibility was complete. However, for 6 of the 7 participants, MC program eligibility continued for 12 to 30 months after the indicator triggered. More timely resolution of the review may have made some of the capitation costs preventable.

Indicator overview

The MEDES indicator control (essentially a flag) is only associated with participants who receive benefits from the Supplemental Security Income (SSI; assistance to the aged, blind and disabled) or Social Security Disability Insurance (SSDI) programs, and/or report a disability. It maintains the participant's MC program eligibility, as required by federal law,[11] until DSS

[11] When an individual is found ineligible for one MO HealthNet category, the department explores eligibility for other MO HealthNet programs prior to ending the individual's current eligibility because 42 CFR 435.909 mandates that Medicaid agencies not require a separate application if an individual receives certain other benefits.

eligibility specialists (ESs) complete a review to determine if the participant is eligible for the state's separate MHABD program.

For such participants, when the MEDES attempts to deactivate eligibility for any reason, the indicator automatically triggers. Once triggered, the participant's eligibility remains active indefinitely (superseding any deactivation attempt), and capitation payments continue indefinitely, until the indicator is manually terminated or the participant's enrollment with an MCO ends.

Because the indicator triggers when MEDES attempts to deactivate eligibility for any reason, we observed the system cannot distinguish between situations that suggest possibility of MHABD eligibility (for example, an update shows income now exceeds a set MC program threshold) from those that do not (for example, the participant is deceased, incarcerated, cannot be located, no longer resides in the state, or did not respond to annual redetermination notices). In the latter case, to prevent overpayments, we also determined it is more efficient for the indicator to not trigger, since standard MEDES controls would deactivate eligibility more promptly.

Regardless of whether the indicator triggers unnecessarily or appropriately, all triggered indicators are intended to be manually tracked, then queued for ES review. The participant's indicator is not terminated (and MC program eligibility is not deactivated) until the review is complete. According to DSS officials, payments to MCOs for the participants are not considered overpayments for the period between when the indicator triggers, and when the ES review is completed.

DSS officials explained that reviews generally take 3 months to complete, but can take significantly longer. The time needed to complete each review varies by participant: "Application processing time for MHABD cases for individuals receiving SSI or SSDI is 45 days," but "When an individual claims a disability and does not receive SSI or SSDI, a Medical Review Team (MRT) determination is necessary to complete the MHABD determination. An MRT determination often takes a minimum of 90 days, but can take a significantly longer time due to needing a disability exam and waiting on medical records from providers." MRT determinations are further impacted by provider cooperation and medical record clarity.

Upon completing the review, the ES terminates the indicator, and MC program eligibility deactivates. Alternatively, if the review finds the participant should remain eligible in the MC program (for example, because the MEDES incorrectly attempted to deactivate eligibility), the ES terminates the indicator but takes additional action to reactivate or maintain eligibility. If a review is not completed, then the indicator remains triggered.

Indicator tracking

The DSS relies on a manual tracking process to ensure all participants with a triggered indicator are queued for ES review. However, per discussions with DSS officials, the following factors reflect difficulties in successfully tracking all necessary reviews. These weaknesses increase the risk that the indicator will remain triggered without ES review:

- While MC program eligibility is administered in the MEDES, MHABD program eligibility is administered using a separate system. The use of two systems requires DSS personnel to manually track the indicators outside of the systems.

- In November 2018, the DSS implemented an external site/queue to track triggered indicators requiring ES review. Indicators triggered prior to this month were generally subject to weaker tracking procedures, in part due to overall MEDES system control limitations. Indicators triggered during or after November 2018 are generally subject to stronger tracking procedures, but continue to require manual effort.

- When the indicator triggers, the MEDES does not automatically create a notification (either internal or external to the MEDES) alerting an ES of the event. Instead, an ES must manually add a task in the external site/queue, to consider the indicator successfully tracked.

- If the indicator triggers because eligibility is deactivated by automatic MEDES controls (without ES action or presence), it is unlikely any ESs will become aware of the indicator, and subsequently the need to manually add a task in the external site/queue.

- Alternatively, if the indicator triggers because eligibility is deactivated by manual ES action, there remains risk the ES will not see the indicator trigger, and subsequently will not realize the need to manually add a task in the external site/queue. This problem is due to the time period between (1) when MEDES first recognizes intent to deactivate eligibility (the ES is present), and (2) when MEDES actually attempts to deactivate eligibility (the ES may not be present). In most situations, when the MEDES first recognizes intent to deactivate eligibility, state and federal law requires the DSS to notify the participant 10 business days before the deactivation may truly occur. This period allows the participant a chance to request an administrative hearing to continue eligibility. When that period expires, if no request is received, the MEDES will attempt to deactivate eligibility (and, subsequently, trigger the indicator). By this time, it is unlikely the ES will return to add a task in the external site/queue.

- During the 3 years ending June 30, 2019 (and after), the DSS ran a daily report regarding disabled participants. However, it was not designed to

identify participants losing MC program eligibility. Therefore, it would not necessarily help department personnel identify indicators that triggered, but were not tracked in the external site/queue. To evaluate further, we requested and received records directly from MEDES for outstanding indicators. DSS officials explained they have begun using the data we requested to enhance tracking efforts going forward.

Review

We reviewed MEDES records generated around January 28, 2020, of participants who (1) had at least one indicator trigger during the 3 years ended June 30, 2019, and (2) the indicator(s) had not been terminated (meaning an ES review either had not been performed or had not been completed). We identified 2,810 such participants for whom the DSS paid approximately $10.47 million in capitation payments during the 3 years ended June 30, 2019, after the indicator triggered.

We reviewed 20 of the 2,810 participants. The DSS paid $101,057 in capitation payments associated with these participants during the 3 years ended June 30, 2019, after their indicator triggered. When we began our review in late March 2020, capitation payments were still being issued on behalf of 16 of 20 participants.

Our review of the 20 participants identified concerns with 17, between two groups, both reflecting weaknesses in tracking processes. Group 1 concerns 10 participants for which overpayments occurred because the indicator triggered unnecessarily. Group 2 concerns 7 participants for which overpayments did not occur, and it was appropriate for the indicator to trigger; but because the DSS review took or was taking a significant amount of time it is likely some of these capitation payments could have been prevented.

Group 1: Indicator trigger was unnecessary

For the 10 participants in this group, the indicator triggered unnecessarily. The participants' eligibility circumstances supported prompt deactivation of eligibility, without need for an ES review.

As shown in Table 3, our review found that overpayments totaling $45,431 (approximately 45 percent of the $101,057) during the 3 years ended June 30, 2019, occurred for the 10 participants. In addition, overpayments totaling $25,038 during the 9 months ended March 31, 2020, continued to occur for 9 of 10 participants.

Table 3: Review of overpayments for Group 1 participants with triggered indicator control

		Capitation Payments			Count of Capitation Months		
Participant	Issue	36 months ending 6/30/19	9 months ending 3/31/20	Total	36 months ending 6/30/19	9 months ending 3/31/20	Total
01	Non-response	$ 1,061	0	1,061	3	0	3
02	Non-response	4,064	3,212	7,276	11	9	20
03	Non-response	3,990	3,219	7,209	11	9	20
04	Unable to locate	4,066	2,057	6,123	20	9	29
05	Unable to locate	2,781	3,212	5,993	8	9	17
06	Unable to locate	1,605	1,511	3,116	10	9	19
07	Unable to locate	3,801	2,057	5,858	19	9	28
08	Left household	10,816	3,630	14,446	26	9	35
09	Voluntary close	10,307	3,258	13,565	29	9	38
10	Other	2,940	2,882	5,822	10	9	19
	Totals	$ 45,431	25,038	70,469	147	81	228

Source: SAO analysis of MMIS capitation payment data. All capitation payment figures represent state and federal shares combined.

Further explanations of the information in Table 3 (specifically, the events causing an attempted deactivation of the participant's eligibility) follow:

- Non-response (3 of 10 participants): The participant or the head of household did not respond to an annual review notice to redetermine eligibility.
- Unable to locate (4 of 10 participants): A DSS attempt to mail communication to the participant was returned as unable to locate. In these situations, federal law and DSS policy allow immediate deactivation of the participant's eligibility if no other address or contact information can be found.
- Left household (1 of 10 participants): The participant moved out of the household.
- Voluntary close (1 of 10 participants): The participant contacted the DSS to voluntarily close his/her case.
- Other (1 of 10 participants): The participant's indicator was triggered for not being pregnant when applying for MO Pregnant Women coverage and non-compliance with Child Support Enforcement.

When our review of this area was substantially completed, the DSS had not deactivated eligibility for 9 of the 10 participants. Therefore, these

participants are at increased risk of continued overpayments. In MAR findings number 3 and 4, we also observed the indicator trigger unnecessarily and caused overpayments for participants in our out-of-state residency and incarceration test work.

DSS officials previously identified problems with the indicator control, including triggering in unnecessary situations, and created a request with its vendor in January 2017 to resolve these issues. However, the underlying cause of the problem has not been resolved and department officials indicated efforts remain in progress.

Group 2: Indicator trigger was appropriate

For the 7 participants in this group, it was appropriate for the indicator to trigger. Overpayments did not occur because the DSS was required to maintain MC eligibility until its review for MHABD eligibility was complete. For 6 of 7 participants, as shown in Table 4, payments continued for 12 to 30 months after the indicator triggered. This length of time may indicate untimely reviews due to control weaknesses previously mentioned. Table 4 also includes the capitation payments issued on behalf of the participants after their respective indicators triggered. It is likely some of these capitation payments were preventable. However, we cannot calculate a specific amount because the time required to complete a given review varies by participant.

Table 4: Listing of capitation payments for Group 2 participants with triggered indicator control

		Capitation Payments			Count of Capitation Months		
Participant	Issue	36 months ending 6/30/19	9 months ending 3/31/20	Total	36 months ending 6/30/19	9 months ending 3/31/20	Total
11	Excessive income	$ 7,900	2,310	10,210	22	6	28
12	Excessive income	2,098	1,863	3,961	6	5	11
13	Excessive income	2,932	3,258	6,190	9	9	18
14	Excessive income	2,994	3,231	6,225	9	9	18
15	Excessive income	5,729	3,212	8,941	16	9	25
16	No dependents	7,275	2,658	9,933	22	8	30
17	No dependents	2,843	2,989	5,832	9	8	17
	Totals	$ 31,771	19,521	51,292	93	54	147

Source: SAO analysis of MMIS capitation payment data. All capitation payment figures represent state and federal shares combined.

Further explanations of the information in Table 4 (specifically, the events causing an attempted deactivation of the participant's eligibility) follow:

- Excessive income (5 of 7 participants): The participant or the head of household had income exceeding established eligibility thresholds.

- No dependents (2 of 7 participants): The participant was the head of household, but his/her child or children left or were removed from the household, leaving the participant without dependents. The presence of dependents was necessary for the participant's own continued eligibility.

When our review of this area was substantially completed, the DSS had not deactivated eligibility for 4 of 7 participants. Therefore, these 4 participants are at increased risk of (potentially preventable) continued capitation payments.

Conclusions

We provided the DSS with a listing of all 2,810 participants with outstanding triggers indicated. While we only formally reviewed 20 participants, we could not further split the remaining 2,790 participants between Group 1 and Group 2. This distinction requires a review of each participant's case to understand why the indicator triggered, and whether it was unnecessary or appropriate. DSS officials could not provide an estimated percent of participants who historically, as a result of the indicator trigger and review, were determined eligible for the MHABD program.

However, from our analysis of the 2,790 remaining participants, 2,440 appear at greatest risk of continued concern (and potential overpayments), and should be further investigated. Capitation payments for the full month of June 2019 were issued on behalf of all 2,440 participants, and nearly all were still actively eligible as of January 2020.

DSS officials indicated they believe that for the majority of the 2,790 remaining participants, the indicators triggered when the tracking procedures were weaker, prior to the November 2018 implementation of an external site/queue. While tracking issues continued after November 2018, this conclusion is generally supported by Table 5, which lists the number of outstanding triggers, and their days/months outstanding since June 30, 2019, for such participants.

Table 5: Duration of outstanding triggered indicators

Days Outstanding since 6/30/19	Months Outstanding since 6/30/19	Count	Percent
0 to 90	0 to 3	27	1%
91 to 365	3 to 12	739	25%
366 to 730	12 to 24	1,100	38%
731 to 1,039	24 to 34	1,034	36%
	Total[1]	2,900	

[1] A given participant can have more than one outstanding trigger.

Source: SAO analysis of MEDES indicator control data.

Under 42 CFR Section 431.958, improper payments are defined as "any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary…"

Without the ability for MEDES to avoid triggering indicators in unnecessary situations, and without effective controls to track and review (or timely review) participants with triggered indicators, the DSS is at increased risk of making overpayments, or otherwise potentially preventable capitation payments.

The DSS may be unable to deactivate eligibility when applicable for participants reported to the department in this finding until after the public health emergency ends, to remain compliant for the temporary increase in the federal share of Medicaid program costs.

Recommendation

The DSS continue working with its system vendor to prevent the indicator from triggering unnecessarily; improve processes to ensure all participants with triggered indicators are successfully tracked and reviewed timely; and deactivate eligibility (as soon as possible, permitting the public health emergency) for all 9 participants in Group 1, and the 4 identified participants in Group 2, if applicable. In addition, the DSS should review the provided participant listing to determine if further action is needed.

Auditee's Response

The DSS continues to work with the MEDES vendor to prevent the indicator from triggering unnecessarily. Additionally, the DSS is working with the MEDES vendor to implement systematic tracking of individuals with triggered indicators to ensure all participants are tracked and reviewed timely. These processes are expected to be complete by June 2021. The DSS will take action to deactivate eligibility for the 9 identified participants in Group 1 when the public health emergency expires. The DSS will review the 4 identified participants in Group 2 for necessary action and if appropriate, the DSS will deactivate eligibility when the public health emergency expires. The DSS is also reviewing the provided participant listing to complete reviews and determine if further action is needed.

3. Out-of-State Participants

The DSS improperly issued capitation payments on behalf of participants who were ineligible due to no longer residing in Missouri. Automatic and manual attempts to deactivate eligibility were not always successful due to MEDES control limitations. We identified 2,615 participants with out-of-state home addresses. For 34 of 35 participants reviewed, overpayments totaled $133,107 during the 3 years ended June 30, 2019, with an additional $17,227 through the 8 months ended February 2020.

We reviewed MEDES address records generated around December 31, 2019 (and later additional records generated around May 18, 2020), to identify participants whose home address was outside of Missouri during the 3 years ended June 30, 2019. We identified 2,615 participants, for whom the DSS paid approximately $6.56 million in capitation payments during their out-of-state periods (within the 3 years ended June 30, 2019).

We reviewed 35 of the 2,615 participants. The DSS paid $139,174 in capitation payments associated with these participants during their out-of-state periods (within the 3 years ended June 30, 2019). As of mid-February 2020, shortly after our review began, capitation payments had been discontinued for all 35 participants.

As shown in Table 6, our review found overpayments totaling $133,107 (approximately 96 percent of the $139,174) during the 3 years ended June 30, 2019, occurred for 34 of 35 participations. In addition, overpayments totaling $17,227 during the 8 months ended February 28, 2020, continued to occur for 11 of 34 participants, before their eligibility was deactivated.

Table 6: Review of overpayments for out-of-state participants

		Capitation Payments			Count of Capitation Months		
Participant	Issue	36 months ending 6/30/19	8 months ending 2/28/20	Total	36 months ending 6/30/19	8 months ending 2/28/20	Total
01	Indicator	$ 1,563	0	1,563	8	0	8
02	Indicator	1,244	0	1,244	5	0	5
03	Indicator	2,226	1,041	3,267	14	7	21
04	Indicator	4,329	1,773	6,102	12	5	17
05	Indicator	1,246	1,170	2,416	9	7	16
06	Indicator	4,084	3,481	7,565	8	6	14
07	Indicator	1,132	0	1,132	9	0	9
08	Indicator	1,559	0	1,559	4	0	4
09	Indicator	1,144	865	2,009	9	6	15
10	Indicator	1,174	0	1,174	4	0	4
11	Indicator	2,033	0	2,033	5	0	5
12	Indicator	4,373	2,664	7,037	14	8	22
13	Indicator	2,693	2,055	4,748	8	6	14
14	Newborn	1,448	0	1,448	2	0	2
15	Newborn	12,111	859	12,970	10	1	11
16	Newborn	11,902	0	11,902	10	0	10
17	Newborn	11,820	960	12,780	10	1	11
18	Newborn	9,703	0	9,703	9	0	9
19	Newborn	8,449	0	8,449	10	0	10
20	Newborn	8,384	0	8,384	7	0	7
21	Newborn	9,439	0	9,439	9	0	9
22	Newborn	3,745	0	3,745	5	0	5
23	Blocked	2,457	0	2,457	8	0	8
24	Blocked	1,274	0	1,274	8	0	8
25	Blocked	2,070	0	2,070	6	0	6
26	Blocked	1,854	0	1,854	9	0	9
27	Blocked	1,426	0	1,426	4	0	4
28	Blocked	3,390	0	3,390	3	0	3
29	Blocked	3,451	2,298	5,749	10	7	17
30	Blocked	1,416	0	1,416	3	0	3
31	Blocked	1,472	0	1,472	9	0	9
32	Blocked	1,009	0	1,009	3	0	3
33	Blocked	4,116	61	4,177	7	1	8
34	Policy error	3,371	0	3,371	5	0	5
	Totals	$ 133,107	17,227	150,334	256	55	311

Source: SAO analysis of MMIS capitation payment data. All capitation payment figures represent state and federal shares combined.

Further explanations of the information in Table 6 follow:

- Indicator (13 of 34 participants): When the DSS added the participant's out-of-state home address in MEDES, the system automatically attempted to deactivate the participant's eligibility. However, as described in MAR finding number 2, because the participant received SSI or SSDI and/or reported a disability, MEDES also automatically triggered the indicator control. Therefore, eligibility remained active. None of these participants overlap with those reviewed in MAR finding number 2.

- Newborn (9 of 34 participants): The participant is a newborn (younger than 1 year old). According to DSS officials, "Currently, MEDES determines [activates] eligibility for newborns for one full year of eligibility and does not take into consideration whether the individual is a Missouri resident or not. This has previously been identified as an issue and there is an open ticket [vendor request] to modify MEDES functionality to take action to close newborns if they move out-of-state." The correction remains in progress. Overpayments involving newborn participants are often significant, because the capitation rates for newborns are higher than rates for most other participants. The monthly rates paid for the 9 participants tested in detail ranged from $701 to $1,262 during the audit period.

- Blocked (11 of 34 participants): The participant was in a "blocked" state that generally prevented automatic eligibility deactivation attempts from being effective. Previously, all MEDES participants were forced into a blocked state in the DSS's long-term efforts to prevent MEDES from automatically deactivating eligibility in an unintended manner. However, this state created additional complexities that required a greater degree of DSS manual action to deactivate eligibility when necessary. DSS personnel manually unblocked individual participants on an as-needed basis until October 2018, when they unblocked all remaining participants.

- Policy error (1 of 34 participants): The participant was moving out-of-state and called the DSS to deactivate his/her eligibility. DSS personnel set the participant's eligibility to deactivate immediately (as opposed to after 10 business days had passed). Federal law and DSS policy only allow this method when the participant makes the request in writing. DSS personnel identified the error and reactivated/re-deactivated eligibility to return to compliance. Overpayments occurred because the second deactivation was not timely.

We provided the DSS with the list of all 2,615 participants identified. While we only formally reviewed 35 participants, we analyzed the remaining 2,580 participants. Of these, 642 are at greatest risk of continued overpayments (MEDES address records indicate the participant remains out-of-state), and

should be further investigated. Capitation payments for the full month of June 2019 were issued on behalf of all 642 participants, and all were still actively eligible as of January 2020. The DSS is allowed to deactivate eligibility for all applicable participants before the public health emergency ends, using the exception for non-residents, and remain compliant for the temporary increase in federal share of Medicaid program costs.

According to 42 CFR 435.403, state agencies must only provide Medicaid to eligible residents of the state. According to DSS officials, "the requirement is only that the individual states they are a resident of the state and intend to remain, even without a fixed address;" however, "having a home address located within the state of Missouri is what the DSS uses to support residency requirements." These home address records were used in our review. Furthermore, DSS policy states "when FSD discovers an individual or household has moved out of state, action must be taken to close the MO HealthNet eligibility."

Without effective controls to identify and discontinue capitation payments issued on behalf of participants who no longer reside in Missouri, the DSS is at increased risk of making overpayments.

Recommendation

The DSS improve efforts to timely and successfully deactivate eligibility, and continue resolving MEDES control limitations as applicable, to prevent issuing capitation payments on behalf of participants no longer residing in Missouri. In addition, the DSS should review the provided participant listing to determine if further action is needed.

Auditee's Response

The DSS is in the process of implementing the Program Participation Analyzer, which is a clearinghouse that ensures duplicate participation does not occur across state lines. This is expected to be implemented in December 2020. The DSS continues to work with the MEDES vendor to resolve MEDES control limitations to deactivate eligibility for participants no longer residing in Missouri. Additionally, the DSS is reviewing the provided participant listing to determine if further action is needed. The implementation of annual renewals in 2018 assisted in addressing this issue.

4. Incarcerated Participants

The DSS is not performing effective incarceration matches, or the results are not always used effectively, to detect, discontinue, and recoup capitation payments issued on behalf of participants who are incarcerated. We identified 515 incarcerated participants potentially missed in the department's match processes. For the 10 participants reviewed, overpayments totaled $73,620 during the 3 years ended June 30, 2019, with an additional $16,117 during the 7 months ended January 2020. As of July 2020, the DSS had recouped the majority of the overpayments.

The DSS uses Missouri Department of Corrections (DOC) data to create monthly reports to identify recently incarcerated MC program participants. Matches detected in these reports do not automatically result in deactivation of a given participant's eligibility. Instead, DSS ESs manually review each match, and potentially confirm information with the DOC, to verify the match results before proceeding.

We compared records of capitation payments to records of individuals who were in the custody of the DOC. We identified 515 participants who were incarcerated during a portion of the 3 years ended June 30, 2019. The DSS paid approximately $1.65 million in capitation payments associated with these participants during their periods of incarceration (within the 3 years ended June 30, 2019).

We reviewed 10 of the 515 participants. We obtained copies of the DSS's July 2017 and January 2019 match reports. None of the 10 participants we selected are listed in these reports, despite several remaining incarcerated during at least one of those months. According to DSS officials, the report is generated using the incarceration month and is not an accumulative report of all incarcerated individuals. Instead, if a match is identified, that initial identification is the only time the participant will appear in a report. Further review of the two reports confirmed that almost all of the participants the DSS detected were newly incarcerated in the month immediately preceding each report (June 2017 or December 2018). None of the 10 participants we reviewed began their incarceration in these months.

The DSS paid $73,620 in capitation payments associated with these participants during their incarceration periods (within the 3 years ended June 30, 2019). As shown in Table 7, our review found the entire amount represented overpayments. When we began our review in mid-October 2019, capitation payments were still being issued on behalf of 9 of 10 participants. Overpayments totaling $16,117 during the 7 months ended January 31 2020, continued to occur for each of them.

Table 7: Review of capitation payments for incarcerated participants

		Capitation Payments			Count of Capitation Months		
Participant	Issue	36 months ending 6/30/19	7 months ending 1/31/20	Total	36 months ending 6/30/19	7 months ending 1/31/20	Total
01	Not detected	$ 11,865	1,109	12,974	36	3	39
02	Not detected	11,182	1,712	12,894	33	5	38
03	Not detected	8,334	2,207	10,541	30	7	37
04	Not detected	5,447	1,773	7,220	15	5	20
05	Not detected	1,808	1,985	3,793	4	5	9
06	Bypass	13,974	1,583	15,557	36	4	40
07	Bypass	4,455	558	5,013	13	2	15
08	Indicator	8,197	1,583	9,780	20	4	24
09	Indicator	3,542	1,834	5,376	11	5	16
10	Indicator	4,816	1,773	6,589	14	5	19
	Totals	$ 73,620	16,117	89,737	212	45	257

Source: SAO analysis of MMIS capitation payment data. All capitation payment figures represent state and federal shares combined.

Further explanations of the information in Table 7 follow:

- Not detected (5 of 10 participants): Prior to our review, the DSS did not detect the participant's incarceration. Among other reasons, DSS reports may fail to detect participants if key data between the DSS and DOC, such as the participant's Social Security number (SSN), disagree. However, our comparisons of key data between the DSS and DOC found the SSN always agreed, and names either agreed or were strong matches.

- Bypass (2 of 10 participants): The participant's bypass state, as described in MAR finding number 1, caused the participant to not be subject to MEDES controls. Therefore, eligibility remained active despite DSS attempts to deactivate eligibility. Neither of these 2 participants overlap with those reviewed in MAR finding number 1.

- Indicator (3 of 10 participants): The system automatically attempted to deactivate the participant's eligibility (potentially for reasons unrelated to incarceration). However, as described in MAR finding number 2, because the participant received SSI or SSDI and/or reported a disability, MEDES also automatically triggered the indicator control. Therefore, eligibility remained active. None of these 3 participants overlap with those reviewed in the other MAR findings.

By mid-October 2019 (when our review of this area was substantially completed), the DSS had not deactivated eligibility for 9 of 10 participants. The DSS deactivated eligibility for all 9 participants by February 2020, recouped $73,718 (82 percent) of overpayments listed in Table 7 by August 2020, and indicated an additional $13,687 (15 percent) would be recouped by

early October 2020. The DSS cannot recoup the remaining $2,332 (3 percent), for the 7 months preceding May 2017, for Participant 03. These overpayments were issued to a previous MCO whose contract ended prior to the May 2017 statewide MC program expansion. The state will still be responsible for repaying the federal share for all of the amount overpaid including the portion not recouped.

We provided the DSS with a list of all 515 participants identified. While we only formally reviewed 10 participants, we analyzed the remaining 505 participants. Of these:

- 18 participants appear at greatest risk of continued overpayments, and should be further investigated. Capitation payments for the full month of June 2019 were issued on behalf of all 18 participants, and nearly all were still actively eligible as of January 2020.

- 487 participants are of reduced (or no) risk of continued overpayments, because prior to June 2019, their eligibility was deactivated and/or they were released from incarceration. However, department personnel need to investigate these participants for recoupment, because overpayments occurred during the 3 years ended June 30, 2019.

Federal law does not explicitly deem incarcerated participants to be ineligible. However, under 42 USC Section 1396d(a)(30)(A), 42 CFR Section 435.1009(a)(1), and 42 CFR Section 435.1010, federal law prohibits states from obtaining federal Medicaid matching funds for health care services provided to inmates of public institutions, such as state prisons and local jails. These laws remain in effect and are not superseded by the Families First Coronavirus Response Act's limitations to deactivate participant eligibility.

According to DSS officials, for cases in which the participant is incarcerated, there is no physical way to provide the service, so enrollment can be retroactively ended. Enrollment is ended on the day before the date of incarceration for incarcerated individuals. Procedures to deactivate eligibility were in effect until August 28, 2019, when Sections 217.930 and 221.125, RSMo, began requiring the DSS to suspend eligibility. The change from deactivating to suspending eligibility has substantially the same effect of discontinuing capitation payments. Suspension expedites the potential reactivation of eligibility for incarcerated participants that meet certain exceptions (need medical attention that requires their release for a minimum of 24 hours); but such services are reimbursed under the fee-for-service model, instead of the capitation payment model.

Without effective controls to detect, discontinue, and/or recoup capitation payments issued to MCOs on behalf of participants who are incarcerated, the DSS is at increased risk of allowing overpayments to continue.

Recommendation

The DSS improve incarceration match processes and procedures, and continue resolving MEDES issues as applicable, to prevent the issuance of capitation payments on behalf of incarcerated participants. In addition, the DSS should review the provided participant listing for further action, including deactivation of eligibility, recoupment of overpayments, and repayment of federal shares.

Auditee's Response

The DSS is working to improve incarceration match processes and procedures.

As noted in the Management Advisory Report, effective August 28, 2019, Sections 217.930 and 221.125, RSMo, require the DSS to suspend MO HealthNet coverage for incarcerated individuals, rather than deactivate eligibility. While the DSS acknowledges that the change from deactivating to suspending eligibility has essentially the same effect of discontinuing capitation payments, the statutory change has required a change in incarceration match processes. These statutory changes require the Department of Corrections (DOC), county, city, and private jails to inform the DSS when an individual receiving MO HealthNet becomes incarcerated. The DSS is working with DOC, county, city, and private jails to develop reports and processes to receive accurate and timely notice of incarcerated individuals requiring suspension and reactivation of MO HealthNet coverage.

Additionally, the DSS has reviewed the provided participant listing and completed the necessary actions to discontinue capitation payments.