
# Department of Health and Human Services

# Centers for Medicare & Medicaid Services
# Center for Program Integrity

# Kansas Medicaid and CHIP Eligibility Determinations Audit

## Audit Period: September 2019 through February 2020

## Final Report

## August 2023

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# Executive Summary

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

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

## Findings and Recommendations

Based on the results of this audit, Kansas correctly determined Medicaid and CHIP eligibility in accordance with federal and state requirements for 88[1] percent and 84 percent of the sampled beneficiaries, respectively. Kansas did not provide CMS with the appropriate claims information to statistically extrapolate the sampled Medicaid improper and potentially improper payments and resulting number of ineligible and potentially ineligible beneficiaries for the audit period.[2] However, CMS determined that Kansas made improper or potentially improper payments totaling $156,916 for the 20 sampled ineligible or potentially ineligible Medicaid beneficiaries. This audit also determined that, during the audit period, Kansas' extrapolated improper and potentially improper eligibility determinations for the CHIP population resulted in $9,672,119 (Federal share) in improper and potentially improper payments. CMS's current statutory authority[3] only allows overpayments to be recovered through the Payment Error Rate Measurement Program (PERM), thus CMS is unable to recover the federal payments associated with the ineligible beneficiaries identified as a result of this audit.[4]

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[1] Kansas did not provide CMS with the appropriate claims information to statistically project improper payments and the overall number of potentially ineligible beneficiaries, such as those noted for CHIP in Appendix C, the accuracy rate for the Medicaid program was calculated by dividing the estimated number of ineligible and potentially eligible beneficiaries (20) by the total number of beneficiaries in the sampling frame (175) to arrive at 88.57 percent overall accuracy. This is the same method employed by the statisticians for the overall accuracy rate for CHIP, see Appendix C.

[2] Subsequent to the sample beneficiary eligibility determinations being completed by the audit team, Kansas recognized and notified CMS that the original Medicaid expenditure data submitted for sampling purposes was incorrect. Because the random sample was selected from an incorrect data universe, it was determined that an extrapolation would not best represent the true condition of the Medicaid program. Kansas reported that duplicated expenditure lines existed within the Capitated payments data resulting in inflated dollars being reported. Due to time and resource constraints, it was not feasible to re-pull the data and perform a second review.

[3] Section 1903(u) of the Social Security Act.

[4] Appendix C includes additional information on the improper payment calculations.

For most eligibility determinations in the samples, Kansas 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, Kansas requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably compatible[5] with electronic sources in accordance with the State's verification plan (§ 435.952(c)(2)). Additionally, this audit found that Kansas verified citizenship or immigration status by electronically verifying citizenship status with the SSA or immigration status with the Department of Homeland Security (DHS).[6] Kansas also correctly determined beneficiaries' Medicaid eligibility for the correct aid category.

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

**Recommendation #1:** In accordance with § 435.916(d), Kansas should ensure changes in circumstance are processed timely.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

**Recommendation #3:** In accordance with § 435.912, Kansas should ensure actions are taken timely to close cases no longer requiring services.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

**Recommendation #5:** In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[7] Kansas should perform an annual renewal of Medicaid and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility.

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

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

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

**Recommendation #6:** In accordance with §§ 433.138(b) and 457.310(b)(2)(ii), Kansas should ensure that any private, third-party health care coverage is identified and documented in the case.

**Recommendation #7:** In accordance with §§ 435.1200(b)(3)(iii) and 435.912, Kansas should ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

**Recommendation #8:** In accordance with §§ 435.406 and 435.407, Kansas should have appropriate controls in place to ensure individuals are not made eligible until all elements of eligibility, such as citizenship, date of birth, and social security number, are verified.

# Kansas' Medicaid and CHIP Beneficiary Eligibility Determinations Audit

## Background

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

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

## Overview of the Medicaid and CHIP Programs

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

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

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

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

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

States operate and fund Medicaid and CHIP in partnership with the Federal Government. 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. Kansas' regular Medicaid and CHIP FMAPs for the audit period (September 2019 through February 2020) were 59.16 percent and 82.91 percent, respectively. Congress authorized an enhancement to the regular FMAPs due to the COVID-19 Public Health Emergency, which increased Kansas' Medicaid and CHIP FMAPs to 62.36 percent and 87.25 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 regulations 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]

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[11] MACPAC FMAPS for Medicaid. Retrieved August 15, 2021, from https://www.macpac.gov/wp-content/uploads/2018/04/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-Federal-Medical-Assistance-Percentages-by-State-FYs-2018-2021.pdf

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

[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.

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] The ACA also provided enhanced FMAP (75 to 90 percent) to support states in the replacement or upgrade of outdated eligibility systems and to establish links to other data sources to implement new streamlined processes.

To promote program integrity when verifying eligibility while also minimizing the amount of paper documentation that applicants and beneficiaries need to provide, the ACA also required states to primarily rely on available electronic data sources to verify information included on the application (or conduct the renewal process), such as data from the SSA, the DHS, and the state Department of Labor.[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]).

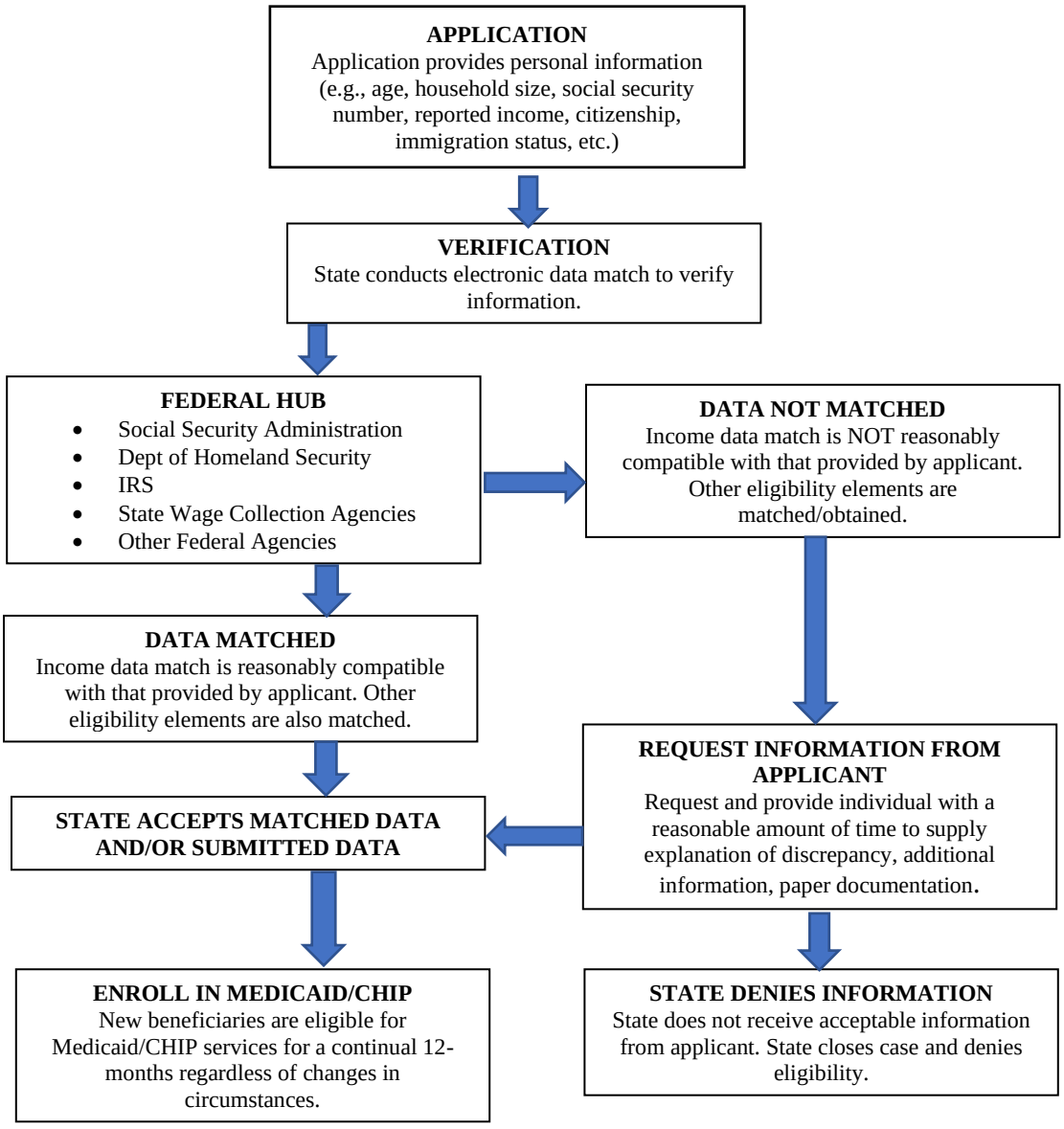
Regulations at §§ 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state. States must submit their verification plans to CMS upon request and provide updated versions of the plans to CMS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

[16] 42 CFR § 433.10(c)(6).
[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 Kansas' Medicaid and CHIP Eligibility Processes

Individuals seeking coverage may apply on-line, through a phone call, or by paper. 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 Kansas through the Data Hub are provided by HHS, the SSA, the DHS, and the IRS, among others. Kansas also uses data sources maintained by the State, such as the SWICA.

*Figure 1*: Kansas' Medicaid and CHIP MAGI Eligibility Process




[20] Kansas MAGI-Based Eligibility Verification Plan. Retrieved September 21, 2021 from https://www.medicaid.gov/sites/default/files/2019-12/kansas-magi-based-verification-plan.pdf

## Overview of the Kansas Medicaid and CHIP Eligibility Determinations Audit

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

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

The audit encompassed the following four areas:

**A. State Oversight of Eligibility Determinations.** CMS established requirements at § 431.10(c) that require the state Medicaid agency (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 and unemployment compensation from SWICA and state unemployment insurance to verify more recent wage records or wage information, if necessary. The State may also request additional information or documentation from beneficiaries for a variety of reasons, including but not limited to, attested income did not closely match verified income, verified assets exceeded what was attested, and 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. 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.

[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.

**D. Required Annual Renewals of Medicaid and CHIP Beneficiaries.** In accordance with § 435.916, periodic renewal of Medicaid eligibility, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, must be renewed once every 12 months and no more frequently than once every 12 months. The State 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 State, including but not limited to information accessed through any data bases accessed by the State under §§ 435.948, 435.949, and 435.956.

# Results of the Audit

## Medicaid

Kansas correctly determined Medicaid eligibility in accordance with federal and state requirements for 88 percent of the sampled Medicaid beneficiaries. In the sample of 175 Medicaid beneficiaries, Kansas correctly determined eligibility in accordance with federal and state requirements for 155 beneficiaries. CMS identified findings for six improper eligibility determinations in which Kansas did not always verify resources, end Medicaid coverage for beneficiaries who moved out of state or indicated they no longer require Medicaid services, or ensure beneficiaries did not belong in another coverage program. In addition, Kansas did not provide sufficient documentation to support the eligibility determinations for 14 potentially ineligible beneficiaries. Because of a lack of supporting documentation, CMS could not definitively determine whether these 14 beneficiaries were eligible for Medicaid. CMS also identified several observations for instances in which eligibility was determined correctly for eight beneficiaries although an error was made at some point during the eligibility determination process.

Of the universe of federal Medicaid payments totaling $1,856,020,417 made on behalf of 338,539 beneficiaries during the audit period, CMS' sample of 175 beneficiaries represented $9,564,141 in federal Medicaid payments. Based on the results of this audit, Kansas made improper or potentially improper payments totaling $156,916 for the 20 sampled ineligible and potentially ineligible beneficiaries.[22] However, as noted earlier in the report, Kansas did not provide CMS with the appropriate claims information to statistically extrapolate the resulting improper payments or the number of ineligible beneficiaries for the audit period.

## CHIP

Kansas correctly determined CHIP eligibility in accordance with federal and state requirements for 84.16 percent of the sampled CHIP beneficiaries. In the sample of 125 CHIP beneficiaries, Kansas correctly determined eligibility in accordance with federal and state requirements for 104 beneficiaries. CMS identified findings for 13 improper eligibility determinations in which Kansas did not always include or calculate all applicable income correctly or verify cases for other health insurance information prior to deeming cases eligible for CHIP. In addition, Kansas

[22] Appendix C includes additional information on the improper payment calculations.

did not provide sufficient documentation to support the eligibility determinations for eight potentially ineligible beneficiaries. Because of a lack of supporting documentation, CMS could not definitively determine whether these eight beneficiaries were eligible for CHIP. CMS also identified several observations in which eligibility was determined correctly for five cases, but the monthly premium was assessed incorrectly. Another observation was made in which eligibility was correctly determined for the case but then incorrectly terminated during the audit period.

Of the universe of federal CHIP payments totaling $49,661,943 made on behalf of 56,156 beneficiaries during the audit period, CMS' sample of 125 beneficiaries represented $195,740 in CHIP payments. Based on the results of this audit, Kansas made improper and potentially improper payments totaling $23,950 for the 21 sampled ineligible and potentially ineligible beneficiaries. Extrapolating these errors to the entire Kansas CHIP population, CMS estimates that, during the audit period, Kansas made federal CHIP payments on behalf of an estimated 8,897 ineligible and potentially ineligible CHIP beneficiaries, totaling an estimated $9,672,119 (federal share) in improper and potentially improper payments.[23]

# Medicaid Findings

Findings are those errors where the State did not make an accurate eligibility determination based on the 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 6 ineligible beneficiaries are described below.

1. **The beneficiary was no longer eligible for Medicaid due to no longer residing in the state.**

   In October 2019, a beneficiary in the low-income families' eligibility category reported that they had moved out of state. Actions should have been taken to close this case effective no later than November 2019; however, Kansas did not close the case until June 2020. There was no documented explanation for the late closure of the case in the case records. Kansas did not provide an explanation for the late closure when requested during the audit.

   Based on this error, total payments of $1,912.97 (federal share) were inappropriately paid for the sampled individual during November 2019 through February 2020.

   **Recommendation #1:** In accordance with § 435.916(d), Kansas should ensure changes in circumstance are processed timely.

2. **The beneficiary was not eligible for Medicaid due to resources being excluded from the eligibility calculation.**

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

A beneficiary in the home and community-based services (HCBS) eligibility category had two renewals covering the audit period. The first renewal was received January 28, 2019, for the eligibility period of January through December 2019, with the second renewal being a passive renewal covering the period of January through December 2020. On March 22, 2019, the eligibility determination and benefit calculator (EDBC) was run for the first renewal. When running the EDBC, the caseworker did not include a self-reported savings account belonging to the beneficiary, which resulted in approval of the beneficiary for long-term care level of services with a monthly obligation of $1,100.85. If the savings account had been included as a resource, the beneficiary would not have been eligible. In January 2020, the passive review ran by batch. The beneficiary was approved for the same level of care with a monthly obligation of $695.35. The savings account was still not included as a resource. If the savings account had been included in the EDBC, the beneficiary would not have been eligible for Medicaid for being over the resource limit.

Based on this error, total payments of $15,461.77 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

3. **The beneficiaries were no longer eligible for Medicaid services due to the individual's household no longer requiring Medicaid coverage.**

**3.A)** A beneficiary in the mandatory poverty level related (MPLR), children ages 1-5 eligibility category was born on January 22, 2016. The beneficiary was an infant at the time of the initial enrollment. Annual renewals were performed for January through December 2017 and January through December 2018, appropriately placing the child into the eligibility category for children, ages 1-5. However, by the start of next enrollment period, January through December 2019, the beneficiary's household was no longer returning the pre-populated renewal forms, which indicated they no longer required Medicaid services. The beneficiary's case should have been closed on January 31, 2019, for failure to provide information; however, the case was not closed by the state until January 31, 2020. There was no documented explanation for the late closure of the case in the case records. Kansas did not provide an explanation for the late closure when requested during the audit.

Based on this error, total payments of $587.80 (federal share) were inappropriately paid for the sampled individual during the audit period.

**3.B)** A beneficiary in the MPLR, infants' eligibility group was born on December 20, 2016. The beneficiary was an infant at the time of the original enrollment. By the time for subsequent enrollment periods (January through December 2018, and January through December 2019), the beneficiary's household was no longer returning pre-populated renewal forms indicating they no longer required Medicaid services. The beneficiary's case should have been closed January 2018; however, the case was not closed by Kansas

until January 31, 2020. There was no documented explanation for the late closure of the case in the case records. Kansas did not provide an explanation for the late closure when requested during the audit. Additionally, the beneficiary would have moved from the category of 'infants and under age 1' with an upper FPL limit of 171 percent, to 'children ages 1-5' with an upper FPL limit of 149 percent.

Based on this error, total payments of $601.42 (federal share) were inappropriately paid for the sampled individual during the audit period.

**3.C)** A beneficiary in the MPLR, infants' eligibility group was born on November 7, 2016. The beneficiary was a deemed newborn when the case opened. By the time of subsequent enrollment periods (November 2017 through December 2018 and November 2018 through December 2019) the beneficiary's household was no longer returning pre-populated renewal forms indicating they no longer required Medicaid services. The beneficiary's case should have been closed on January 31, 2019; however, the case was not closed by the state until January 31, 2020. There was no documented explanation for the late closure of the case in the case records. Kansas did not provide an explanation for the late closure when requested during the audit. Additionally, the beneficiary should have been moved from the category of 'infants and under age 1' with an upper FPL limit of 171 percent, to 'children ages 1-5' with an upper FPL limit of 149 percent.

Based on this error, total payments of $666.04 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #3:** In accordance with § 435.912, Kansas should ensure actions are taken timely to close cases no longer requiring services.

4. **The beneficiary was not eligible for Medicaid coverage and should have been covered under CHIP.**

A beneficiary in the MPLR, children ages 6-18 eligibility group had renewals which crossed two renewal periods during the audit period. The first renewal period was for the coverage period of October 2018 through September 2019 with a monthly income of $2,941.02. As a result, the beneficiary was placed into CHIP with no monthly premium. Upon the next renewal period, October 2019 through September 2020, the household attested to a monthly income of $4,472.00. At this time, the beneficiary remained in CHIP and was assessed a higher premium of $50. On March 17, 2020, the household reported a loss of income. With this loss of income, the case worker incorrectly moved the beneficiary to Medicaid. Even with the change in circumstances, the beneficiary should have remained in CHIP. The change should have taken effect on March 1, 2020, moving forward; however, the case worker backdated the action to start December 1, 2019.

Based on this error, total payments of $176.70 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

# 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. Potential findings and recommendations for the 14 potentially ineligible beneficiaries are described below.

1. **CMS was unable to verify if the beneficiaries were eligible for Medicaid due to a failure to verify resources.**

   **1.A)** A beneficiary in the HCBS eligibility group self-attested to $1,020 in a checking account; however, Kansas staff never verified the account or the amount. There was no documented explanation for why the checking account was not verified in the case records. Kansas did not provide an explanation for the unverified checking account when requested during the audit.

   Based on this error, total payments of $17,104.99 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

   **1.B)** A beneficiary in the HCBS eligibility group was originally denied services due to excessive resources during their April 2019 renewal process. Subsequently, Kansas staff inappropriately applied spousal impoverishment provision rules to the couple's resources (approximately $150,000) to make the beneficiary eligible. However, Medical Assistance Standards for that time period only allowed an upper limit of $126,420 for spousal impoverishment.[24] Financial eligibility using this application of spousal impoverishment was also denied. A request for redetermination was made on June 19, 2019, and eligibility was approved as a greater portion of the couple's resources were attributed to an Individual Retirement Account. Additionally, 50 percent of the value of the couple's land and car (total value $5,970) should have been recorded as assets for the beneficiary but were erroneously excluded. There was no justification in the file for the spousal impoverishment determination and resources were not accounted for completely or rationally when making the beneficiary's financial eligibility determination.[25]

[24] Kansas Medical Assistance Standards. Pg 5. (2019, January 19). Retrieved March 14, 2022, https://www.kancare.ks.gov/docs/default-source/policies-and-reports/kdhe-keesm/kfmam-policy-memos/all-medicaid-program-memos/2019-all-policy-memos/f-8-ks-medical-standard-4-19.pdf?sfvrsn=64804c1b_8

[25] State Medicaid Director Letter (SMD) #15-001, ACA #32. Affordable Care Act's Amendments to the Spousal Impoverishment Statute (2015, May 7). Retrieved March 14, 2022, from https://www.medicaid.gov/federal-policy-guidance/downloads/smd050715.pdf

Based on this error, total payments of $17,328.30 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**1.C)** A beneficiary in the HCBS eligibility group received presumptive eligibility as an SSI recipient prior to the December 2019 annual renewal. During this renewal, the beneficiary self-attested to $771 in income and assets, which consisted of a checking account. The checking account and its value were never verified. Also, the beneficiary's income had switched from SSI to SSDI; the case worker continued the beneficiary's eligibility as an SSI case. The beneficiary's eligibility as an SSI case should have ended and the case should have been placed in a 'spend-down' situation for the eligibility of January 2020 through December 2020.

Based on this error, total payments of $3,478.61 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**1.D)** A beneficiary in the HCBS eligibility group reported themself as a separated individual. The beneficiary was then approved for long-term care level of services; however, during the eligibility audit, the asset verification system (AVS) reported a joint bank account shared with the beneficiary's spouse. This should have triggered Kansas to follow-up on additional resources possibly attached jointly to the beneficiary and spouse. There was no documented explanation for why Kansas did not follow-up on the joint bank account in the case records. Kansas did not provide an explanation for not following-up on the potential additional resources when requested during the audit.

Based upon the beneficiary's income and resources, they were also approved as a Qualified Medicare Beneficiary (QMB) with no beneficiary obligation. The QMB approval could have been different if the spousal resources were included. Inclusion of all resources tied the beneficiary's case could affect overall Medicaid eligibility.

Based on this error, total payments of $14,206.29 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

2. **CMS was unable to verify if the beneficiary was eligible for Medicaid due to a failure to request documentation to support income.**
   A beneficiary in the HCBS eligibility group reported income in the Kansas Eligibility Enforcement System (KEES) that was not reasonably compatible with income from the Kansas Department of Labor (KDOL). There was no documented explanation for why Kansas did not request the documentation to support the income in the case records. Kansas did not provide a clear explanation as to why the failure occurred when requested during the audit.

Based on this error, total payments of $23,773.64 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

3. **CMS was unable to verify if the beneficiary was eligible for Medicaid due to use of inaccurate information.**
When determining eligibility for a beneficiary in the HCBS eligibility group, Kansas used inaccurate information when calculating the beneficiary's obligation. The beneficiary's pension amount was incorrect in KEES and the Medicare Part D expense was not included in KEES. Additionally, the Blue Cross and Blue Shield and Citizen Security expenses were not listed appropriately in other health care coverage. Considering the incorrect pension and understated obligation, the beneficiary's income would be $1,482.98 monthly making them over the income limit for the Medical Savings Plan for Low-income Medicare Beneficiaries (MSP LMB).[26] Kansas should have ensured they were using the correct pension information when determining the beneficiary's Medicaid eligibility.

Based on this error, total payments of $14,758.63 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

4. **CMS was unable to verify Medicaid eligibility due to a failure to conduct an annual review covering the audit period.[27]**
**4.A)** Kansas received the prepopulated renewal form for a beneficiary in the HCBS eligibility group on August 26, 2019, for the certification period of October 2019 through September 2020; however, Kansas failed to process the renewal information through the EDBC. Additionally, Kansas did not allow the Medicare Part D expense of $7.94 to be deducted from the beneficiary's monthly income when calculating the monthly obligation, therefore overstating the beneficiary's obligation. There was no documented explanation for why the renewal information was not processed or why the Part D expense was not deducted in the case records. Kansas did not provide a clear explanation for the cause of these failures when requested during the audit.

[26] Kansas' Medical Savings Program (MSP) is for people who have Medicare and helps with some out-of-pocket expenses. This program may pay for or lower Medicare Part A, Part B and/or Part D premiums, deductibles, and copayments (based on income). To qualify for any level of MSP, individuals must have or be eligible for Medicare Part A and have income and resources below a certain threshold. The income and resource requirements are different for each of the three Medicare Savings Programs/Levels and may change from year to year. LMB pays for or lowers Medicare Part B and D as well as Premiums.

[27] 42 CFR § 435.916 and 42 CFR § 457.343 require annual renewals of individuals whose eligibility is based on modified adjusted gross income methods (MAGI).

Based on this error, total payments of $5,508.93 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.B)** A beneficiary in the HCBS eligibility group stopped receiving SSI in 2017. In January 2018, Kansas staff recorded that the beneficiary's SSI had ceased but did not place an end date in the file which would have triggered the need for a new application considering household income and resources. No Medicaid eligibility renewals have been conducted since 2017. Additionally, the beneficiary has not had a functional review since 1999. There was no documented explanation for why an eligibility and functional review have not taken place. Kansas did not provide an explanation for why these errors occurred when requested during the audit.

Based on this error, total payments of $18,978.64 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.C)** A beneficiary in the HCBS eligibility group did not have any renewals performed on their case from 2016 to early 2020. The beneficiary's case contained no eligibility notes prior to January 2020. A passive renewal was performed in February 2020 for the eligibility period beginning March 2020. Kansas did not provide an explanation for why no renewals were conducted for this beneficiary when requested during the audit.

Based on this error, total payments of $17,161.03 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.D)** A beneficiary in the MPLR, infants' eligibility group did not have any renewals performed on their case from 2016 to early 2020. According to KEES, the beneficiary remained in the 'MPLR or MPLR Infant' category from birth to age 3 ½. In April 2020, a renewal was performed moving the beneficiary to the 'MPLR Age 1-5' category. There was no documented explanation for why no renewals were conducted in the case records. Kansas did not provide an explanation for why no renewals were conducted for this beneficiary when requested during the audit.

Based on this error, total payments of $713.76 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.E)** A beneficiary in the low-income family's eligibility group did not have any renewals performed on their case from 2017 to early 2020. According to Kansas, the case remained open, and a passive renewal was executed on February 9, 2020, approving the beneficiary for the eligibility period of March 2020 through February 2021. There was no documented explanation for why no renewals were conducted in the case records. Kansas did not provide an explanation for why no renewals were conducted for this beneficiary when requested during the audit.

Based on this error, total payments of $1,985.70 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.F)** A beneficiary in the 'MPLR, Children Ages 1-5' eligibility group did not have any renewals performed on their case since 2016. At the time of the review, May 2021, the beneficiary would have been six years of age, and in turn, would have aged out of the 'MPLR, Children Ages 1-5' category with an upper FPL limit of 149 percent. The next age category the beneficiary would be eligible for would be 'MPLR, Children Ages 6-18' with an upper FPL limit of 113 percent. As of the time of the review date, no action had been taken to review or dismiss the beneficiary's case. There was no documented explanation for why no renewals were conducted in the case records. Kansas did not provide an explanation for why no renewals were conducted for this beneficiary when requested during the audit.

Based on this error, total payments of $858.80 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.G)** A beneficiary in the low-income families' eligibility group did not have any renewals performed on their case since 2017. At the time of the review, May 2021, no action had been taken to review or dismiss the beneficiary's case. There was no documented explanation for why no renewals were conducted in the case records. Kansas did not provide an explanation for why no renewals were conducted for this beneficiary when requested during the audit.

Based on this error, total payments of $754.79 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**4.H)** A beneficiary in the 'MPLR, Children Ages 6-18' eligibility group, did not have any renewals performed on their case from September 2017 to January 2020. According to Kansas, the case remained open, and a passive renewal was executed on December 8, 2019, approving the beneficiary for the 'MPLR Children Ages 6-18' category effective February 2020 through January 2021. Only one month of the audit period (February 2020) was actively covered by a renewal. There was no documented explanation for why no renewals were conducted in the case records. Kansas did not provide an explanation for why no renewals were conducted for this beneficiary when requested during the audit.

Based on this error, total payments of $601.42 (federal share) could not be verified as appropriately paid for the sampled individual during September 2019 through January 2020 of the audit period.

**Recommendation #5:** In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[28] Kansas should perform annual renewals of Medicaid and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility.

# Medicaid Observations

During the audit, other issues were identified in the sampled cases that do not represent an error to the State because, while an error was made at some point during the eligibility determination process, eligibility was ultimately determined correctly. Observations result in recommendations that will ensure the State comes into compliance with federal requirements and the state's verification plan. Observations and recommendations for the 8 beneficiaries are described below.

1. **The beneficiary's case did not include a coverage period for their private third-party insurance.**
   A minor beneficiary in the HCBS eligibility group had private third-party insurance through their parent. The private coverage is ongoing; however, Kansas' system shows an end date for the coverage. A period of new coverage for the private coverage had not been created in the system during the audit period. Because Medicaid is the payor of last resort, this may cause Kansas, or contracted health plans, to chase claims that have already been paid by Medicaid rather than avoid paying the claim from the start.[29]

   **Recommendation #6:** In accordance with §§ 433.138(b), Kansas should ensure that any private, third-party health care coverage is identified and documented in the case.

2. **Kansas did not calculate the beneficiary's obligation correctly.**
   **2.A)** A beneficiary in the HCBS eligibility group's case was not reviewed by any Kansas staff since 2017. On August 23, 2019, Kansas received a renewal from the beneficiary for the eligibility period of October 2019 through September 2020, however, a renewal was not performed. The case was pushed through for coverage with an error code, noting that someone was supposed to return to review the case at a later date. The beneficiary's 2017 SSA income was entered into KEES. The system was updated by batch with what it anticipated to be the COLA increases. In 2019, the beneficiary provided Kansas with a letter from the SSA documenting the correct SSA income; however, Kansas did not use this updated income. EDBC ran August and September 2019 eligibility data using the incorrect income from 2017 already in KEES, and on November 11, 2019, the beneficiary was mailed a letter approving coverage and stating that obligations of $285 from the prior had not changed. In December 2019, EDBC was run again using past 2017

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

[29] Medicaid is generally the payer of last resort: by law, all other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. Federal regulation refers to this requirement as third-party liability (TPL), meaning payment is the responsibility of a third party other than the individual or Medicaid. To implement the Medicaid TPL requirements, federal rules require states to take reasonable measures to identify potentially liable third parties and process claims accordingly. Medicaid enrollees also must cooperate with state efforts to pursue other sources of coverage.

income with the anticipated COLA for February 2020 arriving at an obligation amount of $308. Had Kansas used the beneficiary's actual income provided to them by the beneficiary in 2019, the obligation would have been $327. Additionally, Kansas should have ensured they were using the SSA income when determining the beneficiary's Medicaid eligibility.

**2.B)** Kansas had not updated the beneficiary's Medicare Part D to reflect that it was no longer being deducted from the beneficiary's social security check since 2016. Additionally, the beneficiary's monthly Blue Cross and Blue Shield premium had not been updated since 2017. Kansas' failure to update the beneficiary's case resulted in an understated monthly obligation. EDBC shows the obligation to be $1,135.06; the actual monthly obligation to Kansas should have been $1,411.00. Kansas should adjust the obligation to reflect the correction of the errors.

**2.C)** Due to case worker error, Kansas inappropriately allowed a past due and owing expense of $5,091.21 for September and October 2019 when calculating the beneficiary's eligibility and obligation for the HCBS eligibility group. A similar expense of $573.79 was inappropriately allowed for November 2019. These errors inappropriately impacted the beneficiary's obligation for three months of the audit period.

**2.D)** Due to case worker error, Kansas inappropriately counted the Medicare Part D monthly expense of $39.30 twice when calculating the monthly obligation for a beneficiary in the HCBS eligibility group. This error resulted in an understated obligation for the beneficiary. Due to this error, Kansas calculated the obligation as $1,670.21; the correct obligation should have been $1,709.11.

**2.E)** A beneficiary in the HCBS eligibility group inappropriately included an additional qualifying expense which should have decreased the monthly obligation by $20. The EDBC was run on December 21, 2019, and again on January 5, 2020, with no effective changes to the beneficiary's obligation.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

3. **The beneficiary was approved for emergency medical services only rather than full scope Medicaid.**
   A beneficiary in the low-income families' eligibility group was approved for emergency medical services only for December 18-19, 2019, for the birth of a child. Kansas verified the beneficiary's citizenship through SAVE. The beneficiary was an LPR and had met the five-year bar. The beneficiary self-attested to no income and Kansas ran reasonable compatibility tests on the income which were unsuccessful. The claim of no income was followed up on and verified. Kansas performed all necessary steps to verify eligibility and should have made the beneficiary eligible for full scope Medicaid services for an entire 12 months rather than for emergency services to deliver the child only.

**Recommendation #7:** In accordance with §§ 435.1200(b)(3)(iii) and 435.912, Kansas should ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined.

4. **The beneficiary's record reflected SSI income rather than SSA income.**
The record for a beneficiary in the HCBS eligibility group reflected that they had SSI income. Kansas attested that the match with the Data Hub returned an invalid record. At the time, Kansas did not pursue any follow-up. The beneficiary's record has now been corrected to reflect SSA income rather SSI income.

   **Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

# 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 13 ineligible beneficiaries are described below.

1. **The beneficiary was not eligible for CHIP coverage and should have been covered under Medicaid.**[30]
**1.A)** The case worker failed to consider the beneficiary's parent's four months of maternity leave in which no income was received when calculating income for CHIP coverage. The decrease in income reduced the household's FPL from 191 percent to 128 percent. Had the case worker correctly calculated the income, the infant beneficiary would not have been eligible for CHIP; however, the beneficiary would have been eligible for the coverage under the Medicaid program.

   Based on this error, total payments of $3,108.03 (federal share) were inappropriately paid for the sampled individual during the audit period.

   **1.B)** A renewal was received on behalf of the beneficiary on September 23, 2019, for the certification period of November 2019 through October 2020. The household of five was ineligible due to outstanding income. The two wage earners self-attested to combined incomes of $6,773.55. Income totals would have increased if the KDOL or TALX amounts would have been considered. Considering only the self-attested incomes, the

[30] https://www.kancare.ks.gov/docs/default-source/policies-and-reports/kdhe-keesm/kfmam-policy-memos/all-medicaid-program-memos/2019-all-policy-memos/f-8-ks-medical-standard-4-19.pdf?sfvrsn=64804c1b_8 In Kansas, for 2019/2020 newborns to age 1 with an FPL up to 171 percent are covered under Medicaid. Children ages 1-5 with an FPL of up to 149 percent are covered under Medicaid and children ages 6-18 with an FPL up to 113% are covered under Medicaid. Uninsured children with an FPL between 113-138 percent are covered under M-CHIP. Separate CHIP covers children up to 235 percent of FPL.

household was over the upper eligibility limit of $5,909 per month for a household of five. Based on household size and incomes, the beneficiary was not eligible for CHIP services during the eligibility period of November 2019 through October 2020.

A new application was received on December 28, 2019, indicating one parent was no longer in the home, reducing the household size to four. Monthly income for only one wage earner of $2,142 with a household of four should have been used in the new eligibility calculation. The upper Medicaid eligibility limit based of the age of the beneficiary was $3,198 monthly. The case worker did not correctly calculate monthly income, nor did they reduce the household size to the appropriate size of four. Once again, the beneficiary was determined by the state to be eligible for CHIP coverage. Based on the household size and income, the beneficiary was not eligible for CHIP services, but may have been eligible for Medicaid services, for the eligibility period of December 2019 through November 2020.

Based on this error, total payments of $558.72 (federal share) were inappropriately paid for the sampled individual during the audit period.

**1.C)** The beneficiary belongs to a household size of six that included two wage earners in the prior renewal period. While performing verification of incomes for the renewal period of June 2019 through May 2020, Kansas could not verify one of the wage earner's incomes through KEES. Kansas contacted the household to obtain more information and learned that one parent was no longer employed and had not been employed since April 19, 2019. This change in circumstance occurred prior to the beginning of the new renewal period. Although Kansas received clarifying information from the household, the updated information was not used by the case worker in the eligibility calculation. With this loss of income, the beneficiary should have been made eligible for the Medicaid program rather than CHIP.

Based on this error, total payments of $876.39 (federal share) were inappropriately paid for the sampled individual during the audit period.

**1.D)** The beneficiary belongs to a household of five that reported monthly income of $3,947. The reported income was input into the KEES system; however, the correct income was not used in the EDBC system. At the time of the renewal there were no system edits to ensure the KEES and EDBC systems were using the same information and the case worker applied the wrong income when determining financial eligibility. As a result, based on income standards and FPL limits, the beneficiary was incorrectly made eligible for CHIP with an FPL of 113 percent when the beneficiary was eligible for the Medicaid program instead.

Based on this error, total payments of $1,053.44 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #2:** In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly.

2. **The beneficiaries are not eligible due to an incorrect eligibility calculation.**[31]

**2.A)** The beneficiary's family self-attested to two income streams for a monthly total of $5,478.66. One parent's monthly income of $1,225.54 was not included in the eligibility calculation. Had EDBC included this recent change in income, the household's FPL would have been 308 percent. The upper limit for CHIP eligibility was 235 percent. Based on the family's income for a household size of three, the beneficiary was ineligible for CHIP and any other federally funded program.

Based on this error, total payments of $1,095.38 (federal share) were inappropriately paid for the sampled individual during the audit period.

**2.B)** The renewal received for the period of August 2019 through July 2020 from the household of five had two wage earners. The case worker noted that Wage Earner #1's income was not reported; however, the system showed a monthly verified income of $5,960.98. Wage Earner #2 reported a monthly income of $928.60. Reasonable compatibility was run on August 5, 2019, which came back negative from the Kansas Department of Labor (KDOL) and TALX on Wage Earner #2's income. Kansas did not ask to verify the income, instead, the worker put in the journal that Wage Earner #2's income was verified using a monthly TALX income of $2,194.50. In the end, Kansas used only Wage Earner #1's income and Kansas chose to calculate eligibility using the income of $3,096.00 from the prior renewal. EDBC ran with this information and was approved with a 210 percent FPL and a premium of $30 per month. Based on case records, Kansas did not use appropriate incomes when determining eligibility for the beneficiary. Had Kansas used Wage Earner #1's monthly verified income alone, the FPL would have been 238 percent making the beneficiary ineligible for CHIP. Based on the inaccuracies in the eligibility calculation, the beneficiary was not eligible for CHIP during the audit period.

Based on this error, total payments of $1,053.44 (federal share) were inappropriately paid for the sampled individual during the audit period.

**2.C)** The beneficiary's case as of October 2019 noted no income for the household of three, indicating a loss of employment of the wage earner. In December 2019, the household's wage earner provided paystubs showing a monthly income of $2,773. The amount Kansas used to determine financial eligibility for CHIP, however, was $4,166.67. The beneficiary remained in CHIP coverage with a monthly premium of $30 during the audit period. Due to the loss of income from October through December 2019, and the lower income as documented by paystubs from December 2019 forward, the beneficiary

[31] Kansas Medical Assistance Standards. (2019, April). Retrieved March 16, 2022, from https://www.kancare.ks.gov/docs/default-source/policies-and-reports/kdhe-keesm/kfmam-policy-memos/all-medicaid-program-memos/2019-all-policy-memos/f-8-ks-medical-standard-4-19.pdf?sfvrsn=64804c1b_8

may have no longer been eligible for CHIP but would likely have been eligible for Medicaid coverage. The case worker did not document how income was counted or if the loss of income was verified, or the methodology in which eligibility was made throughout any eligibility determinations.

Based on this error, total payments of $1,169.13 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

3. **The beneficiary was not eligible for CHIP due to a failure to provide income information.**
   This beneficiary's household of five returned the prepopulated renewal form on October 4, 2019, for the certification period of November 2019 through October 2020. There were two wage earners for the household. Both parents' incomes were run for reasonable compatibility but only one was successful. Kansas requested additional income information from the parent who failed compatibility. Information was not provided to Kansas. The case was reported as pending on October 30, 2019, for failure to provide (FTP) income information; however, the case was never officially closed. The case worker wrote in the journal that EDBC was run to 'pend' the case, but no EDBC ran to fail them for FTP. The family continued to receive CHIP services with no premium.

   Based on this error, total payments of $1,049.32 (federal share) were inappropriately paid for the sampled individual during the audit period.

   **Recommendation #3:** In accordance with § 435.912, Kansas should ensure actions are taken timely to close cases no longer requiring services.

4. **The beneficiaries were ineligible for CHIP due to a failure to verify income.**
   **4.A)** The case worker noticed that the renewal for this case was overdue and sent a prepopulated renewal form to the household of three. The prepopulated renewal form was received by Kansas on March 19, 2019, for the certification period of May 2019 through April 2020. One of the parents is undocumented and has no social security number, therefore paystubs were requested. Paystubs were received on April 1, 2019; however, the paystubs were in someone else's name (believed to be the parent's in-law). The actual name was crossed out and the parent's name was handwritten on the paystub. Kansas considered the paystubs as valid income records and certified the case. Kansas did not conduct any additional follow-up to verify the parent's income.

   Based on this error, total payments of $1,032.12 (federal share) were inappropriately paid for the sampled individual during the audit period.

**4.B)** Kansas received an online application on June 25, 2019, for an eligibility start date of July 1, 2019. The head of household for this family of three self-attested to no income on the application; however, SWICA reported $3,655 monthly income in the third quarter of 2018. The EDBC used this income for the June 25, 2019, application. Kansas did not verify the parent's self-attested income or perform any tests of reasonable consideration. If the self-attested earnings of no income were verified, a new EDBC should have been run and the beneficiary would not have qualified for CHIP coverage, but instead may have qualified for Medicaid coverage.

Based on this error, total payments of $2,151.36 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

5. **The beneficiaries were ineligible for CHIP because they had private health care coverage.**

**5.A)** This case included a household size of three which had private third-party insurance through Blue Cross and Blue Shield throughout the audit period. The prepopulated renewal form was received by Kansas on June 20, 2019, for the certification period of July 2019 through June 2020. Kansas processed eligibility without checking for third-party insurance prior to determining CHIP eligibility.

Based on this error, total payments of $1,095.38 (federal share) were inappropriately paid for the sampled individual during the audit period.

**5.B)** This case included a household size of two which had private third-party insurance through Blue Cross and Blue Shield throughout the audit period. The prepopulated renewal form was received by Kansas on August 10,2019, for the certification period of September 2019 through September 2020. Kansas processed eligibility without checking for third-party private insurance prior to determining CHIP eligibility.

Based on this error, total payments of $1,095.38 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #6:** In accordance with § 457.310(b)(2)(ii), Kansas should ensure that any private, third-party health care coverage is identified and documented in the case.

6. **The beneficiary was not eligible for CHIP due to income which did not pass reasonable compatibility.**

This case included a household size of four. The renewal received on October 9, 2019, covered the period of November 2019 through October 2020. There were two wage earners in the household. Wages for the prior period were $3,263.00 and $803.25. Wage Earner #1 reported their income to be the same as the prior period ($3,263.00) while the

other reported an income change but did not state what the change was. Reasonable compatibility was not run on the income change, nor did Kansas ask Wage Earner #2 to provide verification of income. Kansas attested that reasonable compatibility was run on Wager Earner #1's income; however, documentation of this does not appear in the system. Also, the journal does not indicate what amount the new Wage Earner's income was. Finally, for November 2019 through October 2020, the case worker ran financial eligibility using Wage Earner #1's income of $3,263.00 and did not include any income from Wage Earner #2.

Based on this error, total payments of $1,053.44 (federal share) were inappropriately paid for the sampled individual during the audit period.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

# 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. Potential findings and recommendations for the 8 potentially ineligible beneficiaries are described below.

1. **CMS was unable to verify CHIP eligibility due to a failure to conduct an annual review covering the audit period.**
   **1.A)** The last renewal for this case was an online renewal in February of 2016 covering the certification period of March 2016 through February 2017. Kansas did not close the renewal for subsequent periods and the beneficiary continued to receive services throughout the review period. In addition, the case included an inappropriate household size of three rather than the correct household size of two. There was no documented explanation for why no renewals were conducted in the case journal records. Kansas did not provide a clear explanation for why no renewals were conducted for this beneficiary when questioned during the audit.

   Based on this error, total payments of $1,214.68 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

   **1.B)** A prepopulated renewal form was received for the beneficiary on June 17, 2016, covering the certification period of July 2016 through June 2017. Kansas did not send out another prepopulated renewal form to the household until March 2020; however, the beneficiary continued to receive CHIP services throughout the audit period. There was no documented explanation for why no renewals were conducted in the case journal records.

Kansas did not provide a clear explanation for why no renewals were conducted for this beneficiary when questioned during the audit.

Based on this error, total payments of $1,095.38 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**1.C)** The last renewal for this case was received on May 4, 2017, for the certification period of June 2017 through May 2018. The case included journal notes discussing when the next review is due; however, no action was taken to conduct a renewal. As a result, CHIP coverage continued through our audit period based on the 2017 renewal. There was no documented explanation for why renewals were not conducted in the case journal records, nor did Kansas provide a clear explanation for why renewals were not conducted for this beneficiary when questioned during the audit.

Based on this error, total payments of $1,083.37 (federal share) could not be verified as appropriately paid for the sampled individual during the audit period.

**Recommendation #5:** In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance,[32] Kansas should perform an annual renewal of Medicaid and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility.

**2. Kansas failed to verify income when the incomes did not pass reasonable compatibility.**

**3.A)** The annual reviews performed in December 2019 and again in January 2020 were both incomplete. Income for both parents did not pass tests of reasonable compatibility. Subsequently, Kansas did not request additional documentation to support the income differences. The EDBC was run on January 4, 2020, and eligibility was approved with an FPL of 230 percent and monthly premium of $50 using the unsupported income.

Based on this error, total payments of $1,032.12 (federal share) could not be verified as appropriately paid during the audit period.

**3.B)** The beneficiary's household of five filed a prepopulated renewal form for the certification period of May 2019 through April 2020. The two adults associated with the case sent a self-attested letter as proof of income for the Wage Earner and proof of unemployment for the other parent. Both adults failed the reasonable compatibility test: KDOL and TALX both indicated that the unemployed parent had income, and the Wage Earner was not reasonably compatible with KDOL. The Wage Earner did submit one pay stub which was higher than the self-attested amount; Kansas applied partial budgeting using the one pay stub. Kansas never followed through on verifying the unemployed adult's income or claim of unemployment; the income was not used in the calculation of

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

eligibility. There was no documented explanation for why the income was not verified in the case journal records. Kansas did not provide a clear explanation for why the income was not verified for this beneficiary when questioned during the audit.

Based on this error, total payments of $1,049.12 (federal share) could not be verified as appropriately paid during the audit period.

**3.C)** The household of three received a prepopulated renewal form for the certification period of June 2019 through May 2020. The household had two wage earners. Wage Earner #1 reported monthly income of $2,889.53, which was reasonably compatible. Wage Earner #2 has been an undocumented citizen since January 2017 and has no social security number. Wage Earner #2 reported $997.36 in monthly wages; Kansas attested that the reasonably compatible tests with TALX and KDOL were unsuccessful because of the undocumented status. Kansas made no attempt to verify Wage Earner #2's income through other sources. EDBC was run on May 28, 2019, with using both Wage Earners' income; this resulted in an FPL of 218 percent and a monthly premium of $50.

Based on this error, total payments of $1,053.44 (federal share) could not be verified as appropriately paid during the audit period.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

3. **The beneficiary could not be verified as eligible for CHIP due to a missing social security number.[33]**
   The beneficiary's date of birth and proof of citizenship were verified through an SSA data match via the Data Hub; however, the file does not provide evidence or documentation of a social security match at the time of the CHIP eligibility determination. The case worker should have ensured that all elements of eligibility were satisfied before making a final eligibility determination. Based on missing elements in the eligibility determination, the beneficiary should not have been eligible for CHIP services.

   Based on this error, total payments of $1,191.68 (federal share) could not be verified as appropriately paid during the audit period.

   **Recommendation #8:** In accordance with §§ 435.406 and 435.407, Kansas should have appropriate controls in place to ensure individuals are not made eligible until all elements of eligibility such as citizenship, date of birth, and social security number are verified.

[33] 42 CFR §§ 910, 920 require social security numbers as a condition of eligibility. In redetermining eligibility, the agency must review case records to determine whether they contain the beneficiary's social security number, if the case record does not contain the required SSN, the agency must require the beneficiary to furnish them.

4. **The beneficiary could not be verified as eligible for CHIP due to a failure to verify income.**
   The household of seven received a pre-populated renewal form for the period of October 2019 through September 2020. The pre-populated renewal form included monthly income of $7,570. Kansas attested that complete tax returns were not returned to support the self-employment income of $7,570 to continue eligibility and Kansas did not request the additional needed information and continued eligibility through the next period. Based on incomplete financial elements in the eligibility determination process, the beneficiary should not have been eligible for CHIP services.

   Based on this error, total payments of $1,095.38 (federal share) could not be verified as appropriately paid during the audit period.

   **Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

# CHIP Observations

During 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 six beneficiaries are described below.

1. **The beneficiary was assessed an incorrect premium.**
   **1.A)** Financial eligibility was determined for the beneficiary using household earnings of $2,372.48. As a result, the beneficiary was determined eligible for CHIP coverage with no premium. Kansas failed to include an additional $1,111.42 of verified earnings in the income calculation. Had Kansas used the additional earnings, the beneficiary's monthly premiums would have been $20.

   **1.B)** Kansas used an inappropriate household size of four rather than the correct household size of three when determining CHIP eligibility. The incorrect household size resulted in the beneficiary being assessed a $30 monthly premium rather than the correct monthly premium of $20.

   **1.C)** Kansas inappropriately used the self-attested income of $3,089.80 to calculate financial eligibility for the beneficiary rather than the paystubs submitted for verification. The paystubs for the two wage earners in the household of four totaled $4,307.59. As a result, the beneficiary was assessed no monthly premium rather than the correct monthly premium of $30.

   **1.D)** Kansas inappropriately used the self-attested income of $3,803.35 to calculate financial eligibility for the beneficiary rather than the more current income from the

paystubs submitted for verification. The paystubs for the two wage earners in the household of four totaled $7,410 for the month. Kansas appropriately verified the monthly income of $7,410. As a result, the beneficiary was assessed a $20 monthly premium rather than the correct monthly premium of $30.

**1.E)** Kansas inappropriately used a household size of three rather than the correct household size of four. Kansas also failed to include all of the monthly income for the household. Kansas only used the monthly income of $2,804 from Wage Earner #1 in the premium calculation. Kansas should have used the total monthly income of $4,735.74 from both Wage Earners. The miscalculation of income resulted in an understated monthly premium for the beneficiary. As a result, the beneficiary was assessed a $20 monthly premium rather than the correct monthly premium of $50.

**Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

2. **The beneficiary was inappropriately terminated from CHIP coverage.**
   The beneficiary was determined eligible for CHIP coverage based on an application dated February 20, 2019, with a coverage period of April 23, 2019, through April 30, 2020. The beneficiary's CHIP coverage was terminated on September 30, 2019, due to a reported income change on August 27, 2019. One of the reported incomes was erroneously end-dated making the beneficiary no longer eligible for CHIP. There was no documentation in the beneficiary's journal to reflect the reason for the employment or income ending. At the time of the audit, Kansas agreed the beneficiary should have remained eligible for CHIP for the entire period.

   **Recommendation #4:** In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program.

# Appendix A: Audit Scope and Methodology

## Scope

CMS' audit covered Medicaid and CHIP beneficiaries who received services from Kansas 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 |
| Mandatory Poverty Level Related Children 6-18 | 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 Kansas Department of Health and Environment employees.

## Methodology

To accomplish the objective, CMS:

- Reviewed applicable federal and state laws, regulations, and other requirements related to Medicaid and CHIP eligibility, including the State's Medicaid eligibility verification plan.
- Selected a stratified random sample of 175 Medicaid beneficiaries and 125 CHIP beneficiaries from a total of 338,539 and 56,156 beneficiaries, respectively, who were determined or redetermined to be eligible during the audit period.
- Obtained application data and documentation to verify the Medicaid or CHIP eligibility of each sampled beneficiary.
- Analyzed the State's documentation supporting beneficiaries' eligibility.

- Estimated the total number of payments made during the audit period on behalf of actual and potentially ineligible beneficiaries and the dollars associated with those payments.
- Calculated an eligibility error rate for both the number of payments and the dollar amounts for both actual and potentially ineligible beneficiaries.

# Appendix B: Statistical Sampling Methodology

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

## Sampling Frame
The Medicaid sampling frame consisted of an Access database containing 338,539 Medicaid beneficiaries in Kansas for whom the State made Medicaid payments totaling $1,856,020,417 for services provided during the audit period. The CHIP sampling frame consisted of an Access database containing 56,156 CHIP beneficiaries in Kansas for whom the State made CHIP payments totaling $49,661,943 for services provided during the audit period. CMS obtained the data for the Medicaid and CHIP beneficiaries from Kansas's Medicaid Management Information System (MMIS). CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frames.

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

## Sample Size
CMS selected 175 Medicaid beneficiaries and 125 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.[34]

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

## Estimation Methodology
Although CMS was able to select a random sample of Medicaid claims, Kansas did not provide CMS with all of the appropriate Medicaid claims information to statistically project the resulting improper Medicaid payments and resulting numbers of potential ineligible Medicaid beneficiaries for the audit period of September 2019 through February 2020.

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

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

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

# Appendix C: Medicaid and CHIP Sample Results and Estimates

## Sample Results

Table 1.1: Medicaid Sample Details and Results for Ineligible Beneficiaries

| Stratum | Frame Size (Beneficiaries) | Sample Size | Value of Sample (Total Payments Associated with Sampled Beneficiaries) | Ineligible Beneficiaries | Value of Payments for Ineligible Beneficiaries |
|---|---|---|---|---|---|
| 1 | 34 | 34 | $56,538,671 | 1 | $1,912.97 |
| 2 | 8,534 | 35 | $2,147,154 | 1 | $15,461.77 |
| 3 | 15,539 | 36 | $1,314,611 | 3 | $1,855.26 |
| 4 | 33,402 | 37 | $420,809 | 1 | $176.40 |
| 5 | 280,730 | 33 | $42,896 | 0 | $0 |
| **Totals** | **338,539** | **175** | **$9,564,141** | **6** | **$19,406.40** |

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

| Stratum | Frame Size (Beneficiaries) | Sample Size | Value of Sample (Total Payments Associated with Sampled Beneficiaries) | Potentially Ineligible Beneficiaries | Value of Payments for Potentially Ineligible Beneficiaries |
|---|---|---|---|---|---|
| 1 | 34 | 34 | $56,538,671 | 4 | $52,415.19 |
| 2 | 8,534 | 35 | $2,147,154 | 1 | $23,223.64 |
| 3 | 15,539 | 36 | $1,314,611 | 1 | $14,758.63 |
| 4 | 33,402 | 37 | $420,809 | 8 | $46,563.07 |
| 5 | 280,730 | 33 | $42,896 | 0 | $0 |
| **Totals** | **338,539** | **175** | **$9,564,141** | **14** | **$137,510.33** |

Table 2.1: CHIP Sample Detail and Results for Ineligible Beneficiaries

| Stratum | Frame Size (Beneficiaries) | Sample Size | Value of Sample (Total Payments Associated with Sampled Beneficiaries) | Ineligible Beneficiaries | Value of Payments for Ineligible Beneficiaries |
|---|---|---|---|---|---|
| 1 | 5 | 5 | $80,082.30 | 0 | $0 |
| 2 | 9,057 | 30 | $37,696.59 | 3 | $ 5,282.54 |

| | | | | | |
|---|---|---|---|---|---|
| 3 | 13,168 | 30 | $32,376.62 | 2 | $ 2,190.76 |
| 4 | 13,737 | 30 | $31,044.97 | 6 | $ 6,226.43 |
| 5 | 20,189 | 30 | $14,540.34 | 2 | $ 1,435.11 |
| **Totals** | **56,156** | **125** | **$195,740.82** | **13** | **$ 15,134.84** |

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

| Stratum | Frame Size (Beneficiaries) | Sample Size | Value of Sample (Total Payments Associated with Sampled Beneficiaries) | Potentially Ineligible Beneficiaries | Value of Payments for Potentially Ineligible Beneficiaries |
|---|---|---|---|---|---|
| 1 | 5 | 5 | $80,082.30 | 0 | $0 |
| 2 | 9,057 | 30 | $37,696.59 | 4 | $4,597.12 |
| 3 | 13,168 | 30 | $32,376.62 | 1 | $1,083.37 |
| 4 | 13,737 | 30 | $31,044.97 | 3 | $3,134.88 |
| 5 | 20,189 | 30 | $14,540.34 | 0 | $0 |
| **Totals** | **56,156** | **125** | **$195,740.82** | **8** | **$8,815.37** |

# Estimates

Table 3.1: CHIP Estimated Number of Ineligible Beneficiaries and Value of Improper Payments
*(Limits Calculated at the 90-Percent Confidence Level)*

| | Estimated Total Number of Ineligible Beneficiaries | Estimated Total Value of Payments for Ineligible Beneficiaries |
|---|---|---|
| Point estimate | 5,877 | $6,373,259.91 |
| Lower limit | 3,257 | $3,501,632.92 |
| Upper limit | 8,497 | $9,244,886.89 |

Table 3.2: CHIP Calculation of Overall Rate of Ineligible Beneficiaries

$$\text{Number of Beneficiaries} = \frac{\text{Estimated No. of Ineligible Beneficiaries}}{\text{Total Number of CHIP Beneficiaries in Sample Frame}} = \frac{5{,}877}{56{,}156} = 10.46\%$$

| | | |
|---|---|---|
| Dollar Value of Payments | Estimated Total Dollars Associated With Ineligible Beneficiaries | $6,373,259.91 |
| | | 12.83% |
| | Total Dollars in Sample Frame | $49,661,943.34 |

Table 4.1: CHIP Estimated Number of Potentially Ineligible Beneficiaries and Value of Potentially Improper payments
*(Limits Calculated at the 90-Percent Confidence Level)*

| | **Total Number of Potentially Ineligible Beneficiaries** | **Total Value of Potentially Improper Payments** |
|---|---|---|
| Point estimate | 3,020 | $3,298,859.29 |
| Lower limit | 1,293 | $1,426,925.77 |
| Upper limit | 4,747 | $5,170,792.80 |

Table 4.2: CHIP Calculation of Overall Rate of Potentially Ineligible Beneficiaries

| | | |
|---|---|---|
| Number of Beneficiaries | Estimated No. of Potentially Ineligible Beneficiaries | 3,020 |
| | | 5.38% |
| | Total Number of Beneficiaries in Sample Frame | 56,156 |

| | | |
|---|---|---|
| Dollar Value of Payments | Estimated Total Dollars Associated with Potentially Ineligible Beneficiaries | $3,298,859.29 |
| | | 6.64% |
| | Total Dollars in Sample Frame | $49,661,943.34 |

# Appendix D: Beneficiary Eligibility Audit Response Form

**INSTRUCTIONS:**

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

| Classification | Issue Description | Agree | Disagree |
|---|---|---|---|
| Recommendation #1 | In accordance with § 435.916(d), Kansas should ensure changes in circumstance are processed timely. | **X** | |
| Recommendation #2 | In accordance with §§§ 435.945, 435.948, and 435.952, Kansas should ensure that income and resources are identified, verified, and calculated correctly. | **X** | |
| Recommendation #3 | In accordance with § 435.912, Kansas should ensure actions are taken timely to close cases no longer requiring services. | **X** | |
| Recommendation #4 | In accordance with § 457.380(d), Kansas should train case workers in the correct calculation and application of income to determine eligibility in the CHIP program. | **X** | |
| Recommendation #5 | In accordance with § 435.916 and CMS' recent COVID-19 Unwinding guidance, Kansas should perform an annual renewal of Medicaid and CHIP eligibility every 12 months to ensure beneficiaries maintain their eligibility. | **X** | |
| Recommendation #6 | In accordance with §§ 433.138(b) and 457.310(b)(2)(ii), Kansas should ensure that beneficiary obligations/premiums are assessed appropriately. | **X** | |
| Recommendation #7 | In accordance with §§ 435.1200(b)(3)(iii) and 435.912, Kansas should ensure that beneficiaries are placed into the correct eligibility category once eligibility has been determined. | **X** | |
| Recommendation #8 | In accordance with §§ 435.406 and 435.407, Kansas should have appropriate | **X** | |

| Classification | Issue Description | Agree | Disagree |
|---|---|---|---|
| | controls in place to ensure individuals are not made eligible until all elements of eligibility, such as citizenship, date of birth, and social security number, are verified. | | |

Acknowledged by:

_____Donna J. Wills, Federal Audits Manager, _____
[Name], [Title]

_____07/31/2023_____
Date (MM/DD/YYYY)
Kansas provided information on the corrective action plans implemented to address the findings identified during the audit as documented below.

**Recommendation #1:** Outlined below is Kansas' CAP teams plan for addressing all changes in circumstances to ensure they are processed timely with the preceding contractor.

*Effective 01/01/2021, KDHE begun utilizing a new Contractor (Conduent) to process Family Medical eligibility requests. When writing and negotiating the terms of this new contract, KDHE ensured that each of the issues outlined in the root cause section of this corrective action plan would be addressed.*

*Service Level Agreements (SLA) - In the new eligibility contract effective 01/01/2021 there are 66 service level agreements in total, 21 of which are related to quality assurance. These SLAs include expectations regarding the following:*

*The timeliness of responses to Coaching Requests, Audits, and Case Returns sent by KDHE. Liquidated damages will be associated with these SLAs:*

- *The accuracy rate for determinations completed by the Contractor. Liquidated damages will be associated with these SLAs.*

**Recommendation #2:** *As income and resource verification is one of the top errors identified during the state of Kansas' most recent audits, there are several sections to the corrective action plan to accommodate the need to improve errors based on KFMAM 1330 and MKEESM 7122:*

1. *KDHE has developed and released several reminders to staff regarding income errors that have been identified by MEQC as well as audits conducted by KDHE. The topic of each reminder and it's release date is included below:*
    a. *Reasonable Compatibility (03/30/2020)*
    b. *Zero Income Records (04/13/2020)*
    c. *Actual Income Versus Average (04/13/2020)*
    d. *End of Employment (04/13/2020)*
    e. *Unemployment Income (07/06/2020)*
    f. *Incomplete Income Statement (07/06/2020)*
2. *KDHE Training has updated the New Hire Curriculum for both E&D and LTC and Family Medical eligibility. This training encourages workers to use KFMAM, MKEESM, KEES user manual, policy memo's, etc. specifically outlining income verification.*
3. *For E&D and LTC eligibility, a business process tool was repurposed to capture document location of income to ensure verification is received for income.*

**Recommendation #3:** *Effective 01/01/2021, KDHE begun utilizing a new Contractor (Conduent) to process Family Medical eligibility requests. When writing and negotiating the terms of this new contract, KDHE ensured that each of the issues outlined in the root cause section of this corrective action plan would be addressed.*

*Service Level Agreements (SLA) - In the new eligibility contract effective 01/01/2021 there are 66 service level agreements in total, 21 of which are related to quality assurance. These SLAs include expectations regarding the following:*

*The timeliness of responses to Coaching Requests, Audits, and Case Returns sent by KDHE. Liquidated damages will be associated with these SLAs:*

- *The accuracy rate for determinations completed by the Contractor. Liquidated damages will be associated with these SLAs.*
- *The Contractor's participation during the sandboxing period (the two weeks following training where trainees process in a controlled environment).*
- *The Contractor's participation in the Corrective Action Planning process for the MEQC and PERM audits.*
- *The Contractor's timeliness in reviewing and correcting errors identified during the MEQC and PERM audits. Liquidated damages will be associated with these SLAs.*
  *Regular meetings with KDHE regarding quality activities.*

*KDHE is confident that with the number of service level agreements related to quality assurance activities and the liquidated damages that are associated with the Contractor's error rate that it will see an increase in the quality of work completed.*

*In addition to the new SLAs included in the contract, KDHE inquired about ways that the new Contractor planned to retain their staff prior to awarding them the contract. Conduent plans to utilize the following to retain their staff: competitive wages, incentives (monetary or other), team building exercises, morale boosting activities (friendly competitions, social events, etc.). Conduent also plans to participate in recruitment activities such as job fairs, college visits, etc.*

*They are confident that with the competitive wages they plan to offer as well as these recruitment activities that they will be able to reach/attract applicants who are looking for a more long-term career opportunity.*

*Conduent does plan to utilize a staffing agency; however, this staffing agency will be used mainly to assist with recruitment activities. Conduent still plans to screen and interview applicants referred by the staffing agency and make the final hiring decision. In addition, Conduent has assured KDHE that there will be a representative from the staffing agency on-site at their location at all times to ensure that all formal disciplinary actions and coaching sessions are carried out timely.*

**Recommendation #4:** *Training materials have also been updated to ensure newly hired employees are trained correctly to prevent income-related issues.*

*Family Medical New-Hire Training and Curriculum Enhancements*

*Enhancements have been made to both the training style and curriculum for new hires. Effective 01/01/2019, KDHE assumed the primary responsibility for training policy and procedure during new-hire classes. The Contractor continues to partner with KDHE by providing an additional trainer to support each class. This additional trainer takes notes during training indicating information in the training material that may need to be updated for future classes based on questions received. They also identify individuals who may be struggling early on in training to ensure extra support can be provided to them as necessary to ensure their success.*

*The curriculum for Family Medical new-hire training was updated in 2021 and continues to be updated as policy changes. The updates also include enhancements made primarily based on feedback received from individuals in previous training classes as well as quality data received through various monitoring activities. Training time has been lengthened to accommodate additional hands-on experience to allow trainees more time to familiarize themselves with the eligibility system. This hands-on experience is conducted in a training environment that imitates the function of the live eligibility system but does not include any consumer data. This allows the trainees to practice processing without affecting consumer benefits.*

*Sandboxing Support*

*After new-hire training is complete there is a two-week "sandboxing" period where trainees remain in the training room to process under the close supervision of Quality, Training, and Operational staff. Effective 01/01/2019, KDHE assumed the primary responsibility for quality monitoring activities and therefore provides most of the support during this time. KDHE conducts audits on 100% of the cases that are worked during sandboxing and delivers their feedback in person to the trainees. Once each trainee receives a specified number of audits without error, they are considered certified to move to the production floor. If a trainee has not certified by the end of the sandboxing period, the Contractor will consider the individual's overall performance during training and sandboxing to determine whether they will be retained*

*or not. If the employee is retained, they will be placed on a development plan for a specified period of time and their employment status will be reevaluated at the end of that period.*

*The Contractor partnered with KDHE during sandboxing and ensures that there are always at least two knowledgeable and experienced individuals in the room to answer any questions the trainees may have. The individuals are known as Subject Matter Experts (SMEs) and are selected for this role by the Contractor based on their quality data from the previous quarter. Once selected, the SMEs are required to attend a training session conducted by KDHE. During this session they learn about various learning styles and how to adapt their communication style to accommodate the needs of the trainees in the classroom. They are also required to pass post-assessment to ensure their understanding of the material that was presented to them.*

*KDHE Quality Initiatives*

*Effective Jan. 1, 2019, all training courses and quality initiatives at the KanCare Clearinghouse for Medicaid/CHIP eligibility became the responsibility of KDHE rather than the contractor. Since KDHE assumed the responsibility, the KDHE Quality staff developed and implemented numerous initiatives to monitor and track/trend quality-related issues, along with federally mandated reviews - Audits, Coaching Requests, Quality Issues, Case Returns, Work with Corrections and MEQC/PERM. Audits can be grouped into four categories - production, sandboxing, targeted and calibration. Production audits are reviews conducted on cases processed by eligibility workers in the previous month. All eligibility workers receive two production audits each month to capture errors in processing. Sandboxing audits are reviews conducted for all cases processed while in the training environment during the first two weeks after training is complete. Targeted audits are reviews conducted on specific types of cases to determine the impact or efficiency of policy/system changes, trainings etc. and will be conducted randomly throughout the course of the year. The fourth and final audit category is calibrations. Once a month KDHE Quality conducts 2 calibration sessions for each functional area (6 total sessions). One session is internal (KDHE Quality Staff) and one is external (KDHE Operations, Contractor Staff, Training). Before the calibration meeting, everyone audits the same case individually and completes and audit form. The audit forms are all submitted to the Quality Supervisors. During the meeting we discuss the errors that were identified on the case and where they should be scored on the audit form. After the calibrations are complete we have one completed audit form for each functional area that is sent out to everyone so that they may keep a copy to refer to. The next quality initiative is coaching requests. These requests are identified by various entities such as Policy, KEES Helpdesk or contractor eligibility etc. Coaching Requests merely provide information that at some point in processing of Medicaid applications/renewals, an error(s) occurred. KDHE Quality has in place a process to capture this information (case number, case name, the error, the worker) and request corrections (if needed). When a coaching request is received, the supervisor of the worker responsible for the error (or designated individual) will correct the issue (if applicable), coach the worker on errors, assist the worker in identifying the root cause, and identify resources to prevent future errors. In addition to coaching requests (which are generally regarding an error made by a specific individual) the Quality Team also receives other Quality Issues in the shared mailbox. These issues are generally forwarded to a specific Agency and the Quality Team tracks whether*

*corrections have been made and a response has been received. When work is transferred from the Contractor to KDHE to complete, the KDHE eligibility worker is responsible for reviewing the information provided by the Contractor. If the KDHE worker finds an error on the case that causes it to need to be sent back for corrections, then the KDHE Worker will issue a Case Return. The case return is delivered to the Contractor's leadership and then passed down to the original worker for corrections. After corrections are complete the case is sent back to the KDHE worker to be completed. Incorrect cases received by KDHE Eligibility workers are not always returned to the contractor for corrections. If not, the KDHE Eligibility worker will make the corrections to the case themselves and then record what had to be corrected, these are known as work with corrections. Along with MEQC/PERM, these quality initiatives provide real-time quality data to track/trend the true error rate for the State of Kansas. This information can also provide information that the CAP is working as implemented. The frequency of these quality initiatives will provide a different insight into the error rate for the State of Kansas and the tracking/trending based on the timing of the request. Case Returns and Work with Corrections quality data is received and trended weekly. Production audit data is received and trended monthly, along with calibration data. Sandboxing quality data is provided at the frequency of training classes - sometimes weekly, biweekly or monthly. Targeted quality data aligns with major policy implementations or systematic changes. Coaching Request and Quality Issue data is received daily and trended monthly. MEQC data is received weekly and trended annually. PERM data is received every three years and trended immediately upon completion of the audit. These reports are provided to KDHE Leadership and KDHE Training to identify if there needs to be changes to the training curriculum, refresher training or changes to policy/system.*

*Contractor Quality Initiatives*

*In addition to the quality measures that have been implemented by KDHE, the Contractor has also implemented internal quality monitoring activities.*

*Through a process of reporting and staff monitoring, the Contractor identifies individuals, teams, and overall trends that negatively impact quality. The trending of quality data ranges from daily to yearly depending on the data source and the sample size of the data being analyzed. The Contractor takes appropriate action, depending on severity and type of issue. Actions taken may include:*

- *Operational audits*
- *Refresher trainings approved by KDHE*
- *Reviews of Policies*
- *Question and Answer Sessions*
- *Second-level auditing*
- *Shadowing*

*Once these opportunities have been provided to the employee and performance has not improved, corrective action, up to and including termination, will be initiated.*

**Recommendation #5:** *From a training perspective, all redetermination training materials were updated and sent through the approval process based on current policies and procedures. See attached Material Review Process that provides further details into those involved in review of the material. These materials are now housed on a document repository (KanShare) that is accessible by all eligibility staff. An inventory spreadsheet has been provided outlining all documents within KanShare and ownership for updating purposes. This document will be triaged annually to ensure all unnecessary documents are purged, leaving only pertinent materials available for staff. As of April 2023, this has been reviewed and ownership determined with next steps being purging outdated documents.*

*In February and March 2023, all eligibility staff who will be tasked with processing redeterminations when they resume in April 2023 attended redeterminations training to ensure their comprehension of policies and procedures. This training was divided into three (3) sections: Part 1 is the policy and procedures of determinations; Part 2 is the application of policy and procedures and Part 3 was a post-assessment to gauge the understanding of redeterminations. A report is attached showing completion of this training for all staff.*

*Lastly, due to the already made enhancements in KEES surrounding redeterminations, all eligibility staff completed 'KEES Reviews Update' training in March 2023. This allows eligibility staff to put together redeterminations from beginning to end and ensure all required documentation is maintained with KEES. A report is attached showing completion of this training for all staff.*

**Recommendation #6:** *Kanas Modular Medicaid System (KMMS) was implemented in April of 2022 helping to aid in verifying Other Health Insurance for our consumers who report having Other Health Insurance.*

*In addition to implementation of the new system, the state of Kansas policy team drafted a policy clarification in February of 2021 regarding third party liability. This clarification alerted eligibility staff that we cannot require an applicant/recipient to provide TPL information as a condition of eligibility, but as long as we have partial information, a referral should be created for the fiscal agent to research and attempt an identification. While these stipulations remain in place, policy has now clarified to further explain how and when the agency is responsible for requesting this information from the consumer and in what instances coverage would be affected due to the consumer's failure to cooperate. Additionally, this also provided key details on how to handle discrepant information so the state of Kansas can ensure that third-party health care coverage was not only identified but documented correctly in the case file and KEES.*

**Recommendation #7:** *As of June 2023, the Medical Hierarchy Chart has been updated to include the appropriate programs and the hierarchy in which eligibility should be determined. In addition to the chart being updated, the state of Kansas updated the A-1 Non-Citizen Qualification Chart on the KDHE Policy Website provide policy guidance for eligibility staff when addressing requests for coverage when the individual attests to being a non-citizen and provides supporting documentation. This chart includes each different USCIS document type, the*

*section codes, alien type, pertinent policy references and whether or not the five-year bar is applicable.*

*As also stated previously, the new hire training curriculum has been updated and includes a lesson in the medical programs and qualifications for each program. This allows staff to have a better understanding of which eligibility category to place beneficiaries in based on their circumstances.*

**Recommendation #8:** *In addition to the new hire training curriculum being updated, KDHE Training continues to provide learning tools for eligibility staff that assist with determining the appropriate verification for eligibility elements such as citizenship, date of birth, and social security number. These tools are known as the Verification Grid. These grids walk staff through completing the data collection pages during case processing. There are four verification grids, one for each of the following types of determinations: Family Medical Applications, Family Medical Reviews, E&D/LTC Applications, and E&D/LTC Reviews. The Application Grid has one column that shows if verification is required. The Review Grid has four columns that show if verification is required. When processing a review, the situation around each source of information must be reviewed to decide which verification column should be used.*