Office of the Auditor General
Performance Audit Report

Medicaid and Children's Health Insurance Program Client Eligibility Determinations

Michigan Department of Health and Human Services

March 2022

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

391-0710-19

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Performance Audit

Medicaid and Children's Health Insurance Program (CHIP) Client Eligibility Determinations

Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0710-19

Released:
March 2022

MDHHS establishes client eligibility for individuals in need of Medicaid and CHIP healthcare coverage. Oversight of the eligibility determination process is primarily performed by the Economic Stability Administration (ESA) within MDHHS. ESA provides guidance in process, policy, training, technology, and leadership to the MDHHS local offices, while MDHHS local office eligibility specialists are responsible for performing client eligibility determinations for Medicaid and CHIP healthcare coverage. During fiscal year 2019, $14.7 billion and $258.2 million in direct beneficiary level payments were issued on behalf of 2.8 million and approximately 237,500 individuals enrolled in Medicaid and CHIP, respectively (see Exhibit 2).

Audit Objective			Conclusion
Objective 1: To assess the effectiveness of MDHHS's efforts to complete accurate Medicaid and CHIP client eligibility determinations.			Moderately effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
Inaccurate eligibility determinations and failure to maintain documentation resulted in estimated improper payments of $2.3 billion and $89.5 million for Medicaid and CHIP, respectively (Finding 1).	X		Disagrees
MDHHS incorrectly transferred an estimated $1.9 million in Medicaid expenditures to CHIP because of inaccurate system information (Finding 2).		X	Disagrees
Of the 316,312 beneficiaries who received transitional medical assistance (TMA), 13% were ineligible, resulting in known improper payments of $24.2 million and $2.1 million for Medicaid and CHIP, respectively (Finding 3).		X	Agrees
Over $52 million in known improper payments occurred because social security numbers (SSNs) had not been verified as required. On average, these Medicaid and CHIP beneficiaries received healthcare coverage for 2.1 and 3.2 years, respectively, without a verified SSN (Finding 4).		X	Disagrees

Findings Related to This Audit Objective *(Continued)*	Material Condition	Reportable Condition	Agency Preliminary Response
Estimated improper payments of $43.6 million and $1.7 million occurred for Medicaid and CHIP, respectively, for beneficiaries whose alien status was not appropriately verified by MDHHS (Finding 5).		X	Disagrees
MDHHS made estimated Medicaid improper payments of $24.2 million for Healthy Michigan Plan (HMP) beneficiaries who had Medicare healthcare coverage (Finding 6).		X	Disagrees
Known inappropriate healthcare coverage payments of $3.6 million occurred on behalf of incarcerated individuals (Finding 7).		X	Agrees
Over 1,100 beneficiaries received $11.7 million in known improper Medicaid payments for healthcare coverage with no corresponding eligibility data to support the Supplemental Security Income eligibility (Finding 8).		X	Disagrees
Observations Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
Restricted access to federal tax return data limited our ability to audit the eligibility determinations for certain Medicaid and CHIP beneficiaries (Observation 1).	Not applicable for observations.		
Use of State of Michigan tax return data could improve the accuracy of Medicaid and CHIP eligibility determinations (Observation 2).			

Audit Objective	Conclusion
Objective 2: To assess the effectiveness of MDHHS's oversight of the Medicaid and CHIP client eligibility determination processes at MDHHS local offices.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not complete sufficient monitoring of eligibility determinations that were the basis for $14.7 billion and $258.2 million in Medicaid and CHIP payments, respectively (Finding 9).	X		Disagrees
MDHHS did not timely use 76% of the 1.5 million system-generated tasks and reminders which help ensure the accuracy of its eligibility determinations (Finding 10).	X		Disagrees
On average, MDHHS did not complete 16% of its monthly required redeterminations in a timely manner (Finding 11).		X	Disagrees

Findings Related to This Audit Objective *(Continued)*	Material Condition	Reportable Condition	Agency Preliminary Response
Of the 1,410 respondents to our survey of 3,600 MDHHS employees responsible for eligibility determinations, 46% indicated they needed additional training and 3% indicated they never received training for determining healthcare coverage eligibility (Finding 12).		X	Agrees
The lack of a process to track, review, and share policy questions and clarifications limits MDHHS's ability to ensure its approximately 3,600 eligibility specialists and supervisors, representing 83 counties, possess necessary resources to ensure accurate eligibility determinations (Finding 13).		X	Disagrees

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March 11, 2022

Ms. Elizabeth Hertel, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Ms. Hertel:

This is our performance audit report on the Medicaid and Children's Health Insurance Program Client Eligibility Determinations, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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BACKGROUND

To receive federal funding for Medicaid and the Children's Health Insurance Program (CHIP), the State is required to submit a State Plan to the U.S. Centers for Medicare and Medicaid Services (CMS). The State Plan indicates Medicaid and CHIP eligibility is governed by the Michigan Department of Health and Human Services' (MDHHS's) rules and regulations. Clients may submit applications online, over the phone, or in person. MDHHS eligibility specialists use the Bridges Integrated Automated Eligibility Determination System* (Bridges) to assist in determining and documenting client eligibility for individuals in need of Medicaid and CHIP healthcare coverage. For eligibility determinations, eligibility specialists use the electronic case file within Bridges to store hard-copy or electronic supporting documentation, such as applications, social security cards, and income and asset verifications.

When a client applies or reapplies for Medicaid or CHIP, information from the application is compared with various federal data sources, such as the Social Security Administration (SSA) and Internal Revenue Service (IRS). If the information is consistent with the data sources, Bridges will automatically enroll the individual in the appropriate type of assistance (TOA). If discrepant information is found, the application is set to pending and an eligibility specialist is required to review the case and will likely request further information from the individual. Also, passive renewals occur when all pertinent information exists, either in the case file or from federal data sources, for an individual and can be used to automatically renew eligibility, without requesting information from the client. Eligibility redeterminations are required at least once every 12 months for beneficiaries previously determined eligible.

While programmatic changes are always occurring, a major modification occurred in 2014 with the implementation of the federally mandated Modified Adjusted Gross Income (MAGI) methodology for determining eligibility for certain Medicaid and CHIP beneficiaries. For MAGI eligibility determinations, MDHHS uses federal income tax return data from the IRS to verify a beneficiary's income information on the application when no other recently verified income information is readily available in the case file.

With the addition of MAGI-based eligibility determinations, Medicaid and CHIP consist of both non-MAGI and MAGI TOAs which contain several sub-programs or categories with varying financial and nonfinancial eligibility factors (see Exhibit 4). Although the State Plan includes some eligibility requirements,

** See glossary at end of report for definition.*

all Medicaid and CHIP eligibility requirements are outlined in MDHHS's Bridges Administrative Manual (BAM) and Bridges Eligibility Manual (BEM), including specific financial and nonfinancial requirements for all TOAs. Examples of MAGI TOAs include children under 19, parents or caretakers of children, pregnant or recently pregnant women, former foster children, and beneficiaries of Maternity Outpatient Medical Services, MIChild, the Flint Water Group, and the Healthy Michigan Plan (HMP). Generally, to receive coverage under a non-MAGI TOA, the individual must be aged 65 or older, blind, disabled, entitled to Medicare, or formerly blind or disabled.

After a client is determined Medicaid or CHIP eligible, MDHHS primarily issues healthcare coverage payments on behalf of the beneficiary in the following ways:

- Capitated Payments*: MDHHS pays managed care organizations a monthly amount which is calculated based on a set rate specific to each member enrolled, regardless if the beneficiaries were provided a service.

- Fee-For-Service (FFS) Payments*: MDHHS directly pays providers for the specific services provided to beneficiaries based on various fee schedules.

- FFS Pharmacy Payments: MDHHS pays its pharmacy benefits manager who reimburses the pharmaceutical companies for prescriptions based on various fee schedules.

- Medicare Premium Payments: MDHHS pays CMS on behalf of certain beneficiaries who qualify for assistance in paying for Medicare premiums, Medicare coinsurance, and Medicare deductibles.

ELIGIBILITY ERRORS AND IMPROPER PAYMENTS

Our audit objective and procedures were directed toward assessing the effectiveness of MDHHS's efforts to complete accurate Medicaid and CHIP client eligibility determinations. We utilized Federal regulations to assist in defining eligibility errors and calculating improper payments as follows:

- Title 42, Part 431, section 804 of the *Code of Federal Regulations** *(CFR)* defines an eligibility error as an error resulting from the State's improper application of federal rules and the State's documented policies and procedures which causes:

    - A beneficiary to be determined eligible when he or she is ineligible for Medicaid or CHIP.

    - A beneficiary to be determined eligible for the incorrect TOA.

** See glossary at end of report for definition.*

- Applications for Medicaid or CHIP to be improperly denied by the State.
- Existing cases to be improperly terminated from Medicaid or CHIP by the State.
- Untimely redeterminations.
- Required element(s) of the eligibility determination process which cannot be verified as being performed/completed by the State.

- Federal regulation 42 *CFR* 431.958 defines an improper payment, in part, as any payment that should not have been made and includes any payment to an ineligible beneficiary.

Therefore, we calculated improper payments, when applicable, to provide context to the reader regarding the value/cost of the eligibility errors noted as a result of our review.

AUDIT OBJECTIVE

To assess the effectiveness* of MDHHS's efforts to complete accurate Medicaid and CHIP client eligibility determinations.

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- MDHHS appropriately discontinued healthcare coverage for deceased individuals when compared with the U.S. Department of Treasury's Do Not Pay* (DNP) tool.
- 100% of applicable sampled payments had a documented certified approval in Bridges for the associated benefit period.
- An estimated $12.6 billion (84%) of total payments was appropriately issued on behalf of eligible Medicaid and CHIP beneficiaries.
- Material condition* related to completing accurate eligibility determinations and maintaining documentation (Finding 1).
- Reportable conditions* related to:
  - Inappropriately transferring payments on behalf of Medicaid beneficiaries to CHIP (Finding 2).
  - Improving the eligibility determination process for clients who qualify for transitional medical assistance* (TMA) (Finding 3).

** See glossary at end of report for definition.*

- Improving the social security number (SSN) verification of clients who apply for Medicaid and CHIP healthcare coverage (Finding 4).

- Improving the verification of the client's alien status (Finding 5).

- Completing accurate eligibility determinations for HMP beneficiaries concurrently enrolled in Medicare (Finding 6).

- Improving controls to prevent or recover healthcare coverage payments issued on behalf of incarcerated individuals inappropriately receiving Medicaid and CHIP coverage (Finding 7).

- Ensuring accurate information for Supplemental Security Income (SSI) related Medicaid beneficiaries who automatically receive full healthcare coverage (Finding 8).

- Observations* related to:

  - Restrictions on access to federal tax return data limits auditors' ability to verify the eligibility determinations for certain Medicaid and CHIP beneficiaries (Observation 1).

  - Using State of Michigan (SOM) tax return data and how it could improve the accuracy of Medicaid and CHIP eligibility determinations (Observation 2).

** See glossary at end of report for definition.*

FINDING 1

Improvements needed to ensure MDHHS completes accurate eligibility determinations and maintains documentation.

MDHHS did not always accurately determine beneficiary eligibility or maintain documentation to support eligibility was processed in accordance with federal and State requirements.

Federal regulations (see Exhibit 1) indicate federal funding is available only for services provided to eligible beneficiaries, require MDHHS to maintain documentation supporting the eligibility decision, and require MDHHS to specify in its State Plan the TOA eligibility categories to whom Medicaid and CHIP is provided and the conditions of eligibility for individuals within those TOAs.

The State Plan indicates eligibility is governed by MDHHS's rules and regulations. The eligibility category requirements are outlined in the eligibility manuals (BEM and BAM), which specialists are instructed to use when determining or assessing eligibility.

We randomly sampled 162 Medicaid and 93 CHIP payments paid on behalf of beneficiaries from October 1, 2018 through September 30, 2019. For 15 (9%) Medicaid and 23 (25%) CHIP payments, we were unable to determine whether MDHHS complied with federal laws and regulations related to MAGI-based eligibility. This was because federal regulations prohibit an auditor from using federal income tax return data and the beneficiaries' case record did not contain other available income information. Federal law does not require other income information be included in the case record when a determination of eligibility is based on MAGI. However, if such information was available, we reviewed it for eligibility purposes to accurately report the sample items that could not be tested.

Inaccurate eligibility determinations and failure to maintain documentation resulted in estimated improper payments of $2.3 billion and $89.5 million for Medicaid and CHIP, respectively.

We completed our testing for the remaining 147 Medicaid and 70 CHIP payments based on the TOA the beneficiaries were enrolled in at the date of service for which the payment was made and found:

Ineligible Beneficiaries

	Subcategory	Medicaid Number	Medicaid Amount	CHIP Number	CHIP Amount
Non-MAGI	Income or assets exceeded the applicable TOA eligibility category limit.	4	$29,589		$
	Did not meet extended care eligibility requirements.	3	9,685		
	Did not meet TMA eligibility requirements.	2	428	4	1,893
	Did not meet acceptable alien status.	1	275		
	Total Non-MAGI	10 (7%)	$39,977	4 (6%)	$ 1,893
MAGI	Income not within the federal poverty level range for the specific TOA eligibility category.	4	$ 608	19	$70,018
	Enrolled in the Parent/Caretaker/Relative TOA eligibility category, however, did not have a dependent child.	1	364		
	Enrolled in HMP while receiving Medicare.	1	24		
	Total MAGI	6 (4%)	$ 997	19 (27%)	$70,018
	Total Ineligible Beneficiaries	**16 (11%)**	**$40,974**	**23 (33%)**	**$71,911**
	Estimated Improper Payments Caused by Ineligible Beneficiaries	**$1,453,584,976**		**$64,325,848**	

This table continued on next page.

Missing Case File Documentation					
		Medicaid		CHIP	
	Subcategory	Number	Amount	Number	Amount
Non-MAGI	Missing support in case file documentation regarding assets or ongoing medical expenses.	3	$11,583		
	Total Non-MAGI	3 (2%)	$11,583	0	$ 0
MAGI	Missing application or income support because of passive renewal occurring inappropriately.	5	$ 1,746	9	$48,446
	Missing income support for all individuals listed on the application.	1	178		
	Total MAGI	6 (4%)	$ 1,925	9 (13%)	$48,446
	Total Missing Case File Documentation	**9 (6%)**	**$13,508**	**9 (13%)**	**$48,446**
Estimated Improper Payments Caused by Missing Case File Documentation		**$817,641,549**		**$25,170,984**	
Total Estimated Improper Payments		**$2,271,226,525**		**$89,496,832**	

MDHHS indicated it did not properly consider all available information when determining beneficiary eligibility because of system issues and staff actions. MDHHS also indicated internal control* was not always sufficient to ensure documentation was retained.

We consider this finding to be a material condition based on our estimate that ineligible and unsupported eligibility determinations may have resulted in fiscal year 2019 improper payments of $2.3 billion (15%) and $89.5 million (35%) for Medicaid and CHIP, respectively. For audit purposes, when documentation is missing or not sufficient, we must conclude that the claimant is not eligible. Although it is possible some of these beneficiaries could be eligible under a different TOA, Federal regulations define an improper payment and eligibility error to include beneficiaries determined eligible for the incorrect TOA. Therefore, we did not review each beneficiary's case file to determine if they were eligible for a different TOA.

RECOMMENDATION

We recommend that MDHHS accurately determine beneficiary eligibility and maintain documentation that eligibility was processed in accordance with eligibility requirements.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with the finding. Given the length of its preliminary response, the response and our auditor's comments are presented on page 47.

** See glossary at end of report for definition.*

FINDING 2

System improvements needed to ensure the correct classification of Medicaid and CHIP expenditures.

MDHHS did not ensure Bridges and the Community Health Automated Medicaid Processing System (CHAMPS) contained the correct Medicaid and CHIP eligibility information to record expenditures to the appropriate program at the time of payment. We estimated $1.9 million in payments made on behalf of Medicaid beneficiaries were inappropriately transferred to CHIP.

Federal regulations require MDHHS to establish and maintain effective internal control over federal programs that provides reasonable assurance it is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of federal awards.

The Affordable Care Act* (ACA) allowed MDHHS to revise the federal poverty level in the CHIP State Plan, subsequently allowing certain Medicaid beneficiaries to be eligible under CHIP and authorizing MDHHS to receive enhanced funding for these beneficiaries. However, the coding in Bridges and CHAMPS had not been updated to reflect these changes. Although Medicaid and CHIP both provide healthcare coverage, their eligibility requirements and their Federal Medical Assistance Percentage* (FMAP) and Enhanced Federal Medical Assistance Percentage* rates differ. To properly reclassify the CHIP eligible beneficiaries, MDHHS processed quarterly summary-level adjustments transferring expenditure amounts from Medicaid to CHIP calculated by analyzing Bridges eligibility data and CHAMPS payment data.

We reviewed MDHHS's quarterly adjustments processed from October 1, 2018 through September 30, 2019 and noted as of November 4, 2019, MDHHS did not maintain detailed documentation of the Medicaid expenditures transferred to CHIP. Therefore, we replicated MDHHS's quarterly queries to identify the underlying $122.3 million of Medicaid expenditures transferred to CHIP (40% of total CHIP expenditures). We sampled 50 transactions and noted 8 (16%) beneficiaries with $2,322 of payments not eligible for CHIP.

MDHHS agrees the query incorrectly included certain qualifiers which contributed to the estimated $1.9 million being inappropriately transferred to CHIP. MDHHS has not reevaluated its query language or the results since its initial creation in 2015. MDHHS stated the Bridges enhancement to correct eligibility classifications was delayed because of funding limitations and competing IT priorities.

RECOMMENDATION

We recommend that MDHHS ensure Bridges and CHAMPS contain the correct Medicaid and CHIP eligibility information for recording expenditures to the appropriate program at the time of payment.

** See glossary at end of report for definition.*

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with the finding.

MDHHS does not agree that the entire amount cited is inappropriate federal reimbursement. All of these beneficiaries were Medicaid eligible, and all payments would have been eligible for regular FMAP. Therefore, the amount cited above is significantly overstated.

MDHHS is always looking for opportunities to improve its programs and how they are operated. MDHHS has been working since 2018 to ensure correct eligibility classifications in Bridges at the time of payment and a solution was implemented in April 2021. All new cases are correctly routed and MDHHS expects that all existing cases will be updated during a 12-month period following the end of the public health emergency. The efforts we have underway to improve this program and its activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Until full implementation is completed, MDHHS will continue its manual process of transferring expenditures from the Medicaid Cluster to CHIP on a quarterly basis. In the interim, MDHHS has made several changes to its quarterly process and will continue to review its methodologies and make adjustments if warranted, until all cases are systematically corrected.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE*

We agree these beneficiaries may be eligible for Medicaid; however, our finding appropriately identified the estimated amount attributable to ineligible CHIP payments because these Medicaid beneficiaries were transferred to, but were not eligible for, CHIP. Regardless of whether MDHHS's efforts to improve processes or implement corrective actions are a direct result of our audit, it does not negate our responsibilities to communicate reportable issues. The department's actions further support this weakness exists and that the finding is warranted. Therefore, the finding stands as written.

** See glossary at end of report for definition.*

FINDING 3

Improvements needed in processing TMA.

MDHHS did not accurately process eligibility determinations or timely discontinue healthcare coverage for beneficiaries receiving TMA, resulting in approximately $26.3 million ($24.2 million Medicaid and $2.1 million CHIP) in known improper payments and approximately $104.9 million in estimated improper payments.

In accordance with federal regulation, MDHHS's Medicaid State Plan specifies it provides extended medical coverage up to 12 months to families with dependent children whose coverage was terminated because of earnings, hours of employment, or loss of earned income disregards* (although the provision expired in 1998, this TOA is still permitted according to federal law). Also, MDHHS's CHIP State Plan specifies CHIP funds are used for providing expanded benefits under MDHHS's Medicaid State Plan. In addition, MDHHS developed policies and procedures related to the TMA healthcare coverage eligibility group that provides coverage for up to 12 months and outlines the requirements to be eligible for full healthcare in this group as including all of the following:

- At least one low-income family (LIF) TOA qualified group member was eligible for and received LIF for 3 of the 6 calendar months immediately preceding the month of LIF denial.
- LIF denial resulted from excess earned income only.
- Earnings of the caretaker relative, caretaker relative's spouse, or a dependent child's parent in the LIF denial determination are greater than zero.

During our review of the 316,312 (280,865 Medicaid and 35,447 CHIP) beneficiaries who received TMA from October 1, 2018 through September 30, 2019, we identified 40,414 (13%) beneficiaries who did not meet the eligibility requirements for TMA as follows:

	Medicaid[1]	CHIP[1]
Beneficiaries who received TMA but no group members received LIF for 3 of 6 calendar months immediately preceding LIF denial[2]	17,390 (6%)	2,628 (7%)
Improper healthcare payments[2]	$18,497,491	$1,828,003
Beneficiaries who received TMA for more than 12 months	18,910 (7%)	1,457 (4%)
Improper healthcare payments	$5,637,373	$277,051
Beneficiaries who received TMA with no corresponding LIF denial because of excess earned income[3]	24 (65%)	5 (83%)
Improper healthcare payments	$21,924	$3,315
Estimated improper healthcare payments	$104,870,469	
Total known improper healthcare payments	$24,156,787	$2,108,369
Total estimated improper healthcare payments	$104,870,469	

[1] One Medicaid ($212) and two CHIP ($961) exception beneficiaries were also reported in Finding 1.

[2] This count does not include the 718 beneficiaries ($1,043,042 improper healthcare payments) reported as beneficiaries who received TMA for more than 12 months.

[3] Five (4 Medicaid and 1 CHIP) of the 29 TMA beneficiaries also did not meet the first requirement in the above table, resulting in $7,407 ($7,287 Medicaid and $120 CHIP) in improper healthcare payments. These amounts were removed from the first requirement in the above table to ensure no duplicated counts of improper healthcare payments.

** See glossary at end of report for definition.*

We summarized the exceptions noted in the preceding table as follows:

a. 20,018 (6%) beneficiaries received TMA but none of their group members had been eligible for and received LIF for 3 of the 6 calendar months immediately preceding the month of LIF denial, resulting in $20.3 million in known improper healthcare payments.

b. 20,367 (6%) beneficiaries received TMA for more than 12 months, resulting in $5.9 million in known improper healthcare coverage payments. These beneficiaries received an average 79 days of additional TMA coverage, ranging from 28 to 881 days.

c. 29 (67%) of the 43 (37 Medicaid and 6 CHIP) sampled TMA beneficiaries received TMA with no corresponding LIF denial because of excess earned income resulting in $25,239 in known improper healthcare payments issued on their behalf, estimating to approximately $104.9 million.

MDHHS indicated it did not properly consider all available information when determining eligibility because of system issues and staff actions. MDHHS also indicated internal control was not always sufficient to ensure documentation was retained. In addition, MDHHS indicated there was a breakdown of internal processes causing the delay in timely termination of some beneficiaries within the TMA Medicaid and CHIP eligibility groups.

RECOMMENDATION

We recommend that MDHHS accurately and timely process eligibility determinations for beneficiaries receiving healthcare coverage from the TMA eligibility category.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees with the finding.

TMA is a 12-month program, however due to overlapping statutory requirements regarding negative action and timely notice rules, cases can legitimately extend to 13 months. A process has been developed for implementation that will be used to determine appropriate actions following the end of the Public Health Emergency.

MDHHS is always looking for opportunities for improving its programs and how they are operated. A system change was implemented in August 2021 to address beneficiaries that received TMA but none of their group members had been eligible for and received LIF for three of the six calendar months immediately preceding the month of LIF denial. MDHHS is working on a system enhancement that will generate redetermination requests 2 months in advance, addressing the issue of beneficiaries receiving TMA for more than 12 months

without violating existing rules or statutory requirements. If necessary, further system enhancements will be initiated to resolve underlying issues as identified following the end of the Public Health Emergency.

FINDING 4

MDHHS did not complete the required SSN verifications for Medicaid and CHIP beneficiaries, resulting in $52.2 million in known improper payments.

Improvements needed to ensure required SSN verifications are completed.

MDHHS policy specifies as a condition of eligibility, beneficiaries must provide an SSN, cooperate in obtaining an SSN, or be excused from supplying an SSN. SSNs are verified against SSA data for accuracy and if SSA is unable to confirm the SSN, a task is generated in Bridges and the eligibility specialist must request verification.

We identified Medicaid and CHIP beneficiaries who had healthcare coverage at some time between October 1, 2018 and September 30, 2019 when an SSN verification did not exist in Bridges, and as of May 15, 2020, MDHHS eligibility specialists had not completed the verifications. Our population is summarized below:

	Medicaid	CHIP
Beneficiaries without a verified SSN	21,816	2,059
Healthcare coverage payments	$48.4 million	$3.8 million
Range of time healthcare coverage received without a verified SSN	1 month to 12 years	1 month to 12 years
Average length of time healthcare coverage received without a verified SSN	2.1 years	3.2 years

We sampled 43 beneficiaries and noted as of July 2020, 21 (49%) beneficiaries still did not have an SSN recorded in Bridges and were not excused from supplying one. Of the 22 beneficiaries with an SSN in Bridges, 13 (30%) were determined to be invalid when we contacted SSA.

We noted MDHHS did not take appropriate action to verify the SSNs. As indicated in the table above, on average, these Medicaid and CHIP beneficiaries received healthcare coverage for 2.1 years and 3.2 years, respectively, without a verified SSN.

RECOMMENDATION

We recommend that MDHHS complete the required SSN verifications for Medicaid and CHIP beneficiaries.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with this finding.

MDHHS disagrees with the methodology applied to determine inappropriate payments. MDHHS acknowledges that there were cases that lacked verification in the case file, however there can be a delay in verification if the beneficiary had applied for and not yet received an SSN.

Federal regulation 42 CFR 435.910 delineates that a State cannot delay an eligibility determination for those who do not or cannot obtain an SSN and must accommodate those who do not qualify for or refuse to get one based on religious declarations and those who have applied for and not yet received an SSN. MDHHS is always looking for opportunities to improve its programs and how they are operated, therefore, MDHHS has requested specific guidance from CMS to determine SSN-requirements related to closure and will make appropriate adjustments if so required. The efforts we have underway to improve policies, programs and oversight activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

As indicated in the finding, our review was conducted as of May 15, 2020, which is at a minimum 7.5 months after the latest possible date an individual applied for assistance, allowing MDHHS time to obtain verification after an initial eligibility determination. Regardless of whether MDHHS's efforts to improve processes or implement corrective actions are a direct result of our audit, it does not negate our responsibilities to communicate reportable issues. The department's actions further support this weakness exists and that the finding is warranted. Therefore, the finding stands as written.

FINDING 5

MDHHS did not ensure all Medicaid and CHIP beneficiaries had an acceptable alien status to receive full healthcare coverage. MDHHS issued an estimated $45.3 million in improper payments.

Improvement needed in alien status verification.

MDHHS policy states that to be eligible for full healthcare coverage, a person must be a U.S. citizen or an alien admitted to the U.S. under a specific immigration status. However, federal regulation states MDHHS must provide full healthcare coverage to individuals who have attested to having satisfactory immigration status during a reasonable opportunity period of 90 days while their immigration status is being verified if they are otherwise eligible for healthcare coverage. After the reasonable opportunity period has ended, MDHHS policy continues to require the alien status of each non-U.S. citizen be verified to be eligible for full healthcare coverage. The beneficiaries who do not meet the acceptable alien status are allowed healthcare coverage for emergency services only if all other eligibility requirements are met.

We reviewed the 60,355 healthcare beneficiaries who were not identified as U.S. citizens and did not have an acceptable alien status from October 1, 2018 through September 30, 2019, of which 18,297 (30%) (17,530 Medicaid and 767 CHIP) beneficiaries did not qualify to receive full healthcare coverage. We sampled 43 beneficiaries from this population and noted 30 (70%) beneficiaries inappropriately received full healthcare coverage, projecting to $45.3 million ($43.6 million Medicaid and $1.7 million CHIP) in improper payments. The remaining 13 (30%) beneficiaries had an inaccurate alien status in Bridges but received the correct healthcare coverage.

MDHHS indicated it did not properly consider all available information when determining eligibility because of system issues and staff actions. MDHHS also indicated its internal control was not always sufficient to ensure documentation was retained.

RECOMMENDATION

We recommend that MDHHS ensure all Medicaid and CHIP beneficiaries have an acceptable alien status to receive full healthcare coverage.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with this finding.

MDHHS disagrees that all cases cited in this finding were ineligible for full Medicaid coverage due to immigration status. Initial eligibility is based on client attestation per Section 1137(d)(4) of the Social Security Act (the Act) and regulations at 42 CFR 435.956 which require MDHHS to provide full Medicaid to individuals who have attested to having satisfactory immigration status during a reasonable opportunity period while their immigration status is being verified if they are otherwise eligible for Medicaid. The reasonable opportunity period is 90 days from

the date of the notice. This means that the individual has 90 days to provide documents to prove their attested satisfactory immigration status. MDHHS has identified numerous cases cited as error in which beneficiaries were correctly receiving full Medicaid coverage based on documentation in the electronic case file or were within the 90-day period.

MDHHS is always looking for opportunities to improve its programs and how they are operated. MDHHS has identified systems issues resulting in incorrect full coverage for a limited number of beneficiaries. MDHHS plans to initiate a project to identify and address the systems issues related to this finding. MDHHS is assessing the available FY22 information technology resources to address the findings in this audit. A supplemental funding request will be evaluated for any systems issues that cannot be resolved with existing appropriations. The efforts we have underway to improve programs, oversight, and IT functionalities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

MDHHS contends it identified "numerous" cases cited as errors in which the beneficiaries were correctly receiving full Medicaid coverage. The finding appropriately depicted these cases by stating, "The remaining 13 (30%) beneficiaries had an inaccurate alien status in Bridges but received the correct healthcare coverage". Further, these 13 exceptions were not included in the estimated $45.3 million in improper payments. Regardless of whether MDHHS's efforts to improve processes or implement corrective actions are a direct result of our audit, it does not negate our responsibilities to communicate reportable issues. The department's actions further support this weakness exists and that the finding is warranted. Therefore, the finding stands as written.

FINDING 6

Improvements needed in determining eligibility for HMP beneficiaries concurrently enrolled in Medicare.

MDHHS did not accurately determine beneficiary eligibility in accordance with federal eligibility requirements for some HMP beneficiaries concurrently enrolled in Medicare, resulting in an estimated $24.2 million in improper Medicaid payments.

Federal regulation indicates healthcare coverage under HMP is for individuals who are not entitled to, or enrolled in, Medicare benefits.

When individuals apply for healthcare coverage, they are required to disclose Medicare coverage on their application. In addition, there is an interface with SSA to identify Medicare coverage that may not have been previously disclosed or to confirm coverage. Our review of 43 of the 18,188 beneficiaries who had greater than 2 months of dual HMP and Medicare coverage at some point from October 1, 2018 through September 20, 2019 noted:

a. 26 (60%) beneficiaries indicated on their application that they received Medicare coverage, yet they were enrolled in HMP which resulted in $38,914 in known improper healthcare payments issued on their behalf.

b. 8 (19%) beneficiaries, although they did not indicate it on their applications, were identified through an interface with SSA as having Medicare coverage which resulted in $13,926 in known improper healthcare payments issued on their behalf.

These 34 beneficiaries received inappropriate HMP coverage for an average of 7 months, ranging from 3 to 43 months.

MDHHS informed us beneficiaries did not always report Medicare coverage appropriately on their application, causing automatic approvals for HMP.

RECOMMENDATION

We recommend that MDHHS accurately determine beneficiary eligibility in accordance with federal eligibility requirements for HMP beneficiaries concurrently enrolled in Medicare.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with the finding.

MDHHS is required to follow The Patient Protection and Affordable Care Act (''ACA''; Public Law 111–148), which requires states to accept self-attestation of all eligibility factors except income and to auto-certify individuals based on this attestation. MDHHS auto-certified many applications cited within this audit based on self-attestation as required. MDHHS is always looking for opportunities to improve its programs and how they are operated. In addition to maintaining compliance with federal regulations, MDHHS implemented several system enhancements prior to the audit that go beyond the requirements established in

the ACA to ensure accurate eligibility. Errors flagged by this audit were identified prior to the implementation of system enhancements and field staff have been provided with guidance to address any remaining cases following the end of the public health emergency. These enhancements include no longer auto-certifying individuals who have Medicare coverage on file from a previous application, checking additional areas of the application for evidence of Medicare coverage, and requests listed on applications for the Medicare Savings Program. The efforts we have underway to improve policies, programs and oversight activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

Regardless of whether MDHHS's efforts to improve processes or implement corrective actions are a direct result of our audit, it does not negate our responsibilities to communicate reportable issues. The department's actions further support this weakness exists and that the finding is warranted. Therefore, the finding stands as written.

FINDING 7

Improved controls needed to prevent or recover healthcare payments issued on behalf of incarcerated individuals.

MDHHS could improve its controls to prevent or recover Medicaid and CHIP healthcare coverage payments issued on behalf of incarcerated individuals who no longer meet eligibility requirements. MDHHS improperly paid approximately $3.6 million in capitated payments and did not take timely action to recoup the payments.

MDHHS policy indicates individuals can remain eligible during their period of incarceration, but coverage is limited to off-site inpatient hospitalization. Also, federal regulation indicates coverage is allowed during the part of the month in which the individual is not incarcerated.

We identified 12,296 incarcerated individuals with healthcare coverage payments issued on their behalf from October 1, 2018 through September 30, 2019 and noted:

a. 5,822 (47%) of the 12,286 incarcerated Medicaid beneficiaries had approximately $3.6 million in known improper capitated payments issued on their behalf.

b. 5 (50%) of the 10 incarcerated CHIP beneficiaries had $2,689 in known improper capitated payments issued on their behalf.

MDHHS informed us retroactive recoupments for capitation payments did not occur for all managed care populations because of prior business decisions that had not been recently evaluated. In addition, there was one system recoupment defect for individuals with incarcerations beginning greater than 24 months ago.

RECOMMENDATION

We recommend that MDHHS enhance its controls to prevent or recover Medicaid and CHIP healthcare coverage payments issued on behalf of incarcerated individuals who no longer meet eligibility requirements.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that improper payments were not always timely recouped. MDHHS healthcare coverage is updated when the file is received from MDOC indicating the incarceration status. MDHHS is not always made aware of the incarceration status prior to payment; however, once incarceration is identified and coverage updated, recoupment is initiated.

During the audit period there was a flaw in the criteria utilized to process recoupments for some health coverage. As a result, capitation payments were not being recouped for some individuals with incarcerations beginning more than 24 months ago. The system issue was fixed, and the recoupments subsequently processed.

FINDING 8

Improvements needed to ensure accurate information for SSI-related Medicaid beneficiaries.

MDHHS did not ensure all Medicaid beneficiaries who automatically received full healthcare coverage because of their SSI status had current and accurate beneficiary information documented in Bridges. This resulted in $11.7 million in fiscal year 2019 improper payments that would likely continue each year until MDHHS corrects the information.

Federal regulation indicates MDHHS must provide Medicaid to individuals who are receiving SSI or individuals who would otherwise receive SSI if not for receiving certain other benefits. MDHHS policy indicates SSI recipients who are Michigan residents will receive Medicaid for the duration of their SSI eligibility. Redeterminations are not required because SSA determines SSI client eligibility and interfaces daily to update MDHHS's SSI client information. MDHHS eligibility specialists are assigned these cases to process only client reported changes and are unable to process enrollment and disenrollment from Medicaid as it is primarily handled electronically. However, MDHHS did not receive updated SSA eligibility data in Bridges for some beneficiaries due to inaccurate beneficiary information and, thus, could not properly monitor these cases.

We reviewed the 1,148 beneficiaries receiving healthcare coverage at some time between October 1, 2018 and September 30, 2019 with no corresponding eligibility data from SSA in Bridges and noted as of August 7, 2020:

	Active Healthcare Coverage	Closed Healthcare Coverage[1]
Beneficiaries without SSA-supported eligibility	984	164
Fiscal year 2019 unsupported healthcare coverage payments	$10.4 million	$1.3 million
Total unsupported healthcare coverage payments[2]	$119.3 million	$16.7 million
Range of time healthcare coverage received without SSA supported eligibility	5 to 11 years	9 to 11 years
Average length of time healthcare coverage received without SSA supported eligibility	10.4 years	9.9 years

[1] Healthcare coverage was active in fiscal year 2019 but closed prior to our review.
[2] Total unsupported healthcare coverage payments from the onset of Bridges, August 2008 through August 2020.

MDHHS reviewed the 984 beneficiaries with active healthcare coverage and determined 6 of the cases were eligible to maintain healthcare coverage and corrected the inaccurate beneficiary information ensuring an accurate data interface. MDHHS also informed us it initiated the process to terminate the Medicaid healthcare coverage for the remaining 978 beneficiaries who were inappropriately receiving full healthcare coverage.

MDHHS indicated when the cases were converted into Bridges, the data did not correctly transfer or populate to the SSI specific screen in Bridges, which resulted in SSA interface failure allowing these cases to continue to receive full healthcare coverage.

MDHHS began converting from the previous systems to Bridges in August 2008.

RECOMMENDATION

We recommend that MDHHS ensure Medicaid beneficiaries who automatically receive full healthcare coverage because of their SSI status have current and accurate beneficiary information documented in Bridges.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with the finding.

Current Bridges functionality ensures that SSI Medicaid cases are properly opened and closed. The audit improperly makes an assumption that each beneficiary converted in 2008 is ineligible. To accurately quantify the duration of the ineligible periods for the identified cases, additional information would have to be obtained from the Social Security Administration for each individual case. The audit period for this objective and finding was October 2018 through September 2019, however healthcare coverage payment are presumed to be ineligible for all of 2019 without validation. MDHHS agrees that there were cases that required manual intervention due to a historic system conversion error.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The $11.7 million in improper payments cited in this finding relates to fiscal year 2019 (October 1, 2018 through September 30, 2019), our audit period and the time frame that MDHHS issued payments with no supporting documentation to substantiate the beneficiaries' SSI Medicaid eligibility. As indicated in the finding, MDHHS determined only 6 (1%) of 984 active Medicaid beneficiaries identified during the audit were eligible for healthcare coverage. Therefore, the finding stands as written.

OBSERVATION 1

Restricted access to federal tax return data limits auditors' ability to verify the eligibility determinations for certain Medicaid and CHIP beneficiaries.

MDHHS's eligibility verification plan indicates it, in part, will utilize IRS tax return data to verify income for certain Medicaid and CHIP beneficiaries. Although federal law allows MDHHS to receive certain tax information from the IRS for the purposes of determining eligibility in Medicaid or CHIP, it prohibits state audit agencies from accessing and using federal tax return information for any other purposes apart from an audit of a state's Department of Treasury.

As indicated in Finding 1, we were unable to determine whether MDHHS complied with federal laws and regulations related to MAGI-based eligibility for 15 (9%) Medicaid and 23 (25%) CHIP sampled payments because of restricted access and because the beneficiaries' case record did not contain other available income information. Auditors are allowed access to SOM tax return data and any other tax information included as part of an SOM tax return. Because IRS and SOM tax return data would be comparable, we obtained three calendar years of SOM tax return data (2017, 2018, and 2019) for these 38 IRS verified beneficiaries. Although verified by the IRS, we identified 4 Medicaid beneficiaries for whom the SOM tax return data was inconsistent with the beneficiary's self-attested income and determined these beneficiaries would have been ineligible based on the MAGI financial eligibility requirements.

For example, one beneficiary's income was verified through the IRS-automated process and the beneficiary received full healthcare coverage for 10 months during fiscal year 2019. However, the income reported on this beneficiary's 2017, 2018, and 2019 SOM tax returns was more than double the associated income threshold, and therefore, the beneficiary did not qualify for healthcare coverage under any MAGI TOA.

Without access to the IRS data used to determine eligibility, we were ultimately unable to validate whether the 15 Medicaid and 23 CHIP beneficiaries met the MAGI eligibility requirements. For fiscal year 2019, we projected that the total number of MAGI beneficiaries with IRS verified income was 357,407 Medicaid and 55,020 CHIP beneficiaries, totaling payments of $1.3 billion and $64.5 million, respectively. This issue can only be addressed at the federal level; however, we are raising the issue because the potential exists it could lead to auditors' inability to sufficiently audit Medicaid and CHIP.

OBSERVATION 2

Use of SOM tax return data could improve the accuracy of Medicaid and CHIP eligibility determinations.

When MDHHS is unable to validate a client's income using the IRS-automated process, it should consider using SOM tax return data to assist with income verifications and improve the accuracy of MAGI-based eligibility determinations.

Although federal regulations neither require it nor prohibit it, MDHHS does not use SOM tax return data to verify income. MDHHS determines healthcare coverage financial eligibility as follows:

- For initial applications, MDHHS attempts to verify the applicants' self-attested income with the IRS through an automated process. If the income is verified and all non-financial eligibility requirements are met, applicants are automatically approved for healthcare coverage. If the income verification fails, an eligibility specialist contacts the applicants to obtain additional information to verify income and determine eligibility.

- For beneficiaries renewing healthcare coverage, the renewal can be automatically approved if beneficiaries consent to MDHHS using IRS tax return data to verify income and the income is verified or if the beneficiaries' income has already been verified within the last 12 months by another source. Otherwise, beneficiaries complete a redetermination application and an eligibility specialist determines eligibility after receiving the necessary information.

As part of our sample identified in Finding 1, we expanded our review for the 123 (60 Medicaid and 63 CHIP) MAGI beneficiaries for whom MDHHS used other sources to verify income by obtaining three years of SOM tax return data (2017, 2018, and 2019). Using the SOM tax return data, we noted some beneficiaries did not meet the MAGI financial eligibility requirements as follows:

	Medicaid	CHIP
Beneficiary would have been ineligible for all MAGI TOAs	4 (5%)	2 (2%)
Beneficiary would have been ineligible under their current MAGI TOA but would have been eligible under a different MAGI TOA	6 (8%)	10 (12%)

For example, one CHIP beneficiary had family household income verified by another source and received full healthcare coverage for 12 months as part of the LIF TOA category. However, the income reported on the 2017, 2018, and 2019 SOM tax returns was more than five times the income threshold for LIF, and therefore, the family household did not qualify for healthcare coverage under any MAGI TOA.

We also identified 6 Medicaid and 10 CHIP beneficiaries who were ineligible under the specified MAGI TOA but would have been eligible under a different MAGI TOA. Failure to account for beneficiary eligibility using the correct TOA could result in MDHHS receiving the wrong amount of federal reimbursement.

In addition to verifying the beneficiary's income, obtaining SOM tax return data can also assist MDHHS in identifying information that is not on an application or documented in Bridges, including household members' SSNs or changes in circumstances for a client such as marital status, living arrangements, or employment. Ultimately, by using the SOM tax information, we identified 4 Medicaid and 2 CHIP beneficiaries who were potentially ineligible for assistance resulting in estimated fiscal year 2019 improper payments of $191,147 and $11,569, respectively. One of the Medicaid beneficiaries and one of the CHIP beneficiaries were also noted as exceptions in Finding 1.

OVERSIGHT OF THE MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATION PROCESSES

BACKGROUND

MDHHS's eligibility supervisors (assistance payments supervisors, family independence specialist managers) along with the eligibility specialists (eligibility specialists, family independence specialist) manage a majority of Medicaid and CHIP eligibility determinations, redeterminations, and any additional case action. The eligibility supervisors and specialists are located throughout Michigan at various county office locations. Depending on the location, some county offices manage only their county cases while others collectively share cases among a group of county offices or are universal caseloads (UCLs) offices.

MDHHS employs several broad strategies to facilitate the receipt and processing of Medicaid and CHIP applications, as well as the assignment of Medicaid and CHIP cases to eligibility specialists throughout the State. For example, eligibility specialists may be assigned to a case directly and, generally, only that specialist will work on the case, or the case may be assigned to the UCL process where cases are worked on a task-by-task basis and multiple specialists may work on the same case. Regardless of how the case is assigned, Bridges has functionality to monitor all cases through, for example, reports or tasks and reminders. In addition to each of the county offices' monitoring functions, centralized oversight is also provided by MDHHS to the county offices.

MDHHS's Learning Management System (LMS) provides training opportunities for MDHHS employees. LMS interfaces with Bridges to obtain users; therefore, any MDHHS employee with access to Bridges has access to LMS. Users can search for and filter the trainings based on the type of public assistance, for example, Medicaid and CHIP. There are three methods in which trainings are delivered in LMS, including materials-based (job aids), live online, and self-paced online. Supervisors can monitor their direct-report staff within LMS by assigning trainings and viewing transcripts.

AUDIT OBJECTIVE

To assess the effectiveness of MDHHS's oversight of the Medicaid and CHIP client eligibility determination processes at MDHHS local offices.

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- MDHHS addressed, on average, all UCL alerts within 30 days.

- Material conditions related to:
    - Enhancing MDHHS's monitoring of beneficiary eligibility for Medicaid and CHIP (Finding 9).
    - Ensuring MDHHS timely completes Bridges tasks and reminders (Finding 10).
- Reportable conditions related to:
    - Improving MDHHS's monitoring of the timely completion of eligibility redeterminations (Finding 11).
    - Improving MDHHS's training program for Medicaid and CHIP eligibility determinations (Finding 12).
    - Improving MDHHS's process for tracking, reviewing, and sharing policy questions and clarifications (Finding 13).

FINDING 9

Enhancements needed in MDHHS's monitoring of beneficiary eligibility for Medicaid and CHIP.

MDHHS did not have a sufficient monitoring process in place, limiting its ability to improve the accuracy and efficiency* of the $14.7 billion Medicaid and $258.2 million CHIP payments issued on behalf of beneficiaries during fiscal year 2019.

MDHHS policy indicates local office management resources should be invested in case reading activities to help improve the accuracy and efficiency of program management. Also, MDHHS policy indicates MDHHS is responsible for conducting quality control reviews in which each month a random sample of households is selected to determine the accuracy of the eligibility decision or negative action.

In addition, federal regulation requires MDHHS to complete a Medicaid Eligibility Quality Control (MEQC) audit every three years which involves MDHHS reviewing at least 400 active cases selected from the total Medicaid and CHIP populations. CMS suspended the MEQC audit from fiscal years* 2014 through 2018 to implement the MAGI financial requirements required by the ACA. After mandating the MEQC be reinstated for calendar year 2019, it was suspended by CMS in May 2020 because of the COVID-19* pandemic.

Results of recent audits demonstrate a crucial need for MDHHS to develop and maintain a comprehensive monitoring process.

We researched recent MDHHS Medicaid- and CHIP-related audits to evaluate the significance of implementing a sufficient monitoring process and reviewed MDHHS's monitoring process from October 1, 2018 through May 30, 2020:

a. Our research noted:

(1) Federal regulation defines requirements related to the Payment Error Rate Measurement (PERM) audit, which requires states and providers to submit necessary information and support to federal contracts to enable the Secretary of Health and Human Services to produce national improper payment estimates for Medicaid and CHIP. The PERM audit is completed once every three years under federal guidance. For the 2019 review year, PERM audit results identified improper payment rates of 12% and 47% for MDHHS's Medicaid and CHIP, respectively.

(2) Statewide single audit* reports for fiscal year 2018 through fiscal year 2020 identified MDHHS with having 1 adverse opinion* and 2 qualified opinions* for Medicaid and 2 adverse opinions and 1 qualified opinion for CHIP. Adverse and qualified opinions indicate serious issues within a program, with an adverse opinion being the most severe opinion that auditors can provide.

** See glossary at end of report for definition.*

b. Our review of MDHHS's monitoring process from October 1, 2018 through May 30, 2020 noted:

(1) MDHHS did not perform case reading activities as outlined in BAM Section 301.

(2) MDHHS did not perform quality control reviews as outlined in BAM Section 320.

(3) No MEQC audits were finalized since 2014 because of the implementation of ACA and the COVID-19 pandemic.

MDHHS stated it monitors Medicaid and CHIP eligibility determinations through MEQC audits. However, prior to and during our audit period, those audits were suspended by CMS. We consider this finding to be a material condition because monitoring is a critical function necessary to ensure the accuracy and efficiency of the $14.7 billion Medicaid and $258.2 million CHIP payments issued on behalf of beneficiaries.

RECOMMENDATION

We recommend that MDHHS implement a sufficient monitoring process to help ensure accurate Medicaid and CHIP eligibility determinations.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with this finding.

MDHHS was compliant with CMS MEQC and PERM monitoring requirements. MDHHS relies on its CMS mandated MEQC and PERM processes to supplement any monitoring conducted at the local level. The federally required audits cited in MDHHS's BAM 320 are the MEQC audits which were suspended during the pandemic. MDHHS completed the required MEQC case review activities between April 2019 and February 2020. However, the MEQC findings and corrective action plans had not been submitted during the audit period because CMS put a pause on MEQC reporting requirements due to the COVID-19 pandemic.

BAM 301 allows flexibility in the implementation of case monitoring at the local office level and MDHHS local office management staff have chosen to complete Medicaid case reads on probationary staff, as well as staff who are not meeting department expectations to fulfill BAM 301 requirements. Effective October 2020, BAM 320 Medicaid monitoring requirements were removed from policy since this is covered under current CMS requirements and part of the PERM and MEQC audit parameters.

MDHHS recognizes the importance of robust monitoring procedures and continuously looks for opportunities to improve on ways to administer its Medicaid program. Therefore, as a result of

the previously conducted PERM cycle, the Eligibility Quality Assurance Section is developing an ongoing Medicaid Eligibility Quality Assurance case review process that will help to further identify areas within eligibility that need attention, with the goal of continuous quality improvement in Medicaid eligibility determinations. These efforts will supplement ongoing PERM and MEQC monitoring, which will sufficiently meet the definition of timely monitoring. Once this process is fully developed, policy changes will be made as necessary and new guidance will be developed and distributed to local office staff.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The monitoring required by MDHHS's BAM Section 320 is different and separate from the MEQC audits. For a monitoring process to be effective, it must be timely. The MEQC audits are completed every three years. By relying on the MEQC audits to replace the monthly reviews required by BAM Section 320, MDHHS's monitoring is inherently insufficient because of the timing of the MEQC audits. This is especially true for the time period 2014 through 2021 when CMS periodically suspended various MEQC audit procedures. In addition, the department's ongoing actions further support this weakness exists and that the finding is warranted. Therefore, the finding stands as written.

FINDING 10

Improvements needed to ensure MDHHS timely completes Bridges tasks and reminders.

MDHHS had not established an effective process to monitor the eligibility specialists' completion of the Bridges non-UCL tasks and reminders. As a result, MDHHS could not ensure eligibility for healthcare coverage was always appropriately determined using accurate information.

Federal regulations require states to timely use the Income Eligibility and Verification System (IEVS) information to determine an individual's eligibility. In addition, MDHHS policy requires eligibility specialists to address system-generated tasks and reminders, within a specified time frame, based on the nature of the task and reminder.

Bridges obtains and utilizes information from IEVS to verify Medicaid and CHIP eligibility for applicants and recipients. To obtain IEVS information, Bridges conducts approximately 15 data exchanges through interfaces with various governmental agencies. Bridges provides the IEVS information through tasks and reminders to the applicable eligibility specialist for use in determining the applicant's eligibility for Medicaid and CHIP.

76% of the 1.5 million system-generated tasks and reminders analyzed were not completed or not completed timely.

We summarized the status of the 1,537,863 Bridges system-generated tasks and reminders provided to approximately 3,900 eligibility specialists between October 1, 2018 and May 31, 2020 and identified 1,162,644 (76%) as processed late or not processed as of June 9, 2020, as follows:

Task and Reminder Alert Description	Processed Late	Not Processed
Unearned Income Notice	361,908 (40%)	94,856 (38%)
Michigan Department of Corrections Update	88,666 (10%)	37,556 (15%)
Citizenship Discrepancy	72,946 (8%)	15,789 (6%)
Medicare Update	42,061 (5%)	19,488 (8%)
Other	348,280 (38%)	81,094 (33%)
Total	913,861	248,783

Our review disclosed:

a. Eligibility specialists did not process 913,861 Bridges tasks and reminders until they were past due by 79 days, on average.

b. Wayne County and Oakland County which represented approximately 27% and 8%, respectively, of the total fiscal year 2019 Medicaid and CHIP caseload had 49% and 13%, respectively, of the 248,783 outstanding Bridges tasks and reminders.

c. Generally, the survey respondents indicated the Bridges tasks and reminders are easy to address.

d. MDHHS's lack of timely review of these tasks and reminders could have contributed to Findings 1, 5, 6, and 7.

In addition, the fiscal years 2019 and 2020 Statewide single audit reports (000-0100-20 and 000-0100-21) noted MDHHS did not ensure eligibility specialists considered and used IEVS information when making eligibility determinations and did not ensure all Medicaid and CHIP applicants and recipients were included in the IEVS data exchanges. These issues can result in a loss of federal funding.

MDHHS indicated internal control and monitoring were not sufficient to ensure eligibility specialists utilized IEVS information in a timely manner to determine eligibility.

We consider this finding to be a material condition because of the extent of tasks and reminders which were not addressed in a timely manner and their role in helping to ensure the accuracy of eligibility determinations.

RECOMMENDATION

We recommend that MDHHS establish an effective process to monitor the eligibility specialists' completion of the Bridges non-UCL tasks and reminders.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with the finding.

Many Tasks and Reminders (T&Rs) are informational or remain active despite action by caseworkers to resolve the issue. Further, not all tasks or reminders are directly linked to a correct eligibility determination. It is inappropriate to assume that all T&Rs that remain on the report result in incorrect cases. Dependent on workload capacity and staffing limitations, local office management is given the latitude to prioritize casework based on the nature of the T&R. Additional monitoring would not address workload saturation which prevents completion of additional T&R's.

MDHHS continues to plan for the Universal Caseload (UCL) expansion. In the interim until UCL is fully functional across Michigan, MDHHS will reiterate T&R policy requirements to staff.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The premise of the IEVS matches is to provide "information" to be used in a timely manner to determine eligibility. These matches are required by federal law. Failure to timely use the IEVS information and monitor the completion of task and reminders undermines the 15 data matches developed specifically to help ensure accurate eligibility determinations. Therefore, the finding stands as written.

FINDING 11

Improvements needed in MDHHS's monitoring of the timely completion of eligibility redeterminations.

MDHHS did not sufficiently monitor the timeliness of Medicaid and CHIP eligibility redeterminations which could help prevent MDHHS from issuing payments on behalf of ineligible beneficiaries.

MDHHS policy requires a completed eligibility redetermination for applicable beneficiaries at least once every 12 months. Bridges generates a redetermination packet to be completed by the beneficiary the month before the redetermination is due, allowing an eligibility specialist time to process a timely redetermination. An eligibility specialist should stop benefits at the end of the benefit period unless a completed renewal exists and the eligibility specialist certifies the new benefit period. However, beneficiary healthcare coverage will not be canceled if beneficiaries completed the redetermination packet but the eligibility specialists failed to complete the redetermination in a timely manner.

Our review of MDHHS's Medicaid and CHIP eligibility redeterminations from October 1, 2018 through February 29, 2020, based on MDHHS's Bridges reports, noted on average, 16% of healthcare redeterminations were overdue each month as follows:

Average Monthly Redeterminations[1]	Average Monthly Overdue Redeterminations	Range of Months Overdue	Average Months Overdue	Percent Overdue[1]
187,966	34,879	1 to 118	3	16%

[1] Does not include January through June 2019, as we were unable to determine the average monthly redeterminations and percent overdue because MDHHS did not have reports available for these months.

MDHHS informed us it relies on the Business Service Centers (BSCs) and local offices to monitor their own redeterminations and each have their own method, including using Bridges reports. However, the monthly redetermination reports were not available for use from January 2019 through June 2019 due to the Bridges technical area having performance issues, which limited MDHHS's abilities to monitor redeterminations. In addition, if Bridges calculates a redetermination date incorrectly, it will inappropriately appear on the Bridges report, further limiting MDHHS's abilities to monitor redeterminations.

RECOMMENDATION

We recommend that MDHHS sufficiently monitor the timeliness of Medicaid and CHIP eligibility redeterminations to help prevent MDHHS from issuing payments on behalf of ineligible beneficiaries.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with this finding.

MDHHS reviewed some of the cases cited by the audit and found examples that were not overdue. The audit also fails to account for business processes and policies that provide extensions to beneficiaries, such as BAM 130 which allows beneficiaries two 10-day extensions to provide required documentation. Further, state policy allows for the processing of overdue redeterminations. Many of these nuances are not reflected in the reports used by the audit. As noted in the finding, the necessary Bridges reports were not always available for distribution during the audit period due to various technical issues. MDHHS is always looking for opportunities to improve its programs and how they are operated. MDHHS acknowledges that sufficient monitoring of reports is a critical function, however, without sufficient resources to reduce worker caseload current monitoring capabilities are limited to the most critical. MDHHS will determine what if any additional measures can be put in place until adequate funding can be allocated for Bridges enhancements and additional staffing resources. The efforts we have underway to improve policies, programs and oversight activities are not necessarily a direct result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

Although MDHHS provided us examples of redetermination cases with extensions, these cases were included on its reports as overdue. Further, it acknowledged its reports were not designed to account for certain processes, such as extensions. This example indicates the need to develop processes to "sufficiently monitor the timeliness of Medicaid and CHIP eligibility redeterminations." Regardless of whether MDHHS's efforts to improve processes or implement corrective actions are a direct result of our audit, it does not negate our responsibilities to communicate reportable issues. The department's actions further support this weakness exists and that the finding is warranted. Therefore, the finding stands as written.

FINDING 12

Improvements needed in MDHHS's training program for Medicaid and CHIP eligibility determinations.

MDHHS should improve its training program and consider instituting continuous education requirements for its eligibility specialists and supervisors. A more comprehensive initial instruction that covers additional TOA eligibility categories and a continuing education program that coordinates more closely with the actual job responsibilities of staff could increase MDHHS's assurance that eligibility specialists and supervisors obtained, and maintained, the skills necessary to ensure accurate eligibility determinations.

SOM policies indicate management should demonstrate a commitment to recruit, develop, and retain competent individuals. Also, management should enable individuals to acquire the relevant knowledge, skills, and abilities appropriate for key roles through professional experience, trainings, and certifications.

Our review of MDHHS's training program available for all eligibility specialists and supervisors noted:

a. MDHHS's 5-week training program for newly hired eligibility specialists covered various public and healthcare assistance programs, including Medicaid and CHIP; however, these trainings did not include all Medicaid and CHIP TOA eligibility categories that specialists process. In addition, of the 1,410 survey respondents, 643 (46%) indicated they needed additional training and 40 (3%) indicated they never received training for determining healthcare coverage eligibility.

b. MDHHS's LMS contains a variety of training opportunities that, as of July 16, 2020, included 86 active Medicaid-related trainings that the approximately 3,600 eligibility specialists and supervisors can voluntarily complete or whose supervisors can directly assign. We summarized selected information, as of August 24, 2020, for 20 of these trainings for active employees below:

Training Title	Released in LMS	Active Employees Who Completed Trainings		Active Employees Completing Trainings in Year 1	
		Number	Percent	Number	Percent
ACA Business Processes Overview	06/04/2015	84	2%	31	37%
ACA Changes to Income	06/04/2015	199	6%	63	32%
ACA Passive Renewal Training for Eligibility Specialists	06/15/2016	908	25%	811	89%
Long Term Care - General Topics v3	10/08/2018	44	1%	15	34%
Part 3 - Medicaid Deductible Frequently Asked Questions	07/01/2019	335	9%	325	97%
MAGI Medicaid v4	01/29/2020	112	3%	112	100%
SSI-Related Medicaid v2	01/29/2020	99	3%	99	100%
Redetermination Module - Eligibility Specialist v3	07/15/2020	391	11%	391	100%
Redetermination Module - Eligibility Specialist[1]	09/28/2016	548	15%	477	87%

Table continued on next page.

Training Title	Released in LMS	Active Employees Who Completed Trainings		Active Employees Completing Trainings in Year 1	
		Number	Percent	Number	Percent
Redetermination Module - Eligibility Specialist v2[1]	11/21/2018	151	4%	66	44%
ACA Bridges Release 8 Updates for Eligibility Specialist	12/08/2015	648	18%	581	90%
ACA Changes to Applications and PDFs	06/04/2015	63	2%	24	38%
ACA MAGI Eligibility Determination - Advanced Income Module 8	09/05/2015	583	16%	448	77%
ACA MIChild Conversion	01/22/2016	203	6%	174	86%
Advanced MAGI Income Self-Employment v2	05/14/2020	36	1%	36	100%
Countable and Non-Countable MAGI Income v2	05/14/2020	10	0%	10	100%
Part 1 - Medicaid Deductibles v2	06/01/2018	393	11%	46	12%
Part 2 - Medicaid Deductibles v2	06/01/2018	393	11%	39	10%
Passive Renewals - Application Registration Changes	06/13/2016	294	8%	259	88%
Verifying Medicare Claims for HMP Clients	03/15/2016	179	5%	131	73%

[1]Trainings that have been deactivated.

We also noted the following observations during our review of the training data:

- 25% or less of active employees completed each training.
- Most employees completed the individual trainings within a year of release, which indicates a majority of the trainings will not have a significant number of participation in the years to come as most trainings were released over a year ago.
- ACA MAGI-based income* eligibility determinations are available, yet 36% of survey respondents indicated they do not understand the MAGI calculation even though MAGI beneficiaries account for a significant portion of total beneficiaries (2.2 million [78%] MAGI Medicaid* beneficiaries and 224,000 [94%] MAGI CHIP beneficiaries).
- 77% of eligibility specialists and supervisors completed 3 or less of the 20 trainings reviewed as follows:

Completed Trainings by Active Employee

Number of Completed Trainings	Number (Percent) of Employees
10 or greater	8 (0%)
6 to 9	141 (6%)
4 to 5	367 (16%)
2 to 3	852 (38%)
1	872 (39%)
Total Employees Who Completed at Least 1 Training	2,240

** See glossary at end of report for definition.*

MDHHS indicated it does not have continuous education requirements for eligibility specialists because the type of cases and experience level varies among eligibility specialists and supervisors and, accordingly, so do the training needs. Also, training is available to all eligibility specialists through LMS, and MDHHS communicates new policy trainings to eligibility specialists throughout the year.

RECOMMENDATION

We recommend that MDHHS improve its training program and consider instituting continuous education requirements for its eligibility specialists and supervisors.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees with this recommendation.

MDHHS is continually working to invest in staff, improve processes, and analyze underlying issues occurring at the local and state level. MDHHS offers new hire training for all employees, as well as on-the-job training in local offices provided by managers and experienced caseworkers. MDHHS' new hire staff training is designed to cover all types of payment assistance programs in Bridges. MDHHS has designed the Medicaid portion of the training to focus on MAGI Medicaid, which makes up over 80 percent of all active Medicaid cases. Due to the volume of information delivered during new hire training, MDHHS is not able to provide individual trainings for each type of Medicaid eligibility category. With additional resources, training and business processes could be improved.

MDHHS supports a continuing education program but does not have the resources to implement a program and ensure appropriate tracking for completion and effectiveness. Based on competing priorities in local offices, as well as the increase in worker caseload demands, caseworkers are challenged by the volume of casework. MDHHS will evaluate if additional staffing could be obtained for implementation of continuing education requirements for eligibility specialists, while maintaining significant caseload demands.

FINDING 13

Improvements needed in MDHHS's process to address policy questions and clarifications.

MDHHS should consider improving its processes for tracking, reviewing, and sharing policy questions and clarifications. Specifically, MDHHS's Economic Stability Administration (ESA) and Medical Services Administration (MSA) should consider coordinating to centrally track and share policy questions and responses. Without such a process, MDHHS limits its assurance that the approximately 3,600 eligibility specialists and supervisors representing 83 counties possess necessary resources to ensure accurate eligibility determinations.

SOM policy indicates management should internally communicate the necessary quality information to achieve the entity's objectives. Quality information should be communicated to all levels of the entity to enable personnel to perform key roles in achieving objectives. Also, management should periodically evaluate communication methods, so the entity has the appropriate tools to timely distribute quality information throughout the entity.

Our review of MDHHS's Medicaid- and CHIP-related policy processes from October 1, 2018 through May 30, 2020 noted:

a. 1,046 (70%) of the 1,494 survey respondents indicated 1 or more BEM and BAM policies and procedures need clarification.

b. Inconsistencies in BSC's processes for tracking and sharing policy questions:

    (1) Two BSCs track policy questions and clarifications on their own and only share with their assigned MDHHS local offices.

    (2) Two BSCs do not have a tracking process.

c. MSA has a central mailbox for policy questions received from ESA staff; however, process improvements should be made by tracking and reviewing questions for commonalities to consider when policy updates are needed.

d. Policies, in some instances, were insufficient and 602 (38%) of the 1,597 survey respondents indicated they were unable to find answers to their policy questions more than 50% of the time. For example, MDHHS does not have a policy specifying the time period paystubs must cover to validate a beneficiary's income. The variation in paystubs for some beneficiaries could result in different eligibility determinations, and therefore, a policy clarification would ensure consistent practice among eligibility specialists.

MDHHS informed us that although it agrees there can always be more communication, it also believes there are resources in place for local office staff to get needed answers.

RECOMMENDATION

We recommend that MDHHS consider making improvements to its process for tracking, reviewing, and sharing policy questions and clarifications.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees with this finding.

MDHHS does not agree that it would be efficient to formally track and share the specific case questions from MDHHS field office staff that are sent to the policy mailbox. These questions are typically due to a unique set of circumstances and if the field staff believe that a BEM/BAM needs further clarification, they are directed to notify field supervisors of the policy concerns. Field supervisors are then required to communicate policy concerns and suggested policy clarifications as needed to central ESA staff and HASA policy staff. Based on feedback from the field and changes to federal guidance, HASA policy staff evaluate the need for revisions to the BEM/BAM language and continuously update policy to provide clarification and examples as necessary. ESA will reiterate this process to field staff and their managers.

MDHHS communicates all policy changes to the field staff for review and comment via email reminders, memos, and website alerts.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The results of our review, inconsistent practices occurring between BSCs, and the survey of eligibility specialist/supervisors all support the need for better analysis and communication regarding policy questions and clarification. This finding is presented as an opportunity for MDHHS to strengthen its internal control in this area. Also, SOM policy indicates that management should periodically evaluate its communication method to ensure timely distribution of quality information. Therefore, the finding stands as written.

Finding 1 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

Finding 1: Improvements needed to ensure MDHHS completes accurate eligibility determinations and maintains documentation.

MDHHS provided us with the following response:

MDHHS disagrees with the finding.

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS strongly disagrees that the estimated improper payments are an accurate depiction of payments in error. MDHHS requested an audit conference to discuss this significant disagreement, during which MDHHS provided additional policy and regulatory background. Additional details were also provided for a subset of the cases wherein the OAG cited the accuracy of MDHHS' eligibility determination despite policy and case documentation that supported the determination made by the caseworker. Given the complexity of Medicaid eligibility, MDHHS took this additional step to partner with the OAG to help educate them on state and federal policy, operations and technology and resolve concerns with incorrect audit findings to ensure an accurate and representative audit product.	Our professional audit staff has decades of experience auditing the Medicaid program via mandated federal single audits (required since the mid-1980s) and various performance audits. Throughout the audit and report preparation processes, if we find exceptions, they undergo an extensive vetting process with the agency to help ensure accurate understanding and application of all noted issues. Late during this audit, MDHHS brought new concerns to the OAG which were discussed in the audit conference, a process the OAG affords to all auditees. We removed 4 exceptions from the finding. The OAG did not remove the remaining exceptions requested by MDHHS because the department could not provide sufficient evidence to establish eligibility as detailed below under MDHHS concerns.
MDHHS does not agree with the methodology utilized by the OAG in this audit. The OAG methodology results in a grossly inflated estimate and an inaccurate representation of potential payments made in error. The calculation of improper payments used as the basis for the extrapolation failed to differentiate cases that lacked eligibility from those that were eligible but placed in a misclassified type of assistance or different benefit category and included cases that MDHHS disagrees were in error. As noted, this resulted in a significantly inflated estimate which exacerbated the estimate made through the OAG's extrapolation methodology. Despite the detailed discussion of these disagreements and the concerns noted in more detail below, the OAG made minimal changes to their findings or methodology.	Our estimate is based on the audit objectives; eligibility error and improper payments as defined by federal law; and the use of an industry-accepted analytical software to statistically select sample items and extrapolate the results of our review: • Our audit's purpose was not to estimate an amount for potential reimbursement to CMS, rather we audited the accuracy of MDHHS's eligibility determinations. Whether an improper payment later results in a sanction or disallowance is at CMS's discretion, not our office's. The estimate provides context regarding the magnitude of the weaknesses in MDHHS' eligibility determination processes. • As noted on report pages 11-12, the OAG used federal regulations to define an eligibility error (42 *CFR* 431.804) and improper payment (42 *CFR* 431.958). These regulations indicate an eligibility error exists when the department assigns an incorrect TOA. • Although we are confident the statistical projection is an accurate best estimate of the likely errors in the population tested, we also performed a second nonstatistical extrapolation which resulted in a combined $2.2 billion (Medicaid and CHIP) estimated error, providing additional assurance regarding the reasonableness of the methodology used.

- As noted above, we eliminated exceptions when sufficient appropriate evidence supported the eligibility. However, even if we eliminated the exceptions the department disagrees with, the likely improper payment amount would still project to a combined $1.3 billion (Medicaid and CHIP). Underscoring the impact of the exceptions identified and the need for the department to improve its internal control.

MDHHS's Concerns:

- ***Inclusion of Permissible Payments:*** *The OAG deemed payments to be improper when CMS would not have made the same determination.*

  MDHHS reviewed the cases and determined that many of these beneficiaries were eligible under other aid categories. Given that these individuals were in fact eligible for Medicaid, there was no improper payment. The improper payment calculation should be limited to those cases truly ineligible for Federal reimbursement. Any other methodological approach grossly misrepresents financial risk to the program and the state.

  The federal government's audit process supports MDHHS' conclusion above. As part of the federal Payment and Error Rate Measurement (PERM) audits, CMS first determines if the beneficiary is eligible in other aid categories, before determining "inaccuracies." Had the scope of the OAG's audit taken these factors into account and noted them as part of its extrapolation, the dollar amount would be significantly lower.

Our testing of MDHHS's eligibility determinations was based on the TOA to which beneficiaries were assigned. If after reviewing MDHHS's documentation, we determined the beneficiary was not eligible for coverage under the assigned TOA, we included it as an eligibility error and an improper payment, as cited by the federal regulations. MDHHS acknowledges these errors by noting some beneficiaries were eligible under other TOAs.

MDHHS acknowledged that as part of the PERM audit, CMS would indicate a "technical deficiency" for situations where a beneficiary was determined eligible under an incorrect TOA, further supporting these situations are an eligibility error. While the PERM audit may not include these "technical deficiencies" as part of their improper payment calculations, the objectives of the PERM audits and this OAG audit are different. Therefore, our methodologies will differ.

- ***Lack of Recognition for Federal Medical Assistance Percentage (FMAP) Differentials:*** *The OAG deemed full payment amounts to be improper when CMS would have only recognized the difference in federal match rates. CMS is interested in the validity of the federal payment, which is defined by the PERM Manual as the difference between what was paid and what should have been paid.*

  When beneficiaries were eligible under different Medicaid benefit categories than audited, the OAG reported the total payment as improper. However, several of these individuals were eligible under another type of assistance with a different FMAP. In such instances, the payment amount is accurate; only the amount of federal and state share requires adjustment and the potential amount of the improper federal reimbursement should have been limited to the difference in CHIP versus Medicaid FMAP rates.

As noted by MDHHS, "*CMS is interested in the validity of the federal payment, which is defined by the PERM Manual".* CMS's federal regulations and manuals which identify the requirements of the PERM audit are likely developed around their objective related to the *"validity of the federal payment".*

Our audit objective and procedures were directed toward assessing the effectiveness of MDHHS's efforts to complete accurate Medicaid and CHIP client eligibility determinations. An inaccurate eligibility determination has numerous implications, such as, incorrect federal or State payment, inaccurate reporting, misuse of resources, or negative implications for a Medicaid or CHIP client. Including the full amount as a payment error provides perspective to the entire magnitude of the issues noted. Also, using this information as a basis for implementing process improvements could result in fewer technical deficiencies in future CMS PERM audits. When technical deficiencies are noted, MDHHS must expend additional resources to determine if the beneficiary is eligible under another TOA, calculate the difference between FMAPs, and negotiate a resolution. MDHHS should strive to determine eligibility under the correct TOA the first time, and not rely on internal control processes based on the hope that if CMS finds a "technical deficiency", the department will be fortunate enough to qualify the beneficiary under another TOA.

For example, a $1,000 payment was made on behalf of a child who was determined eligible for MI Child (CHIP: matched at 98.12% federal) but should have been in a Low-Income Family (Medicaid: matched at 64.45% federal) group. The OAG deemed the full $1,000 payment to be in error, whereas CMS would have only cited the difference in the federal match for which the payment qualified vs. the amount originally drawn, which was $336.70. The $336.70 figure would have then been used in the base amount used by the federal government to extrapolate rather than the $1,000 amount used by the OAG.

Our errors were analyzed in relation to the Medicaid and CHIP programs separately and the TOA to which the beneficiary was assigned. We did not determine the net amount of federal reimbursements received in error for the 2 programs combined. This different methodology is a direct result of the differing objectives for the audits.

- ***Misapplication of MDHHS/CMS Policy:*** *The federal government establishes clear policy for states when they determine or redetermine eligibility. The OAG has assessed cases that they deem improper based on an incorrect interpretation of federal policy.*

We underwent an extensive vetting process with MDHHS to ensure proper interpretation of policy. Below are our responses to the 1 Medicaid and 3 CHIP cases presented as examples of a misapplication of MDHHS's policy.

There were a number of state and federal policies that were misinterpreted or misapplied by the OAG these are represented below.

  - *MAGI Determinations: Federal regulations (42 CFR 435.907 in conjunction with supporting regulations 435.945, 435.948, 435.949, and 435.952) allow MDHHS to consider the case complete when a case is auto certified. IRS data is the most accurate, up to date information, at the time of auto certification. Therefore, the determination was accurate at the time of the MAGI run and auto certification. Relatedly, the exclusion of numerous MAGI certified cases incorrectly exaggerated the improper payment calculation.*
    - *In sample 89 the application was submitted via MI Bridges and the income reported in the application was correctly used in the eligibility determination. Additionally, income is not required to be verified for this eligibility category (U19).*

The OAG acknowledged and applied these federal regulations as part of our review. However, our review also considered if the eligibility specialist properly entered all available information into Bridges, **prior** to the auto certification, to ensure the auto certification was accurate. In sample 89, verified income information was not entered into Bridges, therefore, the verified income was not appropriately considered when determining eligibility.

The OAG does not agree with MDHHS that the IRS data is always "*the most accurate, up to date information, at the time of auto certification".* MDHHS policy requires eligibility specialists to consider new information as it becomes available to determine eligibility. For example, a Medicaid client may have had a full-time job in a previous tax filing year but whose hours were reduced to part time. The income difference between working full- or part-time may be the difference in being eligible or ineligible for Medicaid. If MDHHS obtained current income verification from the beneficiary, the newly verified income should be used instead of the IRS data.

  - *Other Eligibility Determinations: Case workers must adhere to policy and system guidelines that instruct them to make a "point in time" assessment even if income varies after the initial assessment.*
    - *In Sample 52, a 'point in time' assessment was made using the father's earned income. He was not*

The examples provided did not substantiate that we misapplied the "point in time" requirement. In fact, using the income information available at the "point in time" of the initial assessment supports that the beneficiary was not eligible for the assigned TOA. We noted:

- In sample 52, regardless of the RSDI income the beneficiary was not eligible under the CHIP OHK U19 TOA because the beneficiary did not meet the income requirements.

receiving RSDI at that time but began receiving it later. The original OHK U19 determination was correct and would continue for 12 months.

- *In sample 89 a 'point in time' assessment was made when the application was submitted via MI Bridges. Income was further verified during an interview and updated in the eligibility system; however, it did not result in a change to the Medicaid category.*
- *In sample 88, a 'point in time' assessment was made when the client reported increased earned income which MAGI confirmed was over the income limit for LIF. CI from the previous quarter verified earned income had increased since the previous determination. Check stubs were then received further confirming TMA was the correct TOA*

- *Continuous eligibility Requirements: As stated in BEM 131, Children under 19 (U-19) beneficiaries remain eligible for 12 months of continuous eligibility, unless the beneficiary: Reaches age 19; moves out of state; is ineligible due to Institutional Status; is eligible for Foster Care Department Ward (FCDW) coverage; or dies. Further, BEM 500 (pg. 13) Verification Requirements states that this applies for all programs except children under 19.*
  - *In Sample 13, the beneficiary was determined eligible for MiChild for the retro month of April using check stubs. MiChild is a continuous eligibility program and subsequent income changes would not impact the Medicaid Benefits.*
  - *In Sample 52, the application was correctly certified for OHK which is a continuous eligibility category and subsequent income changes would not impact the Medicaid benefits.*
  - *In sample 89, the application was auto certified approved for OHK,*

- In sample 89, MDHHS did not use the verified income resulting in the beneficiary being determined ineligible for the assigned TOA.
- In sample 88, MAGI could not have confirmed the self-attested income because MDHHS did not appropriately update Bridges to include the income from the paper application at the time of the initial determination. Additionally, MDHHS was not in the possession of the CI or check stubs at the time of the initial determination.

The examples provided did not substantiate that we misapplied this requirement. For sample items 13, 52, and 89, the OAG considered continuous eligibility and used the income information available at the time of the certification. The errors noted relate to MDHHS' failure to use available information at the time of certification to appropriately determine eligibility.

which is a 12 month continuous eligibility category, and subsequent income changes would not impact the Medicaid benefits.

Notwithstanding the above noted disagreements, MDHHS is always looking for opportunities for improving its programs and how they are operated. This includes exploring the use of additional data sources to assist with income verification as well as enhanced case worker training. The fact that these efforts to improve policies, programs and oversight activities are underway does not necessarily mean these were done as a result of audit activity and does not mean that MDHHS agrees with all components of a finding. MDHHS can disagree with the OAG's methodology, interpretation of policy, and determinations on particular cases without conceding our commitment to continuous improvement.

Regardless of whether MDHHS' efforts to improve processes or implement corrective actions are a direct result of our audit, it does not negate our responsibilities to communicate reportable issues. The department's actions further support those weaknesses exist and that the findings are warranted. Therefore, the finding stands as written.

SUPPLEMENTAL INFORMATION

Exhibit 1

MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS
Michigan Department of Health and Human Services

Authoritative Sources Referenced Throughout the Audit Report
October 1, 2018 Through September 30, 2019

Finding or Observation Number	Applicable *Code of Federal Regulations*, *United States Code*, or MDHHS or DTMB Policy	Description
1	42 *CFR* 435.1002(b)	Federal funding is available only for services provided to Medicaid eligible beneficiaries.
1	42 *CFR* 457.622(d)	Federal funding is available only for services provided to CHIP eligible beneficiaries.
1	42 *CFR* 435.914	The agency must include in each applicant's case record facts to support the agency's decision on the Medicaid application.
1	42 *CFR* 457.965	The agency must include in each applicant's case record facts to support the agency's decision on the CHIP application.
1, 3	42 *CFR* 435.10	A State plan must specify the groups to whom Medicaid is provided and the conditions of eligibility for individuals in those groups.
1	42 *CFR* 457.70	A State plan must specify the groups to whom CHIP is provided and the conditions of eligibility for individuals in those groups.
1	26 *CFR* 301.6103(a)	Prohibits an auditor from using federal income tax return data.
2	45 *CFR* 75.303	Requires states to establish and maintain effective internal control over federal programs that provides reasonable assurance they are managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of federal awards.
3	42 *USC* 1396r-6	Provides extended medical coverage up to 12 months to families with dependent children whose coverage was terminated because of earnings, hours of employment, or loss of earned income disregards.
4	BEM Section 223	As a condition of eligibility, beneficiaries must provide an SSN, cooperate in obtaining an SSN, or be excused from supplying an SSN.
5	BEM Section 225	To be eligible for full healthcare coverage a person must be a U.S. citizen or an alien admitted to the U.S. under a specific immigration status. Beneficiaries who do not meet the acceptable alien status are allowed healthcare coverage for emergency services only if other eligibility requirements are met.
5	42 *CFR* 435.956	States must provide full healthcare coverage to individuals who have attested to having satisfactory immigration status during a reasonable opportunity period of 90 days while their immigration status is being verified, if they are otherwise eligible for healthcare coverage.
6	42 *CFR* 435.119	Healthcare coverage under HMP is for individuals who are not entitled to, or enrolled in, Medicare benefits.
7	BEM Section 265	Individuals can remain eligible during their period of incarceration, but coverage is limited to off-site inpatient hospitalization.
7	42 *CFR* 435.1009(b)	Healthcare coverage is allowed during the part of the month in which the individual is not incarcerated.
8	42 *CFR* 435.120	States must provide Medicaid to individuals who are receiving, or are deemed to be receiving, SSI.
8	BEM Section 150	SSI recipients who are Michigan residents will receive Medicaid for the duration of their SSI eligibility. Redeterminations are not required because SSA determines SSI client eligibility and interfaces daily to update MDHHS's SSI client information.

This exhibit continued on next page.

MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS
Michigan Department of Health and Human Services

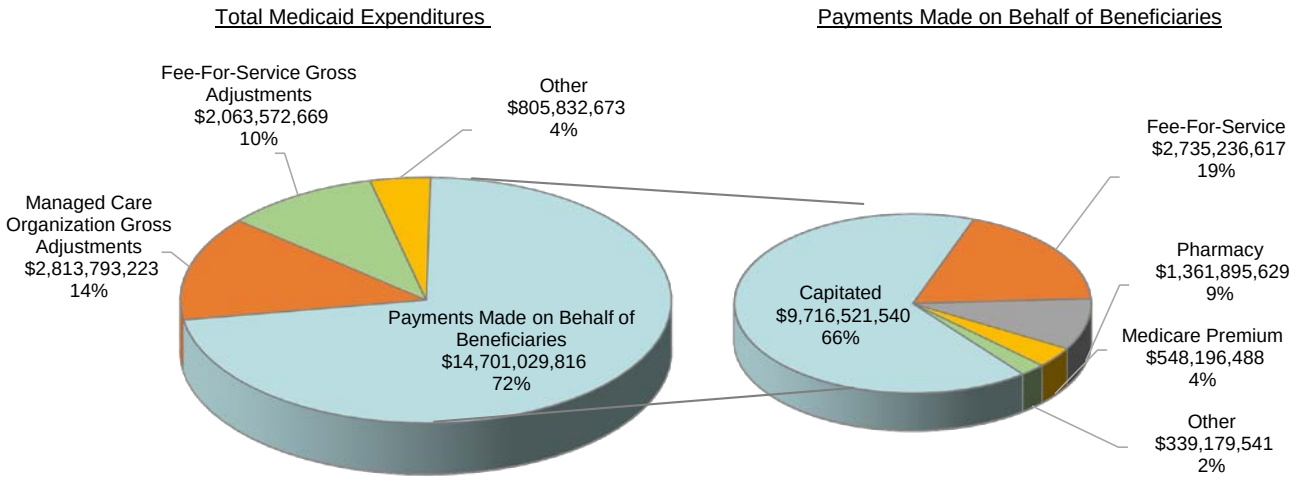
Authoritative Sources Referenced Throughout the Audit Report
October 1, 2018 Through September 30, 2019

Finding or Observation Number	Applicable *Code of Federal Regulations* , *United States Code* , or MDHHS or DTMB Policy	Description
Observation 1	26 *USC* 6103 (l)(21)	Allows states to receive certain tax information from the IRS for the purposes of determining eligibility in Medicaid or CHIP.
Observation 1	26 *USC* 6103 (d)(2)	Prohibits State audit agencies from accessing and using federal tax return information for any other purposes apart from an audit of a state's Department of Treasury.
9	BAM Section 301	Local office management resources should be invested in case reading activities to help improve the accuracy and efficiency of program management.
9	BAM Section 320	MDHHS is responsible for conducting quality control reviews in which each month a random sample of households are selected to determine the accuracy of the eligibility decision or negative action.
9	42 *CFR* 431 Subpart P	Requires states to complete a MEQC audit every three years which involves states reviewing at least 400 active cases selected from the total Medicaid and CHIP populations.
9	42 *CFR* 431 Subpart Q	Requires states and providers to submit necessary information and support to federal contracts to enable the Secretary of Health and Human Services to produce national improper payment estimates for Medicaid and CHIP for the Payment Error Rate Measurement (PERM) audit.
10	42 *CFR* 435.948	Requires states to timely use the IEVS information to determine individual's eligibility.
10	42 *CFR* 435.952	Requires states to timely use the IEVS information to determine individual's eligibility.
10	42 *CFR* 457.380	Requires states to timely use the IEVS information to determine individual's eligibility.
11	BAM Section 210	Requires a completed eligibility redetermination for applicable beneficiaries at least once every 12 months.
12	Principle 4, FMG, Part VII, Chapter 1, Section 200	Management should demonstrate a commitment to recruit, develop, and retain competent individuals. Also, management should enable individuals to acquire the relevant knowledge, skills, and abilities appropriate for key roles through professional experience, trainings, and certifications.
13	Principle 14, FMG, Part VII, Chapter 1, Section 200	Management should internally communicate the necessary quality information to achieve the entity's objectives. Quality information should be communicated to all levels of the entity to enable personnel to perform key roles in achieving objectives. Also, management should periodically evaluate communication methods, so the entity has the appropriate tools to timely distribute quality information throughout the entity.

Source: The OAG prepared the exhibit by compiling the descriptions from the identified sections of the *Code of Federal Regulations* , *United States Code* , and MDHHS or DTMB Policy.

MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS
Michigan Department of Health and Human Services

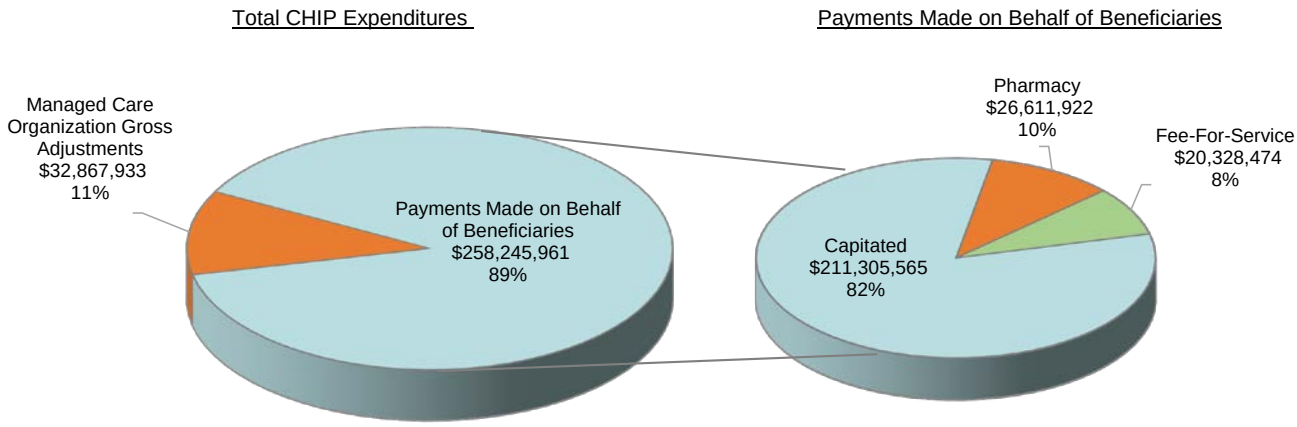
Exhibit 2A - Summary of Medicaid Expenditures From October 1, 2018 Through September 30, 2019



Notes: The following describes the types of expenditures that are not payments on behalf of Medicaid beneficiaries and therefore were not subject to review:

1. Managed Care Organization Gross Adjustments include payments related to Health Reimbursement Arrangements, Speciality Network Access Facilities, Insurance, and Incentives.
2. Fee-for-Service Gross Adjustments include payments related to Medicaid Access to Care Initiatives, Long-Term Care Quality Assurance Supplements, Medicaid Interim Payments, Physician Adjustor, and School Based Services.
3. Total Medicaid expenditures include approximately $6.7 billion of State funds.

Exhibit 2B - Summary of CHIP Expenditures From October 1, 2018 Through September 30, 2019



Notes: The following describes the types of expenditures that are not payments on behalf of Medicaid beneficiaries and therefore were not subject to review:

1. Managed Care Gross Adjustments include payments related to Health Reimbursement Arrangements, Speciality Network Access Facilities, Insurance, and Incentives.
2. Total CHIP expenditures include approximately $5.9 million of State funds.

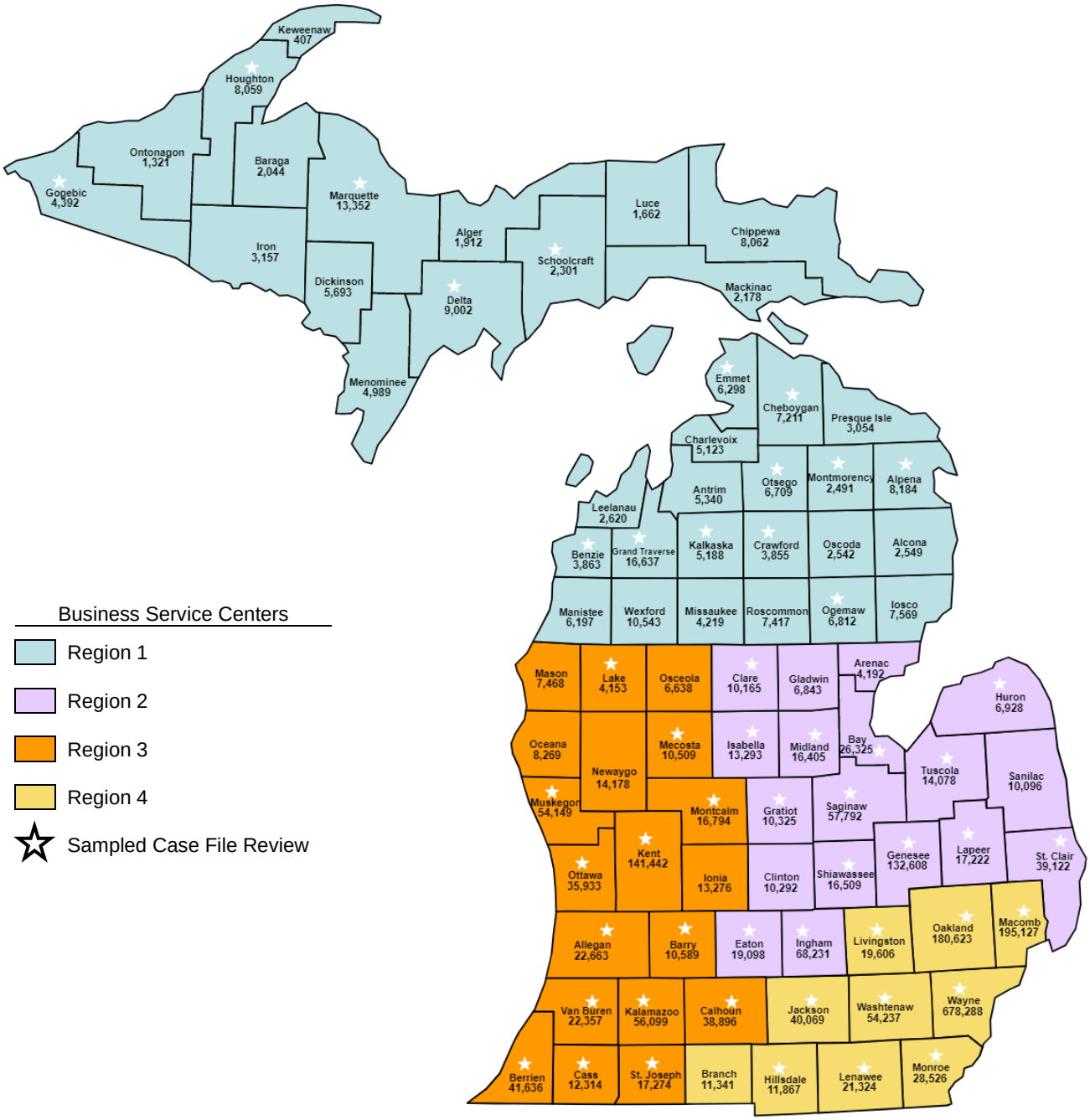
Source: The OAG prepared this exhibit based on data obtained from the Statewide Integrated Governmental Management Applications, CHAMPS, the Michigan Adult Integrated Management System, and the Medicare Buy-In System.

MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS

Michigan Department of Health and Human Services

Map of the Average Medicaid and CHIP Recipient Counts by County

October 1, 2018 Through September 30, 2019



Note: Sample items also included client eligibility determinations processed by MDHHS's central office and not directly assigned to a county.

Source: The OAG prepared this exhibit based on sample item information and data obtained from MDHHS.

MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS
Michigan Department of Health and Human Services

Average Medicaid and CHIP Case and Recipient Counts by County
October 1, 2018 Through September 30, 2019

	Type of Assistance Categories														Total	
	Family Medicaid		Other Children Under 21		Pregnant Woman and Children Under 19		MiChild		Non-SSI Aged, Blind, or Disabled		SSI Aged, Blind, or Disabled		HMP		Medicaid and CHIP	
County	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients
Alcona	310	650	52	54	236	384	22	30	320	338	319	319	683	774	1,942	2,549
Alger	242	517	40	45	180	333	24	45	211	215	168	168	506	589	1,372	1,912
Allegan	3,253	7,116	925	965	2,629	4,887	393	700	2,001	2,051	1,812	1,812	4,580	5,133	15,592	22,663
Alpena	1,033	2,015	193	202	761	1,273	107	161	992	1,024	1,149	1,149	2,110	2,360	6,345	8,184
Antrim	638	1,306	122	126	603	1,098	97	177	535	556	435	435	1,417	1,641	3,846	5,340
Arenac	523	1,063	154	158	421	699	53	89	540	562	473	473	1,007	1,148	3,171	4,192
Baraga	275	521	37	40	211	383	26	47	235	240	170	170	578	643	1,532	2,044
Barry	1,497	3,159	406	420	1,225	2,244	175	332	995	1,031	815	815	2,327	2,589	7,441	10,589
Bay	3,594	7,262	531	553	2,595	4,290	304	467	2,826	2,881	3,256	3,256	7,019	7,616	20,124	26,325
Benzie	479	972	107	110	434	722	70	129	415	432	294	294	1,068	1,202	2,867	3,863
Berrien	5,909	13,047	1,117	1,146	4,104	7,225	466	768	3,777	3,852	4,453	4,453	10,241	11,144	30,068	41,636
Branch	1,656	3,537	371	400	1,324	2,504	181	316	1,061	1,096	929	929	2,248	2,559	7,769	11,341
Calhoun	5,704	11,994	1,176	1,202	3,927	6,767	426	690	3,754	3,852	4,853	4,853	8,814	9,537	28,653	38,896
Cass	1,856	4,043	383	399	1,272	2,276	175	303	1,089	1,127	1,007	1,007	2,860	3,159	8,641	12,314
Charlevoix	602	1,175	164	170	663	1,155	101	177	511	520	469	469	1,301	1,457	3,810	5,123
Cheboygan	859	1,762	208	210	811	1,344	106	164	749	775	722	722	1,958	2,234	5,413	7,211
Chippewa	1,049	2,255	225	229	881	1,456	105	161	747	767	888	888	2,097	2,306	5,992	8,062
Clare	1,462	3,060	239	253	904	1,490	84	137	1,175	1,223	1,259	1,259	2,460	2,743	7,584	10,165
Clinton	1,504	3,108	406	416	1,190	2,089	161	275	833	852	834	834	2,446	2,719	7,375	10,292
Crawford	507	1,026	142	146	378	613	42	71	472	490	416	416	971	1,094	2,928	3,855
Delta	1,171	2,367	243	255	902	1,521	131	212	1,070	1,113	969	969	2,302	2,564	6,788	9,002
Dickinson	739	1,493	176	182	639	1,119	98	161	653	673	503	503	1,425	1,562	4,233	5,693
Eaton	2,819	5,837	724	741	2,107	3,607	283	460	1,645	1,667	1,741	1,740	4,617	5,046	13,934	19,098
Emmet	752	1,383	160	165	812	1,381	150	249	636	656	504	504	1,772	1,960	4,786	6,298
Genesee	20,881	44,279	2,586	2,661	12,082	19,260	1,377	2,123	9,636	9,790	16,464	16,464	35,516	38,031	98,541	132,608
Gladwin	914	1,876	157	165	638	1,059	76	125	767	790	864	864	1,753	1,965	5,170	6,843
Gogebic	554	1,205	88	90	394	647	46	79	622	641	458	458	1,138	1,272	3,300	4,392
Grand Traverse	2,009	3,980	487	505	1,985	3,409	397	645	1,712	1,749	1,345	1,345	4,555	5,005	12,489	16,637
Gratiot	1,458	3,032	284	293	1,154	1,992	120	213	1,112	1,133	1,009	1,009	2,365	2,653	7,503	10,325
Hillsdale	1,649	3,706	337	354	1,223	2,248	155	275	1,180	1,215	1,169	1,169	2,522	2,900	8,235	11,867
Houghton	854	1,928	94	107	809	1,743	180	372	940	968	590	590	2,046	2,352	5,513	8,059
Huron	879	1,799	129	138	767	1,366	122	187	872	893	727	727	1,588	1,818	5,083	6,928
Ingham	9,536	21,186	1,748	1,808	6,217	10,631	651	1,043	5,332	5,441	7,901	7,901	18,611	20,221	49,996	68,231
Ionia	1,981	4,038	416	443	1,551	2,813	231	389	1,130	1,170	1,255	1,255	2,851	3,169	9,415	13,276
Iosco	1,056	2,206	124	131	718	1,169	71	108	889	915	830	830	1,996	2,211	5,683	7,569
Iron	401	882	59	66	264	468	44	73	514	528	293	293	770	847	2,345	3,157
Isabella	1,898	3,836	304	311	1,342	2,226	166	257	1,213	1,243	1,294	1,294	3,794	4,126	10,010	13,293
Jackson	5,875	12,234	1,038	1,078	3,924	6,710	440	718	3,502	3,585	4,596	4,596	10,345	11,149	29,720	40,069
Kalamazoo	8,217	17,266	2,049	2,093	5,561	9,442	632	1,031	4,724	4,809	6,468	6,468	14,084	14,990	41,734	56,099
Kalkaska	668	1,357	195	197	569	999	103	171	560	584	444	444	1,266	1,436	3,804	5,188
Kent	20,375	43,286	4,160	4,367	16,457	29,917	2,389	4,088	11,808	12,159	13,706	13,706	31,322	33,919	100,218	141,442
Keweenaw	33	72	8	9	37	78	10	15	48	50	30	30	133	152	300	407
Lake	538	1,185	79	82	303	524	24	43	545	573	628	628	989	1,119	3,106	4,153
Lapeer	2,505	5,275	503	548	1,939	3,398	280	495	1,551	1,590	1,296	1,296	4,076	4,620	12,150	17,222

This exhibit continued on next page.

MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS
Michigan Department of Health and Human Services

Average Medicaid and CHIP Case and Recipient Counts by County
October 1, 2018 Through September 30, 2019

	Type of Assistance Categories														Total	
	Family Medicaid		Other Children Under 21		Pregnant Woman and Children Under 19		MiChild		Non-SSI Aged, Blind, or Disabled		SSI Aged, Blind, or Disabled		HMP		Medicaid and CHIP	
County	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients	Cases	Recipients
Leelanau	291	592	65	66	308	596	59	103	227	234	135	135	801	895	1,885	2,620
Lenawee	3,060	6,426	612	649	2,468	4,414	301	494	1,957	1,999	1,938	1,938	4,870	5,404	15,206	21,324
Livingston	2,699	5,453	697	740	2,144	3,640	371	639	1,735	1,764	1,449	1,449	5,350	5,921	14,444	19,606
Luce	207	470	53	54	144	252	15	30	186	194	216	216	390	445	1,211	1,662
Mackinac	272	556	66	67	221	358	37	53	275	283	207	207	589	654	1,666	2,178
Macomb	27,347	57,553	3,663	3,866	19,579	33,236	2,643	4,238	15,305	15,789	22,680	22,680	50,472	57,765	141,690	195,127
Manistee	784	1,649	111	117	601	1,018	70	122	698	727	694	694	1,665	1,871	4,623	6,197
Marquette	1,697	3,539	331	347	1,324	2,198	188	301	1,430	1,451	1,095	1,095	4,064	4,421	10,129	13,352
Mason	991	2,092	147	151	788	1,425	106	176	789	818	766	766	1,810	2,040	5,396	7,468
Mecosta	1,476	3,123	256	258	994	1,653	108	169	925	960	1,117	1,117	2,952	3,229	7,828	10,509
Menominee	681	1,441	106	111	491	857	62	112	596	618	475	475	1,221	1,376	3,630	4,989
Midland	2,188	4,537	482	503	1,796	3,026	216	356	1,625	1,675	1,587	1,587	4,204	4,721	12,097	16,405
Missaukee	529	1,185	122	129	463	898	65	116	409	432	340	340	977	1,119	2,905	4,219
Monroe	4,400	9,232	858	891	2,891	4,841	324	530	2,556	2,605	2,586	2,586	7,186	7,842	20,801	28,526
Montcalm	2,446	5,143	437	453	1,850	3,292	233	388	1,409	1,463	1,776	1,776	3,826	4,279	11,978	16,794
Montmorency	312	616	86	85	238	409	30	48	302	311	316	316	617	706	1,901	2,491
Muskegon	8,284	17,180	1,399	1,461	5,477	9,348	627	1,003	4,983	5,094	6,197	6,197	12,857	13,866	39,824	54,149
Newaygo	1,977	4,310	373	395	1,437	2,647	191	349	1,393	1,466	1,458	1,458	3,147	3,553	9,975	14,178
Oakland	24,654	51,684	4,084	4,293	16,811	28,301	2,392	3,963	17,582	18,172	21,268	21,268	48,368	52,943	135,159	180,623
Oceana	1,206	2,824	186	203	845	1,620	119	225	638	667	732	732	1,755	1,999	5,482	8,269
Ogemaw	868	1,833	165	169	626	1,070	82	147	803	840	836	836	1,689	1,918	5,071	6,812
Ontonagon	119	255	26	27	95	173	23	37	243	255	145	145	372	429	1,023	1,321
Osceola	961	2,101	302	304	626	1,085	72	126	588	609	774	774	1,435	1,639	4,758	6,638
Oscoda	312	649	65	68	229	395	33	52	330	350	321	321	624	707	1,913	2,542
Otsego	832	1,680	253	258	784	1,347	126	213	701	725	600	600	1,670	1,886	4,965	6,709
Ottawa	4,888	10,025	1,377	1,464	4,714	8,708	831	1,605	3,217	3,330	2,519	2,519	7,474	8,283	25,020	35,933
Presque Isle	371	765	80	82	280	482	34	60	374	381	356	356	815	928	2,309	3,054
Roscommon	980	2,086	146	152	634	1,035	53	91	817	857	892	892	2,050	2,304	5,573	7,417
Saginaw	8,535	18,225	1,188	1,218	5,336	8,568	502	752	4,951	5,025	8,579	8,580	14,473	15,425	43,563	57,792
Sanilac	1,390	2,985	250	261	1,065	1,905	160	278	1,108	1,147	970	970	2,246	2,551	7,189	10,096
Schoolcraft	288	628	67	72	219	353	28	43	270	281	245	245	610	680	1,727	2,301
Shiawassee	2,501	5,115	426	435	1,764	3,002	225	349	1,526	1,553	1,720	1,720	3,858	4,334	12,019	16,509
St. Clair	5,615	11,877	1,183	1,212	3,988	6,629	519	850	3,687	3,767	3,587	3,587	10,185	11,199	28,764	39,122
St. Joseph	2,699	5,735	628	659	1,826	3,346	251	440	1,522	1,589	1,275	1,275	3,821	4,231	12,021	17,274
Tuscola	1,913	4,128	447	468	1,464	2,474	196	340	1,423	1,467	1,399	1,399	3,343	3,803	10,186	14,078
Van Buren	3,105	6,981	776	807	2,398	4,389	287	503	1,998	2,077	2,080	2,080	4,904	5,520	15,546	22,357
Washtenaw	7,110	15,662	1,075	1,124	4,811	8,083	565	902	4,840	5,022	5,567	5,567	16,408	17,878	40,374	54,237
Wayne	105,332	245,715	11,360	11,849	52,680	88,375	4,214	6,558	46,530	47,463	85,287	85,287	176,417	193,043	481,819	678,288
Wexford	1,470	3,142	251	261	1,132	2,021	130	243	989	1,030	1,145	1,145	2,414	2,702	7,531	10,543
x-Unassigned	313	710	120	123	139	210	6	10	85	87	440	440	425	451	1,527	2,031
Grand Total	355,813	775,194	57,464	59,881	232,821	398,634	27,787	45,784	206,913	212,392	275,572	275,572	620,878	682,693	1,777,248	2,450,150

Note: Column numbers may not add to totals because of rounding.

Source: The OAG prepared the exhibit based on monthly data obtained from the MDHHS Green Book.

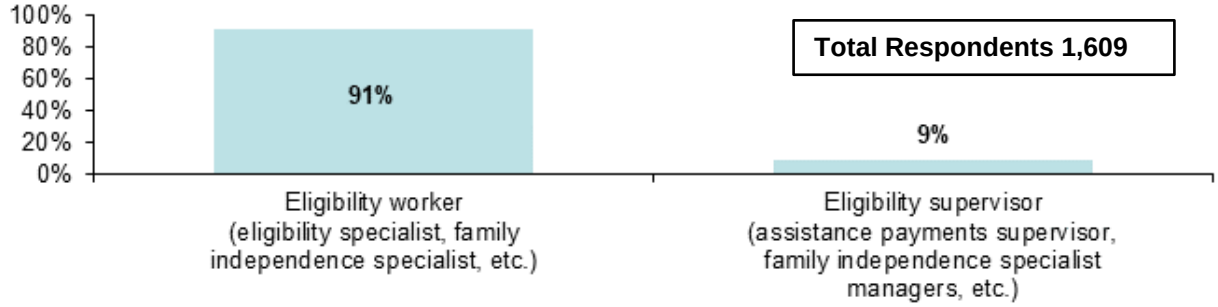
MEDICAID AND CHIP CLIENT ELIGIBILITY DETERMINATIONS
Michigan Department of Health and Human Services

MDHHS Eligibility Specialist and Supervisor Survey Results

1. Please select your MDHHS county:

County	Total		County	Total		County	Total	
Alcona	1	(0.1%)	Gratiot	9	(0.6%)	Missaukee	3	(0.2%)
Alger	1	(0.1%)	Hillsdale	10	(0.6%)	Monroe	23	(1.4%)
Allegan	17	(1.1%)	Houghton	5	(0.3%)	Montcalm	13	(0.8%)
Alpena	4	(0.3%)	Huron	5	(0.3%)	Montmorency	0	(0.0%)
Antrim	7	(0.4%)	Ingham	60	(3.7%)	Muskegon	42	(2.6%)
Arenac	7	(0.4%)	Ionia	8	(0.5%)	Newaygo	9	(0.6%)
Baraga	3	(0.2%)	Iosco	7	(0.4%)	Oakland	101	(6.3%)
Barry	9	(0.6%)	Iron	2	(0.1%)	Oceana	11	(0.7%)
Bay	33	(2.1%)	Isabella	8	(0.5%)	Ogemaw	5	(0.3%)
Benzie	4	(0.3%)	Jackson	47	(2.9%)	Ontonagon	3	(0.2%)
Berrien	26	(1.6%)	Kalamazoo	35	(2.2%)	Osceola	1	(0.1%)
Branch	11	(0.7%)	Kalkaska	5	(0.3%)	Oscoda	5	(0.3%)
Calhoun	38	(2.4%)	Kent	98	(6.1%)	Otsego	5	(0.3%)
Cass	11	(0.7%)	Keweenaw	0	(0.0%)	Ottawa	26	(1.6%)
Charlevoix	0	(0.0%)	Lake	2	(0.1%)	Presque Isle	2	(0.1%)
Cheboygan	5	(0.3%)	Lapeer	9	(0.6%)	Roscommon	5	(0.3%)
Chippewa	5	(0.3%)	Leelanau	1	(0.1%)	Saginaw	38	(2.4%)
Clare	7	(0.4%)	Lenawee	8	(0.5%)	Sanilac	9	(0.6%)
Clinton	6	(0.4%)	Livingston	20	(1.2%)	Schoolcraft	2	(0.1%)
Crawford	3	(0.2%)	Luce	4	(0.3%)	Shiawassee	9	(0.6%)
Delta	12	(0.8%)	Mackinac	2	(0.1%)	St. Clair	21	(1.3%)
Dickinson	5	(0.3%)	Macomb	103	(6.4%)	St. Joseph	17	(1.1%)
Eaton	8	(0.5%)	Manistee	6	(0.4%)	Tuscola	3	(0.2%)
Emmet	5	(0.3%)	Marquette	9	(0.6%)	Van Buren	14	(0.9%)
Genesee	106	(6.6%)	Mason	7	(0.4%)	Washtenaw	33	(2.1%)
Gladwin	7	(0.4%)	Mecosta	9	(0.6%)	Wayne	327	(20.3%)
Gogebic	9	(0.6%)	Menominee	4	(0.3%)	Wexford	15	(0.9%)
Grand Traverse	15	(0.9%)	Midland	14	(0.9%)	Prefer not to answer.	5	(0.3%)

2. Which of the following best describes your job title?



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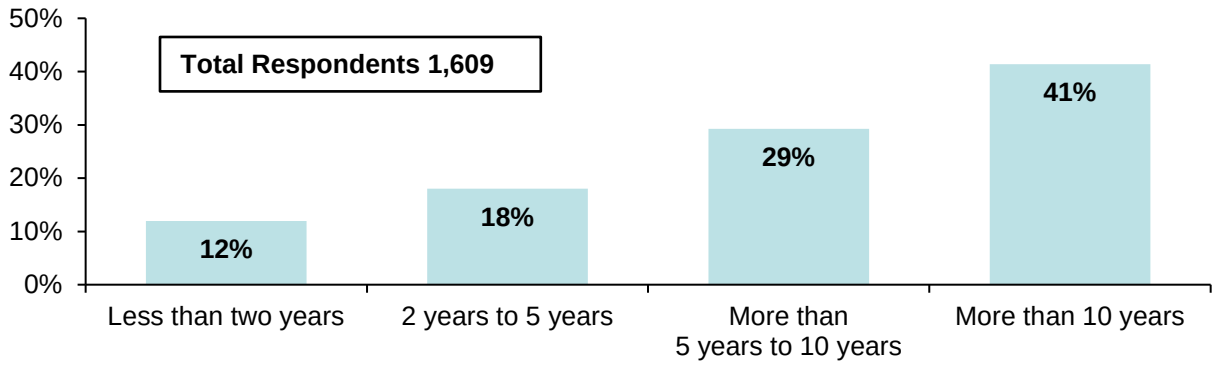
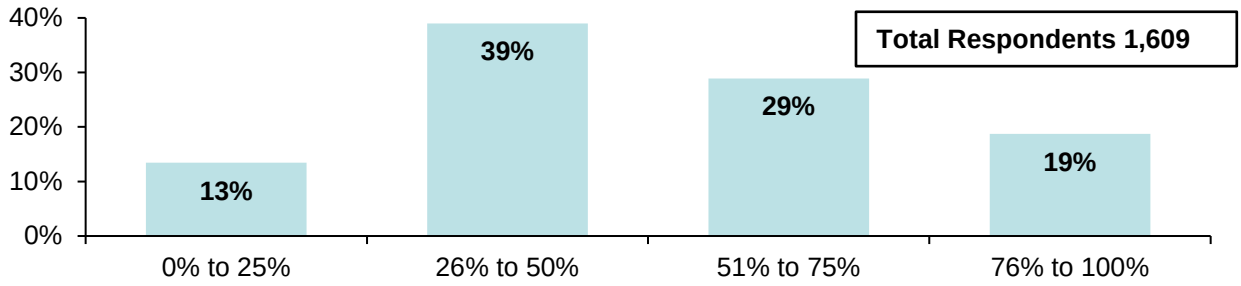
3. How many years of experience do you have involving healthcare coverage eligibility determinations?

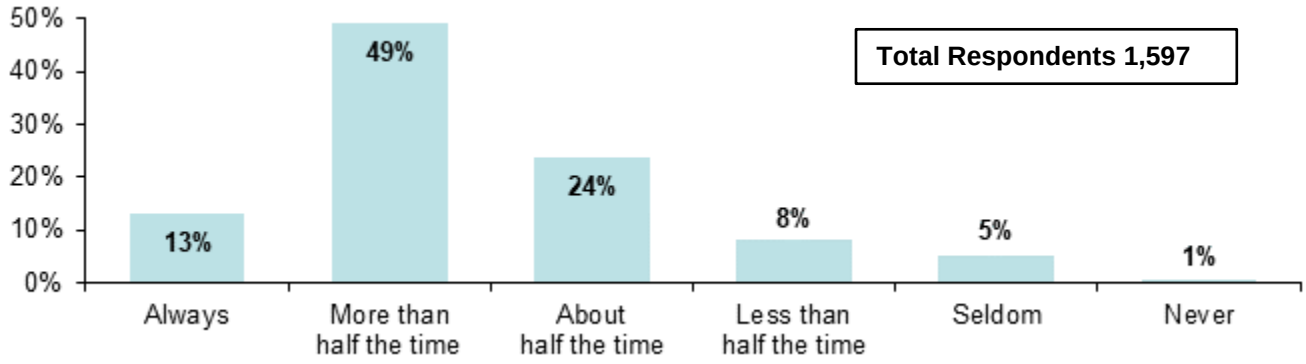


4. What percentage of your time involves healthcare coverage eligibility determinations?



Percent of Time Spent on Healthcare Eligibility Determinations

5. On average, how often are you able to find an answer to your policy question within healthcare coverage policies?



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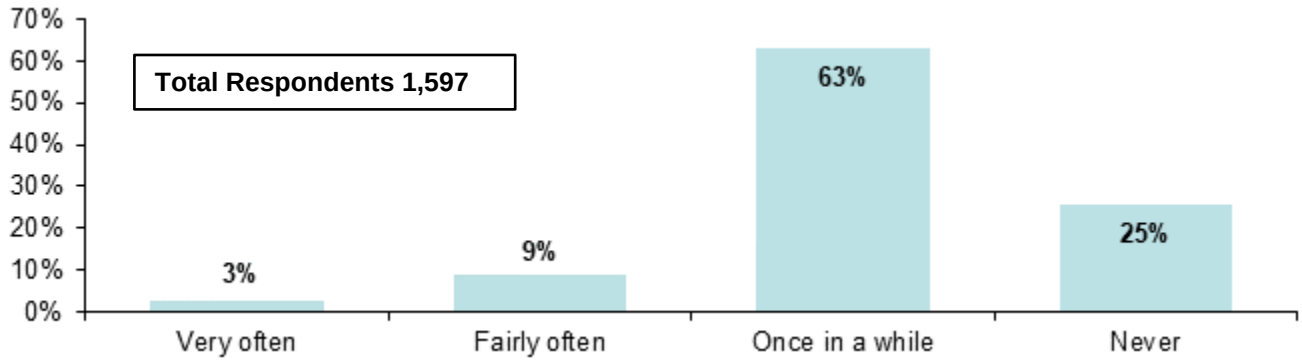
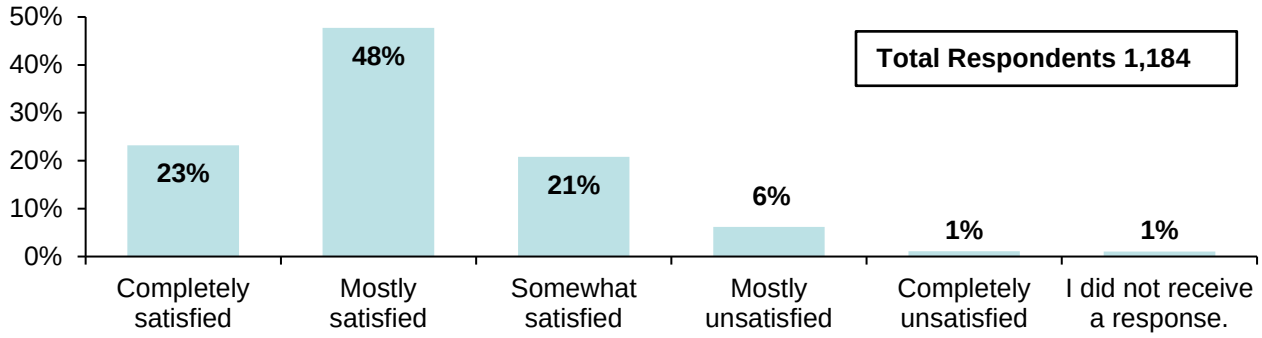
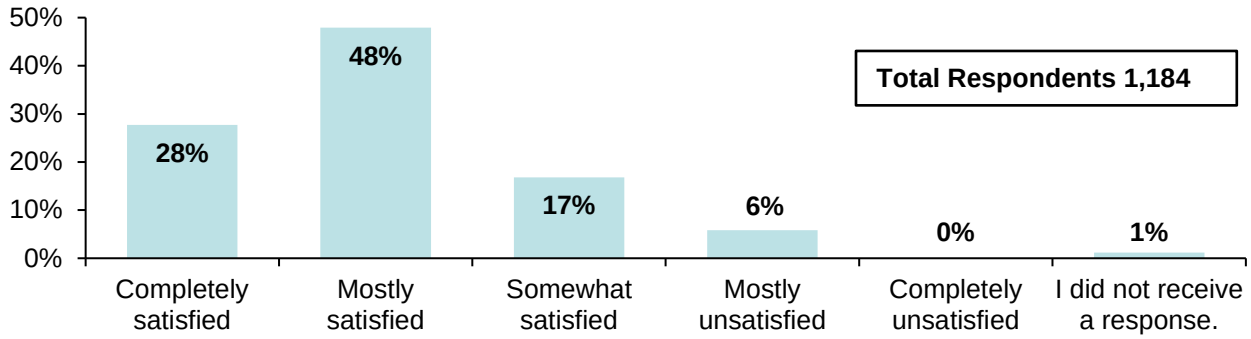
6. How often do you request a policy clarification from Medicaid policy?



7. When you have requested a policy clarification from Medicaid Policy, how satisfied were you with the response?



8. When you have requested a policy clarification from Medicaid Policy, how satisfied were you with the timeliness of the response?



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9. In your opinion, do any of the following Bridges Administrative Manual (BAM) and Bridges Eligibility Manual (BEM) policies and procedures need further clarification? (Select all that apply.)

BAM 115: Application Processing	100	(6.7%)
BAM 210: Redetermination/Ex Parte Review	136	(9.1%)
BAM 220: Case Actions	48	(3.2%)
BAM 300: The Case Record	22	(1.5%)
BAM 310: Confidentiality and Public Access to Case Records	23	(1.5%)
BAM 800: Data Exchanges	66	(4.4%)
BAM 810: Medicare and Medicare Cost-Sharing	133	(8.9%)
BAM 815: Medical Determination and Disability Determination Service	98	(6.6%)
BAM 825: Medical Transportation	131	(8.8%)
BEM 101: Desk Aids	45	(3.0%)
BEM 105: Medicaid Overview	50	(3.4%)
BEM 106: MA Waiver for Elderly and Disabled	89	(6.0%)
BEM 110: Low-Income Family MA (LIF)	39	(2.6%)
BEM 111: Transitional Medical Assistance	72	(4.8%)
BEM 113: Special N/Support	33	(2.2%)
BEM 118: Foster Care Transition Medicaid	60	(4.0%)
BEM 125: Pregnant Women	36	(2.4%)
BEM 126: Group 2 Pregnant Women	63	(4.2%)
BEM 129: Medicaid Under Age 1	30	(2.0%)
BEM 130: MIChild	72	(4.8%)
BEM 131: Healthy Kids	47	(3.2%)
BEM 132: Group 2 Persons Under Age 21	50	(3.4%)
BEM 135: Group 2 Caretakers Relatives	56	(3.8%)
BEM 136: Presumptive Eligibility	81	(5.4%)
BEM 137: Healthy Michigan Plan	68	(4.6%)
BEM 145: Newborns	25	(1.7%)
BEM 150: MA for SSI Recipients	56	(3.8%)
BEM 158: Disabled Adult Children	85	(5.7%)
BEM 163: Ad-Care	72	(4.8%)
BEM 164: Extended-Care	71	(4.8%)
BEM 165: Medicare Savings Programs	95	(6.4%)
BEM 166: Group 2 Aged, Blind and Disabled	72	(4.8%)
BEM 174: Freedom to Work	156	(10.4%)
BEM 211: MA Group Composition	57	(3.8%)
BEM 220: Residence	27	(1.8%)
BEM 221: Identity	17	(1.1%)
BEM 223: Social Security Numbers	25	(1.7%)
BEM 225: Citizenship/Alien Status	161	(10.8%)
BEM 225A: Systematic Alien Verification for Entitlements (SAVE)	155	(10.4%)
BEM 260: MA Disability/Blindness	53	(3.6%)
BEM 400: Assets	101	(6.8%)
BEM 500: Income Overview	68	(4.6%)
BEM 501: Income from Employment	58	(3.9%)
BEM 502: Income from Self-Employment	224	(15.0%)
BEM 503: Income, Unearned	66	(4.4%)
BEM 505: Prospective Budgeting/Income Change Processing	69	(4.6%)
BEM 530: SSI-Related, Group 2 Aged, Blind, Disabled Medicaid Income Budgeting	74	(5.0%)
BEM 536: Determining Budgetable Income – Group 2 Under 21 and Caretaker Relative	74	(5.0%)
BEM 541: MA Income Deductions – SSI-Related Adults	79	(5.3%)
I think all of the BAMs and BEMs are clear.	383	(25.6%)
I think all of the BAMs and BEMs need further clarification.	383	(25.6%)
Other	257	(17.2%)

Total Respondents 1,494

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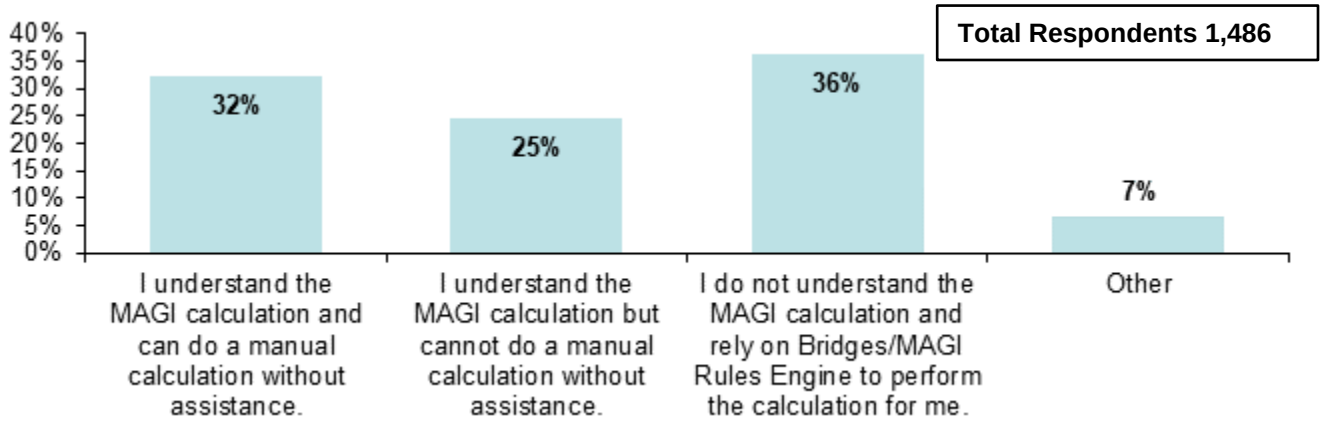
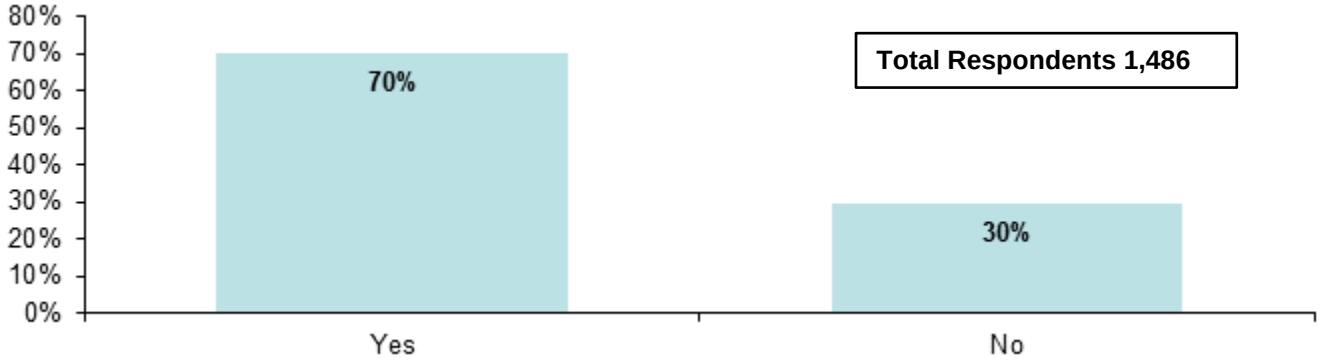
10. Please select the option below that best describes your understanding of the Modified Adjusted Gross Income (MAGI) calculation used for making healthcare coverage eligibility determinations.



11. Do you think it would be helpful to have eligibility workers that specialize in healthcare coverage MAGI-based determinations?



12. Please rate the following Bridges alert types and universal caseload tasks in regard to timely addressing the alert or task.

	Difficult to Timely Address	Somewhat Difficult to Address	Somewhat Easy to Address	Easy to Address
Social security number	65 (5%)	162 (11%)	484 (34%)	715 (50%)
Living arrangements	69 (5%)	189 (13%)	519 (36%)	649 (46%)
Income/asset	90 (6%)	300 (21%)	556 (39%)	480 (34%)
Deceased	70 (5%)	170 (12%)	458 (32%)	728 (51%)
Citizenship	175 (12%)	356 (25%)	462 (32%)	433 (30%)
Case change	64 (4%)	169 (12%)	503 (35%)	690 (48%)
Beneficiary demographics (name, ID, age, etc.)	60 (4%)	137 (10%)	461 (32%)	768 (54%)

Total Respondents 1,426

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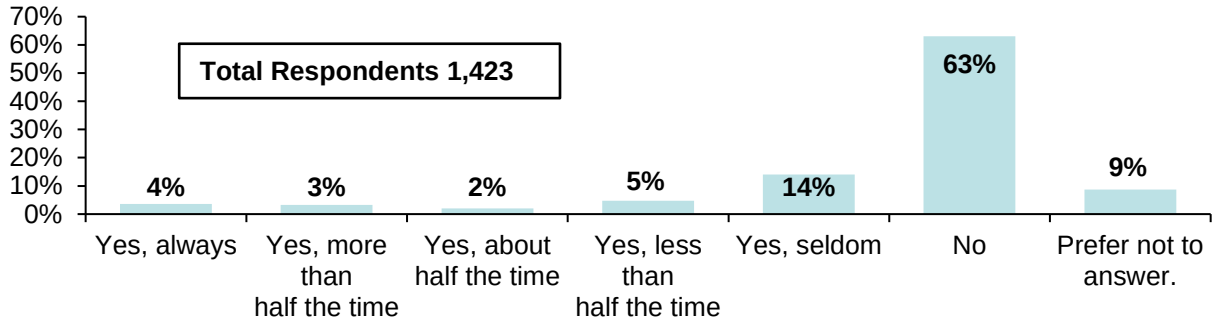
13. How often are changes made to a healthcare coverage eligibility determination due to the following Bridges alert types and universal caseload tasks?

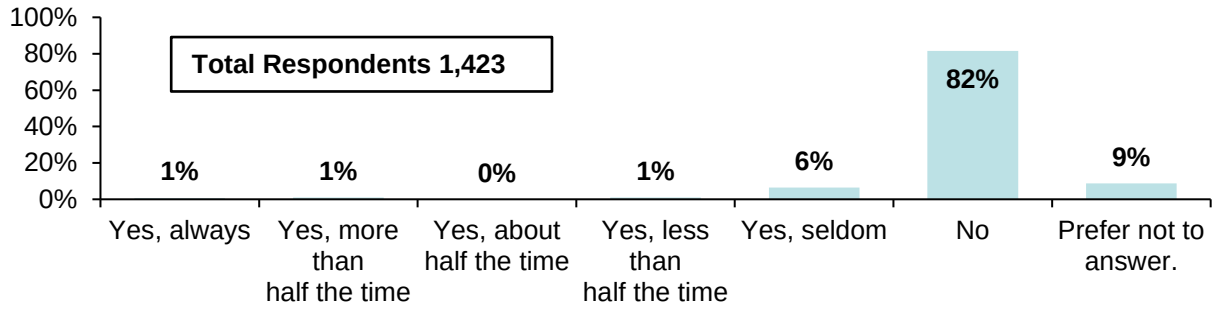
	Always	More Than Half the Time	About Half the Time	Less Than Half the Time	Seldom	Never
Social security number	118 (8%)	89 (6%)	188 (13%)	267 (19%)	597 (42%)	167 (12%)
Living arrangements	135 (9%)	203 (14%)	314 (22%)	351 (25%)	342 (24%)	81 (6%)
Income/asset	279 (20%)	443 (31%)	391 (27%)	167 (12%)	108 (8%)	38 (3%)
Deceased	356 (25%)	61 (4%)	157 (11%)	196 (14%)	569 (40%)	87 (6%)
Citizenship	136 (10%)	107 (8%)	199 (14%)	299 (21%)	573 (40%)	112 (8%)
Case Change	194 (14%)	306 (21%)	469 (33%)	246 (17%)	170 (12%)	41 (3%)
Beneficiary demographics (name, ID, age, etc.)	116 (8%)	88 (6%)	267(19%)	317 (22%)	546 (38%)	92 (6%)

Total Respondents 1,426

14. Have you ever felt pressure to approve healthcare coverage eligibility determinations to meet standard of promptness requirements knowing that a policy requirement was not met?



15. Have you ever approved a healthcare coverage eligibility determination to meet standard of promptness requirements knowing that a policy requirement was not met?



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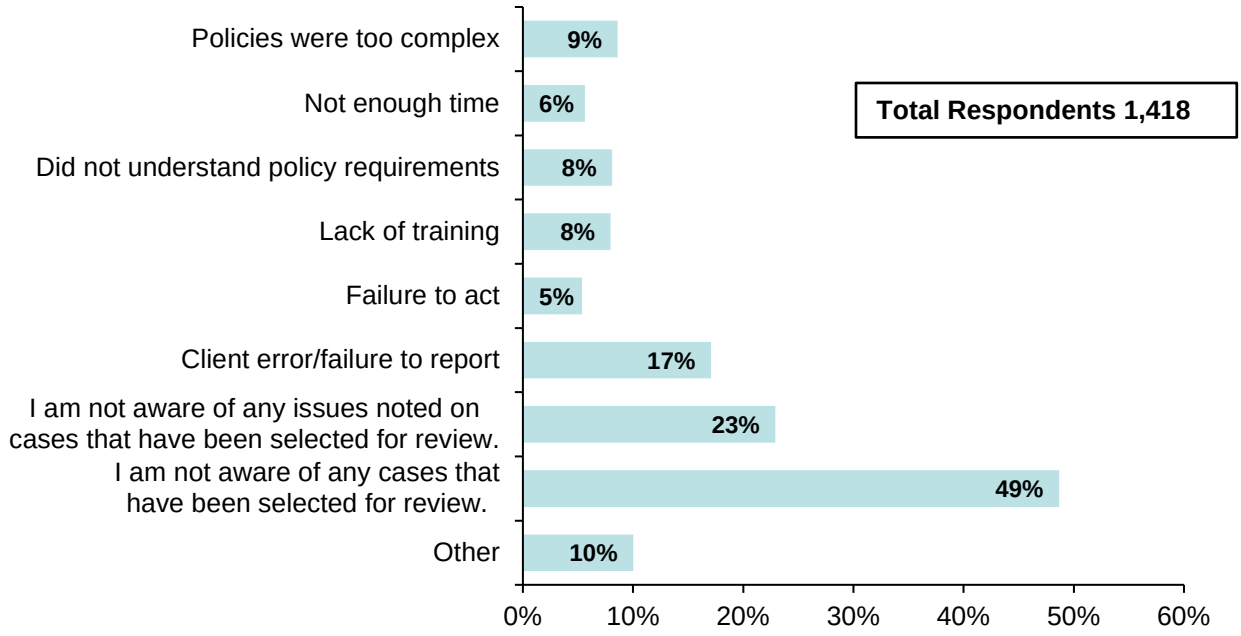
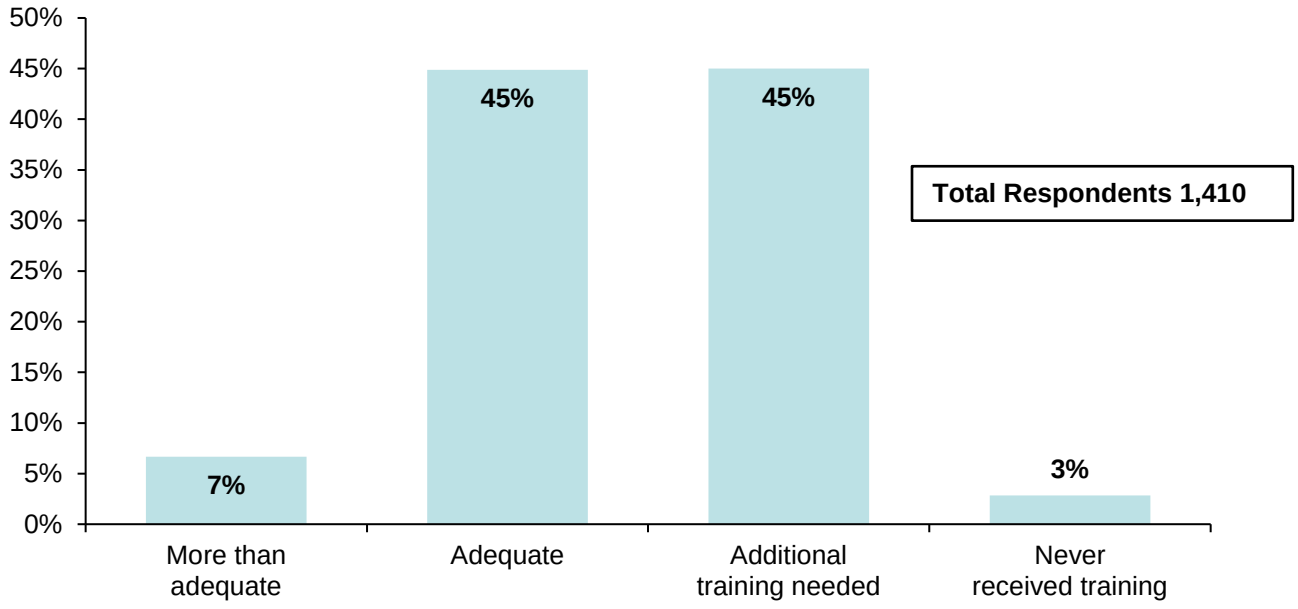
16. If any of your client cases have been selected for review (case reads, audits, etc.) and errors were noted on the case, what were the reasons for the errors? (Select all that apply.)



17. Indicate the level of training you feel you received for determining healthcare coverage eligibility.



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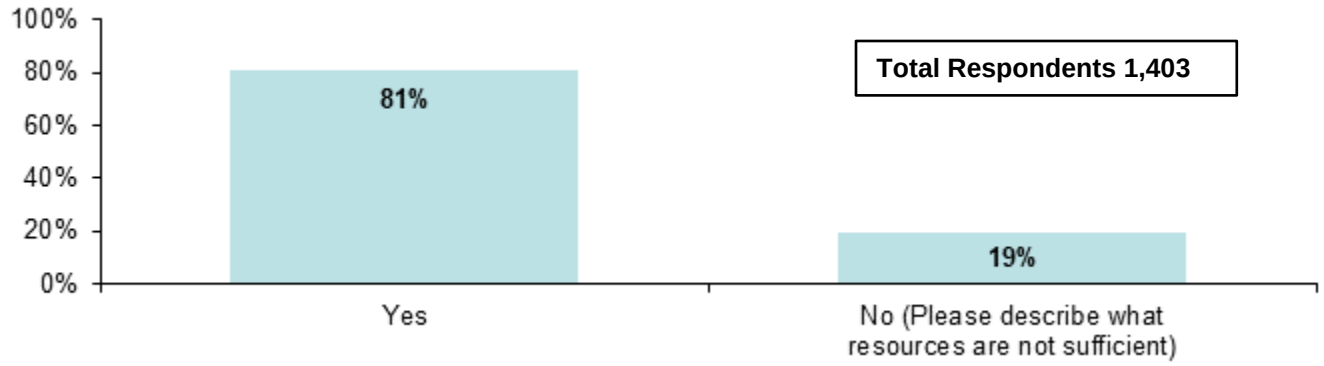
18. Please rate how satisfied you are with the amount of training provided for the following:

	Very Satisfied	Satisfied	Unsatisfied	Very Unsatisfied	Never Received Training in This Topic
ACA changes	77 (5%)	612 (43%)	421 (30%)	116 (8%)	184 (13%)
Asset detection	165 (12%)	821 (58%)	267 (19%)	79 (6%)	78 (6%)
Confidentiality	478 (34%)	801 (57%)	74 (5%)	34 (2%)	23 (2%)
Consolidated inquiry	462 (33%)	805 (57%)	77 (5%)	33 (2%)	33 (2%)
Countable and non-countable MAGI income	107 (8%)	670 (48%)	465 (33%)	118 (8%)	50 (4%)
Deductible calculations	68 (5%)	468 (33%)	530 (38%)	213 (15%)	131 (9%)
Disability verifications	142 (10%)	763 (54%)	324 (23%)	96 (7%)	85 (6%)
Electronic case file documentation	334 (24%)	880 (62%)	115 (8%)	44 (3%)	37 (3%)
Group 2 eligibility determinations (Group 2 caretakers relatives, Group 2 persons under age 21, etc.)	102 (7%)	690 (49%)	420 (30%)	111 (8%)	87 (6%)
Income data collection screens	207 (15%)	903 (64%)	214 (15%)	53 (4%)	33 (2%)
Long-term care	63 (4%)	313 (22%)	334 (24%)	153 (11%)	547 (39%)
MAGI eligibility determinations (HMP, MIChild, LIF, etc.)	115 (8%)	773 (55%)	369 (26%)	107 (8%)	46 (3%)
Medical expenses	100 (7%)	640 (45%)	413 (29%)	182 (13%)	75 (5%)
Passive renewals	85 (6%)	535 (38%)	461 (33%)	149 (11%)	180 (13%)
Redeterminations	280 (20%)	967 (69%)	109 (8%)	43 (3%)	11 (1%)
SSI/Group 1 eligibility determinations (Ad-Care, extended-care, etc.)	189 (13%)	776 (55%)	278 (20%)	90 (6%)	77 (5%)
Standard of promptness time frames	373 (26%)	867 (61%)	103 (7%)	45 (3%)	22 (2%)

Total Respondents 1,410

19. Do you believe you have the appropriate resources needed to make timely and accurate healthcare coverage eligibility determinations?



Source: The OAG created this exhibit to summarize responses received in our survey of eligibility specialists and supervisors.

PROGRAM DESCRIPTION

MDHHS has an approved State Plan to operate a State Medicaid program funded, in part, through Title XIX of the Social Security Act*. MDHHS also has an approved State Plan to operate a State CHIP program funded, in part, through Title XXI of the Act. In Michigan, CHIP provides benefits under a separate child healthcare program (MIChild), as well as providing expanded benefits under the State's Medicaid program.

MDHHS determines client eligibility for individuals in need of Medicaid and CHIP healthcare coverage. The ESA and MSA divisions work together toward MDHHS's overall mission to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for residents to be self-sufficient.

ESA, through its use of BSCs, provides guidance in process, policy, training, technology, and leadership to MDHHS local offices, while MDHHS local office eligibility specialists are responsible for performing client eligibility determinations for Medicaid and CHIP healthcare coverage (see Exhibit 3).

MSA within MDHHS administers Medicaid-related programs that provide healthcare coverage to eligible Michigan residents. Eligible individuals include those enrolled in the Family Independence Program, other low-income families, SSI recipients, pregnant women, children, elderly, disabled, blind, and the medically needy, who except for income, would qualify for regular Medicaid. MSA also oversees many other programs including HMP and MIChild, which serve children whose families have incomes up to twice the federal poverty level.

During fiscal year 2019, $14.7 billion (expenditures include approximately $4.2 billion in State funds) and $258.2 million (expenditures include approximately $4.9 million in State funds) in direct beneficiary level payments were issued on behalf of 2.8 million and approximately 237,500 individuals enrolled in Medicaid and CHIP, respectively (see Exhibit 2). As of June 2020, there were approximately 3,600 MDHHS eligibility specialists and supervisors responsible for determining Medicaid and CHIP eligibility.

** See glossary at end of report for definition.*

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine and evaluate MDHHS's records and processes related to Medicaid and CHIP client eligibility determinations. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The scope of this audit focused on MDHHS's records and processes prior to any changes due to the COVID-19 pandemic and did not include any processing changes due to COVID-19.

As indicated in Observation 1, we were unable to obtain access to the federal tax return data used in determining eligibility for certain Medicaid and CHIP beneficiaries, which ultimately limited our ability to conclude on certain cases.

As part of the audit, we considered the five components of internal control (control environment, risk assessment, control activities, information and communication, and monitoring activities) relative to the audit objectives and determined that all components were significant.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered October 1, 2018 through September 30, 2019 for Objective 1 and October 1, 2018 through May 31, 2020 for Objective 2.

METHODOLOGY

We conducted a preliminary survey to gain an understanding of MDHHS's processes related to Medicaid and CHIP client eligibility determinations and program oversight in order to establish our audit objectives, scope, and methodology. During our preliminary survey, we:

- Interviewed MDHHS's management and staff to obtain an understanding of MDHHS's activities related to Medicaid and CHIP client eligibility determinations and program oversight.
- Reviewed applicable laws, regulations, the Medicaid and CHIP State Plans, and MDHHS policies and procedures related to Medicaid and CHIP client eligibility determinations.
- Gained an understanding of IT systems involved in the eligibility determination process.

** See glossary at end of report for definition.*

- Conducted a walkthrough with MDHHS of five MAGI cases to gain an understanding of the various components that are used in determining MAGI eligibility.

- Analyzed Bridges application, case, and user data to gain an understanding of the number of cases, users, and applications with their respective dispositions (complete, pending, denied, etc.).

- Analyzed various Bridges reports to gain an understanding of the different data elements being utilized for reporting purposes.

- Analyzed the population of 7.2 million cases MDHHS denied Medicaid or CHIP coverage from October 1, 2018 through September 30, 2019 to determine whether consistent denials exist based on various elements such as counties, age, and eligibility categories.

- Analyzed the population of approximately 295,000 Medicaid beneficiaries who qualified for healthcare coverage because of their SSI eligibility from October 1, 2018 through September 30, 2019 to determine whether the appropriate eligibility and payment status code combinations exist.

OBJECTIVE 1

To assess the effectiveness of MDHHS's efforts to complete accurate Medicaid and CHIP client eligibility determinations.

To accomplish this objective, we:

- Reviewed 162 Medicaid and 93 CHIP beneficiaries who were eligible for Medicaid or CHIP at some point from October 1, 2018 through September 30, 2019 to determine the accuracy of the client eligibility determinations based on the TOA the beneficiaries were enrolled in at the date of service for which the payment was made. We randomly selected our samples to eliminate bias. Furthermore, our sample was selected from the population of payments made on behalf of beneficiaries of $14.7 billion and $258.2 million for Medicaid and CHIP, respectively, which enabled us to project the results to these populations. Using this random sample, we also:

    - Verified all SSNs were valid according to SSA's records.

    - Verified all sampled payments had a documented certification in Bridges for the associated benefit period, if applicable.

- Reviewed 75 Medicaid and 86 CHIP beneficiaries who were enrolled in a MAGI TOA and we:
    - Verified the beneficiaries' income with their State tax return information.
    - Determined if eligibility specialists entered income into Bridges accurately.
- Analyzed 15 Medicaid and 23 CHIP beneficiaries who we were unable to determine whether MDHHS complied with federal laws and regulations related to MAGI-based eligibility requirements because of restricted access to federal income tax return data to determine if reasonable compatible income checks were performed accurately.

- Analyzed 316,312 (280,865 Medicaid and 35,447 CHIP) eligibility periods for beneficiaries who were eligible for TMA at some point from October 1, 2018 through September 30, 2019 to determine if the beneficiaries had met the eligibility requirements for TMA.

- Reviewed 43 (37 Medicaid and 6 CHIP) of 139,909 eligibility periods for beneficiaries who received TMA from October 1, 2018 through September 30, 2019 but were likely ineligible for TMA to determine if the beneficiaries had met the eligibility requirements for TMA. We randomly selected our sample to eliminate bias and enable us to project the results to this population.

- Analyzed immigration status data for 110,851 non-U.S. citizens from October 1, 2018 through September 30, 2019 to determine the accuracy of the applicable Medicaid or CHIP beneficiary eligibility determination.

- Analyzed SSN verification data for the 32,745 Medicaid and CHIP beneficiaries without a required SSN verification by SSA from October 1, 2018 through September 30, 2019 to determine if all missing SSN verifications were appropriate.

- Analyzed the population of 18,189 beneficiaries eligible at some point from October 1, 2018 through September 30, 2019 for HMP with concurrent Medicare coverage. We randomly selected 43 beneficiaries to determine if MDHHS was informed of the Medicare coverage. Our random sample was selected to eliminate bias and enable us to project the results to the respective population.

- Analyzed the population of 12,296 (12,286 Medicaid and 10 CHIP) beneficiaries, who had claims with dates of service from October 1, 2018 through September 30, 2019, during an incarceration period obtained from the Michigan Department of Corrections' records to identify improper payments.

- Analyzed the population of 1,148 beneficiaries who had a conversion SSI unearned income record with no correlating information from SSA, but were receiving Medicaid SSI coverage at some point from October 1, 2018 through September, 2019 to determine the accuracy of the eligibility determination.

- Provided the U.S. Department of Treasury with the population of approximately 3 million beneficiaries eligible for Medicaid or CHIP at some point from October 1, 2018 through September 30, 2019 to determine if the DNP tool identified beneficiaries who were deceased and, ultimately, if MDHHS issued payments on their behalf after their date of death.

- Reviewed MDHHS's processes related to the quarterly adjustments processed from October 1, 2018 through September 30, 2019 to determine if the payments were appropriately being transferred from Medicaid to CHIP.

- Reviewed 43 passively renewed cases from the population of approximately 840,000 passively renewed cases from October 1, 2018 through September 30, 2019 to determine if passive renewals occurred appropriately. Our random sample was selected to eliminate bias and enable us to project the results to the respective population.

OBJECTIVE 2

To assess the effectiveness of MDHHS's oversight of the Medicaid and CHIP client eligibility determination processes at MDHHS local offices.

To accomplish this objective, we:

- Surveyed approximately 3,600 eligibility specialists and supervisors to obtain their perspective on aspects of MDHHS's operations, training, policies and procedures, and monitoring and guidance related to client eligibility determinations (see Exhibit 5).

- Obtained an understanding of the federally required PERM and MEQC quality control audits.

- Met with four MDHHS local offices and obtained an understanding of Medicaid and CHIP eligibility determinations, supervision, Bridges, policies and procedures, training, and UCLs.

- Met with the directors for each of the four BSCs and obtained an understanding of their oversight of MDHHS local offices, including communication, case reads, corrective action, and standard of promptness.

- Obtained an understanding of MDHHS's LMS and analyzed training courses available to MDHHS employees in LMS.

- Obtained an understanding of MDHHS's process for tracking, reviewing, and sharing policy questions, clarifications, and updates.

- Analyzed MDHHS Bridges reports utilized as part of monitoring redeterminations to determine whether redeterminations were processed in a timely manner.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 13 findings and 13 corresponding recommendations. MDHHS's preliminary response indicates that it agrees with 3 of the recommendations and disagrees with 10 recommendations.

The agency preliminary response following each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information presented as Exhibits 1 through 5. The information provided in Exhibit 1 supported our observations, findings and conclusions in both objectives. Our audit was not directed toward expressing a conclusion on the information in Exhibits 2, 3, 4, and 5.

GLOSSARY OF ABBREVIATIONS AND TERMS

adverse opinion	A type of modified opinion in which the auditor states that the audited entity did not comply, in all material aspects, with the cited compliance requirements that are applicable to each major federal program.
Affordable Care Act (ACA)	An act passed by the U.S. Congress in March 2010 resulting in the expansion of the Medicaid program in states that chose to expand Medicaid coverage, thereby creating new forms of Medicaid that clients may qualify under. Also known as the Patient Protection and Affordable Care Act.
auditor's comments to agency preliminary response	Comments the OAG includes in an audit report to comply with *Government Auditing Standards*. Auditors are required to evaluate the validity of the audited entity's response when it is inconsistent or in conflict with the findings, conclusions, or recommendations. If the auditors disagree with the response, they should explain in the report their reasons for disagreement.
BAM	Bridges Administrative Manual.
BEM	Bridges Eligibility Manual.
Bridges Integrated Automated Eligibility Determination System (Bridges)	An automated, integrated service delivery system for Michigan's cash assistance, medical assistance, food assistance, child care assistance, and emergency assistance programs.
BSC	Business Service Center.
capitated payment	A per person, per month payment, paid under a system of reimbursement for managed care organizations. The payments are for each beneficiary assigned regardless of the number or costs of services provided.
CHAMPS	Community Health Automated Medicaid Processing System.
CHIP	Children's Health Insurance Program.
CMS	Centers for Medicare and Medicaid Services.
Code of Federal Regulations (CFR)	The codification of the general and permanent rules published by the departments and agencies of the federal government.

COVID-19	The infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. COVID-19 is now a pandemic affecting many countries globally.
Do Not Pay (DNP)	An analytics tool which helps federal agencies detect and prevent improper payments made to vendors, grantees, loan recipients, and beneficiaries.
DTMB	Department of Technology, Management, and Budget.
earned income disregards	A certain amount of earned income that is not taken into consideration when determining eligibility.
effectiveness	Success in achieving mission and goals.
efficiency	Achieving the most outputs and the most outcomes practical with the minimum amount of resources.
Enhanced Federal Medical Assistance Percentage	Calculated rates that the U.S. Department of Health and Human Services uses in determining the amount of federal matching for CHIP expenditures.
ESA	Economic Stability Administration.
Federal Medical Assistance Percentage (FMAP)	Calculated rates the U.S. Department of Health and Human Services uses in determining the amount of federal matching for Medicaid expenditures.
fee-for-service (FFS) payment	A payment to medical providers for services rendered to Medicaid and CHIP beneficiaries.
fiscal year	October 1 through September 30.
FMG	State of Michigan Financial Management Guide.
HASA	Health and Aging Services Administration.
HMP	Healthy Michigan Plan.
ID	identification.

IEVS	Income Eligibility and Verification System.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal control includes the processes for planning, organizing, directing, and controlling program operations. It also includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.
IRS	Internal Revenue Service.
IT	information technology.
LIF	low-income family.
LMS	Learning Management System.
MAGI	Modified Adjusted Gross Income.
MAGI-based income	The income measure used when determining a client's eligibility for MAGI Medicaid. The measure is defined in federal regulation 42 *CFR* 435.603.
MAGI Medicaid	A form of Medicaid introduced under the ACA that uses MAGI-based income measures to determine client eligibility.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. Our assessment of materiality is in relation to the respective audit objective.
MDHHS	Michigan Department of Health and Human Services.
MDOC	Michigan Department of Corrections.
MEQC	Medicaid Eligibility Quality Control.

MSA	Medical Services Administration.
observation	A commentary highlighting certain details or events that may be of interest to users of the report. An observation may not include the attributes (condition, effect, criteria, cause, and recommendation) that are presented in an audit finding.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
PERM	Payment Error Rate Measurement.
qualified opinion	A type of modified opinion in which the auditor identifies a scope limitation or material noncompliance with one or more of the cited compliance requirements that are applicable to each major federal program.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: a deficiency in internal control; noncompliance with provisions of laws, regulations, contracts, or grant agreements; opportunities to improve programs and operations; or fraud.
SAVE	Systematic Alien Verification for Entitlements.
single audit	A financial audit, performed in accordance with the Single Audit Act Amendments of 1996 and the Uniform Guidance, which is designed to meet the needs of all federal grantor agencies and other financial report users. In addition to performing the audit in accordance with the requirements of auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, a single audit requires the assessment of compliance with requirements that could have a direct and material effect on a major federal program and the consideration of internal control over compliance in accordance with the Uniform Guidance.

Social Security Act	An act first passed by the U.S. Congress in 1935 and amended numerous times thereafter; this Act contains the legal basis for multiple federal programs including Medicaid and CHIP.
SOM	State of Michigan.
SSA	Social Security Administration.
SSI	Supplemental Security Income.
SSN	social security number.
TOA	type of assistance.
transitional medical assistance (TMA)	A form of Medicaid a client can qualify for if they meet specific eligibility requirements.
UCL	universal caseload.
USC	*United States Code*.

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