

End of Year Report

State Fiscal Year (SFY) 2025



Missouri Department of Social Services

MMAC

**Missouri Medicaid
Audit & Compliance**

Richard Ferrari - Director

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From the Director:

The Missouri Medicaid Audit & Compliance (MMAC) unit is committed to transparency and sharing our initiatives, efforts and results. As Director, I'm proud to highlight the important work our team does to ensure program integrity in Missouri's Medicaid program. MMAC is committed to working with our providers while maintaining oversight of the Medicaid program to safeguard taxpayer dollars.

MMAC was created by Executive Order 12-02 and is charged with protecting the integrity of the Missouri State Medicaid Program by preventing, detecting, and investigating fraud, waste, and abuse and recovering improperly expended Medicaid Funds, while ensuring high-quality care for Missouri citizens.

To facilitate program integrity and oversight, MMAC's 89 Full Time Equivalent (FTE) employees are organized into the following units with the following responsibilities:

- Provider Enrollment Unit – Conducts rigorous screenings of new providers, revalidates those providers every five years, and performs monthly eligibility checks and screenings.
- Provider Review Unit – Performs post-payment reviews via onsite and desk audits of Medicaid claims submitted by providers to ensure claims comply with state and federal regulations, and MO HealthNet (MHD) policies.
- Investigation & Terminations Unit – Operates the fraud hotline, conducts comprehensive administrative investigations across the state and refers all credible fraud allegations to the Attorney General's Medicaid Fraud Control Unit (MFCU) for criminal or civil action. This unit also conducts continuous screening of providers to ensure they maintain proper licensure in their respective fields.
- Finance Unit – Manages MMAC's budget, tracks overpayments, collections, and calculates cost avoidance. The Finance Unit also oversees a vendor that performs Credit Balance and Commercial Disallowance audits of long-term care facilities and hospitals.
- Administrative Unit – Provides essential support across all units in MMAC.

While MMAC is directly involved in program integrity efforts every day, it's important to recognize that program integrity is a collaborative effort. That effort reaches across many state and federal government agencies as well as sister agencies and partners, including Family

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Support Division (FSD), Department of Health and Senior Services (DHSS), Department of Mental Health (DMH), Attorney General's Office (AGO), Office of Inspector General (OIG), Centers for Medicare & Medicaid Services (CMS), managed care health plans, and contracted vendors, as well as Medicaid participants.

I look forward to our continued partnerships and collective efforts to maintain program integrity, so we can all reduce fraud, waste, and abuse and ensure Medicaid dollars are distributed appropriately and reserved for services for those truly in need.

In your Service,

A handwritten signature in black ink that reads "Richard Ferrari". The signature is written in a cursive, flowing style.

Richard Ferrari
Director, MMAC
January 30, 2026

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Provider Enrollment

Federal regulation [42 CFR § 455, Subpart E](#), and Missouri Code of State Regulations (CSR) [13 CSR 65-2](#) outline requirements for Medicaid enrollment and screening. MMAC must enroll and screen every new provider and revalidate and rescreen enrollment records at least every five years to ensure only those eligible become Medicaid providers.

At the end of SFY 2025, there were 81,565 active Medicaid providers enrolled in MO Medicaid. The number of providers grew by 9% from the previous state fiscal year. The chart below demonstrates provider growth each fiscal year.

Fiscal Year	# of Active Providers
FY '18	61,871
FY '19	63,082
FY '20	64,747
FY '21	65,411
FY '22	69,593
FY '23	70,999
FY '24	74,492
FY '25	81,565

Provider Screening and Enrollment Requirements

Effective January 1, 2018, the 21st Century Cures Act requires all Managed Care Organization (MCO) network providers to be enrolled with the State Medicaid Agency (SMA) within 120 days of contracting with the MCO, or their contract must be terminated. MCO network providers have the option of enrolling as a performing or billing provider with the ability to submit claims to MO HealthNet for services provided to FFS participants, or as an MCO Network Provider that

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cannot submit FFS claims. During SFY2018, MMAC conducted outreach to the MCOs and their network providers to facilitate the required enrollments.

MMAC implemented a new, streamlined MCO network provider enrollment application and began providing regular reports to the contracted MCOs regarding any active, pending, or recently terminated providers. MMAC continues to work with the MCOs to comply with the federal requirement that their in-network providers be enrolled with the State Medicaid Agency (SMA). While the MCOs have 120 days to ensure providers are enrolled with the SMA, most MCOs require their in-network providers to be enrolled with the SMA prior to contracting with the MCO.

Federal and state regulations [42 CFR § 455, Subpart E](#) and [13 CSR 65-2](#) require all newly enrolling and revalidating providers to be screened according to categorical risk levels. Risk levels are identified as limited, moderate, and high. Site visits must be conducted on moderate and high-risk providers. To conserve state resources and speed up the revalidations process, MMAC began coordinating with other state departments, such as the Department of Mental Health, to leverage site visits they may have conducted. Pursuant to federal regulation, MMAC also leverages site visits conducted by approved Medicare providers.

During SFY2025, MMAC's Provider Enrollment unit continued working closely with the Provider Review and Investigations/Terminations units. This was achieved through regular meetings involving all units to discuss suspicious enrollment materials, provider billing, collaboration on non-compliant providers regarding the revalidation process, and external reports and complaints received by the various units.

To see the accomplishments of the Provider Enrollment Unit in SFY 2025, refer to *MMAC General Statistics* on pages 19-20 of this report.

Contracting Team

The Contracting team is a dedicated team that reviews proposals submitted by entities that wish to contract with MMAC and become Medicaid providers, in order to provide In-Home Services (IHS) or Consumer Directed Services (CDS) to eligible Medicaid participants.

Home and Community Based Provider Designated Manager Training

MMAC conducts quarterly Designated Manager training and certification for certain HCBS providers delivering in-home personal care services under the state plan. During SFY2020, MMAC updated the designated manager training materials and processes, and we continue to refine our training each year. Online training materials were rewritten, and a three-hour classroom training course was redesigned to focus on helping prospective Designated Managers locate information on program requirements in state regulations and program policy manuals.

- During SFY2025, a total of 312 providers attended a quarterly training session in Jefferson City.

Home and Community Based Provider Update Training

In the spring and fall of each year, MMAC hosts three consecutive days of training sessions to update all enrolled HCBS on program requirements, new federal or state legislation, new technology being implemented by the state, and provider compliance issues. Through collaboration, there are normally presentations by members of the MO HealthNet Division (MHD) and DHSS on relevant and prevailing topics.

The DHSS presentations include staff from the Division of Senior and Disability Services (DSDS), Family Care Safety Registry (FCSR), and the Special Investigations Unit (SIU). Occasionally, a volunteer HCBS provider will present “peer-to-peer” information.

- During SFY 2025, MMAC’s HCBS Provider Update Training was attended by 1,639 provider representatives.

HCBS/CDS Certified Manager Training

MMAC conducts quarterly Consumer Directed Services (CDS) Manager training and certification for certain HCBS providers delivering in-home personal care services under the Consumer Directed plan.

During SFY2024, the Department of Health and Senior Services updated its CDS regulation to require all CDS providers to have a certified manager. MMAC worked with currently enrolled

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CDS providers to test and meet compliance requirements through FY 2024 and 2025. MMAC then opened the training session to all pending CDS enrollments, and the general public interested in taking the course.

For newly enrolling providers, MMAC created an online training session that includes a three-hour classroom training course focused on the CDS program, enrollment, and provider responsibilities.

- There are currently 1683 certified CDS Managers.
- During SFY2025, a total of 452 providers attended a quarterly training session.
- During SFY-2025, MMAC presented eight provider update sessions, attended by 1,289 provider representatives.

Provider Enrollment System

MMAC was awarded a new decision item (NDI) in the SFY25 budget to implement a new provider enrollment system. The funding received earns a 90% federal match from the Centers for Medicare & Medicaid Services (CMS) during the design/development and implementation (DDI) phase of the project.

The new provider enrollment system kickoff was in July 2025. The new system will be a fully digital solution that will replace an older legacy system. Many manual processes will be automated and streamlined for both MMAC and enrolling providers. The new system will include a “Provider Directory,” which enables participants to search for the services they need from providers. The result of implementing the system will be a modern provider-friendly experience that enables more provider self-service and shorter processing times to become enrolled, while improving the screening, traceability and security of data and interactions to limit the potential for fraud, waste, and abuse.

The “Go-Live” date for the new system is scheduled for January 31, 2027.

Provider Review & Lock-In Section

The Provider Review & Lock-In section of MMAC monitors MO HealthNet provider billing and program compliance and administers the participant Lock-In program. The Provider Review

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section conducts onsite and desk reviews, referred to as post-payment audits to ensure services were billed appropriately and payments were made correctly, in accordance with federal and state regulations and MO HealthNet policies. Additionally, every year, the Provider Review section conducts special projects to detect and identify fraud, waste, and abuse.

Some of the Special Projects conducted in SFY 2025 include the following:

- Single State Audit Sample
- Hospice County Rate
- Hospice on Date of Death Report (claims billed on date of death)
- Participant Date of Death Report (claims billed after death)
- Nursing Home/Hospice Overlaps
- Duplicate billing for Fee for Service (FFS) and Managed Care Organizations (MCOs)
- Laboratory Unbundling for STI claims
- DOC Incarcerated participant claims (started SFY25, continuing into SFY26)

The Provider Review & Lock-In section includes registered nurses, certified coders, auditors and other specialists. There are five distinct areas of responsibility or specialty in the Provider Review section: the Participant Lock-In section, the Clinical Programs section, the Behavioral Health Programs section, Home and Community-Based (HCBS) Programs administered by DHSS, and HCBS Programs administered by DMH.

Lock-In Section

MMAC is responsible for reviewing participants who may be subjecting the Medicaid program to fraud, waste and abuse. This includes a review of a variety of factors, which include:

- The number of physicians prescribing services to a particular participant.
- The number of pharmacies used to obtain prescriptions.
- The frequency of refills or overlapping prescriptions.
- The number of emergency room visits, and

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- The services received.

If a MO HealthNet participant is found to be misutilizing MO HealthNet benefits, the individual can be restricted to a single physician/clinic, pharmacy, or both in accordance with 13 CSR 65-3.010 and may also be referred to the appropriate authorities for possible healthcare fraud investigation and prosecution.

MMAC is committed to keeping the community apprised of its efforts and activities and will continue to publish Lock-In information on the MMAC website. This information is updated monthly.

To see the accomplishments of the Lock-In unit in SFY 2025, refer to MMAC General Statistics on page 21 of this report.

Clinical Programs

The Clinical Programs section is staffed by five registered nurses, one auditor and one Registered Nurse Supervisor. This section reviews the numerous clinical programs offered by MHD, such as ambulance, clinics, physicians, nurse practitioners, radiology, laboratory, hospice, outpatient hospital, and private duty nursing. MMAC can leverage the education and field experience of our registered nurses to identify suspicious billing practices, indicating potential fraud, waste, and abuse.

Behavioral Health

The Behavioral Health section reviews providers in the behavioral health field, such as Applied Behavior Analysis (ABA), Board Certified Behavior Analysts (BCBA), Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC) and psychologists.

HCBS Programs (DHSS & DMH)

Home and Community-Based Services (HCBS) are Medicaid programs that allow seniors and individuals with disabilities to receive care at home or in their communities rather than in institutions. These services are designed to help individuals who need nursing facility-level care remain in the least restrictive environment possible, allowing for independence.

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Consumer Directed Services (CDS) is a specific HCBS model where the Medicaid participant hires, trains, and manages their own Personal Care Attendants (PCA). Common tasks covered by CDS are assistance with Activities of Daily Living (ADL) such as bathing, dressing, grooming, toileting, meal preparation, cleaning, and laundry.

1915(c) Home & Community-Based Waiver Services

Home & Community-Based Waiver Services (HCBS) are included in the Missouri Medicaid Program under the authority of a 1915(c) Waiver approved by the Centers for Medicare & Medicaid Services (CMS). Under a waiver, certain services that could not otherwise be reimbursed under Title XIX may be provided to a select group of participants in order to provide an alternative to institutional care.

The HCBS Section of MMAC Provider Review conducts post-payment reviews of HCBS providers, whether they are agency-model personal care or CDS, and whether the services are provided through State Plan authority or a waiver.

Waivers administered by DHSS include:

- Adult Day Care Waiver
- Aged & Disabled Wavier
- AIDS Waiver
- Brain Injury Waiver
- Independent Living Waiver
- Medically Fragile Waiver
- Structured Family Caregiver Waiver

Waivers administered by the Department of Mental Health include:

- MO Children with Developmental Disabilities Waiver
- Comprehensive Waiver
- Community Support Waiver
- Partnership for Hope Waiver

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HCBS Provider Financial Reports

Certain Missouri Medicaid HCBS providers are required to submit quarterly service and financial reports to MMAC, as well as annual service reports and financial audits.

During SFY2025, MMAC continued to notify non-compliant providers if they failed to submit reports. In certain cases, MMAC imposed administrative sanctions against non-compliant providers.

Investigations

MMAC's Investigation Unit is responsible for conducting investigations into allegations of fraud, waste, and abuse by Medicaid providers and in some instances, participants.

Investigators conduct interviews with providers, witnesses, and participants, including those suspected of violating state and federal regulations and/or statutes. In the event the investigation reveals a credible allegation of fraud by a provider, MMAC will forward the information and investigative report to the Missouri Attorney General's Medicaid Fraud Control Unit (MFCU) or other prosecutorial entity for review for criminal prosecution or civil action.

MMAC receives fraud referrals from the public, other state agencies, providers, and participants, as well as referrals via the MMAC fraud hotline (573) 751-3285 and the report fraud email: mmac.reportfraud@dss.mo.gov. During SY2025, MMAC Investigations received 308 referrals.

During SFY2025, the MMAC Investigations Unit completed 86 fraud investigation cases and made 48 fraud referrals to the MFCU. As a direct result of MMAC's fraud referrals, MFCU filed criminal charges in 25 individual cases during SFY2025. MFCU received criminal convictions on nine (9) individual cases referred by the MMAC Investigations Unit. MFCU participated in the 'National Health Care Fraud Takedown' initiative, charging 15 total defendants with healthcare fraud. Of the 15 total filings by MFCU, eight (8) of the charges were a direct result of MMAC's investigations and referrals to MFCU.

As a result of their investigations, during SFY2025, the MMAC Investigations Unit identified approximately \$1,495,084.83 in fraudulent Medicaid funds paid to Missouri Medicaid providers. Approximately \$222,926.43 has been recovered by the end of the

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fiscal year. A portion of the fraudulent funds is in the process of recovery due to bad debt referrals and pending litigation at the Administrative Hearing Commission.

During SFY2025, the MMAC Investigations Unit focused on professional development and training and monitoring national trends. MMAC Investigators attended training conducted by John E. Reid and Associates, Investigative Interviewing, the National Health Care Anti-Fraud Association (NHCAA), the Health Care Fraud Prevention Partnership, Show Me Excellence, and the National Association of Medicaid Program Integrity. Two investigators achieved their Certified Fraud Examiner (CFE) certifications.

Terminations and Sanctions

In the event a provider violates program policy, state statute, state regulation, or federal regulation, MMAC is responsible for determining whether to impose an administrative action against the provider. In determining an appropriate sanction, MMAC takes into account aggravating and/or mitigating circumstances in accordance with 13 CSR 70-3.030 and may determine to impose any one or more of the following sanctions:

- Attendance at a provider education session
- Referral to a state licensing board or peer review committee
- Referral to a state licensing board for investigation
- Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws
- Transfer to a closed-end provider agreement
- Require prior authorization of services
- Recoupment of identified overpayment from future Medicaid payments
- Placement on 100% Prepayment Review
- Suspension of Medicaid payments or participation
- Termination of Medicaid participation

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The Terminations Unit reviews results of the automated provider screening and monitoring process to identify potentially ineligible providers. They also review information from other sources to identify potentially ineligible providers, resulting in suspensions and terminations of provider participation.

The Terminations Unit completed 2,758 individual Medicaid provider termination and suspension letters. There were 301 “for cause” terminations completed, as well as 564 payment suspensions. The unit also assisted the MMAC Provider Enrollment Unit (PEU) by updating 129 provider enrollment files and notifying the PEU of deficiencies in Medicaid providers’ general information, so the information could be updated accordingly.

Finance Unit

The Finance Unit is responsible for providing a variety of support services to all sections within MMAC. The Finance Unit works with the Department of Social Services’ Division of Finance and Administrative Services (DFAS) and the state Budget Director regarding budgetary control, budget preparation, appropriations, revenue accounts and federal financial responsibilities to ensure compliance with the Missouri Medicaid Title XIX Program.

The Finance Unit is responsible for the procurement of all required supplies, materials, equipment, and professional or general services. The Finance Unit also has charge of a subset of Third-Party Liability (TPL) contractor audits.

Finance staff manage the findings and recoveries from the subset of TPL audits. In SFY2025, MMAC recovered \$6,506,459, an increase from \$4,980,733 in SFY2024.

MMAC’s review of aged accounts receivable (ARs) in SFY2025 resulted in 13 accounts referred to the Attorney General’s Office (AGO) for collection.

MMAC’s tax intercept program with the Department of Revenue began in SFY2015 with ten accounts referred to DOR for potential tax intercepts. During SFY2025, MMAC referred 12 accounts to DOR for potential tax intercept.

The amount of improper Medicaid payments recovered through Provider “Self-Disclosures” remained steady during SFY2025. The number of self-disclosures submitted by enrolled

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Medicaid providers dropped from 7,086 in SFY2024 to 4,971 during SFY2025. The chart below shows provider self-disclosure amounts collected by MMAC for the past five fiscal years:

Provider Self Disclosures

State Fiscal Year (SFY)	Amount
2021	\$4,797,107
2022	\$5,594,163
2023	\$6,837,483
2024	\$4,980,733
2025	\$4,693,779

Administration Unit

The Administration Section provides the overall guidance, support, leadership, and direction. In addition, it is responsible for, but not limited to, the following:

- Providing legislative guidance on Medicaid and health care-related issues.
- Assisting with fiscal notes for new proposed legislation.
- Organizational and collaborative support for administrative actions involving the Administrative Hearing Commission (AHC), MMAC and the Attorney General's Office.
- Creating and implementing auditing and evaluation policies and procedures to detect, investigate and prevent fraud, waste and abuse and to ensure compliance with the Missouri Medicaid Title XIX Program.
- General office support to all teams in MMAC.

Managed Care Health Plans

The MO HealthNet Division contracts with Managed Care Organizations to provide health services in return for a capitated payment. The three general Managed Care Plans, also known as

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Managed Care Organizations (MCOs), are Healthy Blue, Home State Health, and United HealthCare. Additionally, Show Me Healthy Kids is a specialized plan managed by Home State Health for children in state care and custody or foster care.

Each health plan has a Special Investigations Unit (SIU) tasked with detecting, investigating, and preventing fraud, waste, and abuse within its plan. The SIUs review suspicious or “outlier” billing patterns by providers, using data analytics and investigations to protect program integrity and reduce improper payments.

The Missouri Medicaid Audit and Compliance Unit, MO HealthNet Division, the Attorney General’s Office and MCOs meet regularly to collaborate, share information, and identify trends to reduce fraud, waste, and abuse. MMAC conducted quarterly meetings with all health plans and MHD during SFY 2025.

MMAC has a dedicated analyst in the Provider Review Unit to act as the liaison to monitor referrals from all three plans. The analyst reviews each referral and disperses the referral to the appropriate unit within MMAC and/or MHD.

Unified Program Integrity Contractor (UPIC)

The Centers for Medicare & Medicaid Services (CMS) mandates that states contract with a UPIC to enhance the integrity of their Medicare/Medicaid programs. The UPIC works to prevent, detect, and investigate fraud, waste, and abuse by conducting audits, reviews, and investigations of post-payment claims to identify potential overpayments.

The United States is divided into five distinct Unified Program Integrity Contractor (UPIC) regions: Northeast, Southeast, Midwest, Southwest, and Western. Each region is managed by a specific contractor. The Midwest region UPIC contractor is CoventBridge Group, and they service the following states in the Midwest region: IA, IL, IN, KS, KY, MI, MN, MO, NE, OH, and WI.

In addition to conducting audits, CoventBridge provides MMAC access to healthcare consultants for questions on claims.

During SFY2025, CoventBridge provided MMAC with the results of studies involving:

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- Inappropriate Use of Antipsychotic Drugs in Nursing Homes
- Home and Community-Based Services Outlier Analysis
- Skin Substitutes for Wound Care Outliers
- Inappropriate Billing for Intermittent Urinary Catheters
- Lab Billing with Exact Code Combinations
- Inappropriate Billing of HIV PrEP Treatments
- Medicaid Crossovers for Voided Medicare Claims
- Cancer Genetic Testing Outlier Analysis
- Overutilization of Inpatient Sepsis Codes
- Providers Billing Medicaid after Medicare Revocation
- Telehealth Outliers
- Chiropractic Outliers
- Inappropriate Billing of E/M Codes during Inpatient Stay
- Referrals from CMS's Fraud Detection Operation Center
- Hospice Billing Outliers
- Questionable Billing of Safety Beds
- Urine Drug Screening Tests in Sober Homes

Recovery Audit Contractor

The Recovery Audit Contractor (RAC)

Section 6411 of the Affordable Care Act, Expansion of Recovery Audit Contractor (RAC) Program, amends section 1902(a)(42) of the Social Security Act and requires states to contract with a RAC vendor and allows states to reimburse contractors who assist in the identification and

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recovery of improper payments. The Recovery Audit Contractor is tasked with identifying and correcting improper payments and collecting those overpayments.

Missouri's RAC

For calendar years 2016 through April 1, 2026, Missouri was granted a waiver by CMS, exempting it from its requirements to contract with a RAC. The exemption was granted due to Missouri's strong program integrity team, utilizing the TPL contractor for credit balance audits, and because managed care claims are not subject to RAC audits. In calendar year 2026, DSS will request that CMS extend Missouri's RAC waiver once again.

MMAC General Statistics - SFY 2025

Provider Enrollment

Total	SFY2024	SFY2025
New Providers Enrolled	11,612	13,014
Revalidations Processed	1,536	7,171
Applications Rejected	5,191	4,693
Updates Processed	16,343	17,732
Email Inquiries	57,355	60,102

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Provider Enrollment Home and Community Based Contracts

Type of Program	State Fiscal Year (SFY)	New Proposals & Applications Received	Proposals & Applications Returned/ Rejected	Proposals & Applications Pending	Executed Participation Agreements/ Enrolled	Terminated or Placed on Closed-End	# of Agencies Currently Enrolled
Consumer Directed	2024	171	74	73	71	20	1,072
Consumer Directed	2025	144	65	55	82	29	1,095
In-Home Agencies	2024	83	51	37	33	8	593
In-Home Agencies	2025	144	65	55	82	29	1,095
Adult Day Care	2024	13	7	4	7	1	136
Adult Day Care	2025	14	6	1	11	4	147

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Participant Lock-In Program

Participant Reviews	SFY2024	SFY2025
Number of No-Abuse Cases reviewed	455	732
Lock-In Participants (new cases)	508	491
Biennial Reviews Completed (Two-year follow-up)	323	408
Watch Cases	366	501
Watch Cases at six-month follow-up	576	806
Total Participant Reviews	2,228	2,938

Cost Avoidance (Provider Review and Participant Lock-In):

Type	SFY2024	SFY2025
Denied Claims (actual claims denied due to pre-payment reviews)	2,345,115	2,888,594
Provider Audits and Special Projects (calculation based on projected cost savings over a period of one year, taking into consideration actions MMAC has taken)	46,285,274	39,247,057
Participant Reviews (actual claims denied due to lock-in program)	6,751,255	8,610,251
Total	55,381,644	50,745,901

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Provider Review Audits, Special Projects, and Self-Disclosures

Type	SFY2024	SFY2025
Recoveries from Audits and Special Projects	4,218,298	6,019,026
Recoveries from Self Disclosures	4,980,733	4,693,779
Recoveries from TPL Audits	2,047,491	6,506,549
Recoveries from the RAC	0	0
Recoveries from the AGO (MMAC cases)	237,731	231,931
DSS Total	11,484,253	17,451,195
AGO non-MMAC-related recoveries	1,536,655	768,263
Total	13,020,908	18,219,458

Investigations

Type	SFY2024	SFY2025
Investigations Completed	82	86
Medicaid Fraud Control Unit Referrals	51	48
Hotline Calls Received	301	308
Provider Education Presentations	4	8

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Provider Terminations and Payment Suspensions

Type	SFY2024	SFY2025
Provider Terminations	1,946	2,194
Provider Payment Suspensions	79	564

Report Fraud

A collaborative effort to report fraud, waste, and abuse in the MO HealthNet program is essential because no single entity can detect every issue alone. Providers, MCOs, state agencies, law enforcement, and participants each have unique perspectives and access to different information. When these groups work together, it creates a comprehensive system of checks and balances that strengthens program integrity, protects taxpayer dollars, and ensures that resources are directed to those who truly need them. Collaboration also promotes transparency and accountability, making it harder for fraudulent activities to go unnoticed.

Report suspected Medicaid fraud to:

Missouri Medicaid Audit and Compliance (MMAC)

3418 Knipp Drive, Suite F

Jefferson City, MO 65109

MMAC Fraud Hotline: 573-751-3285

MMAC Report Fraud: MMAC.ReportFraud@dss.mo.gov

MMAC General Number: 573-751-3399