LOUISIANA LEGISLATIVE AUDITOR
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Subcommittee on Health Care
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"Medicaid: Compliance with Federal Eligibility Requirements"

Testimony of:
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Chairman Toomey, Ranking Member Stabenow, and distinguished Members of the Committee, my name is Daryl Purpera and I serve as Legislative Auditor for the State of Louisiana. I was elected by the Louisiana Legislature to serve as Louisiana's Legislative Auditor in 2010 and have a total of 35 years of government auditing experience. My office is constitutionally within the Legislative branch of Louisiana government. I serve as an executive committee member for the National Association of State Auditors, Comptrollers, and Treasurers (NASACT), as well as the National Association of State Auditors (NSAA). What I will be relating to you today is this:

1. The Medicaid program, as designed does not require all practical practices that are proven to reduce improper payments.
2. State Medicaid departments are not required to incorporate robust, cost effective, controls to reduce improper payments.
3. State Auditors continue to desire to be a part of the solution of reducing improper payments but do face obstacles.

Louisiana Medicaid Audit Unit

Three years ago, we decided that traditional audit efforts were not enough to curb the nationally reported 10% rate of fraud, waste, and abuse in the Louisiana Medicaid program. With Medicaid increasingly taking a larger portion of the state budget, currently more than 40%, we began to develop a Medicaid Audit Unit, more than doubling our audit resources for Medicaid. For example, the Medicaid expenditures in Louisiana have increased from $8.3 billion in 2016 to $12 billion in 2019 and are expected to increase another $1.3 billion in 2020.

Over the past three years, our Medicaid Audit Unit has issued 16 reports, with eight reports on Medicaid Eligibility and four of those covering the Medicaid Expansion population. We have provided links to three audit reports addressed in my testimony. Our initial expanded audit efforts focused on eligibility due to our assessment of risk. Louisiana is a managed care state with over 90% of the Medicaid enrolled population, or about 1.4 million recipients included. Under managed care as implemented in Louisiana Medicaid, the Louisiana Department of Health makes a per-member-per-month payment, essentially a premium, to a managed care organization for each Medicaid member enrolled. These premium rates vary by demographics and risk group and range from about $187 to $643, with an average rate of about $500 per month. Under this arrangement, eligibility becomes the cost driver for Medicaid rather than claims experience. The total Medicaid cost equals the number of enrolled recipients times an applicable rate. Considering the number of recipients and the current rates in Louisiana, a 1% error in the Medicaid rolls results in approximately $70 million in waste of Medicaid dollars.

Medicaid Audit Reports on Eligibility and the Expansion Population

I want to highlight three of our reports on Eligibility and the Expansion population. The first report is ***Medicaid Eligibility: Wage Verification Process of the Expansion Population***, issued on November 8, 2018. *(Report Highlights)*

In this audit, our message was that when a person is enrolled in Medicaid due to their current monthly income, they essentially get Medicaid for an entire year, even though their income may have changed drastically in the next month. If the change is not voluntarily reported, the department would never know because of relying solely on annual renewals.

In this audit, we tested two selections from the expansion population for only one eligibility factor, the income reported to the Louisiana Workforce Commission, which is the state's labor department where employers are required to report any wages earned in the state.

Our selections tested were not a random sample from the entire expansion population, but more targeted using data analytics to identify and test a high risk population. We identified the expansion population with a household size of one, then ran a data match between this group and the workforce commission income data. Through this match, we identified 19,000 recipients who appeared to earn too much income to be eligible for Medicaid.

From the group of 19,000 recipients, we selected 100 of the highest earners to test. Our testing found that 93% did not qualify for Medicaid for at least some of the eligibility period. We identified $538,705 in improper payments.

We then randomly selected 100 of the remaining untested population to test for income eligibility. We found 82% did not qualify for at least part of the eligibility period and identified $382,420 in improper payments. Since this group was randomly sampled, we projected results to the remaining untested population and identified between $61.6 million and $85.5 million in improper payments.

At the time of our audit, the department only checked wages at the initial application and at annual renewal. We recommended that the department conduct more frequent checks of workforce commission wages, suggesting risk-based quarterly checks.

On May 1, 2019, we issued a follow up report titled ***Update on Wage Verification Process of the Medicaid Expansion Population***. In this audit we noted that the Department of Health acted upon our recommendation from the first report and developed a risk-based process to do quarterly checks between the Medicaid reported income and the workforce income data. As a result of the first income check, the department identified 30,051 ineligibles and removed them from the program for a projected cost avoidance of $14.7 million per month. The Louisiana Medicaid department has now performed 3 quarterly checks and removed 64,228 from the roles resulting in an estimated $385 million in annual cost avoidance.

The third audit on the expansion eligibility population is titled ***Medicaid Eligibility: Modified Adjusted Gross Income Determination Process*** and was issued December 12, 2018. *(Report Highlights)* In this audit, we tested a random sample from an expansion population totaling 220,292 recipients and identified an error rate of 8%. We projected $111 million in annual cost avoidance if controls are implemented to eliminate case workers errors.

Also in this audit, we noted that the department does not use federal and/or state tax information to verify critical eligibility factors. The department accepted self-attested answers on

critical eligibility factors including tax filer status, household size, self-employment income, unearned income, and some retirement income. Federal and/or state tax information is the only electronic data sources that the department could use to verify these factors. Since the department does not use tax data and auditors cannot use tax data to audit Medicaid eligibility, we identified a scope limitation in our audit of Medicaid because we could not obtain sufficient appropriate audit evidence to complete our audit.

Significant Medicaid Issues to be Addressed

From the work of our Medicaid Audit Unit and discussion with other state auditors, we have identified several ongoing issues that could be addressed to help improve the State Medicaid programs.

Medicaid Eligibility Verification Plans

Mandatory verification plans - At this time, Medicaid Eligibility Verification Plans are required to be submitted to CMS. The verification plan identifies each required eligibility factor and notes how the state addresses the requirement. However, these plans are accepted by CMS, but not approved. The states are granted latitude on which eligibility factors are verified and how. While some of the factors may be fully verified through data systems, others may not. For example, Louisiana notes it does not accept self-attestation for income and identifies certain data sources used to verify. However, the data sources are not all-inclusive of possible income sources. While the Louisiana plan notes that self-attestation is not accepted for income, it also notes it accepts self-attestation of income if there is not a data source to verify it. For self-employment income, Louisiana does not use possible data systems, such as tax data, and asks for hard copy documentation to verify self-employment income. However, without the use of a data system, federal and /or state tax data, Louisiana would not be able to determine when self-employment income and other types of unearned income, like rents, royalties, and retirement payments exist but are omitted from the application.

Louisiana also accepts self-attested information on the applicant's tax filer status and household size. Because no tax data is used, Louisiana has no data source to verify these critical eligibility factors. Tax filer status is critical because it drives whether states use CMS "tax filer rules" or "non-tax filer rules" to determined household size. Household size is critical because it sets the allowable income level for the applicant.

Since the verification plans are permissive for the state Medicaid agency, auditors lack criteria to identify and report on insufficient policies and practices, and weaknesses in internal control. If CMS would set firm criteria, like mandatory verification plans with the mandatory use of data systems for all critical eligibility factors, state health departments would have much improved processes to reduce improper payments, and auditors would have stronger tools to audit Medicaid eligibility.

Required Use of Federal and/or State Tax Data

Currently, 27 states use federal tax data in eligibility determinations and renewals while others do not. Since the modified adjust gross income determination rules are based on tax rules and tax data, administering and auditing the state Medicaid program without using tax data is insufficient. We acknowledge changes in this area would require changes in law and/or rule. As noted previously, for critical eligibility factors including tax filer status, household size, self-employment income, some retirement income, and certain other unearned income, like rents and royalties, tax data is the only data source available to use for verification. If data verification is not available to verify critical eligibility factors, states may allow self-attestation. If CMS would set firm criteria mandating the use of tax data, eligibility determination processes would be strengthened and improper payments decreased.

Some maintain that the use of Tax data is not helpful because it represents the past not the present. However, the Louisiana Department of Health (LDH) recently compared 2017 state tax data to 2017 Medicaid recipients and found that 1,672 individuals had incomes that varied from their self-attested income by more than $100,000. Another 8,474 individuals had income that varied between $50,000 and $100,000. After seeking additional information, LDH concluded that 4,227 were no longer receiving Medicaid as of April 2019 post 2017 and another 3,175 had to be removed indicating that 73% of the 10,146 with incomes that varied by more than $50,000 may not have been eligible. This examination by the LDH shows that tax data can be helpful in identifying recipients who have not correctly reported their income.

Verification Law Can Be Counter-Productive

The code of federal regulation, 42:435.916 provides that the Medicaid agency must make a redetermination of eligibility without requiring information from the individual if able to do so based upon reliable information including electronic databases. However, in the case of non-wage income, such as self-employment, the use of databases will not reveal all income and are therefore insufficient.

More Frequent Wage Verification

As shown in our reports and the department's new process to perform quarterly wage verification checks noted above, more frequent wage checks through a data match with the state labor department can provide positive results, especially for the risky expansion population made up of working adults who can experience more frequent changes in income. According to our survey results, 20 states conduct wage checks more frequently than just annual renewals. Checks vary with states reporting interim checks daily, monthly, quarterly, and semi-annually. If CMS required more frequent wage verification, the Medicaid programs would see some positive cost savings.

Improper Payments, Claims Experience Data, and Rate Setting

In Louisiana, the state Medicaid agency contracts with five managed care organizations to provide Medicaid services for about 90% of the Medicaid recipients. The managed care plans are identified as full-risk bearing arrangements. However, improper payments and poor identification and tracking of added service and enhanced payments can skew claims experience data in one year and actually result in rate increases in future years. In April of 2014, the Washington State Auditor's Office issued an audit report on managed care oversight. In this report, the auditor's analysis "showed that for every $1 million in overpayments in 2010, the state potentially paid an additional $1.26 million in premiums in year 2013." Valid claims experience data and efforts to eliminate improper payments are both critical elements for an efficient managed care program. Any errors can affect future rates.

State Auditors Do Not Have Access to Federal Tax Information

Access to the MAGI data is restricted by federal law. 26 USCA 6103(d)(2) restricts the state auditor's access to federal tax information (FTI) to "…for the purpose of, and only to the extent necessary in, making an audit of the…" state tax agency. As a result, my office may access federal tax data when, and only when, auditing the Louisiana Department of Revenue. I cannot use this same tax data to audit Medicaid, SNAP, or TANF. What this means is the information I can hold in my right hand while auditing our tax agency, I cannot let my left hand use while auditing our Medicaid agency. This is a significant, counterproductive restraint placed upon the independent state auditor.

Successes in the Past Few Years

Over the past few years, the State Auditors have worked with the Governmental Accountability Office, the Office of Management and Budget, the Centers for Medicare and Medicaid Services, and the U.S. Department of Health & Human Services – Office of Inspector General to improve current practices. This collaboration will result in more comprehensive audits by State Auditors that I am sure will result in a positive impact and reduced improper payments. In addition, we are continuing our discussions to make further improvements for the future as State Auditors desire to be part of the solution.

Conclusion from an Auditors' Perspective

- The Medicaid improper payment rate is unnecessarily high and can be reduced by implementation of improved eligibility determination practices and enhanced audit procedures.
- The Medicaid program, as designed, is too permissive and does not require all practical practices that are proven to reduce improper payments.
- State Medicaid departments should be required to incorporate robust, cost effective, controls to reduce improper payments.
- State Medicaid departments should use all available resources to verify eligibility and not be restricted from requiring additional information.
- State Auditors should be allowed to use Federal Tax Information to audit this Federal/State program
- The Patient Protection and Affordable Care Act increased the individuals eligible for the program and vital health care, but did so without proper controls to reduce to a minimum the number of individuals who would intentionally, or unintentionally, receive the benefits but truly not qualify under the Act.

Thank you for the opportunity to testify today, and I look forward to answering any questions you may have.