AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 116–460

MEDICAID: COMPLIANCE WITH ELIGIBILITY REQUIREMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

OCTOBER 30, 2019



Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

44–826—PDF WASHINGTON : 2021

COMMITTEE ON FINANCE

CHUCK GRASSLEY, Iowa, *Chairman*

MIKE CRAPO, Idaho
PAT ROBERTS, Kansas
MICHAEL B. ENZI, Wyoming
JOHN CORNYN, Texas
JOHN THUNE, South Dakota
RICHARD BURR, North Carolina
JOHNNY ISAKSON, Georgia
ROB PORTMAN, Ohio
PATRICK J. TOOMEY, Pennsylvania
TIM SCOTT, South Carolina
BILL CASSIDY, Louisiana
JAMES LANKFORD, Oklahoma
STEVE DAINES, Montana
TODD YOUNG, Indiana

RON WYDEN, Oregon
DEBBIE STABENOW, Michigan
MARIA CANTWELL, Washington
ROBERT MENENDEZ, New Jersey
THOMAS R. CARPER, Delaware
BENJAMIN L. CARDIN, Maryland
SHERROD BROWN, Ohio
MICHAEL F. BENNET, Colorado
ROBERT P. CASEY, JR., Pennsylvania
MARK R. WARNER, Virginia
SHELDON WHITEHOUSE, Rhode Island
MAGGIE HASSAN, New Hampshire
CATHERINE CORTEZ MASTO, Nevada

KOLAN DAVIS, *Staff Director and Chief Counsel*
JOSHUA SHEINKMAN, *Democratic Staff Director*

SUBCOMMITTEE ON HEALTH CARE

PATRICK J. TOOMEY, Pennsylvania, *Chairman*

CHUCK GRASSLEY, Iowa
PAT ROBERTS, Kansas
MICHAEL B. ENZI, Wyoming
JOHN THUNE, South Dakota
RICHARD BURR, North Carolina
JOHNNY ISAKSON, Georgia
TIM SCOTT, South Carolina
BILL CASSIDY, Louisiana
JAMES LANKFORD, Oklahoma
STEVE DAINES, Montana
TODD YOUNG, Indiana

DEBBIE STABENOW, Michigan
MARIA CANTWELL, Washington
ROBERT MENENDEZ, New Jersey
THOMAS R. CARPER, Delaware
BENJAMIN L. CARDIN, Maryland
SHERROD BROWN, Ohio
ROBERT P. CASEY, JR., Pennsylvania
MARK R. WARNER, Virginia
SHELDON WHITEHOUSE, Rhode Island
MAGGIE HASSAN, New Hampshire
CATHERINE CORTEZ MASTO, Nevada

CONTENTS

OPENING STATEMENTS

Page

Toomey, Hon. Patrick J., a U.S. Senator from Pennsylvania, chairman, Subcommittee on Health Care, Committee on Finance 1
Stabenow, Hon. Debbie, a U.S. Senator from Michigan 2

WITNESSES

Ritchie, Brian P., Assistant Inspector General for Audit Services, Office of Inspector General, Department of Health and Human Services, Washington, DC 5
Yocom, Carolyn L., Director, Health Care, Government Accountability Office, Washington, DC 6
Purpera, Daryl G., CPA, CFE, Legislative Auditor, State of Louisiana, Baton Rouge, LA 7
Solomon, Judith, senior fellow, Center on Budget and Policy Priorities, Washington, DC 8

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Brown, Hon. Sherrod:
"The Number of Uninsured Children Is on the Rise," by Joan Alker and Lauren Roygardner, October 2019, Georgetown University Health Policy Institute, Center for Children and Families 25
Casey, Hon. Robert P., Jr.:
Statement of Teresa Miller, Secretary, Pennsylvania Department of Human Services, October 30, 2019 45
Purpera, Daryl G.:
Testimony 7
Prepared statement with attachments 46
Responses to questions from subcommittee members 93
Ritchie, Brian P.:
Testimony 5
Prepared statement 94
Responses to questions from subcommittee members 100
Solomon, Judith:
Testimony 8
Prepared statement 101
Responses to questions from subcommittee members 107
Stabenow, Hon. Debbie:
Opening statement 2
Prepared statement with attachments 111
Toomey, Hon. Patrick J.:
Opening statement 1
Prepared statement 116
Yocom, Carolyn L.:
Testimony 6
Prepared statement 117
Responses to questions from subcommittee members 126

COMMUNICATION

Center for Fiscal Equity 131

MEDICAID: COMPLIANCE WITH ELIGIBILITY REQUIREMENTS

WEDNESDAY, OCTOBER 30, 2019

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2 p.m., in Room SD–215, Dirksen Senate Office Building, Hon. Patrick J. Toomey (chairman of the subcommittee) presiding.

Present: Senators Cassidy, Lankford, Daines, Young, Stabenow, Cantwell, Cardin, Brown, Casey, Hassan, and Cortez Masto.

Also present: Republican staff: Alyssa Palisi, Staff Director for Senator Toomey; and Stewart Portman, Health Policy Advisor for Chairman Grassley. Democratic staff: Anne Dwyer, Senior Health Counsel for Ranking Member Wyden; Michael Evans, Deputy Staff Director and Chief Counsel for Ranking Member Wyden; Alex Graf, Staff Director for Senator Stabenow.

OPENING STATEMENT OF HON. PATRICK J. TOOMEY, A U.S. SENATOR FROM PENNSYLVANIA, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator TOOMEY. The committee will come to order. Welcome to the Senate Finance Subcommittee on Health Care hearing on "Medicaid: Compliance With Eligibility Requirements."

It is my pleasure to welcome our four witnesses today as we discuss recent evidence of eligibility errors in the Medicaid expansion population and other issues surrounding State compliance with Federal eligibility requirements.

Our panel contains several nonpartisan government officials who have performed research relevant to today's topic. I look forward to hearing from them.

But first I want to set the stage with a few staggering statistics. The Federal Government improperly spent over $36 billion in the Medicaid program, giving the program an improper payment rate of 10 percent. It accounted for about 26 percent of government-wide improper payments in that fiscal year—that was last year. Federal taxpayers spent almost $12 billion on ineligible Medicaid recipients. And over the next 10 years, the expansion population alone will cost taxpayers a total of $925 billion.

Here is why this matters. Medicaid spending is already on an unsustainable path. Every decade since it was created, Medicaid has grown faster than our economy, a trend that the Congressional Budget Office projects to continue under current law. It is now a

major driver of our Federal deficits and debt, and this trajectory cannot continue in perpetuity without eventually causing a crisis.

Unfortunately, Medicaid's financial condition has worsened in the last decade because Obamacare created a new category of eligibility, working-age childless adults, and gave States a huge financial incentive to cover these working-age individuals over the traditional populations, which are the disabled, the indigent, and the elderly poor.

For every working-age able-bodied adult who enrolls, a State gets 90 cents on the dollar, but just about 60 cents when it enrolls a disabled individual. It does not take a math wizard to figure out how States can game this formula.

Making matters worse, in 2014 the Obama administration stopped auditing States' eligibility determinations. Payment Error Rate Measurement, or PERM audits, gave Congress insight into each State's eligibility errors. Without these reports, we do not have a complete picture of the Medicaid improper payment rate, meaning the estimated 30 percent of improper payments due to eligibility errors could in fact be much higher, resulting in much more perhaps than the $36 billion of taxpayer money being spent improperly.

Ensuring that a taxpayer benefit like Medicaid goes to the intended recipient should not be a partisan issue. States must do a better job of adhering to Federal eligibility requirements, and the Federal Government must do a better job of enforcing the law.

Given the precarious financial condition of Medicaid, if we cannot stop eligibility errors today, this safety net for millions of elderly and disabled may not be there for future generations.

I now yield to the ranking member, Senator Stabenow, for the purpose of an opening statement.

[The prepared statement of Senator Toomey appears in the appendix.]

OPENING STATEMENT OF HON. DEBBIE STABENOW, A U.S. SENATOR FROM MICHIGAN

Senator STABENOW. Well, thank you very much, Mr. Chairman.

I first want to welcome all of the witnesses today. It is a very important topic, and today's hearing will focus on Medicaid eligibility and enrollment and, hopefully as well, the importance of providing health care to millions of Americans through Medicaid.

So let me start by saying we have very different views of health care and the role of Medicaid, and so I respectfully acknowledge that as we move forward. But let me first say, where we have issues with eligibility and enrollment, we need to fix them. And we can agree on that.

But right now, the number one threat to Americans who qualify for or would like to enroll in Medicaid is, frankly, a court case currently before the Fifth Circuit Court actively supported, unfortunately, by the Trump administration. Any day now, the Fifth Circuit Court of Appeals will rule on the *Texas v. United States* case. And everything is at stake here, including protections for people with preexisting conditions, coverage for preventative services like cancer screenings, the ability for children to remain on their par-

ents' health plans until age 26, and the entire Medicaid expansion that covers 17 million Americans.

Thanks to a detailed evaluation by the University of Michigan, we know the facts about Michigan's Medicaid expansion. We call it "Healthy Michigan." And it, first of all, has meant 654,000 people covered in my State. Those with Healthy Michigan coverage not only have better health-care outcomes, they are better able to work and to seek employment. Instead of choosing between staying home and having health care on Medicaid or working a minimum wage job, they now are able to work a minimum wage job and have health care—which is something that I would hope that we would all support.

The expansion created more than 30,000 new jobs and increased economic activity by $432 million in 2017 alone. This was State revenue, revenues no longer needed to pay people sitting in emergency rooms, the most expensive kind of care, and other kinds of treatment options.

Uncompensated care in Michigan hospitals was cut in half. That keeps private insurance rates down and helps our hospitals in rural areas stay open. So I repeat: unfortunately the Trump administration is weighing in, and if they succeed in the Fifth Circuit Court case and strike down the ACA, the expansion is gone in total and millions of Americans lose their health care entirely.

So I would suggest for millions of Americans living in the States right now who are in what is called "the coverage gap," that instead we should be focused on how they can in fact get expanded Medicare as well. And I know Senator Warner has a bill on that that I think is very important.

Unfortunately, the court case and the coverage gap are not the only threats to Medicaid eligibility and enrollment right now, and I would ask, Mr. Chairman, unanimous consent to submit an article from last week's *New York Times* entitled "Medicaid Covers a Million Fewer Children. Baby Elijah Was One of Them."

Senator TOOMEY. Without objection.

[The article appears in the appendix beginning on p. 112.]

Senator STABENOW. Thank you. And let me just read the first paragraph, which says: "The baby's lips were turning blue from lack of oxygen in the blood when his mother, Christine Johnson, rushed him to an emergency room here last month. Only after he was admitted to the intensive care with a respiratory virus did Ms. Johnson learn that he had been dropped from Medicaid coverage."

So why was Elijah dropped from coverage? Why was he ineligible? Was this a case of fraud? No. According to *The New York Times,* Ms. Johnson missed a paperwork deadline, a 10-day window for providing proof of income to the State.

Excessive paperwork and over-regulation are common concerns raised by colleagues when we talk about the interest of business and industry. Was excessive paperwork the reason Baby Elijah lost Medicaid coverage even though he qualified for it? I would say, yes.

The story continued, "All of Ms. Johnson's children are now reenrolled, but she has started receiving thousands of dollars in bills from the baby's hospital stay. Though she is counting on Medicaid to cover retroactively, she is haunted by what might have hap-

pened if the hospital where she took Elijah had considered the case non-urgent and turned them away.

"'I went to the ER thinking he had insurance. If the receptionist had not seen him turning blue, she might have said he is not covered, so we cannot see him today.'"

So the good news, in closing, Mr. Chairman, is that today in Michigan, Medicaid expansion means 97 percent of Michigan children can see a doctor and get the health care that they need. And after decades of progress toward universal coverage for children reached an all-time low uninsured rate of less than 5 percent in 2015 nationwide, we unfortunately are seeing this begin to move up in the wrong direction.

Because of complex enrollment policies pushed by the administration and implemented by States, children, adults, and entire families are losing life-saving health-care coverage. Ms. Johnson had only 10 days with all of her children and all of the things in her life to juggle to reconcile paperwork with the State before her child was kicked off Medicaid.

In some States, if you move and a piece of mail from the State Medicaid office gets returned from your old address, you lose coverage. So today, as we discuss ways to make sure that ineligible people are not being enrolled in Medicaid, which I support, I hope we will also take a hard look at policies that are actually kicking eligible children and families off of their health insurance. I look forward to the discussion.

Thank you, Mr. Chairman.

[The prepared statement of Senator Stabenow appears in the appendix.]

Senator TOOMEY. Thank you, Senator Stabenow. Without objection, any other member's opening statement will be made part of the record.

And now we will hear from our witnesses.

First we will hear from Brian Ritchie, Assistant Inspector General for Audit Services at the Department of Health and Human Services' Office of Inspector General. He will highlight four reports that have found States that are not accurately determining Medicaid eligibility in the expansion or the newly eligible population.

Next we will hear from Ms. Carolyn Yocom from the GAO. She will discuss the GAO's past findings on Medicaid ineligibility in the expansion population and highlight their ongoing work to help the Centers for Medicare and Medicaid Services prevent these improper payments.

For our next witness, I will yield to my colleague from Louisiana for the introduction of Mr. Purpera.

Dr. Cassidy, you are recognized to introduce your constituent.

Senator CASSIDY. Yes. It is a privilege to represent Mr. Purpera. He was unanimously elected by the legislature in Louisiana to serve as the Legislative Auditor for our State in 2010, and has served since.

He had previously served as the first Assistant Legislative Auditor for 3 years, and has 35 years of audit experience, including financial audits, investigative audits, forensic interviews, testifying before courts and legislative committees.

He holds a BS degree in accounting from LSU and has been a Certified Public Accountant since 1985. He has many boards and commissions he has served on, but I will mention one just, again, to give a sense of the stature in which he is held by others in his field. He has been an executive committee member of the National State Auditors Association for 3 years and currently serves as president-elect. He has served as chairman of the National State Auditors Association's Performance Audit Committee from 2014 through 2019, and I could go on.

I am proud to say that Mr. Purpera is dedicated to the fulfillment of the Louisiana Legislative Auditor's mission to, quote, "foster the accountability and transparency of Louisiana Government for providing the legislature and others with audit services, fiscal advice, and other useful information."

I am pleased he is here today to provide that same service to us in the U.S. Congress. Daryl, good to have you here.

Senator TOOMEY. Thank you, Senator Cassidy.

And finally, we have Ms. Judith Solomon, a senior fellow at the Center on Budget and Policy Priorities.

Welcome to each of you, and thank you for joining us. Due to Senate-wide business, we are going to need to limit our witness testimony a little bit. I am going to ask each of you to please try to keep your oral comments to no more than 3 minutes so that we can hopefully get through all of our questions before virtually all of us will need to leave for the Senate-wide business.

And with that, I would like to begin with our first witness. Mr. Ritchie, you are recognized for 3 minutes.

STATEMENT OF BRIAN P. RITCHIE, ASSISTANT INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. RITCHIE. Good morning, Chairman Toomey, Ranking Member Stabenow, and distinguished members of the subcommittee. Thank you for inviting me here today and for your longstanding commitment to ensuring that the Medicaid program's beneficiaries are well-served and the taxpayers' more than half-a-trillion-dollar investment is well-spent. OIG shares your commitment to protecting Medicaid from fraud, waste, and abuse and has an extensive body of work in this area. I will use my time today to focus on the need to accurately determine beneficiary eligibility.

A strong program integrity strategy starts with prevention. Correctly determining eligibility prevents Medicaid from making improper payments for people who are not eligible for the program.

OIG has conducted seven audits in four States: California, Colorado, Kentucky, and New York. Four focused on beneficiaries who were newly eligible after Medicaid expanded to low-income adults with dependent children. The other three audits focused on non-newly eligible beneficiaries. These are individuals who qualified under a traditional coverage group rather than the newly eligible group.

We estimated almost $6.3 billion in Federal payments were made for beneficiaries who were not eligible or who may not have been eligible for Medicaid. This includes instances where beneficiaries

qualified under a traditional coverage group but were incorrectly enrolled in the newly eligible adult group. Almost $1.3 billion of our estimate was for people determined to be newly eligible beneficiaries, while the remaining $5 billion was for non-newly eligible beneficiaries.

Generally, errors associated with both groups were due to States not properly verifying income or citizenship requirements, or beneficiaries being eligible for a different coverage group.

In our reports, we recommended that these States ensure enrollment data systems are able to verify eligibility criteria, develop and implement written policies and procedures, and undertake redeterminations for the sample cases we reviewed, as appropriate.

In conclusion, preventing improper payments starts by correctly determining who is eligible for the program. OIG will continue to prioritize Medicaid oversight to prevent and detect fraud, waste, and abuse and take appropriate action when it occurs. We are committed to ensuring that Medicaid pays the right amount to the right provider for the right service on behalf of the right beneficiary.

Thank you for your ongoing leadership and for affording me the opportunity to testify on this important topic.

[The prepared statement of Mr. Ritchie appears in the appendix.]

Senator TOOMEY. Thank you, Mr. Ritchie.

Ms. Yocom, you are recognized for 3 minutes.

STATEMENT OF CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. YOCOM. Chairman Toomey, Ranking Member Stabenow, and members of the subcommittee, I am pleased to be here today to discuss the importance of ensuring that only Medicaid-eligible people are enrolled in Medicaid.

This Federal-State program finances medical and other health-related services for over 75 million people who are low-income and medically needy. Medicaid's size and complexity make it particularly vulnerable to improper payments, including payments made for people not eligible for coverage.

Today my testimony will focus on improvements needed to better ensure that Medicaid eligibility determinations are accurate. I will discuss CMS oversight of Medicaid eligibility and related expenditures, CMS's efforts to enhance Medicaid data, and the benefits of CMS collaborating with States and other partners, including State auditors.

First, our work has identified improvements needed in CMS oversight of Medicaid eligibility determinations. As one example, in August 2018 we identified weaknesses in how CMS reviews States' expenditures that receive higher Federal matching rates, such as individuals newly eligible for Medicaid through the Patient Protection and Affordable Care Act. One of our recommendations focused on revising the sampling methodology for reviewing such expenditures. CMS initially agreed, but in 2018 stated the agency had no plans to revise its sampling methods. We continue to believe that action is necessary to better target areas of risk.

Second, improvements in Medicaid data could aid program oversight, and CMS has acknowledged the need for better data. The T–MSIS initiative, Transformed Medicaid Statistical Information System, is CMS's primary effort to broaden the scope and improve the quality of State-reported expenditure and utilization data. These data are important for CMS oversight of States' Medicaid expenditures. Continued progress, however, will require a sustained multiyear effort.

Finally, oversight could be improved further through collaborative efforts that leverage and coordinate oversight efforts. Since 2014, CMS has not publicly estimated improper payments due to errors in eligibility determinations. This means the bulk of the information provided comes from sources other than CMS—for example, from State auditors. State auditors are uniquely positioned to help CMS oversee Medicaid, and they have identified deficiencies in State oversight of managed care, eligibility determination processes, and other program components.

Chairman Toomey, Ranking Member Stabenow, and members of the subcommittee, this concludes my prepared statement. I will be pleased to answer any questions you might have.

[The prepared statement of Ms. Yocom appears in the appendix.]

Senator TOOMEY. Thank you, Ms. Yocom.

Mr. Purpera, you are recognized for 3 minutes.

STATEMENT OF DARYL G. PURPERA, CPA, CFE, LEGISLATIVE AUDITOR, STATE OF LOUISIANA, BATON ROUGE, LA

Mr. PURPERA. Thank you, Chairman Toomey, Ranking Member Stabenow, distinguished members. I appreciate the opportunity to come here today.

Three years ago the State auditors around the country responded to the rising costs of Medicaid by really robusting our audit processes as we look at Medicaid each year within our States. We looked at how to control infrastructures, and we also looked at uncovering fraud, waste, and abuse and other improper payments.

In my State—I wanted to highlight three reports that I recently issued. In the first report, our message was basically that when a person is enrolled in Medicaid due to their current monthly income, they essentially receive Medicaid for an entire year, even though their income may have changed drastically. If the change is not voluntarily reported, the department would never know because they are relying solely on annual renewals.

In this particular report we looked at a targeted sample. It was risk-based. We looked at the 19,000 highest wage earners. We found that 82 percent did not qualify for all or a part of the benefits that they received. The error was roughly $61 million to $85 million. We recommended the department begin to look at more frequent wage verification.

In the second report we saw that the department had actually implemented our recommendation. But by the time this report was done, the department had conducted three quarterly wage checks and had removed 64,000 individuals from the rolls at an annual savings of $385 million.

In the third report we looked at the modified adjusted gross income determination process. The department determines eligibility

for a major portion of the recipients based upon modified adjusted gross income. And we found that there was an 8-percent error rate, costing roughly $111 million per year, and that could be avoided if controls were put into place.

We also found that the department was not using State or Federal tax data to verify critical factors such as tax filer status, household size, self-employment, unearned income, and retirement.

Now why do these improper payments occur? Well, in the Medicaid eligibility verification plans, the States have way too much latitude. The States are not required to use Federal tax information. They are permitted, but not required to. The law is often counterproductive in that it allows the self-attestation of income information and very little verification, and the regulations do not require frequent wage checks.

State auditors also do not have access to Federal—let me say it a different way. State auditors do not have the usage of Federal tax information to audit the Federal program. This is a Federal program. The Federal Government asks State auditors to audit this program. And though we can look at Federal tax information on a regular basis, we cannot use Federal tax information to audit a Federal program.

Mr. Chairman, Ranking Member Stabenow, thank you very much.

[The prepared statement of Mr. Purpera appears in the appendix.]

Senator TOOMEY. Thank you, Mr. Purpera.

Ms. Solomon, you are now recognized for 3 minutes.

STATEMENT OF JUDITH SOLOMON, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Ms. SOLOMON. Thank you. Chairman Toomey, Ranking Member Stabenow, and members of the subcommittee, thank you for the opportunity to testify today.

Today's discussion is focusing mostly on making sure only eligible people receive Medicaid, and I share that goal. But we should also be concerned that 7.5 million children and adults who are eligible for Medicaid remain uninsured and that enrollment of children has dropped by almost a million over 2 years. If we do not focus on barriers that keep eligible people uninsured, we will see even more uninsured people. I have four points about how we can and should aim for accuracy in both directions.

First, we need to deal with unnecessary churn of people going on and off of coverage. As we saw in last week's *New York Times* story about Baby Elijah, burdensome eligibility and verification processes cause eligible children and adults to lose coverage. Many reapply and eventually get their coverage back, but gaps in coverage hurt people when they cannot see a doctor or get their prescriptions filled, or are burdened by medical debt.

Meanwhile, health-care providers cannot effectively manage care for people who churn in and out of coverage, and States have to do extra paperwork to re-enroll eligible people.

Second, efforts to make Medicaid eligibility determinations more accurate must take volatile income and living situations into account. Monthly income for the typical low-wage Medicaid enrollee

often varies with seasonal work, unsteady hours, and frequent job changes. When States check income by looking at lagged wage data, they do identify some people who are no longer eligible, but they also identify people with earnings from a job they have lost, or who worked overtime over the holidays. And many of these people end up losing coverage, even though they are still eligible.

And many low-income people, including many families with children, have unstable housing and move frequently. So they lose coverage in States that terminate Medicaid coverage based on just one piece of returned mail.

Third, we can find ways to reduce errors in both directions. First and foremost, States can take up the option for 12-month continuous eligibility. They can also adopt new and better ways to communicate, such as text messages, easier reporting through online portals, and outreach when mail is returned.

Finally, we need to better understand what the studies and audits like the ones we are discussing today show and do not show. Some are misrepresenting the findings of recent audits by saying they show widespread beneficiary fraud. But as Mr. Ritchie testified, the audits show human and system errors that States are addressing.

Thank you for the opportunity to testify. I would be pleased to answer any questions you may have.

[The prepared statement of Ms. Solomon appears in the appendix.]

Senator TOOMEY. Thank you, Ms. Solomon. And thank you all for your testimonies. We are going to now proceed to the question-and-answer phase, and members are reminded that we will each have 5 minutes for questions. And due to the time constraints that we have on the back end of this, please let's all keep our questions under 5 minutes.

I will begin. My first question: Ms. Yocom, could you explain to us a little bit about the Payment Error Rate Measurement, known as PERM, audits—what they accomplish, the current status of those audits, and whether, and if so why, you believe they are important?

Ms. YOCOM. Sure. For the Medicaid program, there are three components that are measured. One is fee-for-service. The second is managed care. And the third is eligibility determinations.

The States—these analyses are done for 17 States each year, and they are done on a rotating basis. So every 3 years you have covered all 51 States, if you count the District. And there are concerns in each of the areas. With eligibility, in particular, we just do not know the answer yet, and we have not known it since 2014.

Senator TOOMEY. And why is that?

Ms. YOCOM. CMS made a choice to not publicly report any eligibility measures. They used a different system instead and worked internally with the States.

Senator TOOMEY. My understanding is that that portion of the PERM audit has resumed, and we expect a report relatively soon. Is that your understanding?

Ms. YOCOM. Yes. Our understanding is, it usually comes out sometime in November.

Senator TOOMEY. In the absence of that report, do we have less comprehensive, less accurate information about eligibility?

Ms. YOCOM. Yes.

Senator TOOMEY. So it is plausible that the improper payment rate that has been estimated at $36 billion could actually be higher than that?

Ms. YOCOM. Yes, it could. We just do not know.

Senator TOOMEY. Thank you.

Mr. Purpera, in your home State of Louisiana, as I understand it, you uncovered 1,672 enrollees with over $100,000 in annual income. And according to your testimony, in each case these individuals self-reported their income. Do you think there is any chance that there is any fraud involved among the 1,672?

Mr. PURPERA. Chairman Toomey, yes, sir, I do think there is a chance. My office is currently investigating some of those situations as we speak. That work was where our Department of Revenue actually came out with that number. As I said earlier, State auditors cannot use tax information. But I was able to get my Department of Revenue to compare their taxing information to the database of the health department. And 1,672, I believe it was, had incomes of over $100,000.

Senator TOOMEY. And if a State allows individuals to self-attest to their own income, what mechanism do they have to stop people from any level of income from signing up for Medicaid?

Mr. PURPERA. Well, the self-attestation is not the problem if the income is strictly wage income. When an individual works for a wage, they get a W–2. That information is reported to the Department of Labor in every State. The problem is, that is only a piece of the puzzle. You still have self-employment, rents, royalties; you have interest incomes. You have many different types of incomes that wage information does not cover. So you have to use tax information. You have to use other sources to go about getting that income.

Senator TOOMEY. Thank you.

Mr. Ritchie, the OIG's work in California found that 43 percent of traditional enrollees, 43 percent, were potentially ineligible. An additional 11 percent are actually ineligible. And, if I understand your testimony correctly, within the Medicaid expansion population, 20 percent are ineligible.

First, do I have these figures correct? And if so, how do we know that these are the numbers?

Mr. RITCHIE. That is correct. We picked a sample, and those are our estimates that we have projected. With our methods, we dug in and reviewed exactly what the State did in each case.

So for each sample case we basically went back and we checked what the State did in order to verify the income, in order to verify each of the eligibility criteria. The potential ineligible rate was much higher in California than the other States. But in each State, we found potentially ineligible enrollees. And I think that is a big distinction that we tried to make in each of our reports and in our dollar figures overall.

We presented the overall total of $6.3 billion to show the extent of the concern from a program integrity standpoint. From an actual ineligible standpoint, we found $1.8 billion across the States. And

then we found $4.5 billion that was potentially ineligible. So from an IG and program integrity standpoint, the controls are not in place to tell that they did things appropriately. And when we found human and system errors, these are cases where they did not have the documentation.

So tying back to Mr. Purpera's statement, they would have self-attested income, and they were supposed to verify that, and they did not have the documentation to show they verified it. Or they may have a system where they check citizenship in the data system, but the system did not have the capability to maintain the documents to show that they verified it. So there is no paper trail and audit trail to show that things were done properly.

Senator TOOMEY. Thank you.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

First, I would ask unanimous consent that a letter to the subcommittee from the State of Louisiana's Health Secretary be submitted for the record.

Senator TOOMEY. Without objection.

[The letter appears in the appendix beginning on p. 115.]

Senator STABENOW. Secretary Gee's letter highlights the tremendous success of the Medicaid expansion program in Louisiana. More than 450,000 people have gained coverage. Seventy-six thousand women have received mammograms. More than 100,000 people have received mental health and substance abuse disorder treatment. And the expansion has created more than 14,000 jobs. And not a single rural hospital has closed since Medicaid was expanded to cover more people, which is also good news.

So, like I indicated in my opening statement, when we have issues with eligibility and enrollment, we certainly want to work together to fix them, but the decision to expand Medicaid was clearly the right one.

So, Mr. Purpera, your November 2018 report on verifying the wages of Medicaid expansion enrollees evaluated the State's old enrollment and eligibility system. Correct?

Mr. PURPERA. Correct.

Senator STABENOW. Okay; and the State implemented, as planned, a new system shortly after your report came out. Is that correct?

Mr. PURPERA. That's correct also, yes.

Senator STABENOW. And I understand in your report that you made five main recommendations, and that you say that the Louisiana Department of Health agreed to all of them, including recommendations like the use of more frequent wage data matches, additional data sources, and staff training. Is that correct?

Mr. PURPERA. Yes, ma'am, that is correct.

Senator STABENOW. Okay; thank you very much. It is also true, for the record, that the Trump administration approved the new enrollment system and even recognized Louisiana in February for their implementation of best practices to eliminate waste, fraud, and abuse. So we should be looking at what is now happening there.

Let me turn to Ms. Solomon. We know that CMS is urging States to check their databases to see if people are over the income limit

for Medicaid expansion, like Louisiana has done. Are there ways States can do this without kicking large numbers of people off coverage?

I know you have touched on some of that, but how do we have that balance? We do not want people who are receiving services who are not eligible. But we also do not want to hurt families where they should be able to receive these services.

Ms. SOLOMON. Yes; I mean, I think there are several things. And I would start, actually, with the people where they do find that they are over-income and do not qualify. What we have not really talked about is, many of those people should then be getting premium subsidies in the marketplace and should stay covered, and very little is being done to guarantee that. So for those, when they do identify people, I think there is an important step to take.

For the others where you do not know, the problem is these notices give 10 days from the date of the notice. They do not reach people. Maybe they get 6 days. They are very unclear. They do not tell people what they really need to do. How do you prove you do not have a job anymore?

And then sometimes they do not reach them because of moves. So I think it really is these new ways of reaching people: using text messages, using online portals, doing outreach when you get returned mail. We did a very quick look, and a tiny number of low-income people move out-of-State when they move. So these are people who are still there. There are things—there is the National Postal Database that States can use. That works very well. So really——

Senator STABENOW. So it is making sure that folks do not end up like little Elijah, who I mentioned, who was in this *New York Times* story, losing health-care coverage because they somehow did not get that notice and were not able to get the paperwork done.

Ms. SOLOMON. Exactly. I think it is recognizing the lives of low-income people. And we have known for decades that increased paperwork is a barrier to coverage.

Senator STABENOW. We hear concerns about increased paperwork all the time, and we need to address that, I think, in every area.

And finally, Ms. Yocom, could you just talk for a moment about GAO's work comparing health-care outcomes in States with and without Medicaid expansion?

Ms. YOCOM. Sure. In particular, GAO did work that looked at the States that expanded Medicaid and the States that did not. We looked at things like unmet health-care needs and found that, across the board within a State, 26 percent of people in expansion States reported having unmet needs, in comparison to 40 percent in non-expansion States.

In terms of financial barriers to health care, we found that, for all individuals in expansion States, there were just 9 percent who reported financial barriers to health care, and 20 percent in non-expansion States.

Senator STABENOW. Thank you, very much.

Senator TOOMEY. Senator Cardin?

Senator CARDIN. Thank you very much, Mr. Chairman. I thank all four of our witnesses.

Ms. Solomon, your statement is something that we all should be concerned about. And that is, we want to make sure that people are enrolled in the programs they are eligible for. So if they are enrolled in the wrong program, or they are ineligible for a particular program, we want to make sure that we have compliance. We all agree on that.

But the numbers that you are telling us show that we are seeing a decline of people covered by Medicaid, and particularly the number of children we have seen decline. And we had bipartisan legislation to extend the CHIP program, and yet we are seeing that people who are eligible are not enrolling in the program.

I saw one study that showed as many as 7.5 million of the uninsured would be eligible for Medicaid coverage, but they are not in the Medicaid program.

So yes, we want to go after eligibility and make sure people are doing the right thing. The chairman asked a good question about fraud. We do not have those numbers. My gut tells me the number of fraudulent cases is probably very small. These are people who just do not have the information. The income varies during the year. They thought they were enrolling in one program, and they were put in a different program. The advice they got was—there are a lot reasons why. And States have all different types of inconsistencies on how they track people into the programs.

I mention that because the State of Maryland, I believe, is starting the very first program in the country that, when you file your tax return, you can check a box and determine your eligibility based, upon your tax returns, for these programs.

So what I guess I am asking is, can we not figure out a simpler way so that the people who are eligible can get into these programs? Their outcomes are going to be better, so it is better for our country. And quite frankly, we might not be doing what we need to, because people are enrolled who should not be. But we are not doing what we should, because too many people who are eligible are not enrolled.

Ms. SOLOMON. Exactly. I think if we go to the intent of the Affordable Care Act, it really was to create that continuum of health coverage; that people could have coverage as their incomes changed.

But what I think we have found is that it is very difficult. First of all, we have a number of States that still have not expanded Medicaid. So we have a coverage gap. But in the States that have, you are really looking at low-wage workers with volatile hours. And then you have this somewhat arbitrary 138 percent of the poverty line that takes not only income but family size into account.

So, if a child grows up and leaves the home, if somebody gets divorced, all of those things really are going to affect eligibility, as are small fluctuations in income for people who are at the border. Which is why I think looking at continuous eligibility, which is now a State option, for children—and some States have done it for adults as well, where people can really stay put in coverage.

If we think about it from a fiscal perspective, many of these people are eligible for marketplace coverage. And that costs Federal dollars as well. So if we let people stay put where they are, look at them at the end of the year, get them back into the same cov-

erage, we are going to end up improving health, eliminating State paperwork, and making it easier for providers, who we more and more are expecting to be accountable for health outcomes. And you just cannot do that if your patients are in and out of coverage.

Senator CARDIN. And I will just add one last thing, Mr. Chairman, and that is, I think that was the intent of the Affordable Care Act, to provide a seamless system. We have not been working to make that a reality. Instead, we have been chipping away—not "we," but some have been chipping away at the Affordable Care Act. And I think some of the consequences we see today are, as you point out, people who may be enrolled and not eligible for the Medicaid program may have been eligible for another program, and the government costs would have been comparable.

And yet, we are showing that as misappropriation. And again, we want them in the right programs, absolutely. But we also want to make sure that people get the coverage that they are entitled to, and that they have access to health care in this country.

Thank you, Mr. Chairman.

Senator TOOMEY. Senator Brown?

Senator BROWN. Thank you, Mr. Chairman. I would say, "Welcome to the subcommittee."

Senator Stabenow already submitted this letter to the committee, and she already had it approved. I want to ask you a few true or false questions. And please, because of the shortness of time and that we have to get to the briefing——

Louisiana's uninsured rate is the lowest it has ever been. True or false?

Mr. PURPERA. I am not really sure about that.

Senator BROWN. You are the auditor; you are not sure?

Mr. PURPERA. I do not know the answer, no.

Senator BROWN. Who might?

Senator CASSIDY. I do. It is.

Senator BROWN. Okay; thank you, Dr. Cassidy.

Louisiana State University estimated that Medicaid expansion created more than 14,000 jobs in the State of Louisiana. True or false?

Mr. PURPERA. There is a report that indicates that. I have never audited that, so I cannot verify that.

Senator BROWN. Dr. Cassidy, do you know that?

Senator CASSIDY. I do not know that.

Senator BROWN. Because of Medicaid expansion, 76,000 women in Louisiana have received breast cancer screenings, and 43,000 individuals have received colon cancer screenings. True or false?

Mr. PURPERA. That is not something I have audited, not something I have verified.

Senator BROWN. Well, this is like human beings, right? This is pretty important stuff.

Mr. PURPERA. Absolutely.

Senator BROWN. And you came to this committee understanding you would have at least some Democrats who support Medicaid expansion. I know what it has meant. When we had a Republican Governor expand Medicaid in my State, I know what it meant in terms of 900,000 people having insurance now who did not have it. And I could give you a whole litany of people who are under 26 on

their parent's plan and the consumer protections on preexisting conditions, and all the things that Senator Stabenow's lawsuit mentioned.

Let me try something else. I thought you would be better prepared than that——

Mr. PURPERA. Senator, I do not mean not to answer your question, it is just—and I do not refute Dr. Gee's letter——

Senator BROWN. I just thought you would know these things. I mean, I know them. I have not been to Louisiana in many years.

Mr. PURPERA. I do not know the number of mammograms performed in Louisiana; I am sorry.

Senator BROWN. And you did not know the insurance rate was down, but fortunately your Senator does. So——

Mr. PURPERA. But I did know that the number of mammograms has increased. That is just an assertion.

Senator BROWN. During her opening statement, Senator Stabenow entered into the record a recent *New York Times* article on Medicaid coverage to a million fewer children. The article tells the story of a Texas family whose baby lost his Medicaid as a result of bureaucratic paperwork. The new Georgetown Center for Children and Families report that came out this morning—which I would like to submit to the record, Mr. Chairman, if I could——

Senator TOOMEY. Without objection.

[The report appears in the appendix beginning on p 25.]

Senator BROWN. It highlights some concerning trends as it relates to the uninsured rate for children. According to this report, over the past few years the number of uninsured children nationwide increased by 400,000. That number includes 29,000 more uninsured children from my home State of Ohio. That is a 27-percent increase in the number of uninsured children between 2016 and 2018.

Would you, Mr. Purpera, elaborate on the real-world consequences of these bureaucratic requirements? And you heard Ms. Solomon talk about the difficulty that these bureaucratic requirements and complex eligibility checks have on families who are eligible. What are the real-world consequences?

Mr. PURPERA. Sure. I probably look at it in an entirely different way. It is a $600-billion program estimated to grow to be a $1-trillion program by 2025. We, roughly, in Louisiana, our per-month pay is about $600 per month, $5,000 or $6,000 per year. In my book as an auditor, that means you need to submit the required documentation when asked.

The issue with Baby Elijah—I understand that is a heart-wrenching story, but that individual did get care. And the reason that it did not have insurance on that day is because the parent did not fill out the paperwork.

The paperwork is not complex. The paperwork is very simple——

Senator BROWN. To you.

Mr. PURPERA. You can, in Louisiana—I do not know about in Texas—in Louisiana you can apply on the telephone, by Internet, or go in in person to many different offices.

Senator BROWN. Did you ever think about the lives of people who are kind of living on the edge, they make $10 or $11 an hour, they have to figure out how to get on the Earned Income Tax Credit,

they have to figure out—you know, they do work that—they clean your hotel room when you come to Washington. And they are doing work, and you may not even ask them their names. Maybe you do. But their lives are not as ordered, and they do not have assistance. And we make these—we know what happens when we make the bureaucratic requirements more.

You who believe in rejecting big government should understand that making individual people's lives, particularly low-income people's lives, harder, means a lot of them do not apply for these programs, right? Are there not human beings who do not apply because of these bureaucratic requirements?

Mr. PURPERA. I am not sure about that.

Senator BROWN. You ought to know—I know you are a numbers guy, but you ought to know the sort of human side of this. Fewer mammograms. Fewer colon cancer screenings. More people—I mean, more people die if you put more of these bureaucratic requirements in, right?

Mr. PURPERA. Actually, I do know the human side. In my other life, I am also a pastor of a church. So I very much understand the human side. But this is a government program. You have to have rules.

Senator BROWN. Okay. Thank you, Mr. Chairman.

Senator TOOMEY. Senator Casey?

Senator CASEY. Thank you, Mr. Chairman.

Mr. Chairman, I am going to start with asking consent to submit for the record a document entitled "Comments of Teresa Miller, Secretary of the Department of Human Services" in Pennsylvania dated October 30, 2019.

Senator TOOMEY. Without objection.

[The document appears in the appendix beginning on p. 45.]

Senator CASEY. Thank you, Mr. Chairman.

And speaking about Medicaid expansion just in one State—it just happens to be our home State, Senator Toomey's State and mine that we represent—here is what Teresa Miller, the Secretary of the Department of Human Services, said. She said—I am quoting now from the statement. I will not quote all of it.

"Over 680,000 individuals have health-care coverage because of Medicaid expansion," unquote. She also goes on to say that "More than 1.4 million people, about one in seven Pennsylvanians under the age of 65, have been covered by Medicaid expansion since February of 2015," unquote.

So in and out of the program—they are big numbers. Maybe more important than the numbers are what she says in the next paragraph, quote, "It is a lifeline for people who otherwise cannot access or afford health insurance," unquote. She goes on to say in the next paragraph, quote, "Medicaid expansion also saves lives," unquote. Referencing Senator Brown's indication of diagnoses, she says that "3,596 people in 2017 alone were diagnosed with just four forms of cancer." She goes on to cite individual examples of individual residents of Pennsylvania who have benefited from Medicaid expansion.

She talks about uncompensated care and the positive impact that has had on our hospitals. And towards the end of her statement she says this, quote, "Research is showing that the expansion is

helping more people enter the workforce, including people with disabilities who formerly had to live in poverty to maintain Medicaid coverage." And she cites a footnote for that from the *American Journal of Public Health.* But that is in the document, if someone wanted to read it.

So I guess one basic question I have—I have a strong belief that Medicaid itself has to be protected from the cuts. The administration has proposed cutting Medicaid itself by $1.5 trillion over 10 years. So the administration believes, based upon I do not know what—they have never really indicated why they want to cut $150 billion a year for 10 years. The administration's position on health care is that a lawsuit or a repeal bill or some measure should be carried forward to wipe out the Affordable Care Act, including wiping out Medicaid expansion.

It does not make much sense to me when you consider the people who are benefiting from Medicaid itself, and the many hundreds of thousands now just in one State who are benefiting.

So, Ms. Solomon, I will start with you. On page 4 of your testimony you say, and I quote, "Recent declines in Medicaid coverage for children and adults are due in part to a greater emphasis on frequent wage checks, more stringent documentation requirements, and terminations based on returned mail," unquote.

If you could talk about that, the question of the paperwork leading to individuals losing coverage—and unfortunately, these individuals in many cases are children.

Ms. SOLOMON. Yes. Thank you. You know, there are some findings from behavioral science that really explain this now. Because I started my career as a legal services lawyer and have been seeing this for decades. But there are studies that really show that low-income people have, you know, they have a lot on their plate, essentially. And these kinds of difficult situations we are putting them in—I have looked at these notices. They are long. They are complicated. They do not really tell people what they need to do.

People are working. They cannot get their call center on the phone because it is during their working hours. Or they do not get the notice at all because they have moved and nobody bothers to follow up on the piece of returned mail.

So all of that just contributes to a situation where we have large numbers of people who end up losing coverage when they are still eligible. We are not doing a good job. And we did—starting with the CHIP in 1997, and through the Affordable Care Act, there was a real effort to simplify and streamline.

And unfortunately I think what we have seen, and what we are seeing in that increased number of ineligible children—of eligible children who are losing coverage—is a reversal of that and a push to do even more paperwork. And we know where that will go.

Senator CASEY. Thank you. And I know we are out of time, Mr. Chairman, but just one citation. The Georgetown study that Senator Brown put in the record, page 3 of that study tracks, in Figure No. 1, the number of uninsured children in the United States in millions 2008–2018. And the good news is, for a while it was going down, and now it is going up.

We can disagree on a lot here, but I hope that people in both parties would be focused on getting that number down again. Thank you, Mr. Chairman.

Senator TOOMEY. Senator Daines?

Senator DAINES. Thank you, Mr. Chairman.

One of the most fundamental responsibilities that we have as United States Senators is to uphold the integrity as to how taxpayer dollars are spent. As we have heard today, the Federal Government improperly spent over $36 billion in the Medicaid program in fiscal year 2018. The sad reality is that every single one of those dollars that is lost due to waste, fraud, and abuse, means a lost investment in improving the health and well-being of vulnerable Montanans.

In fact, according to a 2018 audit, Montana is more at risk for Medicaid fraud and abuse compared to other States. That is deeply concerning. So I am very glad we are taking the time to highlight these issues and discuss solutions that will protect taxpayers and safeguard this program for those who truly need it the most.

Montana is one of only seven states—I guess I can count them on a hand and a couple of fingers here—to do post-enrollment verification of income. This means that they are able to make someone eligible for Medicaid on attestation of income alone, with the understanding that they will check later.

In 2018, a performance audit that was done by the Montana Legislative Audit Division had a sample of 100 cases that showed income errors in self-attested income in 24 percent of the cases. That is one in four. This audit also found that once the data was checked later, the discrepancies were not resolved.

Mr. Purpera, how much variance among States is there in their verification plans?

Mr. PURPERA. Well, each State is allowed to set up their own verification plan. And CMS currently, they do not approve the verification plan. They accept the verification plan. But what I would tell you is that CMS allows far too much latitude in the verification plans and does not require things like the use of tax data. It does not require frequent wage checks and those type of things.

If they would do so, they could reduce some of that improper payment you are talking about.

Senator DAINES. So could you speak a bit more about the importance of those plans and how CMS could help States have stronger eligibility check systems to these plans? How do you either incentivize it with a carrot or a stick to make this happen?

Mr. PURPERA. The plan, the verification plan, is the program that the State is going to use to verify eligibility. But what CMS currently does is allow the State too much latitude. They are able to choose maybe the easiest, or the least-intrusive methodologies, and that does not always result in determining whether the person truly is eligible or not.

Senator DAINES. Mr. Ritchie, OIG audited four States already, and your testimony notes that you are in the process of auditing two more, in fact, Louisiana and Ohio. Can you explain how OIG determines which States to audit? And are there indicators of risk

that might suggest OIG should dedicate resources toward looking into another State?

Mr. RITCHIE. Yes. Typically, we try to do a risk-based analysis because we have limited resources, and we try to target our resources. In these particular audits, we actually did not do risk-based analysis. We were starting these early after ACA had expanded, and the criteria that we used for these, because we were just trying to target a handful of States, was that they had to have expanded eligibility. And we tried to do for almost all of them, both the expansion and the traditional population. Then we tried to get a mix geographically across the country, and a mix of sizes of large States, medium-sized States, and smaller States.

The two that we have ongoing are Louisiana and Ohio, and then the four that we have out. And those are all that we have planned at this point.

A key for us, really, in the fix is CMS, and the things that the chairman and others have talked about, the PERM and the MEQC process. Some of our work in the area is going to shift to looking at that now that CMS is back up and doing these, to make sure that they are working properly.

Senator DAINES. Did it surprise you in the case of Montana, where there's an audit done, that there were discrepancies that were found but there was not follow-up to resolve the discrepancies? I mean, I was in the private sector for 28 years. The audit is step one, but that leads to, really, the outcome, which is to identify the action plan and resolve discrepancies.

Mr. RITCHIE. Yes. It is not worth doing if you are not going to follow through on it. You have to identify it, follow through with the action plan, and do that. That is what we are hoping to see.

And in our reports, we make recommendations to the States and then follow up with them. I know some of ours are still recently out, but we had seen in both Kentucky reports and in one of the New York reports where they have actually implemented policies and procedures to follow up on those and make changes. We are hoping to see that in each of them, and we are hoping that our reports have a more sentinel effect, and that other States will see this and do it too, because we have seen consistent human and system errors that they can also correct.

Senator DAINES. All right; thank you. I am out of time. Thank you, Mr. Chairman.

Senator TOOMEY. Thank you.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you, Mr. Chairman.

I would like your help in putting something in perspective, and I am going to start with you, Ms. Yocom. In your report you state—and I have heard this echoed in this hearing—"In Fiscal Year 2018, the national Medicaid improper payment estimate was approximately $36 billion, which is nearly 10 percent of Federal and Medicaid expenditures."

So that $36 billion in improper payment, which I am hearing is called "fraud, waste, and abuse," is that all attributed to enrollees? Isn't some of that attributed to providers as well?

Ms. SOLOMON. Correct.

Senator CORTEZ MASTO. And so let me just ask you this. So in sheer dollars, does Medicaid tend to see more fraud perpetrated by the providers, the industry, or by the low-income patients?

Ms. YOCOM. Yes. With the caveat that we do not really know what is going on with eligibility right now, but if you go back in time to when all three were being measured, generally the improper payment rate for fee-for-service was much higher, and it continues to be.

Senator CORTEZ MASTO. And I can tell you, for 8 years when I was the Attorney General, the Medicaid fraud unit was under my control, and we went after the providers. And let us put that in perspective, because the providers that we are talking about, that we investigated or prosecuted, are hospitals, doctors, nursing homes, pharmacies, dentists—anyone else who was paid by Medicaid for a health-care service.

And the number that I always heard—because it was hard to quantify—the total amount of abuse, fraud, and waste was 10 percent of the expenditures. And that is what I see here now in 2018. It is still 10 percent of expenditures that are paid on Medicaid.

It has nothing to do with additional fraud because of the expansion States. And Nevada is an expansion State, but we have not seen that. And is that not true?

Ms. YOCOM. Yes. And actually, the fee-for-service improper payment rate is at about 14 percent.

Senator CORTEZ MASTO. Thank you.

And so let me ask, Ms. Solomon, can you talk about the impact of administrative burdens on patients? We have also heard this. And if you would, put that in perspective for us and what that means to ensuring that, yes, we all want to address waste, fraud, and abuse. I think we do. We want more money to stay in the system so it can go to those who need it.

But for those who are truly eligible, we want to make sure they have access to the money that they need. So can you talk a little bit about this?

Ms. SOLOMON. Yes. And that was exactly what the ACA intended to do. I think there was an understanding this was not going to be easy to get everybody slotted into the right program.

And I think in some ways it has been harder than we understood. You know, you are using an eligibility level that is somewhat arbitrary. And there was a study right before implementation that found that half of people with incomes below the level of 138 would have a change over the course of the year that would bring them above.

So we have a really difficult task. States have a really difficult task if we are going to expect, on a monthly basis—because Medicaid is determined based on monthly income—that everybody is always going to be in the right program. So it is very hard.

The administrative burden, I think, of the wage checks in particular is that, while they do find some people who may no longer be eligible and should in many instances shift into the marketplace and remain covered, they also find people who were working overtime, or were working seasonally, or had a job, a second job that they do not have anymore.

And then they are being asked to really prove that. And as I said earlier, the notices are very difficult. They do not really explain what you need to show to remain eligible. And that is really the burden of the paperwork.

There are things we can do. I am not saying that we should stop the wage checks. What I am really saying is that we should think about what do those notices say? How do we communicate with people? How do we make it easy for them to report changes through the use of online portals, through phones that are answered when——

Senator CORTEZ MASTO. Let me cut you off, because I only have so much time, but I think what you said is important. Because I noticed—and listen, I think identifying an appropriate wage verification is key. But we have to be smart about it.

And I know in the Louisiana report that I am seeing, it looks like the Louisiana Department of Health used a wage verification on application of renewal.

Sir, Mr. Purpera, you actually looked at quarterly wage data to get your information. But the concern I have is that quarterly wage data—and let me ask you, Ms. Solomon—does it, could it include what you just said? Could it include a shift worker who took on additional hours around the holidays and now they are ineligible?

Ms. SOLOMON. Yes, it——

Senator CORTEZ MASTO. Could it include someone who received an unexpected promotion and now they are ineligible? Right?

Ms. SOLOMON. Yes, necessarily it is from a——

Senator CORTEZ MASTO. So just doing one snapshot, you are going to actually exclude people who actually need it even though they may have a one-time bump in their income, instead of looking at a full average in total income of an individual. Is that correct?

Ms. SOLOMON. Exactly. It is not current. It is a lag; it is always a lag. You are always looking backwards.

Senator CORTEZ MASTO. Thank you. I notice my time is up. Thank you.

Senator TOOMEY. Senator Cassidy?

Senator CASSIDY. Thank you. This is a weird hearing, because a lot of what we are hearing is nothing related to the topic of the conversation. No one is debating the Medicaid expansion. No one is debating whether Louisiana has these outcomes, which I am—Daryl, I am not sure I could attest to something which you have not personally looked at, as Senator Brown kind of rudely said that you should have been able to. But it is not about that.

It is about, how do we make sure that hardworking taxpayers are supporting those who need support, but not otherwise being defrauded?

And, Mr. Ritchie, I think I heard you say like 20 percent of the Medicaid expansion enrollees in California, you had problems with these enrollees? Did I get that right?

Mr. RITCHIE. Yes. For California we had found, in the dollars, we had $629 million that were newly and ineligible, and then $536 million that were non-newly and were ineligible.

Senator CASSIDY. So just an incredible number of people receiving taxpayer benefits—middle-class taxpayers paying for them, and yet they should not.

Mr. Purpera, you and I had a conversation earlier. I think you mentioned one person on Medicaid was actually a Medicaid provider who had received $4 million in Medicaid payments as a provider? Do I remember that correctly?

Mr. PURPERA. Yes, sir, you do remember that correctly. And, Senator, I am not offended by being—somebody treating me rude. I am treated rude all the time.

Senator CASSIDY. Hang on. Hang on. I know that. So I am going to treat you rude right now, man. I've got to get through this.

So I do not think this is an issue of Medicaid expansion, the value of that. I think it is an issue of making sure the taxpayers get their benefit. And there is an opportunity cost.

I will point out that Medicaid or Medi-Cal payments are so low many providers do not see Medi-Cal patients. And they are so low because the program is spread so thinly. So if we are spreading it so thinly that payments are low and people cannot get access, that in itself is an opportunity cost.

Ms. Solomon, I imagine if I were to propose the following, it would sound kind of attractive to you. I agree with you. If somebody has a bump in their wages because of overtime over Christmas, they should not lose health-care eligibility. Would it not be great if we had a seamless system in which they could, if they earned a little bit more, stay within the same system, kind of a standard set of benefits no matter what income scale you are, and the State would keep them in that and there would not be this kind of ongoing process. Would that not be good?

Ms. SOLOMON. Yes, I mean——

Senator CASSIDY. I think you are a voter for Graham-Cassidy. Unfortunately, none of these folks voted for Graham-Cassidy. But Graham-Cassidy actually would have done that. And unfortunately it was never actually read by most of my colleagues who ended up vociferously criticizing it.

Mr. Purpera, you actually mentioned a couple of things. Some suggestions—and I just want to emphasize by allowing you to comment on them—that right now auditors do not have permission to use income tax data in order to do an audit; that this should be required. As you mentioned, wages are one thing, but if you have rental property with income from that, that may move you out of eligibility, but it is never reported on wages.

Will you elaborate on that, please?

Mr. PURPERA. Yes, sir, Senator. We often find that individuals have self-employment income that they do not report. Currently the rules say that if the Department of Health can verify the self-attestation by looking at the wage data, then they are to go no further.

So if an individual reports no wages, they look at the wage data, and there is nothing there, they qualify. The problem could be they have a business that they are making considerable income in and they are just not reporting it.

So tax information is key. You have to use the tax information, not only——

Senator CASSIDY. Tell me again why that is not routinely done. Because it seems like if we are spreading our Medicaid dollars so thinly that people cannot get in to see a doctor because doctors are

paid below their cost of seeing a patient, and instead perhaps we could do something about that—but to do that, you need to focus benefits on those who need them.

Explain how you could again do a more robust analysis in order to confirm that people are receiving only deserved receipts.

Mr. PURPERA. The rules currently permit it, but they do not require it. Twenty-seven States are doing that, but the remainder of the States are not. But if you had tax data, then you could look to see in the past—that is past information—but you could look to see what were the types of income they were reporting at that point. And that gives you some beginning point to begin to ask questions about what income they have today.

Senator CASSIDY. Gotcha. And for every 1 percent of folks in Louisiana, for example, my own State, who are inappropriately enrolled, how much does that cost taxpayers?

Mr. PURPERA. It is roughly $70 million.

Senator CASSIDY. Seventy million dollars. And you say, I think, it is about 8 percent who are inappropriately enrolled?

Mr. PURPERA. That was one of our eligibility reports.

Senator CASSIDY. So roughly 40-what? Let's say times seven. You are the auditor.

Mr. PURPERA. Four hundred and something.

Senator CASSIDY. Over $400 million. That is real dollars, right?

Mr. PURPERA. Absolutely.

Senator CASSIDY. And in California, if you have that many people, Mr. Ritchie—I am not doing the math, but I can imagine similarly it would be in the billions that would be lost to California taxpayers because of people inappropriately enrolled.

I am out of time. I yield back.

Senator CANTWELL. Mr. Chairman?

Senator TOOMEY. Senator Cantwell?

Senator CANTWELL. I know we are all trying to get to a hearing, so I will be short and just say I am all for having a hearing about what savings we can get from Medicaid. I think the more important question in the law that we passed is, we included a provision for rebalancing. I think Louisiana originally took money to rebalance the Medicaid population off of nursing home care into community-based care.

This is where we are going to get savings. My State did this, and we saved $2 billion. Why? Because if you can deliver home-based care services, they are going to be more affordable.

So I hope we could have a hearing on that, since it has been several years since we implemented it, and many States, as I said, including Louisiana, originally participated by taking Federal dollars to do that efficiency. That is where we are going to find savings. That is where we are going to find efficiencies.

Thank you, Mr. Chairman.

Senator TOOMEY. Thank you. And I want to thank our witnesses for appearing before us today. These are important issues. Ensuring accuracy in Medicaid payments is an area where I think we have gotten some agreement on both sides, and we can work together to guarantee that all low-income families and individuals with disabilities have this important safety net to rely on in the future.

I would like to submit Mr. Purpera's three reports to the record, without objection.

[The reports appear in the appendix beginning on p. 50.]

Senator TOOMEY. Please be advised that the members will have 2 weeks to submit written questions that can be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

And with that, the subcommittee stands adjourned.

[Whereupon, at 3:10 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

SUBMITTED BY HON. SHERROD BROWN, A U.S. SENATOR FROM OHIO

Georgetown University Health Policy Institute, Center for Children and Families

The Number of Uninsured Children Is on the Rise

By Joan Alker and Lauren Roygardner

Key Findings

- **The number of uninsured children in the United States increased by more than 400,000 between 2016 and 2018 bringing the total to over 4 million uninsured children in the nation.** Bipartisan initiatives and the Affordable Care Act that successfully reduced the child uninsured rate for many years have been undercut by recent policy changes, and the U.S. is now reverting backward on children's health coverage. The number of uninsured children and the child uninsured rate are now at the highest levels since 2014, when the ACA's major coverage expansions first took effect. This trend is particularly troubling as it occurred during a period of economic growth when children should be gaining health coverage. The child uninsured rate may increase more rapidly should an economic downturn occur.
- **These coverage losses are widespread with 15 states showing statistically significant increases in the number and/or rate of uninsured children** (Alabama, Arizona, Florida, Georgia, Idaho, Illinois, Indiana, Missouri, Montana, North Carolina, Ohio, Tennessee, Texas, Utah, West Virginia), and only one state (North Dakota) moving in the right direction. States where the uninsured rate for children has increased most sharply are Tennessee, Georgia, Texas, Utah, West Virginia, Florida, and Ohio. With respect to the number of uninsured children, West Virginia, Tennessee, Idaho, Alabama, Ohio, and Montana saw increases of 25 percent or more between 2016 and 2018.
- **Loss of coverage is most pronounced for white children and Latino children (some of which may fall into both categories), young children under age 6, and children in low- and moderate-income families who earn between 138 percent and 250 percent of poverty ($29,435–$53,325 annually for a family of three).** Children whose families are in this income range also have the highest uninsured rates. American Indian/Alaska Native children continue to have the highest uninsured rates by race. African American children saw a slight improvement in their coverage rates during the period examined.
- **States that have not expanded Medicaid to parents and other adults under the Affordable Care Act have seen increases in their rate of uninsured children three times as large as states that have.** Children in non-expansion states are nearly twice as likely to be uninsured as those in states that have expanded Medicaid.

Introduction

For many years, the nation has been on a positive trajectory reducing the number and rate of uninsured children. Having health insurance is important for children as they are more likely to receive needed services, have better educational outcomes,

and their family is protected from the financial risks associated with being uninsured—even for a short period of time. *Recently released data show that this progress is now in jeopardy. For the second year in a row, the uninsured rate and number of uninsured children moved in the wrong direction.*[1] This is unprecedented since comparable data began to be collected in 2008.

The number of uninsured children now exceeds 4 million—*wiping out a sizable share of the gains in coverage made following the implementation of the Affordable Care Act (ACA) in 2014* (see Figure 1). Coverage improvements for children began many years before the ACA was enacted through expansions of Medicaid and the creation of the Children's Health Insurance Program (CHIP). The ACA primarily improved children's coverage rates by increasing the likelihood that eligible children would be enrolled in Medicaid/CHIP when their parents obtained coverage, simplifying eligibility and enrollment procedures, funding new outreach and enrollment efforts, and establishing the individual mandate. Some children benefited from newly available subsidized coverage in the ACA Marketplaces as well.

While children's health coverage rates had been improving for many years prior to 2014, the ACA pushed uninsured rates and numbers for children to their lowest levels on record in 2016. However, since 2016 the nation's progress has reversed course. Starting early in 2017, the new Administration and Congress made an unsuccessful attempt to repeal the Affordable Care Act and deeply cut Medicaid. At the end of 2017, Congress repealed the individual mandate penalty and delayed the extension of the Children's Health Insurance Program (CHIP) for many months—resulting in confusion for families and an ensuing delay in the distribution of CHIP outreach and enrollment grants missing the critical back-to-school outreach opportunity.[2] At a time when families need more help navigating the confusing health coverage landscape, fewer resources are available for ACA outreach and enrollment efforts as a result of cuts made by the Administration in 2017.[3]

In addition, there are clear signs that efforts over many years to streamline Medicaid enrollment and renewal processes for children and their parents are slowing or turning around in many states with more frequent eligibility checks notably on the rise.[4] These factors have contributed to a diminishing infrastructure to support families in need of coverage and an "unwelcoming" climate that is less focused on ensuring that eligible children are enrolled and remain enrolled. Children's participation rates in Medicaid/CHIP went down slightly from 2016 to 2017—the first time that has happened since 2008, when participation began to be measured.[5]

Meanwhile, the Trump Administration has ramped up its rhetoric and policies targeting immigrant communities with a campaign of fear and hostility. These policies are now clearly deterring parents from enrolling their eligible children in Medicaid or CHIP—despite the fact that most of these children are U.S. citizens.[6]

From 2016 to 2018 there were more than 400,000 more children uninsured in the United States.[7] These losses were widespread with 15 states showing statistically significant increases in the number or rate of uninsured children, and usually both. Only one state (North Dakota) showed improvement during this 2-year time period. The lack of forward progress suggests that even well-intentioned states are hard

---

[1] Unless otherwise noted, all data in this report is based on a Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey data for the time period 2016 to 2018. Please see the methodology for more information. Our analysis of last year's data found that the rate and number of uninsured children increased for a one-year period—2016 to 2017. *See* Alker and Pham, "Nation's Progress on Children's Health Coverage Reverses Course," Georgetown University Center for Children and Families, November 2018.

[2] Brooks, T., "CMS Awards $48 million in Outreach Funds for Children's Coverage," Georgetown University Center for Children and Families SayAhh! Blog, July 9, 2019.

[3] *See* Brooks, T., Park, E., and Roygardner, L., "Medicaid and CHIP Enrollment Decline Suggest the Child Uninsured Rate May Rise Again," Georgetown University Center for Children and Families, May 2019, Figure 11.

[4] Artiga, S. and Pham, O., "Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage," Kaiser Family Foundation, September 24, 2019.

[5] Haley, J. et al., "Improvements in Uninsurance and Medicaid/CHIP Participation Among Children and Parents Stalled in 2017," Urban Institute, May, 2019.

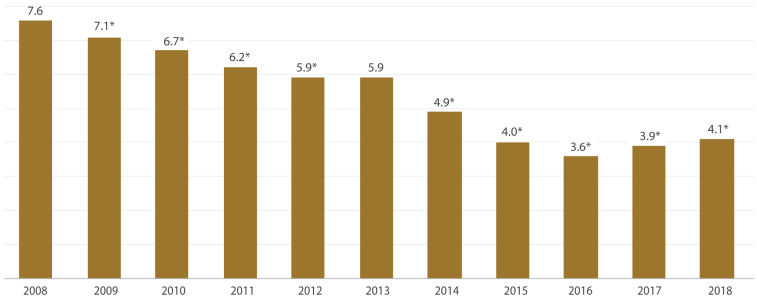
[6] Bernstein, H. et al., "With Public Charge Rule Looming, One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018," Urban Institute blog, May 2019.

[7] The Census Bureau's American Community Survey shows an increase of 406,000 children as noted in Appendix Table 1. The Census Bureau's Current Population Survey shows an increase of 425,000 uninsured children from 2017 to 2018. Berchik, E. and Mykta, L., "Children's Public Health Insurance Coverage Lower Than in 2017," U.S. Census Bureau, September 11, 2019.

pressed to overcome a negative national climate which is reducing children's enrollment in public coverage programs.

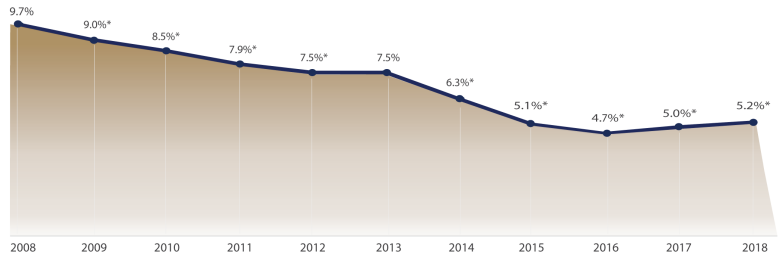
Over the 2-year period, according to the U.S. Census Bureau American Community Survey (ACS), the uninsured rate for children under 19 moved up half of a percentage point from 4.7 percent to 5.2 percent. Results from the Census Bureau's Current Population Survey show a similar jump in the uninsured rate for children from 2017 to 2018—from 5 percent to 5.5 percent.[8]

Figure 1. Number of Uninsured Children in the United States (in millions), 2008-2018



Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State - Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Figure 2. Rate of Uninsured Children, 2008-2018



Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State - Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Sources of coverage

In 2018, the largest source of coverage for children continued to be employer-sponsored insurance, though there was no statistically significant change between 2017 and 2018 despite the continued strong economy and low unemployment rates.[9] Medicaid/CHIP coverage also showed no statistically significant change for the one-year period 2017 to 2018, although administrative data clearly show that Medicaid/CHIP enrollment has declined substantially for children.[10] Comparable information

[8] Berchik, E. and Mykta L., *ibid.*

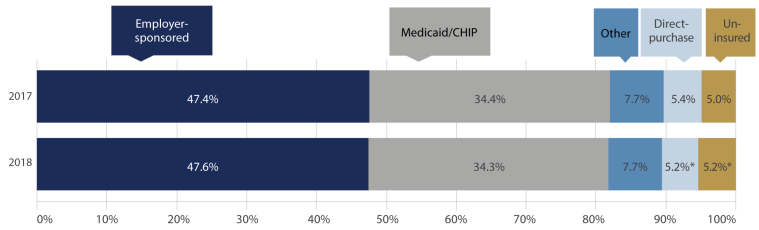
[9] At this time, we are unable to calculate the two-year trend and have examined one-year trends from 2017 to 2018 in Figure 3. When additional data becomes available later this year, we will issue an updated version of this chart. This is also the case for the income and race/ethnicity data displayed in Figures 4 and 5 both of which are one-year trends. Other figures represent two year trends, or longer, as indicated.

[10] Brooks, Park, and Roygardner, *op. cit.*

for 2016 was not available because of a change in the age range used by the Census Bureau. In assessing the 2018 Current Population Survey, the Census Bureau stated in September that the increase in the rate of uninsured children was "largely because of a decline in public coverage." That conclusion is consistent with our ACS findings from last year that found the increase in uninsured children from 2016 to 2017 occurred as Medicaid/CHIP enrollment dropped substantially.[11]

From 2017 to 2018, fewer children were enrolled in direct purchase (or non-group) coverage, which includes subsidized coverage through the federal and state Marketplaces established by the Affordable Care Act. That likely was the result of higher premiums in the non-group market inside and outside the Marketplaces due to actions taken by the Administration and elimination of the individual mandate penalty. The U.S. Centers for Medicare and Medicaid Services data show the number of children under age 18 in families selecting Marketplace plans nationwide during open enrollment actually declined by more than 64,000 between 2017 and 2018.[12] Data on children's enrollment in individual market plans purchased outside of the Marketplaces is not available, but the Congressional Budget Office recently estimated that overall non-elderly individual market enrollment outside of the Marketplaces fell by 1.1 million between 2017 and 2018, on top of a 1.4 million reduction between 2016 and 2017.[13] As a result, *the individual market inside and outside the Marketplaces likely did not provide an alternative coverage source for children losing their Medicaid and CHIP coverage in 2018.*

Figure 3. Sources of Children's Coverage, 2017-2018



Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017-2018 American Community Survey (ACS) data using 1-year estimates from Data.Census.Gov (B27010).

* Change is significant at the 90% confidence level relative to the prior year.

What are the demographic characteristics of uninsured children?

Income: As seen in Table 1, children from low- and moderate-income families earning between 138 percent and 250 percent of the federal poverty level ($29,435–$53,325 annually for a family of three) had the sharpest increase in their uninsured rate and the highest uninsured rate compared to other children. Most of these children are likely eligible for Medicaid or CHIP but not currently enrolled. The national median eligibility level for Medicaid/CHIP across states is 255 percent of federal poverty line.[14] However, there are some states whose CHIP eligibility is lower

---

[11] Alker and Pham, *op. cit.,* p. 3.

[12] Georgetown University Center for Children and Families analysis of Centers for Medicare and Medicaid Services Marketplace Open Enrollment period public use files for 2017, 2018 and 2019, available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html.* Enrollment in 64,257 from 1,068,082 in 2017 to 1,003,825 in 2018, with a reduction of another 21,052 between 2018 and 2019.

[13] *See* Congressional Budget Office, "Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018," *op. cit.* and Eibner, C. and Nowak, S., "The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors," (Washington: The RAND Corporation, July 2018), available at *https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors.*

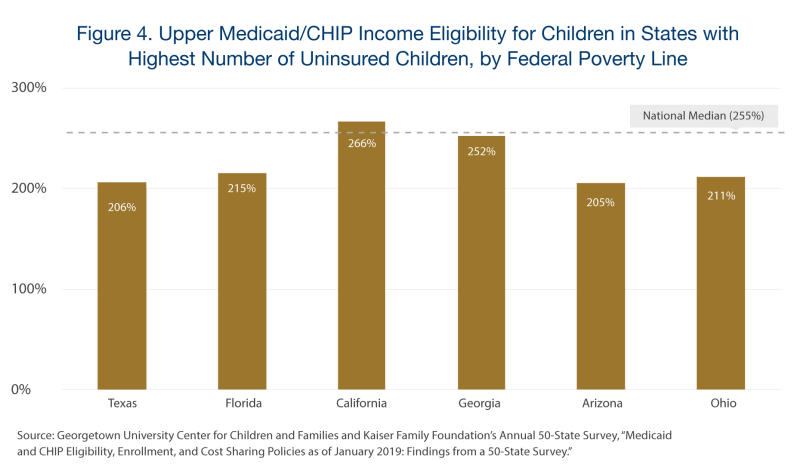
[14] Brooks, T., Roygardner, L. and Artiga, S. et al., "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings From a 50-State Survey," Georgetown University Center for Children and Families, available at *https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/.*

than this, which is likely contributing to the fact that they have large numbers of uninsured children—most notably Texas and Florida (see Figure 4).

Table 1. Percent of Uninsured Children by Census Poverty Threshold, 2017–2018

Poverty Threshold	2017	2018
0–137%	6.8%	6.8%
138–250%	6.9%	7.3%*
250% or above	3.2%	3.5%*

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017–2018 American Community Survey (ACS) data using 1-year estimates from *Data.Census.Gov* (B27019).
*Change is significant at the 90% confidence level relative to the prior year.



Children from higher-income families are also seeing increases in their uninsured rates, though those rates are still considerably lower than the national average. This likely reflects the rapidly increasing cost of employer-sponsored family coverage,[15] reduced participation in subsidized Marketplace coverage, and the repeal of the individual mandate penalty. The "family glitch" may be contributing to the difficulties that families are facing in accessing marketplace subsidies.[16]

Race and Ethnicity: While comparable 2016 data was not available for this indicator, the one-year trend from 2017 to 2018 shows a clear pattern that *Hispanic children (who can be of any race) are seeing significant increases in their uninsured rates* (see Figure 5). These children already have very high rates of uninsurance, and increases are likely the result of a "chilling effect" where mixed status and immigrant families with a parent who is an immigrant and a child who is a citizen are reluctant to enroll their child in public coverage for fear of deportation or being deemed a "public charge."[17] (It is important to note that the proposed public charge rule changes have been temporarily blocked by courts.

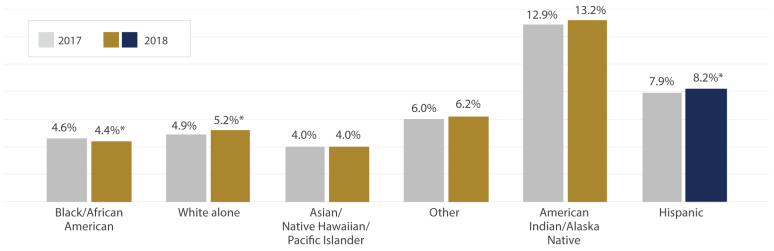
Even if the changes proceed, children's use of Medicaid, in and of itself, will not affect a parent's determination of being a public charge.) Similarly, the Census Bu-

[15] *See* Claxton, G. et al., "Health Benefits in 2019: Premiums Inch Higher and Employers Respond to Federal Policy," *Health Affairs,* September 25, 2019.
[16] Whitener, K. et al., "Future of Children's Health Coverage: Children in the Marketplace," Georgetown University Center for Children and Families, June 2016, p. 7.
[17] *See* Artiga, S., Garfield, R., and Damico, A., "Estimated Impacts of Final Public Charge Inadmissibility Rule on Immigrants and Medicaid Coverage," Kaiser Family Foundation, September 18, 2019.

reau's Current Population Survey shows a very large increase of 1 percentage point in the rate of uninsured Hispanic children.[18]

White children also saw a statistically significant increase in their uninsured rate from 4.9 percent to 5.2 percent, while African American children actually saw a slight improvement and have the lowest rate of uninsured children apart from Asian/Native Hawaiian/Pacific Islander children.

Figure 5. Children's Uninsured Rate by Race and Ethnicity, 2017-2018



Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017-2018 American Community Survey (ACS) data using 1-year estimates from Data.Census.Gov (C27001A-I).

*Change is significant at the 90% confidence level relative to the prior year.

Note: Hispanic refers to a person's ethnicity, therefore Hispanic individuals may be of any race.

Age: A disturbing trend is emerging for babies, toddlers and preschool age children whose uninsured rates are increasing. As Table 2 shows, from 2016 to 2018, their uninsured rate jumped from 3.8 percent to 4.3 percent—*an increase of over 13 percent.* Similarly, the Current Population Survey shows a decline in Medicaid/CHIP for this age group and an even bigger increase in their uninsured rate—from 4.5 percent to 5.3 percent.[19] Young children have long had the lowest uninsured rates but this positive trend has been reversed, and their rate now approaches the national average for all children. The importance of regular preventive care, immunizations, routine care and developmental screenings at this age underscores how essential it is for these young children to have continuous coverage.[20] Older children (age 6 to 18) also saw a significant increase in their uninsured rate from 2017 to 2018 moving up from 5.4 percent to 5.6 percent.

Table 2. Uninsurance Rates by Age, 2016–2018

Age	2016	2018
Under 6 years old	3.8%	4.3%*

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017–2018 American Community Survey (ACS) data using 1-year estimates from *Data.Census.Gov* (B27001).

*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

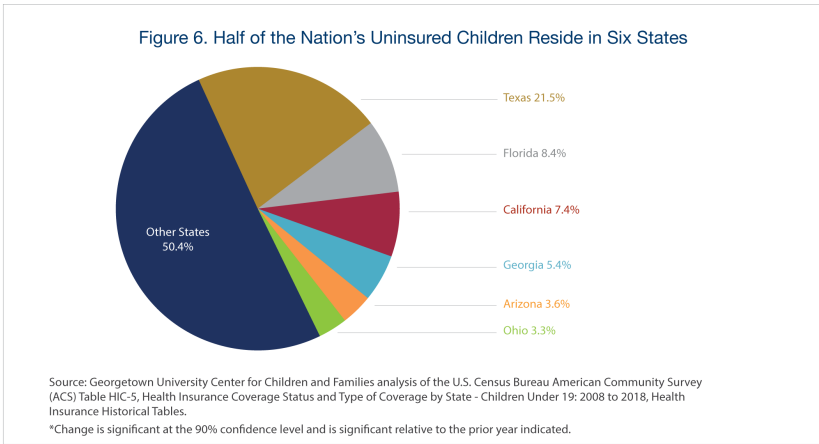
Where do uninsured children live?

Approximately half of the nation's uninsured children reside in six states (see Figure 6). More than one in five live in Texas alone. Florida, California, and Georgia all have more than 200,000 uninsured children. Appendix Table 1 shows the state-by-state breakdown of where the nation's 4,055,000 uninsured children reside.

[18] Berchick, E., *op. cit.*

[19] *Ibid.*

[20] Georgetown University Center for Children and Families is preparing a companion report looking specifically at this age cohort.



Uninsured children are much more likely to live in the South as Table 3 shows. *While 39 percent of the nation's children live in the South, 53 percent of uninsured children do.* No other region of the country has a larger share of uninsured children relative to their overall number of children.

Table 3. Share of Uninsured Children by Region, 2018

Geographic Region	Share of the Total Child Population	Number of Uninsured Children	Share of Nation's Uninsured Children	Uninsurance Rate
Midwest	21.0%	710,000	17.5%	4.3%
Northeast	15.9%	378,000	9.3%	3.1%
South	38.9%	2,142,000	52.8%	7.1%
West	24.2%	824,000	20.3%	4.4%
Total	100.0%	4,054,000	100.0%	5.2%

Midwest—IA, IN, IL, KS, MI, MN, MO, NE, ND, OH, SD, WI
Northeast—CT, ME, MA, NH, NJ, NY, PA, RI, VT
South—AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV
West—AZ, AK, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY
Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage by State—Children Under 19: 2008 to 2018 Health Insurance Historical Tables.
*Change is significant, at the 90% confidence level and is significant relative to the prior year indicated, Data may not sum due to rounding.

Six of the top 10 counties with the highest number of uninsured children are in the South (see Table 4).

Table 4. Top 10 Counties With the Highest Number of Uninsured Children, 2018

County	Total Child Population	Number of Uninsured Children	Rate of Uninsured Children	County Rank by Highest Number of Uninsured Children
United States	77,817,110	4,055,370	5.2%	–
Harris County, TX	1,316,616	166,019	12.6%	1
Dallas County, TX	725,809	110,627	15.2%	2

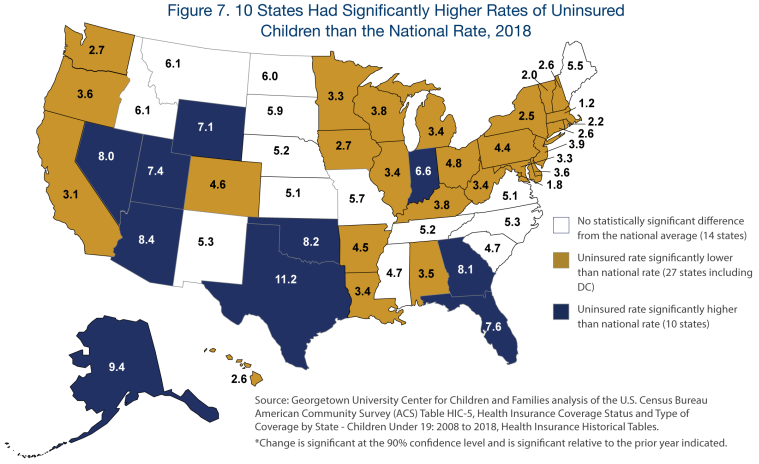
Table 4. Top 10 Counties With the Highest Number of Uninsured Children, 2018—Continued

County	Total Child Population	Number of Uninsured Children	Rate of Uninsured Children	County Rank by Highest Number of Uninsured Children
Maricopa County, AZ	1,111,591	91,989	8.3%	3
Los Angeles County, CA	2,319,159	80,971	3.5%	4
Tarrant County, TX	579,751	62,622	10.8%	5
Cook County, IL	1,191,757	47,618	4.0%	6
Hidalgo County, TX	297,617	46,530	15.6%	7
Bexar County, TX	537,946	44,137	8.2%	8
Miami-Dade County, FL	590,331	41,534	7.0%	9
Clark County, NV	541,860	38,863	7.2%	10

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017–2018 Amercian Community Survey (ACS) data using 1-year estimates from *Data.Census.Gov* (B27010).

As Figure 7 shows, 10 states have child uninsured rates that are significantly higher than the national average. These states (in order of highest rates) are Texas, Alaska, Arizona, Oklahoma, Georgia, Nevada, Florida, Utah, Wyoming, and Indiana. Twenty-seven states are doing better than the national average.

Figure 7. 10 States Had Significantly Higher Rates of Uninsured Children than the National Rate, 2018



Which states have the worst trends?

During the time period examined, no state except North Dakota, went in the right direction. This suggests that it will be very difficult for any state, especially for those with high rates of uninsured children, to continue moving in the right direction until the prevailing national climate changes. *Twelve states (Alabama, Arizona, Florida, Georgia, Illinois, Missouri, North Carolina, Ohio, Tennessee, Texas, Utah, and West Virginia) saw statistically significant increases in both the number and rate of uninsured children from 2016 to 2018.* Three additional states (Idaho, Indiana, and Montana) saw significant increases in either the number or rate during the same period (see Tables 5 and 6).

Table 5 shows the states with significant increases in their uninsured rate—which is the best indicator to compare across states to account for their different sizes. The

states with increases in their uninsured rates of 1 percentage point or higher are: Tennessee, Georgia, Texas, Utah, West Virginia, Florida and Ohio.

Table 6 shows states with the biggest percentage jumps in the number of uninsured children. West Virginia, Tennessee, Idaho, Alabama, Ohio, and Montana all saw increases of 25 percent or more in their number of uninsured children.

Table 5. 13 States With Significant Increase in Rate of Uninsured Children, 2016–2018

State	2016	2018	Percentage Point Change
Tennessee	3.7%	5.2%	1.5%
Georgia	6.7%	8.1%	1.4%
Texas	9.8%	11.2%	1.4%
Utah	6.0%	7.4%	1.4%
West Virginia	2.3%	3.4%	1.1%
Florida	6.6%	7.6%	1.0%
Ohio	3.8%	4.8%	1.0%
Missouri	4.8%	5.7%	0.9%
Alabama	2.7%	3.5%	0.8%
Arizona	7.6%	8.4%	0.8%
Illinois	2.6%	3.4%	0.8%
Indiana	5.9%	6.6%	0.7%
North Carolina	4.7%	5.3%	0.6%

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Table 6. 14 States With Significant Increase in Number of Uninsured Children, 2016–2018

State	2016–2018 Change in the Number of Uninsured	2016–2018 Percent Change
West Virginia	4,000	44.4%
Tennessee	25,000	43.1%
Idaho	7,000	31.8%
Alabama	9,000	28.1%
Ohio	29,000	27.9%
Montana	3,000	25.0%
Illinois	20,000	24.4%
Utah	13,000	22.0%
Georgia	38,000	21.2%
Florida	51,000	17.7%

Table 6. 14 States With Significant Increase in Number of Uninsured Children, 2016–2018—Continued

State	2016–2018 Change in the Number of Uninsured	2016–2018 Percent Change
Missouri	12,000	16.9%
Texas	121,000	16.1%
North Carolina	15,000	13.0%
Arizona	14,000	10.6%

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

States that have not expanded Medicaid are lagging even further behind. States that have not expanded Medicaid to parents and other adults earning 138 percent of the federal poverty level or below are more likely to have higher rates of uninsured children to begin with, and the situation in those states is worsening more rapidly (see Figures 8 and 9). It is well established that when states offer coverage to the whole family, children are more likely to be enrolled.

As Figure 8 shows, the rate of uninsured children grew three times as fast from 2016 to 2018 in states that have not expanded Medicaid compared to states that expanded Medicaid. These results are generally similar to those found by the Census Bureau in its recent report using CPS data.

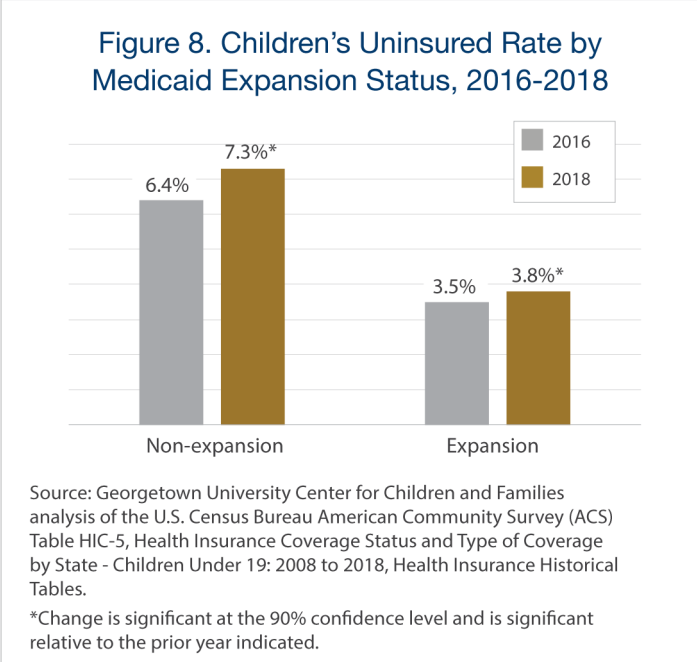
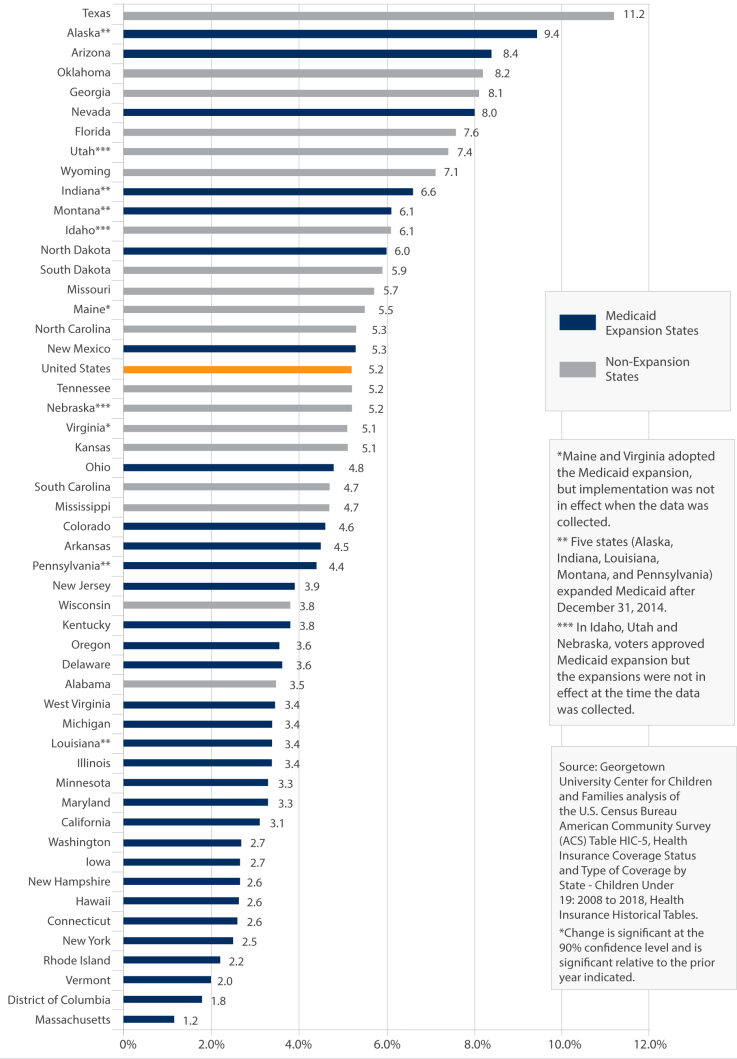


Figure 9. Children's Uninsurance Rates in Medicaid Expansion States and Non-Expansion States, 2018



Conclusion

The alarming increase in the number of uninsured children—up by more than 400,000 children between 2016 and 2018—reverses a longstanding, positive trend that was driven by a bipartisan commitment to children's health coverage and, more recently, implementation of the ACA. The state-by-state analysis found this reversal is widespread, with only one state showing improvement on this critical child health metric. This is particularly troubling as more children became uninsured during a period of economic growth when more people are working and earning more and children should be gaining coverage.

This serious erosion of child health coverage is likely due in large part to the Trump Administration's actions that have made health coverage harder to access and have deterred families from enrolling their eligible children in Medicaid and CHIP. These actions include attempting to repeal the ACA and deeply cut Medicaid, cutting outreach and advertising funds, encouraging states to put up more red tape barriers that make it harder for families to enroll or renew their eligible children in Medicaid or CHIP (or ignoring it when they do), eliminating the ACA's individual mandate penalty, and creating a pervasive climate of fear and confusion for immigrant families. That has left many of these families reluctant to enroll their (largely) citizen children in public coverage for fear of having this held against them.

Continuous health coverage is essential for children—improving their access to needed preventive and routine care, improving their health, educational and economic outcomes as adults, and protecting their families from medical debt and bankruptcy when a child breaks a bone, or worse, has cancer.

There are no signs that this disturbing trend in children's health coverage will abate unless national and state leaders fully rededicate themselves on a bipartisan basis to the goal of ensuring that all children have access to affordable, comprehensive health insurance.

Methodology

Data Sources and Historic Changes to Age Categories for Children

The data presented in this brief derive from the U.S. Census Bureau's annual American Community Survey (ACS) as presented in two sources: (1) Health Insurance Historical Table HIC–05, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018; and (2) the Census Bureau's new data platform, *Data.Census.Gov.* Where only number estimates are available, percent estimates were computed based on formulas provided in the 2018 ACS's "Instructions for Applying Statistical Testing to ACS 1-Year Data."

In order to better align with the current health landscape, the age categories of the 2017 (and 2018) ACS health insurance tables (in American Fact Finder, now *Data.Census.Gov*) were updated so that the age group for children includes individuals age 18 and younger. In 2016 and previous years, the age group for children included individuals age 17 and younger. Therefore, this report uses the HIC–05 table for analysis of 2-year data trends over the period 2016–2018, while using *Data.Census.Gov* for analysis of certain one-year data trends between 2017 and 2018 (with the exception of children under 6 as the change in age range did not impact this group for purposes of 2016 data). Given that the second data source *(Data.Census.Gov)* is limited to exploring an annual trend from 2017–2018, we plan to release an addendum to this report in late Winter 2019 when the IPUMS microdata files become available to explore the two-year trend (2016–2018) for health coverage sources, race/ethnicity and FPL uninsurance changes.

For this report and most previous similar reports, we have examined 2-year trends in the ACS data (in this case, 2016–2018). On two occasions we have departed from this methodology when a significant 1-year change occurred (2013–2014) after the Affordable Care Act was implemented; and 2016–2017 when the number of uninsured children began increasing as a result of efforts to pull back coverage and when Census also changed the age category for children in the ACS).

Margin of Error

The published U.S. Census Bureau data provide a margin of error (potential error bounds for any given estimate) at a 90-percent confidence level. All significance testing was conducted using the Census' Statistical Testing Tool. Except where noted, reported differences of percent or number estimates (either between groups, coverage sources, or years) are statistically significant at a confidence level of 90 percent. Georgetown CCF does not take the margin of error into account when ranking states by the number and percent of the uninsured children by state. Minor differences in state rankings may not be statistically significant. Where estimates were combined to produce new estimates, margin of error results were computed following the U.S. Census' formulas in their April 18, 2018, presentation entitled, "Using American Community Survey Estimates and Margins of Error" by Sirius Fuller.

Geographic Location

We report regional data as defined by the Census Bureau. The ACS produces single-year estimates for all geographic areas with a population of 65,000 or more, which includes all regions, states (including the District of Columbia), and country and county equivalents.

Poverty Status

Data on poverty levels include only those individuals for whom the poverty status can be determined for the past year. Therefore, this population is slightly smaller than the total non-institutionalized population of the U.S. (the universe used to calculate all other data in the brief). The Census Bureau determines an individual's poverty status by comparing that person's income in the past 12 months to poverty thresholds that account for family size and composition, as well as various types of income. (Note that the Census definition of income may vary considerably from how state Medicaid and CHIP programs measure income for purposes of determining eligibility due to differences in how income is counted and household size is determined and other factors.)

Health Coverage

Data on sources of health insurance coverage are point-in-time estimates that convey whether a person has coverage at the time of the survey. Individuals can report more than one source of coverage, so such totals may add to more than 100 percent. Additionally, the estimates are not adjusted to address the Medicaid "undercount" often found in surveys when compared to federal and state administrative data, which, for example, may be accentuated by the absence of state-specific health insurance program names in the ACS.

We report children covered by Medicare, TRICARE/military, VA, or two or more types of health coverage as being covered by an "other" source of health coverage. The Census Bureau provides the following categories of coverage for respondents to indicate sources of health insurance: current or former employer, purchased directly from an insurance company, Medicare, Medicaid or means-tested (includes CHIP), TRICARE or other military health coverage, VA, Indian Health Service (IHS), or other. People who indicate IHS as their only source of health coverage do not have comprehensive coverage according to ACS survey definitions and are therefore considered to be uninsured.

Demographic Characteristics

"Children" are defined as those individuals age 18 and under. The ACS provides one-year health insurance coverage estimates for the following race/ethnicity categories in tables C27001A–I: (A–White alone, B–Black/African-American, C–AI/AN, D–Asian, E–Native Hawaiian/Pacific Islander, F–Some other race, G–More than 1 race, H–White, Non-Hispanic, and I–Hispanic). The Census Bureau recognizes and reports race and Hispanic origin (*i.e.,* ethnicity) as separate and distinct concepts and variables. To report on an individual's race, we merge the data for "Asian alone" and "Native Hawaiian or other Pacific Islander alone." In addition, we report the ACS category "some other race alone" and "two or more races" as "other." Except for "other", all racial categories refer to respondents who indicated belonging to only one race. We report "Hispanic or Latino," as "Hispanic." As this refers to a person's ethnicity, Hispanic and non-Hispanic individuals may be of any race. For more detail on how the ACS defines racial and ethnic groups, see "American Community Survey and Puerto Rico Community Survey 2015 Subject Definitions."

Appendix Table 1. Number of Uninsured Children Under Age 19, 2016–2018

State	2016 Number Uninsured	2016 State Ranking	2018 Number Uninsured	2018 State Ranking
United States	3,649,000	–	4,055,000	–
Alabama	32,000	22	41,000	26
Alaska	20,000	14	18,000	13
Arizona	132,000	47	146,000	47
Arkansas	30,000	20	34,000	21

Appendix Table 1. Number of Uninsured Children Under Age 19, 2016–2018—Continued

State	2016 Number Uninsured	2016 State Ranking	2018 Number Uninsured	2018 State Ranking
California	300,000	50	299,000	49
Colorado	57,000	33	62,000	33
Connecticut	23,000	17	20,000	15
Delaware	7,000	4	8,000	5
District of Columbia	4,000	2	2,000	1
Florida	288,000	49	339,000	50
Georgia	179,000	48	217,000	48
Hawaii	8,000	5	8,000	5
Idaho	22,000	16	29,000	19
Illinois	82,000	40	102,000	40
Indiana	99,000	41	109,000	43
Iowa	20,000	14	21,000	16
Kansas	34,000	23	38,000	23
Kentucky	35,000	24	40,000	25
Louisiana	39,000	26	39,000	24
Maine	13,000	10	15,000	11
Maryland	49,000	29	47,000	28
Massachusetts	15,000	12	18,000	13
Michigan	71,000	36	78,000	35
Minnesota	46,000	27	45,000	27
Mississippi	37,000	25	35,000	22
Missouri	71,000	36	83,000	37
Montana	12,000	9	15,000	11
Nebraska	25,000	18	26,000	17
Nevada	50,000	30	58,000	32
New Hampshire	8,000	5	7,000	4
New Jersey	78,000	38	80,000	36
New Mexico	28,000	19	27,000	18
New York	113,000	44	107,000	42
North Carolina	115,000	45	130,000	45
North Dakota	15,000	12	11,000	8
Ohio	104,000	43	133,000	46

Appendix Table 1. Number of Uninsured Children Under Age 19, 2016–2018—Continued

State	2016 Number Uninsured	2016 State Ranking	2018 Number Uninsured	2018 State Ranking
Oklahoma	79,000	39	83,000	37
Oregon	31,000	21	33,000	20
Pennsylvania	126,000	46	124,000	44
Rhode Island	5,000	3	5,000	3
South Carolina	50,000	30	56,000	31
South Dakota	11,000	8	13,000	9
Tennessee	58,000	34	83,000	37
Texas	752,000	51	873,000	51
Utah	59,000	35	72,000	34
Vermont	2,000	1	2,000	1
Virginia	99,000	41	102,000	40
Washington	46,000	27	47,000	28
West Virginia	9,000	7	13,000	9
Wisconsin	50,000	30	51,000	30
Wyoming	13,000	10	10,000	7

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Appendix Table 2. Percent of Uninsured Children Under 19, 2016–2018

State	2016 Percent Uninsured	2016 State Ranking	2018 Percent Uninsured	2018 State Ranking
United States	4.7	–	5.2	–
Alabama	2.7	9	3.5	18
Alaska	10.3	51	9.4	50
Arizona	7.6	46	8.4	49
Arkansas	4.0	26	4.5	25
California	3.1	13	3.1	11
Colorado	4.3	27	4.6	26
Connecticut	2.8	12	2.6	6
Delaware	3.1	13	3.6	19
District of Columbia	3.1	13	1.8	2
Florida	6.6	43	7.6	45
Georgia	6.7	44	8.1	47
Hawaii	2.5	5	2.6	6

Appendix Table 2. Percent of Uninsured Children Under 19, 2016–2018—Continued

State	2016 Percent Uninsured	2016 State Ranking	2018 Percent Uninsured	2018 State Ranking
Idaho	4.9	36	6.1	40
Illinois	2.6	7	3.4	14
Indiana	5.9	41	6.6	42
Iowa	2.6	7	2.7	9
Kansas	4.5	30	5.1	30
Kentucky	3.3	17	3.8	21
Louisiana	3.3	17	3.4	14
Maine	4.8	33	5.5	36
Maryland	3.4	19	3.3	12
Massachusetts	1.0	1	1.2	1
Michigan	3.1	13	3.4	14
Minnesota	3.4	19	3.3	12
Mississippi	4.8	33	4.7	27
Missouri	4.8	33	5.7	37
Montana	4.9	36	6.1	40
Nebraska	5.1	39	5.2	32
Nevada	7.0	45	8.0	46
New Hampshire	2.7	9	2.6	6
New Jersey	3.7	22	3.9	23
New Mexico	5.3	40	5.3	34
New York	2.5	5	2.5	5
North Carolina	4.7	31	5.3	34
North Dakota	8.0	48	6.0	39
Ohio	3.8	25	4.8	29
Oklahoma	7.7	47	8.2	48
Oregon	3.4	19	3.6	19
Pennsylvania	4.4	29	4.4	24
Rhode Island	2.2	3	2.2	4
South Carolina	4.3	27	4.7	27
South Dakota	4.7	31	5.9	38
Tennessee	3.7	22	5.2	32
Texas	9.8	50	11.2	51

Appendix Table 2. Percent of Uninsured Children Under 19, 2016–2018—Continued

State	2016 Percent Uninsured	2016 State Ranking	2018 Percent Uninsured	2018 State Ranking
Utah	6.0	42	7.4	44
Vermont	1.5	2	2.0	3
Virginia	5.0	38	5.1	30
Washington	2.7	9	2.7	9
West Virginia	2.3	4	3.4	14
Wisconsin	3.7	22	3.8	21
Wyoming	8.8	49	7.1	43

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Appendix Table 3. Change in the Number of Uninsured Children Under 19, 2016 and 2018

State	2016 Number Uninsured	2018 Number Uninsured	2016–2018 Change in Number of Uninsured	2016–2018 Percent Change
United States	3,649,000	4,055,000	406,000*	11.1%
Alabama	32,000	41,000	9,000*	28.1%
Alaska	20,000	18,000	(2,000)	– 10.0%
Arizona	132,000	146,000	14,000*	10.6%
Arkansas	30,000	34,000	4,000	13.3%
California	300,000	299,000	(1,000)	– 0.3%
Colorado	57,000	62,000	5,000	8.8%
Connecticut	23,000	20,000	(3,000)	– 13.0%
Delaware	7,000	8,000	1,000	14.3%
District of Columbia	4,000	2,000	(2,000)	– 50.0%
Florida	288,000	339,000	51,000*	17.7%
Georgia	179,000	217,000	38,000*	21.2%
Hawaii	8,000	8,000	–	0%
Idaho	22,000	29,000	7,000*	31.8%
Illinois	82,000	102,000	20,000*	24.4%
Indiana	99,000	109,000	10,000	10.1%
Iowa	20,000	21,000	1,000	5.0%
Kansas	34,000	38,000	4,000	11.8%
Kentucky	35,000	40,000	5,000	14.3%
Louisiana	39,000	39,000	–	0%

Appendix Table 3. Change in the Number of Uninsured Children Under 19, 2016 and 2018—Continued

State	2016 Number Uninsured	2018 Number Uninsured	2016–2018 Change in Number of Uninsured	2016–2018 Percent Change
Maine	13,000	15,000	2,000	15.4%
Maryland	49,000	47,000	(2,000)	−4.1%
Massachusetts	15,000	18,000	3,000	20.0%
Michigan	71,000	78,000	7,000	9.9%
Minnesota	46,000	45,000	(1,000)	−2.2%
Mississippi	37,000	35,000	(2,000)	−5.4%
Missouri	71,000	83,000	12,000*	16.9%
Montana	12,000	15,000	3,000*	25.0%
Nebraska	25,000	26,000	1,000	4.0%
Nevada	50,000	58,000	8,000	16.0%
New Hampshire	8,000	7,000	(1,000)	−12.5%
New Jersey	78,000	80,000	2,000	2.6%
New Mexico	28,000	27,000	(1,000)	−3.6%
New York	113,000	107,000	(6,000)	−5.3%
North Carolina	115,000	130,000	15,000*	13.0%
North Dakota	15,000	11,000	(4,000)*	−26.7%
Ohio	104,000	133,000	29,000*	27.9%
Oklahoma	79,000	83,000	4,000	5.1%
Oregon	31,000	33,000	2,000	6.5%
Pennsylvania	126,000	124,000	(2,000)	−1.6%
Rhode Island	5,000	5,000	-	0%
South Carolina	50,000	56,000	6,000	12.0%
South Dakota	11,000	13,000	2,000	18.2%
Tennessee	58,000	83,000	25,000*	43.1%
Texas	752,000	873,000	121,000*	16.1%
Utah	59,000	72,000	13,000*	22.0%
Vermont	2,000	2,000	–	0%
Virginia	99,000	102,000	3,000	3.0%
Washington	46,000	47,000	1,000	2.2%
West Virginia	9,000	13,000	4,000*	44.4%
Wisconsin	50,000	51,000	1,000	2.0%

Appendix Table 3. Change in the Number of Uninsured Children Under 19, 2016 and 2018—Continued

State	2016 Number Uninsured	2018 Number Uninsured	2016–2018 Change in Number of Uninsured	2016–2018 Percent Change
Wyoming	13,000	10,000	(3,000)	−23.1%

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Appendix Table 4. Change in the Percent of Uninsured Children Under 19, 2016–2018

State	2016 Percent Uninsured	2018 Percent Uninsured	2016–2018 Percentage Point Change
United States	4.7	5.2	0.5*
Alabama	2.7	3.5	0.8*
Alaska	10.3	9.4	−0.9
Arizona	7.6	8.4	0.8*
Arkansas	4.0	4.5	0.5
California	3.1	3.1	0
Colorado	4.3	4.6	0.3
Connecticut	2.8	2.6	−0.2
Delaware	3.1	3.6	0.5
District of Columbia	3.1	1.8	−1.3
Florida	6.6	7.6	1.0*
Georgia	6.7	8.1	1.4*
Hawaii	2.5	2.6	0.1
Idaho	4.9	6.1	1.2
Illinois	2.6	3.4	0.8*
Indiana	5.9	6.6	0.7*
Iowa	2.6	2.7	0.1
Kansas	4.5	5.1	0.6
Kentucky	3.3	3.8	0.5
Louisiana	3.3	3.4	0.1
Maine	4.8	5.5	0.7
Maryland	3.4	3.3	−0.1
Massachusetts	1.0	1.2	0.2
Michigan	3.1	3.4	0.3
Minnesota	3.4	3.3	−0.1

Appendix Table 4. Change in the Percent of Uninsured Children Under 19, 2016–2018—Continued

State	2016 Percent Uninsured	2018 Percent Uninsured	2016–2018 Percentage Point Change
Mississippi	4.8	4.7	−0.1
Missouri	4.8	5.7	0.9*
Montana	4.9	6.1	1.2
Nebraska	5.1	5.2	0.1
Nevada	7.0	8.0	1.0
New Hampshire	2.7	2.6	−0.1
New Jersey	3.7	3.9	0.2
New Mexico	5.3	5.3	0
New York	2.5	2.5	0
North Carolina	4.7	5.3	0.6*
North Dakota	8.0	6.0	−2.0*
Ohio	3.8	4.8	1.0*
Oklahoma	7.7	8.2	0.5
Oregon	3.4	3.6	0.2
Pennsylvania	4.4	4.4	0
Rhode Island	2.2	2.2	0
South Carolina	4.3	4.7	0.4
South Dakota	4.7	5.9	1.2
Tennessee	3.7	5.2	1.5*
Texas	9.8	11.2	1.4*
Utah	6.0	7.4	1.4*
Vermont	1.5	2.0	0.5
Virginia	5.0	5.1	0.1
Washington	2.7	2.7	0
West Virginia	2.3	3.4	1.1*
Wisconsin	3.7	3.8	0.1
Wyoming	8.8	7.1	−1.7

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Table HIC–5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2018, Health Insurance Historical Tables.
*Change is significant at the 90% confidence level and is significant relative to the prior year indicated.

Endnotes

1. Hudson, J.L. and Moriya, A.S. (2017), "Medicaid expansion for adults had measurable 'welcome mat' effects on their children," *Health Affairs,* 36, n.p. Retrieved from *https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347; also see* Committee on the Consequences of Uninsurance, Institute of Medicine, and Burak, E.W.

(2019), "Parents' and caregivers' health insurance supports children's healthy development," Society for Research in Child Development Child Evidence Brief, 4. Retrieved from *https://www.srcd.org/sites/default/files/resources/%E2%80%A2FINAL%20Child%20Evidence%20Brief%20No4_*HealthInsurance.pdf.
2. Berchick, E., *op. cit.*

SUBMITTED BY HON. ROBERT P. CASEY, JR.,
A U.S. SENATOR FROM PENNSYLVANIA

Medicaid Expansion in Pennsylvania

Comments of Teresa Miller, Secretary of the Department of Human Services

October 30, 2019

Thank you for the opportunity to submit these comments on the impact of Medicaid expansion in Pennsylvania.

Governor Tom Wolf announced in February 2015 that Pennsylvania would join what was then 31 states and the District of Columbia in expanding Medicaid as permitted under the Patient Protection and Affordable Care Act. Since then, Medicaid expansion has had an overwhelmingly positive impact on Pennsylvanians across the commonwealth.

Presently, over 680,000 individuals have health care coverage because of Medicaid expansion. More than 1.4 million people—or about 1 in 7 Pennsylvanians aged 19–64—have been covered by Medicaid expansion since February 2015. The expansion has also contributed to historic lows in Pennsylvania's uninsured rate, which fell from 8.9 percent in 2014 before expansion to 5.5 percent in 2018.

Medicaid expansion provides quality health-care coverage to working Pennsylvanians, students, and Pennsylvanians not yet eligible for Medicare. It is a lifeline for people who otherwise cannot access or afford health insurance. Expanding Medicaid helped people who had gone uninsured for years to access basic health care, opening access to routine health screenings and prescription coverage that allow people to manage their health.

Medicaid expansion also saves lives. Services covered by Medicaid help people maintain their health, access treatment for a substance use disorder, and identify potentially life-threatening illnesses and treat them without fear of financial ruin. In 2017, Medicaid expansion covered 485,151 doctor's office visits, 79,997 cervical cancer screenings, 54,061 breast cancer screenings, 31,042 colon cancer screenings, and 22,401 prostate cancer screenings in Pennsylvania. These cancer screenings resulted in 1,598 breast cancer diagnoses, 843 cervical cancer diagnoses, 386 colon cancer diagnoses, and 769 prostate cancer diagnoses. That's 3,596 people in 2017 *alone* diagnosed with just these four forms of cancer—people who might not have been able to afford these screenings and subsequent treatment without Medicaid expansion. Again, Medicaid expansion saves lives. Don't just take my word for it.

Brian, a resident of Bucks County, gained coverage because of Medicaid expansion in March 2015 after being uninsured for nine years. Before he was able to access Medicaid, he relied on free clinics with limited capabilities for care. In 2016, he was diagnosed with stage three colon cancer. Medicaid expansion allowed him to go through surgery, chemotherapy, and post-treatment screenings knowing that he could focus on his health and not the fear of a bill that might put him in financial ruin. Where would he be without Medicaid expansion?

Shelagh, a resident of Allegheny County, had several injuries that progressed to chronic health conditions because she had very spotty access to health insurance before the Affordable Care Act passed. She had painful attacks she later learned were a result of an inflamed gallbladder, but it took 10 years for her to get a diagnosis. When she was uninsured, she had access to sliding scale clinics, but their diagnostic capabilities were limited because they didn't have equipment like MRIs. It wasn't until she qualified for Medicaid through the expansion that she was able to get a formal and was able to have her gallbladder removed. Before Medicaid expansion, she was not able to qualify for Medicaid and her pre-existing conditions made it impossible for her to get insurance through the private market.

Cindy, a resident of Lancaster County, had health insurance through her husband's job until their marriage ended and she was left uninsured and caring for a son with

disabilities. She qualified for Medicaid because of the expansion, and while covered, had pre-cancerous polyps removed following a routine colonoscopy. Eventually, Cindy was able to become a professional caregiver for her son and now has insurance through her employer. Medicaid expansion was a lifeline when she needed it most, and she credits it with saving her family.

These are just three of the many stories of how the Medicaid expansion helped Pennsylvanians, and they are three of the reasons why Governor Wolf and I will always fight any attempt to scale back or limit Medicaid expansion. I think these stories are important because sometimes we forget the human faces behind our programs, but it would be irresponsible and reprehensible to forget about these stories when making policy. Former Senator and Vice President Hubert Humphrey said the moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those in the shadows of life, the sick, the needy, and individuals with disabilities. If we in government are not constantly looking for ways to help the people we serve achieve better, healthier lives, then what are we doing?

When our people are healthier, our commonwealth is healthier. I can say confidently that Medicaid expansion is making Pennsylvania a better place to live. Make no mistake—any action that reverses the progress made by Medicaid expansion will risk the health and financial well-being of at least 680,000 people.

The effects of Medicaid expansion extend further than just helping people lead healthier lives. Hospitals cannot deny care even if a patient is uninsured. Costs associated with this—known as uncompensated care—are typically made up in rates for care paid by private insurance and other costs. These costs drive rising healthcare costs for all patients and payers. From 2001 to 2014, the amount of uncompensated care increased each year. However, this trend was reversed in the first year of Medicaid expansion, when uncompensated care costs experienced by hospitals in Pennsylvania fell by $92 million. Uncompensated care has continued in each year since Medicaid expansion was first implemented. This has resulted in a 30 percent or $317 million reduction from 2014 through 2018 in uncompensated care. As we in Pennsylvania and states around the nation look for opportunities to bend the health-care cost curve for government, hospitals and health systems, self-funded employers, and people in the private insurance market, we must acknowledge the value Medicaid expansion provides for hospitals' financial stability, especially in rural communities.

We also know that Medicaid expansion is helping people get healthy enough to maintain a job and succeed in employment. If we want people to work, we need a healthy, vibrant workforce. Research is showing that the expansion is helping more people enter the workforce, including people with disabilities, who formerly had to live in poverty to maintain Medicaid coverage.[1]

As we move forward, I hope we can celebrate the success of the Affordable Care Act's Medicaid expansion and continue to make quality, affordable health care accessible to more people. We've made tremendous progress, but there is still more work to be done. Let's build on this progress and not return to a world where people went without care they needed out of fear of financial ruin.

PREPARED STATEMENT OF DARYL G. PURPERA, CPA, CFE,
LEGISLATIVE AUDITOR, STATE OF LOUISIANA

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] Jean P. Hall, Adele Shartzer, Noelle K. Kurth, Kathleen C. Thomas, "Effect of Medicaid Expansion on Workforce Participation for People With Disabilities," *American Journal of Public Health* 107, no. 2 (February 1, 2017): pp. 262–264. *https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303543*.

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 3 years, our Medicaid Audit Unit has issued 16 reports, with 8 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.

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. 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 1 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 and 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 re-

sult 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.

MEDICAID ELIGIBILITY: WAGE VERIFICATION PROCESS OF THE EXPANSION POPULATION

LOUISIANA DEPARTMENT OF HEALTH
MEDICAID AUDIT UNIT

ISSUED NOVEMBER 8, 2018

LOUISIANA LEGISLATIVE AUDITOR
1600 North Third Street
Post Office Box 94397
BATON ROUGE, LOUISIANA 70804–9397

Legislative Auditor
DARYL G. PURPERA, CPA, CFE

Assistant Legislative Auditor for State Audit Services
NICOLE B. EDMONSON, CIA, CGAP, MPA

Director of Performance Audit Services
KAREN LEBLANC, CIA, CGAP, MSW

FOR QUESTIONS RELATED TO THIS PERFORMANCE AUDIT, CONTACT CHRIS MAGEE, PERFORMANCE AUDIT MANAGER, AT 225–339–3800.

Under the provisions of state law, this report is a public document. A copy of this report has been submitted to the Governor, to the Attorney General, and to other public officials as required by state law. A copy of this report is available for public inspection at the Baton Rouge office of the Louisiana Legislative Auditor and at the office of the parish clerk of court.

This document is produced by the Louisiana Legislative Auditor, State of Louisiana, Post Office Box 94397, Baton Rouge, Louisiana 70804–9397 in accordance with Louisiana Revised Statute 24:513. Twelve copies of this public document were produced at an approximate cost of $9.00. This material was produced in accordance with the standards for state agencies established pursuant to R.S. 43:31. This report is available on the Legislative Auditor's website at *www.lla.la.gov*. When contacting the office, you may refer to Agency ID No. 9726 or Report ID No. 80180130.

In compliance with the Americans With Disabilities Act, if you need special assistance relative to this document, or any documents of the Legislative Auditor, please contact Elizabeth Coxe, Chief Administrative Officer, at 225–339–3800.

LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804–9397
www.lla.la.gov
Phone 225–339–3800
Fax 225–339–3870

November 8, 2018

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras,
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report evaluates and identifies areas in which the Louisiana Department of Health (LDH) can strengthen its process of using wage data to determine eligibility of the Medicaid expansion population. Without a sufficient process to determine recipient eligibility, LDH cannot ensure that Medicaid dollars are spent appropriately.

The report contains our findings, conclusions, and recommendations. Appendix A contains the LDH's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of the LDH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Medicaid Eligibility: Wage Verification Process of the Expansion Population Louisiana Department of Health

November 2018

Audit Control #80180130

Introduction

The Louisiana Department of Health (LDH) administers the Medicaid program to provide health and medical services for uninsured and medically-indigent citizens. In 2012, LDH began moving from a fee-for-service (FFS) model, where LDH paid all claims submitted by Medicaid providers for each service performed, to Healthy Louisiana, a full-risk prepaid managed care model.[1] Under LDH's current full-risk prepaid managed care model, it pays a fixed per-member per-month (PMPM) fee to the Managed Care Organization (MCO) for the administration of health benefits and payment of all claims. LDH contracted with five[2] MCOs to operate the Healthy Louisiana Medicaid program through December 31, 2019. However, LDH is responsible for determining Medicaid recipient eligibility and enrolling applicants into Medicaid programs.

We evaluated LDH's process for using state wage data from the Louisiana Workforce Commission (LWC) when determining eligibility for the Medicaid expansion population. Federal law (42 CFR 435.948) states that agencies *must* request infor-

[1] Healthy Louisiana was previously called Bayou Health. A managed care model is an arrangement for health care in which an organization, such as an MCO, acts as a gatekeeper or intermediary between the person seeking care and the physician. FFS still covers some Medicaid recipients who are not eligible for managed care.

[2] LDH contracted with AmeriHealth Caritas Louisiana, Inc., Aetna Better Health, Inc., Healthy Blue, Louisiana Healthcare Connections, Inc., and UnitedHealthcare Community Plan of Louisiana, Inc. on February 1, 2015. AmeriHealth Caritas, Healthy Blue, and Louisiana Healthcare Connections originally contracted with LDH on February 1, 2012.

mation related to wages from state agencies to the extent the agency determines such information is useful to verifying the financial eligibility of Medicaid recipients and applicants. According to LDH's verification plan, caseworkers are required to verify wages at application and upon renewal. This report is the first in a series of two reports where we tested the eligibility of a sample of Medicaid recipients. The second report, scheduled to be issued later this month, evaluates the department's overall process for making eligibility determinations, not just the state wage verification process.

Medicaid Expansion and Eligibility. On July 1, 2016, Medicaid expansion, which provides full Medicaid benefits to individuals from age 19 to 65 years old making income below or equal to 138%[3] of the federal poverty level (or $16,395 per year a for single-person household), was implemented in Louisiana. Prior to Medicaid expansion, only individuals who were low-income persons and who were either 65 years or older, disabled, parents of dependent children, qualified pregnant women, or children were qualified for full Medicaid benefits. According to LDH, approximately 500,000 individuals who did not previously qualify for full Medicaid benefits were enrolled through Medicaid expansion in fiscal year 2017. Because income is the primary determinant for the eligibility of this population, it is important that LDH have a sufficient process to verify the wages of Medicaid recipients.

Medicaid Enrollment Process. LDH enrolls individuals in Medicaid in various ways. LDH accepts Medicaid applications[4] via the Internet, telephone, mail, in-person, and certified application centers. When applying for Medicaid, an applicant must attest to information regarding their residence, demographics, and income. LDH verifies the applicant's attested income using various data sources, such as quarterly wage data from the Louisiana Workforce Commission (LWC). LDH also accepts eligibility determinations from the federally facilitated marketplace (FFM) in which individuals needing health insurance can find and purchase health insurance plans operated by the U.S. Department of Health and Human Services. Beginning July 1, 2016, if the FFM determines that the applicant is eligible for Medicaid, LDH automatically enrolls them in Medicaid. In addition, when LDH expanded Medicaid beginning July 1, 2016, it streamlined enrollment for individuals participating in the Supplemental Nutrition Assistance Program (SNAP) and automatically enrolled certain populations, including individuals already participating in certain Medicaid fee-for-service (FFS) programs. These enrollment methods and whether LDH verifies wage information for each method are summarized in Exhibit 1.

Exhibit 1. Medicaid Expansion Enrollment Method and Income Verification

Enrollment Method	Description
Online/Paper Application	Applicants apply online or on a paper form for Medicaid benefits. **LDH checks the wages for these applicants prior to determining their eligibility for Medicaid.**
Federally Facilitated Marketplace (FFM) Determination	The FFM determines that the applicant is eligible for Medicaid and Louisiana accepts the eligibility determination made by the FFM without further data checks. Louisiana used this methodology from January 2015 through October 2015 and then again from July 2016 through present day. **LDH does not check the wages for these applicants prior to determining their eligibility for Medicaid.**
Fee-for-Service (FFS)	Recipients who were in fee-for-service plans prior to Medicaid expansion received services from providers primarily contracted directly with the state. These Medicaid recipients were automatically enrolled in Medicaid expansion. **LDH did not check wages for these recipients prior to determining their eligibility for Medicaid expansion.**

[3] From July 1, 2016, through February 28, 2017, 138% of the federal poverty level for a single-person household was $1,367 per month, or $16,395 annually. From March 1, 2017, through February 28, 2018, 138% of the federal poverty level for a single-person household was $1,387 per month, or $16,644 annually. Effective March 1, 2018, 138% of the federal poverty level for a single-person household is $1,397 per month, or $16,764 annually.

[4] Medicaid applications are considered to be the official agency document used to collect information necessary to determine eligibility.

Exhibit 1. Medicaid Expansion Enrollment Method and Income Verification—Continued

Enrollment Method	Description
Supplemental Nutrition Assistance Program (SNAP)	After answering four questions on a questionnaire appropriately, individuals who qualified for the SNAP program were enrolled in Medicaid expansion. **LDH did not check wages for these individuals prior to determining their eligibility for Medicaid expansion.**

Source: Prepared by legislative auditor's staff using information from LDH and the Centers for Medicare and Medicaid Services (CMS).

The purpose of our analysis was as follows:

To evaluate the sufficiency of LDH's process of using wage data to determine the eligibility of the Medicaid expansion population.

Our results are summarized on the next page and in detail throughout the remainder of the report. Appendix A contains LDH's response to this report, Appendix B details our scope and methodology, Appendix C shows the enrollment types and eligibility of the 100 Medicaid recipients in our targeted selection, Appendix D shows the enrollment types and eligibility of the 100 Medicaid recipients in our random sample, Appendix E provides a profile of each recipient in our targeted selection, Appendix F provides a profile of each recipient in our random selection, and Appendix G lists previously-issued Medicaid Audit Unit reports.

Objective: To evaluate the sufficiency of LDH's process of using wage data to determine the eligibility of the Medicaid expansion population.

We found that LDH's current process of using wage data at application and renewal to determine the eligibility of the Medicaid expansion population is not sufficient. To evaluate LDH's process, we compared Medicaid data obtained from LDH to quarterly wage data obtained from LWC to determine if LDH paid PMPMs for recipients in single-person households when their wages appeared to exceed the allowable amounts[5] to qualify for Medicaid. Our comparison identified a population of 19,789 Medicaid recipients who had average wages that appeared to exceed the allowable amount to qualify for Medicaid.

To evaluate LDH's process and identify any weaknesses, we first pulled a targeted selection of 100 single-person household Medicaid expansion recipients with the highest wage amounts and reviewed their electronic case records[6] to determine if they were eligible in the period during which they were enrolled in Medicaid from July 1, 2016, through March 31, 2018. We chose this specific population because they had wages that were higher than the allowable amount based on LWC wage data and because other states use a similar risk based methodology to test for changes in recipient wages. Because of the high ineligibility rate we found in this targeted selection, we pulled a random sample[7] of 100 single-person Medicaid expansion recipients, to determine the projected impact of the weaknesses identified in LDH's use of wage data in the eligibility process. We found the following:

- **93 (93.0%) of the 100 Medicaid recipients in the targeted selection did not qualify for $538,795 (66.3%) of the $813,023 in PMPMs LDH paid on their behalf at some point during their Medicaid coverage. This happened, in part, because LDH relies on Medicaid recipients to self-report changes in their wages rather than proactively using LWC wage data to identify changes in recipient wages that occur during the 12 months between application and renewal. LDH's policy decision to be a FFM determination state and caseworker errors also contributed to these ineligible recipients.** At least 20 other states indicated on their CMS verification plans that they check for changes in recipient wages on an interim basis.

[5] From July 1, 2016, through February 28, 2017, 138% of the federal poverty level for a single-person household was $1,367 per month, or $16,395 annually. From March 1, 2017, through February 28, 2018, 138% of the federal poverty level for a single-person household was $1,387 per month, or $16,644 annually. Effective March 1, 2018, 138% of the federal poverty level for a single-person household is $1,397 per month, or $16,764 annually.

[6] Documentation related to eligibility determinations is contained in the electronic case record for each Medicaid recipient. This includes applications, results of LWC wage data checks, and communication with the Medicaid recipient.

[7] There were two individuals from our targeted selection that were randomly selected to be included in the random sample.

- **82 (82.0%) of 100 Medicaid recipients in the random sample did not qualify for $382,420 (47.3%) of the $808,341 in PMPMs LDH paid on their behalf.**

Because this sample was random, we were able to project these results to the entire population of 19,226 single-person household Medicaid expansion recipients. Based on this projection, it appears that LDH may have paid between $61.6 million and $85.5 million in PMPMs for Medicaid recipients who did not qualify at some point during their Medicaid coverage. More frequent checks of LWC wage data could prevent a portion of these PMPMs from being paid on their behalf.

Our findings, along with recommendations to help LDH strengthen its wage verification process when determining eligibility for the Medicaid expansion population, are discussed in more detail on the following pages.

---

93 (93.0%) of the 100 Medicaid recipients in the targeted selection did not qualify for $538,795 (66.3%) of the $813,023 in PMPMs LDH paid on their behalf. This happened, in part, because LDH relies on Medicaid recipients to self-report changes in their wages rather than proactively using LWC wage data to identify changes in recipient wages that occur during the 12 months between application and renewal. LDH's policy decision to be a FFM determination state and caseworker errors also contributed to these ineligible recipients.

When applying for the Medicaid program, applicants attest that the information they have provided on their application is true and that they will report any changes, including increases in income, to LDH. Although Federal law[8] requires that LDH have procedures to ensure that beneficiaries report any changes that may affect their eligibility to LDH in a timely and accurate manner, we found that the majority of the recipients we reviewed did not report increases in their income to LDH even though they had wages that exceeded 138% of the federal poverty level after being qualified for Medicaid.

We found that, based on their wages reported to LWC, 93 (93.0%) of these Medicaid recipients did not qualify at some point during their Medicaid coverage. We also found that these Medicaid recipients did not qualify for $538,795 (66.3%) of the $813,023 in PMPMs LDH paid on their behalf. Of the 93 Medicaid recipients who did not qualify for Medicaid at some point during their coverage, 55 (59.1%) received services through MCOs totaling $164,913 during the months in which they were not eligible. The remaining 38 recipients received no services during the months in which they were not eligible, including at least four who did not appear to know they were on Medicaid.

LDH, similar to 16 other states, checks wage data only at application and at renewal 12 months later.[9] In contrast, at least 20 other states[10] indicated on CMS verification plans that they check for changes in recipient wages on an interim basis, including daily, monthly, quarterly, or on a semi-annual basis, as shown in Exhibit 2. For example, Pennsylvania and Wisconsin perform quarterly data matches to identify discrepancies between eligibility files and wage data and then require caseworkers to review the recipient's case. Nine states indicated they check wages on a quarterly basis, which was the most common interim check time interval. In addition, the verification plans for five states indicated that they receive "new hire" alerts from their LWC equivalent to determine if any Medicaid recipients recently began a new job.[11]

---

[8] 42 CFR 435.916(c).

[9] There are certain instances where Medicaid recipients are administratively renewed, meaning their wages, among other items, are not analyzed to renew eligibility for multiple years.

[10] Seven states indicated that they check wage data when changes are reported by Medicaid recipients.

[11] LWC receives wage information from employers on a quarterly basis. Using this information, LDH could identify new hires.

Exhibit 2. Frequency of Wage Data Checks

Frequency	Number of States
Daily	1
Monthly	2
Quarterly	9
Semi-annually	1
Interim basis, but frequency not specified	7
Total	**20**

Source: Prepared by legislative auditor's staff using information from state's Medicaid verification plans.

According to LDH staff, it does not verify Medicaid recipient wages at all during the 12-month period between initial enrollment and renewal due to the cost. Because it uses a manual system, LDH previously estimated that it would cost approximately $5 million to perform bi-annual wage checks on Medicaid recipients and $14.5 million to perform quarterly wage checks.[12] LDH's cost projections assume that LDH caseworkers will manually check approximately 750,000 applications during each interim check. However, using a risk-based approach similar to the targeted selection we performed would not require the department to check all Medicaid recipients. LWC wage data is reported quarterly by employers, which means LDH could check the eligibility of its Medicaid recipients on a quarterly basis to identify Medicaid recipients with high wages. Our analysis used data matches to identify Medicaid recipients with wages higher than the allowable amount over multiple quarters of LWC wage data and focused on a targeted selection of 100 of them instead of manually checking the entire Medicaid population. Other states use a similar risk-based methodology. Therefore, LDH should use a risk-based model that matches Medicaid eligibility data with LWC wage data to identify those Medicaid recipients whose wages consistently exceed the eligible amounts. According to LDH staff, the department has developed a new eligibility system planned to begin in November 2018 that will allow it to perform wage checks on the entire Medicaid population on a quarterly basis. LDH staff stated that these types of checks cannot be performed for the entire population with its current system. Without the new system, staff would need to work these cases manually. While LDH states that it will be able to do this in the new system, we have not audited the design of the system and cannot verify system capabilities at this time.

LDH's policy decision to become an FFM determination state resulted in 10 (10.0%) of the 100 Medicaid recipients in our targeted selection to initially be determined as eligible even though the use of LWC wage data would have indicated that they were not eligible. As part of the Affordable Care Act, individuals needing health insurance can apply through the Federally Facilitated Marketplace (FFM). If the FFM determines that an individual's income qualifies them for Medicaid, their case is sent to the state in which they reside. However, the FFM does not have access to LWC wage data, meaning it is making eligibility determinations without a full picture of the applicant's wages.[13] All states have the option to accept the FFM's eligibility determinations (called a "determination state") or to perform their own verification of the applicant's eligibility using criteria such as income (called an "assessment state"). At the beginning of Medicaid expansion on July 1, 2016, LDH made a policy decision to switch from being an assessment state to a determination state because it believed that significant improvements were made to the FFM data and expected an increase in the number of cases for caseworkers due to Medicaid expansion. As a result, LDH did not check the LWC wage data of these Medicaid recipients who applied through the FFM until their annual renewal. If LDH had remained an assessment state and checked LWC

[12] LDH's cost estimates included analyst and supervisor salaries, equipment, lease space, furniture, and supplies. It includes hiring 107 staff for bi-annual checks and 313 staff for quarterly checks.

[13] FFM has access to other income sources such as data from the Social Security Administration and Internal Revenue Service, among others, to make Medicaid eligibility determinations.

wage data prior to enrolling applicants received from the FFM, LDH would have determined that these 10 applicants did not qualify for Medicaid.

November 2015: LDH changed from a *determination state* to an *assessment state* due to an ongoing unacceptable error rate in decisions made by the FFM.

July 2016: LDH changed from an *assessment state* to a *determination state* because according to LDH, there were significant improvements in the FFM data and an expected increase in the number of cases for caseworkers due to Medicaid expansion.

LDH caseworkers did not always make correct eligibility determinations because of caseworker errors. This resulted in caseworkers enrolling individuals who did not apply for the program and allowing individuals to qualify for Medicaid when they should not have. In our review of the 100 Medicaid applicants in our targeted selection, we found six instances where caseworkers enrolled individuals who did not apply for Medicaid, did not act upon information they received that affected an applicant's eligibility, and did not document reasons for determining eligibility per LDH policy. Examples of caseworker errors include:

- In two separate instances, LDH caseworkers enrolled individuals in Medicaid who did not apply. In both of these instances, the caseworkers received an application, but keyed in the wrong Social Security numbers to enroll the individuals. In both of these instances, there is no documentation indicating that the individuals were aware they were enrolled in Medicaid, and neither received services through Medicaid.
- In one instance, a Medicaid recipient completed two applications: the first was an online application with LDH Medicaid and the second was an application submitted through the FFM. The FFM application was referred to LDH, meaning that LDH had to make the eligibility determination because at that time LDH was an FFM assessment state. Although the applicant reported no wages, the caseworker identified wages in the applicant's LWC wage data and documented it, reached out to the applicant for more information, did not receive a response, and therefore did not enroll the applicant in Medicaid. However, another caseworker approved the applicant's online application without verifying LWC wages and enrolled the applicant in Medicaid.
- In one instance, the applicant reported income that was not reasonably compatible with what the caseworker found in LWC data within 25% of reported income. Instead of seeking to obtain a reasonable explanation as to why the income amounts differed, the caseworker accepted the attested income without documenting why they did so, which is a violation of LDH policy.
- We also identified two instances where LDH caseworkers did not cancel Medicaid coverage when applicants self-reported changes in wages. For example, a Medicaid recipient who was enrolled in FFS prior to Medicaid expansion became employed and notified a caseworker of their income and that they had obtained private health insurance. Although the recipient's notification was documented in their case file, they were not removed from Medicaid and instead were automatically enrolled into Medicaid expansion. When LDH tried to renew their case one year later, the recipient stated that they did not know that they were on Medicaid and that they were still employed. LDH then canceled their coverage. We also found an example where a Medicaid recipient called a caseworker to cancel coverage because they had found a job. However, the recipient's coverage was not canceled until renewal, 10 months after the call, because LDH requires recipients to request case closure in writing.

Recommendation 1: LDH should conduct more frequent wage data matches to identify Medicaid recipients with incomes that exceed amounts allowable to be eligible for Medicaid. Using these results, LDH should develop a risk-based methodology to identify and review high-risk cases.

Summary of Management's Response: LDH agreed with this recommendation and stated that while its current eligibility data system limits LDH's ability to perform more frequent wage verification, its new eligibility system, which will be implemented in mid-November 2018, will allow LDH to verify wage data on a more frequent basis. LDH stated it plans to use LWC data to replicate the method developed by LLA to identify high-risk cases for review in early 2019.

Recommendation 2: LDH should use LWC wage data and other data sources to verify wages of applicants received from the FFM to ensure more accurate eligibility determinations.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will verify eligibility determinations made by the FFM and terminate coverage for individuals found to be ineligible by the following months once its new eligibility system is implemented.

Recommendation 3: LDH should ensure that its caseworkers re-determine eligibility when they receive information that may affect eligibility of the recipient acting upon all information.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will reinforce training on agency policy that requires caseworkers to consider all information available and promptly re-determine eligibility.

Recommendation 4: LDH should ensure that caseworkers document information used to make eligibility decisions.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will reinforce caseworker training on agency policy that requires documentation of information used to make eligibility decisions. LDH stated that its new eligibility system will automatically store information available to the system for use in eligibility decision-making.

Recommendation 5: LDH should determine if it should allow Medicaid recipients to verbally cancel their coverage using the same methods as when an applicant verbally applies for Medicaid.

Summary of Management's Response: LDH agreed with this recommendation and stated that it is currently evaluating options for allowing applicants to verbally cancel their coverage similar to how applicants verbally apply for Medicaid.

---

82 (82.0%) of 100 Medicaid recipients in the random sample did not qualify for $382,420 (47.3%) of the $808,341 in PMPMs LDH paid on their behalf. Because this sample was random, we were able to project these results to the entire population of 19,226[14] single-person household Medicaid expansion recipients. Based on this projection, it appears that LDH may have paid between $61.6 million and $85.5 million in PMPMs for Medicaid recipients who did not qualify at some point during their Medicaid coverage.

Due to the issues identified within the targeted selection, we performed the same review on a random sample of Medicaid recipients to project the effects of the identified issues on the entire population of 19,226[14] single-person household Medicaid expansion recipients. To accomplish this, we selected a random sample of 100 single-person household Medicaid expansion recipients whose average quarterly wages were higher than 138% of the federal poverty level and reviewed their electronic case records to determine if they were eligible in the period during which they were enrolled in Medicaid.

We found that, based on their wages, 82 (82.0%) of these Medicaid recipients did not qualify at some point during their Medicaid coverage. We also found that these Medicaid recipients did not qualify for $382,420 (47.3%) of the $808,341 in PMPMs paid on their behalf, and the average PMPM paid per ineligible recipient was $3,824. Of these 82 recipients who did not qualify for Medicaid at some point during their coverage, 64 (78.0%) received services through MCOs totaling $173,540 during the months in which they were not eligible. When projecting the average PMPM paid for ineligible recipients ($3,824) to the entire population of 19,226, we found that from July 1, 2016, through March 31, 2018, between $61,570,417 and $85,477,710 in PMPMs may have been paid for Medicaid recipients who did not qualify due to their income exceeding 138% of the federal poverty level. More frequent checks of wages could have prevented a portion of these PMPMs from being paid.

---

[14] We removed 563 individuals who did not appear to be accurate matches on Social Security number due to having different names in the LWC and LDH data. After removing the 563 individuals who did not appear to be true matches, we had a population of 19,226 Medicaid expansion recipients.

Appendix A: Management's Response

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

LOUISIANA DEPARTMENT OF HEALTH

Office of Management and Finance
Bienville Building
628 N. Fourth St.
P.O. Box 629
Baton Rouge, Louisiana 70821–0629
Phone: (225) 342–6726
Fax: (225) 342–5568
www.ldh.la.gov

November 2, 2018

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804–9397

Re: Medicaid Eligibility—Wage Verification Process

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit on the Medicaid eligibility wage verification process. The Bureau of Health Services Financing (BHSF), which is responsible for administration of the Medicaid program in Louisiana, is committed to ensuring the integrity of the Medicaid eligibility determination process through appropriate management controls.

We have reviewed the audit findings and provide the following response to the recommendations documented in the report.

Recommendation 1: LDH should conduct more frequent wage data matches to identify Medicaid recipients with income that exceeds amounts allowable to be eligible for Medicaid. Using these results, LDH should develop a risk-based methodology to identify and review high-risk cases.

LDH Response: LDH agrees with this recommendation. The capabilities of the current Louisiana Medicaid Eligibility Data System (MEDS) are limited, making eligibility determination a manual, labor intensive task. Given the limits of MEDS and a work force supply that is outstripped by workload demands, wage data verification on a basis more frequent than annual has been resource prohibitive. However, the new eligibility system, LaMEDS, to go live in mid-November, will be highly automated, enabling LDH to verify wage data on a more frequent basis. Specifically, LDH plans to use Louisiana Workforce Commission (LWC) data to replicate the method developed by LLA to identify high-risk cases for review by our Recipient Fraud Unit beginning in early 2019.

Recommendation 2: LDH should use LWC wage data and other data sources to verify wages of applicants received from the FFM to ensure more accurate eligibility determinations.

LDH Response: LDH agrees with this recommendation. Following LaMEDS go live, LDH will verify eligibility determinations made by the FFM and terminate coverage for individuals found to be ineligible by the following month.

Recommendation 3: LDH should ensure that its caseworkers re-determine eligibility when they receive information that may affect eligibility of the recipient acting upon all information.

LDH Response: LDH agrees with this recommendation. LDH will reinforce training on agency policy that requires caseworkers to consider all information available and promptly re- determine eligibility when indicated.

Recommendation 4: LDH should ensure that caseworkers document information used to make eligibility decisions.

LDH Response: LDH agrees with this recommendation. LDH will reinforce caseworker training on agency policy that requires documentation of information used

to make eligibility decisions. In addition, LaMEDS will automatically store information available to the system for use in eligibility decision making.

Recommendation 5: LDH should determine if it should allow Medicaid recipients to verbally cancel their coverage using the same methods as when an applicant verbally applies for Medicaid.

LDH Response: LDH agrees with this recommendation. LDH is currently evaluating options for allowing applicants to verbally cancel their coverage similar to how applicants verbally apply for Medicaid.

You may contact Michael Boutte, Medicaid Deputy Director, at (225) 342–0327 or via e-mail at Michael.Boutte@la.gov with any questions about this matter.

Sincerely,
Cindy Rives
Undersecretary

Appendix B: Scope and Methodology

We conducted this analysis under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This analysis focused on LDH's income eligibility processes, primarily concerning its use of LWC wage data. The purpose of this analysis was:

To evaluate the sufficiency of LDH's process of using wage data to determine the eligibility of the Medicaid expansion population.

The scope of our audit was less than that required by Government Auditing Standards. We believe the evidence obtained provides a reasonable basis for our findings and conclusions. To conduct this analysis we performed the following steps:

- Researched relevant federal and state laws, regulations, policies, and guidance regarding the Medicaid eligibility determination process.
- Met with LDH employees to gain an understanding of the eligibility determination processes relative to income and Medicaid expansion.
- Researched and compared verification plans for each of the 50 states and the District of Columbia to current Louisiana standards in regards to the frequency and use of wage data.
- For both our targeted selection and random sample, we analyzed Medicaid data to identify PMPMs paid on behalf of and services received by Medicaid recipients. We also analyzed wage data from LWC to identify quarterly wages of Medicaid recipients and the months in which the recipients were employed. We analyzed driver's license data from the Office of Motor Vehicles to ensure individuals captured in Medicaid and LWC data were truly the same people.
- Conducted a targeted selection of single-person household Medicaid expansion recipients to determine if issues existed in the Medicaid eligibility determination process in regards to the use of LWC wage data. We identified Medicaid recipients to include in the targeted selection by doing the following:
    - We initially identified 195,306 single-person household Medicaid expansion recipients.
    - We joined the population of 195,306 single-person household Medicaid expansion recipients, to LWC data on Social Security number and found that 132,767 recipients had wages.
    - Using the population of 132,767 single-person household Medicaid expansion recipients who had wages in the LWC data, we extracted those who had average quarterly wages over the nine quarters analyzed that exceeded 138% of the federal poverty level in effect at Medicaid expansion. This identified 19,789 single-person household Medicaid expansion recipients whose average quarterly wages over the nine quarters analyzed were higher than 138% of the federal poverty level in effect at Medicaid expansion. We used quarters that included January l, 2016, because this wage data would have been available to caseworkers making eligibility determinations at the beginning of Medicaid expansion. We used quarters that included March 31, 2018, because this was the most recent Medicaid and LWC data at the time of our analysis. The nine quarters used to identify high wages included the following period:
        - Quarter l, 2016–January 1, 2016 through March 31, 2016

- Quarter 2, 2016–April 1, 2016 through June 30, 2016
- Quarter 3, 2016–July 1, 2016 through September 30, 2016
- Quarter 4, 2016–October 1, 2016 through December 31, 2016
- Quarter 1, 2017–January 1, 2017 through March 31, 2017
- Quarter 2, 2017–April 1, 2017 through June 30, 2017
- Quarter 3, 2017–July 1, 2017 through September 30, 2017
- Quarter 4, 2017–October 1, 2017 through December 31, 2017
- Quarter 1, 2018–January 1, 2018 through March 31, 2018

◦ Using these 19,789 Medicaid recipients, we sorted the results to include Medicaid recipients with the average highest wages at the top. We then worked through them case by case to determine if the Medicaid recipients were eligible.

• Conducted a random sample to identify single-person household Medicaid expansion recipients whose wages were higher than the allowable amount of 138% of the federal poverty level. We analyzed quarterly wages and the months during which the Medicaid recipient was employed to determine if the PMPMs paid on behalf of each Medicaid recipient were ineligible due to their wages. We identified Medicaid recipients for the random sample by doing the following:

◦ We initially identified 195,306 single-person household Medicaid expansion recipients.

◦ We joined the population of 195,306 single-person household Medicaid expansion recipients, to LWC data on Social Security number and found that 132,767 recipients had wages.

◦ Using the population of 132,767 single-person household Medicaid expansion recipients who had wages in the LWC data, we extracted those who had average quarterly wages over the nine quarters analyzed that exceeded 138% of the federal poverty level in effect at Medicaid expansion. This identified 19,789 single-person household Medicaid expansion recipients whose average quarterly wages over the nine quarters analyzed were higher than 138% of the federal poverty level in effect at Medicaid expansion. We used quarters that included January l, 2016, because this wage data would have been available to caseworkers making eligibility determinations at the beginning of Medicaid expansion. We used quarters that included March 31, 2018, because this was the most recent Medicaid and LWC data at the time of our analysis. The nine quarters used to identify high wages included the following period:

- Quarter l, 2016–January 1, 2016 through March 31, 2016
- Quarter 2, 2016–April 1, 2016 through June 30, 2016
- Quarter 3, 2016–July 1, 2016 through September 30, 2016
- Quarter 4, 2016–October 1, 2016 through December 31, 2016
- Quarter 1, 2017–January 1, 2017 through March 31, 2017
- Quarter 2, 2017–April 1, 2017 through June 30, 2017
- Quarter 3, 2017–July 1, 2017 through September 30, 2017
- Quarter 4, 2017–October 1, 2017 through December 31, 2017
- Quarter 1, 2018–January 1, 2018 through March 31, 2018

◦ Using the population of 19,789 single-person household Medicaid expansion recipients whose average quarterly wages over the nine quarters analyzed were higher than 138% of the federal poverty level in effect at Medicaid expansion, we removed those individuals who had names that did not appear to be the same in LWC and LDH data. This occurs because information reported to LWC is reported by employers and not validated, while LDH caseworkers sometimes enter wrong identifying information for Medicaid recipients. After removing those that appeared to not be true matches, we had a population of 19,226 Medicaid expansion recipients.

- We then extracted a random sample of 100 Medicaid recipients from the 19,226 single-person household Medicaid expansion recipients and reviewed their case files and wage data to determine how much LDH paid for each recipient to remain enrolled with a managed care organization during months when that recipient's income exceeded 138% of the federal poverty level. Of these 100 Medicaid recipients, 82 were ineligible at some point during the period examined. The average amount of ineligible PMPMs for these 100 Medicaid recipients (including those with $0 in ineligible PMPMs) was $3,824.20 per Medicaid recipient, and the standard deviation was $3,172.22. On this basis, we projected that the dollar amount of ineligible PMPMs for the population of 19,226 single-person household Medicaid expansion recipients was $73,524,063, with a 95% confidence interval of $61,570,417 to $85,477,710. Exhibit B.1 below shows the results of this analysis.

Exhibit B.1. Estimated Ineligible PMPMs

Category	Number
Medicaid Recipients in Sample	100
Ineligible Medicaid Recipients in Sample	82
Average Ineligible PMPM Payments Per Medicaid Recipient in Sample	$3,824.20
Standard Deviation of Ineligible PMPM Payments Per Medicaid Recipient in Sample	$3,172.22
Number of Medicaid Recipients in Sub-population of Single-Person Households Covered by Medicaid Expansion	19,226
Estimated Ineligible PMPM Payments in Subpopulation, Projected from Sample	$73,524,063
Lower Bound of Ineligible PMPM Payments in Sub-population (95% Confidence Interval)	$61,570,417
Upper Bound of Ineligible PMPM Payments in Sub-population (95% Confidence Interval)	$85,477,710

Source: Prepared by legislative auditor's staff using data from LDH and LWC.

- Discussed and provided the results of our analyses to LDH management.

Appendix C: Enrollment Types and Eligibility of the 100 Targeted Selection Medicaid Recipients

Enrollment Method	Number of Applicants Reviewed	Applicants Who Did Not Qualify for Medicaid	Did not Qualify at Some Point During Coverage*	Eligible for Entire Coverage Period
Online/Paper Application	52	4	43	5
FFM Determination	38	1	35	2
FFS	8	2	6	0
SNAP	2	0	2	0
Total	**100**	**7**	**86**	**7**

*If LDH performed interim checks for wages on these individuals, LDH could have prevented PMPMs from being paid after the Medicaid recipient began receiving wages higher than the allowable amount to qualify for Medicaid.

Source: Prepared by legislative auditor's staff using information from state's Medicaid verification plans.

Appendix D: Enrollment Types and Eligibility of the 100 Randomly-Sampled Medicaid Recipients

Enrollment Method	Number of Applicants Reviewed	Applicants Who Did Not Qualify for Entire Time on Medicaid	Did not Qualify at Some Point During Coverage*	Eligible for Entire Coverage Period	Multi-Person Household**
Online/Paper Application	54	2	36	14	2
FFM Determination	20	0	19	1	0
FFS	25	1	24	0	0
Unknown	1	0	0	0	1
Total	**100**	**3**	**79**	**15**	**3**

*If LDH performed interim checks for wages on these individuals, LDH could have prevented PMPMs from being paid after the Medicaid recipient began receiving wages higher than the allowable amount to qualify for Medicaid.

**While we requested only single-person households be included in the list sent by LDH, we did identify instances where the recipient was actually a multi-person household.

Source: Prepared by legislative auditor's staff using information from state's Medicaid verification plans.

Appendix E: Targeted Selection Individual Medicaid Recipient Cases

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
1	$19,903	$17,807	$14,641	$14,214	2	19	$111,785
2	13,708	13,708	0	0	0	19	101,171
3	12,602	12,602	15,845	15,845	0	13	61,685
4	15,220	12,583	41,714	34,829	3	16	88,874
5	19,855	11,410	5,653	821	9	12	99,140
6	10,930	10,930	0	0	0	12	126,284
7	14,702	10,762	12,847	1,720	5	14	104,921
8	11,526	10,556	2,845	2,845	1	12	99,017
9	15,729	10,553	12,364	5,884	6	12	104,925
10	9,991	9,991	44	44	0	12	73,082
11	9,446	8,606	6,034	6,034	1	11	62,400
12	11,036	8,389	76	76	3	10	93,929
13	8,356	8,356	0	0	0	19	112,247
14	9,056	8,254	0	0	1	11	66,494
15	9,056	8,254	4,054	4,054	1	11	82,715
16	11,266	8,217	0	0	3	9	103,628
17	8,127	8,127	0	0	0	12	69,340
18	8,412	7,969	1,172	1,172	1	20	114,797

Appendix E: Targeted Selection Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
19	8,597	7,796	417	417	1	11	63,231
20	11,743	7,757	690	408	5	10	58,701
21	10,530	7,733	0	0	3	9	80,300
22	8,486	7,720	11,713	11,713	1	11	55,988
23	10,761	7,245	3,517	2,073	4	9	65,389
24	11,650	7,061	325	311	6	10	82,867
25	7,737	7,039	0	0	1	11	77,214
26	10,542	7,028	771	355	5	10	64,974
27	10,689	6,963	0	0	4	8	63,323
28	8,242	6,783	4,901	0	2	10	89,964
29	7,338	6,663	0	0	1	11	70,200
30	10,814	6,583	1,103	1,103	5	8	31,290
31	8,819	6,528	22	11	3	9	59,841
32	8,814	6,429	1,569	538	3	8	42,300
33	7,838	6,410	332	212	2	10	77,563
34	12,027	6,330	0	0	6	7	86,705
35	9,459	6,309	8,541	2,037	4	9	58,086
36	6,252	6,251	726	439	1	12	65,830
37	8,532	6,159	0	0	4	8	75,159
38	8,343	6,139	0	0	3	9	63,329
39	7,466	6,138	646	626	2	10	85,172
40	7,624	5,880	154	154	3	10	69,860
41	8,261	5,880	49,036	34,578	4	10	97,945
42	7,135	5,862	10,822	1,567	2	10	57,369
43	8,890	5,740	152	46	4	8	79,326
44	6,616	5,662	3,384	370	2	13	110,536
45	8,711	5,611	1,246	764	4	8	58,929
46	8,452	5,518	26	26	4	8	89,639
47	11,122	5,426	0	0	6	6	46,893
48	9,319	5,419	1,675	833	5	7	64,733
49	9,312	5,418	0	0	5	7	52,982

Appendix E: Targeted Selection Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
50	5,416	5,416	0	0	0	12	93,022
51	8,127	5,377	438	162	4	8	66,424
52	7,128	5,189	7,904	5,899	4	12	145,146
53	9,041	4,803	338	0	6	7	45,330
54	5,729	4,774	162	0	2	11	94,906
55	7,022	4,746	5,265	1,308	4	7	59,557
56	8,676	4,686	258	221	5	6	78,668
57	8,527	4,677	2,379	118	5	6	16,682
58	5,118	4,641	0	0	1	11	51,986
59	6,382	4,633	6,835	0	3	8	69,208
60	4,977	4,539	0	0	1	11	84,145
61	7,668	4,402	76	0	5	7	58,222
62	4,757	4,319	0	0	1	11	70,413
63	5,089	4,201	0	0	2	10	67,378
64	8,860	4,138	9,912	2,311	8	7	113,019
65	8,419	4,117	447	0	6	6	39,387
66	7,080	4,070	0	0	5	7	83,016
67	4,933	4,047	21	18	2	10	45,027
68	5,362	3,968	554	0	3	9	60,237
69	5,278	3,968	2,297	407	3	9	56,175
70	4,812	3,936	667	174	2	10	63,972
71	4,664	3,898	1,001	782	2	11	80,687
72	5,085	3,878	271	135	3	10	66,970
73	4,713	3,793	0	0	2	9	53,180
74	10,463	3,702	6,503	2,016	9	5	51,018
75	4,245	3,479	259	79	2	9	61,099
76	4,357	3,478	44	44	2	8	60,440
77	4,967	3,428	241	178	4	9	114,272
78	6,222	3,393	83	0	6	7	65,837
79	5,442	3,293	5,669	381	5	8	123,900
80	5,416	3,089	0	0	5	7	68,485

Appendix E: Targeted Selection Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
81	9,494	2,764	0	0	9	4	89,582
82	8,343	2,712	97	0	8	4	42,168
83	6,480	2,533	321	205	6	4	50,616
84	5,907	2,350	5,509	3,438	6	4	13,361
85	4,064	2,012	1,129	0	5	5	72,484
86	8,456	2,009	1,668	0	16	5	127,301
87	6,012	1,927	0	0	8	4	19,995
88	11,842	1,809	1,565	198	10	2	43,880
89	3,835	1,672	2,973	618	5	4	53,688
90	5,173	963	2,320	83	9	2	38,525
91	2,365	591	59	18	3	1	7,071
92	879	440	0	0	1	1	17,526
93	4,637	383	258	0	11	1	50,606
94	5,796	0	941	0	13	0	76,759
95	4,357	0	3,889	0	10	0	15,213
96	2,072	0	0	0	6	0	10,396
97	6,687	0	611	0	10	0	7,079
98	17,122	0	0	0	21	0	6,180
99	686	0	0	0	1	0	0
100	5,799	0	2,927	0	10	0	1,932
Total	**$813,023**	**$538,795**	**$294,946**	**$164,913**	**421**	**840**	**$6,774,242**

Note: The totals may not equal the sum of the 100 recipients due to rounding.
Source: Prepared by legislative auditor's staff using information from LDH and LWC.

Appendix F: Randomly-Sampled Individual Medicaid Recipient Cases

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
1	$15,872	$14,939	$3,595	$3,595	1	18	$55,579
2	15,209	13,642	5,119	4,770	2	19	46,303
3	13,267	11,120	23,756	19,437	3	18	43,664
4	14,614	10,753	0	0	4	12	24,668
5	9,826	9,822	37,437	36,888	3	11	33,231

Appendix F: Randomly-Sampled Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
6	13,041	9,478	1,807	1,632	6	15	32,776
7	9,887	8,996	0	0	1	11	44,720
8	12,818	8,860	645	142	6	15	52,400
9	8,611	8,611	8,997	8,997	0	13	40,567
10	8,456	8,018	3,346	3,206	1	20	59,855
11	9,664	7,945	2,194	2,109	2	10	27,991
12	9,130	7,676	488	186	3	18	35,104
13	13,041	7,340	1,984	1,436	9	12	31,725
14	9,152	7,259	759	583	4	17	32,579
15	9,911	7,171	3,595	2,087	3	8	35,572
16	7,194	6,655	3,582	3,582	1	14	25,587
17	8,241	6,639	1,423	1,423	2	9	16,251
18	6,515	6,515	33,165	33,165	0	14	31,975
19	7,029	6,432	1,548	769	1	11	21,529
20	6,916	6,279	0	0	2	16	37,833
21	8,267	6,120	4,330	2,249	3	9	47,410
22	18,951	5,836	7,497	3,299	14	6	29,813
23	7,236	5,670	89	48	3	12	55,599
24	7,438	5,553	448	216	3	8	21,016
25	6,562	5,542	2,672	1,748	3	16	37,415
26	11,122	5,505	25	25	6	6	32,695
27	10,002	5,352	2,929	2,695	4	9	24,344
28	9,309	5,313	675	535	9	11	29,298
29	7,784	5,054	982	624	4	8	19,542
30	6,046	5,024	976	964	2	11	19,934
31	13,708	4,803	114	0	12	7	22,547
32	7,037	4,775	2,682	1,284	6	15	37,567
33	6,009	4,767	883	441	4	16	35,892
34	7,191	4,628	8,827	626	6	11	30,509
35	19,485	4,475	6,634	609	2	10	55,712
36	5,191	4,295	139	139	2	10	24,111

Appendix F: Randomly-Sampled Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
37	8,456	4,245	515	305	10	11	46,801
38	18,459	4,238	9,680	4,049	8	9	27,884
39	5,667	4,222	2,642	1,701	3	9	21,227
40	4,588	4,208	0	0	1	11	23,007
41	13,238	4,181	1,304	1,304	12	6	32,978
42	4,986	4,140	1,176	1,176	2	10	31,660
43	8,860	4,138	9,912	2,311	8	7	113,019
44	6,032	4,032	996	996	7	14	42,900
45	9,702	4,013	1,913	711	11	8	35,871
46	4,393	3,987	1,221	1,221	1	11	32,951
47	9,152	3,883	0	0	12	9	29,853
48	6,653	3,772	793	443	7	9	21,066
49	9,700	3,750	1,618	253	13	8	56,804
50	5,643	3,679	833	593	6	12	43,968
51	6,194	3,664	118	0	6	9	22,686
52	5,371	3,578	539	531	4	8	36,531
53	5,430	3,519	217	0	4	8	28,870
54	4,357	3,478	44	44	2	8	60,440
55	5,960	3,417	1,576	1,170	0	11	31,954
56	4,729	3,212	383	349	5	11	48,222
57	5,743	3,176	0	0	5	7	26,167
58	7,526	3,036	0	0	11	8	26,394
59	4,414	2,826	1,968	658	5	7	34,460
60	6,715	2,618	294	16	9	6	38,778
61	3,290	2,546	386	0	4	8	25,523
62	6,621	2,453	0	0	11	6	23,291
63	5,817	2,408	130	57	7	5	26,272
64	7,251	2,190	36,855	0	14	5	39,318
65	6,990	2,187	1,571	514	7	3	10,605
66	7,926	1,993	230	72	9	3	29,157
67	4,611	1,983	0	0	7	5	17,476

Appendix F: Randomly-Sampled Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
68	5,286	1,952	0	0	11	7	34,444
69	4,637	1,946	216	12	7	5	19,564
70	17,048	1,939	8,415	156	1	4	20,948
71	4,038	1,768	2,288	1,608	8	6	19,407
72	4,086	1,745	476	0	4	3	7,185
73	11,514	1,734	1,813	38	16	3	28,532
74	16,763	1,598	8,511	2,761	19	2	42,328
75	8,062	1,356	3,257	176	10	2	18,125
76	4,558	1,214	16,088	469	8	3	14,705
77	6,161	1,192	25,844	3,678	12	3	25,225
78	2,668	996	7	0	5	3	9,852
79	3,736	977	475	0	10	4	22,863
80	7,733	838	1,190	129	14	2	11,574
81	12,075	784	20,959	6,114	16	1	3,532
82	5,214	750	7,758	416	10	2	21,325
83	7,423	0	1,129	0	10	0	14,917
84	8,559	0	12,844	0	12	0	0
85	4,539	0	1,326	0	2	0	35,931
86	10,497	0	334	0	12	0	17,082
87	6,990	0	7,305	0	10	0	9,770
88	8,530	0	1,170	0	11	0	3,423
89	7,047	0	951	0	10	0	3,462
90	8,918	0	1,601	0	10	0	16,421
91	3,862	0	34	0	10	0	0
92	9,458	0	0	0	12	0	17,700
93	8,703	0	4,079	0	8	0	0
94	5,388	0	1,305	0	0	0	38,005
95	4,922	0	0	0	0	0	10,465
96	4,177	0	895	0	11	0	3,610
97	4,183	0	409	0	5	0	936
98	5,735	0	4,583	0	13	0	1,615

Appendix F: Randomly-Sampled Individual Medicaid Recipient Cases—Continued

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
99	6,164	0	97	0	0	0	40,684
100	5,465	0	1,304	0	12	0	35,496
Total	**$808,341**	**$382,420**	**$386,915**	**$173,540**	**647**	**748**	**$2,888,574**

Note: The totals may not equal the sum of the 100 recipients due to rounding.
Source: Prepared by legislative auditor's staff using information from LDH and LWC.

Appendix G: List of Previous MAU Reports

Issue Date	Title
October 31, 2018	*Identification of Incarcerated Medicaid Recipients*
June 20, 2018	*Reliability of Medicaid Provider Data*
May 2, 2018	*Strengthening of the Medicaid Eligibility Determination Process*
November 29, 2017	*Improper Payments for Deceased Medicaid Recipients*
October 4, 2017	*Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)*
September 6, 2017	*Improper Payments in the Medicaid Laboratory Program*
July 12, 2017	*Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services*
March 29, 2017	*Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers*
March 22, 2017	*Program Rule Violations in the Medicaid Dental Program*
October 26, 2016	*Medicaid Recipient Eligibility—Managed Care and Louisiana Residency*

Source: MAU reports can be found on the LLA's website under "Reports and Data" using the "Audit Reports by Type" button. By selecting the "Medicaid" button, all MAU reports issues by LLA will be displayed; *https://www.lla.la.gov/reports-data/audit/audit-type/index.shtml?key=Medicaid.*

Update on Wage Verification Process of the Medicaid Expansion Population

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID AUDIT UNIT
FOLLOW-UP REPORT
ISSUED MAY 1, 2019

Louisiana Legislative Auditor
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804–9397

Legislative Auditor
DARYL G. PURPERA, CPA, CFE

Assistant Legislative Auditor for State Audit Services
NICOLE B. EDMONSON, CIA, CGAP, MPA

Director of Performance Audit Services
KAREN LEBLANC, CIA, CGAP, MSW

FOR QUESTIONS RELATED TO THIS MEDICAID AUDIT UNIT REPORT, CONTACT CHRIS MAGEE, DATA ANALYTICS MANAGER, AT 225–339–3800.

Under the provisions of state law, this report is a public document. A copy of this report has been submitted to the Governor, to the Attorney General, and to other public officials as required by state law. A copy of this report is available for public inspection at the Baton Rouge office of the Louisiana Legislative Auditor and online at *www.lla.la.gov*.

This document is produced by the Louisiana Legislative Auditor, State of Louisiana, Post Office Box 94397, Baton Rouge, Louisiana 70804–9397 in accordance with Louisiana Revised Statute 24:513. Eleven copies of this public document were produced at an approximate cost of $2.75. This material was produced in accordance with the standards for state agencies established pursuant to R.S. 43:31. This report is available on the Legislative Auditor's website at *www.lla.la.gov*. When contacting the office, you may refer to Agency ID No. 9726 or Report ID No. 82190002 for additional information.

In compliance with the Americans With Disabilities Act, if you need special assistance relative to this document, or any documents of the Legislative Auditor, please contact Elizabeth Coxe, Chief Administrative Officer, at 225–339–3800.

LOUISIANA LEGISLATIVE AUDITOR
Daryl G. Purpera, CPA, CFE
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804–9397
https://www.lla.la.gov/
Phone: 225–339–3800
FAX: 225–339–3870

May 1, 2019

The Honorable John A. Alario, Jr.,
President of the Senate

The Honorable Taylor F. Barras,
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report details the progress made by the Louisiana Department of Health (LDH) in response to recommendations in a November 8, 2018, report issued by the Louisiana Legislative Auditor (LLA). That report, *Medicaid Eligibility: Wage Verification Process of the Expansion Population,* evaluated and identified areas in which LDH could strengthen its process of using wage data to determine the eligibility of the Medicaid expansion population.

In its previous report, the LLA found that 93 (93.0 percent) of 100 Medicaid recipients in a targeted selection analyzed did not qualify for $538,795 (66.3 percent) of the $813,023 in per-member per-month fees (PMPMs) LDH paid on their behalf.

On November 13, 2018, LDH launched its new Medicaid eligibility system, LaMEDS, which allows the Department to perform automated quarterly wage checks. Such quarterly checks were one of the recommendations in the LLA report.

After its new system was implemented, the Department analyzed the 100 recipients from the LLA report and identified $692,663 in ineligible PMPMs paid on behalf of 98 of them. Fifteen of the cases were considered to involve potential fraud and were referred to the Attorney General's (AG) office. The AG's office determined one case was indicative of fraud and an arrest was made, while three cases did not indicate fraud. The remaining 11 cases were still under investigation as of April 11, 2019.

The report contains our findings, conclusions, and recommendations. Appendix A contains LDH's response to this report.

I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of the LDH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Update on Wage Verification Process of the Medicaid Expansion Population

Louisiana Department of Health
May 2019

Audit Control #82190002

Introduction

This report provides an update on specific actions taken by LDH in response to the report titled *Medicaid Eligibility: Wage Verification Process of the Expansion Population*[1] released on November 8, 2018. The Louisiana Legislative Auditor (LLA) made five recommendations in that report, and LDH agreed with all of them. The report found that 93 (93.0%) of the 100 Medicaid recipients in the targeted selection of Medicaid recipients analyzed did not qualify for $538,795 (66.3%) of the $813,023 in PMPMs LDH paid on their behalf.

On November 13, 2018, LDH launched its new Medicaid Eligibility system, LaMEDS. According to LDH, the capabilities of this new eligibility system allow LDH to perform automated quarterly wage checks to verify income as recommended in our report. The objective of this report was to determine how LDH addressed the ineligible individuals identified in our targeted selection and to assess the results of LDH's first quarterly wage check using data from the Louisiana Workforce Commission (LWC).

Results

LDH analyzed the 100 individuals in the targeted selection and identified $692,663 in ineligible per-member per-month fees (PMPMs) paid on behalf of 98 Medicaid recipients. Fifteen potentially-fraudulent cases were referred to the Attorney General's Office (AG), of which the AG has determined that one case was indicative of fraud and resulted in an arrest, three cases did not indicate fraud, and the remaining 11 cases were still under investigation as of April 11, 2019. Prior to February 2019, LDH used LWC wage

[1] *http://app.lla.state.la.us/PublicReports.nsf/0/1CDD30D9C8286082862583400065E5F6/$FILE/0001ABC3.pdf.*

data only while reviewing a recipient's application—and at the earliest one year later during the recipient's renewal—to assist in determining a recipient's Medicaid eligibility. Instead of proactively checking for changes or increases in recipient wages on a quarterly basis, LDH relied on Medicaid recipients to voluntarily report changes in their income to LDH.

We sent the results of our analysis of the targeted selection to LDH for verification, and LDH determined that these recipients were actually ineligible for longer periods of time than was determined by our analysis because our methodology was more conservative.[2] LDH's initial review found that 98 (98.0%) of the 100 recipients did not qualify for $692,663 of the $813,023 in PMPMs paid on their behalf. See Exhibit 1 below for a comparison of the Medicaid recipients, PMPMs, services, and months identified as ineligible by LLA and LDH from the targeted selection.

Exhibit 1. LLA and LDH Targeted Selection Initial Ineligibility Results

Entity	Recipients Ineligible**	PMPMs Ineligible	Services Ineligible***	Months Ineligible
LLA	93	$538,795	$164,913	840
LDH	98	692,663*	234,718	1,079
Difference	**5**	**$153,868**	**$69,805**	**239**

*LDH also identified additional ineligible months for these recipients after the end of our scope (March 31, 2018). However, these additional ineligible months, PMPMs, and services are not included in this exhibit.

**Recipients were ineligible for at least one month during the period of their coverage.

***These costs are incurred by MCOs.

Source: Prepared by legislative auditor's staff using information from LDH.

Of the 100 Medicaid recipients identified in the targeted selection, 15 cases were referred to the AG, which determined that at least one case was indicative of fraud and resulted in an arrest, three cases did not indicate fraud, and the remaining 11 cases were still under investigation as of April 11, 2019. LDH initially sent demand letters to 93 of the 98 recipients identified through its review of our targeted selection, which indicated how much each recipient owed to Medicaid. However, LDH staff later stated that due to CMS requirements they would only seek recoupment from those Medicaid recipients who are convicted of committing fraud. LDH stated that any Medicaid recipients who have paid to LDH the amount in the demand letter and are not found to have committed fraud will be reimbursed.

LDH has established a process to conduct more frequent wage data matches and identified 40,006[3] Medicaid recipients with wages that were higher than the allowable amount to be eligible for Medicaid. Through its review process, LDH terminated the coverage of 30,051 (75.1%)[4] Medicaid recipients. In response to LLA's recommendation that LDH conduct more frequent wage data matches, LDH entered into a data sharing agreement with LWC to receive wage data on a quarterly basis to proactively identify wage changes and increases for Medicaid recipients instead of relying on the recipients themselves to self-report changes. LDH incorporated this new LWC wage data match into its new eligibility system. LDH ran this analysis on 1,549,703 Medicaid recipients and identified 79,851 with wages higher than the allowable amount. LDH then mailed letters to 40,006 recipients with wages higher than the allowable amount who were

[2] LLA's analysis required a Medicaid recipient to be employed consistently with the same employer over a three-month time period in order for one month, the second month, to be considered ineligible. This methodology was used by LLA since Medicaid allows an individual who is unemployed for one day in a month to qualify for Medicaid for the entire month. LDH's methodology identified all months within a quarter (three months) as ineligible if LWC data indicated that the recipient was employed with wages higher than the allowable amount for a specific quarter instead of analyzing the recipient's employment on a monthly basis.

[3] There were 37,041 letters sent to the 40,006 Medicaid recipients. Households with multiple recipients were sent one letter.

[4] As of April 3, 2019, 30,051 of the 40,006 recipients identified by LDH's wage data match lost coverage; 6,493 were determined to be approved individuals; 2,417 were newly approved for coverage after previously losing coverage; and 1,045 recipient cases were awaiting LDH worker action. According to LDH, the majority of these cases were closed due to recipients' failure to respond to requests for information.

not in continuous enrollment.[5] These letters stated that they would lose Medicaid coverage if they did not submit proof of their eligibility by April 1, 2019.

Of the 40,006 Medicaid recipients identified through this analysis and sent letters, 30,051[6] (75.1%) lost Medicaid coverage. The PMPMs associated with the Medicaid recipients who lost coverage due to LDH's wage match totaled approximately $14.7 million[7] for the month of January 2019, which indicates the potential monthly savings for LDH. LDH's new process has improved LDH's ability to more quickly identify changes in wages to ensure that only qualified individuals are on the Medicaid program and dollars are spent appropriately.

Appendix A: Management's Response

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

LOUISIANA DEPARTMENT OF HEALTH
Office of Management and Finance
Bienville Building
628 N. Fourth St.
P.O. Box 91030
Baton Rouge, Louisiana 70821–9030
Phone: (888) 342–6207
Fax: (225) 342–9508
https://ldh.la.gov/

April 29, 2019

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804–9397

Re: Wage Verification Process of the Expansion Population

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit report on the Wage Verification Process of the Medicaid Expansion Population. The Bureau of Health Services Financing, which is responsible for the administration of the Medicaid program in Louisiana, is committed to ensuring the integrity of the Medicaid program.

We have reviewed the results and overall agree with the reported update. Our data sharing agreement with the Louisiana Workforce Commission (LWC) has allowed LDH to conduct more frequent wage verification instead of solely relying on recipients to self-report changes in income. With this change, LDH detected and referred to the Attorney General potentially fraudulent cases, which are currently under investigation. Per federal requirements, LDH will only seek recoupment from Medicaid recipients convicted of committing fraud.

Additionally, in its first quarterly wage check performed in February of 2019, LDH initially terminated the coverage of 30,051 Medicaid adults effective March 31, 2019. However, the vast majority of the closures were for enrollees' failure to respond to LDH's request for information, rather than evidence of ineligibility at present. Since initial closure, over 7 percent of the 40,006 enrollees who received a request for information have since provided proof of eligibility and been re-enrolled in coverage.

LDH is actively monitoring enrollment churn, defined as the cycling in and out of the Medicaid program as life circumstances change. Cognizant of related disruptions in care that put enrollees at risk for poor health outcomes, LDH is actively working on diverse strategies to improve member communications and member responsiveness as a means to reducing coverage termination for purely procedural reasons, such as failure to respond to a request for information.

---

[5] Continuous enrollment is a decision of each state, and examples of these types of Medicaid recipients include children and other groups such as pregnant women. Income identified for those in continuous enrollment was used to assess the eligibility of other household members, but not those in continuous enrollment.

[6] As of April 4, 2019.

[7] This does not account for any effects of Medicaid recipients losing and re-acquiring Medicaid coverage.

You may contact Michael Boutte, Medicaid Deputy Director, at (225) 342-0327 or via e-mail at Michael.Boutte@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

Appendix B: Scope and Methodology

We conducted this analysis under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This analysis focused on the Louisiana Department of Health's (LDH) income eligibility processes, primarily concerning its use of Louisiana Workforce Commission (LWC) wage data. The purpose of this analysis was to determine how LDH addressed the ineligible individuals identified in the targeted selection analysis in our November 2018 report and assess the results of LDH's first quarterly wage check.

The scope of our audit was significantly less than that required by Government Auditing Standards. We believe the evidence obtained provides a reasonable basis for our findings and conclusions. To conduct this analysis, we performed the following steps:

- Researched relevant federal and state laws, regulations, policy, and guidance regarding the Medicaid eligibility determination process.
- Obtained information from LDH on steps taken to address recommendations made in our previous report.
- Analyzed LDH electronic case record information to determine steps taken by LDH on the 100 Medicaid recipients identified in the targeted selection from our previous report.
- Analyzed the results of LDH's first quarterly LWC wage match with Medicaid recipients.

Appendix C: List of Previous MAU Reports

Issue Date	Title
December 12, 2018	*Medicaid Eligibility: Modified Adjusted Gross Income Determination Process*
November 8, 2018	*Medicaid Eligibility: Wage Verification Process of the Expansion Population*
October 31, 2018	*Identification of Incarcerated Medicaid Recipients*
June 20, 2018	*Reliability of Medicaid Provider Data*
May 2, 2018	*Strengthening of the Medicaid Eligibility Determination Process*
November 29, 2017	*Improper Payments for Deceased Medicaid Recipients*
October 4, 2017	*Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)*
September 6, 2017	*Improper Payments in the Medicaid Laboratory Program*
July 12, 2017	*Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services*
March 29, 2017	*Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers*
March 22, 2017	*Program Rule Violations in the Medicaid Dental Program*

Appendix C: List of Previous MAU Reports—Continued

Issue Date	Title
October 26, 2016	*Medicaid Recipient Eligibility—Managed Care and Louisiana Residency*

Source: MAU reports can be found on the LLA's website under "Reports and Data" using the "Audit Reports by Type" button. By selecting the "Medicaid" button, all MAU reports issues by LLA will be displayed; *https://www.lla.la.gov/reports-data/audit/audit-type/index.shtml?key=Medicaid.*

Medicaid Eligibility: Modified Adjusted Gross Income Determination Process

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID AUDIT UNIT REPORT
ISSUED DECEMBER 12, 2018

Louisiana Legislative Auditor
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804–9397

Legislative Auditor
DARYL G. PURPERA, CPA, CFE

Assistant Legislative Auditor for State Audit Services
NICOLE B. EDMONSON, CIA, CGAP, MPA

Director of Financial Audit
ERNEST F. SUMMERVILLE, JR., CPA

FOR QUESTIONS RELATED TO THIS AUDIT, CONTACT WES GOOCH, SPECIAL ASSISTANT FOR HEALTHCARE AUDIT, AT 225–339–3800.

Under the provisions of state law, this report is a public document. A copy of this report has been submitted to the Governor, to the Attorney General, and to other public officials as required by state law. A copy of this report is available for public inspection at the Baton Rouge office of the Louisiana Legislative Auditor and online at *www.lla.la.gov*.

This document is produced by the Louisiana Legislative Auditor, State of Louisiana, Post Office Box 94397, Baton Rouge, Louisiana 70804–9397 in accordance with Louisiana Revised Statute 24:513. Six copies of this public document were produced at an approximate cost of $4.68. This material was produced in accordance with the standards for state agencies established pursuant to R.S. 43:31. This report is available on the Legislative Auditor's website at *www.lla.la.gov*. When contacting the office, you may refer to Agency ID No. 3347 or Report ID No. 80180079 for additional information.

In compliance with the Americans With Disabilities Act, if you need special assistance relative to this document, or any documents of the Legislative Auditor, please contact Elizabeth Coxe, Chief Administrative Officer, at 225–339–3800.

LOUISIANA LEGISLATIVE AUDITOR
Daryl G. Purpera, CPA, CFE
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804–9397
https://www.lla.la.gov/
Phone: 225–339–3800
Fax: 225–339–3870

December 12, 2018

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras,
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our testing of the Louisiana Department of Health's (LDH) Medicaid MAGI eligibility determination process. Proper and timely eligibility decisions are critical to ensure LDH does not expend state and federal funds for ineligible individuals.

The report contains our findings, conclusions, and recommendations. Appendix A contains LDH's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of LDH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Medicaid Eligibility: Modified Adjusted Gross Income (MAGI) Determination Process

Louisiana Department of Health
December 2018

Audit Control #80180079

The Louisiana Department of Health (LDH) administers the Medicaid program to provide health and medical services to eligible Louisiana Medicaid recipients. As the single state Medicaid agency, LDH is responsible for all Medicaid eligibility determinations.

With the implementation of managed care in 2012, eligibility became the cost driver for Medicaid. LDH pays a per member per month (PMPM) rate, essentially a premium, for each Medicaid recipient according to the current eligibility records. **Proper and timely eligibility decisions are critical to ensure LDH is not expending state and federal funds on PMPMs for ineligible individuals.** Considering rising state health care costs and limited budgets, it is important that LDH ensure that Medicaid dollars are spent appropriately.

In 2014, through the Affordable Care Act, federal regulations changed the requirements for Medicaid eligibility determinations to a new methodology using federal income tax data known as Modified Adjusted Gross Income (MAGI). This new methodology better aligned Medicaid eligibility requirements with the requirements used in the Federally Facilitated Marketplace (FFM) so that consistent information could place an applicant in an appropriate, available health insurance program, whether Medicaid or a federally-subsidized private insurance policy through the FFM. The new MAGI determination process significantly changed the way Medicaid eligibility was determined for a large percentage of the Louisiana Medicaid program.

As of June 30, 2018, there were 1.6 million recipients in Louisiana Medicaid. Of these recipients, 1.2 million (75%) were determined eligible in a MAGI eligibility group by LDH and enrolled in one of the managed care organizations (MCO). The MCOs are responsible for payment of provider claims for Medicaid services. LDH paid $5.4 billion in PMPMs for MAGI-determined recipients in state fiscal year 2018.

In July 2016, Louisiana expanded Medicaid to a population of adults who previously had not been eligible for full Medicaid services. Now, adults earning up to 138% of the federal poverty level are eligible for full benefits in Louisiana Medicaid. The Centers for Medicare and Medicaid Service (CMS) regulations require the use of the MAGI-determination methodology for the Medicaid expansion adult group. Since the implementation of Medicaid expansion, approximately 490,000 adults have enrolled in Medicaid. Considering the large number of newly-enrolled recipients, new federal methodology, and quick implementation of Medicaid expansion, we determined this new Medicaid expansion adult population to be a higher-risk eligi-

bility group. Based on this risk, we focused the testing for this report on the Medicaid expansion adult group.

This report is the second in a series of two reports where we tested the eligibility of a sample of Medicaid recipients. Whereas this report evaluated the department's overall process for making eligibility determinations for the MAGI population, the first report titled *Medicaid Eligibility: Wage Verification of the Expansion Population* (issued November 8, 2018) focused on the wage verification process.

The purpose of this report is:

To evaluate LDH's policies and processes for making and documenting MAGI-based eligibility determinations.

Appendix A contains LDH's response to this report, Appendix B details our scope and methodology, Appendix C contains detailed results of our testing, and Appendix D contains a list of previously-issued Medicaid Audit Unit audit reports.

Objective: To evaluate LDH's policies and processes for making and documenting MAGI-based eligibility determinations.

Although MAGI-based eligibility determinations were required by federal regulations beginning in 2014, auditors of state Medicaid programs were instructed to not test the new MAGI determinations [1] because CMS would conduct pilot projects on this process for the first four years of the new eligibility methodology. Due to an oversight by CMS,[2] the instruction to auditors to not test MAGI determinations was inadvertently continued for a fifth year (2018). However, due to risks noted through our continuous Medicaid audit work, we determined that testing MAGI determinations was critical to our audit of Medicaid for 2018. As a result, this report is our first testing of LDH's MAGI determination process.

For this report, we tested eligibility determinations for a random sample [3] of 60 recipients from the Medicaid expansion adult group using MAGI-determinations and renewals for the period of July 2017 through February 2018. Our test included examining initial determination policies and practices as well as renewal policies and practices. Overall, we found that LDH needs to strengthen its policies and processes to ensure eligibility decisions are accurate per federal regulations and supported by adequate documentation. **Our testing found that for all 60 recipients (100%), LDH did not utilize federal and/or state tax data to verify self-attested tax filer status and household size or to verify certain types of income, including self-employment income, out-of-state income, and various unearned income. We consider the department's decision to not use tax data a weakness in internal control** because tax data is the only trusted source for these critical Medicaid eligibility factors. Based on the federal definition of improper payments, CMS could consider all related payments improper. Since LDH did not use tax data and auditors are not granted access to tax data for the purpose of auditing Medicaid, we consider this to be a scope limitation for our audit because we were unable to adequately test Medicaid MAGI-based eligibility determinations without tax data.

Despite the scope limitation, we were able to perform certain audit procedures for LDH's eligibility determination processes by reviewing the information included in the LDH recipient case records documentation. **This testing found that five (8%) of the 60 recipients in our sample were ineligible for Medicaid, based on the issues we identified with LDH's MAGI determination process. Some recipient cases had multiple errors noted. As a result, LDH made payments totaling $60,586 in PMPMs to MCOs on behalf of these ineligible recipients.**

Because this sample was randomly selected, we were able to project these results to the population of 220,292 Medicaid expansion recipients considered for this report. **Based on this projection, it appears that LDH paid PMPMs for 17,623 Medicaid recipients who did not qualify for Medicaid coverage.** Using the LDH eligibility case files and other documentation, we were unable to determine the

---

[1] Per guidance published in the Office of Management and Budget's (OMB) *Compliance Supplement,* which instructs auditors on the audits of federal programs under the Single Audit Act.

[2] CMS did not notify OMB to make the required change to the *Compliance Supplement* to instruct auditors to test all (MAGI and non-MAGI) Medicaid populations for eligibility.

[3] For the 60 sample recipient cases, we examined fiscal year 2018, fiscal year 2017, and fiscal year 2016 (start of expansion) in order to include both renewals and initial determinations in our review.

exact time during our audit period when the recipient became ineligible or whether the recipient was ever eligible. We were only able to determine that the recipient was not eligible based on the case file at the time of our review. Because of this limitation, we cannot reasonably project the amount of improper payments associated with the projected ineligible population. **However, our testing results suggest that if policies and processes are strengthened, the department could experience annual cost avoidance of approximately $111 million.**[4] Without good internal controls, accurate Medicaid eligibility determinations, and adequate documentation to support the eligibility decisions, the department may make PMPM payments to MCOs on behalf of ineligible recipients until the errors are identified and corrected by LDH. Based on the federal definition of improper payments, CMS could consider these payments improper.[5]

The specific issues we found regarding LDH's policies and processes for the MAGI-based eligibility determinations identified in our test are as follows:

- **LDH did not adequately verify critical MAGI-based eligibility determination factors for any of the 60 recipients in our sample.** LDH's policy did not require it to utilize federal and/or state tax data to verify self-attested tax filer status and household size or to verify certain types of income, including self-employment income, out-of-state income, and various unearned income. Instead, LDH made a policy decision to accept self-attested information for these critical eligibility factors when federal tax data could be used to verify the applicant's responses. If LDH does not verify critical eligibility factors, recipients may be deemed eligible when they are not, resulting in the department making PMPM payments to MCOs on behalf of ineligible recipients until the errors are identified and corrected. Based on the federal definition of improper payments, CMS could consider these payments improper.
- **LDH policy allowed caseworkers to renew the eligibility of 50 (83%) of the 60 recipients in our sample without contacting the recipients. For these recipients, LDH conducted electronic verification for some but not all critical eligibility factors.** While this practice may be allowable for certain populations of Medicaid recipients, this practice does not appear to be consistent with federal regulations and/or CMS guidance for all of the populations that received automatic renewals by LDH.
- **LDH caseworkers made incorrect eligibility decisions for five (8%) of the recipients in our sample.** Also, LDH caseworkers did not consistently follow up on requests for information sent to recipients as part of the eligibility determination, resulting in eight (13%) documentation errors for the recipients in our sample. In addition, LDH caseworkers and supervisors did not consistently retain adequate documentation in the case file to support the eligibility decision for 41 (68%) of the recipients in our sample.

In addition to the weaknesses we found with LDH's policies and processes for making MAGI-based eligibility determinations, we identified the following practices that further weaken the process and could impede the department's ability to recoup payments made on behalf of ineligible recipients:

- **LDH did not retain signed Medicaid applications in the case record for 50 (83%) of the 60 recipients in our sample.** LDH's case record copies of the state's online Medicaid application do not capture a signature. Electronic, including telephonically recorded, signatures or handwritten signatures transmitted via any electronic transmission are required for all initial applications by federal regulations. By not retaining evidence of a signed application, LDH may not legally be able to hold the applicant responsible for certain attestations made in the application. Also, LDH did not retain evidence of the delivery of certain required stipulations and notifications to the applicant, in violation of federal regulations.
- **LDH allowed people to apply on behalf of an adult applicant for whom he or she had no legal authority for three (5%) of the 60 recipients in our sample.** LDH accepted applications, including attestations, by anyone acting on behalf of the applicant and allowed recipients to age out of

[4] See Appendix B for our Scope and Methodology.

[5] Public Law No. 107–300, the Improper Payments Information Act of 2002, as amended by Public Law 111–204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010, Presidential memorandum to enhance payment accuracy.

child categories into adult categories without obtaining information and signatures from the now legal adult. Not requiring each legal adult to complete his or her own application could hinder the department's ability to hold the legal adult responsible for self-attested information. Without a separate application, the department is not able to provide evidence that the adult applicant accepted the federally-required stipulations and notifications included in the application.

These findings, along with recommendations to help LDH strengthen its Medicaid MAGI-based eligibility determination process are discussed in more detail on the following pages.

LDH did not adequately verify critical MAGI-based eligibility determination factors for any of the 60 recipients in our sample. LDH policy did not require it to use federal and/or state tax data to verify self-attested tax filer status and household size or to verify certain types of income, including self-employment income, out-of-state income, and various unearned income.

We tested a sample of 60 expansion MAGI-based eligibility determinations and confirmed that for all 60 recipients tested, LDH did not verify tax filer status and household size during initial expansion enrollment or renewal. The tax filer status and household size are both critical eligibility factors that could be electronically verified by using federal tax return data. However, as previously reported in our Medicaid Audit Unit report, *Strengthening of the Medicaid Eligibility Determination Process* issued May 2, 2018, LDH made a policy decision to accept self-attested information for these critical eligibility factors when federal tax data could be used to verify the applicant's responses. Also noted in the report, LDH did not use federal tax data to verify self-employment and certain unearned income. The electronic sources LDH currently chooses to use for verification of income cannot verify self-employment income, income from other states, or unearned income. The policies and practices used by LDH increase the risk that applicants will be determined eligible for Medicaid when they are not, resulting in the department making PMPM payments to MCOs on behalf of ineligible recipients until the errors are identified and corrected by LDH.

LDH did not utilize federal and/or state tax data to verify self-attested tax filer status and household size. For both of these critical factors, LDH accepted self-attested answers from the Medicaid applicant as stated in its MAGI-based Eligibility Verification Plan. Per CMS guidance, the tax filer status is the first step in the MAGI-based eligibility determination. If the recipient is a tax filer, the CMS tax filer rules apply. If the recipient is not a tax filer, a different set of non-tax filer rules apply. The tax filer rules and non-tax filer rules vary in how to determine the household size, so the verification of this first step is critical. The household size is also a critical eligibility factor since the number of people in the household determines what income level is allowable for Medicaid eligibility as shown in Exhibit 1. Without a correct household size, the eligibility income level cannot be accurately determined.

Exhibit 1. Federal Poverty Income Guidelines 138%

Family Size	Monthly Income Effective March 1, 2016	Monthly Income Effective March 1, 2017	Monthly Income Effective March 1, 2018
1	$1,367	$1,387	$1,397
2	$1,843	$1,868	$1,893
3	$2,319	$2,349	$2,390
4	$2,795	$2,829	$2,887
5	$3,271	$3,310	$3,384
6	$3,747	$3,791	$3,881
7	$4,224	$4,272	$4,377
8	$4,703	$4,752	$4,874

Source: Prepared by legislative auditor's staff using information from the LDH Medicaid Eligibility Manual.

Currently, LDH relies on self-attestation from the applicant. The Medicaid application contains a statement indicating that LDH will check several databases including the Internal Revenue Service for verification. The application also asks the recipient about tax filer status and tax dependents. The only electronic sources to verify this information are federal or state income tax data, which LDH currently chooses to not use.

Exhibit 2 illustrates a specific example from our audit outlining how tax filer status can change the proper household size, which changes the Medicaid income limit, and ultimately changes the applicant's Medicaid eligibility. In this example, an adult applied for Medicaid indicating they would be a tax dependent of their parent. At the time of application, the household consisted of a parent, an adult dependent (child), and a minor child. The parent earned a monthly income of $2,913 and expected to file a return and claim both children as dependents. The adult dependent earned a monthly income of $911. LDH incorrectly determined this recipient as eligible by not using the tax dependent status. For this case, each of the three tax filer scenarios is shown in Exhibit 2. Only Scenario 2 correctly reflects the facts as presented in the case file. This case is scheduled for closure by LDH, more than two years after initial enrollment. Based on the case files and facts of the case, it appears the recipient was never eligible. This example shows why both the tax filer status and household size are critical factors in the MAGI-based determination process.

Exhibit 2. Example of the Effect of MAGI Tax Filer Status and Household Size on Medicaid Eligibility

	Scenario 1	**Scenario 2**	**Scenario 3**
Tax Filer Status	Tax Filer—Expects to File a Return	Tax Dependent—Expects to be Claimed as a Dependent	Non-Filer/Non-Dependent—Does not Expect to File a Return or be Claimed as a Dependent
MAGI-based Household	1	3	1
Monthly Income	$911	$2,913	$911
Medicaid Income Limit for Adult Group in 2016	$1,367	$2,319	$1,367
Eligible/Ineligible	Eligible	Ineligible	Eligible
Eligibility determination correct based on *actual* facts per case file?	**Incorrect**	**Correct**	**Incorrect**

Scenario 1: Adult child (age 19) lives with a parent and younger sibling. The adult child claims he/she will file his/her own tax return.
Scenario 2: Adult child (age 19) lives with a parent and younger sibling. The adult child claims he/she will be a dependent on his/her parent's tax return.
Scenario 3: Adult child (age 19) lives with a parent and younger sibling. The adult child claims he/she will not file a tax return and will not be claimed as a dependent on the parent's return.
Source: Prepared by legislative auditor's staff using information from CMS guidance and LDH recipient case records.

LDH did not use federal tax data to verify certain types of income, including self-employment income, out-of-state income, and various unearned income. Per federal regulations, LDH can use information from other agencies in the state, and other state and federal programs in order to assist with verification of financial information. CMS requires state Medicaid programs to develop and submit a MAGI-based Eligibility Verification Plan that notes significant eligibility factors and defines how the state will address verification for each factor. While CMS requires this form to be completed and submitted, CMS does not either approve or disapprove the state's verification plan, allowing the state great flexibility on how eligibility is verified.

The Medicaid application asks the recipient about employment, other income, deductions, and yearly income. LDH made policy decisions for which of these answers are allowed to be accepted with just the self-attestation from the applicant, which answers need to be verified, and how that verification is to be performed.

LDH utilizes several state and private data systems to verify some income. However, the systems used are not comprehensive. For example, LDH uses quarterly wage and unemployment benefits (UI) information from the Louisiana Workforce Commission (LWC). In addition, LDH also uses a private data system, TALX, which provides information on employment status and income from some employers nationwide. However, this system is limited to only those employers that choose to participate. Exhibit 3 notes the types of income that must be considered in the MAGI-based eligibility determination, whether or not LDH verifies this type of income, and if so, the systems that are used. The exhibit also notes any limitations of the systems used for verification.

Exhibit 3. MAGI-based Income Types and Data System Verification

Income Type	Verified with Data Source	Verification Source	Explanation and Limitations
Taxable wages/ salary (gross)	Yes	LWC wage data	State wages reported to LWC by employers. Would not include wages earned in another state.
	Yes	Private databases	Wages from some nationwide employers, but only those that choose to participate in the private system.
Taxable interest	No	Tax data	LDH does not use tax data for any verification.
Self-employment net income (profit after subtracting business expenses)	No	Tax data	LDH does not use tax data for any verification.
Taxable Social Security	Yes	SSA	LDH uses a real-time connection to Social Security Administration data.
Alimony received	No	Tax data	LDH does not use tax data for any verification.
Most retirement benefits	Partial	PARIS	Provides some income for Veterans Administration benefits, but most other retirement benefits are not verified.
Net capital gains (profit after subtracting capital losses)	No	Tax data	LDH does not use tax data for any verification.
Most investment income	No	Tax data	LDH does not use tax data for any verification.
Unemployment benefits	Yes	LWC UI data	LWC Unemployment Compensation data system.
Rental or royalty income	No	Tax data	LDH does not use tax data for any verification.

Exhibit 3. MAGI-based Income Types and Data System Verification—Continued

Income Type	Verified with Data Source	Verification Source	Explanation and Limitations
Other taxable income such as canceled debts, court awards, jury duty pay not given to employer, and gambling prizes or awards	No	Tax data	LDH does not use tax data for any verification.

Source: Prepared by legislative auditor's staff using CMS regulations and LDH MAGI-based Eligibility Verification Plan.

As noted previously, LWC data does not capture self-employment income, income earned in other states, and royalty/rental income. Additionally, if a self-employed recipient does not report self-employment income as part of their application, LDH has no way of identifying that income as an omission. LDH relies solely on the recipient to report self-employment income and unearned income and does not use tax data as proof of self-employment income. Our testing noted three recipients with self-employment income or unearned income identified. For these cases, we noted the following:

- For one case, LDH accepted a handwritten statement representing one month of income from an employer with the same last name as the recipient with no additional inquiry.
- For one case, LDH accepted the recipient's attestation without requiring additional documentation to support the attestation.
- For one case, LDH accepted an application with self-employment income omitted while another state system, Supplemental Nutrition Assistance Program (SNAP), noted the income.

For all three of the cases, currently used systems did not provide verification of the self-employment or unearned income. Since the case file did not include adequate evidence to support the eligibility decision, we considered each of the three cases as documentation errors in our testing results in Appendix C, Exhibit C–3. However, any of these three errors could be eligibility determination errors if the self-employment and unearned income were verified and found to be at an amount to make the recipient ineligible. Because the LDH caseworker did not obtain and retain adequate documentation and auditors do not have access to tax data, we cannot determine if these three recipient cases were eligible or not.

We consider the department's policy decision to not use tax data to be a weakness in internal control since tax data is the only trusted source for verifying the Medicaid applicant's self-attested information for tax filer status, household size, self-employment income and deductions, and certain unearned income. As noted in Exhibit 3, LDH made policy decisions to not use federal or state tax return data for any verification. Without using tax data, LDH does not have an electronic source to verify any of the information or omissions from the amounts self-attested for the "other income" and "deductions" section of the application. We found this lack of internal control to be present in all 60 cases tested and also applicable to all 1.2 million MAGI-based determinations. See Appendix C, Exhibit C–2.

Income tax data, while for the previous year, could offer verification and valuable information on past tax reporting of tax filer status, household size (tax dependents), self-employment income, and other adjusted income and deductions. LDH management stated it intends to obtain federal income tax data to assist in eligibility determinations beginning in May 2019. Until that time, applicant information for several possible income sources is accepted as self-attested with no verification. This practice leaves the state vulnerable to errors or omissions that increase the risk that applicants could be determined eligible for Medicaid when they are not.

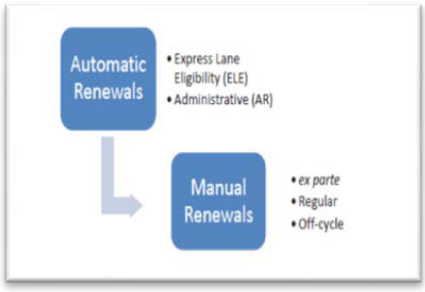
Recommendation 1: LDH should strengthen its processes for eligibility determinations. LDH should also ensure that all critical eligibility factors are verified rather than relying on self-attestation from the recipient.

Summary of Management's Response: Management concurred, noting that the new eligibility system will automate the verification of critical eligibility factors. LDH also noted that in May 2019 LDH will begin using federal tax data in the verification process.

Auditor's Additional Comments: Per LDH, federal tax data will not be used in the new eligibility system until May 2019, which will be 11 of the 12 months of fiscal year 2019. As a result, our audit scope limitation will continue to be present for fiscal year 2019.

LDH policy allowed caseworkers to renew the eligibility of 50 (83%) of the 60 recipients in our sample without contacting the recipients. For these recipients, LDH conducted electronic verification for some but not all critical eligibility factors.

Federal regulations require an annual renewal of eligibility for Medicaid recipients whose financial eligibility is determined using MAGI-based income. Renewal should be based on reliable information contained in the individual's account or other current information available to the agency. If possible, available information should be used before requiring information from the individual. LDH used both automatic and manual renewals.



Source: *LDH BHSF Eligibility Administrative Procedures Manual – Renewal Processing (Non-LTC)*

LDH used three types of renewals where caseworkers made the renewal determination without contacting the Medicaid recipient. These renewals are as follows:

- Express Lane Eligibility (ELE)—determines the recipient under 19 years of age to be automatically recertified for another year of Medicaid eligibility if the recipient has an active SNAP case and is receiving SNAP benefits.
- Administrative Renewal (AR)—determines the recipient automatically recertified for another year of Medicaid eligibility, with no contact or verification, for cases unlikely to have changes in income and/or personal status that would cause ineligibility. Per LDH policy, these renewals would only be applied to certain eligibility populations where little or no change in eligibility circumstances would be expected.
- Exparte—determines the recipient recertified for another year of Medicaid eligibility based on a review made by the department without the active involvement of the enrollee. However, Exparte includes electronic verification of some, but not all, eligibility factors to ensure the recipient's critical eligibility factors have not significantly changed to make them now ineligible.

We noted 50 of the 60 recipients tested were renewed for one or more years using ELE, Administrative Renewal, or Exparte, with no contact with the recipient.

While ELE and Exparte are established renewal methodologies, administrative renewals do not exist in federal guidance. Administrative renewals appear to be a practice developed by Louisiana Medicaid to cut down on the required

workload for LDH eligibility caseworkers when processing annual renewal determinations.

LDH's administrative renewal practice does not appear to meet the department's own criteria for an administrative renewal which should only be applied to certain eligibility populations where little or no change in eligibility circumstances would be expected. Per our testing, administrative renewals did occur for the Medicaid expansion adult population. Per LDH, when an administrative renewal is applied to an expansion adult recipient, LDH matches the recipient to SNAP records to ensure the recipient has an active case. Any recipient with an active SNAP case is automatically renewed for another year without any further electronic verification or contact with the recipient. The SNAP case may provide some assurance about the recipient's income, but SNAP alone may not be enough to determine the Medicaid recipient eligible.

Even though automatic renewals may be allowable for certain populations of Medicaid recipients, this practice does not appear to be consistent with federal regulations and/or CMS guidance for all of the populations that received automatic renewals by LDH. The expansion adult group, which is made up primarily of working adults, is the eligibility group most likely to have changes from year to year that could significantly change eligibility factors, especially household size and income. Renewals that do not confirm critical MAGI-based eligibility factors put the state at risk for improper eligibility decisions particularly for the expansion group. If LDH uses an automatic renewal and does not verify critical eligibility factors, the recipient's eligibility may be renewed in error, resulting in the department making PMPM payments to MCOs on their behalf until the errors are identified and corrected.

Due to the use of ELE, AR, and Exparte renewals, LDH often relied on tax filer status and tax dependent information from previous, older applications. In one instance, we did not find evidence of tax filer status in the case record for an expansion adult group recipient. The agency provided an application dated January 2014, where the recipient declared she would not file taxes and was not a tax dependent. The non-disabled recipient, born in 1986, is likely to have changes in circumstances over the past four years. The recipient's case was closed in December 2017 after the recipient failed to respond to a request for information. The recipient had not received any services since 2012.

Our Medicaid Audit Unit report *Managed Care and Louisiana Residency,* issued October 26, 2016, reported that automatic renewals processed without direct contact with the recipient contributed to approximately $1 million in improper payments from February 2012 through May 2016 due to out-of-state residency for Louisiana Medicaid recipients. If LDH does not verify critical eligibility factors, the recipient's eligibility may be renewed in error, resulting in the department making PMPM payments to MCOs on the behalf of ineligible recipients until the errors are identified and corrected.

> **Recommendation 2:** LDH should verify MAGI-based eligibility criteria annually using reliable data sources. LDH should also reconsider using automatic renewals for MAGI-based cases until all critical eligibility factors can be verified using reliable data systems.
>
> **Summary of Management's Response:** Management concurred, noting that no automatic renewals will be processed in the new eligibility system.

LDH caseworkers made incorrect eligibility decisions for five (8%) of the recipients in our sample. Also, LDH caseworkers did not consistently follow up on requests for information sent to recipients as part of the eligibility determination, resulting in eight (13%) documentation errors for the recipients in our sample. In addition, LDH caseworkers and supervisors did not consistently retain adequate documentation in the case file to support the eligibility decision for 41 (68%) of the recipients in our sample.

LDH is required by federal regulations[6] to include in each applicant's case record adequate evidence and facts to support the department's decision on the application. Our testing included a detailed review of recipient case records. We noted inconsistency of documentation in the case records regarding income verification, resulting in errors in the eligibility decisions. We also noted inconsistency in caseworkers' actions regarding private insurance, returned mail, and requests for additional infor-

[6] 42 CFR 435.914.

mation from the applicant. In addition, we noted limited review and supervision of caseworker activity.

Based on federal review standards, CMS could consider the lack of documentation to support the eligibility decision as errors and improper payments.

LDH caseworkers made incorrect eligibility decisions for five (8%) of the recipients in our sample. LDH case record guidelines only require the caseworker to document the systems the caseworker utilized to verify the applicant's income. However, when discrepancies in income are noted, the caseworker should document the amounts used to resolve the differences. There is no requirement to include a database screenshot or other evidence to support the caseworker's efforts. As a result of this permissive policy, we found that documentation practices varied greatly by caseworker. Case records included full screenshots, limited screenshots, case notes with amounts, and case notes without amounts. This inconsistency in practices from caseworkers can result in inadequate documentation to support the eligibility determinations. For 17 recipients, we noted instances of documentation issues related to income that included notes with no income, income counted incorrectly, notes that do not indicate system clearances were done, and notes that indicate system clearances were done when they were not. For five of the 17 recipients, the caseworkers made incorrect eligibility decisions or lacked adequate information to make the decision. We noted the following:

- For one recipient, in 2016, the case record noted that self-attested income exceeded the allowable amount and reasonable compatibility was not met. The caseworker sent a request for information to verify the income but determined the recipient as eligible even though the response to the request for information was never received. LDH closed the case in December 2017 when the recipient again failed to respond to the request for information. An LDH post eligibility review related to our work confirmed this result.
- For one recipient, in 2017, the caseworker accepted self-attested income with no verification. The caseworker noted that systems were checked when they were not. An LDH post eligibility review related to our work confirmed this result. LDH closed the case in September 2018.
- For one recipient, in 2017, the caseworker noted that income checks were performed, but no system checks were actually completed, resulting in the recipient's eligibility for two renewal periods when income actually exceeded the allowable amount. An LDH post eligibility review related to our work confirmed this result. Additionally, the recipient household size was not properly considered. LDH closed the case in October 2018.
- For one recipient, in 2018, the caseworker did not account for increased earnings, resulting in eligibility when the recipient actually exceeded the allowable income. An LDH post eligibility review related to our work confirmed this result. LDH closed the case in September 2018 after the recipient failed to respond to a request for information related to proof of earnings.
- For one recipient, self-attested rental income was included on a 2016 application. The case was subsequently Exparte renewed in 2017 and 2018 with system checks only without any verification of the rental income. The recipient had new income in 2018 that would make the recipient ineligible if the rental income still existed at amounts previously reported.

We consider these five cases to be eligibility determination errors in our testing results in Appendix C, Exhibit C–1. We consider all 17 cases to be documentation errors in Appendix C, Exhibit C–3.

Caseworkers do not always use available private insurance information in their eligibility consideration. For certain LDH programs—Louisiana Children's Health Insurance Program (LaCHIP) and the Breast and Cervical Cancer (BCC) program—having other health insurance makes the recipient ineligible for Medicaid. For all other programs, the recipient can be covered by private insurance and be eligible for Medicaid as long as Medicaid is the payer of last resort as required by federal regulations, meaning the private insurance must pay first. According to LDH, monthly premiums are adjusted by LDH's actuary in consideration of private insurance coverage. Insurance coverage is a question on the Medicaid application. LDH has a contractor responsible for identifying recipient linkage to private insurance and recovery of any amounts owed to LDH if Medicaid was not the payer of last resort as required under federal regulations.

Our testing noted one instance where the caseworker did not adequately consider private insurance when evidence was present in the case file. For this recipient, TALX income verification information noted that the recipient and the family participated in employer sponsored insurance at the recipient's place of work. There was no evidence that the caseworker considered this information. We also noted the recipient's children were on LaCHIP, which stipulates that covered children must not have other insurance. We consider this eligibility determination to be a documentation error in our testing results in Appendix C, Exhibit C–3.

Caseworkers did not always adequately consider mail returned to the department as undeliverable and the potential impact on eligibility. For one recipient, the case file contained returned mail dated November 15, 2016. Returned mail could indicate that the recipient moved out of state, was incarcerated, or was deceased. The caseworker did not reconsider the recipient's eligibility until July 2017 and did not close the case until September 2017 after the recipient did not respond to a request for information letter. The last evidence of utilization of services by this recipient occurred in October 2016. As a result, LDH paid PMPMs for this recipient for almost a year when faster action on the returned mail might have avoided making payments to the MCOs on behalf of the ineligible recipient. We consider this eligibility determination to be a documentation error in our testing results in Appendix C, Exhibit C–3.

Caseworkers renewed eligibility without recipients responding to their requests for required information such as proof of income. LDH caseworkers sent out requests for information to recipients for various reasons. Two types of requests that we noted were (1) letters notifying the recipient that it was time to renew their Medicaid eligibility determination including steps the recipient must take and (2) letters requesting proof of earnings. In both request types, specific instructions are provided with dates for the recipient's required response. To meet the requirement of due process, Medicaid allows enrollees an adequate timeframe to provide needed information. For renewals, LDH policy provides 30 days for the recipient to respond to request for information on MAGI cases, and 10 days are allowed for all others. If no response is received within the days allowed, the caseworker should determine the recipient ineligible and close the case. For applications, LDH policy provides for 10 days on responses to request for information. Our testing noted nine instances for eight recipients where the recipient did not respond to the request for required information, but LDH renewed their eligibility anyway without the appropriate response.

- For four recipients, the caseworkers requested proof of earnings but renewed the cases without a response from the recipient.
- For one recipient, the caseworker did not receive the proof of income documentation requested but instead accepted the recipient's statement for renewal.
- For one recipient, the caseworkers sent a case review letter noting appropriate ways for the recipient to renew. The letter clearly states the recipient must make contact by one of the listed methods by the noted date or coverage will end. The caseworker renewed coverage without the required response.
- For one recipient, the caseworker did not receive two separate requests for information, one for a case review letter and the other for proof of earnings. The eligibility was renewed despite no response to either inquiry.
- For one recipient, an application was accepted approximately 22 days after a request for information was due. The case record does not contain information as to why the case was not closed after the initial request for information was not answered. After receiving the application, a second request for information was sent with a due date in the next month. The recipient did respond to the request and eligibility was ended the next month, two months after the due date of the first request for information.

For these eight recipient cases, we consider the determinations to be documentation errors in our testing results in Appendix C, Exhibit C–3.

In our testing of case files, we found limited evidence of supervision and review of caseworker activity, documentation, and eligibility decisions. It appears that caseworkers are given latitude in applying LDH Medicaid policies and practices. Per LDH, each supervisor is required to conduct a formal case review on 30 cases per quarter. LDH employs approximately 117 supervisors and 540 caseworkers, with a supervisor for every four or five caseworkers. With 1.6 million re-

cipients, each caseworker is responsible for an average caseload of approximately 2,900 cases per year, or 725 cases per quarter. As a result, each supervisor is providing oversight for about 3,400 cases per quarter but formally reviewing 30 (< 1%). Per LDH, supervision and review other than the formal review occurs routinely but is not specifically documented. Also, per LDH, supervisors' reviews were reduced for the second quarter of 2018 and then suspended in September 2018 due to supervisors participating in the implementation of the new eligibility system. Without adequate supervision and review, the risk of eligibility decision errors by caseworkers increases. This increases the risk of the department making PMPM payments to MCOs on the behalf of ineligible recipients until the errors are identified and corrected.

In addition to our testing for this report, we also noted issues with inconsistent activity by caseworkers in our Medicaid Audit Unit report *Medicaid Eligibility: Wage Verification of the Expansion Population,* issued November 8, 2018.

> **Recommendation 3:** LDH should strengthen its processes to ensure that eligibility case determinations are supported by definitive, auditable documentation and promote consistency among caseworkers. Also, supervision and review of caseworker activity should be strengthened to ensure consistency of documentation and accurate eligibility determinations.
>
> **Summary of Management's Response:** Management concurred, noting that the new eligibility system will store the information available for use in the eligibility decision and create an audit trail for caseworker decisions. LDH also noted the ongoing efforts to train, supervise, and review caseworker actions.

LDH did not retain signed Medicaid applications in the case record for 50 (83%) of the 60 recipients in our sample. LDH's case record copies of the state's online Medicaid application do not capture a signature, which is required. By not retaining evidence of a signed application, LDH may not legally be able to hold the applicant responsible for certain attestations made in the application.

Federal regulations require initial applications and renewal forms signed by the applicant. If the agency cannot renew solely based on available information, a renewal form is required and must be signed in accordance with 42 CFR 435.907(f).[7] Per federal regulations, electronic, including telephonically recorded, signatures or handwritten signatures transmitted via any electronic transmission are required for all initial applications.[8]

According to LDH policy, the Medicaid application form:

- Is the official agency document used to collect information necessary to determine eligibility;
- Is the applicant's formal declaration of financial and other circumstances at the time of application;
- Is the applicant's certification that all information provided is true and correct;
- Shall not be altered after the applicant has signed the form; and
- May be used in a court of law.

In our review of 60 adult expansion group MAGI-based renewals and initial determinations for the period of 2016 through the date of our review in 2018, we found 50 recipients[9] (83%) with either no application on file or with an online application in the case file with the signature line blank. We noted the following:

- For 37 of the 50 recipients, an electronic application was included in the case file, but none of the applications contained the federally-required evidence of a signature.
- For 13 of the 50 recipients, no application was included in the case file for the period of our review.

---

[7] 42 CFR 435.916(a)(3).
[8] 42 CFR 435.907(f).
[9] Auditor counted by recipient instead of by instances and years. Some recipients submit multiple applications during the year.

For the 13 recipients with no application on file in the case record, we further noted the following:

- Nine were enrolled into the adult eligibility group from an existing LDH program in July 2016.
- Three were enrolled in the adult eligibility group using applications completed by others, with no application signed by the recipient.
- One was enrolled into the adult eligibility group using a pending disability application from 2015.

We considered these 50 recipients with unsigned applications or no applications to be documentation errors in Appendix C, Exhibit C–3.

According to LDH, applications/renewals generated through the online application system (electronic applications) contain a "sign and submit" feature. However, the system does not record the electronic signatures of the applicant in a manner that the department can provide evidence of the signature after submission, which appears to violate federal regulations. Without evidence of a signed application, LDH may not legally be able to hold the applicant responsible for certain attestations made in the application. Also, without a signature, LDH did not retain evidence of the delivery of certain required stipulations and notifications to the applicant, in violation of federal regulations.

> **Recommendation 4:** LDH should maintain as part of the recipient's case record the Medicaid application with evidence of the signature as required by federal regulations.
>
> **Summary of Management's Response:** Management concurred, noting that the new system will capture and store the electronic signature with the application.

LDH allowed people to apply on behalf of an adult applicant for whom he or she had no legal authority for three (5%) of the 60 recipients in our sample. LDH accepted applications, including attestations, by anyone acting on behalf of the applicant and allowed recipients to age out of child categories into adult categories without obtaining information and signatures from the now legal adult. Not requiring each legal adult to complete his or her own application could hinder the department's ability to hold the legal adult responsible for self-attested information.

According to LDH policy, anyone may apply for medical assistance. The following individuals may apply for assistance on behalf of someone else:

- The applicant/tax filer.
- A tax filer for a dependent claimed on their federal income tax return.
- A parent or legal guardian of a child. Note: A minor may apply for assistance without the consent of the parent or legal guardian with whom they reside.
- A curator or other legal representative of an adult.
- A spouse or other responsible person acting on behalf of the applicant.
- The appropriate Office of Juvenile Justice worker for a child in the custody of the state.
- An authorized representative.
- Any other person who is acting for the applicant.
- Other authorized agencies.

The policy also notes that if there is another non-related adult included on the application, only the signature of the applicant is required. While the policy and practice is understandable in cases involving minors, legal guardianships, state custody situations, and incapacitated individuals, allowing others to complete applications for adults with legal majority[10] could hinder the department's ability to hold the legal adult responsible for self-attested information. This policy allows a person to apply on behalf of an applicant for whom he or she has no legal authority. The policy may place the department at risk of violating personal identifying information

[10] Majority is defined as the age at which a person, formerly a minor, is recognized by law to be an adult, capable of managing his or her own affairs and responsible for any legal obligations created by his or her actions.

requirements by allowing queries of income information for the non-related adults included on the application without the consent of the legal adult.

Also per current LDH policy and practice, when a recipient ages out of a child case at age 19, LDH closes the child type case and opens a case as an adult with a single-member household without getting an application and without communicating with the recipient regarding tax filer status, household size, and taxable income.

In a review of 60 expansion renewals and initial determinations, we found three instances where the recipients were not contacted and the case file included no information that would indicate the recipient knew of the application being made on their behalf. As a result, the department may be hindered in its ability to hold the legal adult responsible for self-attested information. Without a separate, signed application, the department may not be able to provide evidence that the adult accepted the federally-required stipulations and notifications included in the application. The specific instances we found are as follows:

- One instance where a parent submitted and provided attestation for their child who is a legal adult.
- Two instances where recipients were transitioned into an adult eligibility group case from child cases without an application.

For the case with applications completed by a parent, the recipient did utilize services, indicating they are aware of their Medicaid status. For the two cases of eligibility transition, the recipients did not use services since 2014 and 2016, respectively. This could be an indication that the recipient was unaware of their continued eligibility. We noted these three cases as documentation errors in Appendix C, Exhibit C–3.

To ensure that each legal adult has knowingly provided self-attested information for which they can be held liable, each legal adult should file their own application, provide their own attestations, and accept the required stipulations and notifications. Current LDH policies and practices may violate federal regulations since no evidence is retained to prove that required stipulations and notifications were delivered and accepted by the legal adult recipient.

Recommendation 5: LDH should reassess the current application policies that allow one adult to complete the application for another legal adult and allow a recipient to age out of a child category to an adult category without an application and contact with the now legal adult.

Summary of Management's Response: Management concurred, noting that they will reassess current policies regarding applications. Management also noted that, in some situations, current policies are required by federal regulations.

Appendix A: Management's Response

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

LOUISIANA DEPARTMENT OF HEALTH
Office of Management and Finance
Bienville Building
628 N. Fourth St.
P.O. Box 629
Baton Rouge, Louisiana 70821–0629
Phone: (225) 342–6726
Fax: (225) 342–5568
www.ldh.la.gov

December 7, 2018

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804–9397

Re: Medicaid Eligibility—Modified Adjusted Gross Income Determination Process

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit report on the Medicaid eligibility modified adjusted gross income (MAGI) determination process. The Bureau of Health Services Financing, which is responsible for administration of the Medicaid program in Louisiana, is committed to ensuring the integrity of the Medicaid eligibility determination process through appropriate management controls.

We have reviewed the findings and provide the following response to the recommendations documented in the report.

Recommendation 1: LDH should strengthen its processes for eligibility determinations. LDH should also ensure that all critical eligibility factors are verified rather than relying on self-attestation from the recipient.

LDH Response: LDH agrees with this recommendation and continuously works to strengthen its eligibility determination processes. With the new eligibility system, LaMEDS, LDH will automate the verification of critical eligibility factors in accordance with 42 CFR §§ 435.940–435.965. Additionally, in May 2019, LDH will incorporate federal tax information into LaMEDS for use in the verification process.

Recommendation 2: LDH should verify MAGI-based eligibility criteria annually using reliable data sources. LDH should also reconsider using automatic renewals for MAGI-based cases until all critical eligibility factors can be verified using reliable data systems.

LDH Response: LDH agrees with this recommendation. With the implementation of LaMEDS, there are no automatic renewals. MAGI based cases are renewed by the use of current case information and interface with all data sources available to determine eligibility or via direct contact with the applicant for any MAGI cases that are not extended on an ex parte basis.

Recommendation 3: LDH should strengthen its processes to ensure that eligibility case determinations are suppo1ted by definitive, auditable documentation and promote consistency among caseworkers. Also, supervision and review of caseworker activity should be strengthened to ensure consistency of documentation and accurate eligibility determinations.

LDH Response: LDH agrees with this recommendation. LDH continuously reinforces caseworker training on agency policy requiring documentation of information used to make eligibility decisions. LDH supervisors review caseworker actions daily, including random sampling of cases for comprehensive review and targeted reviews of cases for specific issues. In addition, LaMEDS routes all cases assigned to the new employee to the supervisor for review and approval before finalizing the eligibility decision. In all cases, LaMEDS automatically stores information available to the system for use in eligibility decision making, creating an audit trail for case worker decisions.

Recommendation 4: LDH should maintain, as pa1t of the recipient's case record, the Medicaid application with evidence of the signature as required by federal regulations.

LDH Response: LDH agrees with this recommendation. While the previous online application required an electronic signature from the applicant, it did not create or store a printed name as evidence in the electronic case record. However, the new system, LaMEDS, automatically stores the electronic signature in the Enterprise Document Management System.

Recommendation 5: LDH should reassess the current application policies that allow one adult to complete the application for another legal adult and allow a recipient to age out of a child category to an adult category without an application and contact with the now legal adult.

LDH Response: LDH agrees with this recommendation. LDH will reassess current policies regarding applications. However, for enrollees who age out of a child category and who remain in the same tax filer household, federal regulations (42 CFR § 435.907) require that LDH accept an application from an adult who is in the applicant's MAGI household.

You may contact Michael Boutte, Medicaid Deputy Director, at (225) 342–0327 or via e-mail at Michael.Boutte@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

Appendix B: Scope and Methodology

The purpose of our analysis was:

To evaluate LDH's policies and processes for making and documenting MAGI-based eligibility determinations.

The scope of our project was significantly less than that required by Government Auditing Standards. However, we believe the evidence obtained provides a reasonable basis for our findings and conclusions. To conduct this analysis, we performed the following steps:

- Obtained a copy of the Medicaid eligibility files. Obtained LDH documentation cross-walking MAGI eligibility cases and non-MAGI cases to the aid categories and the type cases noted in the data files.
- Randomly sampled 60 cases from a population of 220,352 cases from the expansion adult group up for renewal in fiscal year 2018, but also determined eligible for the entirety of fiscal year 2017. While the sample cases were from fiscal year 2018 activity through February 2018, review of the cases considered activity from January 2016 through February 2018 in order to get a more comprehensive view of the case records.
- Obtained and reviewed the Medicaid eligibility policy and procedure documents from the LDH intranet and the LDH website.
- Worked with LDH personnel to ensure a proper understanding of policies and procedures.
- Reviewed electronic case records from fiscal year 2016 through February of fiscal year 2018.
- Provided results to LDH officials to validate our findings and conclusions and for further investigation.
- Based on the results and errors noted in our random sample, we projected the unduplicated eligibility cases error rate of 8% to the untested population of 220,292 cases, resulting in 17,623 likely ineligible recipients. We calculated the average annual PMPM paid for the tested and untested population. We used the projected ineligible recipients and the annual average of PMPMs paid per recipient to estimate $111 million in annual cost avoidance if noted deficiencies in processes are corrected.

Appendix C: Test Results

Eligibility Errors

Our testing noted 5 (8%) unduplicated eligibility case errors. See **Exhibit C–1.**

Exhibit C–1. Errors Resulting in an Incorrect Eligibility Decision

Errors	Percent Error	Error Noted
5 of 60	8%	Errors in income calculation resulted in incorrect eligibility decision

Source: Prepared by legislative auditor's staff using information from audit test results and LDH recipient case records.

Internal Control Deficiencies

LDH does not use federal tax return data to verify the self-attested information provided by Medicaid applicants regarding various critical eligibility factors, even though tax data was designed as the primary component to use in the MAGI-based eligibility determinations. We consider the department's decision to not use tax data a **weakness in internal control,** since tax data is the only trusted source for verifying the Medicaid applicant's self-attested information for tax filer status, household size, self-employment income and deductions, and certain unearned income. See **Exhibit C–2.**

Exhibit C–2. Weaknesses in Internal Control

Errors	Percent Error	Internal Control Deficiency
60 of 60	100%	No verification of tax filer status included in the case file
60 of 60	100%	No verification of household size included in the case record
60 of 60	100%	Tax data was not used to verify modified adjusted gross income

Source: Prepared by legislative auditor's staff using information from audit test results and LDH recipient case records.

Errors Due to Lack of Documentation

For 82% of the cases tested, we noted insufficient documentation to fully support the eligibility determination as correct. This percentage is for 49 unduplicated cases. Some cases had multiple errors. Per federal regulations, reviewers can determine a payment to be improper if they note insufficient documentation or a lack of documentation to support the payment. Our testing noted inconsistency in the case files and multiple instances of insufficient documentation. See **Exhibit C–3.**

Exhibit C–3 Errors Due to Lack of Documentation

Errors	Percent Error	Error noted
8 of 60	13%	LDH caseworker did not consistently follow up on requests for information sent to recipients as part of the eligibility determination.
3 of 60	5%	LDH caseworker did not obtain adequate documentation to verify self-employment income to support the eligibility determination.
17 of 60	28%	LDH caseworker did not maintain sufficient evidence in the case file to document the verification of income and appropriate consideration of the income noted.
1 of 60	2%	LDH did not request any documentation to verify rental/royalty income noted on application.
1 of 60	2%	LDH caseworker did not properly consider private insurance.
1 of 60	2%	LDH did not document its action taken or the consideration of the impact of returned mail noted in the eligibility file.
2 of 60	3%	The caseworker rolled an adult child into the adult eligibility group upon the recipient turning 19 years old without obtaining a signed application, including attestations from the adult recipient.
1 of 60	2%	The caseworker enrolled an adult recipient using an application completed and submitted by his/her mother, without obtaining a signed application, including attestations from the adult recipient.
37 of 60	62%	LDH did not maintain evidence of a signature on electronic applications during our reporting period (2016–2018).
13 of 60	22%	LDH did not maintain a copy of the accepted application in the case file and considered during our reporting period (2016–2018).

Source: Prepared by legislative auditor's staff using information from audit test results and LDH recipient case records.

Appendix D: MAU Issued Reports Detail

Issue Date	Title
November 8, 2018	*Medicaid Eligibility: Wage Verification of the Expansion Population*
October 31, 2018	*Identification of Incarcerated Medicaid Recipients*
June 20, 2018	*Reliability of Medicaid Provider Data*
May 2, 2018	*Strengthening of the Medicaid Eligibility Determination Process*
November 29, 2017	*Improper Payments for Deceased Medicaid Recipients*
October 4, 2017	*Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)*
September 6, 2017	*Improper Payments in the Medicaid Laboratory Program*
July 12, 2017	*Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services*
March 29, 2017	*Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers*
March 22, 2017	*Program Rule Violations in the Medicaid Dental Program*
October 26, 2016	*Medicaid Recipient Eligibility—Managed Care and Louisiana Residency*

Source: MAU reports can be found on the LLA's website under "Reports and Data" using the "Audit Reports by Type" button. By selecting the "Medicaid" button, all MAU reports issued by LLA will be displayed; *https://www.lla.la.gov/reports-data/audit/audit-type/index.shtml?key=Medicaid.*

QUESTION SUBMITTED FOR THE RECORD TO DARYL G. PURPERA

QUESTION SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Based on your experience, do you believe that use of current wage data will improve the overall accuracy of Medicaid eligibility determinations and reduce improper payments?

Answer. Yes. In Louisiana, we have shown that more frequent wage data checks can improve the overall accuracy of Medicaid eligibility determination and reduce improper payments.

At this time, Federal regulations require consideration of income for Medicaid recipients at the time of application and at annual renewal. Based on the audit work I presented to the committee, we have shown that checking income only once a year leaves unmitigated risk that recipients will continue in Medicaid when their status has changed during the year and are now ineligible, especially with the Expansion population of working adults.

In Louisiana, we have seen that more frequent checks of income absolutely works to reduce improper payments. In the Medicaid Audit Unit report that I presented, *Medicaid Eligibility: Wage Verification of the Expansion Population,* issued November 8, 2018, we recommended that the Louisiana Department of Health (LDH) conduct more frequent wage checks to mitigate the identified risk. LDH agreed with our recommendation.

In response to our recommendation, LDH began performing quarterly matches of eligibility data to state labor department wage data, with the first match using data from the quarter ending December 2018.

To date, LDH has performed three quarterly matches, as shown below.

Statistics From Quarterly Matches to LWC Wage Data

Month Performed	Quarter for Labor Data	Number of Requests for Information Sent Due to Match	Results	Month of Closure
February 2019	December 2018	39,162	LDH removed 34,789 recipients and continues to work on 236 cases—89%	April 2019
May 2019	March 2019	14,930	LDH removed 12,403 recipients and continues to work on 867 cases—83%	July 2019
August 2019	June 2019	27,898	LDH removed 17,036 recipients—61%	October 2019

Source: Compiled by the legislative auditor's staff using data provided by LDH.

As shown above, 64,228 Medicaid recipients have been removed due to excess income for the first three quarterly data matches. With the Louisiana managed care premium rates averaging about $600 per member per month, if each of these recipients were ineligible for just one month prior to removal, improper payments would total over $38 million.

The latest wage check was performed in November 2019 for September 2019 wage data. While the department has not completed the process yet, preliminary information obtained from LDH show an additional 27,578 cases where the wage data shown was in excess of eligibility levels. Requests for information are pending for these recipients and answers will be evaluated. If the final results are similar to the first 3 quarters, another 17,000 to 24,000 could be removed.

PREPARED STATEMENT OF BRIAN P. RITCHIE, ASSISTANT INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Chairman Toomey, Ranking Member Stabenow, and distinguished members of the committee. I am Brian P. Ritchie, Assistant Inspector General for Audit Services, U.S. Department of Health and Human Services. Thank you for your longstanding commitment to ensuring that the Medicaid program's 67 million beneficiaries are well-served and the taxpayers' approximately $600-billion investment is well-spent. I appreciate the opportunity to discuss the Office of Inspector General's (OIG's) work on Medicaid beneficiary eligibility determinations and what more can be done to secure the future of this important program.

INTRODUCTION

Medicaid spending represents one-sixth of the national health care economy, and Medicaid serves more people, including some of the Nation's most vulnerable individuals, than any other Federal health-care program. In 2010, Congress enacted the Patient Protection and Affordable Care Act (Pub. L. No 111–148) and the Health Care and Education Reconciliation Act (Pub. L. No. 111–152), collectively known as the Affordable Care Act (ACA). The ACA mandated changes to Medicaid eligibility rules, such as calculating income based on modified adjusted gross income, a measure of income that is based on Internal Revenue Service rules. The ACA also provided States with the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these "newly eligible beneficiaries."

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These traditional coverage groups include low-income parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly. Although many "newly eligible beneficiaries" applied for Medicaid coverage for the first time after the passage of the ACA, many people who applied for coverage qualified for these traditional coverage groups. We refer to these individuals as "non-newly eligible beneficiaries."

OIG shares the committee's commitment to protecting Medicaid from fraud, waste, and abuse and has an extensive body of oversight work in this area. A strong program integrity strategy starts with prevention. Correctly determining beneficiary eligibility prevents Medicaid from making improper payments for people who are not eligible for the program.

For the past several years, OIG has conducted several audits of States' Medicaid eligibility determinations under the Medicaid eligibility rules changed by the ACA. To date, OIG has issued seven audit reports of four States: four on newly eligible beneficiaries and three on non-newly eligible beneficiaries.

We found that these States made payments on behalf of beneficiaries who were not eligible, or who may not have been eligible, for Medicaid. We also identified instances where States received higher Federal reimbursement rates than appropriate on behalf of beneficiaries who were eligible for a traditional eligibility group; but were incorrectly enrolled as newly eligible. These four States did not comply with requirements to verify applicants' income, citizenship, identity, and other eligibility criteria. We estimated that almost $6.3 billion in Federal payments were associated with these incorrect, or potentially incorrect, eligibility determinations.

My testimony today details this work, which was done in California, Colorado, Kentucky, and New York. I will discuss the types of errors, the estimated number of beneficiaries affected, and the associated amount of dollars impacted for both newly eligible and non-newly eligible groups; as well as how both human and system errors contributed to these payments. Our audit period for California, Kentucky, and New York was October 1, 2014, to March 31, 2015; and our audit period for Colorado was January 1, 2014, to September 30, 2015. We have additional ongoing audits in Louisiana and Ohio assessing Medicaid eligibility determinations for newly eligible beneficiaries, as well as an audit in Colorado for non-newly eligible beneficiaries. These reports will be issued as they are completed.

STATES DO NOT ALWAYS CORRECTLY DETERMINE MEDICAID ELIGIBILITY FOR BOTH NEWLY ELIGIBLE AND NON-NEWLY ELIGIBLE BENEFICIARIES

Correctly determining beneficiary eligibility is vital to the accuracy of Medicaid payments. To ensure that Medicaid makes payments on behalf of the right beneficiary, it is critical to determine whether the beneficiary receiving services is actually eligible for Medicaid, as well as for the specific eligibility category the beneficiary has been placed in. The seven recent OIG audits of four States estimated that almost $6.3 billion in Federal Medicaid payments has been made on behalf of beneficiaries who are ineligible or who may have been ineligible for Medicaid or their assigned eligibility category. Beneficiaries that States determined to be newly eligible accounted for almost $1.3 billion of these payments, and the remaining $5 billion was for beneficiaries that States determined to meet one of the non-newly eligible Medicaid categories.

METHODOLOGY

For each of our seven audits, we reviewed the Medicaid eligibility determinations made by the State Medicaid agency for a random sample of beneficiaries, classified as newly eligible or non-newly eligible depending on the audit, to determine whether the State agency made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements.

For each sampled beneficiary, we obtained, where possible, application data and documentation used to support the State agency's eligibility determination. Reviewing that data and documentation, we determined whether the State agency followed Federal and State requirements and its own procedures to verify eligibility information when making the eligibility determinations. In instances where the eligibility documentation, data, or the State's determination was unclear, we followed up with State agency officials.

If we were able to determine that a beneficiary was not eligible for Medicaid based on the application data and documentation, we refer to the beneficiary as ineligible. As an example, a sampled beneficiary attested to having income, supported by documentation, which was above the Medicaid income limit. In this example, the State agency incorrectly determined the beneficiary to be eligible and incorrectly claimed Federal reimbursement for payments made on behalf the ineligible beneficiary. We also refer to a beneficiary as ineligible if the beneficiary was eligible for a traditional coverage group but the State incorrectly determined that the beneficiary was newly eligible. As an example, a sampled beneficiary attested to having

income that was below 100 percent of the Federal poverty level. The beneficiary qualified for Medicaid under a traditional coverage group but was not newly eligible. As result, the State agency incorrectly received a higher Federal reimbursement rate for this beneficiary. In this type of case, we used the difference between the higher Federal reimbursement rate for the newly eligible population and the lesser reimbursement rate for the traditional population when determining the amount of Federal reimbursement that was incorrectly claimed.

If we were unable to conclusively determine eligibility because the State agency did not have sufficient supporting documentation or did not verify eligibility in accordance with Federal and State requirements, we refer to the beneficiary as potentially ineligible. As an example, a sampled beneficiary had not had a Medicaid eligibility redetermination since 2011. There were no case notes or other documentation between November 2011 and April 2017, and the State agency could not explain why no annual redetermination had been performed, as required, since 2011. For this type of situation, the State agency may have claimed Federal reimbursement for an ineligible beneficiary.

Based on our sample results in each audit, we estimated the total number of ineligible beneficiaries and beneficiaries who were potentially ineligible during our audit period; we also estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible beneficiaries and potentially ineligible beneficiaries during our audit period.

RESULTS FROM FOUR AUDITS ON MEDICAID ELIGIBILITY FOR NEWLY ELIGIBLE BENEFICIARIES

OIG reviewed whether certain States correctly determined eligibility, following changes made by the ACA to Medicaid eligibility rules.

OIG reviews of Medicaid eligibility determinations by California, New York, Colorado, and Kentucky revealed that these States did not always comply with Federal and State requirements to verify applicants' income, citizenship, identity, and other eligibility criteria. Generally, errors associated with newly eligible beneficiary determinations were due to the State agencies not properly verifying income or citizenship requirements; or the beneficiary being eligible under a different Medicaid eligibility group. In total, across these four States, OIG estimated that more than $721 million in Federal Medicaid payments were made on behalf of 498,434 ineligible beneficiaries. More than $534 million in Federal Medicaid payments were made on behalf of 127,020 beneficiaries who may have been ineligible. In total, that is almost $1.3 billion in Federal Medicaid payments made for more than 625,000 beneficiaries that were ineligible or potentially ineligible.

Both human and system errors contributed to these payments. As an example, human error occurs when State agency officials making eligibility determinations do not correctly act on known information. We identified instances where State agency officials incorrectly determined beneficiaries to be newly eligible even though the beneficiaries' application data or supporting documentation clearly demonstrated that their household income amounts were above the allowed maximum threshold of 138 percent of the Federal poverty level.

We found that some enrollment data systems were lacking the ability to (1) deny or terminate ineligible beneficiaries; (2) properly redetermine eligibility when a beneficiary aged out of an eligibility group; (3) maintain records, in accordance with Federal requirements, relating to eligibility determinations and verifications; and (4) retrieve and use information from other Government databases, such as those managed by the Social Security Administration and Department of Homeland Security. For example, we identified instances where a State agency electronically verified that a change in beneficiary income was above the allowable threshold but the system continued to make payments on behalf of the beneficiary. This occurred because the State systems did not have the functionality to discontinue Medicaid for a beneficiary who became ineligible due to a change in income after a previous determination had already been made.

RESULTS FROM THREE AUDITS ON MEDICAID ELIGIBILITY FOR NON-NEWLY ELIGIBLE BENEFICIARIES

OIG also reviewed whether certain States were correctly determining eligibility for non-newly eligible beneficiaries in accordance with Federal and State requirements. Errors associated with non-newly eligible beneficiaries were generally due to beneficiaries not meeting income requirements (including not submitting required tax information forms) or specific coverage group requirements. Additionally, there

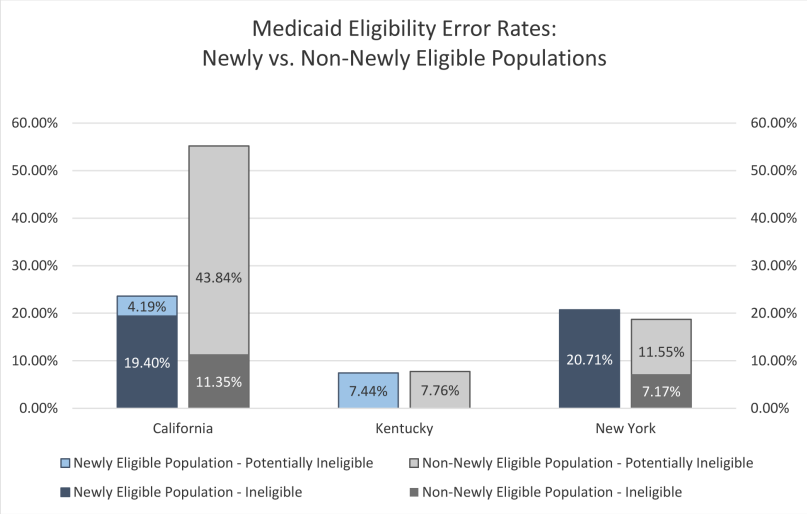
were a few errors due to beneficiaries not meeting citizenship and residency requirements. As a result of States incorrectly determining beneficiaries' eligibility, payments were made on behalf of those beneficiaries that were ineligible or potentially ineligible, resulting in improper and potentially improper costs to the Federal Government.

OIG reviews of Medicaid eligibility determinations by California, New York, and Kentucky revealed that these States did not always comply with Federal and State requirements to verify applicants' eligibility. In total, across these three States, OIG estimated that more than $1.05 billion in Federal Medicaid payments were made on behalf of 1,186,635 ineligible beneficiaries. More than $3.98 billion in Federal Medicaid payments were made on behalf of 3,788,248 beneficiaries who may have been ineligible. In total, more than $5 billion in Federal Medicaid payments were made for more than 4.9 million beneficiaries who were ineligible or potentially ineligible.

As with OIG's newly eligible audits, the non-newly eligible audits showed that both human and system errors contributed to these payments; specifically, (1) State agency staff did not consider all relevant information when making determinations, (2) caseworkers made errors, (3) system delays occurred during a system conversion, and (4) State agencies did not always maintain documentation to support their eligibility determinations.

COMPARISON OF NEWLY ELIGIBLE AND NON-NEWLY ELIGIBLE ERRORS

In the three States where we have completed audits of both newly eligible and non-newly eligible beneficiary eligibility determinations, we have found eligibility determination errors in both groups. Kentucky and New York had relatively comparable error rates between both the two beneficiary groups, whereas California had a higher error rate for the non-newly eligible group (see chart below).



CONCLUSION

Correct determination of beneficiary eligibility is vital to the accuracy of Medicaid payments. Seven recent OIG audits of four States estimated that almost $6.3 billion in Federal Medicaid payments has been made on behalf of beneficiaries who were ineligible or who may have been ineligible. These include inaccurate eligibility determinations for both the newly eligible and the non-newly eligible beneficiary groups (see Attachment A listing information on our seven reports).

To address the concerns that we identified, we recommended that these States ensure that enrollment data systems be able to verify eligibility criteria, develop and implement written policies and procedures to address vulnerabilities, and undertake redeterminations as appropriate.

OIG will continue to prioritize Medicaid oversight to prevent fraud, waste, and abuse and take appropriate action when they occur. We are committed to ensuring that Medicaid pays the right amount, to the right provider, for the right service, on behalf of the right beneficiary.

Thank you for your ongoing leadership and for affording me the opportunity to testify on this important topic.

Attachment A

Report Title	Report Number	Date Issued	Ineligible		Potentially Ineligible	
			Beneficiaries	Dollars	Beneficiaries	Dollars
Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A–07–16–04228	August 2019	85,085	$66,525,688	13,372	$26,797,483
New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries	A–02–16–01005	July 2019	383,893	$520,295,792	618,057	$1,297,308,200
California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	A–09–17–02002	December 2018	802,742	$536,039,109	3,100,260	$2,616,843,793
California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	A–09–16–02023	February 2018	366,078	$628,838,417	79,055	$402,358,529
New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A–02–15–01015	January 2018	47,271	$26,221,803	0	–
Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements	A–04–16–08047	August 2017	0	–	69,931	$72,800,000
Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A–04–15–08044	May 2017	0	–	34,593	$105,075,377
Totals			**1,685,069**	**$1,777,920,809**	**3,915,268**	**$4,521,183,382**
Grand Totals			**5,600,337**	**$6,299,104,191**		

QUESTIONS SUBMITTED FOR THE RECORD TO BRIAN P. RITCHIE

QUESTION SUBMITTED BY HON. JOHN THUNE

Question. In your testimony you discussed that the OIG has identified issues in State systems used to determine Medicaid eligibility. When visiting the State of South Dakota's Medicaid website, the public can view the number of individuals eligible for Medicaid by county, by month. Are all States able to pull this level of detail? If not, what steps do policymakers and CMS need to take to ensure that all State systems are functioning correctly to prevent improper payments?

Answer. We do not have information regarding the level of eligibility detail available to all States. To ensure that all State systems are functioning correctly and correctly identify eligibility errors, we encourage policymakers and CMS to work with States to address previous recommendations that we have made. OIG has made specific recommendations to States we have audited regarding system functionality. For example, we recommended that the California State Medicaid agency ensure it has the system functionality to use Social Security Administration data to verify whether a beneficiary is entitled to or enrolled in Medicare.

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Do you recommend States consistently use current and verified wage data as part of their Medicaid eligibility determination processes to improve payment accuracy and administrative efficiency?

Answer. Yes, States should consistently and correctly use current and verified wage data. However, many of the incorrect eligibility determinations we identified during our audits resulted from States making human or system errors. Information about an applicant's earnings was available. At times, the information showed that the applicant was not eligible for Medicaid. Yet, because of human or system errors, the applicant was incorrectly enrolled in the program. We recommend States follow existing rules that include using financial information related to wages, net earnings from self-employment, unearned income, and resources from IRS, SSA, State wage system and State unemployment insurance.

Question. Would you recommend that CMS issue guidance directing States to consistently use data sources available at the Federal level, such as current employment and income data accessible through the CMS Federal Data Services Hub, to accurately verify eligibility for Medicaid?

Answer. We recommend that CMS ensure that States are following existing eligibility requirements. Issuing guidance may help ensure that States understand current rules. We note that both California's and New York's eligibility verification processes use the Federal Data Services Hub. However, both States had errors related to income verification even though the Federal Data Services Hub was a data source. Using the Federal Data Service Hub is an important component of verifying eligibility, but CMS and States must ensure there are strong internal controls, policies, and procedures that make use of the data consistent with existing eligibility requirements. Similar to our response to Senator Toomey's first question, that means addressing human and system errors as well.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. Medicaid enrollment has grown substantially in recent years, even for non-expansion States. In South Carolina, for instance, Medicaid and CHIP enrollment totaled 1,036,851 in August of this year, marking a 17.9-percent increase over August 2014 levels. Over the same 5-year period, the State's population grew by closer to 5 or 6 percent, so population growth alone cannot explain the rise in enrollment. Furthermore, whereas South Carolina's unemployment rate was at 6.6 percent in August 2014, it had fallen to 3.2 percent by August 2019, representing a drop of more than 50 percent. Our economy is strong, with more South Carolinians entering the workforce to pursue sustainable opportunities, and yet our State's Medicaid enrollment figures remain high.

While South Carolina's State government takes important steps to ensure program integrity and robust eligibility determination processes, programmatic growth across the country will increasingly spur the need for additional tools, supports, and

resources from Federal agencies and other key stakeholders as States seek to bolster their internal processes.

I understand that a number of Federal agencies and States incorporate current wage data into their eligibility determination processes for Medicaid and other government benefit programs. This type of data, for instance, is available at no cost to State Medicaid agencies through the CMS Federal Data Hub. However, use of this data is not a consistent practice.

Do you recommend that States consistently use current and verified wage data as part of their Medicaid eligibility determination processes to improve payment accuracy and administrative efficiency?

Answer. Yes, States should consistently and correctly use current and verified wage data. However, many of the incorrect eligibility determinations we identified during our audits resulted from States making human or system errors. For example, audits of California and New York found income errors even though those States use the Federal Data Services Hub. In other words, information about an applicant's earnings was available. At times, the information showed that the applicant was not eligible for Medicaid. Yet, because of human or system errors, the applicant was incorrectly enrolled in the program. We recommend States follow existing rules that include using financial information related to wages, net earnings from self-employment, unearned income, and resources from IRS, SSA, State wage system and State unemployment insurance.

Question. Are there concrete steps that we can take, when working with States, to raise awareness of this type of data and to encourage effective utilization thereof?

Answer. States need to be aware of existing rules and the importance of making correct eligibility determinations based on current information that is available. States also should be encouraged to take all steps necessary to reduce human and system errors to the greatest extent possible. The reduction of these types of errors would help to eliminate many of the errors we identified during our audits.

QUESTION SUBMITTED BY HON. TODD YOUNG

NATIONAL DIRECTORY OF NEW HIRES

Question. The Federal Government currently has systems available to verify income, like the National Directory of New Hires (NDNH)—which has been used for many years in programs such as the Temporary Assistance for Needy Families, SNAP, and housing. The President's budget proposed using NDNH in Medicaid for program integrity.

If you had access to this data, do you think it would help with preventing, identifying, and recovering improper payments—and how?

Answer. OIG does not have a basis to determine whether access to NDNH data could help prevent, identify, and recover improper payments related to Medicaid eligibility. OIG does not currently have access to the NDNH and cannot judge how useful it might be.

PREPARED STATEMENT OF JUDITH SOLOMON, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

Chairman Toomey, Ranking Member Stabenow, and members of the Health Subcommittee of the Finance Committee, thank you for today's opportunity to testify. My name is Judith Solomon. I am a senior fellow on the health team at the Center on Budget and Policy Priorities, a nonprofit, nonpartisan policy institute located here in Washington. The Center conducts research and analysis on a range of Federal and State policy issues affecting low- and moderate-income families. The Center's health work focuses on Medicaid, the Children's Health Insurance Program (CHIP), the Affordable Care Act (ACA), and Medicare. I have spent over 40 years working on Medicaid, beginning as a legal services attorney and in several positions focusing on Medicaid policy issues affecting children, seniors, and people with disabilities.

The ACA provides a continuum of coverage for low-income adults, including an expansion of Medicaid for adults with incomes below 138 percent of the poverty line and subsidized individual market coverage for those with incomes above that level.

The ACA also includes provisions intended to create a seamless, no-wrong-door, coordinated eligibility system that allows people to enroll in and move between Medicaid, CHIP, and marketplace coverage depending on their circumstances. Streamlined enrollment is particularly important for low-wage workers, who had high rates of uninsurance before enactment of the ACA.

The audits that are the focus of today's hearing illustrate the challenge of implementing a streamlined enrollment system that gets people enrolled in the right program at initial application and when their circumstances change. But we shouldn't let that challenge detract from how the coverage expansions under the ACA have achieved their goals of reducing uninsured rates and improving access to care, financial security, and health, especially in the States that have implemented Medicaid expansion.

Medicaid expansion has led to significant coverage gains and reductions in uninsurance among low-income people. Most studies show Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security for low-income people. And an increasing number of studies show improved self-reported health following expansion and an association between expansion and certain positive health outcomes.[1] But the ACA's vision hasn't been entirely realized in the 14 States yet to expand, and as this hearing shows there is still work to do to streamline enrollment and avoid gaps in coverage.

Today's hearing concerns eligibility errors in Medicaid, primarily whether people are being properly enrolled and whether they are remaining enrolled after they are no longer eligible. But we shouldn't limit our definition of program integrity to the occurrence and likelihood of these types of errors. We should also be concerned that there are many eligible people who aren't enrolled in coverage and others whose coverage is incorrectly being taken away because of barriers in the eligibility and enrollment process, including excessive paperwork, inadequate communication, and other factors. In 2017, 25 percent of uninsured people, 7.5 million in total, were eligible for Medicaid, according to the Urban Institute.[2]

In large part, both the eligibility errors that are the focus of today's hearing and the processes that leave many eligible people uninsured stem from the challenges of operationalizing precise eligibility limits based on income and household circumstances for people whose situations frequently change. Focusing only on the potential for errors in one direction rather than also addressing what's needed to ensure people can easily enroll, stay enrolled, and transition to other forms of coverage when their situations change will likely exacerbate the recent rise in uninsurance among both children and adults.

STATES FACE MULTIPLE CHALLENGES IN DETERMINING MEDICAID ELIGIBILITY

As noted, the ACA created a continuum of coverage for low-income people based on their income as a percentage of the poverty line, which takes into account both household income and household size. But income and household size aren't static. Children grow up and leave the home. People get married and divorced. And income changes over the course of a year are especially prevalent among low-income people. Low-wage jobs are often unstable, with frequent job losses and work hours that can fluctuate from month to month. Many Medicaid enrollees also work seasonal jobs in industries such as retail or tourism. A study looking at participation of working-age adults in the Supplemental Nutrition Assistance Program (SNAP), which has Federal income limits close to those of the Medicaid expansion, found that workers earning low wages are frequently in and out of work and on and off SNAP as their earnings fall and rise.[3] A similar study looking at Medicaid showed similar income volatility.[4]

---

[1] Larissa Antonisse et al., "The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review," Kaiser Family Foundation, August 15, 2019, *https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/*.

[2] Linda J. Blumberg et al., "Characteristics of the Remaining Uninsured: An Update," Urban Institute, July 2018, *https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf*.

[3] Brynne Keith-Jennings and Raheem Chaudry, "Most Working-Age SNAP Participants Work, But Often in Unstable Jobs," Center on Budget and Policy Priorities, March 15, 2018, *https://www.cbpp.org/research/food-assistance/most-working-age-snap-participants-work-but-often-in-unstable-jobs*.

[4] Aviva Aron-Dine, Raheem Chaudry, and Matt Broaddus, "Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements," Center on Budget and Policy Priorities,

Another study completed soon after enactment of the ACA showed the majority of people with income below 138 percent of the poverty line at the beginning of a 12-month period had income above 138 percent of the poverty line at some point during those 12 months. Conversely, about 40 percent of people with income between 138 and 200 percent of the poverty line saw their income fall below 138 percent of the poverty line at some point over the course of a year.[5] Thus, it was clear from the outset that the low-income adults gaining coverage under the ACA would experience frequent changes in eligibility for Medicaid and subsidized coverage.

There are other factors that continue to make it challenging for states to ensure that eligible people get enrolled, stay enrolled when they are eligible, and move to other coverage when their incomes or other circumstances change:

- **Replacing and modernizing State eligibility and enrollment systems to accommodate the ACA's vision of streamlined enrollment.** Upgrading enrollment systems and adopting new business processes was a huge undertaking for States, and the audits that are the subject of this hearing reflect system and caseworker errors, particularly in the first years of implementation, that continue to be addressed.
- **Requiring that States use income levels for claiming enhanced match different from those used to determine eligibility.** Most expansion States must not only determine whether peoples' income is below 138 percent of the poverty line, but also must determine whether they can claim enhanced Federal matching funds for the costs of their care. Determining the right match rate requires a separate assessment of whether an individual would be eligible under the State's pre-ACA rules or whether they are newly eligible under the expansion. This determination requires a precision that is often difficult to attain and is reflected in some of the audit findings where States claimed the higher match for people who were eligible under pre-ACA rules. For example, a State may correctly determine that a parent's income is below 138 percent of the poverty line but incorrectly claim enhanced match if it makes a mistake in finding that her income is above the pre-ACA eligibility level for parents. The error is in the match the State claims, not in eligibility of the person being covered.
- **Training eligibility workers on brand new tax-based rules for determining Medicaid eligibility.** The use of "Modified Adjusted Gross Income" to determine eligibility was a sea change for States, significantly changing prior rules on what income counts and who is considered in a household. Caseworkers had to learn the rules on tax treatment of income, including complex rules on how dependents' income is treated and who is considered a dependent under tax rules.
- **Limitations on the utility of tax data and other electronic data to verify income of low-wage workers who are self-employed, often change jobs, work on a seasonal basis, and have variable hours.** Verifying income largely through electronic data as the ACA suggests has been difficult to do for some low-wage workers although helpful for many others who no longer must submit pay stubs or other documentation. Medicaid eligibility depends on monthly income, which can change frequently. Electronic data sources and State wage databases often don't reflect people's current circumstances, because the data aren't up to date, or people's circumstances have changed since the data match, leading to requests for documentation that are difficult to fulfill. And electronic data aren't available for people who are self-employed.
- **Difficulties in effectively communicating complex eligibility rules.** Medicaid rules require that people notify the State Medicaid agency when their situations change to the extent that they are no longer eligible for coverage. This assumes people know that small changes in income or changes in their household composition may make them ineligible and that they should report these changes. Proper reporting is especially difficult for people

April 11, 2018, *https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements.*

[5] Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs,* February 2011, *https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.1000.*

with frequent income changes based on seasonal employment or variable hours.

CHALLENGES LEAD ELIGIBLE PEOPLE TO LOSE COVERAGE

The audits by the Government Accountability Office, Health and Human Services Office of Inspector General (OIG), and the State of Louisiana find errors in eligibility determination due to caseworker error, inadequate system capacity, and lack of documentation in case files. Most of these errors reflect the challenges inherent in determining eligibility. In some of the cases, enrollees may have failed to make timely reports of income changes, but variable income and difficulty knowing when to report make timely reporting difficult. For example, a parent who works extra hours in a month or two may not report knowing her hours will soon return to a lower level.

Meanwhile, the audits don't measure whether eligible people are unable to enroll or are losing their coverage when they remain eligible. Recent declines in Medicaid coverage for children and adults are due in part to a greater emphasis on frequent wage checks, more stringent documentation requirements, and terminations based on returned mail.[6] When State wage checks show income above the eligibility level, states require people to respond and prove they are still eligible within 10 days of the date of the notice, which sometimes reaches them just a few days before the deadline. In addition to short deadlines, the notices are difficult to understand, and people often don't know how to show they remain eligible if, for example, the increase in wages was just temporary.

Research and decades of experience in enrolling low-income children and adults in coverage show that increasing paperwork can lead to loss of coverage among eligible people due to difficulties completing processes and providing documentation.[7] Behavioral science helps explain why this is the case, teaching that everyone has limited attention and cognitive bandwidth, but people living in poverty face chronic scarcity, which forces them simultaneously to manage multiple challenging problems and requires enormous mental effort.[8]

The story of a Texas family in a recent *New York Times* story is a stark illustration of the consequences of increased paperwork for families facing multiple challenges. A baby's mother didn't respond quickly enough to a notice from the State to show her baby was still eligible and didn't even know her son lost coverage until she took him to the hospital. Her other two children had previously lost coverage for reasons she didn't understand, and she had given up trying to re-enroll them because it was so hard.[9]

Frequent changes in income and household composition, the complexity of rules governing whose income counts, and the need to make separate determinations of who is eligible for enhanced match make errors inevitable. The types of errors identified in the audits can be reduced but not eliminated. But a sole focus on improving accuracy by more frequent wage checks, increased documentation requirements, and terminating coverage when mail is returned will result in further declines in enrollment and will significantly increase errors in the other direction—taking coverage away from people who are eligible.

We've seen the impact of paperwork and the difficulty of reaching people to effectively explain complex rules in the implementation of work requirements in Arkansas and New Hampshire, where large numbers of eligible people lost coverage or were at risk of losing it. About 3 or 4 percent of those subject to the Arkansas work requirement were not working and did not qualify for exemptions, studies esti-

---

[6] Robin Rudowitz et al., "Medicaid Enrollment and Spending Growth: FY 2019 and 2020," Kaiser Family Foundation, October 2019, *http://files.kff.org/attachment/Issue-Brief-Medicaid-Enrollment-and-Spending-Growth-FY-2019-2020.*

[7] Samantha Artiga and Olivia Pham, "Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage," Kaiser Family Foundation, September 24, 2019, *https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/.*

[8] Harrison Neuert et al., "Work Requirements Don't Work: A behavioral science perspective," *Ideas* 42, March 2019, *http://www.ideas42.org/wp-content/uploads/2019/04/ideas42-Work-Requirements-Paper.pdf.*

[9] Abby Goodnough and Margot Sanger-Katz, "Medicaid Covers a Million Fewer Children. Baby Elijah Was One of Them," *New York Times,* October 22, 2019, *https://www.nytimes.com/2019/10/22/upshot/medicaid-uninsured-children.html?action=click&module=Top%20Stories&pgtype=Homepage.*

mated.[10] Yet each month, 8 to 29 percent of those subject to the requirement failed to report sufficient work hours; many didn't report any hours. And over 75 percent of those required to report hours (that is, those not automatically exempted by the State) failed to do so each month.[11] Likewise, a study estimates that all but a small minority of Medicaid expansion beneficiaries in New Hampshire are either working or ill or disabled (and therefore should qualify for exemptions), yet 40 percent of those subject to the work requirement were set to lose coverage had the State not put the policy on hold.[12]

FREQUENT CHANGES IN ELIGIBILITY ARE COSTLY

Frequent changes in eligibility, often referred to as "churn," disrupt the continuity of care and coverage. Coverage changes are associated with changes in physicians, increased use of the emergency room, and decreased medication adherence even for many who don't experience gaps in coverage.[13] Churn also creates problems for health-care providers and Medicaid managed care organizations, limiting their ability to provide effective care and increasing their administrative costs as people cycle in and out of coverage. People who churn in and out of coverage have higher health-care costs, some studies suggest.[14] Churn is also costly for States, creating extra work to process new applications for people who remain eligible after losing coverage.

Frequent changes in eligibility work at cross-purposes with efforts to better manage care in order to lower costs and improve health outcomes. Federal and State programs, including Medicaid, are increasingly shifting to value-based care models that reward providers for managing patients' care and providing low-cost, high-value services. Value-based payment models are intended to give providers greater incentive to reduce costs and improve care by strengthening care coordination, avoiding duplicative or low-value care, and helping patients obtain high-value, low-cost services, such as preventive and primary care and medications to manage chronic conditions. But it's difficult for providers to coordinate and manage their patients' care if they are not continuously enrolled in health coverage.[15]

STATES CAN DECREASE CHURN

Some States have decided churn is so counterproductive that they have changed their eligibility rules to limit the frequency with which households need to change coverage due to changes in income. States have the option to provide children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) with "continuous eligibility"—a full year of coverage regardless of changes in their family's income. States can also elect to provide continuous eligibility to adults through a Medicaid waiver. To date, 24 States have adopted continuous eligibility for children in Medicaid, and 26 have adopted it for CHIP. So far, Montana and New York are the only States with continuous eligibility for adults. Utah has a proposal pending.

In States that have not adopted continuous eligibility, it's likely that some people still remain enrolled in Medicaid for a period after their income rises; similarly, it's likely that some people remain enrolled in the marketplaces for a period after their income falls. But while the audits being considered today have led some to claim that the Federal Government is spending large sums on people who are inappropriately enrolled in Medicaid, the reality is that the fiscal impact of these mistakes is often limited. Medicaid expansion enrollees whose incomes rise modestly above 138 percent of the poverty line are generally eligible for subsidized marketplace cov-

---

[10] Anuj Gangopadhyaya et al., "Medicaid Work Requirements in Arkansas," Urban Institute, May 24, 2018, *https://www.urban.org/research/publication/medicaid-work-requirements-arkansas.*

[11] Arkansas Department of Human Services, "ARWorks Reports," *https://humanservices.arkansas.gov/newsroom/toolkits.*

[12] Rachel Garfield et al., "Understanding the Intersection of Medicaid and Work: What Does the Data Say?", Kaiser Family Foundation, August 8, 2019, *https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/.*

[13] Benjamin D. Sommers et al., "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many," *Health Affairs,* October 2016, *https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455.*

[14] Anthem Public Policy Institute, "Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States," June 2018, *https://www.communityplans.net/wp-content/uploads/2019/04/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf.*

[15] Hannah Katch, "Restrictive Medicaid Policies Will Impede Innovation to Improve Care and Reduce Costs," Center on Budget and Policy Priorities, March 14, 2019, *https://www.cbpp.org/research/health/restrictive-medicaid-policies-will-impede-innovation-to-improve-care-and-reduce.*

erage. And for people with low incomes, the Federal cost for subsidized marketplace coverage is similar to (or sometimes greater than) the Federal cost for Medicaid.[16]

While continuous eligibility is the best approach, States can take other steps to decrease churn without increasing the number of ineligible people receiving coverage:

- **Improve communication with enrollees.** Written notices are often lengthy and complex without clear directions on what people must do to stay covered. In addition to improving enrollee notices, states can use phone calls, text messaging, and email to reach enrollees. Text messages are commonly used by low-income people, can reach them more quickly than traditional mail, can remind enrollees about needed verification documents, and can even collect information.[17] States should also use online and case management portals, through which enrollees can report changes in income and household size, view notices, and see when their renewal paperwork is due.[18]
- **Streamline verification of eligibility through self-attestation and use of electronic data to verify eligibility factors.** Part of the ACA's approach to streamline eligibility relies on electronic data sources to verify eligibility at application and renewal. When verifying income, State Medicaid agencies compare the sworn attestations that clients make on their application and renewal forms to available electronic data. The attestation and data source are considered "reasonably compatible" if they are both below the eligibility threshold, even if the amount of income in the attestation is different from the amount in the electronic data source. Under reasonable compatibility, states require documentation only when the difference between the attestation and data source affects eligibility. There are best practices States can take to fully implement reasonable compatibility policy and minimize the need for paper documentation.[19] States can, and most do, allow sworn self-attestation of eligibility factors such as age, household size, and tax filing status to reduce paperwork.
- **Use information collected and verified from other programs such as SNAP to determine eligibility.** About three-quarters of households receiving SNAP benefits in 2014 had at least one member receiving health coverage through Medicaid or CHIP. States can use data that SNAP programs collect and verify at application and renewal to renew Medicaid eligibility, among other strategies.[20]
- **Follow up on returned mail.** Arkansas is an example of a State that terminates people's coverage based on just one piece of returned mail. That's a big

---

[16] The Congressional Budget Office (CBO) estimates the 2019 annual average Federal cost of covering an individual in Medicaid or CHIP at $4,620, compared to $6,490 for covering an individual in the ACA marketplace. While these cost estimates are not directly comparable due to differences in the people who are eligible for coverage in these programs, they are suggestive evidence that coverage through Medicaid is not more costly to the Federal Government than coverage through the marketplace. Additional Treasury Department data show that ACA marketplace subsidies for those between 150 percent and 200 percent of poverty—those just above the Medicaid expansion level—are greater than the average subsidy, further suggesting that the Federal Government pays a similar amount, or perhaps less, for people with incomes modestly above 138 percent of the poverty line who remain enrolled in Medicaid. *See,* "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029," Congressional Budget Office, May 2019, *https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf;* and "Health Tax Provisions and Analysis, Table 3, Premium Tax Credit, 2018," U.S. Department of the Treasury, accessed September 2019, *https://home.treasury.gov/policy-issues/tax-policy/office-of-tax-analysis.*

[17] Jennifer Wagner, "Leveraging Text Messaging to Improve Communications in Safety Net Programs," Center on Budget and Policy Priorities," May 8, 2019, *https://www.cbpp.org/research/poverty-and-inequality/leveraging-text-messaging-to-improve-communications-in-safety-net.*

[18] Sonal Ambegaokar, Rachael Podesfinski, and Jennifer Wagner, "Improving Customer Service in Health and Human Services Through Technology," Social Interest Solutions and Center on Budget and Policy Priorities, August 23, 2018, *https://www.cbpp.org/research/health/improving-customer-service-in-health-and-human-services-through-technology.*

[19] Jennifer Wagner, "Reasonable Compatibility Policy Presents an Opportunity to Streamline Medicaid Determinations," Center on Budget and Policy Priorities, August 16, 2016, *https://www.cbpp.org/research/reasonable-compatibility-policy-presents-an-opportunity-to-streamline-medicaid.*

[20] Jennifer Wagner and Alicia Huguelet, "Opportunities for States to Coordinate Medicaid and SNAP Renewals," Center on Budget and Policy Priorities, February 5, 2016, *https://www.cbpp.org/research/health/opportunities-for-states-to-coordinate-medicaid-and-snap-renewals.*

reason the State saw enrollment decline by 60,000 people over an 18-month period even before it started taking coverage away from people who didn't comply with a work requirement.[21] Many low-income people move frequently within a State, so rather than assume they moved out of State when mail is returned, which Arkansas appears to do, States can use the postal service's National Change of Address system and use text, mail, or phone to reach people before taking their coverage away.

Adopting continuous eligibility and these other measures would decrease errors in both directions, increasing the accuracy of eligibility determination while also making it easier for people to enroll, stay enrolled, and transition to other coverage when their eligibility changes. Focusing just on increased wage checks and documentation may reduce the number of *ineligible* people who receive Medicaid, but it will likely end up taking coverage away from a greater number of *eligible* people.

RECENT CLAIMS OF WIDESPREAD ELIGIBILITY ERROR BASED ON FAULTY ANALYSIS

Some opponents of Medicaid expansion have relied on a recent study finding that significant numbers of people who reported in census surveys that they have annual income above the Medicaid cutoff appeared to have gained coverage through the expansion.[22] But those reporting survey income above 138 percent of poverty could be eligible for the Medicaid expansion for many legitimate reasons. They could, for example, be eligible for part of the year because they had low income in some months due to temporary unemployment or unstable hours; Medicaid eligibility is generally based on monthly, not annual, income. Or, they could have income from child support or other sources that don't count toward Medicaid eligibility. Or, in their responses to the census questions, they could have provided rough estimates of their incomes rather than precise answers. The census surveys don't verify income, while Medicaid does.

In addition, some higher-income people whom surveys record as enrolled in Medicaid may be enrolled in other coverage (such as marketplace coverage), either because they responded incorrectly to the survey questions or because of the way that census studies infer Medicaid enrollment for those who don't answer the relevant survey question.

Moreover, the OIG audits—particularly those from Kentucky, which was the subject of an earlier study based on survey data with similar findings—don't show widespread enrollment of people with incomes over the poverty line, further debunking the attempt to use survey data as a proxy for improper enrollment.

CONCLUSION

Thank you for the opportunity to testify. I look forward to responding to your questions.

QUESTIONS SUBMITTED FOR THE RECORD TO JUDITH SOLOMON

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Do you recommend States consistently use current and verified wage data as part of their Medicaid eligibility determination processes to improve payment accuracy and administrative efficiency?

Answer. As my written testimony explains, using electronic data to verify eligibility is a key component in State efforts to streamline their eligibility systems and decrease paperwork. However, when States use these data to update information on eligible enrollees, they should take steps to avoid ending coverage for people who remain eligible. These steps include using multiple methods of communication including email and text messages, improving notices which are often confusing and unclear about what enrollees need to do to stay covered, identifying situations where a change in income may be temporary or may not actually affect eligibility,

---

[21] Benjamin Hardy, "Scrubbed from the system," *Arkansas Times,* August 9, 2018, *https://arktimes.com/news/cover-stories/2018/08/09/scrubbed-from-the-system.*

[22] Brian Blase, "Health Reform Progress: Beyond Repeal and Replace," Galen Institute, September 2019, *https://galen.org/assets/Health-Reform-Progress-Brian_Blase.pdf;* and Brian Blase and Aaron Yelowitz, "Medicaid Deception," *Wall Street Journal,* August 14, 2019, *https://www.wsj.com/articles/obamacares-medicaid-deception-11565822360.*

and making it simple for enrollees to report changes and respond to notices through on-line portals and readily accessible call centers.

Question. Would you recommend that CMS issue guidance directing States to consistently use data sources available at the Federal level, such as current employment and income data accessible through the CMS Federal Data Services Hub, to accurately verify eligibility for Medicaid?

Answer. Medicaid regulations already require that States use information from electronic data sources to the extent the information is useful. This includes information from the data hub along with information from State wage and unemployment records, SNAP, and other public assistance programs (42 CFR §§ 435.948 and 435.949).

QUESTION SUBMITTED BY HON. TIM SCOTT

Question. Medicaid enrollment has grown substantially in recent years, even for non-expansion States. In South Carolina, for instance, Medicaid and CHIP enrollment totaled 1,036,851 in August of this year, marking a 17.9-percent increase over August 2014 levels. Over the same 5-year period, the State's population grew by closer to 5 or 6 percent, so population growth alone cannot explain the rise in enrollment. Furthermore, whereas South Carolina's unemployment rate was at 6.6 percent in August 2014, it had fallen to 3.2 percent by August 2019, representing a drop of more than 50 percent. Our economy is strong, with more South Carolinians entering the workforce to pursue sustainable opportunities, and yet our State's Medicaid enrollment figures remain high.

While South Carolina's State government takes important steps to ensure program integrity and robust eligibility determination processes, programmatic growth across the country will increasingly spur the need for additional tools, supports, and resources from Federal agencies and other key stakeholders as States seek to bolster their internal processes.

I understand that a number of Federal agencies and States incorporate current wage data into their eligibility determination processes for Medicaid and other government benefit programs. This type of data, for instance, is available at no cost to State Medicaid agencies through the CMS Federal Data Hub. However, use of this data is not a consistent practice. Do you recommend that States consistently use current and verified wage data as part of their Medicaid eligibility determination processes to improve payment accuracy and administrative efficiency? Are there concrete steps that we can take, when working with States, to raise awareness of this type of data and to encourage effective utilization thereof?

Answer. Medicaid regulations already require that States use information from electronic data sources to the extent the information is useful. This includes information from the data hub along with information from State wage and unemployment records, SNAP, and other public assistance programs (42 CFR §§ 435.948 and 435.949).

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

INCREASE IN THE NUMBER OF UNINSURED CHILDREN

Question. There have been an alarming number of reports about States taking action to decrease the number of people in their Medicaid programs. I think we can all agree about the need to ensure appropriate oversight and integrity of the Medicaid program. This is why I am concerned about eligible individuals, particularly children, getting kicked off of health-care coverage.

According to the U.S. Census Bureau, about 4.3 million children did not have any health coverage in 2018, an increase of 425,000 from 2017. That is almost half a million children more uninsured children in just one year.

It is incredible that there was an increase of half a million uninsured children, because last year this committee made a bipartisan commitment to continue funding for the Children's Health Insurance Program (CHIP) for 10 years.

How unprecedented is this increase of uninsured children—now for the second year in a row?

Answer. Coverage for children began to improve with the enactment of the Children's Health Insurance Program in 1997 and the trend continued with the enactment of the Affordable Care Act in 2014. The past 2 years have unfortunately shown a reversal of this longstanding trend.

Question. Do you know why the United States is seeing this increase in uninsured children? Or what policies could be causing this?

Answer. I agree with most experts that cite three primarily reasons: the Trump administration's public charge rule and other actions affecting immigrants that have created a chilling effect on enrollment for immigrant families even though their children remain eligible; the administration's emphasis on increased verification of income and other eligibility factors that have increased paperwork and made it harder to enroll; and a decrease in resources available for outreach and enrollment assistance.

Question. What should Congress do to address the increase of uninsured children?

Answer. Oversight of the administration's executive actions that appear to be increasing the number of uninsured children could lay a basis for reversing those actions either legislatively or by a future administration. And Congress could provide additional resources for outreach and enrollment assistance.

IMPROVING MEDICAID ELIGIBILITY DETERMINATIONS

Question. Earlier this year, Maryland passed a first-in-the-nation measure to make it easier for people without health insurance to find out if they qualify for low-cost insurance after they file their taxes. The new law will create a box for people to check on State income tax returns.

If a taxpayer checks the box, the State's health-care exchange will see if the person qualifies for Medicaid or premium tax credits based on information in the tax return. Those who qualify for Medicaid will be enrolled automatically. The exchange will reach out to people who qualify for private coverage.

Maryland's new program makes it easier, not more difficult, for eligible low-income people to receive coverage through Medicaid. Many individuals do not even know they qualify for Medicaid or premium tax credits.

The audits we are discussing today found that errors in eligibility or enrollment were often due to caseworker error, inadequate system capacity, and lack of documentation in case files.

Can you discuss best practices that States can take to both improve the accuracy of their eligibility determinations and make sure that eligible people are able to stay enrolled?

Answer. As my written testimony explains, the best way to ensure that eligible people can enroll and stay enrolled is by implementing continuous eligibility, which allows people to remain covered for a year once they're determined eligible unless they move out of State or become ineligible based on age. Continuous eligibility is an option for children in Medicaid and CHIP and New York and Montana have implemented continuous eligibility for adults through a Medicaid waiver. Continuous eligibility avoids the churn that results from frequent changes in eligibility that occur due to wage volatility and changes in household circumstances. Other steps States can take are detailed at pages 7 and 8 of my written testimony, including improving their written notices, using multiple means of communication including email and text messages, using on-line portals and readily accessible call centers, streamlining verification through the use of electronic databases, and using information collected and verified from other programs especially SNAP.

MEDICAID EXPANSION EXPANDING SUBSTANCE USE DISORDER TREATMENT

Question. Maryland was one of the initial 26 States that decided to expand its Medicaid program to cover individuals making up to 138 percent Federal Poverty Level. In 2017, almost 300,000 Marylanders obtained health-care coverage because of Medicaid expansion.

Medicaid expansion covers groups who were traditionally left out of public health coverage such as low-income adults without children and many low-income individuals with substance use disorders, chronic mental illness or disabilities, who struggle to maintain well-paid jobs, but don't currently meet disability standards for Medicaid.

For example, Medicaid expansion enabled 1.29 million low-income people with substance use disorders in States like mine to gain access to coverage that is unavailable to their peers in non-expansion States.

As many of my colleagues know first-hand, our country and our constituents are in the midst of an opioid crisis—something the full committee discussed during a hearing on October 24th. However, with States taking aggressive administrative actions in the name of addressing potential fraud and waste in the Medicaid program, I fear eligible adults in need of behavioral health treatment may be impacted and left without health coverage.

Could you speak to the importance that Medicaid Expansion has played in getting needed treatment to those with substance use disorders and mental health needs?

Answer. Providing coverage and access to care for these individuals has been one of the most significant impacts of Medicaid expansion. For example, since Medicaid expansion took effect, the share of opioid-related hospitalizations in which the patient was uninsured has plummeted 79 percent in expansion States, compared to just 5 percent in non-expansion States. Before expansion, there was no pathway to coverage for most adults needing behavioral health treatment, because they were under 65, not caring for a dependent child and didn't meet strict disability standards. State resources for treatment were limited, and many adults now eligible for Medicaid had unmet needs not only for behavioral health care but also co-occurring physical health conditions. In contrast, many States now are taking steps through Medicaid waivers and other Medicaid options to improve the delivery of care to people needing behavioral health treatment. Unfortunately in States that haven't expanded large numbers of adults still lack access to comprehensive care.

Question. What would be the impact on this population of people if President Trump's policy to eliminate Medicaid expansion went into effect?

Answer. It would be a complete reversal of the gains that have been made in addressing unmet treatment needs for a significant number of adults with behavioral health conditions making it impossible for States to continue the progress they have made and are continuing to make to improve their behavioral health systems and increase provider capacity.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

CONTINUOUS ENROLLMENT

Question. Constant churning in and out of the health coverage has a direct, negative effect on beneficiaries. And it's expensive. That's why I introduced the Stabilize Medicaid and CHIP Coverage Act. This legislation would provide stability in coverage for all Medicaid and CHIP beneficiaries by ensuring 12 months of continuous coverage.

In your written testimony you state that continuous eligibility is the best approach to keeping eligible people enrolled *and* increasing the accuracy of the eligibility process. Can you share more about how continuous eligibility works and why it would be the best approach?

Answer. Continuous eligibility allows people to stay enrolled for a year once they are determined eligible unless they leave the State or age out of coverage. Continuous eligibility is a State option for children in Medicaid and CHIP, and two States—New York and Montana—have Medicaid waivers allowing them to implement continuous eligibility for adults.

Continuous eligibility avoids the churn that often occurs for low-income households who experience frequent changes in income and household circumstances. Churn disrupts care and is costly for States and managed care organizations and other providers. Churn makes it harder for health plans to better manage care in order to lower costs and improve health care outcomes, working at cross-purposes with value-based care models that reward providers for care management and providing low-cost, high-value services.

While the Affordable Care Act includes provisions to ensure smooth transitions between Medicaid and marketplace coverage, we have found in practice these transitions are generally impossible without a gap in coverage. For people who do lose eligibility for Medicaid based on increased income, aligning Medicaid with calendar year marketplace enrollment would make it easier to achieve seamless transitions.

Question. In your written testimony, you mention the challenges that cause edible Medicaid beneficiaries to lose coverage. Can you share more about the issues with these predatory tactics that force eligible beneficiaries off Medicaid?

Answer. Many of the problems beneficiaries have in staying enrolled are due to inadequate communication, especially confusing written notices that don't clearly set out what beneficiaries should do to stay enrolled. Often people don't even get the notices because of mail delivery issues or out-of-date addresses. And States are only giving people 10 days from the date of the written notice to take action, which often leaves them just a few days to gather information to show they are still eligible. Other issues include difficulty in responding to notices because call centers aren't accessible due to call volume or inadequate hours for people who work and State failure to follow up on mail that is returned to them.

BUREAUCRATIC REQUIREMENTS

Question. The new Georgetown Center for Children and Families report released on October 30th, highlights some incredibly concerning trends as it relates to the uninsured rate for children. According to the new Georgetown Center for Children and Families report, over the past 2 years, the number of uninsured children nationwide increased by more than 400,000. That number includes 29,000 more uninsured children from my home State of Ohio. That's a 27.9 percent increase in the number of uninsured Ohio children between 2016 and 2018.

Can you please elaborate on how these bureaucratic requirements and complex eligibility checks prevent eligible families from receiving the health services and benefits?

Answer. My answer to question #2 above details the issues that are often leading to loss of coverage and illustrate the importance of continuous eligibility to combat churn and loss of coverage. Other factors that are leading to the increase in uninsured children are fear in the immigrant community due to the Trump administration's public charge rule and other anti-immigrant actions and decreased resources for outreach and enrollment assistance.

PREPARED STATEMENT OF HON. DEBBIE STABENOW,
A U.S. SENATOR FROM MICHIGAN

Thank you, Mr. Chairman, for holding this hearing today.

Welcome to our witnesses, and thank you for being here.

Today's hearing will focus on Medicaid eligibility and enrollment. Where we have issues with eligibility and enrollment, we need to fix them. We should all be able to agree on that. But right now, the number one threat to Americans who qualify for—and would like to enroll in—Medicaid is the Trump administration.

Any day now, the Fifth Circuit Court of Appeals will rule on the *Texas v. United States* case. Everything is at stake here, including protections for people with preexisting conditions, coverage for preventive services like cancer screenings, the ability for children to remain on their parents' health plans until age 26—and the entire Medicaid expansion that covers 17 million Americans.

Thanks to a detailed evaluation by the University of Michigan, we know the facts about what Medicaid expansion, which we call the Healthy Michigan Plan, has meant for the 654,000 people covered in my State. Those with Healthy Michigan coverage not only have better health care outcomes, they are better able to work and to seek employment. The expansion created more than 30,000 new jobs, and increased economic activity is creating $150 million in new tax revenue.

Uncompensated care at Michigan hospitals has been cut in half. That keeps private insurance rates down, and helps our hospitals in rural areas stay open.

So I repeat—if the Trump administration succeeds in the Fifth Circuit Court case and strikes down the ACA, the expansion is gone, and millions of Americans lose their health care entirely. Instead of attacking the Medicaid expansion in court, this administration should be focusing on the real Medicaid crisis: 17 States still have not expanded their Medicaid program.

Millions of Americans living in those States are caught in what is called the "coverage gap," unable to enroll in Medicaid expansion or afford comprehensive health insurance.

Senator Warner has a bill, which I am proud to cosponsor, that would allow States that expand Medicaid now the same full Federal matching funds as States that expanded earlier. The Senate should pass that bill so millions more Americans have coverage. Unfortunately, the court case and the "coverage gap" are not the only threats to Medicaid eligibility and enrollment right now.

I ask unanimous consent to submit an article from last week's *New York Times* titled: "Medicaid Covers a Million Fewer Children. Baby Elijah Was One of Them." The first paragraph reads: "The baby's lips were turning blue from lack of oxygen in the blood when his mother, Kristin Johnson, rushed him to an emergency room here last month. Only after he was admitted to intensive care with a respiratory virus did Ms. Johnson learn that he had been dropped from Medicaid coverage."

So why was Elijah dropped from coverage? Was he found ineligible? Was this a case of fraud?

No. According to *The New York Times,* Ms. Johnson missed a 10-day window for providing proof of income to the State. That might be why Elijah lost Medicaid coverage even though he qualified for it.

The story continued: "All of her children are now re-enrolled. But she has started receiving thousands of dollars in bills from the baby's hospital stay—bills she is counting on Medicaid to cover retroactively. And she is haunted by what might have happened if the hospital where she took Elijah had considered the case non-urgent and turned them away."

"I went to the ER thinking he had insurance," she said. "If the receptionist had not seen him turning blue, she might have just said, 'He's not covered, so we can't see him today.' I do think about that."

After decades of progress toward universal coverage for children, the United States reached an all-time low uninsured rate of under 5 percent in 2016. However, since then, we have been moving in the wrong direction. Thanks to complex enrollment policies pushed by the Trump administration and implemented by States, children, adults, and entire families are losing lifesaving health coverage they qualify for. Ms. Johnson only had 10 days to reconcile with the State before her child was kicked off Medicaid.

In some States, if you move, and a piece of mail from the State Medicaid office gets returned from your old address, you lose your coverage. In other words, the Trump administration is building a wall of paperwork to keep people from seeing their doctors.

So today, as we discuss ways to make sure that ineligible people aren't being enrolled in Medicaid, I hope we will also take a hard look at policies that are actually kicking eligible children and families off of their health insurance.

I look forward to having this discussion.

Thank you.

From *The New York Times,* October 22, 2019

MEDICAID COVERS A MILLION FEWER CHILDREN. BABY ELIJAH WAS ONE OF THEM

By Abby Goodnough and Margot Sanger-Katz

Officials point to rising employment, but the uninsured rate is climbing as families run afoul of new paperwork and as fear rises among immigrants.

HOUSTON—The baby's lips were turning blue from lack of oxygen in the blood when his mother, Kristin Johnson, rushed him to an emergency room here last month. Only after he was admitted to intensive care with a respiratory virus did Ms. Johnson learn that he had been dropped from Medicaid coverage.

The 9-month-old, Elijah, had joined a growing number of children around the country with no health insurance, a trend that new Census Bureau data suggests is most pronounced in Texas and a handful of other states. Two of Elijah's older siblings lost Medicaid coverage two years ago for reasons Ms. Johnson never understood, and she got so stymied trying to prove their eligibility that she gave up.

"I've been on this emotional roller coaster," Ms. Johnson, 34, said of Elijah's loss of coverage, an error that happened apparently because she didn't respond quickly enough to a letter asking for new proof of income. "It's been a very scary month."

Nationwide, more than a million children disappeared from the rolls of the two main state-federal health programs for lower-income children, Medicaid and the Children's Health Insurance Program, between December 2017 and June, the most recent month with complete data.

Some state and federal officials have portrayed the drop—3 percent of enrolled children—as a success story, arguing that more Americans are getting coverage from employers in an improving economy. But there is growing evidence that administrative changes aimed at fighting fraud and waste—and rising fears of deportation in immigrant communities—are pushing large numbers of children out of the programs, and that many of them are now going without coverage. The declines are concentrated in a minority of states; in other places, public coverage has actually increased.

An analysis of new census data by The New York Times shows the number of children in the United States without any kind of insurance rose by more than 400,000 in a two-year period, between 2016 and 2018, after decades of progress toward universal coverage for children.

Some of the states that saw the largest increases in uninsured children—like Tennessee and Texas—were those that created rules to check the eligibility of families more frequently or that reset their lists with new computer systems. In some states with large immigrant populations like Florida, doctors and patient advocates report growing concern among parents that signing up their children (who are citizens) may hurt their own chances of getting a green card or increase their risk of deportation.

When asked about the drop in Medicaid enrollment, government officials tend to point first to the improved economy, which has undoubtedly enabled some families to gain jobs with private insurance.

"Unemployment remains low, wage growth is up, and we now see fewer people relying on public assistance," Seema Verma, the administrator of the Centers for Medicare and Medicaid Services, wrote on Twitter in April. "That's something to celebrate."

In many states with large declines, like Tennessee and Missouri, officials cited the stronger job market.

Kelli Weldon, a spokeswoman for the Texas Health and Human Services Commission, cited "record-low unemployment levels" for its contraction in Medicaid enrollment.

But the census analysis also shows increases in the rate of uninsured children in states with enrollment declines, including Tennessee, Texas, Idaho and Utah.

In Texas, the number of uninsured children rose by around 120,000 between 2016 and 2018. State officials increased paperwork requirements in 2014 for families covered under both Medicaid and CHIP, which serves children whose income is slightly higher than Medicaid's.

Instead of checking eligibility once a year, as many states do, Texas enrolls children for six months and then checks databases for four consecutive months to ensure family income is still low enough to qualify. If the databases show the income has gone over the limit, families are notified by mail and have 10 days to prove otherwise or lose Medicaid.

A bipartisan bill in the state legislature this spring sought to make income checks annual again after data suggested several thousand eligible children were being dropped from Medicaid each month, but it never got a vote.

Other states have also begun checking family incomes more often, or removing families who may have moved if mail is returned to the state.

"The way they are doing this seems clearly designed to throw people off this program," said Eliot Fishman, a senior director at the consumer group Families USA, who was a top Medicaid official in the Obama administration.

When Tennessee updated its enrollment computer system in 2016, it generated thousands of errors. Medicaid and CHIP enrollment in the state has declined by

more than 55,000 children since January 2018, according to the Georgetown Center for Children and Families.

Tennessee's Medicaid director, Gabe Roberts, said that besides the improved economy, the decline in enrollment was a result of updating the computer system and clearing up a backlog of old cases.

Gordon Bonnyman, co-founder of the Tennessee Justice Center, which has been helping families struggling with lost coverage, was skeptical, saying the state response has revealed "a remarkable lack of curiosity about what happened to these kids."

The census shows that about 25,000 more children there have become uninsured since 2016.

A large body of evidence shows that Medicaid coverage for children has lasting effects on their lives, improving their health, educational attainment and even adult earnings. In 2010, the Affordable Care Act made it easier for states to check whether families qualified for Medicaid without requiring them to fill out paperwork, a strategy proven to increase coverage rates. The A.C.A. also made it harder for states to expel poor families for paperwork errors.

The changes helped the uninsured rate among children reach its lowest level ever in 2016, with fewer than 5 percent without coverage.

Trump administration officials have not explicitly tried to limit children's Medicaid coverage. But Ms. Verma has repeatedly encouraged state officials to safeguard "program integrity," by doing more vigorous checks of enrollees' eligibility. More recently, her office reviewed the reductions and concluded that problems with state computer systems may be a factor in some places.

"While the economy is the most consistent driver of enrollment that we observed, we have found evidence that other more state-specific factors may be driving individual state experiences," an agency spokesman, Johnathan Monroe, said in an email.

Medicaid and CHIP eligibility does depend on household income, meaning that, as wages rise, some families may be earning too much to qualify. Yet the patterns in coverage suggest reasons beyond improved finances. In Tennessee, for example, the biggest declines in Medicaid enrollment have come in counties with the highest unemployment rates, a Justice Center analysis found.

History has shown that when states require more paperwork from Medicaid beneficiaries, more eligible people fall through the cracks. Medicaid beneficiaries tend to move often; to have unstable hours and incomes; and to have literacy challenges that can make it hard to submit detailed renewal packages or verify their incomes frequently.

The specter of a pending "public charge" rule—which could penalize green card applicants who use public benefits like Medicaid—is causing many immigrant patients to decline enrollment, according to a Kaiser Family Foundation survey of community health centers. This month a federal judge temporarily blocked that rule from taking effect.

Texas leads the nation in the number of uninsured children and adults. In Houston, Maricela, a single mother, had carefully filled out the paperwork to re-enroll her younger two children, both citizens, in Medicaid every year since they were born—until now. A permanent resident from El Salvador who earns minimum wage as a hotel maintenance worker, she was so worried about jeopardizing her status that she decided to let their coverage lapse in August. Because of the deportation risk, she agreed to share only her first name.

"My worst fear is that I could end up without my legal status and be separated from my children," Maricela said this month at Epiphany Community Health Services, a nonprofit group that helps people find health coverage. "That would be fatal for me."

Her older son, 11, has asthma; at his last doctor's visit before his coverage ended, she pleaded for extra medicine. His main treatment, a generic version of Singulair, could cost $150 a month without insurance. Listening to him cough at night, she finally decided to take the risk and re-enroll both boys in Medicaid.

"I had to do it," she said, "But I'm afraid."

Dr. Sogol Pahlavan, a Houston pediatrician, said the rate of her patients on Medicaid dropped to 70 percent in 2018, from 75 percent a year earlier. She is part of a practice that has 10,000 patients, and the number of uninsured has grown commensurately, with families citing both the impending public charge rule and administrative hurdles.

"It's definitely going to affect the community, because somebody ultimately has to bear that cost," she said. "These kids are still here; their chronic disease isn't going away just because they're losing health coverage."

For Ms, Johnson, Elijah's stay at Texas Children's Hospital led to an appointment with an enrollment counselor who helped her try to figure out what had happened. Trying to re-enroll her older children earlier this year, she was asked for proof of income and missed the 10-day window to provide it; that may be why Texas dropped Elijah from Medicaid even though he qualified because he was a baby.

All of her children are now re-enrolled. But she has started receiving thousands of dollars in bills from the baby's hospital stay—bills she is counting on Medicaid to cover retroactively. And she is haunted by what might have happened if the hospital where she took Elijah had considered the case non-urgent and turned them away.

"I went to the E.R. thinking he had insurance," she said. "If the receptionist had not seen him turning blue, she might have just said, 'He's not covered, so we can't see him today.' I do think about that."

John Bel Edwards
GOVERNOR

Rebekah E. Gee, MD, MPH
SECRETARY

State of Louisiana

LOUISIANA DEPARTMENT OF HEALTH
Office of the Secretary
Bienville Building
628 N. Fourth St.
P.O. Box 629
Baton Rouge, Louisiana 70821–0629
Phone: (225) 342–9500
Fax: (225) 342–5568
https://ldh.la.gov/

October 28, 2019

The Honorable Patrick J. Toomey
Chairman
U.S. Senate
Committee on Finance,
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Debbie Stabenow
Ranking Member
U.S. Senate
Committee on Finance,
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Toomey and Ranking Member Stabenow:

As Louisiana's Secretary of Health and a practicing physician, I take seriously my constitutional charge to promote the health and welfare of Louisiana's people, while also responsibly managing the taxpayer dollars used to fund our programs, especially the state's Medicaid program, which serves 1.6 million Louisianans. Every day, we work to promote better health for our people and I am exceptionally proud of the work we have done to increase access to health care through our Medicaid expansion.

Governor John Bel Edwards' decision to expand Medicaid in 2016 resulted in more than 450,000 Louisiana residents gaining coverage and access to lifesaving health care. Louisiana's low income working residents can now see a primary care doctor when needed and receive preventive screenings. The results are life changing for our

residents—76,000 women have received mammograms, 43,000 individuals have received colon cancer screening and more than 100,000 people have received mental health or substance use disorder treatment.

The Medicaid expansion in Louisiana is saving lives.

In addition to significant physical and mental health benefits for our residents, the Medicaid expansion has had significant fiscal benefits for our state. By expanding Medicaid, Governor Edwards brought our federal tax dollars home, contributing to our state's economic growth. An analysis by Louisiana State University estimates that Medicaid expansion created more than 14,000 jobs in our state. And while our neighboring states have seen waves of rural hospital closures, not a single rural hospital has shuttered its doors during Governor Edwards' administration, which benefits everyone living in our rural communities. It comes as no surprise that, in a statewide survey, 76 percent of Louisiana residents said they approve of Medicaid expansion.

Thanks to Medicaid expansion, Louisiana has its lowest uninsured rate ever, which at 8 percent is below the national average. In order to promote the health and welfare of Louisianans, we need to build upon the success of the Medicaid expansion and continue to foster a culture of health coverage.

While we've expanded Medicaid to working adults, our department also maintains a culture of continuous quality improvement and is diligently working to ensure proper use of Medicaid dollars. Through the federal Centers for Medicare and Medicaid Services, the Trump Administration has acknowledged our success in this arena.

We appreciate the ongoing partnership we have with CMS, especially as we have undertaken the modernization of Louisiana's legacy eligibility system, which was the single largest technology implementation in our state government's history. Our new system is a powerful tool for managing program eligibility and, as a result of this implementation, Louisiana is doing more than it ever has to root out fraud, waste and abuse and to ensure that those who are eligible are the ones getting Medicaid.

The Louisiana Legislative Auditor, despite knowing the Louisiana Department of Health was implementing more robust technology, released a report last fall pertaining to wage verification, just weeks before our new automated eligibility system went into place. That report on our outdated prior system has been widely misrepresented. Several reputable nonpartisan health policy organizations—such as the Georgetown Center for Children and Families and the Center on Budget and Policy Priorities—agree.

We have been careful to look at how our new system can improve on the Department's ability to make timely and accurate eligibility systems, while also reducing churn and ensuring procedural reasons are not the reason for loss of coverage. Like the dozens of other states who have implemented new technologies for Medicaid enrollment, Louisiana is continuously learning and improving as we adapt to our new system.

The fact is that never in the history of Louisiana have we had more tools to ensure proper eligibility for Medicaid participants. And never in the history of our state have we done more to ensure that hard working Louisianans have access to the health care they need to thrive.

Please do not hesitate to reach out if the Committee has questions or if the Department and I can be of assistance to you in any way.

Sincerely,

Rebekah E. Gee, MD, MPH
Secretary
Louisiana Department of Health

PREPARED STATEMENT OF HON. PATRICK J. TOOMEY,
A U.S. SENATOR FROM PENNSYLVANIA

Welcome to the Senate Finance Subcommittee on Health Care hearing "Medicaid: Compliance With Eligibility Requirements."

It is my pleasure to welcome our four witnesses today as we discuss recent evidence of eligibility errors in the Medicaid expansion population and other issues sur-

rounding State compliance with Federal eligibility requirements. Our panel contains several nonpartisan, government officials that have performed research relevant to today's topic.

I look forward to hearing from them.

But first, I want to set the stage with a few staggering statistics:

- The Federal Government improperly spent *over $36 billion* in the Medicaid program, giving the program an improper payment rate of 10 percent;
- It accounted for *about 26 percent* of government-wide improper payments in that fiscal year, that was last year;
- Federal taxpayers spent *almost $12 billion* on ineligible Medicaid recipients; and
- Over the next 10 years, the *expansion population alone* will cost taxpayers a total of $925 billion.

Here's why this matters: Medicaid spending is already on an unsustainable path. Every decade since it was created, Medicaid has grown faster than our economy, a trend the Congressional Budget Office (CBO) projects to continue under current law. It is now a major driver of our Federal deficits and debt. And this trajectory cannot continue in perpetuity without eventually causing a crisis.

Unfortunately, Medicaid's financial condition has worsened in the last decade because Obamacare created a new category of eligibility—working age, able-bodied, childless adults—and gave States a huge financial incentive to cover these working-age individuals over the traditional populations, which are the disabled, the indigent, and the elderly poor.

For every working-age able-bodied adult it enrolls, a State gets 90 cents on the dollar, but just about 60 cents when it enrolls a disabled individual.

It doesn't take a math wizard to figure out how States can game this formula.

Making matters worse, in 2014 the Obama administration stopped auditing States' eligibility determinations. Payment Error Rate Measurement, or PERM audits, gave Congress insight into each State's eligibility errors. Without these reports, we don't have an complete picture of the Medicaid improper payment rate, meaning the estimated 30 percent of improper payments due to eligibility errors could in fact be much higher—resulting in much more perhaps than the $36 billion of taxpayer money being spent improperly.

Ensuring a taxpayer benefit like Medicaid goes to the intended recipient shouldn't be a partisan issue.

States must do a better job of adhering to Federal eligibility requirements and the Federal Government must do a better job enforcing the law.

Given the precarious financial condition of Medicaid, if we can't stop eligibility errors today, this safety net for millions of elderly and disabled may not be there for future generations.

PREPARED STATEMENT OF CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

October 30, 2019

Medicaid Eligibility: Accurate Beneficiary Enrollment Requires Improvements in Oversight, Data, and Collaboration

Why GAO Did This Study

Medicaid, a joint Federal-State health-care program, is one of the Nation's largest sources of funding for medical and other health-related services for tens of millions of low income and medically needy individuals. In fiscal year 2018, estimated Federal and State expenditures for Medicaid were $629 billion. The size and complexity of Medicaid make the program particularly vulnerable to improper payments—including payments made for people not eligible for Medicaid.

States have significant flexibility to design and implement their Medicaid programs based on their unique needs. These programs are administered at the State level, overseen at the Federal level by CMS, and jointly funded by the States and Federal

Government. The Federal Government matches most State expenditures for Medicaid services based on a statutory formula. Under the Patient Protection and Affordable Care Act, States have the option to expand their Medicaid programs to cover nearly all adults with incomes at or below 133 percent of the Federal poverty level. States that choose to expand their programs receive a higher Federal matching rate for the Medicaid expansion enrollees.

This testimony will cover improvements needed to ensure accurate eligibility determinations and focuses on (1) CMS's oversight of Medicaid eligibility and related expenditures; (2) CMS's efforts to improve Medicaid data; and (3) other opportunities to improve oversight and ensure appropriate enrollment. This testimony is generally based on GAO findings and recommendations on the Medicaid program issued from 2015 through 2018, and steps taken to address them through September 2019.

What GAO Found

The Centers for Medicare and Medicaid Services (CMS) has taken steps to improve its oversight of the Medicaid program; however, GAO has identified areas where additional actions could improve program oversight and ensure that only eligible individuals are enrolled in the Medicaid program. These actions include closing gaps in oversight of eligibility determinations and related expenses, improving data, and furthering Federal-State collaboration.

Gaps in oversight of Medicaid eligibility determinations and related expenses. Since 2014, CMS has not estimated improper payments due to erroneous eligibility determinations; it plans to report these estimates in November 2019. GAO found that for fiscal year 2017 Medicaid expansion enrollees accounted for nearly a quarter of all Medicaid enrollees and Federal Medicaid expenditures. GAO's prior work has identified gaps in CMS oversight, which affects the Federal match. An accurate determination of eligibility is critical to ensuring that only eligible individuals are enrolled, that they are enrolled in the correct eligibility group, and that States' expenditures are appropriately matched with Federal funds for Medicaid enrollees. GAO recommended that CMS conduct reviews of Federal Medicaid eligibility determinations to ascertain their accuracy and institute corrective actions where necessary, and revise the sampling methodology for reviewing expenditures for the expansion population. CMS concurred with these recommendations, though has since indicated that it will not revise the sampling methodology. We continue to believe that additional steps are needed to fully implement these recommendations.

Better Medicaid data. Improvements in Medicaid data could aid program oversight to ensure that only eligible beneficiaries are enrolled. CMS officials acknowledged the need for improved data and cited the Transformed Medicaid Statistical Information System (T–MSIS) initiative as its primary effort—conducted jointly with States—to improve the collection of Medicaid expenditure and utilization data. According to CMS officials, aspects of T–MSIS are designed to broaden the scope and improve the quality of State-reported data, as well as the data's usefulness to States. GAO made a series of recommendations related to T–MSIS. CMS concurred with the recommendations, but some have not been fully implemented, including expediting the use of T–MSIS data for oversight, and outlining a plan and associated time frames for using the data for oversight.

Further Federal-State collaboration needed for oversight and appropriate enrollment. GAO has previously reported that collaborative activities between the Federal Government and the States are important to improving oversight of the Medicaid program. CMS has ongoing efforts to engage State agencies and others through a national Medicaid training program for State officials and partnerships to combat Medicaid fraud. Recently, steps were taken to better enable State auditors to audit States' eligibility determinations to ensure beneficiaries qualify for the Medicaid program and are enrolled in the correct eligibility group. GAO has previously suggested that CMS could leverage the unique qualifications of State auditors and help improve program integrity by further providing State auditors with a substantive and ongoing role in auditing State Medicaid programs.

Chairman Toomey, Ranking Member Stabenow, and members of the subcommittee:

I am pleased to be here today to discuss the importance of ensuring that only eligible individuals are enrolled in the Medicaid program. This Federal-State program is one of the Nation's largest sources of funding for medical and other health-related services for over 75 million low-income and medically needy individuals. In fiscal year 2018, estimated Federal and State Medicaid expenditures for Medicaid were

$629 billion. The size and complexity of Medicaid make the program particularly vulnerable to improper payments—including payments made for people not eligible for Medicaid. In fiscal year 2018, the national Medicaid improper payment estimate was approximately $36 billion—nearly 10 percent of Federal Medicaid expenditures. Due to concerns about the adequacy of fiscal oversight, Medicaid has been on our list of high-risk programs since 2003.[1]

The Medicaid program is a partnership between the Federal Government and the States, with the Federal Government matching most State expenditures for Medicaid services on the basis of a statutory formula known as the Federal Medical Assistance Percentage (FMAP).[2] Within broad Federal requirements, States have significant flexibility to design and implement their programs based on their unique needs, resulting in over 50 distinct State Medicaid programs.[3] These programs are administered at the State level and overseen at the Federal level by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

The Patient Protection and Affordable Care Act (PPACA) gave States the option to expand their Medicaid programs by covering nearly all adults with incomes at or below 133 percent of the Federal poverty level (FPL) beginning January 1, 2014.[4] States choosing to expand their programs receive a higher Federal matching rate for these Medicaid expansion enrollees.[5] PPACA also includes a new approach to assessing individuals' financial eligibility for Medicaid.

My testimony today will cover improvements needed to ensure accurate beneficiary enrollment and will focus on:

1. CMS oversight of Medicaid eligibility and related expenditures;
2. CMS's efforts to improve Medicaid data; and
3. Other opportunities to improve Medicaid oversight and ensure appropriate enrollment.

My remarks are based on our large body of work examining the Medicaid program, specifically our reports issued and recommendations made from 2015 through 2018, and steps HHS and CMS have taken to address these recommendations through September 2019. Those reports provide further details on our scope and methodology. (See app. I for selected recommendations and a list of related GAO reports at the end of this statement.) For further context, my remarks reference the most recently available data from CMS on Medicaid beneficiary enrollment and expenditures, including enrollment and expenditures for Medicaid expansion enrollees in fiscal year 2017, information reported by State auditors, and the Office of Management and Budget's (OMB) 2019 Compliance Supplement. We conducted all of the work on which this statement is based 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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

---

[1] GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas,* GAO–19–157SP (Washington, DC: March 6, 2019).

[2] The FMAP is calculated using a statutory formula based on the State's per capita income, with the Federal Government paying a larger portion of Medicaid expenditures in States with low per capita incomes relative to the national average, and a smaller portion for States with higher per capita incomes.

[3] Medicaid programs are administered by the 50 States, the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

[4] Pub. L. No. 111–148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111–152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA. PPACA also permitted an early expansion option, whereby States could expand eligibility for this population, or a subset of this population, starting on April 1, 2010.

[5] In this testimony, Medicaid expansion enrollees refer to (1) individuals who would not have been eligible under the rules in effect on December 1, 2009, and whose coverage began after their State opted to expand Medicaid as authorized by PPACA; and (2) individuals who were not traditionally eligible, but were covered by Medicaid under a State-funded program or preexisting State demonstration as of December 1, 2009, in States that subsequently opted to expand Medicaid as authorized under PPACA.

BACKGROUND

The Federal Government and States share responsibility for the financing and administration of the Medicaid program. With regard to financing, Medicaid is funded jointly by the Federal Government and States, with FMAP rates ranging from a statutory minimum of 50 percent to a statutory maximum of 83 percent. Under PPACA, expenditures for Medicaid expansion enrollees are matched at 90 percent for fiscal year 2020.

Program administrative responsibilities are shared between States and the Federal Government. State administrative responsibilities include, among other things, determining eligibility, enrolling beneficiaries, and adjudicating claims. With regard to eligibility, States are primarily responsible for verifying eligibility and enrolling Medicaid beneficiaries. These responsibilities include

- Verifying and validating individuals' eligibility at the time of application and periodically thereafter,
- Accurately assigning enrollees to the appropriate eligibility group, and
- Promptly disenrolling individuals who are not eligible.[6]

PPACA requires States to use third-party sources of data to verify eligibility to the extent practicable. Consequently, States have had to make changes to their eligibility systems, including implementing electronic systems for eligibility determination and coordinating systems to share information.[7] In addition, States have had to make changes to reflect new sources of documentation and income used for verification. In certain circumstances, States may delegate responsibility to the Federal Government to make eligibility determinations.

At the Federal level, CMS is responsible for overseeing States' design and operation of their Medicaid programs and ensuring that Federal funds are appropriately spent. CMS oversees State enrollment of beneficiaries and reporting of expenditures. For example:

- CMS reviews and approves States' Medicaid eligibility verification plans, which rely primarily on information available through data sources—including Federal data sources such as the Social Security Administration and the Internal Revenue Services, or State data sources such as State tax records or unemployment information—rather than paper documentation from families.
- CMS has various review processes in place to ensure that expenditures reported by States are supported and consistent with Medicaid requirements. The agency also has processes to check whether the correct Federal matching rates were applied only to expenditures receiving a higher than standard Federal matching rate, which can include certain types of services and populations.
- CMS estimates Medicaid improper payments, including improper payments due to erroneous beneficiary eligibility determinations. Although CMS has not calculated the improper payments related to beneficiary eligibility determinations since 2014, it plans to begin reporting this estimate in November 2019.

CMS OVERSIGHT OF MEDICAID ELIGIBILITY DETERMINATIONS AND RELATED EXPENDITURES HAS GAPS

Our previous work has identified gaps in CMS oversight of Medicaid eligibility determinations, which affect the Federal matching rate. An accurate determination of eligibility is critical to ensuring that only eligible individuals are enrolled, that they are enrolled in the correct eligibility group, and that States' expenditures are appropriately matched with Federal funds for Medicaid enrollees. The implications of inaccurate eligibility determinations can be significant, especially given the growth in enrollment and spending of the expansion population, which represented nearly one quarter of program enrollment and Federal expenditures in fiscal year 2017.[8] (See fig. 1.)

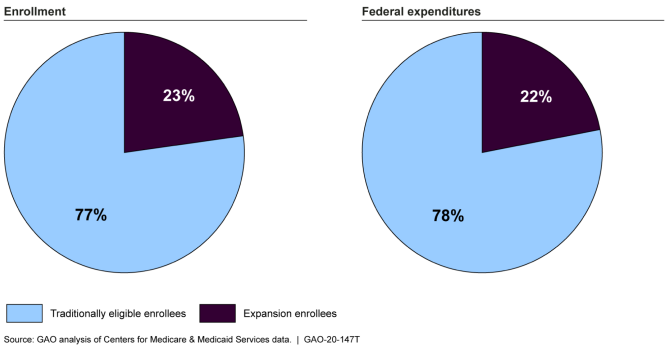
---

[6] Factors that States verify include, among others, citizenship, immigration status, age (date of birth), Social Security number, income, residency, and household composition.

[7] For additional information on States' changes to their eligibility systems, *see* GAO, *Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist,* GAO–15–169 (Washington, DC: December 12, 2014).

[8] Our analysis of Medicaid expansion enrollment excludes totals reported by the U.S. territories of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto

Figure 1: Medicaid Enrollees and Federal Expenditures by Eligibility, Fiscal Year 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-20-147T

Notes: Figure excludes totals reported by the U.S. territories of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Federal expenditure totals exclude New York, which had a significant adjustment from the prior period in fiscal year 2017.

Enrollment data represent enrollment for the month of September 2017, the last month of fiscal year 2017.

Traditionally eligible enrollees are eligible under historic eligibility categories.

Expansion enrollees are (1) individuals whose coverage began after their State opted to expand Medicaid as authorized by the Patient Protection and Affordable Care Act (PPACA), and (2) individuals who were not traditionally eligible, but were covered for Medicaid under a State-funded program or a State demonstration as of December 1, 2009 in States that subsequently opted to expand Medicaid as authorized by PPACA.

In September 2016, we reported on our undercover testing for determining Medicaid eligibility and the vulnerabilities we found.[9] We found weaknesses that led to inaccurate eligibility determinations. For example, three of eight fictitious applications we submitted to Federal and State marketplaces were approved for Medicaid, despite having identity information that did not match Social Security Administration records.[10] These results, while illustrative of the challenges of assuring accurate eligibility determinations, cannot be generalized.

With respect to CMS's reviews of eligibility determinations, in 2015, we also found that CMS did not review Federal Medicaid eligibility determinations in the States that delegated such authority to the Federal Government.[11] Based on our findings, we made the following recommendations.

- CMS should use information obtained from State and Federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately. In February 2019, we considered this recommendation implemented, as CMS confirmed that it was sharing information between its

Rico, and the U.S. Virgin Islands. Federal Medicaid expenditure totals exclude New York, which had a significant adjustment from the prior period in fiscal year 2017.

[9] See GAO, *Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015,* GAO–16–792 (Washington, DC: September 9, 2016). To do this testing, we submitted eight fictitious applications through Federal marketplaces for two States and States' marketplaces in two States in 2015. All four States' Medicaid programs had expanded eligibility. Our testing also included attempts to obtain other subsidized health-plan coverage in addition to Medicaid.

[10] PPACA provides for the establishment of health insurance marketplaces to assist consumers in comparing and selecting among insurance plans offered by participating private insurers of health-care coverage. Under PPACA, States may elect to operate their own health-care marketplaces, or they may rely on the Federal Health Insurance Marketplace, known to the public as *HealthCare.gov*.

[11] GAO, *Medicaid: Additional Efforts Needed to Ensure That State Spending Is Appropriately Matched With Federal Funds,* GAO–16–53 (Washington, DC: October 16, 2015).

eligibility reviews and quarterly expenditure reviews regarding Medicaid expansion enrollees.[12]

- CMS should conduct reviews of Federal Medicaid eligibility determinations to ascertain their accuracy and institute corrective action plans where necessary. CMS has taken some action to review Federal eligibility determinations; however, until the review results are publicly reported, which CMS expects to occur in November 2019, this recommendation is not fully implemented. We will continue to monitor CMS's implementation of this recommendation.

In August 2018, we reported that improvements in oversight of State expenditures could help CMS ensure that individuals are enrolled in the correct Medicaid eligibility group.[13] CMS processes for reviewing expenditures reported by States and FMAP rates collectively have had a considerable Federal financial benefit, with CMS resolving errors that reduced Federal spending by over $5.1 billion in fiscal years 2014 through 2017. However, we identified weaknesses in how CMS targets its resources to address risks when reviewing whether States' expenditures are supported and consistent with Medicaid requirements. For example:

- CMS devotes similar levels of staff resources to review expenditures despite differing levels of risk across States. For example, the number of staff reviewing California's expenditures—which represent 15 percent of Federal Medicaid spending—is similar to the number reviewing Arkansas' expenditures, which represents 1 percent of Federal Medicaid spending.
- Additionally, CMS reviews a sample of claims for expansion enrollees to examine Medicaid expansion expenditures, but the sample size does not account for previously identified risks in a State's program. Specifically, as we noted in a 2015 report, CMS's sampling review of expansion expenditures was not linked to or informed by reviews of eligibility determinations conducted by CMS, some of which identified high levels of eligibility determination errors.[14]

To address these weaknesses, we made three recommendations, including that the Administrator of CMS revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk. CMS concurred with this recommendation, but in November 2018, CMS officials indicated that given the agency's resources, they believe the current sampling methodology is sufficient and have no plans to revise it. However, we continue to believe action is needed to better target areas of high risk and this recommendation remains unimplemented.

Our examination of Medicaid eligibility determinations will continue as we have work underway that will describe:

- How selected States decide the basis of eligibility for individuals who may qualify for Medicaid under more than one category of eligibility, such as a low-income individual with a disability;
- What is known about the accuracy of Medicaid eligibility determinations and selected States' processes to improve the accuracy of determinations; and
- CMS efforts to recoup funds related to eligibility errors.

We expect to complete this work early next year.

CMS EFFORTS TO IMPROVE MEDICAID DATA COULD BENEFIT PROGRAM OVERSIGHT

Improvements in Medicaid data could benefit program oversight, including ensuring that only eligible beneficiaries are enrolled. CMS has acknowledged the need for improved Medicaid data and the Transformed Medicaid Statistical Information Sys-

[12] States report data on their aggregate expenditures to CMS, which then uses that data to reimburse States for the Federal share of program spending. CMS conducts quarterly expenditure reviews of this State-reported data. The CMS–64 is used to collect State-reported data on aggregate expenditures. These data are used to reimburse States for the Federal share of program spending.

[13] *See* GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures,* GAO–18–564 (Washington, DC: August 6, 2018).

[14] *See* GAO–18–564 and GAO–16–53. We previously found that eight of the nine States we reviewed reported errors resulting in incorrect eligibility determinations. We recommended that CMS use information obtained from assessments of State eligibility determinations to inform its review of expenditures for different eligibility groups. In February 2019, CMS confirmed that the agency will continue to share information as it conducts eligibility determination reviews for estimating improper payments. This will allow CMS to continue using information on eligibility determination errors to better focus the expenditure reviews.

tem (T–MSIS) initiative is the agency's primary effort—conducted jointly with States—to improve its collection of Medicaid expenditure and utilization data.[15] According to CMS officials, aspects of T–MSIS are designed to broaden the scope and improve the quality of State-reported data, as well as the data's usefulness for States. T–MSIS also includes automated quality checks that should improve the quality of data that States report. In addition:

- T–MSIS is designed to capture significantly more data from States than was previously reported. For example, T–MSIS will include a beneficiary eligibility file that will have expanded information on enrollees, such as their citizenship, immigration, and disability status; and expanded diagnosis and procedure codes associated with their treatments.
- T–MSIS also is intended to benefit States by reducing the number of reports CMS requires them to submit, and by improving program efficiency by allowing States to compare their data with other States' data in the national repository or with information in other CMS repositories, including Medicare data.

With the continued implementation of T–MSIS, CMS has taken an important step toward developing a reliable national repository for Medicaid data. While recognizing CMS's progress, we have made several recommendations aimed at improving the quality and usefulness of T–MSIS data. For example, we recommended in 2017 that CMS refine its T–MSIS data priority areas to identify those that are critical for reducing improper payments and expedite efforts to assess and ensure their quality.[16] CMS has implemented this recommendation, yet other recommendations that CMS concurred with related to T–MSIS have not been fully implemented, including outlining a specific plan and associated time frames for using T–MSIS data for oversight.[17]

FURTHER COLLABORATION WITH STAKEHOLDERS COULD IMPROVE PROGRAM OVERSIGHT AND BETTER ENSURE APPROPRIATE ENROLLMENT

We have previously reported that oversight of the Medicaid program could be further improved through leveraging and coordinating program integrity efforts with State agencies, State auditors, and other partners.[18] CMS has engaged State agencies and other partners to promote program integrity through the Medicaid Integrity Institute, a national training program for States, and other partnerships to combat Medicaid fraud. These efforts have created more opportunities for program integrity professionals to collaborate, share best practices, and ultimately increase the effectiveness of their oversight activities.

We have also testified that State auditors are uniquely positioned to help CMS in its oversight of State Medicaid programs, because of their roles and responsibilities—which can include carrying out or overseeing their State's single audits.[19] Through their program integrity reviews, State auditors have identified improper payments in the Medicaid program and deficiencies in the processes used to identify them. For example, State auditors have found that in some cases their State Medicaid agencies' eligibility determinations did not identify or address beneficiaries' changes in circumstances, and in other cases relied on incorrect or incomplete income or asset information.

---

[15] *See* GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements,* GAO–17–173 (Washington, DC: January 6, 2017).

[16] GAO–17–173.

[17] See GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight,* GAO–18–70 (Washington, DC: December 8, 2017).

[18] *See* GAO, *Medicaid: Opportunities for Improving Program Oversight,* GAO–18–444T (Washington, DC: April 12, 2018); *Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks,* GAO–18–598T (Washington, DC: June 27, 2018); and *Medicaid: CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity,* GAO–18–687T (Washington, DC: August 21, 2018).

[19] See GAO–18–687T. Organizations based in the United States with expenditures of Federal funding of $500,000 or more ($750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization's fiscal year are required to send an audit report to the OMB, in accordance with the Single Audit Act, as amended, and OMB implementing regulations. *See* 31 U.S.C. §§ 7501–7507; 2 CFR pt. 200, subpt. F (2017) (as added by 78 Fed. Reg. 78590, 78608 (December 26, 2013)). A single audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the schedule of expenditures of Federal awards; (2) gaining an understanding of and testing internal control over financial reporting, and the entity's compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain Federal programs (*i.e.,* the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain Federal programs.

- A 2018 audit of New Jersey's Medicaid program found the State was not identifying and disenrolling some deceased individuals.[20] When State auditors conducted a data match to a Social Security number verification service, they found managed care payments of $510,834 and fee-for-service claims of $217,913 for 41 individuals after their reported date of death. Auditors recommended that the eligibility system be reconciled with a Social Security number validation service on a periodic basis to better identify deceased individuals.
- In 2017, State auditors in North Carolina found that most of the 10 sample county departments of social services did not consistently provide adequate oversight or controls for the eligibility determination of new applications and re-certifications.[21] For new applications, the auditors showed accuracy error rates ranging from 1 percent to nearly 19 percent; for redeterminations of eligibility, accuracy error rates ranged from 1 percent to 23 percent.
- Based on information from an independent verification service, State auditors in New York found, during a 9-month period in 2014, that 354 Medicaid enrollees were actually deceased, and that the State made $325,030 in Medicaid payments for a subset of these individuals.[22] Auditors noted that the State's eligibility system did not have a standard process to periodically verify the life status of all enrollees and end coverage for deceased individuals.

In April 2019, the Comptroller General and representatives from the National State Auditors Association sent a letter to CMS requesting changes to the Compliance Supplement to leverage State auditors' ability to examine key areas of Medicaid, including improvements in the oversight of Medicaid eligibility processes. The Compliance Supplement—which is issued by the OMB based on agency input and direction—is used by State auditors during their annual audit of State entities that administer Federal financial assistance programs, including Medicaid.

In June 2019, OMB issued the 2019 Compliance Supplement, which included changes related to overseeing testing of eligibility determinations that GAO and the State auditors had proposed.[23] Specifically, the supplement now permits State auditors to test eligibility determinations to ensure that beneficiaries qualify for the Medicaid program and are in the appropriate enrollment category. The supplement also notes a requirement for States to coordinate with other State and Federal insurance affordability programs, including the federally facilitated exchanges.

These changes to the Compliance Supplement will better enable State auditors to audit States' eligibility determinations to ensure beneficiaries qualify for the Medicaid program and are enrolled in the correct eligibility group. Such eligibility determinations will supplement CMS's eligibility determination reviews and may yield insights into program weaknesses that CMS could learn from and potentially address nationally. We continue to believe that CMS could help improve program integrity by further providing State auditors with a substantive and ongoing role in auditing their State Medicaid programs.

Chairman Toomey, Ranking Member Stabenow, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

---

[20] New Jersey Legislature Office of Legislative Services, Office of the State Auditor, Department of Human Services, Division of Medicaid Assistance and Health Services NJ FamilyCare Eligibility Determinations, July 1, 2014 to July 30, 2017 (Trenton, NJ: September 25, 2018).

[21] State of North Carolina, Office of the State Auditor, North Carolina Medicaid Program, Recipient Eligibility Determination (Raleigh, NC: January 2017).

[22] New York State Office of the State Comptroller, Division of State Government Accountability, Appropriateness of the Medicaid Eligibility Determined by the New York State of Health System, Report 2014–S–4 (Albany, NY: October 28, 2015).

[23] 2 CFR pt. 200, subpt. F, app. XI (2019).

Table 1: Status of Selected GAO Recommendations to Strengthen CMS's Oversight of Medicaid Beneficiary Enrollment, Through September 2019

GAO recommendation	Status of recommendation; actions needed to implement recommendations
Improving oversight of Medicaid eligibility determinations and related expenditures	
Issue guidance to States to better identify beneficiaries who are deceased (GAO–15–313)[a]	Recommendation implemented; no action needed.
Conduct reviews of Federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary (GAO–16–53)[b]	Not fully implemented. Conduct a systematic review of eligibility determinations reached by federally facilitated exchanges, and implement any corrective actions. The Department of Health and Human Services indicated that it will include results of eligibility determinations for two States where there were Federal eligibility determinations when it begins reporting improper payment estimates due to erroneous eligibility determinations in November 2019. It is too early to assess whether this will be sufficient for identifying and correcting errors and associated payments.
Use the information obtained from State and Federal eligibility reviews to inform the Centers for Medicare and Medicaid Services' (CMS) review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately (GAO–16–53)[b]	Recommendation implemented; no action needed.
Complete a comprehensive, national risk assessment and take steps, as needed, to assure that resources to oversee expenditures reported by States are adequate and allocated based on areas of highest risk (GAO–18–564)[c]	Not fully implemented. Conduct a national risk assessment to determine whether resources for financial oversight activities are adequate and allocated—both across the CMS's regional offices and oversight tools—to focus on the greatest areas of risk, and take steps to reallocate staff and resources, as appropriate.
Clarify in internal guidance when a variance analysis on expenditures with higher match rates is required (GAO–18–564)[c]	Not fully implemented. Update internal guidance on conducting variance analyses for expenditures with higher Federal matching rates to assure that analyses are consistently conducted.
Revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk (GAO–18–564)[c]	Not implemented. Update CMS's sampling methodology for reviewing expenditures to account for risk factors like program size and high levels of eligibility determination errors.[d]

Table 1: Status of Selected GAO Recommendations to Strengthen CMS's Oversight of Medicaid Beneficiary Enrollment, Through September 2019—Continued

GAO recommendation	Status of recommendation; actions needed to implement recommendations
Improving Medicaid data to benefit program oversight	
Take immediate steps to assess and improve the data available for Medicaid program oversight, including, but not limited to, the Transformed Medicaid Statistical Information System (T–MSIS). Such steps could include (1) refining the overall data priority areas in T–MSIS to better identify those variables that are most critical for reducing improper payments, and (2) expediting efforts to assess and ensure the quality of these T–MSIS data (GAO–17–173)[e]	Recommendation implemented; no action needed.
Take additional steps to expedite the use of data for program oversight. Such steps should include, but are not limited to, efforts to (1) obtain complete information from all States on unreported T–MSIS data elements and their plans to report applicable data elements; (2) identify and share information across States on known T–MSIS data limitations to improve data comparability; and (3) implement mechanisms, such as the Learning Collaborative, by which States can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T–MSIS data (GAO–18–70)[f]	Not fully implemented. Continue taking steps to make T–MSIS data usable for Medicaid program oversight, such as (1) obtaining information on the completeness and comparability of T–MSIS data, (2) notifying States of their compliance status and obtaining corrective action plans, and (3) establishing mechanisms for ongoing feedback and collaboration across States.
Articulate a specific plan and associated time frames for using T–MSIS data for oversight (GAO–18–70)[f]	Not fully implemented. Outline a specific plan and associated time frames for using T–MSIS data for oversight.

Source: GAO | GAO–20–147T.

[a] GAO, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls,* GAO–15–313 (Washington, DC: May 14, 2015).

[b] GAO, *Medicaid: Additional Efforts Needed to Ensure That State Spending Is Appropriately Matched With Federal Funds,* GAO–16–53 (Washington, DC: October 16, 2015).

[c] GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures,* GAO–18–564 (Washington, DC: August 6, 2018).

[d] According to agency officials, CMS believes its sampling methodology is sufficient and has no plans to revise it. The agency noted that the current methodology requires a minimum sample size, but gives reviewers the flexibility to expand the size of the sample if warranted by risk and as resources permit. We continue to believe that the current methodology does not sufficiently target areas of high risk.

[e] GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements,* GAO–17–173 (Washington, DC: January 6, 2017).

[f] GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight,* GAO–18–70 (Washington, DC: December 8, 2017).

QUESTIONS SUBMITTED FOR THE RECORD TO CAROLYN L. YOCOM

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Do you recommend States consistently use current and verified wage data as part of their Medicaid eligibility determination processes to improve payment accuracy and administrative efficiency?

Answer. An accurate determination of eligibility is critical to ensuring that only eligible individuals are enrolled, that they are enrolled in the correct eligibility group, and that States' expenditures are appropriately matched with Federal funds.

State Medicaid agencies generally have flexibility in the sources of information they use to verify and validate individuals' financial eligibility at the time of application. While GAO has not made recommendations about the use of wage data for Medicaid eligibility determinations, GAO has reviewed audits that used different

data sources to verify Medicaid beneficiary eligibility and those audits indicate that wage and other data sources have limitations:

- Wage data do not capture self-employment income and unearned income, such as rents, and royalties. Therefore, individuals may have income not captured in wage data.
- Federal and State tax data are available for individuals who filed tax returns. However, tax returns may be dated and not reflective of current income.

Also, GAO expects to complete an examination of Medicaid eligibility determinations early next year. It will describe: how selected State Medicaid agencies decide the basis of eligibility for individuals who may qualify for Medicaid under more than one category of eligibility, such as a low-income individual with a disability; what is known about the accuracy of Medicaid eligibility determinations and selected State; Medicaid agencies' processes to improve the accuracy of determinations; and CMS efforts to recoup funds related to eligibility errors.

Question. Would you recommend that CMS issue guidance directing States to consistently use data sources available at the Federal level, such as current employment and income data accessible through the CMS Federal Data Services Hub, to accurately verify eligibility for Medicaid?

Answer. Although GAO has not made recommendations concerning the use of particular data sources for Medicaid eligibility determinations, GAO's work—including its review of others' work—has generally found that different data sources have different limitations; for example, wage data do not capture certain types of income such as self-employment, rents, and royalties. Federal and State tax data may be dated and not reflective of current income.

GAO has reported on the enrollment and verification controls of the Federal Health Insurance Marketplace and made a recommendation about the data hub.[1] The data hub is a central feature of the Marketplace enrollment controls and, among other things, provides a mechanism to check applicant-provided information against a variety of Federal data sources. GAO recommended that the Department of Health and Human Services take steps to improve the data-matching process and reduce the number of applicant inconsistencies in the data hub. CMS implemented this recommendation, which should improve data-matching capability and help ensure that applicants meet program eligibility requirements.

QUESTION SUBMITTED BY HON. TIM SCOTT

Question. Medicaid enrollment has grown substantially in recent years, even for non-expansion States. In South Carolina, for instance, Medicaid and CHIP enrollment totaled 1,036,851 in August of this year, marking a 17.9-percent increase over August 2014 levels. Over the same 5-year period, the State's population grew by closer to 5 or 6 percent, so population growth alone cannot explain the rise in enrollment. Furthermore, whereas South Carolina's unemployment rate was at 6.6 percent in August 2014, it had fallen to 3.2 percent by August 2019, representing a drop of more than 50 percent. Our economy is strong, with more South Carolinians entering the workforce to pursue sustainable opportunities, and yet our State's Medicaid enrollment figures remain high.

While South Carolina's State government takes important steps to ensure program integrity and robust eligibility determination processes, programmatic growth across the country will increasingly spur the need for additional tools, supports, and resources from Federal agencies and other key stakeholders as States seek to bolster their internal processes.

I understand that a number of Federal agencies and States incorporate current wage data into their eligibility determination processes for Medicaid and other government benefit programs. This type of data, for instance, is available at no cost to State Medicaid agencies through the CMS Federal Data Hub. However, use of this data is not a consistent practice. Do you recommend that States consistently use current and verified wage data as part of their Medicaid eligibility determination processes to improve payment accuracy and administrative efficiency? Are there

---

[1] *See* GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk,* GAO–16–29 (Washington, DC: February 23, 2016).

concrete steps that we can take, when working with States, to raise awareness of this type of data and to encourage effective utilization thereof?

Answer. State Medicaid agencies generally have flexibility in the sources of information they use to verify and validate individuals' financial eligibility at the time of application. While GAO has not made recommendations concerning the use of particular data sources for Medicaid eligibility determinations, it has reviewed audits that used different data sources to verify Medicaid beneficiary eligibility and those audits indicate that wage and other data sources have limitations:

- Wage data do not capture self-employment income and unearned income, such as rents, and royalties. Therefore, individuals may have income not captured in wage data.
- Federal and State tax data are available for individuals who filed tax returns. However, tax returns may be dated and not reflective of current income.

GAO has previously reported that oversight of the Medicaid program could be further improved through leveraging and coordinating program integrity efforts with State agencies, State auditors, and other partners.[2] CMS has engaged State agencies and other partners to promote program integrity through the Medicaid Integrity Institute, a national training program for States, and other partnerships to combat Medicaid fraud. These efforts have created more opportunities for program integrity professionals to collaborate, share best practices, and ultimately increase the effectiveness of their oversight activities. In addition, in June 2019, OMB issued the 2019 Compliance Supplement, which included changes related to overseeing testing of eligibility determinations that GAO and State auditors had proposed.[3] Specifically, the supplement now provides instructions for State auditors to test Medicaid eligibility determinations to ensure that beneficiaries qualify for the Medicaid program. The supplement also notes that Federal regulations require States to coordinate with other State and Federal insurance affordability programs, including the federally facilitated exchanges, which should better ensure that Medicaid beneficiaries are enrolled in the correct eligibility group, and that States' expenditures are appropriately matched with Federal funds.

QUESTION SUBMITTED BY HON. TODD YOUNG

NATIONAL DIRECTORY OF NEW HIRES

Question. The Federal Government currently has systems available to verify income, like the National Directory of New Hires (NDNH)—which has been used for many years in programs such as the Temporary Assistance for Needy Families, SNAP, and housing. The President's budget proposed using NDNH in Medicaid for program integrity.

If you had access to this data, do you think it would help with preventing, identifying, and recovering improper payments—and how?

Answer. We thank Congress for confirming GAO's access to the NDNH through the GAO Access and Oversight Act of 2017, signed into law in January 2017.[4] Access to the directory has improved our ability to oversee Federal programs. For example, in June 2019 we identified indicators of potential fraud or error in income information for borrowers repaying certain Federal loans with income driven repayment plans based on an analysis of NDNH wage data.[5] We found that about 95,100 income-driven repayment plans were held by borrowers who reported no income, yet may have earned enough wages to warrant monthly student loan payments according to NDNH data. We recommended that the Department of Education obtain data to verify the income of borrowers who report no income on income driven repayment plan applications, and implement data analytic practices and follow-up procedures to verify borrower reports of no income. These recommendations have not yet been implemented.

---

[2] *See* GAO, *Medicaid: CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity,* GAO–18–687T (Washington, DC: August 21, 2018).

[3] 2 CFR pt. 200, subpt. F, app. XI (2019).

[4] Pub. L. No. 115–3, 131 Stat. 7 (January 31, 2017).

[5] *See* GAO, *Federal Student Loans: Education Needs to Verify Borrowers' Information for Income-Driven Repayment Plans,* GAO–19–347 (Washington, DC: June 25, 2019).

QUESTION SUBMITTED BY HON. BENJAMIN L. CARDIN

INCREASE IN THE NUMBER OF UNINSURED CHILDREN

Question. There have been an alarming number of reports about States taking action to decrease the number of people in their Medicaid programs. I think we can all agree about the need to ensure appropriate oversight and integrity of the Medicaid program. This is why I am concerned about eligible individuals, particularly children, getting kicked off of health-care coverage.

According to the U.S. Census Bureau, about 4.3 million children did not have any health coverage in 2018, an increase of 425,000 from 2017. That is almost half a million children more uninsured children in just one year.

It is incredible that there was an increase of half a million uninsured children because last year this committee made a bipartisan commitment to continue funding for the Children's Health Insurance Program (CHIP) for 10 years.

How unprecedented is this increase of uninsured children—now for the second year in a row?

Do you know why the United States is seeing this increase in uninsured children? Or what policies could be causing this?

What should Congress do to address the increase of uninsured children?

Answer. According to the Centers for Disease Control and Prevention's (CDC) National Health Interview Survey, the rate of uninsured children was 11.6 percent in 1999 and steadily declined to 4.5 percent in 2015. Since then, the rate has increased to 5.2 percent in 2018. The U.S. Census Bureau's American Community Survey, which can provide historical rates since 2008, has identified a similar pattern. The rate of uninsured children was 9.7 percent in 2008, declined to 4.7 percent in 2016, and then increased to 5.2 percent in 2018. The Census Bureau attributed the increased uninsured rate to declines in the percentage of children covered by Medicaid and the Children's Health Insurance Program (CHIP). GAO has not assessed recent trends related to the rate of uninsured children; however additional study of the reasons behind the recent trend could help identify potential policy actions to address the issue.

QUESTION SUBMITTED BY HON. SHERROD BROWN

ACCESS TO VITAL HEALTH-CARE SERVICES

Question. In Ohio, there are 36,000 children in foster care served by Medicaid. And 52 percent of children and adults served by Medicaid receive behavioral health services. These services are essential to Ohio, as our communities and families are dealing with effects of the addiction crisis every day.

Are there any studies that account for how Medicaid expansion has improved access to these vital mental and behavioral health services for children and adults?

Answer. In June 2015, we reported that State officials in six States told us that Medicaid expansion generally resulted in greater availability of behavioral health treatment.[6] The changes were greater in three States that did not have previous coverage options for low-income adults. For example, officials in one State noted that individuals had access to services that were not available prior to Medicaid expansion, such as peer support services.

Further, in September 2018, we reported that the percentage of low-income adults who reported financial barriers to obtaining mental health care was lower in expansion States than non-expansion States.[7] About four percent of low-income adults in expansion States reported financial barriers to mental health care, while about 6 percent of low-income adults in non-expansion States reported such barriers.

---

[6] *See* GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States,* GAO–15–449 (Washington, DC: June 19, 2015).

[7] *See* GAO, *Medicaid: Access to Health Care for Low-Income Adults in States With and Without Expanded Eligibility,* GAO–18–607 (Washington, DC: September 13, 2018).

COMMUNICATION

CENTER FOR FISCAL EQUITY
14448 Parkvale Road, Suite 6
Rockville, Maryland 20853
fiscalequitycenter@yahoo.com

Statement of Michael G. Bindner

Chairman Toomey and Ranking Member Stabenow, thank you for the opportunity to submit these comments for the record to the Subcommittee on Health Care Committee. I will rely on the Administration witnesses to outline the current case and will focus on options to overcome the need for compliance monitoring.

An adequate income removes the incentive to cheat. We suggest a $20 per hour minimum wage for workers and stipends for students. No worker is ever kept on shift absent workload, regardless of wage. No high wage worker is allowed to go home when customers are waiting. It is why overtime pay exists. No one should have to work for nothing, to be paid with only an expanded refundable child tax credit. This will end the need for the term "working poor."

Students from ESL to Ph.D. (regardless of migration status) who are employed will be covered by the plan that the employer participates in, or through a public option, a single-payer plan or under a subsidy to training providers under the plan that covers their workers. Medicaid or a public option will be available to anyone who falls through the cracks, even without pre-registration. The latter will be federally funded but managed by state and local case workers in governmental or charitable settings.

Medicaid compliance should not be an issue. In our proposal, Medicaid will be for those individuals who have nowhere else to go. Medicaid spending for seniors and the disabled will be shifted to the federal government into a new Medicare Part E. This will save state budgets in the out-years (as would including base funding of pensions to Social Security, with appropriate asset transfers).

Adopting a single-payer option, particularly Medicare for All, removes the need for any compliance as to eligibility. Please see Attachment One for our previous comments on these options.

There has been discussion of a wealth tax to pay for any such plan. We believe that any such tax should be reserved for paying down the debt. Please see Attachment Two for our prior comments on why this is essential for high income taxpayers. The usual ratio of income taxes to gross debt is $6 to $9 of debt liability for every dollar if tax paid. The current ratio is $13.

Rather than a wealth tax, which is both complicated and inappropriate for funding current operations, the creation of tax prepayment bonds will quickly pay down the debt and avoid future interest costs. Adopting this solution requires achieving a balanced budget for all other expenditures.

Paying for any health insurance subsidy should be accomplished by a long-term funding stream; preferably one collected from employers. Payroll taxes for this purpose are regressive. A better tool is the subtraction value-added tax laid out as part of our standard tax plan. The Subtraction Value-Added Tax (S-VAT) is an employer paid Net Business Receipts Tax. It will be used as a vehicle for tax expenditures including health care (if a private coverage option is maintained), veterans' health care for non-battlefield injuries, educational costs borne by employers in lieu of taxes as either contributors, for employee children or for workers (including ESL and remedial skills) and an expanded child tax credit.

An adequate CTC discourages abortion, and as such enactment must be scored as a must pass in voting rankings by pro-life organizations (and feminist organizations as well). An inflation adjustable credit should reflect the cost of raising a child through the completion of junior college or technical training. To assure child subsidies are distributed, S-VAT will not be border adjustable.

Employer-based taxes, such as a subtraction VAT or payroll tax, will provide an incentive to avoid health care taxation by providing such care. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid or Medicare for All. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral—as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise.

Ultimately, employer taxation should be replaced with employer provided care as part of a cooperative system which has members control production, distribution finance, consumption and retirement savings. There should be many such cooperatives. A state-run entity would produce corruption.

The S–VAT can be used for personal accounts in Social Security, provided that these accounts are insured through an insurance fund for all such accounts, that accounts go toward employee ownership rather than for a subsidy for the investment industry. Both employers and employees must consent to a shift to these accounts, which will occur if corporate democracy in existing ESOPs is given a thorough test. So far it has not.

S–VAT funded retirement accounts will be equal dollar credited for every worker. They also have the advantage of drawing on both payroll and profit, making it less regressive.

Our previous comments on how employee ownership would work is found in Attachment Three.

Cooperatives and other companies who hire their own doctors and pharmacists, whether as part of a cooperative purchase program or as an offset to a single-payer program (whether it is Single Payer Catastrophic or Medicare for All) will need no eligibility compliance function. All members will be this modality, as well as use of a subtraction VAT generally, ends the need for 1099 employment.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment One—Hearing on Pathways to Universal Health Coverage, June 12, 2019

There are three methods to get to single-payer: a public option, Medicare for All and single-payer with an option for cooperative employers.

The first is to set up a **public option** and end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs.

The second option is Medicare for All, which I described in an attachment to comments presented in June and previously in hearings held May 8, 2019 (Finance) and May 8, 2018 (Ways and Means). Medicare for All is essentially Medicaid for All without the smell of welfare and with providers reimbursed at Medicare levels, with the difference funded by tax revenue.

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs say-

ing, "don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund); and Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management. Much of this is now managed care, as is Medicare Advantage (Part C).

Medicaid lingers in the background and the foreground. It covers the disabled in their first two years (and probably while they are seeking disability and unable to work). It covers non-workers and the working poor (who are too poor for Obamacare) and it covers seniors and the disabled who are confined to a long-term care facility and who have run out their assets. It also has the long-term portion which should be federalized, but for the poor, it takes the form of an HMO, but with no premiums and zero copays.

Obamacare has premiums with income-based supports (one of those facts the Republicans hate) and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan.

Either Medicare for All or a real single payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value-added tax (so it would not appear on receipts nor would it be zero rate at the border, since there would be no evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All and leave it alone.

The third option is an **exclusion for employers,** especially employee-owned and cooperative firms, who provide medical care directly to their employees without third party insurance, with the employer making HMO-like arrangements with local hospitals and medical practices for inpatient and specialist care.

Attachment Two—The Debt, the Future is Calling: It Wants a Refund, 2019

In the future we face a crisis, not in entitlements, but in net interest on the debt, both from increased rates and growing principal. This growth will only feasible until either China or the European Union develop tradable debt instruments backed by income taxation, which is the secret to the ability of the United States to be the world's bond issuer. While it is good to run a deficit to balance out tax cuts for the wealthy, both are a sugar high for the economy. At some point we need incentives to pay down the debt.

The national debt is possible because of progressive income taxation. The liability for repayment, therefore, is a function of that tax. The Gross Debt (we have to pay back trust funds too) was $19 Trillion when this table was created. Income Tax revenue is roughly $1.4 Trillion per year. That means that for every, dollar you pay in taxes, you owe $13 in debt (although this will increase). People who pay nothing owe nothing. People who pay tens of thousands of dollars a year owe hundreds of thousands.

The answer is not making the poor pay more or giving them less benefits, either only slows the economy. Rich people must pay more and do it faster. My child is becoming a social worker, although she was going to be an artist. Don't look to her to pay off the debt. Your children and grandchildren and those of your donors are the ones on the hook unless their parents step up and pay more. How's that for incentive?

If that is not enough, let's talk raw numbers. If you look at total debt and the fact that it is 13 times income tax collections, then the wealthy 1% are in hock to the rest of us to the tune of 7 Trillion dollars (yes, with a T). The next 9% owe $6 trillion, the next 40% owe $5 trillion, with the bottom half owing slightly less than the top 1,409 family taxpaying units. Note that this is FY 2016 data. FY 2017 will be available next month.

Strata	Lower Limit in $Thousands	Effective Tax Rate	Taxes Paid in $Billion	Amount of Debt Owed in $Trillions
Bottom 50%	$0	3.7%	$43.9	$0.57
50% to 75%	$40	15.6%	$158.5	$2.06
75% to 90%	$81	17.8%	$ 238.0	$3.09
90% to 95%	$140	21.1%	$162.1	$2.11
95% to 99%	$198	23.5%	$301.6	$3.92
Top 1%	$ 481	26.9%	$ 538.3	$ 7.00
Top 1,409 Households			$46.9	$0.61

Attachment Three

A. Employee Ownership, March 7, 2019

Employee ownership is the ultimate protection for worker wages. Our proposal for expanding it involves diverting an ever-increasing portion of the employer contribution to the Old-Age and Survivors fund to a combination of employer voting stock and an insurance fund holding the stock of all similar companies. At some point, these companies will be run democratically, including CEO pay, and workers will be safe from predatory management practices. Increasing the number of employee-owned firms also decreases the incentive to lower tax rates and bid up asset markets with the proceeds.

Establishing personal retirement accounts holding index funds for Wall Street to play with will not help. Accounts holding voting and preferred stock in the employer and an insurance fund holding the stocks of all such firms will, in time, reduce inequality and provide local constituencies for infrastructure improvements and the funds to carry them out.

ESOP loans and distribution of a portion of the Social Security Trust Fund could also speed the adoption of such accounts. Our Income and Inheritance Surtax (where cash from estates and the sale of estate assets are normal income) would fund reimbursements to the Fund.

At some point, these companies will be run democratically, including CEO pay, and workers will be safe from predatory management practices. This is only possible if the Majority quits using fighting it as a partisan cudgel and embraces it to empower the professional and working classes.

The dignity of ownership is much more than the dignity of work as a cog in a machine.

B. Hearing on the 2016 Social Security Trustees Report

In the January 2003 issue of *Labor and Corporate Governance,* we proposed that Congress should equalize the employer contribution based on average income rather than personal income. It should also increase or eliminate the cap on contributions. The higher the income cap is raised, the more likely it is that personal retirement accounts are necessary. A major strength of Social Security is its income redistribution function. We suspect that much of the support for personal accounts is to subvert that function—so any proposal for such accounts must move redistribution to account accumulation by equalizing the employer contribution.

We propose directing personal account investments to employer voting stock, rather than an index funds or any fund managed by outside brokers. There are no Index Fund billionaires (except those who operate them). People become rich by owning and controlling their own companies. Additionally, keeping funds in-house is the cheapest option administratively. I suspect it is even cheaper than the Social Secu-

rity system—which operates at a much lower administrative cost than any defined contribution plan in existence.

If employer voting stock is used, the Net Business Receipts Tax/Subtraction VAT would fund it. If there are no personal accounts, then the employer contribution would be VAT funded.

Safety is, of course, a concern with personal accounts. Rather than diversifying through investment, however, we propose diversifying through insurance. A portion of the employer stock purchased would be traded to an insurance fund holding shares from all such employers. Additionally, any personal retirement accounts shifted from employee payroll taxes or from payroll taxes from non-corporate employers would go to this fund.

The insurance fund will save as a safeguard against bad management. If a third of shares were held by the insurance fund than dissident employees holding 25.1% of the employee-held shares (16.7% of the total) could combine with the insurance fund held shares to fire management if the insurance fund agree there was cause to do so. Such a fund would make sure no one loses money should their employer fail and would serve as a sword of Damocles to keep management in line. This is in contrast to the Cato/PCSSS approach, which would continue the trend of management accountable to no one. The other part of my proposal that does so is representative voting by occupation on corporate boards, with either professional or union personnel providing such representation.

The suggestions made here are much less complicated than the current mix of proposals to change bend points and make OASI more of a needs-based program. If the personal account provisions are adopted, there is no need to address the question of the retirement age. Workers will retire when their dividend income is adequate to meet their retirement income needs, with or even without a separate Social Security program.

No other proposal for personal retirement accounts is appropriate. Personal accounts should not be used to develop a new income stream for investment advisors and stock traders. It should certainly not result in more "trust fund socialism" with management that is accountable to no cause but short-term gain. Such management often ignores the long-term interests of American workers and leaves CEOs both over-paid and unaccountable to anyone but themselves.

If funding comes through a Subtraction VAT, there need not be any income cap on employer contributions, which can be set high enough to fund current retirees and the establishing of personal accounts. Again, these contributions should be credited to employees regardless of their salary level.

Conceivably a firm could reduce their S–VAT liability if they made all former workers and retirees whole with the equity they would have otherwise received if they had started their careers under a reformed system. Using Employee Stock Ownership Programs can further accelerate that transition. This would be welcome if ESOPs became more democratic than they are currently, with open auction for management and executive positions and an expansion of cooperative consumption arrangements to meet the needs of the new owners.