MEDICAID ELIGIBILITY: WAGE VERIFICATION PROCESS OF THE EXPANSION POPULATION

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID AUDIT UNIT
ISSUED NOVEMBER 8, 2018

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

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

DGP/aa

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Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

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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 information 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 & 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

[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.

[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.

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.**
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).

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

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.

- **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.**

[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 are 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.

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.

[8] 42 CFR 435.916(c)

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]

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.

[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.
[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.

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 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

[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.

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

[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.

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.

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

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

Cindy Rives
Undersecretary

CR/mb

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:

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 Sub-population, 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
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

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
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
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
81	9,494	2,764	0	0	9	4	89,582
82	8,343	2,712	97	0	8	4	42,168

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
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
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
37	8,456	4,245	515	305	10	11	46,801

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
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
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

Recipient	PMPM Paid	Ineligible PMPMs Paid	Services Received	Ineligible Services Received	Months Qualified on Medicaid	Months Not Qualified on Medicaid	Wages During Medicaid Coverage
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
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