MEDICAID ELIGIBILITY: MODIFIED ADJUSTED GROSS INCOME DETERMINATION PROCESS

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID AUDIT UNIT REPORT
ISSUED DECEMBER 12, 2018

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

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

DGP/ch

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Medicaid Eligibility: Modified Adjusted Gross Income (MAGI) Determination Process
Louisiana Department of Health

December 2018

Audit Control #80180079

Introduction

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

eligibility 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.**

[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.

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 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

[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.

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 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: 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.			
	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**
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.
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.

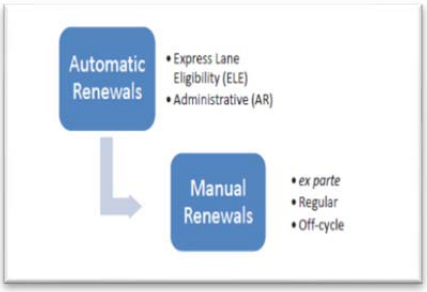
Recommendation 1: LDH should strengthen its processes for eligibility determinations. LDH should also ensure that all critical eligibility factors are verified rather than relying on self-attestation from the recipient.

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 information 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

[6] 42 CFR 435.914

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 recipients, 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.

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

[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.

- 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 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.

[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.

- 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

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.

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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.

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 part 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

Cindy Rives
Undersecretary

CR/mb

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