MEDICAID RECIPIENT ELIGIBILITY
MANAGED CARE AND LOUISIANA RESIDENCY

LOUISIANA DEPARTMENT OF HEALTH
STATE OF LOUISIANA

MEDICAID AUDIT UNIT
ISSUED OCTOBER 26, 2016

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Medicaid Recipient Eligibility - Managed Care and Louisiana Residency

October 2016

Audit Control # 80160098

Introduction

The Louisiana Department of Health (LDH), formerly known as the Department of Health and Hospitals, is responsible for the administration of the state's Medicaid program. Between 2012 and 2014, LDH moved from a fee-for-service model, where LDH paid all Medicaid claims, to a managed care model for most acute care, behavioral health, and dental services. Under managed care, LDH pays a per member per month (PMPM) fee, essentially a premium, to five private insurance companies to serve as managed care organizations (MCOs).[1] Each MCO manages the medical care of the Medicaid recipients enrolled in its plan and pays the Medicaid claims. The Louisiana Medicaid managed care program is named Healthy Louisiana, formerly known as Bayou Health.

Louisiana Medicaid Residence Requirement. Per Section I-1900 of the *Louisiana Medicaid Eligibility Manual*, LDH must provide Medicaid to eligible residents of Louisiana. In general, the state of residence is the state where the individual is living with the intent to reside. Individuals can still be considered residents when traveling outside of the state without an intent to reside elsewhere or when an individual is placed by the state in an out-of-state institution.

Managed Care versus Fee-for-Service. With Medicaid managed care, Medicaid recipient eligibility determinations become the cost driver for the Medicaid program. Under the legacy Medicaid fee-for-service program, if a recipient moved out of the state and stopped receiving medical services from enrolled Louisiana Medicaid providers, no claims were generated by medical providers, resulting in no paid claims and no cost to the state. Under managed care, the state cost is generated each month through the payment of the PMPM for each Medicaid recipient shown as eligible. **Even if the recipient is out of state and getting no services in Louisiana, the state is still paying the full monthly Medicaid cost for them.**

Eligibility/Enrollment of Recipients. LDH remains responsible for maintaining accurate eligibility files and ensuring all enrolled recipients are eligible for Louisiana Medicaid, including the residence requirement. **Accurate eligibility files are critical to ensuring PMPM payments are only made for eligible individuals.**

[1] The current five MCOs are AmeriGroup, AmeriHealth, Louisiana Healthcare Connections, United Healthcare, and Aetna.

Since managed care was implemented, Louisiana Medicaid total enrollment has increased by 4%, from 1,362,410 in fiscal year (FY) 2012 to 1,417,304 in FY 2014.[2] Under Medicaid expansion, an additional 278,000[3] individuals have been added as of August 10, 2016.

The objective of our work was to review **LDH's processes for verifying that Medicaid recipients meet the Louisiana residence requirement for eligibility.**

Appendix A contains LDH management's response to this report, and Appendix B details our scope and methodology.

Review of LDH's Processes for Verifying Medicaid Recipient Eligibility: Louisiana Residence Requirement

Overall we found that LDH needs to strengthen its processes for verifying and updating, in a timely manner, the eligibility of Medicaid recipients who do not meet the state residence requirement. **From February 2012 through May 2016,[4] LDH paid $943,274 in PMPMs for 160 recipients who were ineligible due to out-of-state residency.**

13,141 recipients had no claim activity by the Healthy Louisiana plans for four years.

Using data analysis, we considered Louisiana Medicaid recipients with LDH Healthy Louisiana PMPM payments from calendar years 2012 through 2015 and compared the recipients to Healthy Louisiana MCO claims activity for those recipients. We identified 13,141 recipients with no MCO claims activity by the Healthy Louisiana plans. We also considered PMPM payments and claims data for managed care behavioral health services and managed care dental services. Since we would expect some medical claim activity for any recipient over a four-year period, we identified the following possible causes why an enrolled recipient would have no activity:

- The recipient may have moved out of state and no longer had medical activity with Louisiana Medicaid providers.
- The recipient may be incarcerated and would not be eligible for Medicaid services.
- The recipient may have died.
- The recipient may have obtained other full-coverage insurance.

[2] Medicaid annual reports http://dhh.louisiana.gov/index.cfm/newsroom/detail/1699
[3] LDH press release http://dhh.louisiana.gov/index.cfm/newsroom/detail/3928
[4] Due to the timing of PMPM payments, this includes dental PMPMs paid for service dates through May 2016 and Healthy Louisiana PMPMs paid for service dates through April 2016.

In each of these cases, however, the recipient would not be eligible for Medicaid services; so PMPM payments should no longer be paid on their behalf. For this report, we focused on recipients with out-of-state addresses.

413 of 13,141 recipients had out-of-state addresses.

After conducting additional data analysis on the 13,141 recipients with no claims activity by the Healthy Louisiana plans, we noted 413 recipients with out-of-state addresses as of April 2016. Because state residence is a requirement for Louisiana Medicaid, we reviewed 160 of the 413 for MCO claims activity, fee-for-service claims activity, and LDH's various eligibility systems to determine the last evidence of services provided in Louisiana to arrive at an estimated date for when the recipient moved out of the state. While enrollees do not lose their residence status because of temporary absences from Louisiana with intent to return,[5] it appears, based on evidence in the LDH eligibility files, that all 160 recipient's absences reviewed were more than temporary.

LDH paid $943,274 in PMPM fees for 160 recipients with out-of-state addresses.

In most cases, it was not possible to determine a definitive date of the out-of-state move. Our estimate was based on all available evidence in the LDH eligibility case files, including caseworker notes, correspondence, returned mail, and our consideration of past claims activity. For 120 recipients, we agreed on a consensus date with LDH personnel. For the remaining 40, we did not agree with LDH's date, since LDH mostly used the date when it became aware of the residence change, and we primarily considered the lapse of time with no healthcare claim activity. **Using our estimated dates, we identified $943,274 in erroneous payments to MCOs that could have been avoided if adequate eligibility review processes were in place.** Using LDH's estimated dates, erroneous payments total $757,280. See Exhibit 1 below.

Exhibit 1 – Known Questioned Costs

	Per Auditors	Per LDH
Healthy Louisiana	$871,840	$695,848
Behavioral Health	35,339	28,040
Dental	36,095	33,392
Total	**$943,274**	**$757,280**

Based on the results of the testing of a statistical sample and related claims, we projected our results to the remaining 253 eligibility cases containing out-of-state addresses. All of these

[5] Louisiana Medicaid Eligibility Manual section I-1900 details residency requirements. http://new.dhh.louisiana.gov/assets/medicaid/MedicaidEligibilityPolicy/I-1900m.pdf

recipients were likely not eligible due to out-of-state residence with likely erroneous PMPM payments. If the average PMPM error per recipient from the sample is applied to the remaining 253 recipients, **there is an additional $1,491,552 in questionable payments**.

Weaknesses in LDH's eligibility verification process.

Our review of the Medicaid eligibility determination files noted the following issues and weaknesses in LDH's verification of recipient eligibility with respect to the Louisiana residence requirement:

- **Untimely Notifications by the Recipient**. Recipients are required to notify LDH when changes in status occur. While the recipient, recipient's family, or an authorized representative reported an out-of-state move to LDH, the notification was not always timely and was often years after the move. In one example, the recipient called during 2015 and reported an out-of-state move that occurred three years prior.

- **Renewals Processed without Contact with Recipient.** Our review of the Medicaid renewal process noted that **the majority of the out-of-state renewals were processed without direct contact with the recipient.** LDH is required to periodically review the eligibility of Medicaid recipients to verify that enrollees continue to meet the criteria for ongoing eligibility. In one case, LDH acknowledged that four annual renewals, from 2011 through 2015, were granted without any contact with the recipient. LDH processes eligibility renewals using various renewal methods ranging from completely automated renewals to actual contact with recipients. See Exhibit 2 below.[6]

Exhibit 2 - Types of Renewals	
Social Security (SSI)	Automatic per federal database
Administrative; Express Lane Eligibility; MAGI Case Extension	Automatic recertification without contact with enrollee or agency review
Exparte	Review by the agency without active involvement of the enrollee
Regular/Telephone Renewal	Contact with enrollee by mail or telephone

- **Eligibility Files Not Updated Prior to Implementation of Managed Care**. Some recipients left Louisiana prior to the implementation of managed care, indicating LDH did not implement managed care with updated recipient files. **In two examples, the recipient left Louisiana sometime in 2002 (almost 14 years ago), and the other recipient left Louisiana in 2006 (almost 10 years ago).**

[6] Louisiana Medicaid Eligibility Manual section K-100 renewal requirements:
http://dhh.louisiana.gov/assets/medicaid/MedicaidEligibilityPolicy/K-0000m.pdf

- **Other Systems Used by the Eligibility Section Not Updated.** Some information obtained from other state and federal systems used to help verify recipient information and status conflicted with information obtained directly from the recipient. In one example, the recipient reported an out-of-state move during October 2013. LDH took appropriate action and discontinued the eligibility. However, the recipient's eligibility for another federal program, SNAP, remained open, and LDH defaulted to the other program determination, erroneously re-enrolling the recipient's eligibility in January 2014. The recipient remained eligible for 13 months until the recipient again reported that they continued to live in another state. Discrepancies like this can cause significant issues for automatic eligibility determinations and renewals that rely on system information rather than contact with the recipient. Our review also noted that nine of these recipients continue to receive SNAP benefits.

- **Medicaid Caseworker Error**. Information was available to and/or obtained by the caseworker that would be cause for case closure. However, the cases were left open and renewed for years before eventual closure. In one example, **another state system indicated the recipient moved in 2011, but the recipient's case was renewed until December 2015.**

- **Cases Not Closed by LDH**. Cases have not been officially closed in LDH systems despite having out-of-state addresses on file. This situation occurred mainly with SSI cases where data is sent to LDH from the federal government. LDH is unable to change the SSI information in a recipient's file in the eligibility system and must wait for the information to be transferred by SSI. **In one example, there was a three-year lag between the out-of-state move and the update to LDH's systems.**

- **No Follow-up of Returned Mail**. Returned mail was received by LDH without any follow-up action. In some cases, returned mail was received for multiple years, and the cases were still renewed each year. For example, **return mail was received for one recipient every year since 2012 until the case was closed in 2015**.

- **No Monitoring of MCO Claims Data**. LDH did not monitor MCO claims data from the health plans at a recipient level for lack of utilization to determine if recipients were accessing care or to determine if the MCO claims data was incomplete at the recipient level.

- **Medicaid Enrollment in Other States.** Some recipients were enrolled in Louisiana and other state Medicaid programs concurrently. For example, **one recipient confirmed benefits in Kentucky and Louisiana since 2011 when contacted by LDH**.

- **Other Family Members Identified**. Our review identified at least 38 other recipients (relatives) that moved out-of-state with the family. There may be other recipients (relatives) not identified by our review.

- **Medicaid Case Closures.** Of the cases closed, none were closed prior to **February 2015,** suggesting a possible lack of eligibility update efforts prior to that date.

Conclusion and Recommendations

Based on the results of our review, **LDH needs to strengthen its processes for verifying and updating, in a timely manner, the eligibility of Medicaid recipients who do not meet the Louisiana Medicaid residence requirement. Because of weaknesses in the current processes, LDH did not identify recipients who moved out of state in a timely manner and therefore continued to pay PMPM fees to the managed care organizations. Our review noted erroneous payments of $943,274 from February 2012 through May 2016,[7] with an additional $1,491,552 in questionable payments.**

Our review focused on recipients with out-of-state addresses already updated by LDH. Other recipients who have moved from Louisiana and have not been identified by LDH likely exist. Erroneous PMPM payments for these recipients likely continue.

Recommendations:

(1) LDH should design and implement processes to ensure that eligibility determinations are reviewed and updated routinely, especially for the in-state residence requirement, to prevent PMPM payments for ineligible recipients.

(2) LDH should strengthen its current eligibility renewal practices to mitigate the risks of allowing renewals without direct contact with the recipient and automatic renewals relying on other governmental programs and systems. More direct contact should be considered.

(3) LDH should perform routine analysis of recipient utilization of services and consider if evidence showing no utilization over a number of years could be indicative of out-of-state residency. For the remainder of the population of more than 13,000 recipients identified with no claim activity since the implementation of managed care, LDH should review the cases to determine if these recipients meet all requirements of Medicaid eligibility.

(4) With the shift to managed care, LDH should establish a robust eligibility determination system to avoid the cost of erroneous PMPM payments.

[7] Due to the timing of PMPM payments, this includes dental PMPMs with service dates through May 2016 and Healthy Louisiana PMPMs with service dates through April 2016.

Under Louisiana Revised Statute 24:513, this report is a public document, and it has been distributed to appropriate public officials.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

LL:AC:WG:EFS:aa

MEDICAID RESIDENCY ELIGIBILITY 2016

APPENDIX A: MANAGEMENT'S RESPONSE

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 14, 2016

Daryl G. Purpera, CPA, CFE
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RE: Medicaid Recipient Eligibility – Managed Care and Louisiana Residency

Dear Mr. Purpera:

We have carefully reviewed the above referenced draft report and provide the following response to recommendations documented in the report.

Recommendation:

LDH should design and implement processes to ensure that eligibility determinations are reviewed and updated routinely, especially for the in-state residence requirement, to prevent PMPM payments for ineligible recipients.

Response:

The Louisiana Department of Health (LDH) has introduced additional methods of capturing information which negatively affects eligibility. Wherever possible, we have pursued options that do not rely on staff capacity, which has been severely reduced over the past decade. For example, since January 2012, our Managed Care Organizations (MCOs) have been able to transmit demographic data changes to LDH that are reported directly by plan members, since plans have more direct and frequent contact with members. LDH staff take appropriate action to update this information in the Eligibility system.

Members can also report demographic updates at Application Centers, by calling our toll free hotline, by using the online portal or by email to Healthy@la.gov or MedWeb@la.gov.

On a procedural level, we have long mandated termination of eligibility on receipt of information which indicates out-of-state residence. As standing policy also permits closure when mail is returned with no forwarding address, LDH devoted staff in March 2016 to reviewing returned correspondence. A new Affordable Care Act requirement that States must mail a Form 1095-B to everyone that had minimum essential coverage in the prior calendar year generated over 800,000 notices in January 2016. Thousands of notices were returned undeliverable due to address changes or unknown addresses.

Staff were dedicated to work through the returned mail, reviewing case records and other systems to determine if more current information was available for active enrollees whose mail had been returned. Most of the returned mail was for individuals whose coverage that ended throughout the year. The Eligibility system was updated to reflect information found or the member's coverage was set to close if they could not be located. This provided a near-complete review of everyone in full-benefit programs. Since this is an annual mailing, we feel that it will continue to provide another opportunity to update member information on the Eligibility system.

In July 2016, we implemented a process whereby receipt of returned mail will trigger notification to the MCOs of an impending closure. The MCOs attempt to contact the member to confirm ongoing residency or a move out-of-state. This dovetails with their existing responsibility to transfer any changes in demographic data to the Department for update and review.

Health Plan Advisory #16-27 was issued on September 26, 2016 to outline procedures for MCO's to report to LDH on member related returned mail. Plans must report to LDH within 30 days if they are unable to make contact with the member to verify demographics. LDH will review records and research other agencies' systems to determine if more current information is available. The enrollee's coverage is set to close at the end of the month if no information is found.

Since February 2016, the Enrollment Broker provides weekly reports of members with out of state addresses. These reports are worked by field staff and monitored by Eligibility managers. We are also working with data analysts to prepare routine monthly reports of members with addresses on file that are outside of Louisiana.

Recommendation:

LDH should strengthen its current eligibility renewal practices to mitigate the risks of allowing renewals without direct contact with the recipient and automatic renewals relying on other governmental programs and systems. More direct contact should be considered.

Response:

Federal regulations require that states conduct redeterminations of eligibility without requiring information from the individual if it is able to do so based on information in the record or other information available to the agency. Louisiana has been recognized as a national leader in retention efforts primarily for utilizing streamlined methods and automation to conduct renewals.

LDH spent years working to improve retention efforts to minimize the number of eligible children that were losing coverage at renewal based on failure to meet laborious manual paper processes. Everything that is in place today is based on lean six sigma and organized process improvement initiatives in cooperation with detailed data analysis to yield the lowest Payment Error Rate Measurement (PERM) rates in the country. PERM reviews eligibility and claims. For eligibility a sample population is reviewed to determine the accuracy of the decision. Claims are then reviewed to determine if providers billed correctly. Both are used to determine the state's overall payment error rate.

These processes will be further enhanced with the implementation of a new eligibility and enrollment system in 2017 that will offer opportunities to automate manual processes and enhance opportunities for reporting changes in circumstances.

In May 2016, LDH expanded the existing staff augmentation support contract with the University of New Orleans for additional eligibility support which will help ensure prompt action on information received, such as mail returned undeliverable or reports of residency changes from MCOs as mentioned above. This contract extension will also allow us to dedicate resources to completing renewals, locating non-responsive enrollees and conducting thorough system clearances to obtain current information on members at renewal.

Recommendation:

LDH should perform routine analysis of recipient utilization of services and consider if evidence showing no utilization over a number of years could be indicative of out-of-state residency.

Response:

The risk adjustment process includes an adjustment to the capitation rate specific for non-utilizers. An analysis by Mercer confirmed that the Louisiana non-utilizer percentage is within the normal range of other states.

In its partnership with the MCOs administering benefits to Medicaid enrollees, LDH has established parameters to flag beneficiaries when claims arrive from out-of-state providers who do not reside in border areas considered as in-state for purposes of ensuring enrollee access in medically underserved areas. Since we have already begun to use claims data to signal possible changes in eligibility (e.g. labor and delivery claim codes on Pregnant Woman certifications) and the MMIS (Medicaid Management Information System) is slated for upgrade in the future, we anticipate that this together with Medicaid Modernization improvements will permit more incisive analysis of claims and utilization patterns, enabling the precise remedy recommended here.

Recommendation:

With the shift to managed care, LDH should establish a robust eligibility determination system to avoid the cost of erroneous PMPM payments.

Response:

LDH is in the process of implementing a new eligibility and enrollment system which will have robust interfaces that can provide updated information that is now manually obtained. This will facilitate improved communication and data exchange between the Department and other partner agencies, providers, MCO's and enrollees. These enhancements will automate and aggregate verification retrieval from existing systems to display all pertinent information to eligibility staff without manually searching each data source. The first phase of the implementation is scheduled for August 2017.

In the longer term, the total replacement of the current Medicaid eligibility mainframe and associated information architecture, will further improve data exchange between the Department and partner agencies to permit more derivative and interpretative analyses of claims and utilization data which may suggest a loss of Louisiana residency as well as other changes which may affect eligibility.

These enhancements will automate and aggregate verification retrieval from existing systems to display pertinent information to eligibility staff and minimizing the need to manually search each data source.

Please contact Diane Batts at (225) 342-2300 if you have any questions or need any additional information regarding this finding.

Sincerely,

Jen Steele
Medicaid Director

JS:DSB

c: Diane Batts
Pam Diez
Bill Perkins

APPENDIX B: SCOPE AND METHODOLOGY

The objective of our work was **to review the Louisiana Department of Health's (LDH) processes for verifying that Medicaid recipients meet the Louisiana residence requirement for eligibility.** The scope of our engagement was significantly less than an audit conducted in accordance with *Government Auditing Standards*. The following procedures were performed:

- We isolated Louisiana Medicaid recipients with LDH Healthy Louisiana premium payments from calendar years 2012 through 2015 and compared the recipients to Healthy Louisiana managed care organizations (MCO) claims activity for those recipients. We identified 13,141 recipients with **no MCO claims paid by the Healthy Louisiana plans.** From this population, we noted 413 recipients with **out-of-state addresses** as of April 2016. Healthy Louisiana per member per month (PMPM) fees for the 413 recipients totaled $2,740,411 for calendar years 2012 through 2015. Because state residence is a requirement for Louisiana Medicaid, we selected a sample for review.

Other procedures included:

- Met with LDH staff to obtain an understanding of eligibility systems.
- Examined fee for service claims (including PMPMs) and MCO claims data.
- Researched eligibility cases using various LDH eligibility systems.
- Obtained expenditure data from the state accounting system.
- Provided results to LDH for feedback. Requested any available additional information for consideration.
- Requested and obtained responses from LDH.