



Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

**Louisiana Medicaid Eligibility Determinations for the Adult
Expansion Population**

Review Period: January 2019 through March 2019

Eligibility Review

Final Report

September 2020

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Executive Summary

In June 2018, the Centers for Medicare & Medicaid Services (CMS) announced a Medicaid Program Integrity Strategy that includes initiatives designed to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. A key component of the strategy is performing reviews of Medicaid beneficiary eligibility determinations in states identified as high-risk by previous U.S. Department of Health and Human Services Office of Inspector General (OIG) and state audit findings to hold states accountable for accurate beneficiary eligibility determinations.

CMS conducted a review of the Louisiana Department of Health's (herein, referred to as Louisiana) eligibility determination process. CMS' primary review objective in the performance of this review was to identify whether the state determined Medicaid eligibility at the point of application or re-determination for beneficiaries in the adult expansion population using financial methodologies based on modified adjusted gross income (MAGI) in accordance with Federal and state eligibility requirements, and claimed the appropriate Federal Medical Assistance Percentage (FMAP) on behalf of these beneficiaries. Other objectives included identifying and assessing the impact of any changes to Medicaid eligibility policy due to the Affordable Care Act (ACA) and determining whether non-expansion enrollment categories were impacted by the expansion enrollment process.

Louisiana provided technical comments in response to the draft report, which can be found in Appendix D. Several technical corrections were made to the final report as a result of these comments.

Louisiana Correctly Determined Medicaid Eligibility for 99.5 Percent of the Adult Expansion Population

Based on the extrapolated results of this review (review period: January 2019 - March 2019), Louisiana correctly determined Medicaid eligibility in accordance with Federal and state requirements for 99.5 percent of the adult expansion population beneficiaries. This review also determined that during the review period, Louisiana's improper eligibility determinations for the adult expansion population resulted in \$3,835,749.21 (Federal share) in improper payments.¹

For most eligibility determinations in the sample, Louisiana verified financial information related to wages, net earnings from self-employment and unearned income from a combination of the following data sources: the State Wage Information Collection Agency (SWICA), Internal Revenue Service (IRS), Social Security Administration (SSA), and state unemployment insurance. (42 CFR § 435.948(a)(1)) Louisiana requested additional information or documentation from applicants and beneficiaries if attested income was not reasonably

¹ See Appendix C for extrapolation methodology and calculation.

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compatible with electronic sources in accordance with the state's verification plan.² (42 CFR § 435.952(c)(2)) Additionally, this review found that the state verified citizenship or immigration status by electronically verifying citizenship status with the SSA and immigration status with the Department of Homeland Security (DHS).³ Louisiana also correctly determined beneficiaries' Medicaid eligibility for the correct aid category.

In the sample of 64 adult expansion population beneficiaries, Louisiana correctly determined eligibility for 62 beneficiaries. For the two improper eligibility determinations, Louisiana did not always include, or calculate correctly, all applicable income or appropriately make changes to household size for the newly enrolled adult group due primarily to caseworker error. As a result, out of the \$387,947.23 (Federal share) sampled, \$3,299.38 (Federal share) were identified as being paid in error. Based on the sampled errors, CMS estimates that during the review period, Louisiana made Federal Medicaid payments on behalf of an estimated 2,325 ineligible adult group beneficiaries, totaling an estimated \$3,835,749.21 (Federal share) in improper payments, out of 438,559 total adult group beneficiaries with Federal Medicaid payments of \$629,468,057.97.

Results of the Review

CMS identified two eligibility determination errors as a result of this review. CMS recommends that Louisiana ensure that: (1) eligibility caseworkers understand and implement all controls and follow the state's intended policies and practices outlined in the verification plan, and (2) renewals are performed to cover all periods that individuals are enrolled in Medicaid.

² Louisiana MAGI-Based Eligibility Verification Plan. Retrieved on September 16, 2019 from <https://www.medicaid.gov/medicaid/program-information/eligibility-verification-policies/downloads/louisiana-verification-plan-template-final.pdf>.

³ 42 CFR §§ 435.406 and 435.949. Citizenship and non-citizen eligibility, Verification of information through an electronic service. Retrieved December 3, 2018 from https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1406&rgn=div8 and https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1949&rgn=div8.

Eligibility Review: Louisiana Medicaid Eligibility Determinations for the Adult Expansion Population

Background

Medicaid is a joint Federal and state program that, together with the Children's Health Insurance Program (CHIP), provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.⁴

Federal law requires states to cover certain groups of individuals under the state's Medicaid program. Low income families, qualified pregnant women and children and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.⁵

States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services (CMS). CMS reimburses states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP), which is developed from criteria such as the state's per capita income. The regular program FMAP varies by state and ranges from 50 to 75 percent. Louisiana's regular FMAP for the review period (January 2019 through March 2019) was 65 percent.⁶

Medicaid Coverage for the Adult Expansion Population under the Affordable Care Act (ACA)

As of August 2019, 36 states, including the District of Columbia, elected to expand Medicaid coverage under the ACA.⁷ Prior to the ACA, low-income, non-disabled adults without dependent children generally were not eligible for Medicaid, regardless of income. Section 2001 of the ACA established a new eligibility group providing health care coverage to previously ineligible

⁴ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

⁵ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

⁶ Kaiser Family Foundation (2018). Federal Medical Assistance Percentage (FMAP) and Multiplier for States. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/State-indicator/Federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷ Medicaid.gov. Adult Coverage Expansion Map as of July 2020. Retrieved August 3, 2020 from <https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf>.

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adults under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (subsequently codified in regulations at 42 CFR § 435.119). These changes were significant in that, for the first time since the establishment of the Medicaid program in 1965, states could receive Federal Medicaid funds, without a waiver, to provide coverage to low-income individuals without regard to disability, parental status, or most other categorical limitations. The ACA's changes to Medicaid eligibility criteria expanded coverage to nearly all non-elderly adults with incomes at or below 138 percent⁸ of the Federal Poverty Level (FPL).

The ACA also established a new methodology for determining income eligibility for Medicaid and CHIP based on the applicant's modified adjusted gross income (MAGI). MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents, and adults. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. The MAGI-based methodology does not allow for income disregards that vary by state or by eligibility group, and does not allow for an asset or resource test.⁹

The ACA also provided enhanced FMAP for the adult expansion population. From 2014 to 2016, the Federal Government funded 100 percent of allowable health care costs for the newly eligible adult population. The FMAP dropped to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent for 2020 and beyond. States were eligible to receive the enhanced FMAP for those beneficiaries who would not have been eligible for benefits as of December 1, 2009, or who were eligible under a waiver but not enrolled in the program because of limits or caps on waiver enrollment.¹⁰ The ACA also provided enhanced FMAP (75 to 90 percent) to support states in the replacement or upgrade of outdated eligibility systems and to establish links to other data sources to implement new streamlined processes.

Beginning in January 2014, to promote program integrity when verifying eligibility while also minimizing the amount of paper documentation that applicants and beneficiaries needed to provide, states were required to primarily rely on available electronic data sources to verify information included on the application (or conduct the renewal process). Medicaid and CHIP agencies now rely primarily on information available through electronic data sources (e.g., the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the state Department of Labor) rather than paper documentation from applicants and beneficiaries for purposes of verifying eligibility for Medicaid and CHIP.¹¹

⁸ Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR § 435.119 define the income standard for the group at 133 percent of the FPL; however, the income counting methodology allows for an income disregard equivalent to five percentage points of the FPL when a household is on the edge of eligibility for Medicaid or CHIP. As a result, the effective income standard for the adult group is 138 percent of the FPL.

⁹ Medicaid.gov. Keeping America Healthy. Medicaid Eligibility. Retrieved December 3, 2018 from <https://www.medicaid.gov/medicaid/eligibility/index.html>.

¹⁰ Kaiser Family Foundation. (2014, September 29). Understanding How States Access the ACA Enhanced Medicaid Match Rates. Retrieved December 9, 2018 from <https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

¹¹ Regulations at 42 CFR 435.945, 435.948 and 457.956 describe income and eligibility verification requirements.

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Documentation or other information is requested when electronic data is unavailable or not reasonably compatible (i.e., consistent with electronic data) in accordance with a state's verification plan.¹² States are also able to accept self-attestation of some elements of eligibility when making determinations.

Regulations at 42 CFR 435.945(j) and 457.380(j) require states to develop and update a plan describing the Medicaid and CHIP eligibility verification policy and procedures adopted by the state. States must submit their verification plans to CMS upon request. CMS issued a MAGI-based Eligibility Verification Plan template that all states submitted to CMS in preparation for 2014. CMS reviewed each plan and provided technical assistance as needed to ensure the plans were in compliance with Federal regulations. States must provide updated versions of the plans to CMS if the state subsequently changes verification policies and procedures captured in the template.

The implementation of the ACA established new policies that simplified enrollment of MAGI eligible individuals into Medicaid and CHIP. Required elements of the streamlined eligibility and enrollment process include:

- Provide a single, streamlined application for Medicaid, CHIP, and Marketplace coverage that individuals can submit online, by phone, in-person, or mail
- Eliminate use of asset tests for groups eligible based on MAGI
- Eliminate in-person interview requirement for individuals who apply or whose eligibility is being renewed on the basis of MAGI
- Utilize electronic data matches to verify eligibility criteria to the greatest extent possible and only request paper documentation when unable to obtain information electronically
- Complete renewals once every **12 months** and no more frequently than once every 12 months for groups eligible based on MAGI
- Seek to renew coverage based on information from the beneficiary's account and available data sources before requesting information from the individual (these renewals are addressed as ex parte¹³)

Medicaid Adult Expansion Population in Louisiana¹⁴

In 2013, prior to expansion, the U.S. Census Bureau reported that Louisiana's uninsured rate was 16.6 percent. From 2016 to 2017, Louisiana's uninsured rate dropped from 10.3 percent to 8.4 percent – the largest drop among states.¹⁵

¹² Medicaid.gov. Keeping America Healthy. Medicaid/CHIP Eligibility Verification Plans. Retrieved December 9, 2018 from <https://www.medicaid.gov/medicaid/eligibility/verification-plans/index.html>.

¹³ An ex parte renewal is a redetermination of eligibility that can be made based on reliable information available to the agency, including information accessed through electronic data sources, without requiring information from the individual. This is also referred to as a passive renewal.

¹⁴ Health Insurance.org. (2018, November 25). Louisiana and the ACA's Medicaid Expansion. Retrieved March 14, 2019 from <https://www.healthinsurance.org/Louisiana-medicaid/>.

¹⁵ Louisiana Office of the Governor. (2018, September 18). U.S. Census Bureau: More Louisianans Than Ever Have Health Insurance. Retrieved August 25, 2019 from <http://gov.louisiana.gov/index.cfm/newsroom/detail/1573>

As of May 2019, Louisiana had 1,382,262 individuals enrolled in Medicaid and CHIP — a net increase of 35.54 percent since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.¹⁶ From January 1 2019 through March 31, 2019 (the review period), the state made Medicaid payments totaling \$629,468,057.97, on behalf of 438,559 beneficiaries, for all beneficiaries enrolled in the adult group.

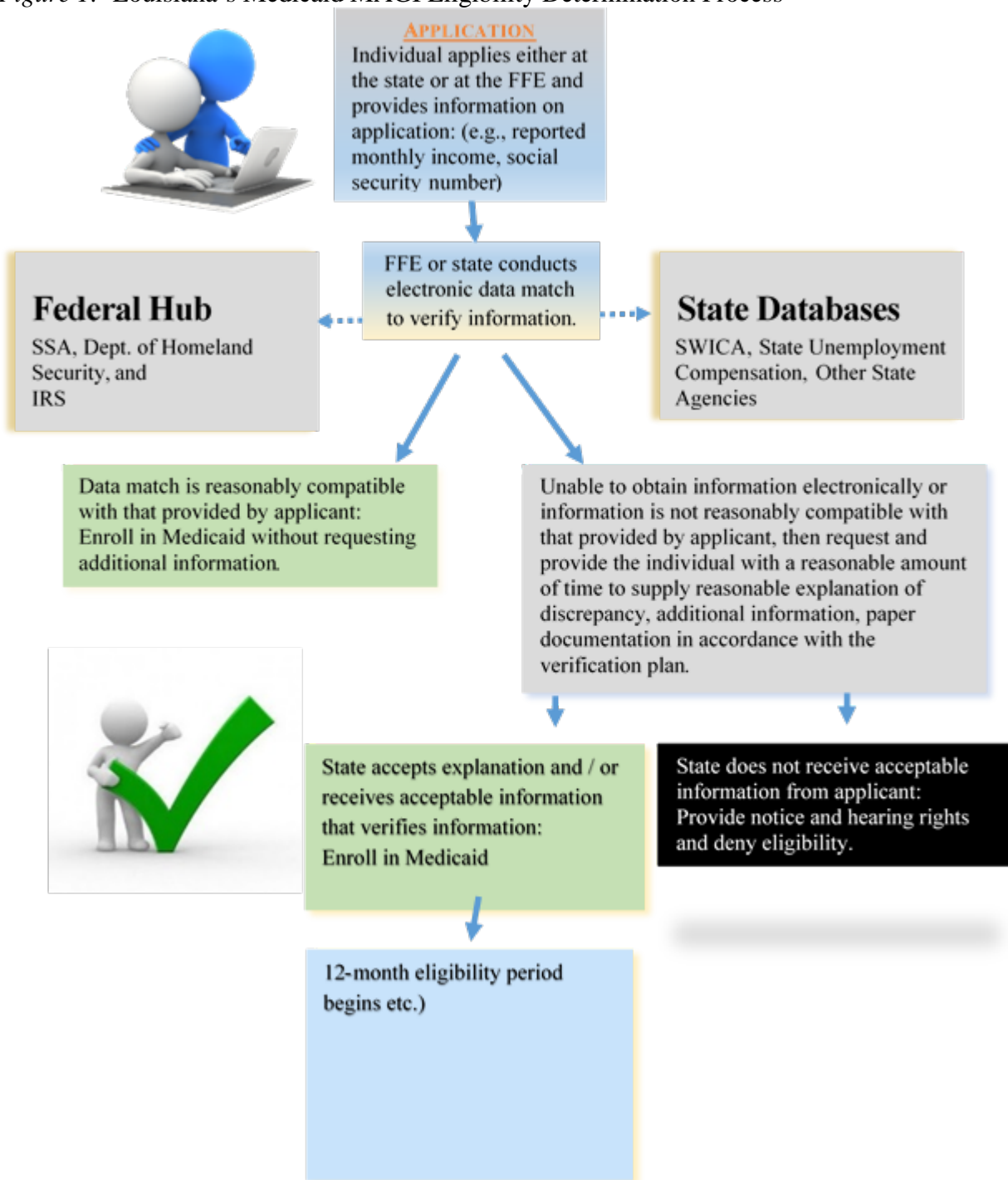
Louisiana’s Medicaid Eligibility Process

Louisiana has expanded Medicaid to the adult group and utilizes the Federal Facilitated Exchange (FFE), Healthcare.gov enrollment platform. Individuals seeking health coverage in Louisiana may apply through the state Medicaid agency or the FFE, Healthcare.gov. For individuals who apply for coverage on HealthCare.gov, the FFE determines eligibility for MAGI Medicaid and CHIP, if able to do so based on verification of information using multiple electronic data sources available through the Federal Data Services Hub (Data Hub). The data sources used by Louisiana through the Data Hub are provided by HHS, the SSA, the DHS, and the Internal Revenue Service (IRS) (at the time of this review, the state did not use the IRS for applications filed directly with the state), among others. Louisiana is considered a determination state and must accept the FFE determination as final and enroll the individuals promptly.¹⁷ For applications submitted directly to the state and for all cases at renewal and other changes in circumstances, Louisiana may also use other data sources maintained by the state, such as the Louisiana Workforce Commission (LWC), in accordance with the state’s verification plan. See Figure 1 for the Medicaid MAGI Eligibility Process for individuals who apply for coverage through the state agency.

¹⁶ Medicaid.gov. Keeping America Healthy. Medicaid & CHIP in Louisiana. Retrieved August 26, 2019 from <https://www.medicaid.gov/state-overviews/stateprofile.html?state=Louisiana>.

¹⁷ 42 CFR §§ 435.1200(c). Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs. Retrieved February 11, 2020 from <https://www.law.cornell.edu/cfr/text/42/435.1200>.

Figure 1: Louisiana’s Medicaid MAGI Eligibility Determination Process



Louisiana Legislative Auditor Reports

In November 2018, the Louisiana Legislative Auditor (LLA) issued its first of two reports on Louisiana’s eligibility and verification processes for the adult group.

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The first report¹⁸ focused on the state's verification processes. The LLA identified a sample population of single-person household adult group beneficiaries whose income appeared to exceed the allowable amount for Medicaid during the audit period of July 1, 2016 through March 31, 2018, based on information the auditor obtained from quarterly wage data. From there, the LLA selected two samples, both consisting of 100 Medicaid adult group beneficiaries in a single-person household. The first sample was a targeted sample which selected those beneficiaries with the highest wage amounts. The second sample was a random sample. The LLA used electronic matches to state wage data to determine whether beneficiaries' income exceeded Medicaid limits between annual redeterminations, and whether improper payments were made to Medicaid Managed Care Organizations (MCOs) during these months.

In the targeted sample, 93 of the 100 beneficiaries reviewed were found to be ineligible for the adult group. This resulted in \$538,795 or 66 percent of payments made by Louisiana during the audit period being improper due to the beneficiaries being over income.

In the random sample, 82 of the 100 beneficiaries reviewed were found to be ineligible for the adult group. This resulted in \$382,420 or 47 percent of payments made by Louisiana during the audit period being improper due to being over income during the payment month.

The LLA estimates that the state issued an overpayment of between \$61.6 and \$85.5 million for the 19,226 single-person household beneficiaries enrolled in the adult group during the audit period.

In December 2018, the LLA issued the second report¹⁹ that tested eligibility determinations. The LLA identified a sample of 60 Medicaid adult group beneficiaries using MAGI-determinations and renewals for the period of July 2017 through February 2018.

The LLA identified five specific findings as a result of the review: (1) federal or state tax data was not used to verify MAGI-based eligibility factors, (2) policy allowed for caseworkers to renew eligibility for certain cases where the state assumed there was no change in information resulting in some renewals potentially without sufficient basis, (3) caseworker errors resulted in incorrect eligibility determinations and inadequate case documentation, (4) a copy of the signed application was not retained, and (5) individuals were allowed to apply on the behalf of the intended beneficiary.

The report stated that Louisiana paid \$60,586 to MCOs on behalf of five individuals found to be ineligible for Medicaid. Based on the extrapolated results, the LLA estimated that Louisiana made payments on behalf 17,623 ineligible Medicaid beneficiaries. The LLA was unable to reasonably estimate an extrapolated improper payment amount because the exact timing of when

¹⁸ Louisiana Legislative Auditor report, *Medicaid Eligibility: Wage Verification Process of the Expansion Population*. Retrieved January 7, 2020 from [https://www.lla.la.gov/PublicReports.nsf/1CDD30D9C8286082862583400065E5F6/\\$FILE/0001ABC3.pdf](https://www.lla.la.gov/PublicReports.nsf/1CDD30D9C8286082862583400065E5F6/$FILE/0001ABC3.pdf).

¹⁹ Louisiana Legislative Auditor report, *Medicaid Eligibility: Modified Adjusted Gross Income Determination Process*. Retrieved January 7, 2020 from [https://lla.la.gov/PublicReports.nsf/0C8153D09184378186258361005A0F27/\\$FILE/0001B0AB.pdf](https://lla.la.gov/PublicReports.nsf/0C8153D09184378186258361005A0F27/$FILE/0001B0AB.pdf).

the beneficiaries became ineligible for Medicaid was not able to be determined from the case files reviewed.

CMS reviewed the LLA's reports and noted observations where the findings would not in all cases result in an error under Federal policy requirements. For example, in some cases, the LLA relied on income data sources that states are not Federally required to use. In other cases, the LLA did not fully account for all of the steps the state is required to take when reviewing an income data source that leads to a conclusion that the data is not a current representation of the individual's circumstances (i.e., steps required when a change in circumstances is identified before an individual's enrollment can be terminated). Failure to account for all of the steps likely led to inflated findings in the LLA report as not all findings represent errors under Federal policy requirements.

Louisiana's New Eligibility Control Strategies

In February 2019, Louisiana implemented two new control strategies aimed at reducing improper payments for individuals who were not eligible. These changes were implemented, in part, as a response to two LLA reports, described above.

The first control strategy helped mitigate the risk of beneficiaries who experience increased income but who have not reported those changes. The control strategy includes performing quarterly income data matches with the LWC, in addition to annual renewals of eligibility, as required by Federal regulation. Adults who appear to be over 138 percent of the FPL based on the LWC data are mailed a notice that provides a 60-day response period, requesting the beneficiary to provide current income information and supporting documentation, if the beneficiary disagrees with the LWC data (e.g., seasonal or temporary work or loss of employment). If the beneficiary fails to provide the requested information within the response period, their eligibility will be terminated. Louisiana's first data match was performed on February 1, 2019, and the second data match was performed on May 1, 2019. See Figure 2 for data on the first quarterly data match and Figure 3 for data on the second quarterly data match.

CMS did note one system issue during the February match. Any social security number having a leading "0" in any sequence was not recognized, and therefore, not included in the data match. See the 'Observations' section for more information on this issue.

Figure 2: Results of February 2019 Income Data Match

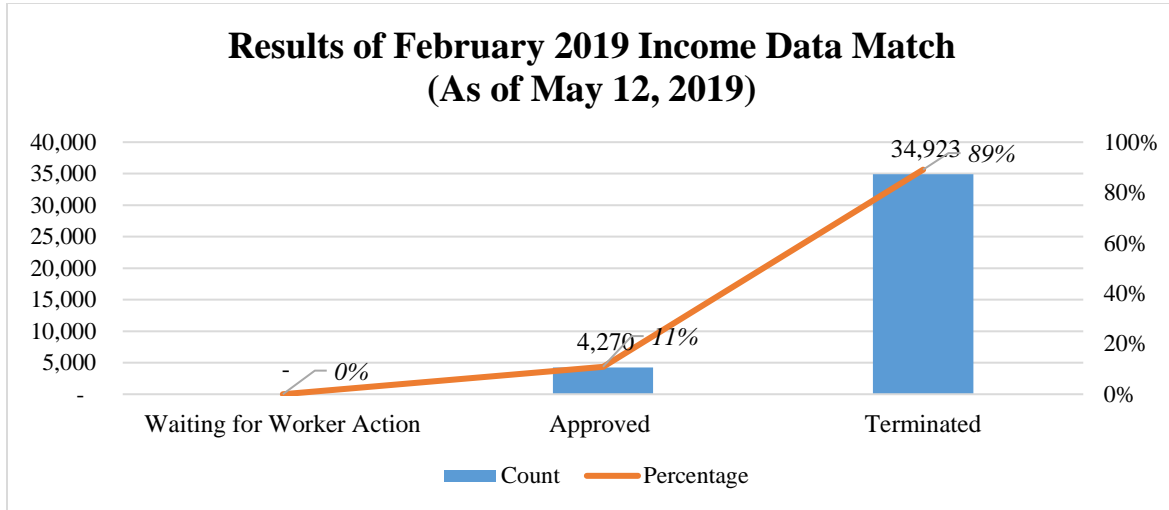
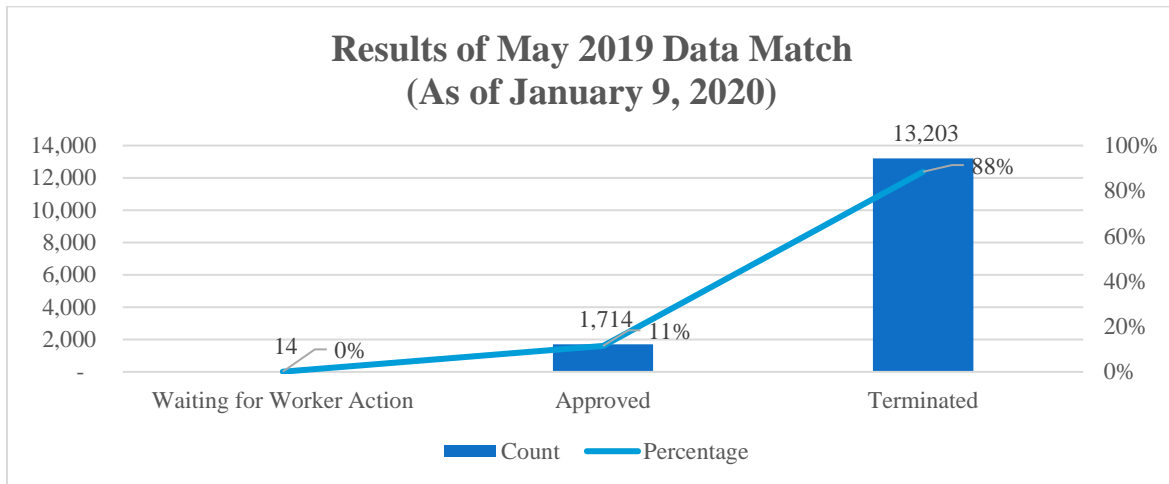


Figure 3: Results of May 2019 Income Data Match



In addition to the quarterly income data matches, Louisiana added a second control strategy that helped ensure only income-eligible individuals are added to the new adult population. Louisiana implemented this strategy by conducting income data matches for FFE determinations. Under Louisiana’s Medicaid expansion program, Louisiana accepts the FFE’s MAGI-based eligibility determinations as final determinations, when the FFE is able to verify all eligibility criteria. Then on the day a Medicaid determination is received from the FFE, Louisiana enrolls the beneficiary and also completes an income data match with the LWC that same evening. If the LWC data is not reasonably compatible with the attested and verified income from the FFE determination, Louisiana will send a request for information to the applicant for additional income documentation. The beneficiary’s eligibility may be continued or denied based on the receipt and

outcome of the additional documentation. See the ‘Observations’ section for more information on this issue.

Scope and Methodology of the Review

This review included individuals covered by Louisiana’s Medicaid adult expansion population. CMS chose Medicaid beneficiaries who received services during the review period of January 1, 2019 through March 31, 2019. A stratified random sample of 64 beneficiaries was selected for review.

Appendix A contains the details of the review scope and methodology, Appendix B contains the statistical sampling methodology, and Appendix C provides the sample results and estimates of ineligible beneficiaries and associated payments made for those beneficiaries.

Results of the Review

CMS conducted a review of Louisiana’s eligibility determination process. CMS’ primary review objective in the performance of this review was to identify whether the state determined Medicaid eligibility at the point of application and redetermination for individuals in the adult group using financial methodologies based on MAGI in accordance with Federal and state eligibility requirements and claimed the appropriate FMAP on behalf of these beneficiaries. Other objectives included (1) identifying and assessing the impact of any changes to Medicaid eligibility policy due to the ACA, and (2) determining whether non-expansion enrollment categories were impacted by the expansion enrollment process.

In the sample of 64 beneficiaries, Louisiana correctly determined eligibility for 62 beneficiaries. For the two improper eligibility determinations, Louisiana did not always include, or calculate correctly, all applicable income or appropriately make changes to household size for the newly eligible adult group. Both errors appear to be caseworker errors, rather than system errors, related to eligibility determination processes implemented in response to the ACA.

Based on the extrapolated results of this review (review period: January 2019 - March 2019), Louisiana correctly determined Medicaid eligibility in accordance with Federal and state requirements for 99.5 percent of the adult expansion population beneficiaries. CMS estimates that during the review period, Louisiana made Federal Medicaid payments on behalf of an estimated 2,325 ineligible adult group beneficiaries, totaling an estimated \$3,835,749.21 (Federal share) in improper payments, out of 438,559 total adult group beneficiaries with Federal Medicaid payments of \$629,468,057.97.

Details regarding the findings of this review are below, including the two eligibility errors that resulted in findings for this report, as well as report outcomes of the other review objectives and additional observations.

1. Eligibility Determinations

Louisiana Medicaid Eligibility Determination Review

Based on the extrapolated results of this review, Louisiana correctly determined Medicaid eligibility in accordance with Federal and state requirements for 96 percent of the adult expansion population beneficiaries.

Specifically, in accordance with its MAGI verification plan, for 99.5 percent of the adult group beneficiaries, CMS found that Louisiana accurately:

- Used the Data Hub to verify financial information related to wages, net earnings from self-employment and unearned income from the SWICA, SSA, and state unemployment insurance (42 CFR § 435.948(a)(1)).
- Requested additional information or documentation from beneficiaries if attested income was not reasonably compatible with electronic sources in accordance with the state's verification plan (42 CFR § 435.952(c)(2)).
- Verified citizenship or immigration status by electronically verifying citizenship status with the SSA and the DHS.²⁰ Discrepancies were resolved timely during the 90-day inconsistency periods.²¹
- Used Healthcare.gov to continuously provide and maintained supporting documentation (e.g., paystubs, letters from employers, additional citizenship information) when such information was required to verify eligibility.

The two eligibility errors identified by CMS are described below. These errors show that Louisiana did not always include, or calculate correctly, all applicable income or appropriately make changes to household size for the newly eligible adult group. Both errors appear to be caseworker errors, rather than system errors, related to eligibility determination processes implemented in response to eligibility processing changes under the ACA.

1.1) The individual was ineligible for Medicaid for the entire three months of the sample due to household income exceeding the income standard.

The applicant attested to a monthly income of \$1,768 or 170 percent of the FPL.

The state reviewed income data sources. Then, in this case, the eligibility caseworker used income of \$553 per month from a data source to approve eligibility. If the caseworker had used the attested income as appropriate, the applicant would not have been eligible.

Based on this error, the review estimates total payments of \$1,795.01 were inappropriately paid during the review period.

²⁰ 42 CFR §§ 435.406 and 435.949. Citizenship and non-citizen eligibility, Verification of information through an electronic service. Retrieved December 3, 2018 from https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1406&rgn=div8 and https://www.ecfr.gov/cgi-bin/text-idx?SID=b8877dc2571bbf3b18594e0e6c8e1814&mc=true&node=se42.4.435_1949&rgn=div8.

²¹ The Act § 1902(ee)). Retrieved December 8, 2018 from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

1.2) The individual was ineligible for Medicaid for the entire three months of the sample due to failure to complete a renewal.

The beneficiary's eligibility was appropriately renewed in April 2017. Subsequent to the April 2017 renewal, the beneficiary's child aged out and became eligible for the new adult aid category. The beneficiary submitted an application for the child in October 2017 and also included herself for renewal at that time causing an off-cycle renewal. This renewal should have been effective through October 2018. CMS could not locate a renewal covering the review period, indicating that this was a caseworker error.

Based on this error, the review estimates total payments of \$1,752.71 were inappropriately paid during the review period.

2. Policy Assessment

One of the objectives of this review was to identify and assess the impact of any changes to the state's Medicaid eligibility policy and practices due to the ACA. During the course of this review, CMS worked with state staff and reviewed state policies, as well as State Plan Amendments (SPAs).²² CMS' review did not find evidence that the new MAGI enrollment regulations established under the ACA have impacted any other non-MAGI enrollment or eligibility policies.

3. Enrollment in the Adult Expansion Category (Higher FMAP)

One of the objectives of this review was to ensure that only eligible individuals were enrolled in the adult expansion category and that the state claimed the appropriate FMAP for services on behalf of those individuals – either increased FMAP for individuals newly eligible, or regular FMAP for individuals not newly eligible. According to the sample review of 64 beneficiaries, the state's system correctly determined beneficiary's Medicaid eligibility category at application and redetermination (e.g., Louisiana's adult group). Test work did not indicate that any lower FMAP eligibility group individuals had been enrolled inappropriately.

Additionally, a review of non-expansion aid category population counts over time did not indicate that the state was shifting populations from lower FMAP populations to higher FMAP populations, such as the adult group.

²² A state plan is an agreement between a state and the Federal Government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. When a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to CMS for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information. Medicaid.gov, Medicaid State Plan Amendments. Retrieved January 3, 2020 from <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html>.

Observations

During the course of the review, other issues were identified in the sample regarding caseworker and system errors, as well as FFE determinations. These items do not represent an error to the state but eligibility determinations outside the sample could have been impacted.

1. **Caseworker action could inappropriately affect future eligibility determinations.**

The applicant attested to a monthly income of \$700. The LWC reported \$900 per month. The caseworker then interpreted the \$900 LWC monthly amount as a quarterly amount and used \$300 as the monthly LWC data amount. The eligibility caseworker relied on attested monthly income of \$700 per month to determine eligibility, even though, the reasonable compatibility calculation provided by the system indicated 28 percent, which was greater than the state's reasonable compatibility threshold of 10 percent outlined in Louisiana's verification plan and policy (further the difference between the attestation of \$700 and the data of \$900 was actually 23 percent, while the difference between the incorrect data calculation of \$300 and the attestation of \$700 was 43 percent). No request for information was sent to the applicant for additional documentation to support the attested amount per the state's verification plan.

In this case, the data available was sufficient to verify the attested income under the state's verification policy at the time of the case action; however, caseworker errors such as these have the potential for inappropriately determining applicants as eligible.

2. **System and caseworker issues that could have caused cases to be inappropriately closed.**

The beneficiary married and forwarded income information into Louisiana to add their spouse to the case and to also re-determine Medicaid coverage. The eligibility worker added the spouse but did not re-determine the beneficiary's coverage.

3. **Risks of caseworker oversight of additional controls.**

The applicant was a nurse who had made in excess of qualifying income in the three quarters prior to applying for the adult group. The applicant's employer reported that the applicant had taken a temporary leave of absence but may work intermittently. The eligibility worker determined the applicant eligible but placed the applicant on "high risk" review for December 1, 2018 for an income review. Based on this review, it appears the high-risk review was never completed. The next review was performed in May 2019; the applicant was found eligible due to no income.

In this case, the beneficiary remained eligible despite the oversight of the additional income review. However, controls such as high-risk reviews that are not observed place Medicaid at risk of maintaining eligibility when individuals are no longer eligible.

4. **An example of a beneficiary that should be flagged in the state's new quarterly income data matches.**

The beneficiary originally was enrolled in the pregnant woman aid category in December 2016 and delivered a child in August 2017. Subsequently, the beneficiary was enrolled into the PCR aid category. At the time of renewal in September 2018, the beneficiary was

determined ineligible for the PCR aid category using the first quarter of 2018 LWC data for being over income and enrolled into the adult group.

The beneficiary's income should have been flagged during the newly implemented quarterly income data match with the LWC in February 2019. The income for the third quarter of 2018 was \$9,350, or 164 percent of FPL. However, there was an issue with the first income data match. Any social security number having a leading "0" in any sequence was not recognized, and therefore, not included in the data match.

For purposes of this review, this was not considered an error although the beneficiary appears to be ineligible for Medicaid based on income from the third quarter of 2018. The state followed the correct protocol in the original eligibility determination for the adult group, and the state was not required to follow-up with an additional income verification until the time of the beneficiary's annual renewal, which would have been in September 2019.

5. An example of a potential risk for Louisiana under its Medicaid expansion program.

The beneficiary's case was transferred by the FFE to Louisiana as eligible for the adult group. Louisiana received the determination on February 18, 2019 with an effective Medicaid eligibility date of November 26, 2018. On February 19, 2019, Louisiana sent the beneficiary a request for income information due to the LWC-reported income for the prior four quarters indicating income above the applicable income threshold. The beneficiary did not reply to the request for information. The case was closed April 1, 2019.

For purposes of this review, this was not considered an error although the beneficiary was ineligible for Medicaid based on income. Louisiana followed the correct protocol in accordance with Federal requirements under its Medicaid expansion program by accepting the FFE determination as final and enrolling the beneficiary into Medicaid. However, with the state's additional control strategy in place, Medicaid payments of \$1,563.25 were made on behalf of the beneficiary during the three-month review period before the case was closed.

Recommendations for Improvement

CMS recommends that Louisiana:

1. Ensure eligibility caseworkers understand and implement all controls and follow the state's intended policies and practices outlined in the verification plan;
2. Ensure renewals are performed to cover all periods individuals are enrolled in Medicaid.

Appendix A: Review Scope and Methodology

Scope

CMS' review covered Medicaid beneficiaries in the MAGI adult group under section 1902(a)(10)(A)(i)(VIII) and 42 CFR § 435.119 who received services from Louisiana for the period of January 1, 2019, through March 31, 2019 (review period).

CMS limited the review to those applicable to our objective. The testing included a review of supporting documentation at the state agency to evaluate whether the state agency determined the applicant's eligibility in accordance with Federal and state requirements and the controls surrounding those activities. In addition, CMS gained an understanding of the policies and procedures for determining whether individuals eligible for the adult group met the eligibility requirements described in the statute and regulations. CMS performed fieldwork from April 2019 through July 2019 with the state agency in Baton Rouge, Louisiana.

Methodology

To accomplish the objectives, CMS:

- Reviewed applicable Federal and state laws, regulations, and other requirements related to Medicaid eligibility;
- Obtained and reviewed Louisiana's MAGI-Based Verification Plan, which captures the data sources the state uses to verify applicant and beneficiary's eligibility at application and redeterminations (including changes in circumstances), along with information about the state's policies for requesting additional information from an individual when data sources are not sufficient to verify the individual's eligibility;
- Assessed internal controls by:
 - Interviewing officials from the Louisiana Department of Health to obtain an understanding on how Louisiana (1) processes an individual's application and renewal information and (2) verifies an applicant's eligibility for enrollment in Medicaid.
 - Holding discussions with state agency officials to obtain an understanding of policies, procedures, and guidance for determining Medicaid eligibility;
 - Performing a walk-through of the applicant information and determination of eligibility verification processes for enrollment in Medicaid; and
 - Determining how the system documents that the verification and determination of eligibility processes occurred.
- Obtained a database of all Medicaid paid claims data in Louisiana with service dates during the review period (excluding claims for services provided to American Indians/Alaska Natives already covered by 100 percent FMAP);
- Created a sampling frame of 438,559 Medicaid beneficiaries for which the state agency made Medicaid payments totaling \$676,847,374.71; and

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- Selected a stratified random sample of 64 Medicaid beneficiaries receiving services in Louisiana during the review period.
- For each sample item, reviewed application and renewal data and documentation to support the eligibility determination made for the services to determine:
 - The organization or agency that made the eligibility determination;
 - Whether the agency making eligibility determinations followed implemented procedures to verify eligibility documentation; and
 - Whether beneficiaries determined to be eligible under the adult expansion population met Federal and state eligibility requirements, such as income level, residency, immigration status, and documentation of U.S. citizenship.
- Held discussions with state agency officials to obtain an understanding of how policies, procedures and guidance for determining Medicaid eligibility have changed with regards to verification both pre and post ACA.
- Discussed the results of the review with state agency officials in an informal exit conference.

Appendix B: Statistical Sampling Methodology for Louisiana

Target Population

The target population consisted of all beneficiaries determined eligible and enrolled in the adult expansion group under the ACA, excluding American Indians and Alaskan Natives, for whom the state agency made Medicaid payments for services provided during the review period.

Sampling Frame

The sampling frame consisted of an Access database containing 438,559 adult group eligible Medicaid beneficiaries in Louisiana for whom the state agency made Medicaid payments totaling \$676,847,374.71 (\$629,468,057.97 Federal share) for services provided during the review period. CMS obtained the data for the Medicaid beneficiaries from Louisiana's Medicaid Management Information System (MMIS). CMS excluded American Indian and Alaskan Native beneficiaries from the sampling frame. American Indians and Alaskan Natives are subject to different Federal matching ratios and were not a part of this review.

Sample Unit

The sample unit was an adult group eligible Medicaid beneficiary.

Sample Design

CMS used a stratified random sample.

- Stratum 1: A certainty stratum for Medicaid beneficiaries who were categorized as being adult group eligible for Medicaid under the ACA with total Federal Medicaid payments greater than or equal to \$50,000 per beneficiary. This stratum consisted of four Medicaid beneficiaries with payments totaling \$302,975.52 (\$281,767.23 Federal share).
- Stratum 2: Medicaid beneficiaries who were categorized as being adult group eligible for Medicaid under the ACA with total Federal Medicaid payments greater than or equal to \$1,661 per beneficiary. This stratum consisted of 34,877 Medicaid beneficiaries with payments totaling \$86,668,403.96 (\$80,601,615.68 Federal share).
- Stratum 3: Medicaid beneficiaries who were categorized as being adult group eligible for Medicaid under the ACA with total Federal Medicaid payments less than \$1,661 per beneficiary. This stratum consisted of 403,678 Medicaid beneficiaries with payments totaling \$589,875,994.69 (\$548,584,675.06 Federal share).

Sample Size

CMS selected 64 Medicaid beneficiaries: 4 from certainty stratum 1 and 30 each from random strata 2 and 3.

Source of Random Numbers

CMS generated the random numbers using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

Estimation Methodology

CMS used the OIG/OAS statistical software to estimate the total number of ineligible Medicaid beneficiaries and the total amount of Medicaid payments for the ineligible beneficiaries for whom the state agency claimed Federal reimbursement. CMS also used this software to calculate the lower and upper limits of the 90 percent confidence intervals associated with these estimates.

In addition, CMS determined the percentage of ineligible beneficiaries by dividing the estimated number of ineligible beneficiaries by the total number of beneficiaries in the sampling frame. CMS also determined the percentage of Federal dollars expended for potentially ineligible beneficiaries by dividing the estimated amount of Federal dollars expended by the total amount of Federal dollars in the sampling frame.

Appendix C: Sample Results and Estimates

Sample Results

Table 1: Sample Detail and Results

Stratum	Frame Size (Beneficiaries)	Sample Size	Value of Sample (Federal Share of Payments Associated with Sampled Beneficiaries)	Ineligible Beneficiaries	Value of Improper Payments (Federal Share)
1	4	4	\$281,767.23	0	\$0.00
2	34,877	30	\$64,298.34	2	\$3,299.38
3	403,678	30	\$41,881.66	0	\$0.00
Totals	438,559	64	\$387,947.23	2	\$3,299.38

Estimates

Table 2: Estimated Number of Ineligible Beneficiaries and Value of Overpayments (Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Ineligible Beneficiaries	Total Value of Improper Payments (Federal Share)
Point estimate	2,325	\$3,835,749.21
Lower limit	-331 ²³	-\$546,415.44
Upper limit	4,981	\$8,217,913.86

Table 3: Calculation of Overall Rate of Ineligible Beneficiaries

Number of Beneficiaries	Estimated No. of <u>Ineligible Beneficiaries</u>	2,325
		0.53%
	Total Number of Beneficiaries in Sample Frame	438,559
Dollar Value of Payments	Estimated Federal Dollars Associated with <u>Ineligible Beneficiaries</u>	\$3,835,749.21
		0.61%
	Total Federal Dollars in Sample Frame	\$629,468,057.97

²³ The estimated negative values for the lower bound confidence interval are due to the small sample size, the small number of ineligible observed, and the use of the normal distribution which assumes larger values for these two quantities.

Appendix D: Louisiana Department of Health Comments

Summary of state feedback:

Page 7: Black box in flow chart does not account for procedural closures if applicant fails to respond. Can we please add that they can also deny/close for failure to respond timely.

Page 7: Blue box and corresponding *note are incorrect. Louisiana does not have an 1115 waiver for eligibility or 12 months' continuous coverage for all beneficiaries. In fact, we now reassess eligibility by checking wages for adults every quarter. It does have 12 months' continuous coverage for only children under the State Plan. Can we correct this information?

Page 12: 1.1 - CY2019 reference is incorrect. Screenshots in cases were from pre-LaMEDS implementation November 2018. With LaMEDS (Louisiana automated Medicaid Eligibility System) implementation, business rules are automated and self-attested income would be used in the budget for the determination. There is a reduced potential for caseworker error. Can we make an adjustment to this section?

Page 13: 1.2 - Caseworker incorrectly decided the case after the children were added to the case. With LaMEDS implementation, business rules are automated based on current household size and current income. When the eligibility verification is run through LaMEDS, the system will place the person in the most appropriate type of assistance. There is a reduced potential for caseworker error because it reduces manual decision-making. Can we please add a note that the new system corrects this deficiency?

Page 13: 1.3 - October 2018 renewals were deferred per CMS approval in the APD, which was why this did not occur on the normal schedule for October 2018. There was some confusion with CMS on process for requesting renewal deferrals with the launch of our new system, and so the State started resuming renewals in December 2018. However, all renewals were not fully caught up until Summer of 2019. **Is it possible to exclude this case from the findings given the circumstances and confusion over deferred renewals and CMS approval on the APD?** We have supporting documentation. Also, since LaMEDS implementation, business rules are automated. When a case change is reported, if all members can be renewed without requesting additional information for the off cycle member, the household members' renewal dates will be synced. The new renewal date will be 12 months from the last eligibility determination. This reduces the potential for caseworker error to allow more than 12-month renewal period, so we feel it is corrected.

Page 14: Observations #1 - With LaMEDS implementation, business rules are automated. Reasonable Compatibility calculation is now automated and does not rely on caseworker to make this calculation outside of the eligibility determination system. If the applicant/enrollee's self attested income is above the 10% reasonable compatibility when compared to electronic data sources then an RI is automatically generated to request proof of income for the determination process. The system tracks the due date of the request for information. Can we note that this was corrected with implementation of the new system?

Page 14: Observations #3 - Can we note that this issue was resolved with a system enhancement on 02/07/2019?

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Page 15: Observations #5 - As noted above, the state began renewals again after implementation of its new eligibility system starting in December 2018, however, renewals were phased in due to the confusion over CMS approval for deferral. As such, this case was not reviewed in December 2018 while the state allocated resources to managing learning curve and launch of the new system and restarting renewals through a phased in approach. Instead, the state initiated quarterly wage checks in February 2019 with the Louisiana Workforce Commission replacing high risk codes used in the previous Medicaid Eligibility System. Request for information letters are auto sent and due date for information is tracked. This will reduce potential caseworker errors. Is there a note we can we make on this observation?

Page 16: Observations #6 - In February 2019, the first quarterly wage check was run manually. While running the process manually, there were some problems with the data match. Can we note that the state corrected this issue in March 2019 before the next quarterly wage check?