

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**LOUISIANA DID NOT CORRECTLY
DETERMINE MEDICAID ELIGIBILITY FOR
SOME NEWLY ENROLLED
BENEFICIARIES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Christi A. Grimm
Principal
Deputy Inspector General**

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Office of Inspector General

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Report in Brief

Date: January 2021

Report No. A-06-18-02000

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

The Patient Protection and Affordable Care Act gave States the option to expand Medicaid coverage to low-income adults without dependent children. It also mandated changes to Medicaid eligibility rules and established a higher Federal reimbursement rate for services provided to these beneficiaries, which led us to audit whether States were correctly determining eligibility for these newly eligible beneficiaries. States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services. Louisiana was one of 36 States, along with the District of Columbia, that chose to expand Medicaid coverage.

Our objective was to determine whether Louisiana made Medicaid payments on behalf of newly eligible beneficiaries who did not meet Federal and State eligibility requirements.

How OIG Did This Audit

We reviewed a stratified random sample of 120 newly eligible beneficiaries who had Medicaid payments made on their behalf from July through December 2016. We reviewed supporting documentation to determine whether Louisiana made payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements for the newly eligible (e.g., income, citizenship, and residency requirements).

Louisiana Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

What OIG Found

For our sample of 120 beneficiaries, Louisiana made Medicaid payments on behalf of 115 who met eligibility requirements for the new adult group. However, for the remaining five beneficiaries, Louisiana made payments on behalf of four beneficiaries who did not meet requirements and one beneficiary who may not have met requirements. Our audit covered 408,509 newly eligible beneficiaries for whom the State agency made Medicaid payments totaling \$1.2 billion (100 percent Federal share). Based on our sample results, we estimated that Louisiana made Medicaid payments of \$20.1 million (100 percent Federal share) on behalf of 16,358 beneficiaries who did not meet requirements. These deficiencies occurred because Louisiana did not always meet Federal and State requirements when making eligibility determinations because analysts did not always follow the State's established procedures.

What OIG Recommends and Louisiana's Comments

We recommend that Louisiana: (1) promptly provide notice and cancel the eligibility of beneficiaries identified with income over the allowable limit; (2) educate State analysts on established policies and procedures regarding requirements to promptly provide notice and cancel eligibility, verify income, and provide retroactive eligibility; and (3) redetermine, if necessary, the current Medicaid eligibility status of the sampled beneficiaries for whom income or dependent verifications did not meet Federal and State requirements.

Louisiana agreed with our recommendations and described actions it had taken. Louisiana disagreed with some of our findings and provided additional documentation under separate cover to support its stance on the findings with which it disagreed. Based on our review of Louisiana's comments and additional documentation, we revised some of our findings and reduced our estimate of Medicaid payments and beneficiaries who did not meet requirements.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA).¹ Generally, the ACA gave States the option to expand Medicaid coverage to low-income adults without dependent children and established a higher Federal reimbursement rate for services provided to these beneficiaries.² The ACA also included changes to Medicaid eligibility rules, such as requiring that income be calculated on the basis of modified adjusted gross income (MAGI)³ and that income be at or below 133 percent of the Federal Poverty Level (FPL) for newly eligible beneficiaries. These changes led us to audit whether States were correctly determining eligibility for newly eligible beneficiaries.

This audit is part of an ongoing series of Office of Inspector General (OIG) audits of newly eligible beneficiaries. We selected Louisiana to ensure that our audits covered States in different parts of the country. See Appendix B for a list of related OIG reports.

OBJECTIVE

Our objective was to determine whether Louisiana’s Department of Health (State agency) made Medicaid payments on behalf of newly eligible beneficiaries who did not meet Federal and State eligibility requirements.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, States must cover certain population groups. Generally, individual eligibility criteria are met by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of United States citizenship. For many eligibility groups, income is calculated in relation to a percentage of the FPL.

¹ P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

² In this report, we refer to these low-income adults for whom the States receive a higher Federal reimbursement rate as “newly eligible beneficiaries” or “the new adult group.”

³ The Social Security Act (the Act) §§ 1902(e)(14)(A)–(D); 26 U.S.C. § 36B(d)(2)(B). This methodology to determine a person’s income is based on Internal Revenue Service (IRS) rules.

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.⁴ The standard FMAP varies by State and generally ranges from 50 to 75 percent.⁵

Medicaid Coverage for Newly Eligible Beneficiaries Under the Affordable Care Act

Before implementation of the ACA, most State Medicaid programs did not cover certain groups of individuals (e.g., childless, low-income individuals from the ages of 19 to 64). The ACA expanded Medicaid coverage to these groups of individuals (i.e., newly eligible beneficiaries).

Medicaid Coverage Before Implementation of the Affordable Care Act

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid. These mandatory coverage groups included low-income parents and other caretaker relatives with dependent children, pregnant women, people with disabilities, children, and the elderly. A State had the option, under its State plan, to provide Medicaid coverage to other groups.

Medicaid Coverage After Implementation of the Affordable Care Act

Beginning in 2014, the ACA provided States with the option to expand their Medicaid programs to cover more low-income people, including nondisabled adults without dependent children.^{6, 7} In States that elected to implement this option, individuals were eligible for Medicaid in the new adult group if they met certain criteria, such as age (not being younger than 19 or older than 64 years of age) and income (not having an income exceeding 133 percent of the FPL),⁸ in addition to meeting citizenship and State residency requirements.⁹

⁴ The Act § 1905(b).

⁵ 79 Fed. Reg. 71427-71428 (Dec. 2, 2014) and 80 Fed. Reg. 73781-73782 (Nov. 25, 2015).

⁶ ACA § 2001(a)(1)(C).

⁷ The ACA required States to expand their Medicaid programs for certain categories of individuals. However, the U.S. Supreme Court found that this expansion violated the Constitution "by threatening existing Medicaid funding." *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012). The decision allowed States the option to refuse to expand their Medicaid programs and not face any reduction in current Medicaid funding.

⁸ 42 CFR § 435.119(b)(5). The Act established the FPL threshold at 133 percent but allows for a 5-percent income disregard, making the effective threshold 138 percent of the FPL (§ 1902).

⁹ The Act § 1902(a)(10)(A)(i)(VIII).

Section 2001 of the ACA authorized an FMAP of 100 percent for the qualified expenditures incurred by newly eligible beneficiaries enrolled in the new adult group.¹⁰ This “newly eligible FMAP” was set to remain at 100 percent through 2016, gradually decreasing to 90 percent by 2020.¹¹

The ACA required States to make several changes to their Medicaid application and enrollment processes. Changes included requiring States to use a single, streamlined enrollment application that facilitated screening an individual’s eligibility for all potential health coverage options, including Medicaid, the Children’s Health Insurance Program (CHIP), and qualified health plans available through the health insurance marketplaces.¹² In most cases, the ACA required States to use MAGI, a measure of income that is based on Internal Revenue Service (IRS) rules, to determine an individual’s income.¹³

As of May 29, 2020, 36 States (including Louisiana) and the District of Columbia had elected to expand Medicaid coverage.¹⁴

Medicaid Eligibility Verification Requirements

Generally, individuals meet eligibility criteria by satisfying certain Federal and State requirements related to income, residency, immigration status, and documentation of United States citizenship. For many coverage groups, income is calculated in relation to a percentage of the FPL.

States are required to have an income and eligibility verification system for determining Medicaid eligibility, and, upon CMS’s request, a verification plan describing the State agency’s policies and procedures for implementing the eligibility verification requirements.¹⁵ States must verify individuals’ eligibility information, such as citizenship or lawful presence, and

¹⁰ The Act defines “newly eligible” as “an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the [ACA], is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage . . .” (§ 1905(y)(2)(A)).

¹¹ 42 CFR § 433.10(c)(6).

¹² ACA § 1413(b).

¹³ The Act §§ 1902(e)(14)(A)–(D); 26 U.S.C. § 36B(d)(2)(B). The use of MAGI to determine Medicaid eligibility does not apply to certain groups of beneficiaries, such as seniors who are 65 years of age or older and medically needy individuals.

¹⁴ Kaiser Family Foundation, “Status of State Action on the Medicaid Expansion Decision.” <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>, accessed on June 12, 2020.

¹⁵ The Act §§ 1137(a) and (b); 42 CFR § 435.945(j).

entitlement to or enrollment in Medicare, through electronic sources.¹⁶ States may accept an individual's attestation for certain information, such as pregnancy status and household composition (e.g., household size and family relationships), without further verification.¹⁷

Louisiana's Process for Determining Medicaid Eligibility

Louisiana expanded Medicaid coverage to the new adult group, effective July 1, 2016. In Louisiana, the State agency administers the Medicaid program, known as Healthy Louisiana. The State agency is responsible for making Medicaid eligibility determinations. An individual may apply for Medicaid in various ways, such as online through the Healthy Louisiana website or in person at a parish office.

The State Agency's Income and Eligibility Verification Systems

To determine Medicaid eligibility, the State agency uses its Medicaid Eligibility Data System (MEDS).

The State agency enrolls individuals in Medicaid in various ways. The State agency accepts Medicaid applications via the internet, telephone, mail, and in person at certified application centers. When applying for Medicaid, an applicant must attest to information regarding their residence, demographics, and income. The State agency verifies the applicant's attested income using various data sources, such as quarterly wage data from the Louisiana Workforce Commission (LWC). Beginning in 2016, the State added additional methods for individuals to enroll in Medicaid:

- Effective April 20, 2016, for individuals who apply for health care coverage through the federally facilitated marketplace (FFM),¹⁸ the State delegated its Medicaid eligibility determination authority to the FFM.
- Beginning July 1, 2016, when the State agency expanded Medicaid, it streamlined Medicaid enrollment for individuals already participating in the Supplemental Nutrition Assistance Program (SNAP).¹⁹ The State also automatically transitioned certain

¹⁶ 42 CFR §§ 435.945(a) and (b) and 435.949.

¹⁷ 42 CFR §§ 435.945(a) and 435.956.

¹⁸ Under the ACA, States had the option to establish and operate their own marketplaces, called State-based marketplaces. In States that chose not to operate their own marketplaces and for State-based marketplaces that choose to use the Federal platform, CMS operates the FFM. CMS operates HealthCare.gov, the official website for the FFM. The FFM verifies applicant information using its eligibility and enrollment system to determine eligibility in available insurance programs, including Medicaid.

¹⁹ Because SNAP and Medicaid requirements are nearly identical, CMS allowed the State to enroll in Medicaid without having to complete a Medicaid application those individuals who had already been determined eligible for SNAP. The State required SNAP enrollees to complete a questionnaire attesting to household income.

populations, including individuals already covered under certain Medicaid waiver programs.

To verify eligibility during our audit period, the State agency used multiple electronic data sources, including State sources such as LWC and sources available through the Federal Data Services Hub (Data Hub).²⁰ The data sources available through the Data Hub are provided by the U.S. Department of Health and Human Services, the Social Security Administration (SSA), the U.S. Department of Homeland Security, and IRS, among others.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicaid beneficiaries in the newly eligible adult group who had payments made on their behalf from July 1 through December 31, 2016 (audit period).²¹ We reviewed a stratified random sample of 120 Medicaid beneficiaries who were determined or redetermined to be eligible after Louisiana expanded its Medicaid coverage. We reviewed the supporting documentation to evaluate whether the State agency determined the applicants' eligibility in accordance with Federal and State requirements.

Beneficiaries who were enrolled based on determinations that did not meet Federal and State requirements may not be eligible for Medicaid coverage. We did not assess beneficiaries for Medicaid eligibility categories other than the newly eligible category.

We limited our review of internal controls to those related to verifying applicant identity and determining applicant eligibility for Medicaid enrollment. In addition, we gained an understanding of the State agency's policies and procedures for ensuring that beneficiaries enrolled under the expanded Medicaid coverage met the eligibility requirements described in the ACA.

We performed fieldwork at the Louisiana Medicaid office and LWC in Baton Rouge, Louisiana.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

²⁰ ACA § 1411(c). The Data Hub is a single conduit that sends electronic data to and receives electronic data from multiple Federal agencies; it does not store data. Federal agencies connected to the Data Hub include the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the IRS.

²¹ This period covered the first 6 months of Medicaid expansion in Louisiana.

FINDINGS

The State agency made Medicaid payments on behalf of some newly eligible beneficiaries who did not meet or may not have met Federal and State eligibility requirements. Of our sample of 120 beneficiaries, the State agency made payments on behalf of 115 beneficiaries who met eligibility requirements for the new adult group, but it made payments on behalf of 5 beneficiaries who did not meet or may not have met eligibility requirements for the new adult group. Specifically, the State agency made payments on behalf of beneficiaries who:

- did not meet income requirements,
- did not meet requirements related to coverage for dependent children,
- did not have any medical claims for retroactive coverage, and
- may not have met income requirements.

The State agency made Medicaid payments on behalf of some newly eligible beneficiaries who did not meet or may not have met Federal and State eligibility requirements because analysts did not always follow its established procedures.

Our audit covered 408,509 newly eligible beneficiaries for whom the State agency made Medicaid payments totaling \$1,184,288,756 (100 percent Federal share). Based on our sample, we estimated that the State agency made Federal Medicaid payments totaling \$20,142,953²² on behalf of 16,358²³ ineligible beneficiaries.

The State Agency Made Payments on Behalf of Beneficiaries Who Did Not Meet Income Requirements

Individuals must have household income that is at or below 138 percent FPL for the applicable family size to be eligible for Medicaid under the new adult group (the Act § 1902(a)(10)(A)(i)(VIII); 42 CFR § 435.119(b)(5)). The State agency must verify financial information related to wages; net earnings from self-employment; unearned income; and resources such as the State Wage Information Collection Agency (SWICA), IRS, and SSA; to the extent the State determines such information is useful to verifying the financial eligibility of an individual (42 CFR § 435.948(a)(1)).

²² The two-sided 90-percent confidence interval associated with this estimate ranges from \$7,583,058 to \$42,886,561.

²³ The two-sided 90-percent confidence interval associated with this estimate ranges from 6,214 to 33,752.

During a beneficiary's annual renewal process required to ensure they continue to meet eligibility requirements, State analysts identified two beneficiaries as ineligible because their incomes exceeded allowed amounts.²⁴ State analysts identified these two beneficiaries as ineligible on August 23 and October 6, 2016. However, the State agency continued to make managed care organization (MCO) payments on behalf of these two beneficiaries for up to 3 months after determining they were ineligible. These errors occurred because the State agency failed to provide notice to the beneficiary and terminate eligibility after determining the beneficiaries were no longer eligible. To illustrate, a State analyst identified one of the two beneficiaries as ineligible on August 23, 2016. However, because the analyst did not issue a closure notice at that time and close eligibility, the State made payments for 3 additional months to the MCO at a total cost of \$945.

For the two beneficiaries, the State agency made payments totaling \$2,633, through December 2016, after determining the beneficiaries were no longer eligible. The State agency removed the two beneficiaries after our audit period.

The State Agency Made Payments on Behalf of a Beneficiary Who Did Not Meet Requirements Related to Coverage for Dependent Children

A State may not provide Medicaid coverage under the new adult group to a parent or other caretaker relative living with a dependent child if the child is under age 19, unless such child is receiving benefits under Medicaid, CHIP, or otherwise is enrolled in minimum essential coverage (42 CFR §435.119).

For one sampled beneficiary, the State agency did not verify the beneficiary's child had minimum essential coverage before approval of eligibility. On her application, the beneficiary attested to having children in the household, but the State analyst did not verify the children were receiving benefits under Medicaid or CHIP, or were otherwise enrolled in minimum essential coverage. During our audit, the State agency confirmed the children did not have coverage during the audit period. As a result, the beneficiary did not meet eligibility requirements for the new adult group.

The State made payments of \$1,438 on behalf of this beneficiary for the 4 months (September to December 2016) that she was enrolled in the new adult group during our audit period.

²⁴ The State had automatically transitioned these two beneficiaries to the new adult group from Medicaid waiver programs—one from the Greater New Orleans Community Health Connection and one from the Take Charge Plus program. The State applied the annual renewal dates applicable to the waiver programs to the new adult group. As a result, during the renewal process, State analysts determined these beneficiaries had income over the allowable amount for eligibility.

The State Agency Made Payments on Behalf of a Beneficiary Who Did Not Have Any Medical Claims for Retroactive Coverage

Medicaid generally provides for retroactive coverage of care and services furnished up to 3 months before the date of the application, if the applicant received Medicaid services at any time during that period and would have been eligible at the time such care and services were furnished, had they applied (42 CFR § 435.915).

For one sampled beneficiary enrolled in Medicaid managed care through the expedited SNAP process, the State agency improperly provided for 2 months of retroactive enrollment. The beneficiary returned the SNAP beneficiary questionnaire to verify she met the additional Medicaid requirements in September 2016.²⁵ However, even though the beneficiary had no claims (i.e., care or services furnished) during July and August, the State analyst provided retroactive enrollment, and the State made payments to the beneficiary's MCO for the 2 months.

The State made payments of \$969.24 on behalf of this beneficiary for the 2 months (July and August 2016) of retroactive enrollment in the new adult group.

The State Agency Made Payments on Behalf of a Beneficiary Who May Not Have Met Income Requirements²⁶

Individuals must have household income that is at or below 138 percent FPL for the applicable family size to be eligible for Medicaid under the new adult group (the Act § 1902(a)(10)(A)(i)(VIII); 42 CFR § 435.119(b)(5)). The State agency must verify financial information related to wages; net earnings from self-employment; unearned income; and resources such as SWICA, IRS, and SSA, to the extent the State determines such information is useful to verifying the financial eligibility of an individual (42 CFR § 435.948(a)(1)). In addition, a State agency must maintain individual records on each applicant and beneficiary, including information on income and eligibility verification and facts essential to determination of initial and continuing eligibility (42 CFR § 431.17).

The State agency did not verify the income of one sampled beneficiary who was automatically transitioned to the new adult group from the Greater New Orleans Community Health Connection, a Medicaid waiver program. The State agency had no documentation that it had verified the income of this beneficiary in the previous 4 years before adding him to the new adult group in July 2016. The State agency auto-renewed the beneficiary each year without required documentation of income verification. The State agency canceled the beneficiary's

²⁵ The State required SNAP enrollees to verify information related to the income and residence of any household members.

²⁶ The error described in this section is separate from the four errors that we used to calculate our estimates related to ineligible beneficiaries because this beneficiary may have been eligible.

eligibility at the end of November 2016, after it verified that his income for the quarter ended September 2016 exceeded the allowed amount.

The State made payments of \$2,190 on behalf of this beneficiary for the 5 months (July to November 2016) that he was enrolled in the new adult group.

RECOMMENDATIONS

We recommend that Louisiana's Department of Health:

- promptly provide notice and cancel the eligibility of beneficiaries identified with income over the allowable limit;
- educate State analysts on established policies and procedures regarding requirements to promptly provide notice and cancel eligibility, verify income, and provide retroactive eligibility; and
- redetermine, if necessary, the current Medicaid eligibility status of the sampled beneficiaries for whom income or dependent verifications did not meet Federal and State requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our recommendations and described its actions for ensuring that its eligibility determinations comply with Federal and State requirements. The State agency also addressed each of our four findings and stated that it agreed fully with two of them and in part with two of them. Under separate cover, the State agency provided additional documentation to support its stance on the aspects of those findings with which it disagreed. Based on our review of the State agency's comments and additional documentation, we revised one of our findings. As discussed further below, we maintain that the rest of our findings are valid. The State agency's comments appear in their entirety as Appendix E.

THE STATE AGENCY MADE PAYMENTS ON BEHALF OF BENEFICIARIES WHO DID NOT MEET INCOME REQUIREMENTS

State Agency Comments

The State agency agreed with our determinations for two of the four beneficiaries identified in our draft report as ineligible because they did not meet income requirements, but the State agency disagreed with our determinations and provided additional documentation for the remaining two beneficiaries. Specifically, the State agency stated that it had correctly determined eligibility because the two beneficiaries met income requirements.

Office of Inspector General Response

After reviewing the State agency's comments and the additional documentation provided, we revised our determinations for two beneficiaries identified in our draft report as ineligible based on income.²⁷ We revised our findings accordingly.

THE STATE AGENCY MADE PAYMENTS ON BEHALF OF A BENEFICIARY WHO MAY NOT HAVE MET INCOME REQUIREMENTS

State Agency Comments

The State agency partially disagreed with our determination for the beneficiary identified as potentially ineligible in our draft report because he may not have met income requirements. The State agency stated that it timely issued a closure notice for this beneficiary in November 2016 when the beneficiary did not respond to the State agency's letter to confirm income data during the beneficiary's renewal process in October 2016. The State agency also commented that we did not include the payments made on behalf of this beneficiary in our estimate of payments made on behalf of ineligible beneficiaries.

Office of Inspector General Response

We maintain that the beneficiary referenced in the State agency's comments was potentially ineligible. Although the State ended the beneficiary's eligibility in November 2016, we maintain that the beneficiary may not have been eligible to automatically transition into the newly eligible group in July 2016 because the State agency did not have any documentation showing it had verified the beneficiary's income in the previous 4 years. However, because we did not determine whether the beneficiary exceeded the income limits during the prior years, we determined him to be potentially ineligible and did not include payments made on his behalf in our overall estimate.

OTHER MATTERS

We found that, if the State had been required to perform income verifications more frequently than once every 12 months, eight of our sampled beneficiaries may not have continued to be eligible for Medicaid after their initial enrollment.

Under Federal law, States are required to make "point-in-time" eligibility determinations. That is, when making an eligibility determination, States must use information that is current and

²⁷ For one of the beneficiaries we determined as eligible based on the additional documentation provided by the State agency, we also adjusted our results in the Other Matters section. We had excluded that beneficiary from the estimate of payments and beneficiaries who may have no longer been eligible for Medicaid under the new adult group because she was included in the estimate in the Findings section.

available at the time of the determination.²⁸ Louisiana implemented continuous coverage for beneficiaries determined to be eligible for Medicaid based on income requirements. Based on an annual determination, beneficiaries are eligible to receive Medicaid coverage for their entire 12-month authorization period. The State agency is not required to redetermine Medicaid eligibility before the end of this period unless it is notified of updated information that would affect the beneficiary's eligibility status.²⁹ We note that the State agency complied with Federal requirements for performing income verifications; however, we obtained income data applicable to our audit period that was available to the State agency subsequent to the eligibility determination.

Quarterly income data from LWC for the single-member households of our sampled beneficiaries (70 of 120) showed that 8 beneficiaries had income after their initial enrollment that was above the maximum effective income eligibility threshold (138 percent of the FPL).^{30, 31} Although the State agency correctly determined these beneficiaries as newly eligible when they applied for Medicaid, income data available subsequent to that determination indicated that these beneficiaries may have no longer qualified to be newly eligible if more frequent determinations were performed.

Had the State agency performed more frequent income verifications, based solely on our subsample of 70 single-member household beneficiaries, we estimate that it could have reduced Federal Medicaid payments by as much as \$83,486,374³² for 38,102³³ beneficiaries who may have no longer been eligible for Medicaid under the new adult group. Because our testing was limited to single-member households, the potential cost savings may vary based on

²⁸ This point-in-time principle is explicitly retained in the ACA as it relates to the application of the MAGI-based methodology. In accordance with this requirement, States must use an individual's current monthly income in evaluating the eligibility of new applicants and either current monthly income or projected annual income for the remainder of the year for current beneficiaries.

²⁹ Under the Medicaid eligibility rules, the State is not required to perform redeterminations more than once every 12 months. However, if the State is notified of a change in the status of a beneficiary that affects eligibility, it is required to redetermine eligibility for Medicaid before the 12-month authorization period expires.

³⁰ Before a State agency terminates eligibility or reduces benefits based on available electronic data for financial information, it must first request additional information from the beneficiary. We did not conduct this additional step; therefore, these beneficiaries may have had additional information that would have supported their eligibility.

³¹ If available, we obtained quarterly LWC data. We did not evaluate the accuracy of the data provided by LWC. Though we requested records for 70 beneficiaries, LWC did not have records for 34 of the 70. This may have been because the beneficiary was unemployed or self-employed, or the employer submitted inaccurate records (e.g., incorrect Social Security number).

³² The two-sided 90-percent confidence interval associated with this estimate ranges from \$41,473,866 to \$151,137,781.

³³ The two-sided 90-percent confidence interval associated with this estimate ranges from 20,675 to 61,726.

testing all household sizes and on the frequency of income verifications the State may choose to perform.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered newly eligible Medicaid beneficiaries on whose behalf the State made payments from July 1 through December 31, 2016 (audit period).

We limited our review of internal controls to those related to verifying applicant identity and determining applicant eligibility for Medicaid enrollment. We obtained an understanding of internal controls regarding how the State agency processes an applicant's information and verifies an applicant's eligibility for enrollment in Medicaid. In addition, we gained an understanding of the policies and procedures for determining whether newly enrolled beneficiaries enrolled under the enhanced Medicaid coverage met the eligibility requirements described in the ACA. We did not assess newly eligible beneficiaries' eligibility for alternative Medicaid eligibility categories or contact beneficiaries to obtain additional supporting documentation.

We performed fieldwork at the State agency and LWC in Baton Rouge, Louisiana.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements, regulations, and CMS guidance regarding the implementation of ACA changes related to the enrollment of newly eligible beneficiaries;
- interviewed State agency officials to obtain an understanding of internal controls regarding how the marketplace processes an applicant's information and verifies an applicant's eligibility for enrollment in Medicaid;
- selected a stratified random sample of 120 beneficiaries from a total of 408,509 beneficiaries who were determined or redetermined to be newly eligible during the audit period;
- reviewed application data and documentation to verify the Medicaid eligibility of each sampled beneficiary;
- analyzed the State agency's documentation supporting beneficiaries' Medicaid eligibility;
- estimated the total number of ineligible and potentially ineligible beneficiaries;

- estimated the total amount of Federal Medicaid reimbursement made on behalf of ineligible and potentially ineligible beneficiaries;
- reviewed income data from the LWC and determined whether the income exceeded allowable amounts for eligibility; and
- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Ohio Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-05-18-00027</u>	11/10/2020
<i>Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place</i>	<u>A-07-18-02812</u>	3/24/2020
<i>Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-07-16-04228</u>	8/30/2019
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries</i>	<u>A-02-16-01005</u>	7/17/2019
<i>California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<u>A-09-17-02002</u>	12/11/2018
<i>California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements</i>	<u>A-09-16-02023</u>	2/20/2018
<i>New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-02-15-01015</u>	1/5/2018
<i>Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements</i>	<u>A-04-16-08047</u>	8/17/2017
<i>Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries</i>	<u>A-04-15-08044</u>	5/10/2017

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of beneficiaries determined newly eligible for Medicaid under the ACA for whom the State agency made Medicaid payments for services provided from July 1 through December 31, 2016.

SAMPLING FRAME

The sampling frame consisted of an Excel spreadsheet containing 408,509 newly eligible Medicaid beneficiaries under the ACA in Louisiana for whom the State agency made Medicaid payments totaling \$1,184,288,756 (\$1,184,288,756 Federal share) for services provided during the audit period. We obtained the data for the Medicaid beneficiaries from Louisiana's Medicaid Management Information System.

SAMPLE UNIT

The sample unit was a newly eligible Medicaid beneficiary.

SAMPLE DESIGN

We used a stratified random sample. The strata were as follows:

- Strata 1 and 2: beneficiaries who were auto-enrolled or received fast-track enrollment for the new adult eligibility group from another program (SNAP, the Greater New Orleans Community Health Connection, Take Charge+, Qualified Medicare Beneficiary, and other eligible programs) during the period July 1 through December 31, 2016. Stratum 1 contains payments totaling less than \$2,888.43, and stratum 2 contains payments totaling \$2,888.43 or more.
- Strata 3 and 4: beneficiaries who were categorized as enrolling directly into the new adult eligibility group (i.e., without having first been enrolled in another program) during the period July 1 through December 31, 2016. Stratum 3 contains payments totaling less than \$1,950.30, and stratum 4 contains payments totaling \$1,950.30 or more.

SAMPLE SIZE

We selected 120 Medicaid beneficiaries, 30 from each stratum.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OIG/OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the Medicaid beneficiaries within strata 1, 2, 3, and 4. After generating the random numbers for each of these strata, we selected the corresponding Medicaid beneficiary in the sampling frame for our sample.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate the point estimate for the total number of ineligible and potentially ineligible Medicaid beneficiaries in the sampling frame. We also used this software to calculate the point estimate for the total dollar value of the payments for any ineligible and potentially ineligible Medicaid beneficiaries. The 90-percent confidence intervals for these estimates were calculated using the empirical likelihood approach, which we programmed using Microsoft Excel software.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES³⁴

Table 1: Sample Detail and Results for Ineligible Beneficiaries

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Ineligible Beneficiaries	Value of Payments for Ineligible Beneficiaries
1	142,050	\$301,135,338	30	\$66,699	1	\$945
2	143,712	603,570,324	30	118,165	2	2,657
3	61,278	64,131,201	30	36,895	1	1,438
4	61,469	215,451,892	30	107,110	0	0
Total	408,509	\$1,184,288,756	120	\$328,869	4³⁵	\$5,040

Table 2: Sample Detail and Results for Beneficiaries from Single-Member Households Who May Have No Longer Qualified as Newly Eligible Based on Income Data Available After Eligibility Determinations

Stratum	Beneficiaries in Frame	Value of Frame	Sample Size	Value of Sample	Number of Potentially Ineligible Beneficiaries	Value of Payments for Potentially Ineligible Beneficiaries
1	142,050	\$301,135,338	30	\$66,699	4	\$6,948
2	143,712	603,570,324	30	118,165	4	10,560
3	61,278	64,131,201	30	36,895	0	0
4	61,469	215,451,892	30	107,110	0	0
Total	408,509	\$1,184,288,756	120	\$328,869	8	\$17,508

**Table 3: Estimated Number of Ineligible Beneficiaries and Value of Associated Payments
(Limits Calculated at the 90-Percent Confidence Level)**

	Total Number of Ineligible Beneficiaries	Total Value of Payments Associated With Ineligible Beneficiaries
Point estimate	16,358	\$20,142,953
Lower limit	6,214	7,583,058
Upper limit	33,752	42,886,561

³⁴ The frame values for the individual strata do not sum to the overall frame total due to rounding.

³⁵ In addition to the four ineligible beneficiaries, we identified one beneficiary whose income was not properly verified by the State.

**Table 4: Estimated Number of Beneficiaries from Single-Member Households Who May Have No Longer Qualified as Newly Eligible Based on Income Data Available After Eligibility Determinations and Value of Associated Payments
(Limits Calculated at the 90-Percent Confidence Level)**

	Total Number of Potentially Ineligible Beneficiaries	Total Value of Payments Associated With Potentially Ineligible Beneficiaries
Point estimate	38,102	\$83,486,374
Lower limit	20,675	41,473,866
Upper limit	61,726	151,137,781

APPENDIX E: STATE AGENCY COMMENTS

John Bel Edwards
GOVERNOR



Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

November 13, 2020

Patricia Wheeler
Regional Inspector General for Audit Services
Department of Health and Human Services, Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: OIG Draft Report: Louisiana Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries (Audit Report Number: A-06-18-02000)

Dear Ms. Wheeler:

Thank you for the opportunity to respond to the findings of the OIG Draft Report: Louisiana Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries (Audit Report Number: A-06-18-02000). The Department's responses to your recommendations and findings are below.

Finding 1: LDH made payments on behalf of beneficiaries who did not meet income requirements.

LDH Response to Finding 1: LDH concurs with OIG's finding related to two beneficiaries—Sample 6 and Sample 57. Corrective action measures are detailed under the recommendations sections of this response. LDH disagrees with this finding as it relates to the two remaining beneficiaries—Sample 47 and Sample 56. Beneficiary names are protected due to HIPAA.

- **Sample 47** – LDH disagrees that it made payments on behalf of this beneficiary when beneficiary did not meet income requirements and provides the following explanation. Beneficiary's renewal was scheduled for October 2016, but LDH's review was extended due to the 2016 Great Flood. Beneficiary's renewal was processed in January 2017 and closed effective January 31, 2017 based on beneficiary's 2016 second quarter earnings (April-June 2016) as reported by the Louisiana Department of Development & Training (LDET), later renamed Louisiana Workforce Commission (LWC). However, the beneficiary's 2016 fourth quarter earnings (October-December 2016) as reported by LDET were

Bienville Building • 628 N. Fourth St. • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: (888) 342-6207 • Fax: (225) 342-9508 • www.ldh.la.gov
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\$8,136.00 or \$2,712.00/month, which is less than the Adult Group qualifying Federal Poverty Income Guidelines (FPIG) at 138 percent, or \$2,795.00. Therefore, beneficiary met income requirements and LDH correctly made payments on behalf of beneficiary. In support of our explanation, LDH provided its case activity logs, renewal correspondences, and closure letters to OIG for review/consideration.

Please note, the below response regarding Sample 56 is based on the current OIG draft report. Additional documentation was submitted to OIG on October 30, 2020, for review/consideration. On November 9, 2020, OIG confirmed that Sample 56 will be removed as a finding.

- **Sample 56** – LDH disagrees that it made payments on behalf of this beneficiary when beneficiary did not meet income requirements and provides the following explanation. On April 13, 2016, Medicaid issued a Decision Letter to beneficiary stating that beneficiary is approved for family planning services through Louisiana’s Take Charge Plus Program beginning January 1, 2016. The decision letter indicates that LDH will contact the beneficiary in December 2016 for renewal. On April 26, 2016, Medicaid issued a notice to the beneficiary, informing them that they will move to the new Adult Group (or expansion program) on July 1, 2016 if they are still enrolled in Take Charge Plus and/or Greater New Orleans Community Health Connection (GNOCHC) as of June 30, 2016. The December 2016 renewal date remained in effect. LDH subsequently issued a letter informing the beneficiary of expansion coverage beginning July 1, 2016.

On July 13, 2016, Medicaid received a Federally Facilitated Marketplace (FFM) referral application on behalf of the beneficiary. The beneficiary had attested income totaling \$1,100.00 (or \$550.00/bi-weekly) and LWC monthly wages from three employers totaling \$336.67, both of which are below the Adult Group FPIG. Data from LWC received as part of the FFM referral application also supports income eligibility for a household of one according to Adult Group income requirements. Because the beneficiary was already certified and remained eligible for coverage under the Adult Group, the LDH Eligibility Analyst canceled the automated determination for the Modified Adjusted Gross Income (MAGI) determination from the FFM. LWC portal information was available to LDH in advance of the December 2016 renewal date. For

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these reasons, LDH contends that the beneficiary met income requirements and LDH correctly made payments on behalf of the beneficiary. In support of our explanation, LDH provided all supporting documentation to the OIG for review/consideration.

Finding 2: LDH made payments on behalf of beneficiaries who did not meet requirements related to coverage for dependent children.

LDH Response to Finding 2: LDH concurs with the OIG's finding related to this beneficiary—Sample 76. Corrective action measures are detailed under the recommendations section of this response.

Finding 3: LDH made payments on behalf of beneficiaries who did not have any medical claims for retroactive coverage.

LDH Response to Finding 3: LDH concurs with the finding related to this beneficiary—Sample 33.

Finding 4: LDH made payments on behalf of beneficiaries who may not have met income requirements.

LDH Response to Finding 4: LDH disagrees in part with this finding—Sample 14. *Please note, during a meeting with OIG on October 13, 2020, to discuss its findings/recommendations, OIG confirmed that Finding 4 is not/will not be classified as an error and is not included in its \$42.3 million extrapolation.*

Sample 14 – LDH disagrees in part that it made payments on behalf of this beneficiary when beneficiary did not meet income requirements. Although LDH concurs that beneficiary did not meet income requirements, LDH contends that the beneficiary's case was timely closed effective November 30, 2016. For the months of July through September 2016, beneficiary failed to report changes in income as required. During the annual renewal process, LDH became aware of a change in the beneficiary's income per LWC data and issued a 30-day Request for Information (RI) letter to beneficiary on October 5, 2016. The beneficiary's renewal was due in October 2016. When LDH received no response to the RI letter, LDH issued a closure notice on November 9, 2016.

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The OIG has made the following recommendations to LDH:

Recommendation 1: LDH should promptly provide notice and cancel the eligibility of beneficiaries identified with income over the allowable limit.

LDH Response: We concur that promptly providing notice and cancellation when appropriate is the responsibility of LDH. We will continue our responsibility to do so as recommended.

Recommendation 2: LDH should educate eligibility analysts on established policies and procedures regarding requirements to promptly provide notice and cancel eligibility, verify income, and provide retroactive eligibility.

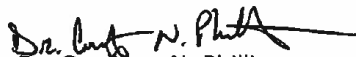
LDH Response: LDH regularly provides training to its eligibility analysts related to established eligibility policies and procedures and will continue to ensure that they are informed as eligibility policies and procedures are updated.

Recommendation 3: LDH should redetermine, if necessary, the current Medicaid eligibility status of the sampled beneficiaries for whom income or dependent verifications did not meet Federal and State requirements.

LDH Response: Redeterminations were conducted of the sampled beneficiaries. Corrective action is complete for this recommendation.

Rebecca Harris, Interim Medicaid Deputy Director, serves as the lead on this matter. If you have any questions or concerns, please contact Ms. Harris by email at Rebecca.Harris@la.gov or by telephone at 225-342-2907.

Sincerely,


Dr. Courtney N. Phillips