DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

MAR - 8 2019

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter concerning the troubling findings of the November 2018 Louisiana Legislative Auditor's report on wage verification practices for the Medicaid expansion population. I appreciate your interest in this important issue and share your concerns. As you know, the federal-state partnership is central to the success of the Medicaid program, and the Centers for Medicare & Medicaid Services (CMS) plays a critical role in ensuring that states are compliant with federal statute and regulations and that only eligible individuals are enrolled in Medicaid. CMS continuously works to strengthen our Medicaid program integrity efforts to ensure that taxpayer dollars are spent appropriately. I appreciate the opportunity to address your concerns and provide you with an update on our ongoing and planned actions regarding this issue.

**CMS's Engagement with Louisiana Regarding the State Audit**

CMS has carefully reviewed the Louisiana Legislative Auditor's report on wage verification practices and the subsequent report released in December 2018 on the state's eligibility determination practices for the expansion population. In addition to our close analysis of the report's findings, we have held multiple discussions with the Louisiana Department of Health to understand the methodology used for completing the audit and the overall findings. We have also begun analyzing the state's current processes and the extent to which CMS will need to provide further technical assistance to address remaining issues.

The auditor's findings are deeply troubling. As reflected in the Louisiana Legislative Auditor's report and reiterated by the state during our meetings, the Louisiana Department of Health has indicated that it has plans to implement nearly all of the recommendations included in the state audit reports, including more frequent use of data matching to identify potential changes in beneficiary income that may affect eligibility, as described below. As we understand, recent upgrades to Louisiana's eligibility systems will help to address some of the issues identified by the Louisiana Legislative Auditor. CMS remains committed to continuing to work with the state and provide technical assistance and ongoing oversight as it implements additional changes to processes to reduce potential errors.

Prior to release of the report, CMS staff had the opportunity to meet with Louisiana's Legislative Auditor, Daryl Purpera, to discuss how states and CMS could enhance program integrity efforts.

We are considering those recommendations as we explore ways to strengthen our federal oversight in this area.

**Requirements for Identifying Changes in Circumstances**

Federal regulations at 42 CFR 435.916(c) require that states establish procedures designed to ensure that Medicaid beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. Further, these changes must be reportable through multiple modes, including online, by phone, in person, and by mail. Regulations at 42 CFR §435.916(d) further require that states must promptly redetermine eligibility whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility. In verifying eligibility, including eligibility based on self-reported information, states primarily rely on electronic data sources, including the federal data services hub, to check the accuracy of application information, along with additional data sources including other data from state and federal agencies, like quarterly wage data and commercially-available resources such as TALX. If applicants submit information that conflicts with the electronic verification attempt, CMS regulations require that states seek additional information from applicants, such as the submission of additional documentation.

Beyond these requirements, federal statute and regulations permit states[1] to conduct more frequent income and other checks using state wage data or other electronic sources. Currently, 40 states report that they conduct this type of periodic post-enrollment data matching to ensure that Medicaid beneficiaries continue to be eligible. Louisiana reports that it plans to implement this policy through new periodic data matching of income through state wage data in 2019. CMS will provide technical assistance to facilitate these efforts. CMS is also actively assessing current statute, regulations, and state practices to explore ways to enhance state efforts and federal oversight in these areas.

**CMS's Oversight of Medicaid Eligibility**

As you know, on June 26, 2018, CMS announced a new Medicaid Program Integrity Strategy that prioritizes accountability and integrity protections in Medicaid. The strategy includes new and enhanced initiatives that will create greater transparency and accountability for Medicaid program integrity performance, enable increased data sharing and robust analytic tools, and seek to reduce Medicaid improper payments across states. The initiatives include increased beneficiary eligibility oversight, stronger audit functions, and enhanced enforcement of state compliance with federal rules.

As part of CMS's strategy to improve program integrity and increase oversight of states' beneficiary eligibility determinations, we are auditing states previously found to be high risk by the Department of Health and Human Services' Office of Inspector General (OIG) to examine how these high risk states determine eligibility for Medicaid benefits. These states are New York, Kentucky, and California. These audits include assessing the effect of Medicaid expansion

[1] See https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-21-13.pdf

and its enhanced federal match rate on state eligibility policy. The objectives of the audits are to determine whether beneficiary eligibility was adjudicated appropriately for the new adult group and whether services for beneficiaries in the new adult group were assessed the correct Federal Medical Assistance Percentages (FMAP).

CMS does not currently have the statutory authority to recoup overpayments for eligibility errors that may be identified through these new audits; however, CMS does have the authority to issue disallowances, and states are required to return overpayments, in certain circumstances, as described below. Using these new audits to recoup overpayments would require a legislative change. To that end, I am happy to discuss this issue further with you and would welcome the opportunity to work with you on that effort.

CMS will also consider broadening these audits to include other states based on a risk analysis, including, but not limited to issues noted during the review of State Plan Amendments (SPAs) for expansion approval; findings from other review programs, such as the Payment Error Rate Measurement (PERM) program and the Medicaid Eligibility Quality Control (MEQC) program; and audits conducted by other entities, such as the OIG, Government Accountability Office (GAO), and/or state auditors. Because of the number of findings identified by the state auditor's reviews, CMS will include Louisiana in a future audit.

In addition to these new eligibility audits, under a CMS regulation published in July 2017,[2] CMS will once again measure the current improper payment rate for the eligibility component of the PERM program, beginning with the fiscal year (FY) 2019 reporting period. Under the PERM program, each state is reviewed on a rolling three-year basis to produce an annual national improper payment rate for the Medicaid program. Current regulations will allow CMS to begin to issue potential disallowances to states based on PERM program findings in FY 2022, when all states have been reviewed once under the revised rule. CMS also uses the MEQC program, which uses state-directed reviews in the two off-cycle PERM years, to address Medicaid beneficiary eligibility vulnerabilities. Under the MEQC program, if states find active cases for which eligibility determination errors were made, they are required to assess the financial implications of the error during the three-month period after the erroneous eligibility date. States will be required to return the federal share of any overpayments made as a result of these erroneous eligibility determinations through the quarterly CMS-64 and CMS-21 reporting processes.

Additionally, as part of our enhanced efforts to ensure fiscal integrity for the Medicaid program, CMS is working with all states on the important components of proper and efficient administration of a Medicaid program. As new states are electing to expand coverage to the new adult group, we are seeking documentation to clearly articulate how individuals in the Medicaid adult group are accurately determined, identified, categorized, and claimed in state systems to ensure that claims are appropriately applied to the correct eligibility category and ultimately reported at the proper FMAP

[2] See https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicaid-program-and-childrens-health-insurance-program-chip-changes-to-the

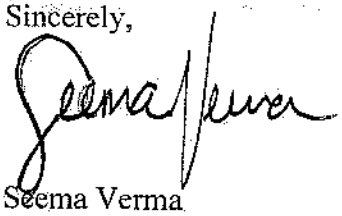
rate. To this end, we expect each state to develop comprehensive test plans specific to their beneficiary eligibility processes that would describe the end-to end-testing strategy being employed to demonstrate the operational capacity for accurate eligibility determination and renewal functionality. We look for evidence to support that states have taken appropriate measures to ensure compliance with federal and state requirements, as well as to detect, prevent, and mitigate fraud, waste, and abuse. CMS is also in the process of ensuring that existing expansion states meet these expectations as well.

**Recoupment of Federal Medicaid Dollars**

CMS is concerned with ensuring that states finance their share of Medicaid expenditures within statutory and regulatory requirements. CMS has regulatory procedures in place to deny SPAs, waivers, and demonstrations that result in additional Medicaid base or supplemental payments to providers that are not authorized under the applicable statutes and regulations. If CMS determines that claims were reported in error or fraudulently, CMS may pursue corrective action to ensure that the state changes its practices and may use the disallowance process to recover federal financial participation that has been paid inappropriately. As you know, this Administration inherited a backlog of potential disallowances where CMS, OIG, or state oversight activities identified potentially unallowable state claims. Since March 2017, when I arrived at CMS, we have issued over $879 million in total disallowances. We are committed to achieving more expeditious resolution of these types of issues, as they arise, to prevent new backlogs from developing in the future, thereby ensuring federal funds are repaid in a timely manner.

Thank you for your interest in the steps CMS is taking to ensure that Louisiana's Medicaid program is operating in the best interests of its citizens and American taxpayers. We share your commitment to helping make sure that taxpayer dollars are spent on needed items and services for beneficiaries who are truly eligible to be enrolled in the Medicaid program. Should you have additional questions, please contact the CMS Office of Legislation at 202-690-8220. I will also provide this response to Representative Jim Jordan.

Sincerely,



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