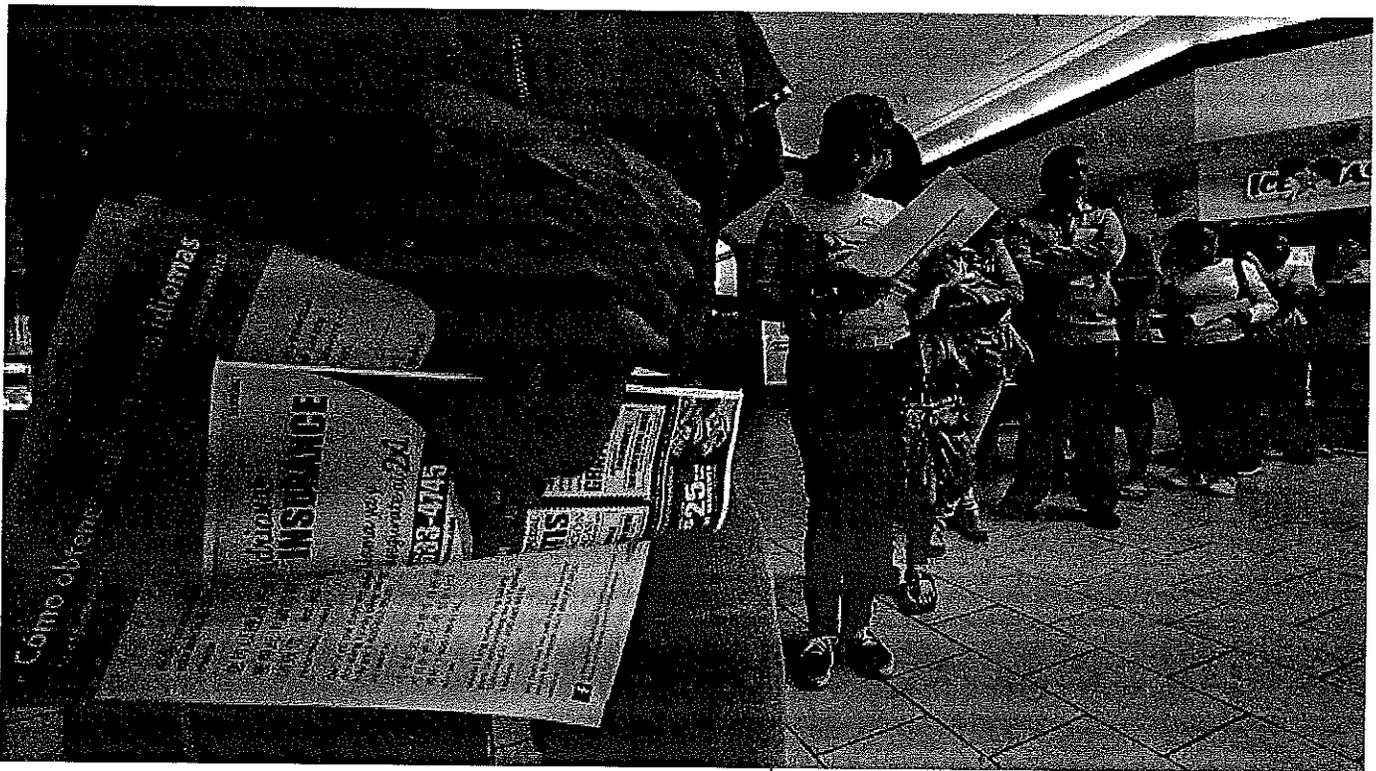


BUSINESS

# California Medicaid expansion enrolled hundreds of thousands of ineligible people, federal report finds

By CHAD TERHUNE  
KAISER HEALTH NEWS | MAR 26, 2018



A Covered California enrollment line at the Panorama Mall in 2014. Enrollees' incomes were checked and, if qualified, they were signed up for Medi-Cal instead of a subsidized health plan. (Irfan Khan / Los Angeles Times)

California signed up an estimated 450,000 people under Medicaid expansion who may not have been eligible for coverage, according to a report by the U.S. Health and Human Services Department's chief watchdog.

In a Feb. 21 [report](#), the HHS inspector general estimated that California spent \$738.2 million on 366,078 expansion beneficiaries who were ineligible. It spent an additional \$416.5 million for 79,055 expansion enrollees who were "potentially" ineligible, auditors found.

Auditors said nearly 90% of the \$1.15 billion in questionable payments involved federal money, while the rest came from the state's Medicaid program, known as Medi-Cal. They examined a six-month period from Oct. 1, 2014, to March 31, 2015, when Medicaid payments of \$6.2 billion were made related to 1.9 million newly eligible enrollees.

There were limitations to the California review, however. The audit extrapolated from a sample of 150 beneficiaries. The authors reported a 90% confidence level in their results — whereas 95% would be more common. That meant that the number of those ineligible could have been as low as 260,000 or as high as 630,000.

“If HHS has a strong reason to believe that California is systematically making enrollment errors, it would be helpful to show that in a more robust analysis,” said Ben Ippolito, a healthcare economist at the American Enterprise Institute, a conservative think tank. “The federal government should ensure that states are being good stewards of federal money.”

Nonetheless, the audit highlighted weaknesses in California’s Medicaid program, the largest in the nation with 13.4 million enrollees and an annual budget topping \$100 billion, counting federal and state money. Medicaid covers 1 in 3 Californians.

The inspector general found deficiencies in the state’s computer system for verifying eligibility and discovered errors by caseworkers. The Medicaid payments cited in the report covered people in the state’s fee-for-service system, managed-care plans, drug treatment programs and those receiving mental health services.

California’s Department of Health Care Services, which runs Medi-Cal, said in a statement that it agreed with nearly all of the auditors’ recommendations and that the agency “has taken steps to address all of the findings.”

In a written response to the inspector general, California officials said several computer upgrades were made after the audit period and before publication of the report that should improve the accuracy of eligibility decisions.

Among the 150 expansion enrollees analyzed in detail, 75%, or 112, were deemed eligible for the Medicaid program in California. Auditors discovered a variety of problems with the other 38 enrollees.

During the audit period, 12 enrollees in the sample group had incomes above 138% of the federal poverty line, making them ineligible financially for public assistance, according to the report.

In other instances, beneficiaries were already enrolled in Medicare — the federal health insurance for people 65 and older or who have severe disabilities — and did not qualify for Medi-Cal. One woman indicated she didn’t want Medi-Cal but was enrolled anyway.

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in the state or county computer systems.

California was one of 31 states to expand Medicaid under the 2010 Affordable Care Act. The health law established a higher federal reimbursement for these newly eligible patients, primarily low-income adults without children. After expansion started in 2014, the HHS inspector general’s office began reviewing whether states were determining eligibility correctly and spending taxpayer dollars appropriately.

In a similar audit released in January, the inspector general estimated that New York spent \$26.2 million in federal Medicaid money on 47,271 expansion enrollees who were ineligible for coverage. (The sample size there was 130 enrollees.) Overall, New York had far fewer expansion enrollees and related spending than California.

“It is inevitable that in a big rollout of new eligibility for any public program there are going to be glitches in implementation,” said Kathy Hempstead, a health policy expert and senior advisor at the Robert Wood Johnson Foundation. “The inspector general wants to make sure that states are being sufficiently careful.”

The California audit didn’t request a specific repayment from the state, but the findings were sent to the U.S. Centers for Medicare & Medicaid Services for review. CMS officials didn’t respond to a request for comment.

Donald White, a spokesman for the inspector general’s office, said the agency stood by the report’s findings and declined to comment further.

*Terhune is a senior correspondent for Kaiser Health News, an editorially independent publication of the Kaiser Family Foundation.*



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Chad Terhune



Chad Terhune previously covered the business of healthcare, including medical costs, patient safety and the rollout of the federal health law. Prior to joining in 2012, he was an award-winning reporter for the Wall Street Journal and Businessweek. Chad spent more than a decade at the Journal and his stories on health insurance won a National Press Club award. At Businessweek, his stories on health reform and subprime mortgages earned recognition from the New York Press Club and Investigative Reporters and Editors. He graduated from the University of Florida. Terhune left The Times in January 2016.

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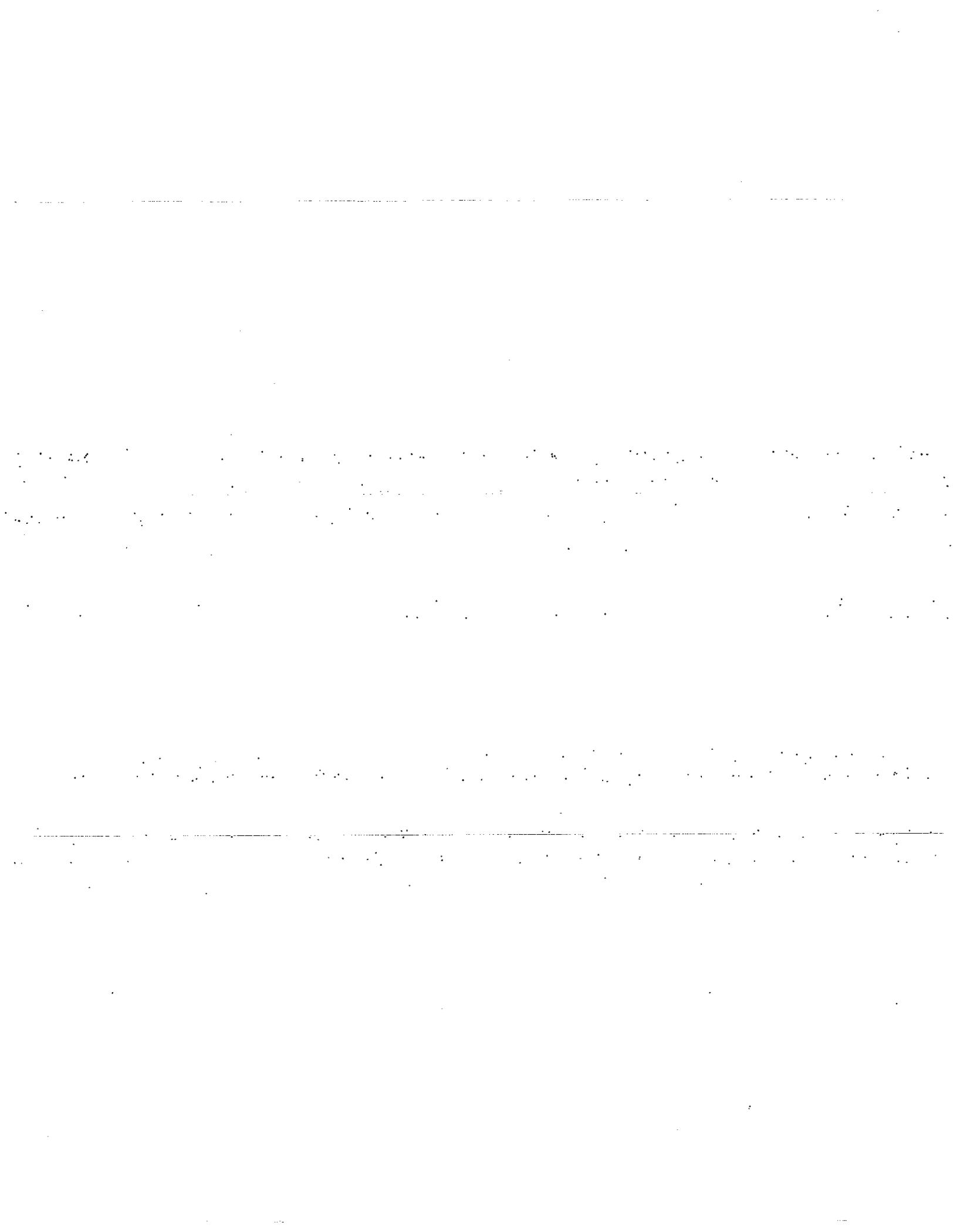
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MEDICAID EXPANSION

# Medicaid expansion enrollment is on track to surpass projections

By Adam Crepeau on April 2, 2019

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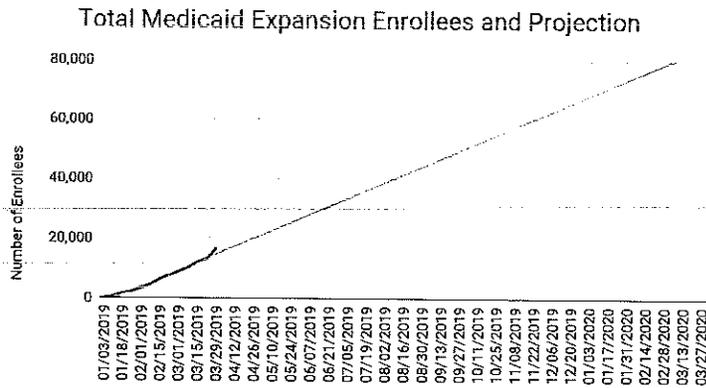
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### FACEBOOK

Medicaid expansion enrollment under Governor Janet Mills is taking off – almost 16,800 individuals have enrolled to receive Medicaid benefits under the new eligibility requirements. The Manatt report cited by Governor Mills in her State of the Budget Address expects just over 70,000 people to enroll by fiscal year 2021 and a cost to the state of \$159 million over the biennium.

Despite this, Governor Mills in her biennial budget proposed to dedicate approximately \$147 million to expansion over the biennium, and to stash away \$29 million in a Medicaid reserve account to pay for potential cost overruns.

When Medicaid expansion was on the ballot in 2017, proponents claimed that just over 70,000 people would enroll in the program. At the current rate of 1,292 new enrollees per week, the state is on track to exceed enrollment projections by January 2020. Higher-than-expected enrollment is not far-fetched and could result in the program costing more to taxpayers. In fact, other states that expanded their Medicaid programs experienced an average of 92 percent cost overruns, almost doubling the cost of expansion.



Source: Maine Department of Health and Human Services, The Maine Heritage Policy Center



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When Illinois expanded Medicaid to able-bodied adults, their health department projected a maximum enrollment of 380,000 new individuals. By March 2017, over 650,000 enrolled under expansion, costing the state more than double what was initially projected.

If Maine experiences a 50 percent cost overrun (less than average) in the 2020-21 biennium, it would cost an additional \$44 million after the reserve account is depleted. Taking this risk could result in tax increases for Mainers, especially if the biennial budget spends all projected revenue or revenue projections do not pan out.

Governor Mills also approved a temporary call center to streamline the enrollment process. Job training for this facility began on April 1 and may result in a larger weekly enrollment rate. If this occurs and enrollment is steady throughout the biennium, the state may exceed initial enrollment projections before the end of the calendar year. This would undoubtedly increase the cost of Medicaid expansion, which will require state taxpayers to chip in more of their hard-earned money.

According to the Maine Department of Health and Human Services, almost 14,000 of the people already enrolled under expansion are adults without children (83 percent of new enrollees). These individuals are being prioritized over people with intellectual and developmental disabilities who continue to languish on Medicaid and state-funded wait lists.

Governor Mills' proposed budget funds just 300 new slots in existing programs for Mainers with intellectual and developmental disabilities, which is the minimum amount required by law. In other words, the budget expands Medicaid to thousands of adults without children but does little to eliminate wait lists for the truly needy. In essence, we're rolling out the red carpet for a population that should be working while kicking truly vulnerable Mainers to the back of the line.

It's also worth mentioning that Governor Mills rejected the Section 1115 demonstration waiver requested by former Governor LePage and approved by the federal government. The waiver would have required able-bodied adults who receive Medicaid benefits to work, volunteer, search for jobs, or go to school a minimum of 20 hours per week.

Allowing able-bodied adults to become dependent upon a government program is irresponsible governance – if individuals can work, they should be required to do so in order to receive government benefits. In sum, this administration is ignoring the truly needy by spending hundreds of millions of dollars to allow able-bodied, childless adults to receive Medicaid benefits, without requiring them to work.

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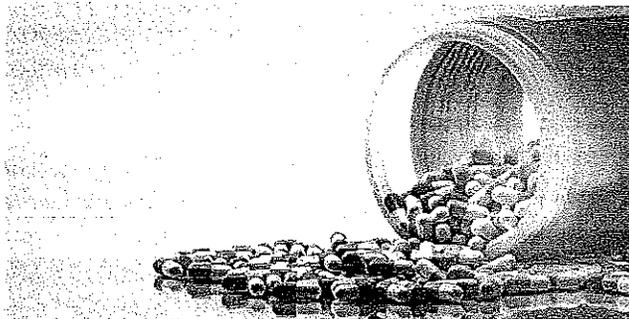
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NEWS

## Louisiana Medicaid audit 'deeply troubling' to federal agency

Posted Mar 19, 2019



The U.S. Centers for Medicare and Medicaid Services said it will include Louisiana in a future review of how "high risk states" determine eligibility for government-financed Medicaid benefits, in response to work done by Louisiana Legislative Auditor Daryl Purpera.

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### By The Associated Press

The federal Medicaid agency described a November audit that said Louisiana's Medicaid expansion program may have spent as much as \$85 million on ineligible enrollees as "deeply troubling" and said it could seek repayment of misspent money.

The U.S. Centers for Medicare and Medicaid Services said it will include Louisiana in a future review of how "high risk states" determine eligibility for government-financed Medicaid benefits, in response to work done by Louisiana Legislative Auditor Daryl Purpera.

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But the federal agency, known as CMS, also noted a computer system change launched by Gov. John Bel Edwards'

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"As we understand, recent upgrades to Louisiana's eligibility systems will help to address some of the issues identified," CMS Administrator Seema Verma wrote in a March 8 letter to U.S. Sen. Ron Johnson, a Wisconsin Republican and chairman of a Senate oversight committee.

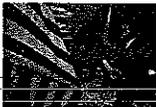
Verma's letter, provided to The Associated Press by Purpera's office, came in response to concerns Johnson and U.S. Rep. Jim Jordan of Ohio, the top Republican on a House oversight committee, raised in January about Purpera's audit.

Though the federal Medicaid agency has limited legal authority to seek return of overpayments made through eligibility mistakes, Verma wrote that it can recoup misspent federal funds from states through a "disallowance" in certain circumstances.

"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," Verma wrote.

Louisiana Department of Health spokesman Robert Johannessen said the department hasn't had any discussions with CMS about recouping funds because of the audit.

Auditors in Purpera's office used a random sample of 100 Medicaid expansion recipients, to check if their income exceeded the eligibility threshold. Projecting those results across the entire expansion population, auditors wrote, suggests the health department spent between \$61.6 million and \$85.5 million over 20 months on people who weren't eligible for coverage.



### Louisiana may have paid up to \$85 million to ineligible Medicaid recipients, audit says

Edwards supporters have criticized the methodology used by auditors. Republicans have seized on the report to bolster their claims that the Democratic governor was so focused on expanding Medicaid when he took office in 2016 that he didn't make sure his administration could properly administer the expansion and avoid abuse.

The Edwards administration points to its computer upgrade and to letters sent to 37,000 Medicaid enrollees in February notifying them they appear to earn too much to stay in the health insurance program.

More than 500,000 working poor and other nonelderly adults have been added to the Medicaid rolls since Edwards, running for a second term on the October ballot, expanded the program.

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Under Medicaid expansion, adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level — about \$16,750 for a single adult or \$28,680 for a family of three — are eligible for the coverage. The federal government pays most of the cost. Louisiana is paying a share that eventually increases to 10 percent, but lawmakers passed financing tools to help cover the state's share, including a tax hike charged on health maintenance organizations.

- *Melinda Deslatte, Associated Press*

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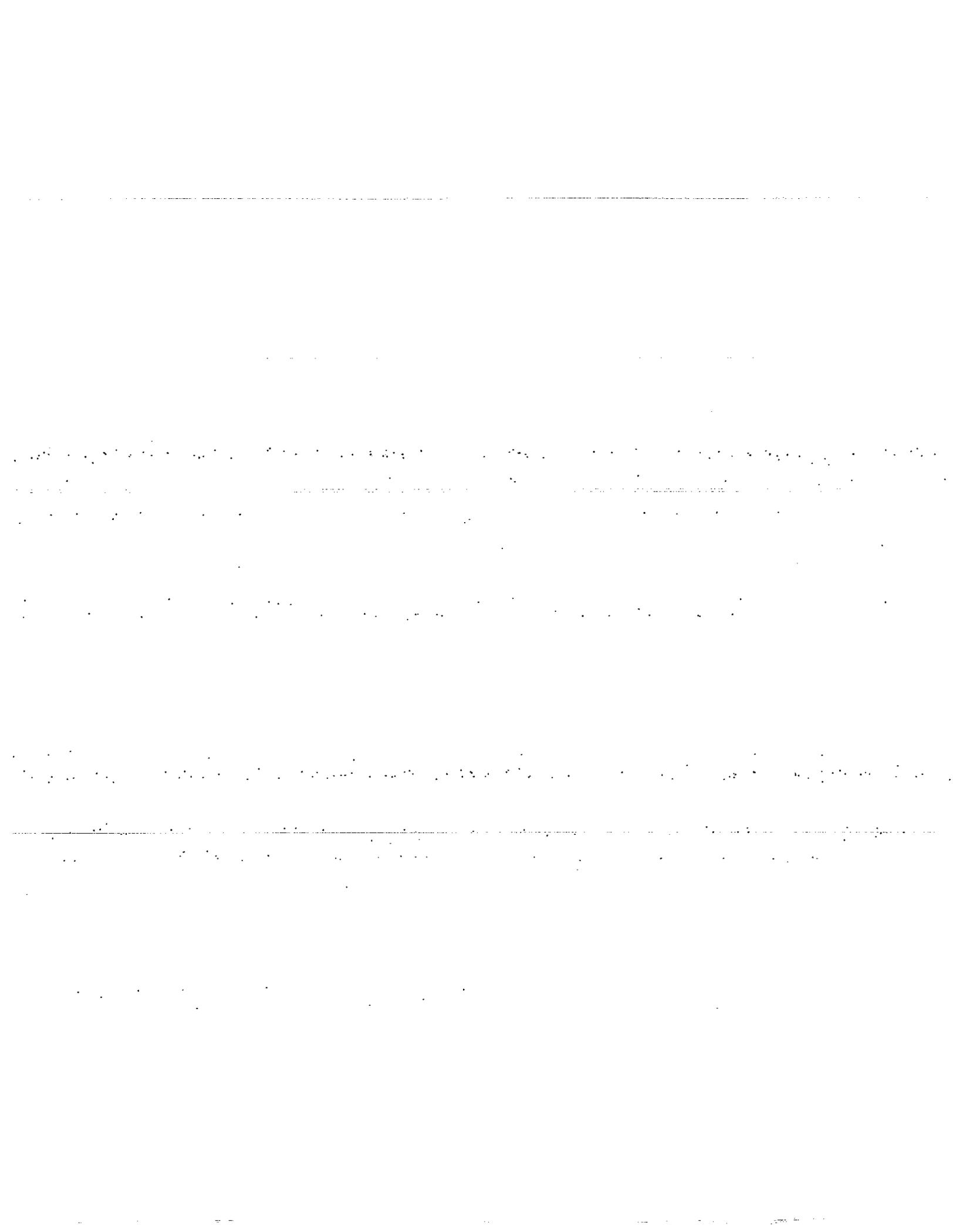
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## NEWS

## Louisiana removes 30,500 from its Medicaid rolls

Updated Apr 3, 2019:  
Posted Apr 3, 2019



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By The Associated Press

More than 30,000 people in Louisiana have been booted from the Medicaid program, after an upgraded state computer check determined they earn too much to receive the taxpayer-financed health insurance.

Louisiana's health department sent notices to 40,000 Medicaid recipients in February, warning them they would lose the insurance coverage unless they could demonstrate by March 29 that they met the program's income requirements.

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Three-quarters of those who received the letters — 30,500 people — lost their benefits at the end of March, said agency spokesman Robert Johannessen. Nearly all of them are non-elderly adults enrolled through the Medicaid expansion that Democratic Gov. John Bel Edwards enacted in 2016.

"Either they did not respond to the letter or they earn too much. It could be both," Johannessen said. "We are still processing some paperwork so that 30,500 could change, but not substantially."

An upgraded computer system identified those who were deemed ineligible for Medicaid coverage. The system does quarterly eligibility checks, rather than previously performed annual checks, and uses more wage data for comparison.

Medicaid Director Jen Steele described the enrollment system in a statement as "more robust than what we had before, allowing us to run more frequent checks on information that drives eligibility decisions, including employment status and income."

Under the prior system, Steele said the 40,000 people sent income-verification letters would have been identified, but over a 12-month period instead of all at once. The next quarterly income eligibility check will be done in May, she said.

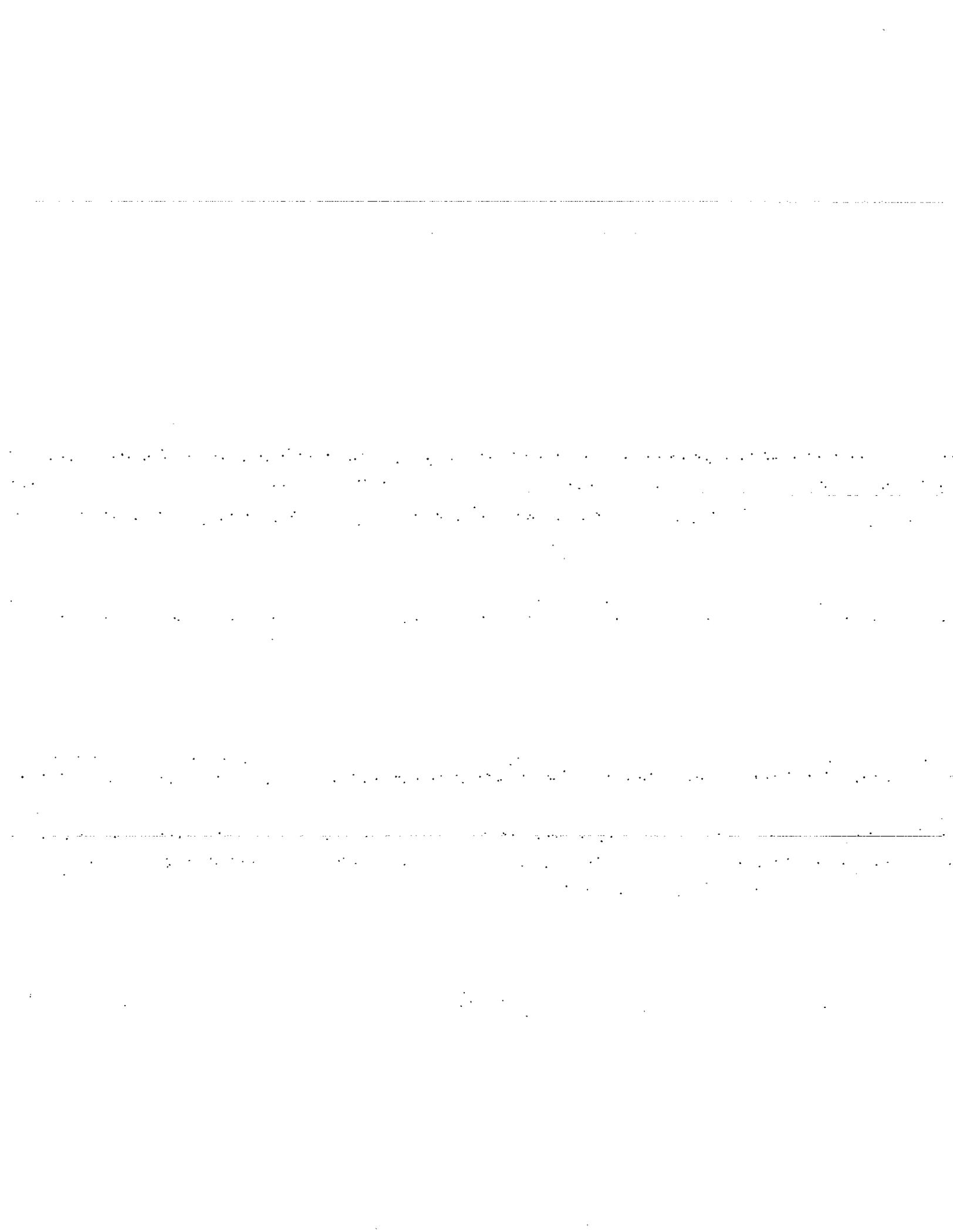
Republican officials and Louisiana Legislative Auditor Daryl Purpera have raised concerns that the Medicaid program, paid with a mix of nearly \$13 billion in state and federal dollars, has wasted millions on people who shouldn't be receiving the government-financed coverage.

Purpera's office released a report in November that projected Louisiana's Medicaid expansion program may have spent as much as \$85 million over 20 months on people who weren't eligible for coverage. Democrats have criticized the methodology used by auditors. But the Edwards administration and the U.S. Centers for Medicare and Medicaid Services, the federal agency that oversees the government health insurance coverage, also said the computer system change was expected to help address Purpera's findings.

More than 500,000 people have been added to the Medicaid rolls since Edwards, running for a second term on the October ballot, expanded the program in a move that rankled Republicans.

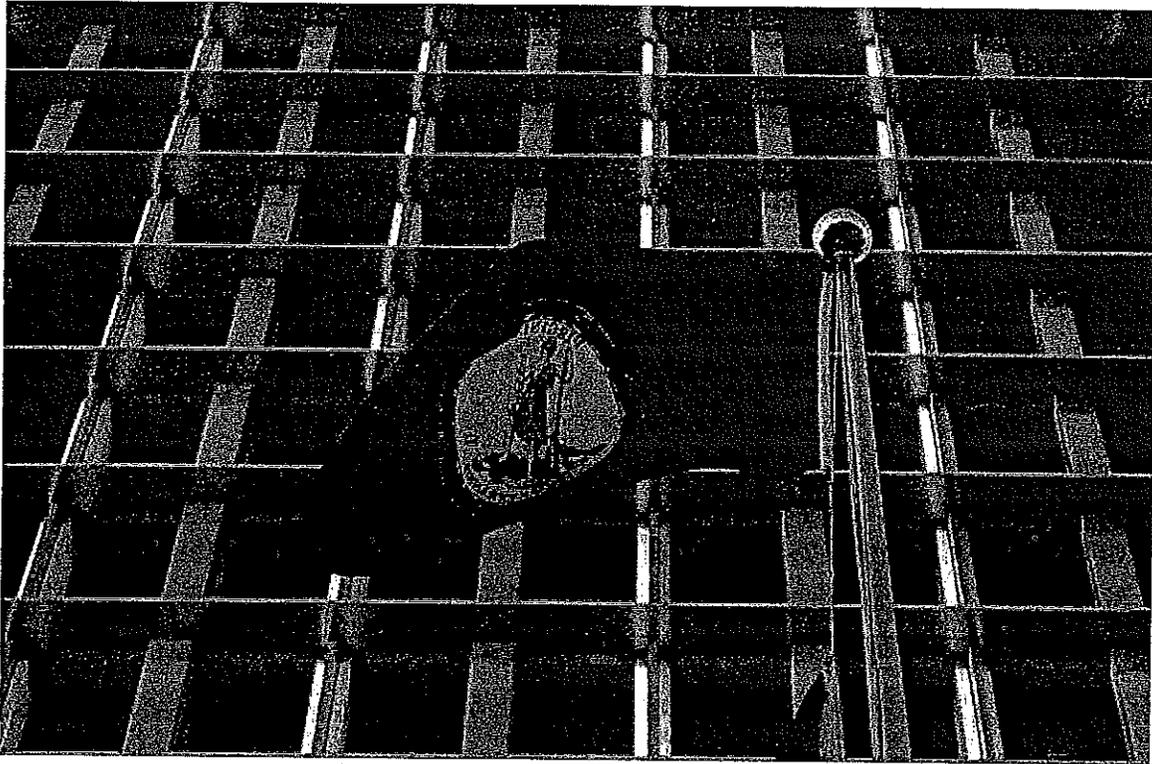
Under Medicaid expansion, adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level — about \$16,750 for a single adult or \$28,680 for a family of three — are eligible for the coverage. The federal government pays most of the cost. Louisiana is paying a share that eventually increases to 10 percent, but lawmakers passed financing tools to help cover the state's share, including a tax hike charged on health maintenance organizations.

Health department leaders say some people enrolled through Medicaid expansion likely have fluctuating or seasonal changes in employment that could keep them going in and out of the Medicaid program throughout the year, as their wages change.



## Will thousands of new Medicaid enrollees inundate an already overloaded social services workforce?

By Katie O'Connor - September 20, 2018



Virginia's 120 local social services departments are on the front lines when determining eligibility for benefit programs like Medicaid, and they're trying to prepare for the wave of applicants they'll likely see once Medicaid expansion hits the state in January.

That could be a daunting task, though, as the state's eligibility workers are already overworked and have a low retention rate. According to the League of Social Services Executives, 40 percent of benefits eligibility specialists in local departments leave within five years.

The state has taken steps to ease the burden on those local departments, including hiring 310 additional staff members to spread the work around — but there are still some doubts of whether that's enough.

During a Joint Subcommittee for Health and Human Resources Oversight meeting Wednesday, Elaine Burgess, president of the Virginia Benefits Program Organization who works in Virginia Beach, said most of the workers in her agency have caseloads of up to 800 cases.

They are expected to determine each person's eligibility within 30 days — a tough lift with such a large number of cases.

And in January, 400,000 more people are predicted to apply for Medicaid.

At Wednesday's meeting, Del. Scott Garrett, R-Lynchburg, expressed concern about the workforce's ability to sign up that many new members when they're already so stressed.

"This is my greatest heartburn: That we make the commitment and we're not ready to roll it out," he said.

But Virginia Department of Social Services Commissioner Duke Storen said officials doubt that all 400,000 people will converge on local departments.

Right now, only 35 percent of those who enroll in Medicaid do so through a local department, while others are enrolled in other ways, like through the state's Cover Virginia Call Center or the online application portal, CommonHelp.

Some groups will also be automatically enrolled in Medicaid, such as those on GAP, or Governor's Access Plan, which is for adults with serious mental illness.

And the Department of Medical Assistance Services, which manages Medicaid in Virginia, is also working to transition Virginia's relationship with the Affordable Care Act's marketplaces. In the past, if someone applied to the marketplace when they likely qualified for Medicaid, their application would be forwarded on to Virginia, resulting in months of backlogs during some open enrollment periods.

But Virginia is trying to change that process so that the marketplaces can determine Medicaid eligibility based on Virginia's rules, the setup that some states have already.

"The combination of automatic enrollment and expedited enrollment and pushing CommonHelp and pushing the call center means that we believe that we are not going to have going to have an influx of 400,000 applications at the local Departments of Social Services, and we are very intentional about making sure that doesn't happen," Storen told the subcommittee Wednesday.

The 310 number for additional workers was based on the best estimate available earlier this year when the General Assembly was considering the budget, he said.

Del. S. Chris Jones, R-Suffolk, said the General Assembly spent countless hours trying to formulate the right numbers and that he feels confident that, based on the data that was available at the time, 310 was the right number.

"I think we all want preciseness in everything we do, but this is almost like a helicopter with a million moving parts," he said. "I understand the alarm and the concern, but I am comfortable, based on what we had on the time."

Storen noted that the Virginia Department of Social Services likely won't know if the local departments will have enough staff until several months into implementation, by which time it will likely be too late to add a request to the budget.

But he said on Wednesday, with even more recent data available, 310 is the right number. There is some flexibility in the Cover Virginia Call Center, too, to add more capacity and handle additional applications if that proves to be necessary.

"My tea leaves are no better than anybody else's, but I can say we have spent a lot of thoughtful time on this, and I think we're in a good place, I really do," he said. "And if we're not, then I'll let you know."

#### Katie O'Connor

Katie, a Manassas native, has covered health care, commercial real estate, law, agriculture and tourism for the Richmond Times-Dispatch, Richmond BizSense and the Northern Virginia Daily. Last year, she was named an Association of Health Care Journalists-Regional Health Journalism Fellow, a program to aid journalists in making national health stories local and using data in their reporting. She is a graduate of the College of William and Mary, where she was executive editor of The Flat Hat, the college paper, and editor-in-chief of The Gallery, the college's literary magazine.

