Testimony by Legislative Auditor Daryl Purpera, CPA, CFE
To the Joint Meeting of the Subcommittee on Government Operations
& the Subcommittee on Intergovernmental Affairs
April 12, 2018 at 10:00 a.m.
Room 2154 of the Rayburn House Office Building

Chairmen and members, my name is Daryl Purpera and I am the Legislative Auditor for the State of Louisiana. With me is Mr. Wesley Gooch, Special Assistant for Healthcare Audit. I was elected by the Louisiana Legislature to serve as Louisiana's Legislative Auditor in 2010 and have a total of 34 years of government auditing experience. My office is provided constitutionally within the Legislative branch of Louisiana government. I am also Chairman of the Louisiana Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives. I serve as an executive committee member for the National Association of State Auditors, Comptrollers, and Treasurers (NASACT), as well as the National Association of State Auditors (NSAA).

I have come today to speak to you specifically about the underutilization of the State Auditor's in the fight against fraud, waste, abuse, and improper payments in the Medicaid program. While I will focus on the issues we face with regard to the Medicaid program, these comments apply also to other programs such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). I come as a professional government auditor and not a Medicaid, SNAP, or TANF expert. What I am about to testify to today, is the ongoing result of collaboration of my office, the Louisiana Medicaid Fraud Task Force, NASACT, NSAA, and the United States Government Accountability Office (GAO). My comments will focus on the (1) inadequate audit requirements, (2) the auditors' lack of adequate access to Federal Tax Data, and (3) costly effect of the Reasonable Compatibility Standard, and (4) the need for a new approach to auditing Medicaid programs.

I began these efforts after learning that the Centers for Medicare and Medicaid Services (CMS) estimates that the projected loss from improper Medicaid payments exceeds $50.6 billion each year across our nation. Of that amount, federal dollars account for $29.1 billion while the states collectively account for the remaining $21.5 billion[1]. At a time when our country and many states are facing difficult financial decisions, finding a way to help stem this fraud, waste, and abuse and other improper payments is critical.

[1] CMS 2015 Medicaid and CHIP Improper Payments Report (www.cms.gov/Research-Statistics-Data-and-Systems)

Single Audit Requirements

State Auditors across our nation are required annually to audit the various federal programs such as Medicaid under the Single Audit Act. The Single Audit Act of 1996 was enacted to streamline and improve the effectiveness of audits of federal awards expended by states, local governments, and not-for-profit entities, as well as to reduce audit burden. The Single Audit Act requires these audits, referred to as "single audits" to be conducted by an independent auditor. Single audits have a significant public interest component as they are relied on by state and federal agencies as part of their administrative responsibilities for determining compliance with the requirements of federal awards by non-federal entities.

The Single Audit Act gives the Director of the Office of Management and Budget (OMB) the authority to develop government-wide guidelines and policy on performing audits to comply with the Act. The most recent OMB regulation issued for this purpose is Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). It includes uniform cost principles and audit requirements for federal awards to nonfederal entities and administrative requirements for all federal grants and cooperative agreements. The audit requirements are provided to independent auditors, like my office, through program Compliance Supplements.

Now, I will begin to address what I believe to be significant deficiencies in the audit process that are likely resulting in fraud, waste, abuse, and other improper payments going undetected year after year and thereby costing our taxpayers substantial precious resources.

Inadequate Audit Requirements

The Medicaid program has, as a key determination of eligibility, an income component based on the Modified Adjusted Gross Income (MAGI) of the recipient. However, the Compliance Supplement for Medicaid[2] specifically provides that the auditor should not test eligibility for determinations based on MAGI. The guidance states that "Detailed testing is performed under the Medicaid and CHIP Eligibility Review Pilots, which serve as CMS's oversight of Medicaid and CHIP eligibility determination during the initial years of Affordable Care Act implementation." As a result of this guidance, state auditors, and other independent auditors, do not conduct the audit work needed to ensure that recipients meet the income

[2] Compliance Supplement Medicaid Cluster 4-93.778-15, Section E.1

requirements of the programs using MAGI information. Further, I have learned that CMS, through its Pilot program, assigned the Louisiana MAGI eligibility review to the Louisiana Department of Health, the agency responsible for administering the Medicaid program. Therefore, there is no independent review of income eligibility. This scope limitation upon the state auditor is a significant departure from proper auditing procedures. Basically, in many cases, no independent reviewer is looking at this key component of eligibility.

State Auditors Do Not Have Access to Federal Tax Information

Access to the MAGI data is restricted by federal law. 26 USCA 6103(d)(2) restricts the state auditor's access to federal tax information (FTI) to "…for the purpose of, and only to the extent necessary in, making an audit of the…" state tax agency. As a result, my office may access federal tax data when, and only when, auditing the Louisiana Department of Revenue. I cannot use this same tax data to audit Medicaid, SNAP, or TANF. What this means is the information I can hold in my right hand while auditing our tax agency, I cannot let my left hand use while auditing our Medicaid agency. This is a significant, counterproductive restraint placed upon the independent state auditor.

Furthermore, federal regulations for administering the Medicaid program do not require the examination of federal tax data when making eligibility determinations or subsequent renewals. We found that while 25 state Medicaid agencies utilize federal tax information (FTI) in some manner, the remainder does not. CMS policy allows states to choose which electronic data sources are used. Some of these sources, for example, wage data, does not include all sources of income sources, such as self-employment, and can therefore lead to incorrect eligibility conclusions. Again, because MAGI is a key component of eligibility determination, I believe the use of FTI should be mandatory.

Costly Effect of Reasonable Compatibility Standard

CMS rules provide that states may incorporate a process known as the reasonable compatibility standard (RCS) during their enrollment process. Under this process, when an applicant attests to an income amount that falls within eligibility standards (138% Federal Poverty Level) but electronic information, such as state workforce data (wage records), exceeds the eligibility maximum, the state may use the applicant attested income as long as the difference between the two does not exceed the predetermined RCS. Louisiana adopted an RCS of 25%. Therefore, under this process, an applicant could have an income as much as 172% of FPL and still be considered eligible. The original intent of the RCS appears to have been the streamlining

of the eligibility process, not expanding the income level of eligibility. CMS has indicated that this process assists individuals when they move between Medicaid and the Federal Facilitated Exchange (FFE) since the FFE uses a 25% RCS. However, what this does not consider is that in the FFE program, any under-reporting of income by a recipient is verified through the filing of their annual IRS tax form and any amounts of assistance that were incorrectly provided are reduced from the taxpayers refund. The Medicaid program has no process in place to rectify instances where the RCS has resulted in individuals being deemed eligible and given services, but are later determined to have not actually qualified for the program.

Why These Issues are Important

Now let me tell you why I believe this to be so important. During Louisiana's 2017 Regular Legislative Session, the Louisiana Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force) was created. I've had the pleasure to chair this Task Force and it includes members of the Louisiana legislature as well as the Louisiana Department of Health and Department of Revenue. As part of our work, we conducted a test of eligibility based on state tax records. Our sample included 860,000 Louisiana Medicaid applicants which was basically the entire 2016 adult population of Medicaid recipients. Approximately 39% of recipients had filed 2016 Louisiana tax returns or roughly 335,400 recipients. Of those that filed, 25% or 83,850 had gross incomes that differed by $20,000 or more than the amounts reported to Medicaid. Sixty-two percent, or 207,948, had tax incomes that differed by $10,000 or more than the amounts reported to Medicaid. While we cannot make final conclusions based on this data, it does indicate a significant possibility that those individuals with incomes greater than amounts permitted by the program will be considered eligible for Medicaid thereby increasing the cost to both the state and federal governments. For example, if the 83,850 recipients mentioned above were discovered to have been ineligible, this could be costing the program from $352 million to $503 million annually.

Our test also considered the household size which is another component of eligibility determinations. The results of the test indicated that 48% of applicants had household sizes for Medicaid that differed from their tax basis household size. Again, this indicates a risk that Medicaid household size is not accurate and may result in individuals being considered eligible when they are not. The Task Force made numerous recommendations and I have provided you a copy of those for your information.

Fee-For-Service to Managed Care

As state Medicaid programs move from traditional fee-for-service (FFS) to managed care, the OMB audit requirements have not kept up with the shift in risk. While fee-for-service audit requirements are rather detailed, managed care audit requirements focus only on whether the Medicaid recipient is eligible and whether the state made the proper per member per month (PMPM) premium payment. There are no audit requirements to consider the encounters claims from the managed care plans, the actual managed care payments to providers, the managed care plans' program integrity efforts, or the qualifications of the managed care providers that are not enrolled Medicaid providers. New managed care regulations were released in 2016 and some of this audit gap will be addressed as these new regulations are phased in and implemented.

Need For New Audit Tools

With the changes in program delivery and the identification of the high rate of improper payments, a new audit approach is needed that utilizes data analytics to enhance our results. Data analytics provides the tools designed to aid the analyst, auditor or investigator as they attempt to extract, from data sources including millions of transactions, the information most meaningful to their audit. Data analytics enables auditors to narrow their focus and efforts on those areas of greatest risk. In addition, the use of predictive modeling enables the auditor to use known schemes of fraud, waste and abuse to identify those transactions with highest risk based upon observed behavior within the data. The ultimate goal of this process is identifying those transactions or behaviors that demonstrate the greatest risk. In addition, state auditors should be provided access to both state and federal tax data to properly audit the income portion of eligibility determinations. Furthermore, we have learned that what happens in one state is most likely happening in others. Therefore, sharing of data, algorithms, behavior models, and results enables the auditor to multiply the success of this program.

Results So Far

The early results that have been published by the Louisiana Legislative Auditor include:

- In October 2016, we reported that the Louisiana Department of Health (LDH) did not properly identify Medicaid recipients who had moved out of state. Because managed care recipients are funded much like an insurance policy through a per-member per-month fee, the LDH erroneously paid nearly $1 million in premiums with an additional $1.5 million in questionable payments. Using data analytics, we determined that over

thirteen thousand recipients had no claims over a four year period and of those, 413 had out of state addresses. A review of 160 of these recipients confirmed that all 160 were living outside of Louisiana on a permanent basis. Our LDH continues to investigate the bulk of the thirteen thousand questionable recipients and implement controls to prevent reoccurrence.

- In March 2017, we reported that LDH paid $6.4 million over a four-year period in dental claims that violated program rules and another $4.4 million that may have violated program rules. Using data analytics, we matched paid claims against program rules resulting in over one-hundred thousand claims that did not comply with program rules.
- In March 2017, we reported that LDH paid $1.4 million in duplicate Medicaid payments. Using data analytics, we isolated payments LDH made under two or more different Medicaid ID's for the same service, provided during the same period, for the same individual.
- In March 2017, we reported that LDH paid $620,000 in payments for overlapping services and $326,915 to direct care workers while the recipients were hospitalized or in nursing facilities.
- In September 2017, we reported that LDH paid $4.2 million in improper payments that violated certification rules for laboratory services or involved invalid laboratory procedure codes.
- In October 2017, we reported that LDH's managed care plans had paid $150,196,886 through T1015 all-inclusive claims without required accompanying detail increasing risk that appropriate services were not provided, claims were unbundled, or not covered.
- In November 2017, we reported that LDH paid $717,820 in improper payments for 712 deceased recipients.

Other state auditors have used data analytics and issued numerous reports disclosing:

- Disallowed drug claims including excess drug quantities, missing or invalid prescriptions, and unauthorized or inappropriate refills.
- Inappropriate Premium Payments including:

  - Improper or questionable premium payments for recipients who were subsequently dis-enrolled retroactively and the Managed Care Operator (MCO) was not at risk during the disenrollment periods
  - Overpayments for FFS claims for recipients whose services had been covered by managed care
  - Claims billed with incorrect information pertaining to other health insurance
  - Recipients diagnosed with end state renal disease who were entitled to Medicare coverage at the time of claim
  - Improper episodic payments to home health care providers, and
  - Overpayment for newborn claims that had been submitted with incorrect birth weights
- Administrative MCO costs including:
  - Overpaid MCOs in mainstream managed care premiums attributable to administrative costs and incorrect calculation of actuarial sound rates
  - Overpaid for services procured though a corporate affiliate that should have been classified as administrative costs
  - Overpaid due to un-allowed administrative costs included in rate structure
- Incorrectly identified providers as 340B providers, consequently, the drug claims that these providers had submitted were improperly excluded from the Medicaid Drug Rebate Program

My office is continuing projects that will be completed shortly including:

- Using data analytics to identify instances where per member per month payments continued to be made to the managed care plans while the Medicaid recipient was incarcerated. Any payments made while the recipient was incarcerated would be considered improper payments.

- Using data analytics to determine if the Louisiana Medicaid agency is obtaining valid data from the managed care plans that allow the agency and auditors to identify the actual provider who provided the service, the exact location of the service provided, and what organization was paid for the service. Without reliable provider information, further data analytic efforts to identify potential fraud, waste, and abuse is greatly hampered.

- Using data analytics to identify Medicaid recipients who are enrolled with a managed care plan but have not been provided any services for multiple years. This lack of utilization of services could identify recipients who are no longer living in the state, are now deceased, or are incarcerated. Also, to determine what outreach efforts the managed care plan is making to encourage preventative health care by the recipients.
- Using multiple state data sources to identify a potentially high-risk eligibility population to test the validity of state processes for determining initial eligibility and future renewals. Our project will determine whether state practices meet federal regulations, especially for income determinations.

New Approach to Auditing Federal Programs Is Needed

What I am proposing is the creation of a national, collaborative audit approach focused on reducing fraud, waste, abuse, and other improper payments. Such an approach may provide an immediate impact at both the federal and state levels and could offer a clear path to reducing Medicaid, SNAP, and TANF costs without reducing needed assistance to those served. This approach will build on infrastructure that already exists and it will build upon the successes some states have already achieved to enhance their audit capacity.

In addition to the hindrance of access to federal tax information, the state auditors also face budgetary challenges to properly fund these vital audit functions. Since many state auditors charge their client agencies for audits performed and attempt to keep audit costs at the lowest possible level, they are rarely able to do more than is minimally required.

I believe that a solution should be sought that establishes a national audit framework, directly funded with federal funds, that is focused on reducing fraud, waste, abuse and other improper Medicaid payments. Given the size of the program, I have no doubt it will result in a positive return on investment.

This concludes my prepared remarks and I, as well as Mr. Gooch are available to answer any questions you may have.