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It is an honor to share Oklahoma's perspectives and experiences on a critically important topic like program integrity in an ever-changing health care delivery environment. It is important to note that this testimony is that of only one state's program and is not made on behalf of other states or associations. Equally important is the acknowledgment that solutions offered here are not to the exclusive benefit of Oklahoma. This testimony highlights and reinforces the need for state flexibility rather than uniform mandates.

Oklahoma maintains is a dedication to the integrity of every aspect of our program. Recent changes have included improving the process for determining member eligibility, provider contracting and enrollment, claims payment, medical necessity, asset verification, or service verification.

Prior to the implementation of the Affordable Care Act, Oklahoma made investments toward developing the nation's first fully automated, real-time online enrollment system. Currently, two-thirds of Oklahoma's applications for Medicaid are received from a personal or public computer through our online system. When added to the applications from partners in the community on behalf of applicants, over 99% are being processed in real-time, through a rules-based decision engine. In addition to relieving a tremendous administrative burden, this system allows for real-time enrollment while strengthening the state's ability to verify reported information with various sources including: Social Security Administration; Department of Homeland Security; and Oklahoma Employment Security Commission.

Oklahoma's pride in its constant dedication to improving its program integrity is reflected in its payment error rate measurement (PERM). The PERM program is an audit conducted by CMS on a three-year rolling cycle to measure the accuracy of payments made for Medicaid covered goods and services. The audit takes into consideration member eligibility, provider eligibility and medical necessity. Oklahoma's most recent PERM audit identified a 0.24% payment error – the lowest amongst the 17 states within the same cycle. This success is a testament to an engaged provider services and training infrastructure, as well as Oklahoma's continual audits using PERM criteria during the interim between PERM audits.

Many of the issues being addressed during the upcoming hearing are issues that Oklahoma is facing, or has attempted to address in the past.

HR 1771

Since its creation, the statutes and regulations governing the Medicaid program have been amended numerous times, and now consist of complex, interrelated provisions that are often difficult to understand. One such area surrounds standards to prevent "spousal impoverishment." Unfortunately, individuals are now using court-recognized loopholes to transfer significant resources to a spouse, transfers that should disqualify them from Medicaid. There are primarily two statutes (42 USC § 1396p and 42 USC §1396r) that are being misused, which if not corrected conceivably could bankrupt Medicaid. States have denied applicants who are clearly above Medicaid's income and/or resource limits, only to have courts order the approval of such applications as a result of certain estate planning loopholes that they recognize are contrary to Medicaid's intended purpose, but can only be corrected by Congress.

Medicaid statutes allow the spouse of a Medicaid applicant for long-term care to keep a certain amount of his/her resources, so that he/she is not required to become impoverished before their spouse can receive care. The spouse of the applicant is referred to as the "community spouse," while the applicant is referred to as the "institutionalized spouse." The amount the community spouse is allowed to retain is called the community spouse resource allowance, or CSRA. In general, Medicaid will divide the couple's total resources in half to determine the CSRA.

The maximum amount of the CSRA is about $117,000, which is set by CMS. The maximum resource amount of the institutionalized spouse varies by state; in Oklahoma, it is $2,000. The resources exceeding the CSRA must be spent down in order for the institutionalized spouse to qualify for Medicaid.

Morris v. Ok. Dept. of Human Services is the seminal 10th Circuit decision, which directly impacts not only Oklahoma and five other states in the circuit, but has also been extended or relied upon in at least three other federal circuits and several state courts. The court's ruling essentially permits a married couple to shelter a potentially unlimited amount of assets, through the use of non-assignable, non-transferable annuities, in order for the spouse in need of medical care to qualify for Medicaid. In reversing the district court, the Court of Appeals stated: "**Although we understand the district court's concerns regarding the exploitation of what can only be described as a loophole in the Medicaid statutes, we conclude that the problem can only be addressed by Congress."**

Although the *Morris* case only involved the relatively small sum of $54,000, in the wake of that decision, other applicants have not surprisingly taken advantage of the court's ruling and have purchased similar annuities to shelter significantly greater assets. For example, in another

reported case (Jantzen), the couple sought to shelter approximately $215,000, forcing Oklahoma to pay for medical care for an individual who quite clearly is not one of Oklahoma's "neediest citizens" for whom Medicaid assistance was intended. Faced with budgetary constraints, it also means that Oklahoma was forced to divert funds that should have been used for others who truly are in need.

The rationale of the court's decision in *Morris* and similar cases has since been extended by courts in Oklahoma and by at least on 10th Circuit decision to other financial vehicles that similarly thwart Medicaid's intended purpose. In particular, we have seen a significant increase in the use of non-assignable, non-transferable promissory notes to shelter assets, which the courts have thus far condoned. The impact is the same: significant amounts of wealth can be protected, forcing the states to pay for medical care that the applicant would otherwise first be required to pay. In Oklahoma, applicants have attempted to use such tactics to shelter more than $1 million in resources, and have been used as a matter of routine in applications involving assets in the $250,000 to $600,000 range. These schemes are not unique to Oklahoma, and the abuse creates a strain on states' budgets, depleting Medicaid funds that are intended to assist the most vulnerable population.

The passage of H.R. 1771 would help stem the exploitation of Medicaid funds that the courts permit because they believe the law is not sufficiently clear. While it doesn't address the separate issue of promissory notes, the amendment would no longer allow annuities to be used as a vehicle to avoid Medicaid's 60-month look back period that restricts certain transfers of assets to determine the institutionalized spouse's Medicaid eligibility for long term care.

HR 2446

Oklahoma, like many other states, is no stranger to electronic visit verification (EVV) for personal care services. For a little over five years, our largest home and community-based services waiver has been using EVV technology that has proven to be very valuable. Simply stated, the benefit to employing these systems is three fold:

1) confirmation of service delivery reduces gaps in care plans and strengthens program integrity;
2) helps to assure member safety; and
3) saves money.

Through the first three years of the EVV system, Oklahoma had over a 5 to 1 return on its investment through resulting cost savings. There were definite lessons to be learned during implementation, which should be considered before scaling a program up to a level where it is mandatory. Consideration of how EVV systems will interact with claims payment and processing should be given priority in order to maintain solid program integrity. In addition, contingencies should exist to allow for technology issues that may arise so they can be handled without interrupting services.

HR 2339

The issue of lottery winnings was one recently identified and actions have already been taken at the state level in Oklahoma in order to prepare for potential changes at the federal level. Oklahoma House Bill 1619 directs the Oklahoma Lottery Commission to notify the Oklahoma Health Care Authority of lottery winnings up to a certain amount to verify a recipients continued

eligibility is appropriate. The state is aware that because of loopholes in calculating monthly income, it is possible for a member to not lose eligibility if the winnings are taken as a lump sum. Since people lose eligibility at the end of the month using the applicable ten day notice requirement, they would just have to apply at the beginning of the following month. In Oklahoma, with online enrollment a member could lose eligibility before midnight on the last day of the month and reapply at 12:01 a.m. the next day and receive it right back.

Possible eligibility without H.R. 2339 by using 10-day notice (Member with $1000 monthly income and $48,000 won in March)

Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Income	$1,000	$1,000	$49,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Eligible	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

With H.R.2339 (Member with $1000 monthly income and $48,000 won in March with winnings spread over 12 months)

Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Income	$1,000	$1,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000
Eligible	Y	Y	Y	N	N	N	N	N	N	N	N	N