Office of the Washington State Auditor
Pat McCarthy

Performance Audit

Reducing Costs through Faster Medicaid Income Verifications

October 10, 2017

This performance audit examined whether the Health Care Authority (HCA) could reduce spending on benefits for people who do not qualify for those benefits by more quickly verifying the income of Medicaid clients. HCA had a significant backlog of income verifications during fiscal year 2017. When the Affordable Care Act was implemented in 2014, Washington expected to enroll 237,000 new adults into Medicaid by the end of the year. HCA was funded to manage this expected caseload. However, actual enrollment of new adults was 511,000, more than double the expected enrollment.

Despite the higher-than-expected enrollment, the number of HCA staff conducting income verifications did not increase, resulting in a backlog of applications waiting for processing. This backlog contributed to slow verification processing times and resulted in ineligible clients receiving five months of benefits on average before coverage was stopped. In spring 2017, HCA significantly improved verification processing productivity, which will help reduce the backlog and the amount of benefits purchased for people who do not qualify.

The audit determined that HCA could further reduce the amount of benefits purchased for ineligible clients if it hires additional verification workers starting in July 2018. This would likely result in net state savings that total about $13 million for the two years ending June 2020. Because of funding restrictions, HCA will need a legislative appropriation to pay for these additional employees.

Report Number: 1019985

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Executive Summary

The Affordable Care Act (ACA) requires states to establish a streamlined, coordinated approach to enroll applicants into Medicaid, a federal program that provides health care to low-income people. The ACA allows states to verify an applicant's income before or after enrollment. Most states verify income before enrolling them, which helps these states avoid purchasing benefits for ineligible people. However, this may result in individuals not receiving health care at a critical time. Washington's Health Care Authority (HCA) verifies income after enrollment allowing clients to receive health care until HCA makes a final decision on eligibility. HCA receives more than 500,000 new Medicaid applications each year.

To determine initial eligibility for Medicaid, HCA relies on applicants to report their income. If that figure is under the federal income limit, HCA enrolls the applicant into Apple Health, Washington's Medicaid program. Verification then occurs in two stages. The agency verifies the applicant's income through automated comparisons to income data from the Employment Security Department (ESD) and the IRS. If these comparisons show the applicant's income exceeds the federal limit, HCA asks the applicant for more information. Based on the applicant's response, HCA decides whether to continue benefits. Historically, 23 percent of new applicants and 17 percent of renewing clients require this secondary manual verification of income.

While HCA is verifying income, the enrollee receives benefits. HCA stops purchasing benefits if the client's verified income exceeds the federal limit. Under federal program rules, the enrollee is not required to repay HCA for the benefits received. The state helps fund these programs and has an interest in containing Medicaid expenses.

This performance audit examined whether HCA can verify Medicaid client incomes more quickly to reduce the amount of benefits purchased for clients not eligible for benefits.

All states must verify the income of Medicaid clients. Because most states do this before they enroll clients into Medicaid, federal rules require verifications be completed within 45 days of application to ensure clients don't have to wait longer than that for benefits. States like Washington, which enrolls clients before confirming income, are not required to meet the 45-day standard.

In fiscal year 2014, when Medicaid expansion began, enrollment of new adults in Washington was more than double what was expected. But the number of HCA staff conducting income verifications did not increase. Consequently, HCA did not have sufficient staff to verify all new and renewing clients' income in fiscal years 2014 through 2016 as required. This resulted in HCA continuing to purchase benefits for ineligible clients until their incomes were eventually checked in the subsequent year's verification cycle.

To address the staffing deficiency, HCA improved its processes, so that by fiscal year 2017, it began verifying all clients' incomes. Nonetheless, it has had difficulty completing these verifications in a timely manner. For most of fiscal year 2017, HCA averaged more than 120 days to verify income. This resulted in an average of five months' benefits purchased for ineligible clients.

The use of "ineligible" in this report

A person's eligibility for a program is determined by factors such as age, family size and income. If HCA has questions about someone's income, and the applicant does not respond to those questions, HCA terminates benefits. In this report, we use the terms "ineligible" or "does not qualify" to mean both:

- Applicants whose income showed they were not eligible
- Applicants who failed to provide evidence of their income when asked and did not later reapply during the 20 months included in the data we used for this audit

More than half this time can be attributed to HCA's verification backlog. HCA's verification workers receive about 25,600 cases each month, and the backlog totaled about 112,000 cases as of June 2017. Because HCA did not have enough verification staff to process the volume of applications, and had not yet implemented changes to decrease its processing times, HCA purchased about $15.1 million to $19.2 million in state-funded benefits for people who ultimately did not qualify for benefits for fiscal year 2017.

In spring 2017, HCA significantly improved verification productivity rates through a Lean process improvement initiative, as shown in the graphic below. The higher productivity resulting from this initiative will gradually reduce the size of HCA's backlog and the amount of benefits it purchases for ineligible people starting in fiscal year 2018. Even with these improvements, the state faces delays and potential overpayments as HCA works through the backlog.

What is HCA's verification backlog?

This report considers all cases waiting to have client incomes verified under federal rules to make up the agency's verification backlog. For the purpose of managing its verification work, HCA defines "backlog" as cases that have awaited verification for more than 60 days.

During 2017, HCA made process improvements that increased the number of verifications processed each month

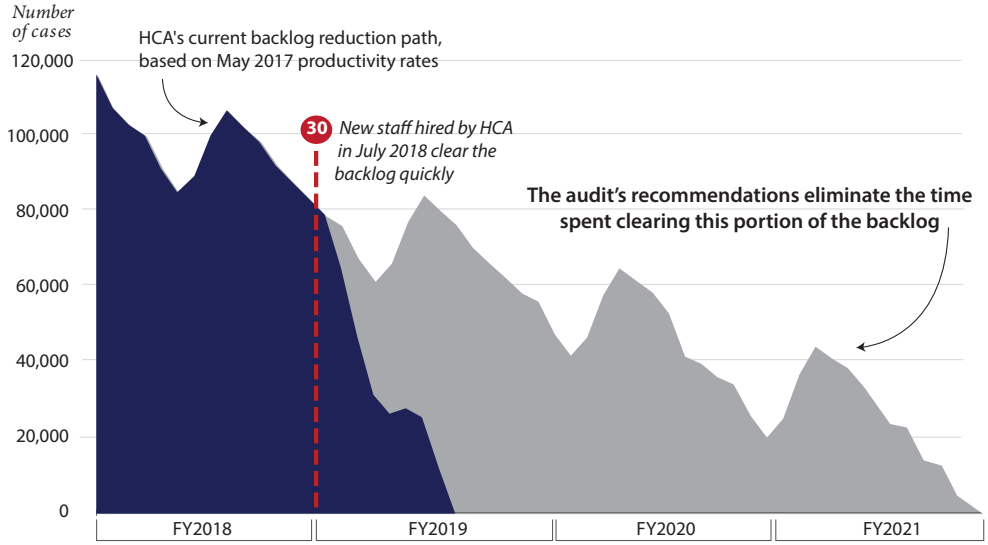
Source: Auditor analysis of data from HCA's verification management system.

HCA collects data measuring staff productivity at the aggregate staff level and at the individual employee level. However, HCA lacks formal performance benchmarks that would help managers evaluate staffing needs. HCA does not have eligibility verification quotas for individual staff.

With the improved productivity rate, it will take an estimated four years for HCA to clear the backlog at its current staffing. If the Legislature funds additional verification staff starting in July 2018, HCA could eliminate its backlog by spring 2019, which would likely result in net state savings (after additional staffing costs) that total about $13 million during the two years ending June 2020.

The graphic at right shows the significantly quicker reduction in the backlog achieved by adequate staffing levels and HCA's improved productivity rate. The agency will need to work with the Legislature to fund these additional workers.

By following audit recommendations, HCA could eliminate its backlog by second half of fiscal year 2019, saving about $17 million over two years



Source: Auditor analysis of data from HCA's verification management system.

Additionally, by formalizing its policies, HCA could reassure the state that the cleared backlog of cases will not return, as long as it has adequate funding.

HCA could achieve additional savings by prioritizing those cases with the highest cost to the state while it continues to work through its backlog. This method may require approval from Centers for Medicare and Medicaid Services (CMS).

Recommendations

To reduce the verification backlog, processing time and the benefits purchased for ineligible clients, we recommend the Health Care Authority:

1. Add verification staff. This will require HCA to:
   - Obtain more office space to house these new workers
   - Work with the Legislature to obtain the necessary funding for additional staff and office space
2. Work with the union representing verification workers to establish written performance benchmarks, which would improve management of verification staffing levels and individual staff performance
3. Work with CMS to identify options to prioritize verifications on clients in programs with larger state-funded premiums while working through the backlog

We recommend the Legislature:

1. Provide HCA with funding in fiscal year 2019 to increase the number of agency verification staff

Introduction

The Affordable Care Act (ACA), enacted by Congress in 2010, allowed states to offer Medicaid coverage to more people. When the ACA was implemented in 2014, Washington's Apple Health program expanded to include 600,000 low-income adults, in addition to the nearly 1 million participants that consisted primarily of women, children, adults with dependent children, and disabled adults. Initially, federal funds paid the full cost for the new enrollees. Starting in fiscal year 2017, the state paid 5 percent of the new costs. The ACA requires the state's portion to rise to 10 percent in 2020.

In light of the Legislature's duty to fully fund basic education while also beginning to bear an increasing share of Medicaid expansion costs, some legislators wanted to ensure that Apple Health controlled unnecessary expenses. Legislators and staff said they supported an audit that explored whether it was possible to reduce spending on benefits for people who do not qualify.

This performance audit examined how the Health Care Authority (HCA) verifies Medicaid client income to answer this question:

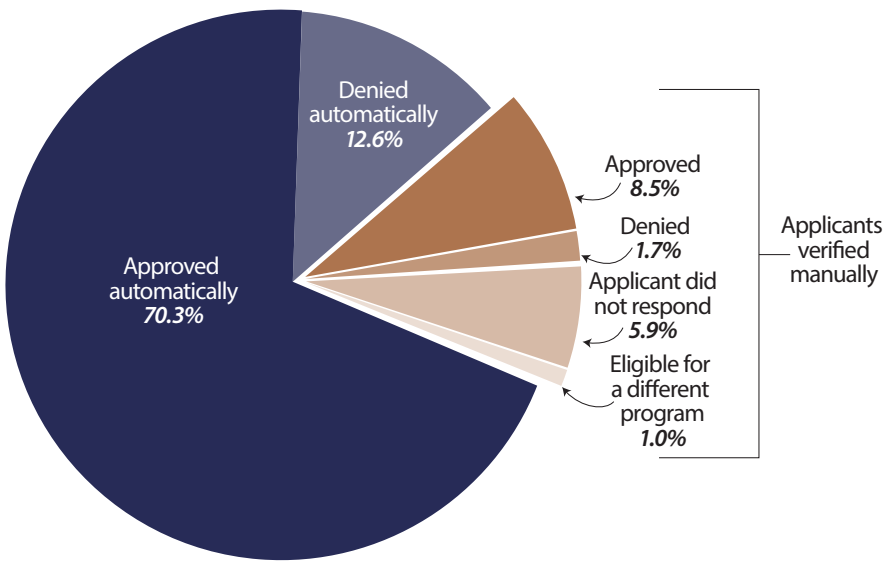
- Can HCA reduce spending on medical coverage benefits for people who do not qualify for those benefits by more quickly verifying the incomes of Medicaid clients?

Washington verifies the income of Medicaid applicants after starting coverage for them

Under the ACA, states must take a coordinated and streamlined approach to eligibility and enrollment processes for Medicaid. The ACA allows states to verify income either before or after enrollment. Washington has chosen to verify income after enrollment, covering clients until it can make a final decision on eligibility. Verifying income quickly can minimize benefits purchased for people later determined to be not eligible.

In Washington, HCA enrolls new Medicaid applicants based on self-reported income. If this self-reported income meets eligibility standards, HCA enrolls the applicant into Apple Health. Verification then occurs in two stages (illustrated in **Exhibit 1**). First, HCA's automated system compares the self-reported income with income data from the Employment Security Department (ESD) and the IRS. In most cases, the income is confirmed and the client stays in Apple Health. If these data sources show the income exceeds the threshold for coverage, HCA verifies the information manually by checking other sources and possibly requesting more information from the applicant. Based on the results of these checks, HCA determines whether to continue benefits.

Exhibit 1 – About 17% of applications are manually verified by an HCA employee



Source: Auditor analysis of data from HCA's verification management system.

Uncertainty about the ACA's future may make the audit's recommended cost avoidance measures even more important

Washington received about $2.7 billion in federal funding for Apple Health expansion in fiscal year 2017. If Congress repeals or reduces the ACA's expansion of Medicaid to uninsured adults, the state could face significant costs if it were to continue to offer this expanded coverage at its own expense. The measures recommended in this audit would help HCA minimize these costs.

Background

Each year, Washington receives more than $4 billion in federal funds and contributes nearly $1.2 billion in state matching funds to support various Medicaid programs that have income-based eligibility rules serving about 1.4 million clients. These amounts exclude Medicaid programs that are based on other eligibility criteria, such as disability, which were not examined as part of this audit. The Affordable Care Act (ACA) gives states significant flexibility in determining their Medicaid eligibility verification policies and procedures. Regardless of the approach, states verify applicants' self-reported income by reviewing electronic data through various federal, state and private sources. More than 40 states verify income before enrolling applicants, while the remaining states, including Washington, verify income after enrollment (listed in **Exhibit 2**).

The advantage of verifying income before enrollment is that states avoid purchasing benefits for people who don't qualify. However, this may result in individuals not receiving health care at a critical time.

Washington chose its verification approach after considering various stakeholder views and the drawbacks to pre-enrollment verification. Pre-enrollment verification would delay access to care for eligible clients. Even if HCA decided to pursue this policy, because its current application system enrolls Medicaid clients based on self-attested income, such a change would also require a substantial effort to modify its IT environment.

Exhibit 2 – States that verify incomes after enrollment

Colorado
Delaware
Hawaii
Montana
New Hampshire
Oklahoma
Vermont
Washington

Size of HCA's verification staff and its primary focus

HCA has about 145 verification workers. These employees spend about 60 percent of their time working on income verifications. The rest of their time is spent answering client questions and verifying other Medicaid eligibility factors. New staff members require four weeks of training before they can process income verifications.

HCA verifies new and existing Medicaid applicants' incomes to ensure they are eligible for benefits

HCA determines a new applicant's initial Medicaid eligibility based on self-reported income. If the income meets federal eligibility standards, HCA enrolls the applicant into Apple Health. If the income exceeds the federal standard, HCA initiates steps to stop Medicaid coverage and advises clients to purchase health insurance on the state's Health Benefits Exchange.

After enrolling the client, HCA compares the reported income to wage data from the Employment Security Department (ESD) and the IRS. If that comparison triggers questions about the client's eligibility, HCA checks other sources and may ask the client to provide information, such as pay stubs, that demonstrates eligibility.

Enrollee income limits

For new adult enrollees, the federal limit is set at 133 percent of the federal poverty level.

The limit for pregnant women is 193 percent.

About 23 percent of new applicants and 17 percent of renewals trigger additional reviews. While HCA is verifying income, the client continues to receive benefits. In the event that HCA terminates benefits because income exceeds the federal limit, an enrollee is not required to repay HCA for any benefits received. New Medicaid applicants make up a little less than half of the verifications that HCA performs. HCA also verifies the incomes of existing Medicaid clients annually to determine whether to continue benefits for another year. The ineligibility rates resulting from these reviews of new and renewing clients average about 35 percent, including those who fail to respond.

Consistent with Centers for Medicare and Medicaid Services (CMS) rules, HCA starts verifying a client's ability to renew Apple Health coverage about 60 days before annual benefits expire. If ESD and IRS records support a client's continued eligibility, HCA will auto-renew their coverage for the next year. Otherwise, clients have to manually renew their coverage and self-report their current income, which is then manually verified. Both clients who auto-renew and clients who need to manually renew receive renewal letters letting them know what information HCA has on file for their household.

HCA has a verification backlog, which affects how quickly the agency verifies client income

When the ACA was implemented in 2014, Washington expected to enroll 237,000 new adults into Medicaid by the end of the year. HCA was funded to manage this expected caseload. Actual enrollment of new adults was 511,000, more than double the expected enrollment. Despite the higher than expected enrollment, the number of HCA staff conducting income verifications did not increase. Consequently, HCA did not verify all new and renewing clients' income in fiscal years 2014 through 2016 as required by federal rules. Instead, HCA prioritized the new adults covered under the ACA's Medicaid expansion in fiscal year 2015, then added other groups over the next one and a half years until all clients were verified starting in fiscal year 2017.

HCA's verification staff receives about 25,600 new and renewing clients each month that require income verification. The verification backlog totaled more than 112,000 applicants in June 2017. Although most states are required to conduct their income verifications within 45 days because they do not enroll clients until the verification is complete, HCA's processing times are significantly longer due to the backlog, which was produced by unexpectedly high enrollment. Consequently, HCA purchases more months of benefits for people with ineligible incomes before ending those benefits.

Scope & Methodology

This performance audit sought to identify ways that the Health Care Authority (HCA) could verify Medicaid clients' incomes faster to reduce the amount of medical coverage benefits purchased for people with ineligible incomes. To conduct this performance audit, we reviewed HCA's verification manual and its Centers for Medicare and Medicaid Services (CMS) approved verification plan. We also analyzed data for fiscal years 2016 and most of 2017:

- *Data from HCA's verification management system.* Verification workers use this system to manage their new and renewing verification caseloads.
- *Rates, workload volume and the timing of that workload.* Auditor's efforts to verify the accuracy and completeness of this data was limited to inquiring about the reasons for unusual workload fluctuations between fiscal years 2016 and 2017.

We interviewed HCA managers responsible for verifying client's incomes and HCA's counterparts in other states. We compared HCA's verification processing times and approaches to those of other states. We also considered information from other states to see if reducing the number of days clients have to respond to inquiries about their eligibility would be useful. We found this approach would yield little cost savings to the state and did not pursue it further.

We used statistical software to determine how much Washington will spend on benefits for ineligible recipients in the coming years, then created alternate scenarios in which cases were prioritized differently and/or more workers were hired. We compared these scenarios to the status-quo forecast and calculated the expected savings.

Audit performed to standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with Generally Accepted Government Auditing standards (December 2011 revision) issued by the U.S. Government Accountability Office. 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. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains more information about our methodology.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the State Auditor's Office will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (**www.leg.wa.gov/JLARC**). The State Auditor's Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion.

Audit Results

This performance audit sought to answer the following question:

- Can the Health Care Authority (HCA) reduce spending on benefits for people who do not qualify by more quickly verifying the incomes of potential Medicaid clients?

HCA can reduce its purchases of Medicaid benefits for people who do not qualify by hiring more verification workers and maintaining current process improvements.

During state fiscal year 2016 and most of fiscal year 2017, HCA had too few verification staff and a significantly lower verification productivity rate than exists today. This prevented HCA from performing all of the Medicaid income verifications that the Centers for Medicare and Medicaid Services (CMS) required, or from performing them in a timely manner. Although HCA's verification workers receive about 25,600 cases each month, the backlog totaled about 112,000 cases as of June 2017. This large backlog resulted in people who did not qualify receiving on average about five months of benefits before those benefits were discontinued. Consequently, HCA purchased about $15.1 million to $19.2 million in benefits for people who did not qualify in fiscal year 2017, an amount that could have been avoided if the agency was fully staffed.

In spring 2017, HCA undertook a major review of the income verification process. The agency made changes and nearly doubled the 15,000 monthly verifications that HCA previously averaged. This should reduce the amount of benefits HCA purchases for people who do not qualify beginning in fiscal year 2018. Although HCA now verifies about 27,400 cases a month, exceeding the average monthly incoming caseload of 25,600, it will take about four years to eliminate the backlog with the current number of employees. However, if HCA hires 30 additional verification workers and additional managers to supervise them starting in July 2018, while maintaining current productivity levels, the backlog could be eliminated by spring 2019. This would likely result in net state savings that total about $13 million (after accounting for the cost of staff) for the two years ending June 2020.

If followed, the recommendations resulting from this audit can expedite elimination of the backlog, improve processing time, and reduce the amount of benefits purchased for people who do not qualify.

Starting in fiscal year 2017, HCA verifies all new and renewing clients as required by CMS

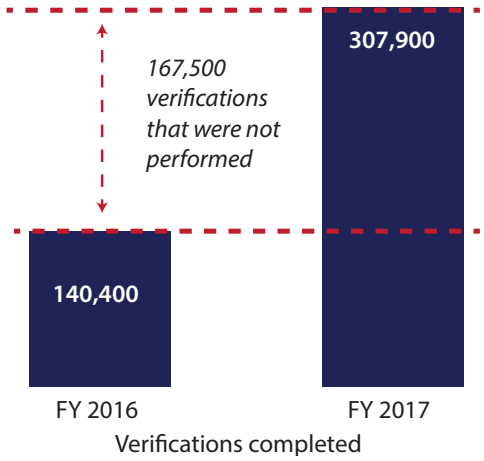
Before and after the passage of the Affordable Care Act (ACA), CMS required states to take additional manual procedures to verify income for all clients if the Employment Security Department (ESD) and other electronic income databases show clients may have incomes that exceed Medicaid income limits. CMS also requires states to verify the income of all existing Medicaid clients annually.

Although HCA now verifies income for all new and renewing clients, it did not do so consistently until fiscal year 2017. When the ACA was passed, the agency had too few verification staff and a lower productivity rate than needed to complete all required verifications. Since then, HCA has identified inefficiencies and initiated process improvements, as well as identified additional funding for short-term staff increases.

Exhibit 3 compares the number of applications verified by HCA in fiscal year 2016 with the number estimated for fiscal year 2017. This comparison shows HCA did not verify about 167,500 client incomes during fiscal year 2016. Consequently, HCA likely purchased more than 12 months of benefits for about 35 percent of these 167,500 clients who were not eligible until their incomes were eventually checked in the following year's verification cycle.

Exhibit 3 – HCA did not verify all clients' incomes in FY 2016, but did in FY 2017

FY 2017 verifications include projected data for May and June



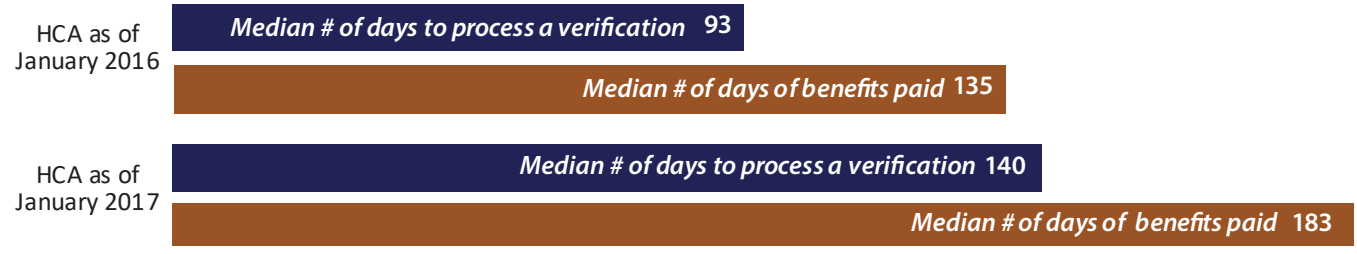
Source: Auditor analysis of data from HCA's verification management system.

Until very recently, HCA had a growing verification backlog, which prolonged benefits for ineligible clients

Exhibit 4 shows how HCA's verification processing time increased from January 2016 to January 2017 and how the average number of days of benefits purchased for people who did not qualify also increased.

Exhibit 4 – Longer verification times result in more days of benefits purchased for ineligible people

January 2016 compared to January 2017



Source: Auditor analysis of data from HCA's verification management system.

HCA responded to the backlog by taking steps that significantly improved verification productivity

To address its backlog, HCA recently analyzed its verification process and significantly improved the number of verifications staff can perform. A process-improvement workgroup revealed that HCA could reduce processing times by about 40 percent by eliminating unnecessary steps. For example, HCA could stop calling clients prior to sending a letter requesting documents for income verification. The workgroup concluded these calls did little to help complete reviews. **Exhibit 5** shows the extent of this improvement, based on 145 employees spending 60 percent of their time on income verifications.

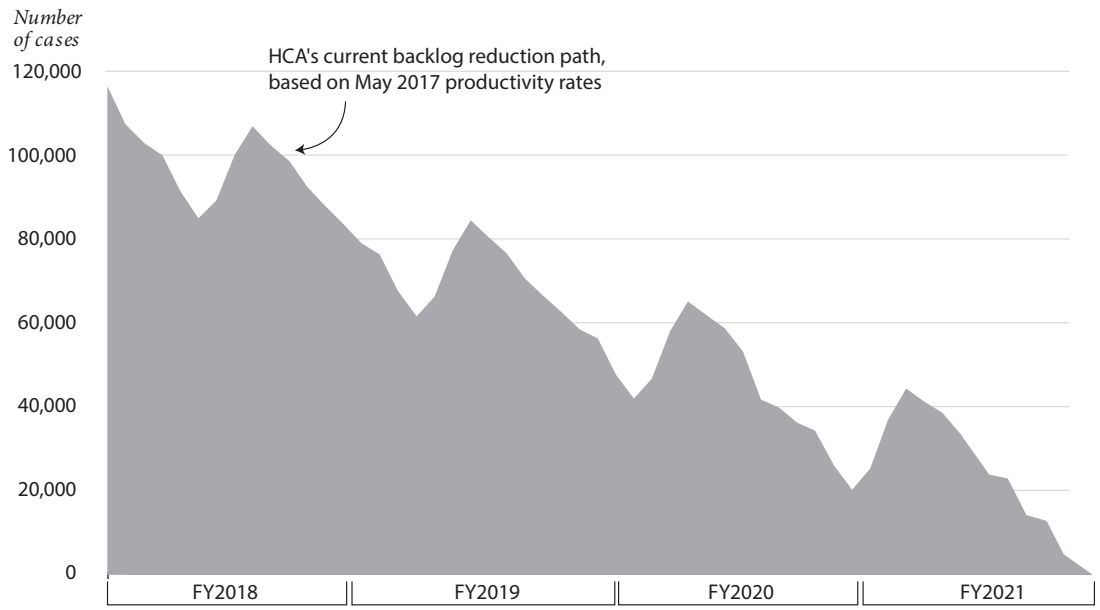
Exhibit 5 – During 2017, HCA made process improvements that increased the number of verifications processed to exceed average incoming workload

Process improvements implemented April-May 2017

Source: Auditor analysis of data from HCA's verification management system.

With its new process, HCA now completes about 1,800 more verifications each month than it receives. The difference between HCA's verification productivity and its incoming workload means HCA can now start to gradually reduce its backlog. However, without more staff, HCA's verification backlog will persist for about four years. **Exhibit 6** shows the estimated drop in HCA's backlog through October 2021 assuming no employees are added.

Exhibit 6 – The recently improved verification rate will help HCA eliminate its backlog by fall 2021



Source: Auditor analysis of data from HCA's verification management system.

HCA's improved verification productivity significantly reduced its future risk of repayment to CMS

CMS requires states to conduct reviews that assess the accuracy and timeliness of their eligibility determination processes. After the ACA was passed in 2010, these assessment and reporting requirements were temporarily suspended. Starting in federal fiscal year 2018, they will be re-established and subject to audit. HCA took three additional steps to hasten the reduction of the backlog and benefits purchased for people who do not qualify:

- *Hiring temporary employees.* During the first half of 2017, HCA used some limited discretionary funds to hire 20 temporary verification staff through June 2017. This was an important first step, but HCA needs more workers to fully address the backlog.
- *Building a new information system that allows workers to better manage workload.* The old system gave HCA staff monthly downloads of cases. The new system allows verification staff to receive new cases daily, and filters out cases if staff have already verified the client's income, helping prevent duplicative activity.
- *Assessing whether to automate the use of a third-party employment and income verification database.* This database provides HCA with up-to-date employment information for some clients. Verification workers now check this database one case at a time. Automating its use so cases are compared against the database in batches would result in further improvements to HCA's verification productivity and reduce the number of additional verification workers needed.

The audit identified additional steps HCA could take

In addition to the internal improvements HCA has made, the agency should:

- Hire more verification staff
- Formalize expectations for processing times
- Prioritize income verifications on programs that cost the state the most money

Hiring more verification staff would help HCA eliminate its backlog more quickly and achieve net state savings that likely total about $13 million for the two years ending June 2020

Because of the lower verification productivity rates HCA had for most of fiscal year 2017, and because the agency had too few verification staff to confirm the incomes of new and renewing clients, HCA purchased about $15.1 million to $19.2 million in avoidable state-funded benefits for people with ineligible incomes in fiscal year 2017 (not considering the cost of additional staff).

Improvements made by HCA should reduce the amount of benefits HCA purchases for ineligible persons in fiscal year 2018. HCA can achieve further reductions in fiscal years 2019 and 2020 by increasing the number of verification staff. **Appendix B** describes the basis for the estimated amount of possible avoidable spending.

More verification staff would help HCA achieve further savings for both the state and the federal government. Although the audit found that HCA now has enough verification staff to keep up with incoming caseload, without further improvements to the verification productivity rate, the agency cannot eliminate the backlog before June 2020. Unless it hires 30 more verification staff and additional managers to supervise them, HCA will spend an estimated $110.2 million more on Medicaid benefits for people with ineligible incomes for the two years ending June 2020. **Exhibit 7** shows the state- and federally-funded portions of these avoidable benefits.

Exhibit 7 – Estimated avoidable benefits for two years ending June 2020 assuming HCA hires more verification workers

Federal	$93.6 million
State	$16.6 million
Total	$110.2 million

Note: Avoidable benefits above assume HCA maintains current verification productivity rates.

Source: Auditor analyses of data from HCA's verification management system.

If HCA hired additional verification workers starting in July 2018, the backlog could be eliminated by spring 2019 and the agency could avoid spending an estimated $16.6 million in state-funded benefits and $93.6 million in federally-funded benefits. **Appendix C** details the hiring schedule. Due to restrictions in how HCA can use existing funding, the agency would require a $1.5 million legislative appropriation to pay for these added workers. Because Medicaid benefits are provided through managed care policies, the state would also see a reduction in its 2 percent tax on premiums. **Exhibit 8** shows the net costs the state could avoid during the two years ending June 2020 if HCA hires the additional workers.

Exhibit 8 – Estimated net state savings for two years ending June 2020 assuming HCA hires more verification workers

Avoidable benefits	$16.6 million
Less necessary state-funded staffing costs	($1.5 million)
Less reduction in 2% premium tax	($2.2 million)
Net state savings	$12.9 million

Note: Avoidable benefits above assume HCA maintains current verification productivity rates.

Source: Auditor analyses of data from HCA's verification management system.

HCA will need to house new verification staff. HCA does not currently have office space for new verification workers and will need to find additional space before hiring more employees. Our estimates include HCA's projected costs for office space. HCA management said the amount of space it needs could be reduced by allowing more seasoned verification staff to telework.

Formalizing expectations for processing times would help HCA better manage verification staff's performance

As recognized by HCA managers, HCA needs high-quality information to manage staffing levels and performance. HCA implemented an improved verification tracking system in 2016, which provides managers with higher-quality performance information. HCA has not yet adopted a formal performance benchmark for its verification staff, such as the number of expected monthly verifications. Such benchmarks are key to encouraging continuous process improvement and to holding staff accountable. HCA is moving cautiously so it does not set the benchmark too low as it works through process improvements. HCA said changes to employee performance measures can only be done through the collective bargaining process.

Prioritizing income verifications on programs with the highest cost to the state could result in further savings

Agency officials said staff prioritize some types of cases, but for the most part, they verify client incomes on a first-received, first-processed basis. Because some Medicaid programs have a significantly higher state match than others, further prioritization may offer more opportunities to avoid spending on benefits for ineligible clients. For example, coverage for pregnant women has a monthly state match of nearly $500 per client, while the match for Medicaid-expansion adults is less than $20.

Moreover, the ineligibility rates among those undergoing manual verification differ significantly depending on the program and client type. For example, one program has an ineligibility rate of less than 10 percent for renewing clients who are manually verified, while another has an ineligibility rate of more than 50 percent for new clients who are manually verified. Focusing on those programs with state match and ineligibility rates that result in the highest cost to the state while working through the backlog would allow HCA to avoid additional benefits estimated at more than $9.8 million for the three years ending June 2020.

This approach may require approval from CMS, as prioritizing state funds would reduce the $93.6 million in federal savings shown in Exhibit 7.

Recommendations

The Health Care Authority (HCA) has significantly improved the operations in its Medicaid verifications office during the past six months. These improvements by themselves do not yield the full potential of cost savings identified through this performance audit.

To reduce the verification backlog, processing time and the benefits purchased for ineligible clients, we recommend HCA:

1. Add verification staff. This will require HCA to:
   - Obtain more office space to house these new workers
   - Work with the Legislature to obtain the necessary funding for additional staff and office space
2. Work with the union representing verification workers to establish written performance benchmarks, which would improve management of verification staffing levels and individual staff performance
3. Work with CMS to identify options to prioritize verifications on clients in programs with larger state-funded premiums while working through the backlog

We recommend the Legislature:

1. Provide HCA with funding in fiscal year 2019 to increase the number of agency verification staff

Agency Response

STATE OF WASHINGTON

October 9, 2017

The Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office (SAO) performance audit report, *Reducing Costs through Faster Medicaid Income Verifications*. The Health Care Authority (HCA) worked with the Office of Financial Management to provide this response.

We appreciate SAO's recognition that over the past few years HCA has effectively implemented process improvements to manage the unexpected volume of people who applied for health care benefits under the federal Affordable Care Act. We particularly appreciate SAO's willingness to constantly adjust its analyses to adapt to the ever-changing, continuously improving results HCA provided throughout the audit.

As this report illustrates, HCA has been able to leverage existing resources to significantly decrease the backlog of cases requiring a manual eligibility review. Staff completed almost twice as many post-eligibility reviews in FY 2017 as they did in FY 2016. Because the results have been so successful, we believe we can eliminate the backlog of cases waiting verification for more than 60 days with about half the additional FTEs that the audit estimates we need.

We agree with the SAO's conclusion that completing post-enrollment eligibility reviews sooner will result in savings for Washington state. We are less certain about how much savings there will be. It is unclear whether the 5.9 percent of applicants who failed to respond to our request for additional information met income requirements during the period they received benefits. We do know that we re-enroll people who contact us once they realize their benefits have ended.

The most recent data shows that 94.2 percent of Washington state residents have health insurance. The Health Care Authority provides Medicaid/CHIP benefits to 1.9 million of those residents, including the 1.5 million residents classified as non-elderly and non-disabled residents in this report. We are proud to provide the benefits as quickly as we do.

We are committed to providing high-quality free or low-cost health care to all eligible residents and will continue to make that our first priority as we identify and implement improvements to the eligibility determination process.

Sincerely,

Lou McDermott
Acting Director
Health Care Authority

David Schumacher
Director
Office of Financial Management

cc: David Postman, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
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OFFICIAL STATE CABINET AGENCY RESPONSE TO THE PERFORMANCE AUDIT ON REDUCING COSTS THROUGH FASTER MEDICAID INCOME VERIFICATIONS

OCTOBER 9, 2017

This coordinated management response to the State Auditor's Office (SAO) performance audit report received September 25, is provided by the Office of Financial Management and the Health Care Authority (HCA).

SAO PERFORMANCE AUDIT OBJECTIVES:

The SAO designed the audit to answer:

1. Can the Health Care Authority verify Medicaid applicants' incomes faster to reduce the amount of benefits purchased from insurance companies for people with ineligible incomes?

SAO Findings:

1. Hiring more verification staff would help HCA eliminate its backlog more quickly and achieve net state savings that likely total about $13 million for the two years ending June 2020.
2. Formalizing expectations for processing times would help HCA better manage verification staff's performance.
3. Prioritizing income verifications on programs with the highest cost to the state could result in further savings.

SAO Recommendation 1: Add verification staff. This will require HCA to work with the Legislature to obtain the necessary funding for hiring people and leasing additional office space.

STATE RESPONSE: HCA agrees with the recommendation and is taking steps to increase staffing.

Action Steps and Time Frame

- Using unexpected savings generated from staff taking leave without pay, HCA hired several non-permanent staff to focus solely on income verifications. We anticipate these staff continuing until June 30, 2018. *Hiring completed by 9/1/17.*
- HCA will submit a 2018 supplemental budget request for additional staff to complete income verifications. *By 10/9/17.*

SAO Recommendation 2: Work with the union representing verification workers to establish written performance benchmarks, which would improve management of verification staffing levels and individual staff performance.

STATE RESPONSE: HCA agrees with the recommendation for performance benchmarks. While HCA does not have union-approved production standards, leadership does monitor staff work

performance to ensure quality and quantity. Before developing workload standards, HCA wants to confirm workload processes are stabilized to help ensure accurate production standards.

Action Steps and Time Frame

- Continue to monitor work performance to ensure quality and quantity. Develop performance expectations for staff. *By 11/2018*

SAO Recommendation 3: Work with Centers for Medicare & Medicaid Services (CMS) to identify ways to prioritize verifications on clients in programs with larger state-funded premiums while working through the backlog.

STATE RESPONSE: HCA agrees with the recommendation and will work with CMS to explore prioritization options.

Action Steps and Time Frame

- Conduct an analysis of General Fund dollars expended per coverage group to identify possible savings. *By 6/30/18.*
- Develop prioritization proposal. *By 8/30/18.*
- Present proposal to CMS. *By 9/30/18.*

SAO Recommendation 4 to the Legislature: Provide HCA with funding in fiscal year 2019 to increase the size of agency verification staff.

STATE RESPONSE: Not applicable.

Appendix A: Initiative 900

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments. Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Audit Results section of this report.

I-900 element		Addressed in the audit
1.	Identify cost savings	**Yes.** The audit identified ways to reduce the amount of benefits purchased for ineligible people.
2.	Identify services that can be reduced or eliminated	**Yes.** The audit identified ways to reduce the amount of benefits purchased for ineligible people.
3.	Identify programs or services that can be transferred to the private sector	**No.** Evaluating options for privatization was not within the audit scope.
4.	Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**Yes.** The audit analyzed a growing backlog of client income verifications. The audit determined that HCA has too few verification staff to verify all applicants' incomes in a timely manner.
5.	Assess feasibility of pooling information technology systems within the department	**No.** Evaluation of pooling IT systems was not within the audit scope.
6.	Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**Yes.** The audit recommends increasing the number of workers who conduct income verifications.
7.	Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**No.** Statutes and administrative rules that specify when benefits start do not require modification. Administrative rules around income verification do not require modification. However, the audit does recommend that the Legislature provide funding for HCA to increase the size of its verification staff.
8.	Analyze departmental performance data, performance measures and self-assessment systems	**Yes.** HCA implemented an improved verification tracking system in 2016, which provides managers with higher-quality performance information. The audit determined that HCA has not established formal performance targets for its verification staff and management.
9.	Identify relevant best practices	**Yes.** We compared HCA's processing times to California's.

Appendix B: Methodology

To conduct the audit analysis, we obtained HCA verification management system data showing the number of cases received and verified by HCA's verification staff during fiscal years 2016 and 2017. To determine whether this data was complete, we:

- Compared fiscal year 2016 data to fiscal year 2017 data.
- Identified significant fluctuations in the quantity of cases received and verified.
- Obtained explanations for why the number of cases received and verified in fiscal year 2016 were significantly lower than those received and verified in fiscal year 2017.

Forecasts prepared by the Caseload Forecast Council (CFC) were used to estimate future Medicaid caseload. Our Office's methodologist reviewed the CFC's approach to develop those forecasts and considered it reasonable for audit purposes. We did not use statistical forecasting methods similar to those used by the CFC to estimate caseload through fiscal year 2020 or to estimate the workload of HCA's verification unit (known as MEDS). Since we anticipated substantial savings and our projections were short-term, methodologies that are more precise were not necessary to demonstrate that savings will exceed additional staffing costs.

We generated a hypothetical MEDS workload for June 2017 through June 2020. To create this dataset, actual case records processed by MEDS from each month in fiscal year 2017 were copied to a new database, then date fields were adjusted to reflect future Medicaid applications and renewals. To ensure the number of cases for each future month was proportionate to the forecasted caseloads generated by the CFC (given the historical percentage of Medicaid cases that have been sent to the MEDS unit for further review), we duplicated the entire set and then randomly selected records to delete. This hypothetical dataset reflects the seasonal variations in applicant types (such as more Medicaid expansion clients during Washington Health Benefit Exchange's open enrollment months and more children around the opening and closing of the school year). The CFC forecasts project Medicaid caseload only through June 2019. To extend the hypothetical Medicaid caseload and MEDS workload through June 2020, we assumed fiscal year 2020 would have month-to-month variations and growth rates similar to the CFC projections for fiscal year 2018.

At the beginning of each day, cases are sorted and assigned to MEDS staff for review according to priority. We ran several simulations against the hypothetical MEDS' workload dataset. Each simulation determined which cases to process each day for the next 1,157 days under a variety of different scenarios. We used five different priority schemes across our simulations:

- Prioritizing pregnancy cases and handling all other cases as first-in, first-out. This is how MEDS currently prioritizes cases.
- Prioritizing cases by likely *cost to the state* in incorrect benefits, using medical coverage group (applicant type) to determine the likely cost
- Prioritizing cases by likely *cost to the state* in incorrect benefits, using medical coverage group and whether the case is an application or renewal to determine the likely cost.
- Prioritizing cases by likely *total cost* (state plus federal) in incorrect benefits, using medical coverage group to determine the likely cost
- Prioritizing cases by likely *total cost* in incorrect benefits, using medical coverage group and whether the case is an application or renewal to determine the likely cost.

The simulation determines which cases to assign to MEDS workers each day based on the number of workers available and the prioritization scheme. Once a case is assigned, the simulation determines when it will close and quantifies the benefits paid for ineligible recipients. We used historical percentages to determine the probability of a future case being determined ineligible.

How the number of employees affects the backlog

To determine the number of verification workers required, we increased the number of workers until the backlog was eliminated, then reduced the number of workers as needed to keep up with ongoing demand. We first ran a scenario based on the current staffing level and prioritization method. We then ran each scenario based on either increased staffing starting next fiscal year (July 2018) or phased-in staffing after July 2018. All other scenarios were compared to the status quo scenario to determine the amount of avoidable benefits to ineligible persons, the increased staff cost and the net savings.

The calculations reflect anticipated future changes in state-federal match for Medicaid premiums, but do not reflect the cost of living wage increase for state employees approved by the Legislature in 2017. The size of the cost of living increase is small in comparison to the estimated savings, so even if our calculations were adjusted, anticipated savings will still exceed increased staffing costs.

Assumptions made for these analyses

The accuracy of these estimates is limited by several assumptions. If any of those assumptions are altered, the actual achieved staffing cost and/or benefit savings may be affected. These assumptions include:

- Current policy and law remain unchanged by HCA, the state Legislature, Congress or federal agencies
- The CFC's forecast of Medicaid expansion and traditional Medicaid populations is correct, and the case mix and monthly fluctuation patterns in caseload size for future Medicaid populations will be similar to the fiscal year 2017 population
- The increased productivity rate achieved by the MEDS unit in May 2017 will be maintained over time
- The type and percentage of future cases sent to the MEDS unit will be similar to fiscal year 2017
- The number of cases sent to the MEDS unit is directly proportional to the projected Medicaid caseload size
- The likelihood of a particular case type being determined ineligible will not change

Appendix C: Current vs Proposed Staffing Alternatives

Figure 1 shows two staffing alternatives, the current HCA model and one proposed in this audit. The latter can help the agency achieve $16.6 million in avoidable benefits for the two years ending June 2020, but would require HCA to hire more verification workers. Although not shown in the table, HCA can also avoid a much smaller amount of benefits from July 2020 through October 2021.

The 91 FTEs shown in the "HCA current model" column reflect the portion of time that 145 verification employees work on *income* verifications. The 121 FTEs in the "Auditor-proposed alternative" column reflects the addition of 30 staff who would work solely on *income* verifications. This number does not reflect the additional managers that would be hired as well.

Figure 1 – HCA's current staffing model compared to the auditor-proposed model

	HCA's current model		Auditor -proposed alternative	
Month	Estimated backlog	Staffing model	Estimated backlog	Staffing model
July 2018	76,262	91	76,262	91
August 2018	73,707	91	64,624	121
September 2018	65,363	91	47,220	121
October 2018	59,527	91	32,301	121
November 2018	63,946	91	27,660	121
December 2018	74,664	91	29,295	121
January 2019	81,490	91	27,038	121
February 2019	77,489	91	13,965	121
March 2019	73,983	91	1,376	121
April 2019	68,252	91	0	121
May 2019	64,257	91	0	121
June 2019	60,266	91	0	121
July 2019	56,440	91	0	121
August 2019	54,256	91	0	121
September 2019	46,143	91	0	121
October 2019	40,504	91	0	121
November 2019	45,109	91	0	121
December 2019	56,046	91	1,854	121
January 2020	62,978	91	0	121
February 2020	59,590	91	0	81
March 2020	56,641	91	0	81
April 2020	51,342	91	0	79
May 2020	47,828	91	0	79
June 2020	44,269	91	0	79
			Additional state-funded staff costs: $1.5 million	
			State-funded benefits avoided: $16.6 million	

Note: The number of FTE employees in the auditor-proposed staffing model excludes supervisory staff, but the cost of six supervisory employees, along with the necessary building costs, have been included in the $1.5 million estimated cost.

Source: Auditor staffing analysis based on client case files and HCA's verification productivity rates contained in HCA's verification management system.