PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

Examining Washington's Concurrent Medicaid Enrollments

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State Auditor's Office contacts

State Auditor Pat McCarthy
564-999-0801, Pat.McCarthy@sao.wa.gov

Scott Frank – Director of Performance and IT Audit
564-999-0809, Scott.Frank@sao.wa.gov

Justin Stowe – Assistant Director for Performance Audit
564-201-2970, Justin.Stowe@sao.wa.gov

Melissa Smith – Principal Performance Auditor
564-999-0832, Melissa.Smith@sao.wa.gov

Lori Reimann Garretson – Senior Performance Auditor
564-201-0956, Lori.Garretson@sao.wa.gov

Audit team
Kenza Abtouche, Michelle Fellows, James Geluso, Lisa Weber

Kathleen Cooper – Director of Communications
564-999-0800, Kathleen.Cooper@sao.wa.gov

To request public records

Public Records Officer
564-999-0918, PublicRecords@sao.wa.gov

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Executive Summary

State Auditor's Conclusions (page 34)

In Washington alone, Medicaid provides health insurance for one out of four state residents. Given the importance of this national program, it is a natural point of interest for auditors across the country. We joined our colleagues at the U.S. Department of Health and Human Services, Office of Inspector General, and peer state auditing agencies to examine the prevalence and cost of concurrent enrollment.

Concurrent enrollment occurs when more than one state Medicaid program enrolls the same person. Those who are concurrently enrolled may have simply moved to a new state, sometimes to take a new job, or in other cases, they may have no permanent residence and are struggling to access both housing and health care. Importantly, concurrent enrollment carries no benefit to the person being covered. It does cost states and the federal government more money, however.

I like the analogy of a leaky faucet used in this report. Just as a leaking faucet results in the loss of water for no gain to the homeowner, concurrent enrollment results in additional costs to taxpayers without a benefit to the people served by Medicaid. To take this analogy further, an undetected water leak can also lead to an unexpectedly large water bill. The same is true for concurrent enrollment. Our analysis projected that during the audit period, Washington unnecessarily paid, on average, $8.6 million a year in premiums for longer term concurrent enrollees who were resident in our sample of seven other states.

We found Medicaid needs federal solutions for early identification of concurrent enrollments. One reason we joined in this work with other states was to document the local ramifications of a national issue. We worked especially closely with our neighbors in Oregon and have included detailed information about the complex nature of concurrent enrollment between our two states. However, Washington state agencies can improve their communication regarding concurrent enrollment, and we make recommendations in that regard. Overall, this report provides valuable insights into the issue for Washington, our fellow state governments and our federal partners.

Background (page 8)

Medicaid is Washington's largest public assistance program, providing health insurance for more than one in four Washingtonians. In fiscal year 2023, federal and Washington state funds for Medicaid spending totaled more than $19.6 billion.

State Medicaid agencies have turned toward a managed care model to reduce costs and better manage how health services are used. Under the managed care model, the Health Care Authority (HCA) contracts with managed care organizations (MCOs) to provide services. HCA pays each of the MCOs a monthly premium for each person enrolled with them. In exchange, the MCOs must provide covered services for all enrollees and comply with HCA's contracts. About 2 million people – 84% of Washington's approximately 2.4 million total Medicaid enrollees – receive physical and behavioral health care through one of five MCOs.

Concurrent enrollment, when one person is enrolled in Medicaid managed care in two or more states, results in multiple governments paying for a benefit that the client receives only once. When someone moves from one state without closing their Medicaid coverage, then signs up for Medicaid in the new state, the result is that two states are paying for two policies when only one is needed. The prior state's money could be spent on something else that provides a benefit to someone.

Multiple premium payments for concurrent enrollments are an example of a "leaky faucet" in the metaphorical pipes of government. These fiscal leaks can be tightened without cutting any services, because being enrolled in more than one state's Medicaid program provides little benefit to clients.

The 2020 public health emergency resulted in changes to the procedures states would usually take to address concurrent enrollments. The federal government tied continuous enrollment in Medicaid to an increase in federal funding. All states were still expected to disenroll people they confirmed had moved out of state, but the federal guidance required them to take additional steps to confirm that clients had indeed become residents of other states before disenrolling anyone. Requirements on clients to inform state Medicaid agencies when they moved out of state remained unchanged.

The Office of the Washington State Auditor conducted this performance audit in collaboration with the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). HHS-OIG has access to federal data that no state can obtain on its own, and it shared data with Washington that served as the foundation for this audit. HHS-OIG performed its own audit of concurrent enrollments in 2022. Its report recommended that the federal Centers for Medicare and Medicaid Services (CMS) provide states enrollment data that identifies Medicaid beneficiaries who were concurrently enrolled in two states' Medicaid managed care programs, but CMS disagreed with the recommendation.

On average, Washington paid $8.6 million a year on unnecessary premiums for clients residing in just seven states reviewed, with even more costs nationwide (page 13)

States double-paid millions in premiums because Washington and other states had the same clients on their Medicaid rosters. By the last year of the public health emergency, states spent about $135 million on unneeded premiums for clients concurrently enrolled with Washington Medicaid. More than 131,000 people were concurrently enrolled in Medicaid managed care programs in Washington and at least one other state during calendar years 2019-2022.

A note about terms in this report

We use the term "premium" throughout this report to refer to payments made to the managed care organizations for health coverage. These payments are also referred to as a "capitated payment" or a "PMPM," for "per member per month."

After analyzing the entire dataset we received from HHS-OIG, we closely reviewed a sample of concurrent enrollments in the seven states with the most concurrent enrollees, including a large sample from Oregon. Our projections show Washington unnecessarily paid, on average, $8.6 million a year in premiums for long-term concurrent enrollees residing in these seven states.

- In the Oregon sample, five in 10 clients were resident in Oregon while Washington paid for their health insurance.
- In the sample of the other six states, four in 10 clients were resident in those states while Washington paid for their health insurance.

In the Oregon sample, the audit team explored concurrent enrollments between neighboring states and when different agencies determine eligibility. Premium payments for Medicaid managed care clients who were resident in other states were made, due to various factors, by both HCA and the Department of Social and Health Services (DSHS); the latter agency administers Medicaid for about 5% of managed care clients. Some Oregon concurrent enrollees regularly visited providers in both states, making it challenging to tell which state should pay for their coverage. Additionally, inaccurate information from the Social Security Administration resulted in clients being reenrolled into Washington's Medicaid program, even after these clients informed DSHS they left the state.

We also found that across states, challenging personal situations contributed to many concurrent enrollments. Adults in our sample were twice as likely to be homeless compared to the general Medicaid managed care population, and many concurrent enrollments reflected complex individual circumstances. These circumstances included fleeing from domestic violence and managing substance use disorders.

Washington could improve existing processes to reduce unnecessary premium payments, but Medicaid needs better nationwide solutions

(page 25)

While Washington agencies have processes to detect nonresident enrollees, HCA and DSHS could improve inter-agency communication, including automated notification systems. The two agencies sent information to the Public Assistance Reporting Information System (PARIS), run by the U.S. Department of Health and Human Services, which used information from all the states to identify people receiving services in more than one state. (The PARIS process was functional during the audit period, but as of August 23, 2024, the process was on hold pending new federal agreements.) Also, both HCA and DSHS have units that process returned mail.

Further, DSHS sends automated alerts to notify HCA in certain circumstances when a client has likely moved out of state. These alerts happen when DSHS closes a client's case for no longer meeting residency requirements or when its systems show an out-of-state address. However, only certain scenarios triggered these notifications. In some cases, DSHS caseworkers knew clients had likely moved out of Washington, but in these situations, the system was not programmed to send a notification to HCA. HCA managers said they would like to receive this information from DSHS.

In addition, HCA could reduce and even recover unnecessarily paid premiums by amending MCO contracts. HCA can recover premiums mistakenly paid to the MCOs in several circumstances, such as when people are deceased, incarcerated or institutionalized. However, these circumstances do not include concurrent enrollees later determined to be resident in another state. Also, MCOs may spot concurrent enrollees faster than state agencies could by comparing their client rosters across states. Eighty-five percent of Washington's managed care clients are covered by an MCO operating in at least one other state. MCOs could compare their own rosters across the states they operate in to identify concurrent enrollments. Managers at MCOs reported that both contract amendments would be actionable.

Still, limitations of federal processes hinder Washington in identifying and resolving concurrent enrollments. The PARIS system does not capture every case of concurrent enrollment, and results vary widely by state. In addition, inaccurate information from the Social Security Administration, together with a lack of clear guidance from federal partners, resulted in unwanted reenrollments. As a national program, Medicaid needs federal solutions for early identification of concurrent enrollments.

Recommendations (page 35)

We made recommendations to HCA and DSHS to improve existing processes and to update the state's contracts with MCOs.

We also communicated other potential improvements related to letters sent to Medicaid clients, including using U.S. Postal Service database information, to HCA management and those charged with governance in a letter dated September 23, 2024.

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 Office of the State Auditor 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 Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology.

Background

Medicaid provides health insurance for more than one out of four Washingtonians

Medicaid is a jointly funded state and federal partnership that provides medical coverage for people with low incomes. Washington's Medicaid program, known as Apple Health, covers a wide array of services for people whose income levels are low enough, based on their age and factors like family size and pregnancy. It is Washington's largest public assistance program, with about 2.4 million people enrolled during fiscal year 2023, representing more than one in four Washingtonians.

Washington's Medicaid clients are in many cases children or people who cannot work due to a disability or other circumstance. Many may be in unstable housing situations or lack housing altogether, which means they are more likely to move from place to place more often than the average person.

The Health Care Authority (HCA) is the state Medicaid agency, responsible for meeting numerous federal requirements including oversight of Medicaid programs administered through other agencies, such as the Department of Social and Health Services (DSHS). The federal Centers for Medicare and Medicaid Services (CMS) works in partnership with these state agencies to administer Medicaid.

The federal financial contribution for Medicaid varies based on many factors, including the service provided and state per capita incomes, with states funding the rest of the cost. In fiscal year 2023, federal and Washington state funds for Medicaid spending totaled more than $19.6 billion: Medicaid spending accounted for about one quarter of the state budget.

In Washington, most Medicaid clients received insurance through managed care, at a cost of $9.9 billion a year

State Medicaid agencies across the country have turned toward a managed care model to reduce costs and better manage how health services are used. Rather than paying doctors and other health care providers directly, HCA contracts with five managed care organizations (MCOs) to provide services. MCOs are private

companies that provide eligible people enrolled in an approved insurance program, including Medicaid, with access to health care services. Proponents of managed care say the companies can reduce costs and better manage how health services are used. The companies vary in size and structure: Some MCOs are large, publicly traded for-profit companies operating in multiple states, while others are not-for-profit companies working within a single state.

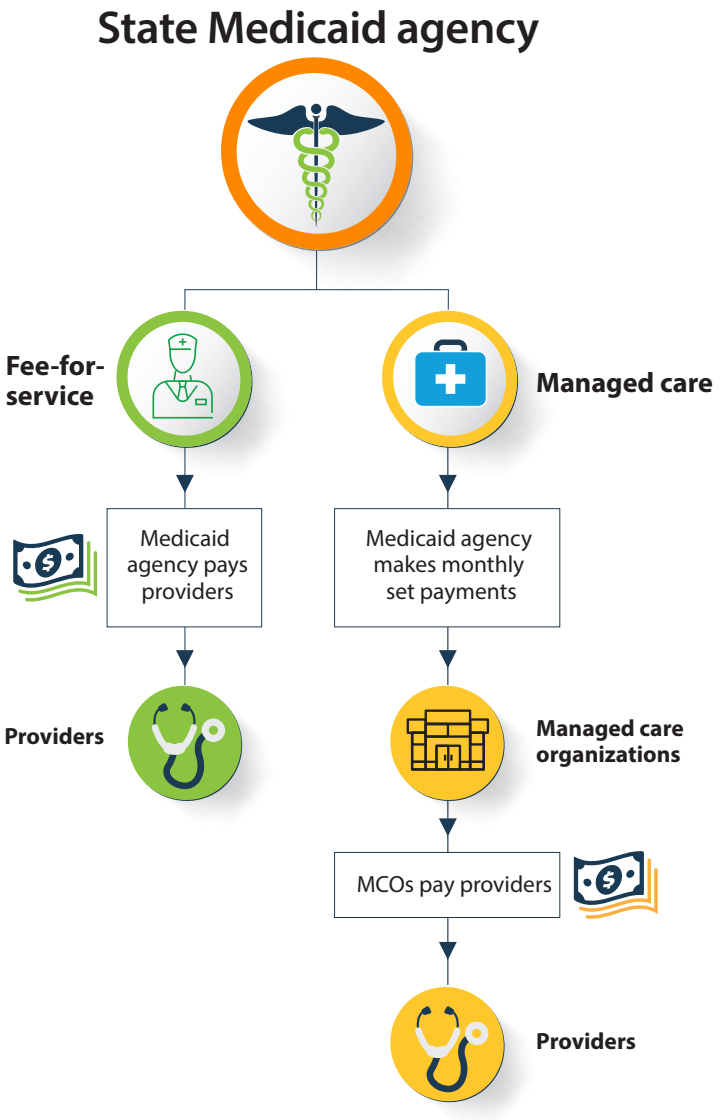
HCA pays each of the MCOs a monthly premium for each person enrolled with them (illustrated in **Exhibit 1**). In exchange, the MCOs must provide covered services for all enrollees and comply with HCA's contracts. About 2 million people – 84% of Washington's approximately 2.4 million total Medicaid enrollees – receive physical and behavioral health care through one of five MCOs.

In fiscal year 2023, managed care accounted for about half of Washington's Medicaid spending, with roughly $9.9 billion in premiums paid to the five MCOs. The remainder was paid to fee-for-service providers. While fewer clients are covered through fee-for-service, they receive far more costly services such as long-term care. Although Washington has been transitioning away from fee-for-service and toward managed care, HCA's contracts with the MCOs do not include all Medicaid services because HCA has determined that fee-for-service is a more cost-effective option in some situations.

A note about terms in this report

We use the term "premium" throughout this report to refer to payments made to the managed care organizations for health coverage. These payments are also referred to as a "capitated payment" or a "PMPM," for "per member per month."

Exhibit 1 – Comparing fee-for-service and managed care processes for paying Medicaid service providers



Source: Auditor prepared.

Three agencies – two state, one federal – are involved in determining Medicaid eligibility

Two Washington state agencies administer almost all its Medicaid programs.

- HCA administers Medicaid programs for people who qualify based on their income (MAGI, from Modified Adjusted Gross Income). This includes about 95% of managed care recipients in Washington.
- DSHS administers Medicaid programs for people who receive long-term care or who are elderly or disabled, representing about 5% of managed care recipients in Washington.

In most states, the federal Social Security Administration is responsible for determining Medicaid eligibility for people who are enrolled in Supplemental Security Income (SSI), a program that provides monthly cash assistance for people who are blind, disabled or older than 65 and have limited resources. In these states, a person receiving SSI is also qualified for Medicaid medical insurance. The Social Security Administration sends data confirming this to Washington's systems, which automatically enroll clients in the state's Medicaid program.

When people who meet the income or disability qualifications apply for Medicaid in Washington, they will receive the coverage. Both HCA and DSHS want to ensure every qualified client is enrolled because the agencies were created to deliver health care and other services. Agency staff view their mission, assigned to them by the Legislature, as making sure every qualified person has health insurance.

Concurrent enrollment in managed care results in wasteful spending with little benefit to clients

Like most states, Washington enrolls people in Medicaid using the addresses applicants provide, including homeless or domestic violence shelters. State agencies accept the applicant's statement they are a Washington resident, a policy called self-attestation. Also, lack of a fixed address does not impose a barrier to receiving health insurance.

Concurrent enrollment, when one person is enrolled in Medicaid managed care in two or more states, results in multiple governments paying for a benefit that the client receives only once. It typically occurs when clients relocate from one state to another and, in the flurry of tasks involved in moving, forget to inform the state Medicaid agency they are leaving. They establish residency in their new state, and then enroll in its Medicaid program. (See sidebar for an explanation of the distinction between "living in" and "residing in" a state.)

Washington Administrative Code makes an important distinction in Medicaid enrollment between "living in" and "residing in" a certain location, even though the terms might appear synonymous. A person might live temporarily in another state, for example to care for an elderly parent or to work at a short-term job assignment, and still be considered resident in Washington if they intend to return to the state.

The situation has consequences for Medicaid spending: The new state pays its MCO the insurance premium to provide needed health care to the client, while the prior state continues to pay an MCO for insurance the client does not need. The prior state's money could be spent on something else that provides a benefit to someone.

Multiple premium payments for concurrent enrollments are an example of a "leaky faucet" in the metaphorical pipes of government. These fiscal leaks can be tightened without cutting any services, because being enrolled in more than one state's Medicaid program provides little benefit to clients. Even though the excess payments are additional profit for the MCOs, the amount is modest, less than 1% of the $9.9 billion in premiums the MCOs received from Washington in fiscal year 2023.

Federal regulations address concurrent enrollments. For example, if a state learns that its Medicaid client is a resident of another state, it must promptly redetermine eligibility, closing the client's Medicaid enrollment if appropriate. All state Medicaid agencies must cover any emergency services clients might need, even if they travel to another state. Finally, regulations allow state Medicaid agencies to pay for some types of services across state lines, if that is the best way to guarantee clients' access to care.

The COVID-19 public health emergency increased the number of concurrent enrollments

The federal government's March 2020 declaration of the COVID-19 public health emergency required changes to the procedures the states would usually take to address concurrent enrollments. The government's first concern was to ensure people retained health insurance, and so it tied continuous enrollment in Medicaid to additional funding through an increase in the Federal Matching Assistance Percentages (FMAP). All states were still expected to disenroll people they confirmed had moved out of state, but the federal guidance required them to take additional steps to confirm that clients had indeed become residents of other states before disenrolling anyone.

HCA's policies closely matched federal guidance, so Washington appropriately terminated coverage for some clients, but also retained many clients on Medicaid when it might have terminated their coverage in normal times. By contrast, according to auditors in other states, those states did not take several appropriate actions that were available to resolve concurrent enrollments, because they were reluctant to risk the increased federal funding by inappropriately disenrolling someone, and this greatly increased the number of such enrollments across the nation.

The federal government did not rescind this guidance until March 2023, shortly before the public health emergency ended in May 2023, so these rules were still in effect at the end of 2022, which was the end of the time period our audit studied.

This audit examined how much Washington paid for concurrent Medicaid coverage and how to limit unnecessary premiums in the future

The U.S. Department of Health and Human Services, Office of Inspector General, (HHS-OIG) is leading an effort to reduce concurrent enrollment for Medicaid clients. This office has access to federal data that no state can obtain on its own, including information about clients who were enrolled in Medicaid in multiple states. HHS-OIG performed its own audit of concurrent enrollments in 2022. Its report recommended that the federal Centers for Medicare and Medicaid Services (CMS) provide states nationwide enrollment and payment data that identifies Medicaid beneficiaries who were concurrently enrolled in two states' Medicaid managed care programs. CMS disagreed with the recommendation and said that PARIS already allows states to compare eligibility. HHS-OIG invited states to perform their own audits with data about their states.

The Office of the Washington State Auditor is one of the state audit offices that collaborated with HHS-OIG. The data that HHS-OIG shared with Washington served as the foundation for this audit. We also partnered with auditors in the Oregon Secretary of State's office, because they also received HHS-OIG data, and collaborated with auditors in two other states. Additionally, three other states had already received their data, performed similar audits and published reports, and we were able to learn from their work. See **Appendix C** for more information about these reports, as well as those published by HHS-OIG.

This audit answered the following questions:

1. To what extent did Washington pay premiums to managed care organizations for enrollees concurrently enrolled in another state Medicaid program?
2. What additional steps could the Health Care Authority and the Department of Social and Health Services take to ensure managed care organizations are not paid for enrollees who no longer live in Washington?

Audit Results

On average, Washington paid $8.6 million a year on unnecessary premiums for clients residing in just seven states reviewed, with even more costs nationwide

Results in brief

States double-paid millions in premiums because Washington and other states had the same clients on their Medicaid rosters. By the last year of the public health emergency, states spent about $135 million on unneeded premiums for clients concurrently enrolled with Washington Medicaid. More than 131,000 people were concurrently enrolled in Medicaid managed care programs in Washington and at least one other state during calendar years 2019-2022. (See the sidebar for a note about data used in our analyses.)

After analyzing the entire dataset, we closely reviewed a sample of concurrent enrollments from seven states with the most concurrent enrollees, including a large sample from Oregon. Our projections show Washington unnecessarily paid, on average, $8.6 million a year in premiums for long-term concurrent enrollees residing in these seven states. In the six-state sample, four in 10 clients were resident in those states while Washington paid for their health insurance; in the Oregon sample, five in 10 clients were resident in Oregon.

Data used in our analyses

The federal Department of Health and Human Services, Office of Inspector General (HHS-OIG) gave the audit team a dataset that detailed every client concurrently enrolled in Medicaid managed care programs in Washington and at least one other state for three months or more. The data covered calendar years 2019-2022.

For our analysis, we assumed that other states paid a premium amount similar to what our state pays. Appendix B contains details about the data and how we analyzed it.

The Oregon sample explored concurrent enrollments between neighboring states and when different agencies determine eligibility. This sample showed both the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) made premium payments for Medicaid managed care clients who were residents of other states. A contributing factor was that some Oregon concurrent enrollees regularly visited providers in both states, making it challenging to tell which state should pay for their coverage. Additionally, inaccurate information from the Social Security Administration resulted in clients being reenrolled into Washington's Medicaid program, even after the clients informed DSHS they left the state.

We found that across states, challenging personal situations contributed to many concurrent enrollments. Adults in our sample were twice as likely to be homeless, compared to the general Medicaid managed care population, and many concurrent enrollments reflected complex individual circumstances.

States double-paid millions in premiums because Washington and other states had the same clients on their Medicaid rosters

As discussed in the background section of this report, concurrent enrollment occurs when someone is enrolled in Medicaid managed care in two or more states, resulting in multiple governments paying for a benefit that the client receives only once. This waste can be eliminated without cutting any services, because being enrolled in more than one state's Medicaid program provides little benefit to clients.

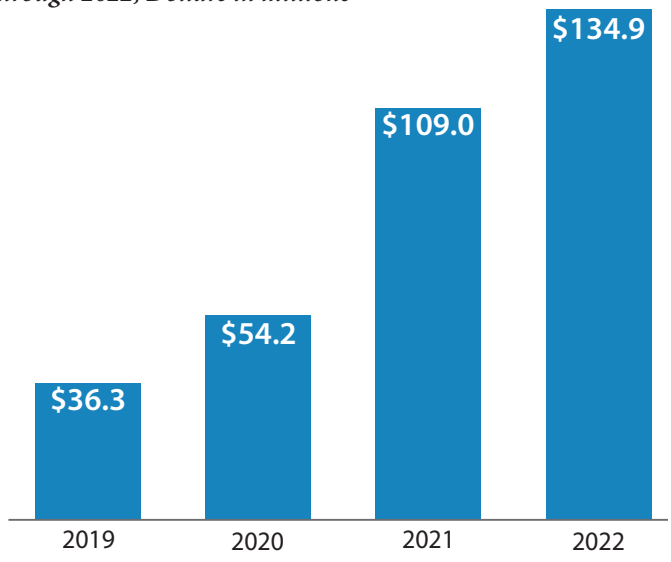
By the last year of the public health emergency, states across the nation spent about $135 million on unneeded premiums for clients concurrently enrolled with Washington Medicaid

While concurrent enrollments have always been a costly problem, the public health emergency exacerbated the issue. During 2019, states spent approximately $36 million on medical premiums for clients of Washington Medicaid and at least one other state. The next year, the COVID-19 pandemic triggered a public health emergency during which the federal government encouraged states to keep people covered by Medicaid. To incentivize this coverage, the federal government increased the money it sent to states through the Federal Matching Assistance Percentages (FMAP).

States were allowed to disenroll clients who died, moved to other states or asked to be removed. However, according to auditors in other states, those states did not take several actions that would have been available to resolve concurrent enrollments because they were reluctant to risk increased federal funding by inappropriately disenrolling someone. While Washington's guidance closely mirrored federal expectations, those expectations included increased verifications to ensure people had indeed established residency in another state. This contributed to a sharp rise in the cost of concurrent enrollments, as shown in **Exhibit 2**.

Exhibit 2 – Premiums paid by Washington for concurrent enrollees in Medicaid managed care

Data from 2019, one year before public health emergency, through 2022; Dollars in millions



Source: Auditor calculation from data provided by HHS-OIG.

During this four-year period, the percentage increase in the cost of concurrent enrollment (272%) was about 10 times the percentage increase in overall Medicaid enrollment (28%). This shows that increased enrollment in the program was not a key driver of these increased costs.

Payments for concurrent enrollments across all four years come to more than $300 million. Although we could only directly evaluate data with managed care organization (MCO) premium payments made by Washington, it is reasonable to assume another state paid a similar amount for these clients' care, essentially creating duplicate payments. Some of these clients were Washington residents, so Washington was rightly responsible for their care, but another state paid unnecessary premiums for someone who was not a resident of their state. The rest were resident in the other state, so Washington was paying for unnecessary insurance. In total, states across the nation spent $300 million on unneeded and unused health insurance premiums.

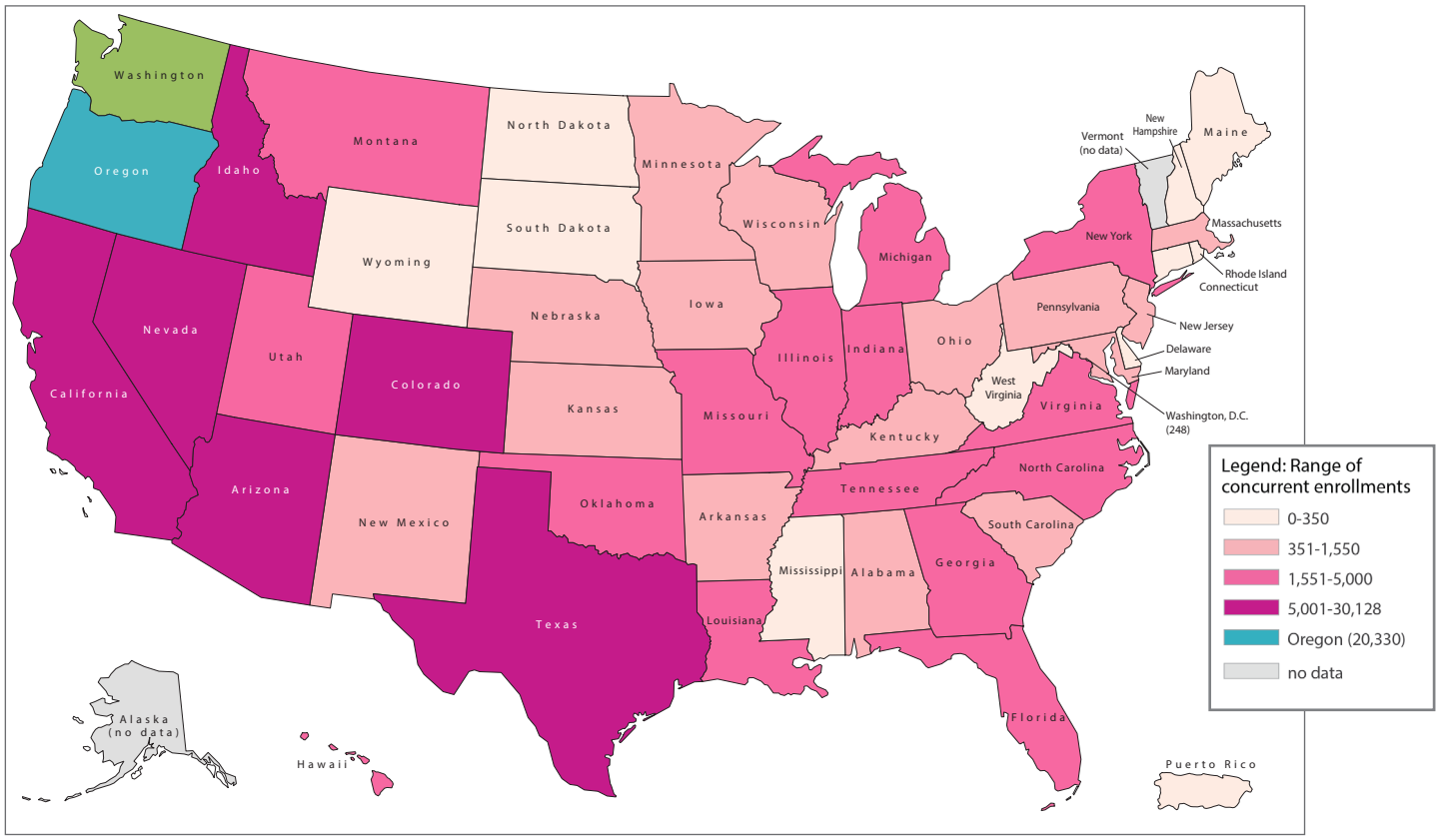
We made our estimate conservative to account for circumstances outside the state agencies' control

This is a conservative estimate, because we did not count the first two months of concurrent enrollment for each client. Medicaid managed care is purchased by the calendar month; whenever a person enrolls in a new state, their coverage is effective from the first, so covering the full calendar month. This federally required practice creates one inevitable month of concurrent enrollment. Existing systems to identify concurrent enrollees (such as the federal Public Assistance Reporting Information System (PARIS) reports described on page 26) are unlikely to help a state find someone as quickly as the start of the second month of their residency in the other state. For one thing, PARIS reports have been processed only quarterly. Another delay may be prompted by new federal rules that, starting in December 2025, will require the state to make a good-faith effort to contact a client if that state receives an out-of-state address from another source.

More than 131,000 people were concurrently enrolled in Medicaid managed care programs in Washington and at least one other state during calendar years 2019-2022

After evaluating the extensive HHS-OIG dataset for the four-year period we reviewed, we found more than 131,000 clients were concurrently enrolled in Medicaid in Washington and at least one other state for at least three months. The distribution of concurrent enrollees is shown in the map in **Exhibit 3**. Washington shared Medicaid managed care enrollees with every state except two, because Alaska and Vermont do not make payments to MCOs for their Medicaid programs. In most cases, each client was enrolled in only one other state, but in about 5% of cases, a single individual was enrolled in three or more states.

Exhibit 3 – Concurrent enrollments with Washington Medicaid

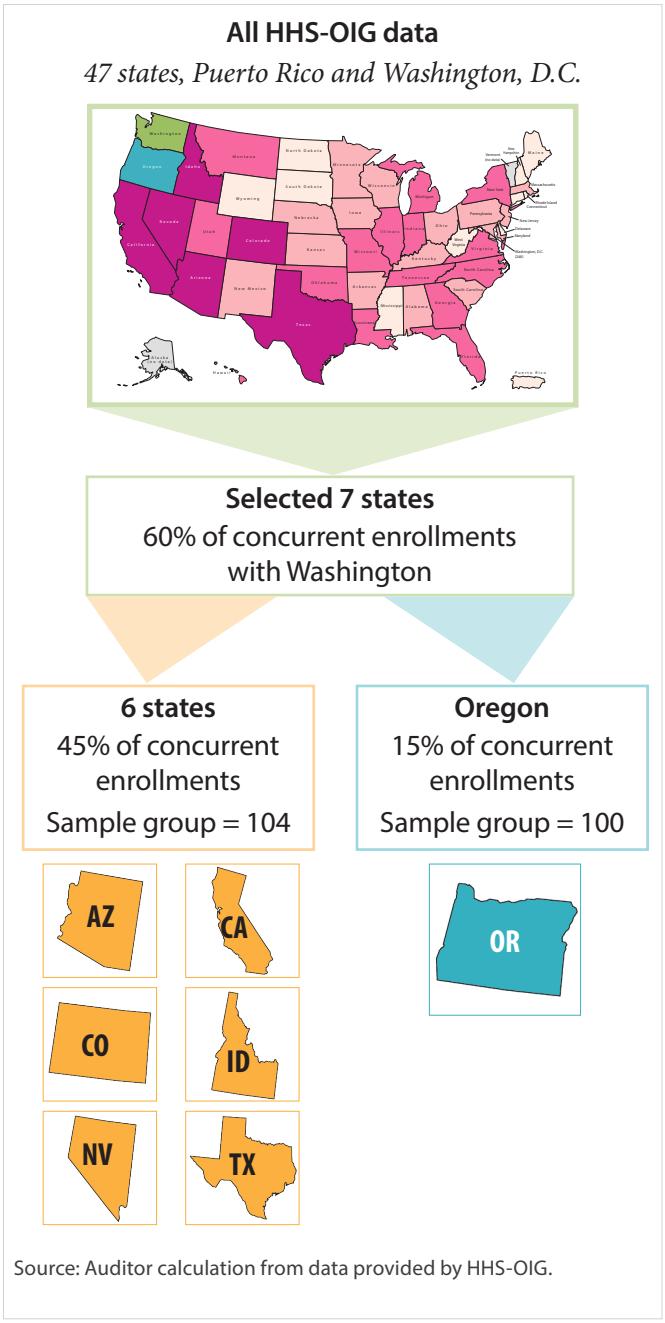


Source: Auditor calculation from data provided by HHS-OIG.

After analyzing the entire dataset, we closely reviewed a sample of concurrent enrollments

To learn more about the reasons behind concurrent enrollments, we narrowed our analyses from the national picture to two narrower samples. We chose seven states, which together account for 60% of Washington's concurrent enrollees; this group included Oregon. We then split the seven states into two groups: six states and Oregon, which was given a separate special focus. The illustration in **Exhibit 4** shows our selections and resulting sample of enrollees.

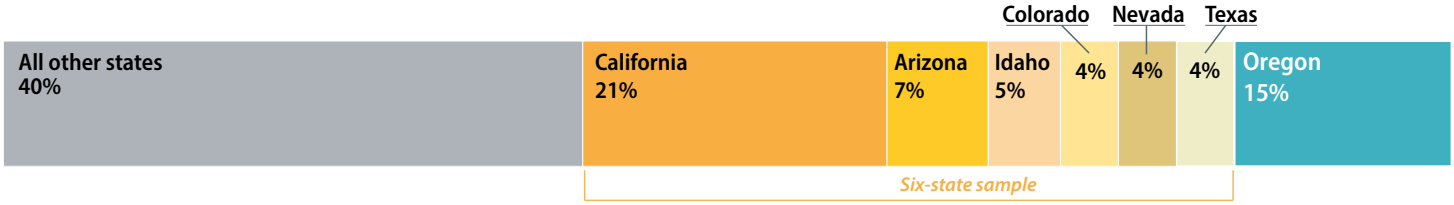
Exhibit 4 – State sample groups in this audit



Source: Auditor calculation from data provided by HHS-OIG.

Exhibit 5 breaks out the percentage of concurrent enrollees in the seven states (it also shows the 40% of all other concurrent enrollees as one group).

Exhibit 5 – The two samples represent seven states with 60% of Washington's concurrent enrollees



Source: Auditor calculation from data provided by HHS-OIG.

Our projections show Washington unnecessarily paid, on average, $8.6 million a year in premiums for long-term concurrent enrollees in seven states

Within the seven states, we focused more closely on people who were concurrently enrolled for six months or more. After examining our samples, we projected our results to the full population of these clients, in Oregon and the other six states.

We estimate that Washington spent about $8.6 million a year on Medicaid managed care premiums when a state other than Washington should have been responsible for the client, as shown in **Exhibit 6**. This conservative estimate includes only clients who were enrolled for six months or more in one of the seven states, and it underestimates the total amount of premiums Washington paid for nonresidents. The seven states we reviewed account for just 59% of Washington's concurrent enrollments of six months or more nationwide; this is just slightly less than the 60% of people with three or more months of concurrent enrollment. Given that percentage, we made a proportional estimate of the unnecessary premiums Washington paid during the audit period. The total unnecessary premiums Washington paid across all states could have been as high as $14.7 million a year.

Exhibit 6 – Projected unnecessary premiums paid by Washington

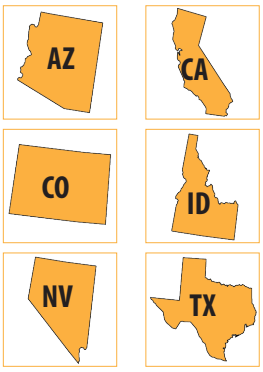
Six-state sample	$28.9 million
Oregon sample	$5.4 million
Total for 7 states	**$34.3 million**
Estimated average each year	*$8.6 million*

Source: Auditor calculation from data provided by HHS-OIG and information from Washington state agencies and Medicaid agencies in other states.

There are several important considerations to our methodology to bear in mind, which we discuss in greater detail in Appendix B. The focus of our audit fieldwork was to identify additional processes that could identify concurrent enrollments, because existing processes may require up to six months to identify and resolve a current enrollment. For that reason, we set the bar for our analysis conservatively at six months out-of-state concurrent enrollment, even though we had data for premiums paid for clients who had concurrent enrollment and out-of-state residence for five months or less. We did not count up to two months of overlap to account for anticipated transition time as a client moves from one state's Medicaid program to another's. We also did not count any months where case files specifically noted coverage was left open due to federal requirements related to the public health emergency. In addition, we did not count situations where we could not clearly establish a client's residency.

Finally, HCA's contracts with the MCOs allow it to recover profits that an MCO makes over a certain point (and also obligates HCA to help cover losses). This risk mitigation provision, called a "risk corridor" is calculated after the end of the contract period. In a year when an MCO has high profits, HCA would recover enough that it effectively recoups the premiums from concurrent enrollments for that MCO. But if an MCO has low profits or even losses, HCA would not recover

any of these premiums. In either case, we did not consider these recoveries in our calculation of unnecessary premiums because they do not change the total amount of unnecessary premiums. Also, despite having this contract clause, it remains the case that better processes would have saved money upfront by avoiding unnecessary payments rather than recouping excess profit retroactively.



In the six-state sample, four in 10 clients were resident in those states while Washington paid for their health insurance

Four in ten clients (42%) in our six-state sample (which represents 45% of all concurrent enrollments) were resident out of state for part or all the time Washington paid premiums on their behalf. We drew conclusions about where clients were resident based on data in DSHS' eligibility system and information from Washington state agencies, including health care services received, licensing information, employment and public K–12 school enrollment records, and information from other states' Medicaid agencies on in-person appointments and health care encounters in those states.

In our residency determinations, we also included cases kept open due to the public health emergency even though we excluded them from our projections. Some out-of-state clients' coverage was kept open only because of federal regulations during the public health emergency, and there was little HCA or DSHS could have done to prevent these concurrent enrollments. Nevertheless, we included these clients in our counts of out-of-state residents because they were not Washingtonians.

In drawing our conclusions about residency, we had access to much more information than either HCA or DSHS had at the time. Also, our determinations were retrospective, but HCA and DSHS had to determine residency in real time, especially in the stressed years of the pandemic. Furthermore, the agencies lacked access to some of the sources we used, such as school enrollment records and licensing information.

Exhibit 7 shows our determination of residency status for concurrently enrolled clients in the six-state sample. We grouped the results of our analysis into five categories; by far the largest single group (54 of 104 people in the sample) were clients who were indeed resident in Washington.

Exhibit 7 – Residency determinations for clients in the six-state sample

Source: Auditor calculation from data provided by HHS-OIG and information from Washington state agencies and Medicaid agencies in other states.

Here are examples of residency determinations we made based on the available information.

- **Resident in Washington:** The client was enrolled in Washington schools for the entire period of concurrent enrollment; narrative notes in Washington's eligibility system explained the client and family had recently moved to Washington.
- **Partly in state / Partly out of state:** The client was concurrently enrolled in Washington and another state for two separate periods of time. First period: client had health care claims and used EBT benefits out of state. Second period: client worked and received health care in Washington every month.
- **Out of state:** The client surrendered a Washington driver's license and obtained a driver's license in the other state at the beginning of the concurrent enrollment period and received medical care in the other state for several months afterward. There was no information from Washington systems that placed the client in Washington.
- **Unknown:** Neither Washington systems nor data provided by other states placed the client in Washington or another state.
- **Simultaneously using services in two states:** The client regularly received health care services covered by both Washington and the neighboring state's Medicaid for multiple months and had reported addresses in both states.

The number of clients simultaneously using services in more than one state was greater in our analyses of clients in the Oregon sample, discussed below.

The Oregon sample explored concurrent enrollments between neighboring states and when different agencies determine eligibility

Our Oregon sample was specifically designed to explore concurrent enrollments between neighboring states and when different Washington state agencies determine client eligibility. Working with auditors at the Oregon Secretary of State's office, we drew a sample of 100 people based on Oregon program enrollment data. Fifty clients were enrolled in Medicaid through Supplemental Security Income (SSI), and 50 were enrolled based on income (MAGI, from Modified Adjusted Gross Income).

We designed the sample in this way because:

- Premiums for the SSI population are often higher. While the average monthly premium payment was $322 for all concurrent enrollees, our review showed premiums of over $1,000 a month were common amongst the SSI population, occurring about 40% of the time.

- In Washington, DSHS administers SSI recipients' coverage, while HCA administers MAGI Medicaid. This allowed us to examine differences in how these two agencies address concurrent enrollments.

Just over half (51%) of the people in our Oregon sample were resident outside of Washington for all (35 out of 100) or part of their concurrent enrollment period (16 out of 100). **Exhibit 8** shows our determination of residency status for concurrently enrolled clients in the Oregon sample.

Exhibit 8 – Residency determinations for clients in the Oregon sample

Source: Auditor calculation from data provided by HHS-OIG and information from Washington state agencies and Medicaid agencies in other states.

Both DSHS and HCA made premium payments for Medicaid managed care clients who were resident in other states

We estimate that during our four-year audit period, Washington spent about $2.9 million on premiums for adults enrolled in MAGI Medicaid (managed by HCA) but who were actually resident in Oregon. We estimate that Washington also spent about $2.0 million on premiums for clients enrolled in SSI or SSI-related programs (managed by DSHS) but who were resident in Oregon. The estimated costs may appear similar, but the two groups of clients served are very different. Premium rates are much lower under the MAGI program, and many more clients are eligible through MAGI than under SSI and SSI-related programs. **Exhibit 9** shows both the average annual costs and our projection for the four years covered by the audit.

Exhibit 9 – Projected unnecessary premiums paid for Medicaid clients resident in Oregon

Calendar years 2019-2022

Medicaid program	Projected premiums paid by WA for OR residents	Annual average
MAGI adult	$2.9 million	$725,000
SSI/SSI-related	$2.0 million	$500,000

Source: Auditor calculation from data provided by HHS-OIG and information from Washington state agencies and Medicaid agencies in other states.

Some Oregon concurrent enrollees regularly visited providers in both states, making it challenging to tell which state should pay for their coverage

Our analysis of the Oregon-only data found that some concurrent enrollees regularly visited providers in both states, sometimes for many months. In most cases, concurrent enrollees received care from only one state. However, nine people, mostly living along the Washington-Oregon state line, were not only concurrently enrolled in both states' Medicaid coverage, but also used both states' insurance to access services for extended periods. The clients did not need to have coverage in

two states because each state Medicaid agency is already responsible for ensuring that contracted MCOs provide all necessary services.

Our review of case files did not suggest that these enrollees were intentionally abusing the Medicaid program. (Only one of these cases showed some indicators of potential fraud.) Like the total Oregon sample, a third of these clients were homeless and did not have a permanent residence. The mobile nature of this population makes it challenging for either state Medicaid agency to determine the client's state of residence. Some clients lived in the Portland-Vancouver metropolitan area, where crossing the Columbia River for work, shopping and services is already common. In one example, a client who needed regular medical treatment used medical services in both cities every few days. Each state's Medicaid program covered their own provided medical services, but the client should nonetheless have been insured by just one state at a time. These cases were not limited to the Portland area; we noted similar cases in rural counties along the state line.

Inaccurate information from the Social Security Administration resulted in clients being reenrolled into Washington's Medicaid program, even after these clients informed DSHS they left the state

Oregon and Washington use the same SSI eligibility criteria for Medicaid, but their processes for determining eligibility differ. Oregon's state Medicaid agency makes eligibility decisions for SSI recipients. Washington, like most other states, instead relies on eligibility decisions made by the Social Security Administration. While the practice of having the Social Security Administration make eligibility determinations streamlines the process, it can inadvertently create concurrent enrollments when administration data is out of date and incorrectly places in Washington a client who has moved and enrolled in another state's Medicaid program.

We found multiple instances of clients who had been automatically reenrolled in Washington Medicaid, despite being out-of-state residents, due to inaccurate information provided by the Social Security Administration. When the administration's data shows a client's residence as Washington, DSHS' eligibility system automatically enrolls the client in Medicaid. Case file narratives demonstrated that even after clients told DSHS that they had moved out of state, coverage in Washington would often automatically reopen when inaccurate data from the Social Security Administration continued to show them as resident in Washington. The following section discusses how this and other gaps in federal guidance have contributed to unwanted automatic reenrollments.

Inaccurate Medicaid automatic reenrollments not only cost Washington money, but in some cases affected Medicaid coverage in the client's new state. In one case, the client's parent had called DSHS two years after their child's Medicaid coverage had been closed, because the child had been automatically reenrolled in Washington due to inaccurate data from the Social Security Administration. This interfered with

the child's coverage in Oregon, and cost Washington more than $9,000 for eight months of premiums for insurance that would never be used.

Across states, challenging personal situations contributed to many concurrent enrollments

Adults in our sample were twice as likely to be homeless, compared to the general Medicaid managed care population

HCA and DSHS case notes showed that homelessness contributed to many concurrent enrollments. Adults in the samples we reviewed were more than twice as likely to be experiencing homelessness compared to Washington's general adult managed care population. A third of these clients were homeless (31% of the six-state sample and 35% of the Oregon sample), while rates of homelessness for Washington's adult managed care population ranged between 10% and 15% during our audit period. In one example, case notes recorded that when asked for proof of Washington residency, the client responded that she was homeless and traveled between Washington and Idaho. Although the client used benefits almost exclusively in Idaho for many months, she was also in Washington regularly. In another example, a client used benefits in both Washington and Oregon, and reported traveling back and forth between the states.

Guidance in place during the public health emergency particularly contributed to concurrent enrollment for homeless clients. Federal requirements designed to ensure continuous eligibility at that time specified that state agencies had to confirm clients were living out of state before terminating coverage. Washington, like other states, therefore did not disenroll clients whose whereabouts were unknown or clients whose mail was returned to HCA or DSHS with no forwarding address. These changes in federal expectations likely increased the number of homeless clients who remained on Washington Medicaid rolls from March 2020 through December 2022 (the end of our audit period).

Many concurrent enrollments reflected complex individual circumstances

While some people in our sample were chronically homeless, others were in unstable housing situations. Case notes recorded clients' uncertainty about where they would be living in the near future. Case notes also recorded multiple instances of people who fled domestic violence. In one case, this meant a client moving every few months back and forth between Washington and another state.

Many clients had significant health concerns that could directly affect their ability to perform regular activities. Case files noted issues such as substance use disorder and psychiatric illnesses. In one example, records showed the client had been in and out of residential treatment centers over many months, such that social workers often had difficulty locating the client. This person left one such residential treatment center and was described by staff as incoherent. Other files documented people who had received in-patient drug and alcohol treatment in more than one state over many months.

Untangling the complex histories of people affected by homelessness, housing instability and mental illnesses adds to the difficulty agencies experience in determining the residency of these clients.

Washington could improve existing processes to reduce unnecessary premium payments, but Medicaid needs better nationwide solutions

Results in brief

While Washington agencies have processes to detect nonresident enrollees, HCA and DSHS could improve inter-agency communication, including automated notification systems. In addition, HCA could reduce and even recover unnecessarily paid premiums by amending contracts with MCOs. Under the current contracts, all efforts to identify concurrent enrollees must occur before the state makes payments. While HCA can recover premiums mistakenly paid to the MCOs in several circumstances, it cannot recoup premiums paid for concurrent enrollees who establish residency in another state. Furthermore, MCOs may spot concurrent enrollees faster than state agencies could by comparing client rosters across states.

Limitations of federal processes hinder Washington in identifying and resolving concurrent enrollments. The federal Public Assistance Reporting Information System (PARIS) does not capture every case of concurrent enrollment, and results vary widely by state. Also, while the PARIS process was functional during the audit period, as of August 23, 2024, the process was on hold pending new federal agreements. In addition, inaccurate information from the Social Security Administration, together with a lack of clear guidance from federal partners, resulted in unwanted reenrollments. As a national program, Medicaid needs federal solutions for early identification of concurrent enrollments.

Washington agencies have processes to detect nonresident enrollees, but could improve inter-agency communication

Washington expects all Medicaid clients to report changes that affect their eligibility, such as out-of-state moves, within 30 days. This expectation appears on HCA's website, in Washington Administrative Code, as well as the Code of Federal Regulations. HCA and DSHS also communicate this expectation during the application process and annual reviews.

Clients can report changes in circumstances in a variety of ways, including by telephone, email, fax or letter. HCA Medicaid clients can also update their addresses by editing their contact information on the Healthplanfinder website used to apply for income-based (MAGI, from Modified Adjusted Gross Income) Medicaid. DSHS Medicaid clients can report changes to their local community services office or by contacting their case worker. However, as our audit found, a client reporting a change of residency does not always result in removal from Washington's rolls in a timely manner.

If a client fails to report relocation out of state, or if the client did report the move and the case was not closed properly, HCA and DSHS can use any of several methods to identify nonresident clients. Two of the most important methods are PARIS reports and returned mail; **Exhibit 10** sets out several additional methods.

Exhibit 10 – Methods to identify nonresident clients

Source of information	How it is used
Public Assistance Reporting Information System (PARIS)	PARIS is a quarterly federal reporting process managed by the U.S. Department of Health and Human Services. Individual states send in information about recipients of Medicaid and other joint state/federal programs, such as the Supplemental Nutrition Assistance Program (SNAP). These records are matched to find any clients who are enrolled in multiple states at the same time. Matching records are sent back to individual states for resolution. Medicaid state agencies are required to participate in this process, but the frequency and comprehensiveness of participation is voluntary. Washington participates quarterly by submitting information about all Medicaid and SNAP clients.
Returned mail	Both HCA and DSHS have units specifically dedicated to processing returned mail. When mailings to clients are returned as undeliverable by the U.S. Postal Service, staff in these units attempt to locate current addresses for clients, contact them, and then disenroll them as needed.
Managed care organizations (MCOs)	MCOs are contractually required to notify HCA whenever they learn a Medicaid enrollee has moved out of state. HCA has a unit to follow up on these reports; staff attempt to verify the current address, disenrolling clients as needed.
Contacts from other states	Just as Washington may reach out to other state Medicaid agencies to resolve questions about client residency, other states may also contact Washington. States compare enrollment dates, service usage dates and other information to determine the state in which the client is currently resident.

continued on page 27

Exhibit 10 – Methods to identify nonresident clients, *continued*

Source of information	How it is used
Contacts from other Washington state agencies	HCA has established an Eligibility Updates Inbox where other divisions within HCA and agency partners (including DSHS) can communicate client eligibility changes. A unit within HCA is responsible for following up on these reports. Additionally, HCA and DSHS have set up automated alerts to each other when significant case actions occur, for example, when food assistance has been closed because the client no longer meets residency requirements. HCA and other DSHS units supporting these clients can then review the case to determine whether the client still qualifies for Medicaid.
Social Security Administration	DSHS receives a regular data feed from the Social Security Administration with information (including residency determination) for Washington residents who receive Supplemental Security Income (SSI) benefits. SSI recipients are automatically enrolled or disenrolled in Medicaid in Washington based on residential addresses from the Social Security Administration's records. However, our audit work found that residential address information in this data source can sometimes be significantly out of date.
Annual reviews	State agencies must conduct eligibility reviews for Medicaid at least every 12 months. If case files do not record a client's move before the renewal date, contact with clients during the eligibility review process could discover that they are no longer resident in Washington. However, the requirement for annual eligibility reviews was waived during the public health emergency and did not resume until April 1, 2023.

Source: Auditor analysis of agency procedures, HCA's contract with the MCOs and interviews with agency management.

HCA and DSHS could improve inter-agency communication, including automated notification systems

HCA and DSHS each have their own residency verification processes for their Medicaid programs; DSHS also manages SNAP and other similar assistance programs. When a client becomes ineligible for programs at one agency by moving out of Washington, they likely also become ineligible for programs at the other.

To ensure HCA is made aware of people who appear to have moved away, DSHS created two automated notifications to alert HCA caseworkers. When a DSHS caseworker closes a client's benefits due to out-of-state residency, the action prompts an automatic notification to HCA. We found these notifications worked as intended and HCA staff responded to them in a reasonable timeframe. However, only certain closure codes triggered these notifications, and in some cases, DSHS caseworkers were aware clients had likely moved out of Washington but closed the cases for reasons that did not trigger a notification to HCA.

For example:

- DSHS closed food benefits for a client who had been using benefits exclusively out of state for months and did not complete a mid-certification review. After this client's food benefits were closed, DSHS systems alerted staff that the client was out of state but staff cleared the alerts because the agency had already closed food benefits and thus had no further action to take, at least from their perspective. Since closing the food benefit did not trigger a notification, HCA did not learn the client left Washington and Medicaid benefits remained open for 16 more months.
- DSHS was contacted by another state concerning a person's application for benefits there. DSHS staff told the other state that the person was no longer receiving food benefits in Washington but was still enrolled in Medicaid, and the client would have to contact HCA to close the Medicaid account. The DSHS caseworker had no instructions or procedures to follow to contact HCA, and the system that triggers automated alerts was not programmed to react to this situation. As a result, Medicaid coverage was open for 10 more months.

HCA managers believe additional information could be useful, and had they known about the circumstances in these examples, they could have initiated HCA's residency verification process. On the other hand, they also said they did not want to be flooded with low-value notifications showing, for example, that clients have used electronic benefit cards out of state, which is allowed and not sufficient reason to inquire into residency.

Notwithstanding such concerns, DSHS and HCA could work together to find ways to consistently communicate when clients have likely established residency in another state. One possibility is to use DSHS' existing data to identify combinations of circumstances that indicate a likely move out of state – such as when DSHS is notified by another state that a client is applying for benefits there – and create new automated alerts to inform HCA of the change. Another option is to update policies and procedures to empower DSHS caseworkers to use the existing Eligibility Update Inbox (as described in Exhibit 10) to contact HCA directly when they believe a client has likely moved out of state. While HCA is not allowed to rely solely on information from DSHS or another agency, this would serve as a notification that HCA should initiate its own residency verification process.

By amending MCO contracts, HCA could reduce and even recover unnecessarily paid premiums

Reducing payments to MCOs for residents in other states falls under wider program integrity efforts, which ensure the right payment is made to the right provider for the right reason. Indeed, MCOs are key partners in Washington's

program integrity efforts, and HCA's contracts with the MCOs outline numerous related requirements. These contracts are the foundation of Washington's managed care program, and subject to regular updates.

Under the current contracts, all efforts to identify concurrent enrollees must occur before the state makes payments

HCA can recover premiums mistakenly paid to the MCOs in several circumstances, but it cannot recoup premiums paid for concurrent enrollees who establish residency in another state. HCA's contracts with the MCOs allow for premium recoupment in several scenarios, including when people are deceased, incarcerated or institutionalized. Recovery is also possible when it is later determined a client had private insurance or Medicare. However, these contractual provisions do not include concurrent enrollees who have established residency in another state.

Our case-file review identified several instances in which Washington paid multiple months of premiums for someone who had clearly left the state and established residency elsewhere. For example, Washington paid monthly premiums of $1,078 while California presumably paid a similar amount for the same person from November 2019 to May 2020. Case records showed the client never used SNAP benefits in Washington, only in California, which indicates residency in California. Current contract terms prevent Washington from recovering the $7,500 in double-paid premiums.

By contrast, Wisconsin's contract allows for recoupment when "the member initiates a move out of the MCO service area." Such a contract provision should not harm providers or patients, if it focuses on clients who have clearly left the state and not received any services in Washington. When we asked managers at Washington's MCOs for their feedback on this potential contract provision, they said premium recovery is a regular part of business. Their main concern was that the provision be written such that HCA does not recover premiums for members who have received medical care in Washington. If the MCOs then had to recover payments already made to their providers, MCO representatives said doing so would create financial challenges and administrative stress. Since the provision is intended to recover premiums for clients who are resident in another state, MCOs typically should not have made payments to Washington providers on these clients' behalf and the change should have no effect on their providers. The new provision should not affect clients who have left Washington either, as the mistaken premium payments would simply be subtracted from future amounts HCA owes the MCOs.

HCA's contract with the MCOs has a provision that allows the state to recover money in years when an MCO sees profits above a certain level. However, our analysis showed that, even with this risk-corridor provision, recouping premiums would in most instances provide a net gain for the state.

Furthermore, by comparing client rosters across states, MCOs may spot concurrent enrollees faster than state agencies could

An analyst we spoke with at HCA pointed out that there are a limited number of MCOs operating across the nation, and they could play an important role in identifying concurrent enrollments. Of the five MCOs operating in Washington, four are subsidiaries of parent companies that together enrolled 47% of all Medicaid managed care clients nationwide, according to the Kaiser Family Foundation. Those four companies also enrolled 85% of Washington's Medicaid managed care clients. Given the reach of these nationwide organizations, it is quite possible that someone concurrently enrolled in Medicaid in multiple states could be enrolled with the same company, especially if they had a positive experience with it in the first state and therefore decided to enroll with it again in the second state.

MCOs have the ability to identify people enrolled in their programs in multiple states, and with more regularity than the PARIS process. When we asked managers at the MCOs for their feedback on a potential contract update related to matching enrollment records across states, all said it was possible; one said they already make these types of comparisons regularly. Also, MCOs can match enrollment records on a monthly basis, while the PARIS process only occurs quarterly. These comparisons are limited in that they would identify only concurrent enrollments occurring within the same MCO, but without MCOs checking their various state rosters, some concurrent enrollments might not otherwise be identified by any existing process.

Limitations of federal processes hinder Washington in identifying and resolving concurrent enrollments

Washington depends on two systems operated by federal agencies to identify clients who are concurrently enrolled in other states, and to determine eligibility for certain programs. But both systems have flaws, with a variety of causes, which limit their effectiveness for all states, including Washington.

The PARIS system does not capture every case of concurrent enrollment, and results vary widely by state

The accuracy of concurrent enrollment matches made through PARIS depends entirely on states across the nation regularly sharing their complete lists of clients with this federal program. However, not all states send as much data to PARIS as Washington does: Some do not submit data for clients on all assistance programs, just Medicaid, and some do not include their full rosters of clients. In parts of 2020, some states did not send data at all.

The best illustration of limited participation is the most populous state in the union, California. California made up the largest share of concurrent enrollees with Washington, even greater than Oregon. In our sample, only 65% of California's concurrent enrollees appeared in any PARIS reports we examined. By contrast, we identified 98% of the enrollees in the Oregon sample in the PARIS reports. Notably, California does not send PARIS data for clients who receive SNAP or anyone younger than 21.

Overall, in our seven-state sample, 91% of clients appeared in PARIS reports during the time they were concurrently enrolled. Auditors in other states reported similar results. Rhode Island auditors used a sample of nine states and Puerto Rico and found that 82% of out-of-state enrollees appeared in PARIS reports they reviewed. Ohio auditors used a sample of 11 states and found 73% of out-of-state enrollees appeared in PARIS reports.

However, not all samples produced such robust results. With a different sample of 200 clients, drawn at random from three months of our dataset from HHS-OIG, DSHS staff could match only 38% of the enrollees in the next two PARIS reports. The DSHS sample differed from our case-file review sample because it drew from all states; our sample drew from only seven states. Our sample also had a deliberately large sample of clients from Oregon, who almost always had PARIS alerts. Beyond that, we do not know why this nationwide sample showed such different results, compared to the samples drawn by the audit team and auditors in other states.

In May 2024, the PARIS system ceased operations. While the service was administered by the U.S. Department of Health and Human Services, the actual computing was done by a data-matching center in the Department of Defense. The data-sharing agreement between the two departments had expired and a new one had not been signed. Staff at the Department of Defense said the quarterly match expected in June 2024 would not be sent. As of August 23, 2024, the PARIS program had begun working with the U.S. Department of the Treasury to match enrollment records for states' public benefit programs. However, officials at the Treasury Department said it would not start running the matches until at least 40 states had signed on to participate, so the timeline for when this would start was uncertain.

Inaccurate information from the Social Security Administration, together with a lack of clear guidance from federal partners, resulted in unwanted reenrollments

SSI recipients resident in Washington automatically qualify for Medicaid in Washington, which means that coverage remains open as long as a person is receiving SSI. However, our case-file review identified multiple instances in which clients were automatically reenrolled in Washington Medicaid after moving out of state due to inaccurate information provided by the Social Security Administration.

Washington, like 33 other states and the District of Columbia, has an agreement that states the Social Security Administration determines Medicaid eligibility for clients enrolled in SSI, who are then automatically enrolled in Washington's Medicaid program. This automated process draws on client residential information on file in the administration's data systems. Oregon, like seven other states, has taken an alternative approach: the state agency alone determines Medicaid eligibility and enrolls the client.

For the automated system to work as intended, data in the client's Social Security file must be accurate and up to date. If a Medicaid client receiving SSI in Washington moves to Oregon and enrolls in Oregon's Medicaid program, but has not changed the address on file with the Social Security Administration, the inaccurate residential address will cause the automated system to reenroll the client in Washington. Inaccurate information from the administration results in the client being concurrently enrolled in both Washington and Oregon.

Issues with inaccurate information were compounded by a lack of clear guidance from federal partners, which resulted in inconsistent guidance for DSHS caseworkers

DSHS devised a workaround to prevent unwanted automatic reenrollments based on inaccurate information from the Social Security Administration. Case workers could click a specific box in the case files when they knew clients had established residency in another state to prevent the reenrollment. However, during our audit period, only some teams at DSHS knew they could use this method. Also, some managers at HCA and DSHS were concerned that blocking unwanted automatic reenrollments might violate Washington's agreement with the Social Security Administration, even if there is clear evidence the client has established residency in another state.

The audit team reviewed all available sources – including federal regulations and policy manuals – and reached out to the Social Security Administration and the Centers for Medicare and Medicaid Services. We were unable to find any clear guidance at the federal level regarding actions states should take when they have clear and compelling evidence that a client has established residency in another state but the Social Security Administration still has an old address on record. Once HCA has obtained clear instructions from the Social Security Administration, Centers for Medicare and Medicaid Services, or its own legal counsel, DSHS will need to craft consistent guidance for its staff, describing how they should respond in these situations.

As a national program, Medicaid needs federal solutions for early identification of concurrent enrollments

Medicaid may be a federal-state partnership, but the federal government has more influence over states than the states have over the federal agencies. For many aspects of the concurrent enrollment problem, a real solution can only be achieved at the federal level. The options recommended in this report would make marginal improvements, but Washington can only do so much by itself. HCA and DSHS staff, and other state auditors around the country who examined the issue, all said federal action is needed. Participation in the existing PARIS process is inconsistent, and even among states that participate fully, there is inconsistency in the way the data is submitted, which limits how useful it can be.

A federal solution is possible. For SNAP, another nationwide program administered by the states, the U.S. Department of Agriculture is establishing a National Accuracy Clearinghouse. Once it is in place, the department will require every state to submit its roster of SNAP clients daily; its interface will allow states to check national rosters at the moment when people apply to make sure they are not enrolled in another state. This was in fact the procedure for Medicaid a decade ago. Washington had to check that an applicant was not enrolled in Medicaid in another state before enrolling them. That process was halted in 2013 when changes precipitated by the Affordable Care Act resulted in some states setting up marketplace exchange websites where people could purchase subsidized health insurance. However, the exchanges could no longer check against other states' Medicaid rosters. Adding such functionality requires a nationwide effort to be successful, but a federal solution resembling the SNAP Clearinghouse has yet to be built.

State Auditor's Conclusions

In Washington alone, Medicaid provides health insurance for one out of four state residents. Given the importance of this national program, it is a natural point of interest for auditors across the country. We joined our colleagues at the U.S. Department of Health and Human Services, Office of Inspector General, and peer state auditing agencies to examine the prevalence and cost of concurrent enrollment.

Concurrent enrollment occurs when more than one state Medicaid program enrolls the same person. Those who are concurrently enrolled may have simply moved to a new state, sometimes to take a new job, or in other cases, they may have no permanent residence and are struggling to access both housing and health care. Importantly, concurrent enrollment carries no benefit to the person being covered. It does cost states and the federal government more money, however.

I like the analogy of a leaky faucet used in this report. Just as a leaking faucet results in the loss of water for no gain to the homeowner, concurrent enrollment results in additional costs to taxpayers without a benefit to the people served by Medicaid. To take this analogy further, an undetected water leak can also lead to an unexpectedly large water bill. The same is true for concurrent enrollment. Our analysis projected that during the audit period, Washington unnecessarily paid, on average, $8.6 million a year in premiums for longer term concurrent enrollees who were resident in our sample of seven other states.

We found Medicaid needs federal solutions for early identification of concurrent enrollments. One reason we joined in this work with other states was to document the local ramifications of a national issue. We worked especially closely with our neighbors in Oregon and have included detailed information about the complex nature of concurrent enrollment between our two states. However, Washington state agencies can improve their communication regarding concurrent enrollment, and we make recommendations in that regard. Overall, this report provides valuable insights into the issue for Washington, our fellow state governments and our federal partners.

Recommendations

For the Health Care Authority and the Department of Social and Health Services

To address the lack of notifications for some clients who have likely become residents of other states, as described on pages 27-28, we recommend they:

1. Continue collaboration between HCA and DSHS to streamline processes, and work together to ensure that DSHS notifies HCA when clients enrolled in SNAP or other programs, who are also enrolled in income-based (MAGI) Medicaid, move out of state

To address the uncertainty concerning how to handle SSI enrollees who have established residency in another state, as described on pages 31-32, we recommend they:

2. Request needed clarity from the Social Security Administration and the Centers for Medicare and Medicaid Services about when and how state Medicaid agencies can determine SSI clients are no longer eligible for the state's Medicaid program due to out of state residency.
    a. Once that guidance has been clarified, update and provide consistent procedures to all caseworkers

For the Health Care Authority

To recover premiums unnecessarily paid to MCOs, as described on page 29, we recommend it:

3. Amend HCA's contracts and processes with the MCOs to allow the state to recover premiums for concurrent enrollees later determined to be resident in another state

To address the need for additional ways to identify concurrent enrollments, as described on page 30, we recommend it:

4. Amend HCA's contracts and processes to require MCOs to identify instances when that MCO's enrollment records show the same person is enrolled in more than one state's Medicaid program, and then to inform these states that someone is concurrently enrolled in their Medicaid programs.

We also communicated other potential improvements regarding early identification of client moves to HCA management and those charged with governance in a management letter dated September 23, 2024. The effectiveness of these changes could not be determined with certainty and therefore are not included in this report. Nevertheless, if implemented, these suggestions would result in additional improvement beyond the recommendations listed above.

Agency Response

STATE OF WASHINGTON

October 22, 2024

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 performance audit report, *Examining Washington's Concurrent Medicaid Enrollments*.

Under federal regulations, state agencies must provide Medicaid to eligible residents of the state, unless a person has established residency and enrolled in Medicaid in another state. The Medicaid agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the state if the person intends to return, unless another state has determined that the person is a resident there for purposes of Medicaid.[1]

The state must also provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving Supplemental Security Income (SSI).[2] Under the state's agreement with the Social Security Administration (SSA), SSA is responsible for determining eligibility for Medicaid related to SSI clients. The state has a data exchange with SSA that provides information to the state from SSA regarding client eligibility and residency. If clients do not update their residency status with SSA and are still receiving SSI, then the state is required by federal regulations to provide Medicaid.

The federal government focuses on ensuring that individuals maintain Medicaid eligibility; therefore, disenrolling a Medicaid client is a serious matter. The state must verify – with certainty – that the client has permanently moved out of state before disenrolling them from Medicaid. As detailed in the audit report, the state uses the Public Assistance Reporting Information System (PARIS) and residency information from other assistance programs to monitor out-of-state residency changes. However, if clients are not forthcoming regarding their change of residency, the process to verify their current state of residency and Medicaid enrollment is not an easy task.

We appreciate the SAO acknowledging that states need federal solutions for early identification of people enrolled in Medicaid in more than one state concurrently. States currently lack comprehensive real-time data that would confirm a client is enrolled in another state's Medicaid program at the same time.

The SAO's report also highlights how the public health emergency (PHE) exacerbated this issue. While concurrent enrollment was an issue prior to the PHE, existing procedures limited the impact. As stated in the audit report, concurrent enrollment increased 272% from 2019 to 2023, yet remained less than 1% of the Medicaid program. During the PHE, retaining access to care was critical. Federal guidance temporarily prioritized retention of care and discouraged disenrollment. Implementation of these policies across the country resulted in higher rates of concurrent enrollment.

[1] 42 CFR 435.403(a) and (j)(3)
[2] 42 CFR 435.120

During the audit, HCA staff presented information demonstrating that the potential financial risk of concurrent enrollment is mitigated through the managed care rate-setting process and the risk mitigation mechanism known as the risk corridor. Monthly premiums paid to managed care organizations (MCOs) are determined by actuarial capitation rates, which cover the underlying costs of operating the program. In essence, the capitation rate is determined by dividing total costs incurred by MCOs in the base year by total projected enrollment for the upcoming year. Removing a significant number of concurrent enrollees could increase premium payments in future years because reducing membership while maintaining the same benefit costs means that the cost per person is more. Under the risk corridor program, MCOs are limited to profit and loss margins each year, which can reduce the financial impact of concurrent enrollment.

HCA and DSHS are committed to improving this process. Pursuing concurrent enrollment more aggressively comes with risks to the program. We will consider the impacts of implementing each SAO recommendation as we continue to comply with federal requirements.

We take our role as stewards of Washington's resources and access to care seriously. We encourage you to share the results of the audit with the federal government and promote the idea of a federal system to help the states reduce unnecessary spending.

Sincerely,

Pat Sullivan	Jilma Meneses	Sue Birch
Director	Secretary	Director
Office of Financial Management	Department of Social and Health Services	Health Care Authority

cc: Joby Shimomura, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Rob Duff, Executive Director of Policy and Outreach, Office of the Governor
Mandeep Kaundal, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Scott Frank, Director of Performance Audit, Office of the State Auditor
Dr. Charissa Fotinos, State Medicaid Director, Health Care Authority
William Sogge, External Audit Compliance Specialist, Health Care Authority

Official Response to Performance Audit on Examining Washington's Concurrent Medicaid Enrollments – October 22, 2024

The Department of Social and Health Services (DSHS), Health Care Authority (HCA), and Office of Financial Management (OFM) provide this management response to the State Auditor's Office (SAO) performance audit report received on September 23, 2024.

SAO Performance Audit Objectives

The SAO's performance audit addressed two questions:

1. To what extent did Washington pay premiums to managed care organizations for enrollees concurrently enrolled in another state Medicaid program?
2. What additional steps could HCA and DSHS take to ensure managed care organizations are not paid for enrollees who no longer live in Washington?

Recommendations 1-2 to HCA and DSHS in brief:

SAO Recommendation 1: To address the lack of notifications for some clients who have likely become residents of other states, we recommend they:

1. Continue collaboration between HCA and DSHS to streamline processes, and work together to ensure that DSHS notifies HCA when clients enrolled in SNAP or other programs, who are also enrolled in income-based (MAGI) Medicaid, move out of state.

STATE RESPONSE: HCA and DSHS concur with the recommendation.

Action Steps and Time Frame

- HCA will work with DSHS on a process improvement project and determine if there are any actions they can take that will improve communications between the agencies. *By December 31, 2025.*

SAO Recommendation 2: To address the uncertainty concerning how to handle SSI enrollees who have established residency in another state, we recommend they:

2. Request needed clarity from the Social Security Administration and the Centers for Medicare and Medicaid Services about when and how state Medicaid agencies can determine SSI clients are no longer eligible for the state's Medicaid program due to out of state residency.
   a. Once that guidance has been clarified, update and provide consistent procedures to all caseworkers.

STATE RESPONSE: HCA and DSHS concur with the recommendation.

Action Steps and Time Frame

- HCA will contact the Centers for Medicare and Medicaid Services and the Social Security Administration for official guidance. *By March 31, 2025.*
- HCA will provide DSHS official guidance regarding how to process eligibility for SSI recipients determined to be out of state. *By June 30, 2025.*

Recommendations 3-4 to HCA in brief:

SAO Recommendation 3: To recover premiums unnecessarily paid to Managed Care Organizations, we recommend it:

3. Amend HCA's contracts and processes with the MCOs to allow the state to recover premiums for concurrent enrollees later determined to be resident in another state.

STATE RESPONSE: HCA partially concurs with the recommendation.

Action Steps and Time Frame

- HCA will meet with the contracted actuary and MCOs to determine whether amending the contract to recover premiums for concurrent enrollees is in the best interest of the Medicaid program. *By March 30, 2025.*
- If applicable, HCA will submit amendments to the contracts. *By January 1, 2026.*

SAO Recommendation 4: To address the need for additional ways to identify concurrent enrollments, we recommend it:

4. Amend HCA's contracts and processes to require MCOs to identify instances when that MCO's enrollment records show the same person is enrolled in more than one state's Medicaid program, and then to inform these states that someone is concurrently enrolled in their Medicaid programs.

STATE RESPONSE: HCA concurs with the recommendation.

Action Steps and Time Frame

- HCA will evaluate the impact of the reporting and submit a contract amendment to require MCOs to identify instances when enrollment records show the same person is enrolled in more than one state's Medicaid program. *By July 31, 2025.*

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

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 Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**Yes.** This audit identifies ways to avoid paying Medicaid premiums for clients who are residents of other states.
2. Identify services that can be reduced or eliminated	**No.**
3. Identify programs or services that can be transferred to the private sector	**No.**
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**No.**
5. Assess feasibility of pooling information technology systems within the department	**No.**

I-900 element	Addressed in the audit
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**No.**
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**No.**
8. Analyze departmental performance data, performance measures and self-assessment systems	**No.**
9. Identify relevant best practices	**No.**

Compliance with generally accepted government auditing 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 as published in *Government Auditing Standards* (July 2018 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.

The mission of the Office of the Washington State Auditor

To provide citizens with independent and transparent examinations of how state and local governments use public funds, and develop strategies that make government more efficient and effective. The results of our work are widely distributed through a variety of reports, which are available on our website and through our free, electronic subscription service. We take our role as partners in accountability seriously. We provide training and technical assistance to governments and have an extensive quality assurance program. For more information about the State Auditor's Office, visit www.sao.wa.gov.

Appendix B: Objectives, Scope and Methodology

Objectives

The purpose of this performance audit was to determine how many people were enrolled in Medicaid managed care in Washington and at least one other state at the same time, and identify improvements Washington can make to ensure the state makes premium payments only for eligible residents. The audit addressed the following objectives:

1. To what extent did Washington pay premiums to managed care organizations (MCOs) for enrollees concurrently enrolled in another state Medicaid program?
2. What additional steps could the Heath Care Authority (HCA) and the Department of Social and Health Services (DSHS) take to ensure MCOs are not paid for enrollees who no longer live in Washington?

For reporting purposes, the audit results have been organized into key findings. The messages relate to the original objectives as follows:

- On average, Washington paid a projected $8.6 million a year on unnecessary premiums for clients residing in just seven states reviewed, with even more costs nationwide (pages 13-24) - This finding addresses Objective 1.
- Washington could improve existing processes to reduce unnecessary premium payments, but Medicaid needs better nationwide solutions (pages 25-33) - This finding addresses Objective 2.

Scope

This audit focused on determining the extent to which Washington paid Medicaid managed care premiums for clients who were resident in other states. It also sought opportunities to improve HCA and DSHS' current processes.

Our audit period was January 1, 2019, through December 31, 2022. This period coincided with the coronavirus pandemic and consequent public health emergency, which affected Medicaid enrollment and disenrollment processes. However, while federal requirements tied additional funding to maintaining continuous eligibility for all enrollees eligible on March 18, 2020, through the end of the public health emergency, the federal Centers for Medicare and Medicaid Services (CMS) provided guidance on how states could terminate coverage for clients who had moved out of state while still being eligible for the increased federal funding. Although states were still expected to terminate coverage for clients who had moved out of state, the public health emergency affected eligibility processes.

We were unable to determine if some concurrent enrollment matches from the Public Assistance Reporting Information System (PARIS) were acted upon because of data limitations. The relevant metadata expires after three years, and our audit period began five years before the start of audit fieldwork.

Methodology

We obtained the evidence used to support the findings, conclusions and recommendations in this audit report during our fieldwork period (January through May 2024), with some additional follow-up work afterward. We have summarized the work we performed to address each of the audit objectives in the following sections.

Objective 1: To what extent did Washington pay premiums to MCOs for enrollees concurrently enrolled in another state Medicaid program?

To determine how many people were concurrently enrolled with Washington and at least one other state Medicaid program, we analyzed data received from the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG).

- HHS-OIG provided a dataset from the Transformed Medicaid Statistical Information System (T-MSIS). This dataset identified people for whom Washington and another state, district or territory paid premiums for at least three months between January 1, 2019, and December 31, 2022. This data also included birth dates, states and territories of concurrent enrollment, and the costs of premiums paid by Washington.
- For the people in the dataset, we analyzed the payments made, duration of concurrent enrollment, age of clients, and states of concurrent enrollment.
- We did not include the first two months of premiums paid for each client in our calculations, because some coverage overlap is inevitable when a client transitions to another state.

To determine how many concurrent enrollees were not residents of Washington, we:

- Reviewed federal and state laws and rules
- Created a stratified random sample of concurrent enrollees from the dataset provided by HHS-OIG
- Reviewed data from various sources to determine likely residency
- Projected our results

Federal and state laws and rules

To understand relevant federal and state laws and rules, we:

- Reviewed federal laws and regulations, including the Families First Coronavirus Response Act, which affected Medicaid redeterminations and eligibility from March 2020 through the end of our audit period
- Reviewed relevant state laws (Revised Code of Washington 41.05.021) and regulations (Washington Administrative Code Chapters 182-503 and 182-504)
- Reviewed guidance from CMS, including all-state meeting transcripts and presentations

Created a sample

Sampling frame

The sampling frame, sometimes referred to as the sample population or universe, consisted of people listed in the dataset we received from HHS-OIG who were concurrently enrolled in a Medicaid managed care program in Washington and one of seven other states with the highest overlap in terms of number of clients.

We calculated each client's number of months overlap and the median monthly premium paid by Washington during the person's concurrent enrollment period.

- Monthly premium amount: We selected a break point at $600 per month as a logical place to distinguish higher-rate clients from lower-rate clients, based on the rate schedule that lists rates for each Medicaid program.
- Length of time for premium overlap: We calculated the greatest number of months a client overlapped with a particular state. For purposes of calculating projections, we only used cases in our sample with an overlap of six months or more.

Sample unit

The sample unit was a person's concurrent enrollment period with a particular state.

Sample design and sample size

We created two distinct samples from the sampling frame. Each sample used a stratified random sampling design. Each sample was divided into people with concurrent enrollments for three to five months consecutively, and those with concurrent enrollments for six months or more.

We drew most of the sample from clients who had six months or more coverage overlap with another state, because existing processes should identify clients who have left the state within that amount of time. The focus of audit fieldwork was identifying additional processes that should exist to identify concurrent enrollments, rather than limitations of existing processes. However, we also assembled a small sample of people with three to five months of overlap. Our primary purpose for doing so was to determine if there were factors that led to an early resolution of cases with concurrent enrollment. Other than the client self-reporting the move, we did not find anything meaningful. Therefore, we only reported projections for the sampling category of six months or more of concurrent enrollment.

We used Stata/SE 17.0 to assign a random number to each client in the sampling frame, then sampled clients by identifying the lowest random numbers that met the criteria for each stratum in the sampling design.

Sample details: Six-state group

The six-state sample consisted of clients concurrently enrolled with Arizona, California, Colorado, Idaho, Nevada or Texas (45% of all concurrent enrollments in the HHS-OIG dataset). Because some people were enrolled in more than one of these states during our audit period, this sample comprised 104 people. We broke the sampling frame down into a low versus high premium amount, and a short versus long length of time for premium overlap. **Figures 1** and **2** show the sampling frame and sample size by state for the six-state sample with three to five months of concurrent enrollment. **Figures 3** and **4** (on the following page) show the sampling frame and sample size by state for the six-state sample with six or more months of concurrent enrollment.

Figure 1 – Sampling frame for Sample 1a: Number of clients with 3 to 5 months overlap

State	Premium amount		Total
	Less than $600/month	More than $600/month	
California	10,194	1,661	11,855
Arizona	3,636	724	4,360
Idaho	3,282	530	3,812
Colorado	1,462	241	1,703
Texas	2,049	226	2,275
Nevada	1,956	344	2,300
Total	**22,579**	**3,726**	**26,305**

Figure 2 – Sample distribution for Sample 1a: Number of clients with 3 to 5 months overlap

State	Premium amount		Total
	Less than $600/month	More than $600/month	
California	1	1	2
Arizona	1	1	2
Idaho	1	1	2
Colorado	1	1	2
Texas	1	1	2
Nevada	1	1	2
Total	**6**	**6**	**12**

Figure 3 – Sampling frame for Sample 1b: Number of clients with 6 months or more overlap

State	Premium amount		Total
	Less than $600/month	More than $600/month	
California	15,998	2,275	18,273
Arizona	4,208	913	5,121
Idaho	2,416	401	2,817
Colorado	3,770	802	4,572
Texas	3,061	303	3,364
Nevada	2,379	548	2,927
Total	**30,843**	**4,985**	**35,828**

Note: Totals represent total unduplicated counts. Because some clients were resident in multiple states across the audit period, totals may sum to a lower count than the sum of the column values.

Figure 4 – Sample distribution for Sample 1b: Number of clients with 6 months or more overlap

State	Premium amount		Total
	Less than $600/month	More than $600/month	
California	8	8	16
Arizona	8	8	16
Idaho	8	8	16
Colorado	8	8	16
Texas	8	8	16
Nevada	8	8	16
Total	**48**	**48**	**96***

* Some clients selected for the sample were resident in multiple states, so the final sample size contained only 92 individual persons.

Sample details: Oregon group

The Oregon sample consisted of clients concurrently enrolled with the state of Oregon (15% of all concurrent enrollments in the HHS-OIG dataset). This sample was based on the type of Medicaid program in which the client is enrolled.

Working with Oregon auditors, we selected a sample of 100 clients who were concurrently enrolled in Washington and Oregon at some point during our audit period. Oregon auditors had access to specific Medicaid program enrollment information, so we created a sample that consisted of 50% clients enrolled in income-based (MAGI, from Modified Adjusted Gross Income) Medicaid and 50% enrolled in Supplemental Security Income (SSI) or SSI-related Medicaid. These two programs represent 94% of

Washington's concurrent enrollees with Oregon. During fieldwork, we verified that adults enrolled in MAGI Medicaid in Oregon were highly likely (88%) to be enrolled in MAGI Medicaid in Washington, and those enrolled in the Blind & Disabled Medicaid program in Oregon were highly likely (87%) to be enrolled in SSI or an SSI-related Medicaid program in Washington. MAGI Medicaid children were undersampled because the Medicaid agency in both Washington and Oregon is especially reluctant to end insurance coverage for children.

Another reason for drawing a separate sample for Oregon is that both states manage MAGI clients and SSI clients through separate agencies; doing so allowed us to examine any differences in the way each agency identifies concurrent enrollments under separate management structures. This joint approach to sampling also allowed us to explore issues unique to concurrent enrollments when there is a major city on either side of the state line. **Figure 5** shows the sampling frame by length of concurrent enrollment for the three main Medicaid programs. **Figure 6** displays the sampling distribution.

Figure 5 – Sampling frame for Sample 2

Duration	MAGI adult	MAGI child	SSI/SSI-related	Total
3 to 5 months	6,751	3,867	554	**11,172**
6 or more months	4,872	2,520	485	**7,877**
Total	**11,623**	**6,387**	**1,039**	**19,049**

Figure 6 – Sample distribution for Sample 2

Duration	MAGI adult	MAGI child	SSI/SSI-related	Total
3 to 5 months	5	5	5	**15**
6 or more months	35	5	45	**85**
Total	**40**	**10**	**50**	**100**

Making residency determinations for both sample groups

For each client in our two samples, we determined likely residency by reviewing data from the following systems and datasets.

- **DSHS systems,** including the Automated Client Eligibility System and Barcode. These systems include eligibility information, narratives from caseworkers each time the case is opened, and communications to and from DSHS and clients.
- **HCA encounter data,** which is a record from MCOs of all services received by enrollees. Information includes service dates, providers and provider locations.
- **Department of Licensing data** on driver's licenses, identification cards and instructional permits, for each month from January 2019 through December 2022. This also includes information reported to the Department of Licensing from other states when clients surrendered Washington identification.
- **Employment Security Department Next Generation Tax System data,** which provides information on clients' reported work hours, employer and location.

- **Office of Superintendent of Public Instruction Comprehensive Education Data and Research System data,** which provides information on Washington public school enrollment and disenrollment for clients aged 2-21 during our audit period.
- **Questionnaire responses** from state Medicaid agencies from five of the six states in our six-state sample. (Texas did not provide information.)
- **Information from auditors with the Oregon Secretary of State** regarding clients' health care encounters, interactions with Oregon caseworkers, and Supplemental Nutrition Assistance Program (SNAP) usage records.

Projections from the sample to the sampling frame

We used RAT-STATS (v 1.9.0.0) to conduct a stratified variable appraisal to determine the total amount of premiums paid for clients when a state other than Washington should have been responsible for the client's care. Examined values were the total premiums paid by Washington during the client's concurrent enrollment period with a particular state. Difference values were the total premiums paid by Washington when a state other than Washington should have paid the monthly premium for that client.

Our projections are based upon residency determinations from our sample of cases with concurrent enrollments (see discussion above for sources used to establish residency). The projections are a conservative estimate because:

- We only included clients who had an overlap with another state for six months or more. The projection accounts for about 59% (similar to, but slightly less than, the 60% with three or more months of concurrent enrollment) of all the clients who had concurrent enrollments with another state, district or territory for at least six months or more during our audit period. DSHS receives quarterly alerts from CMS (known as PARIS reports) listing clients enrolled in Medicaid through more than one state simultaneously. According to DSHS, by the time it receives the quarterly PARIS report, processes it and a caseworker is given enough time to research the overlap and terminate coverage, six months may have gone by.
- We only included premium payments in our projections for clients whose residency was clear beyond a preponderance of the evidence. Washington's Medicaid agency has made a decision to err on the side of providing Medicaid coverage when a client's state of residence is unclear.
- If the client did report the move out of state, projections include those clients determined to be residing out of state. We did not include the first month of concurrent enrollment because both states must pay the premium for the month of the move, since premiums are paid through the end of a month and the other state must insure the client immediately. However, we did include any additional months of premium payments beyond the first month of the move.
- If the client did not report the move, we also did not include the second month of concurrent enrollment. Federal rules require any move reported by a source other than the client to be verified before the person can be disenrolled in Medicaid within that state. Recently, CMS established the minimum length of time a client has to respond to an inquiry to verify residency to be 30 days, so moves requiring verification will certainly require a second month for resolution going forward.

- Some cases were left open during the public health emergency due to federal requirements to ensure continued access to care (see more information about this in the body of the report). We did not count premiums Washington paid for a case left open due to this reason, as stated in case file notes, in our projection, even if the client clearly was no longer a Washington resident.
- Sometimes cases were closed by a caseworker but then were reopened automatically (see more information about this in the body of the report). We did include in our projection any premiums paid for months when the case was reopened while the client was still residing out of state.

Confidence intervals for projections

Figures 7-10 list point estimates and confidence intervals for our projections. The point estimate is the single best guess for the value across the entire sampling frame. The lower and upper limits represent the 90% confidence interval around this point estimate. This means if we were to repeat our study using 100 different samples, 90 times out of 100 our projection would be expected to fall within this confidence interval.

Figure 7 – Estimates of unnecessary premium payments paid by Washington for the 2019–2022 six-state sample

Limits calculated using a 90% confidence interval

	Total amount
Point estimate	$28.9 million
Lower limit	$14.2 million
Upper limit	$43.6 million

Figure 8 – Estimates of unnecessary premium payments paid by Washington for the 2019–2022 Oregon sample

Limits calculated using a 90% confidence interval

	Total amount
Point estimate	$5.4 million
Lower limit	$3.6 million
Upper limit	$7.1 million

Figure 9 – Estimates of unnecessary premium payments paid by Washington for the 2019–2022 Oregon sample, MAGI adults

Limits calculated using a 90% confidence interval

	Total amount
Point estimate	$2.9 million
Lower limit	$1.3 million
Upper limit	$4.4 million

Figure 10 – Estimates of unnecessary premium payments paid by Washington for the 2019–2022 Oregon sample. SSI/SSI-related

Limits calculated using a 90% confidence interval

	Total amount
Point estimate	$2.0 million
Lower limit	$1.3 million
Upper limit	$2.7 million

Objective 2: What additional steps could HCA and DSHS take to ensure MCOs are not paid for enrollees who no longer live in Washington?

To evaluate how HCA and DSHS could improve identification of clients who had moved out of Washington and reduce premiums paid on their behalf, we:

- Gained an understanding of current processes
- Determined if processes in place worked correctly and ways they could be improved
- Worked with auditors from other states and reviewed relevant federal and state audits
- Interviewed appropriate staff and managers at state agencies and MCOs
- Reviewed datasets we used to determine residency in Objective 1

Gained an understanding of current processes

We reviewed relevant policies and procedures regarding eligibility, residency and changes of circumstance at HCA and DSHS.

Determined if processes in place worked correctly

We reviewed the processes currently in place and tested some key controls. See Work on Internal Controls, below, for more information.

Worked with auditors in other states and reviewed relevant federal and state audits

We reviewed other state and federal audits regarding concurrent enrollment, including audits completed by HHS-OIG and states including Louisiana, Massachusetts, Ohio and Rhode Island. A list of these audits is available in Appendix C. We also collaborated with auditors in Kentucky, Ohio and Oregon, along with HHS-OIG, throughout our audit.

Interviewed staff and managers at state agencies and MCOs

To learn about processes and procedures in place to help identify people who are enrolled in another state's Medicaid program, we conducted interviews with managers, program integrity staff and eligibility staff at HCA and DSHS. We asked about how both agencies find out a client is no longer a resident of Washington, how information is shared between agencies, and procedures in place to terminate coverage when a person is no longer a resident of Washington. We also asked managers and staff for their suggestions to improve or enhance current processes. Additionally, we discussed our recommendations regarding potential contract amendments for MCOs with management at these organizations.

Reviewed datasets we used to determine residency

We reviewed the datasets we used to determine residency in Objective 1 to see if they would be available and useful for HCA and DSHS to use in residency determinations.

Work on internal controls

Internal controls were significant within the context of the audit objectives. We did the following work on internal controls:

- Determined controls HCA and DSHS have in place to identify clients residing out of state
- Conducted additional testing in selected areas

Determined controls HCA and DSHS have in place

We determined what controls HCA and DSHS had in place by reviewing their policies and procedures related to residency determinations and processing change of circumstances. We also interviewed HCA and DSHS program integrity staff about controls to identify clients residing out of state. In addition, we evaluated the design of the controls.

Conducted additional testing in selected areas

We conducted additional testing on the following controls:

- PARIS reports: PARIS is a data-matching service that matches recipients of public assistance to check if they receive duplicate benefits in two or more states. DSHS receives the PARIS report quarterly, and both HCA and DSHS use the PARIS reports to identify concurrent enrollees. We reviewed available information to see if clients in programs administered by HCA and DSHS had PARIS alerts during their concurrent enrollment periods.
- Alerts from DSHS to HCA: DSHS has alerts ("ticklers") that automatically generate in certain cases relating to residency (for example, when DSHS benefits are closed due to a client no longer being a resident). We tested to see if the alerts were generated as expected and addressed by staff in a timely manner. We also identified situations that would not generate alerts, but DSHS caseworkers had reason to believe a client was likely residing out of state.
- Communication from MCOs on client address changes: MCOs provide reports of client change in circumstances, including residency, to HCA. We reviewed these reports to determine how frequently the MCOs sent them.

Appendix C: Audits Reviewing Concurrent Enrollments

The federal government and auditors in other states have conducted audits of Medicaid managed care concurrent enrollments. This appendix provides a brief summary of each audit's findings and links to the websites where these reports were published. In addition, we are aware of audits on this topic that were underway in Oregon and Kentucky at the time we published our report.

Audit reports published by the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG)

Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States

September 2022, A-05-20-00025

This audit found that 47 states, districts and territories made payments on behalf of Medicaid managed care beneficiaries who were concurrently enrolled in more than one state. Because the HHS-OIG was concerned the problem might be systemic, it embarked on a nationwide investigation of the topic. Across the nation, state Medicaid programs incurred costs of about $72.9 million for 208,254 concurrent enrollees in August 2019, and about $117.1 million for 327,497 concurrent enrollees in August 2020. Data was drawn from a national enrollment data system, the Transformed Medicaid Statistical Information System (T-MSIS). This data is available to the Centers for Medicaid and Medicare Services (CMS), but it does not share this data with individual states. HHS-OIG made a recommendation to CMS to share T-MSIS data with states so they could better identify concurrent enrollments, but CMS did not concur with this recommendation.

Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State

November 2020, A-05-19-00023

This audit explored concurrent enrollment with the state of Ohio. Auditors examined concurrent enrollments during the month of August 2018 and found the state paid an estimated $5.9 million for beneficiaries who were concurrently enrolled and resident in another state.

Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State

February 2021, A-05-19-00031

This audit explored concurrent enrollment with the state of Illinois. Auditors examined concurrent enrollments during the month of August 2018 and found the state paid an estimated $3.8 million for beneficiaries who were concurrently enrolled and resident in another state.

Minnesota Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State

May 2021, A-05-19-00032

This audit explored concurrent enrollment with the state of Minnesota. Auditors examined concurrent enrollments during the month of August 2018 and found the state paid an estimated $1.1 million for beneficiaries who were concurrently enrolled and resident in another state.

Florida Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

February 2023, A-05-21-00028

This audit explored concurrent enrollment with the state of Florida. Auditors examined concurrent enrollments during the month of August 2020 and found the state paid an estimated $6.9 million for beneficiaries who were concurrently enrolled and resident in another state.

Audit reports published by other states

Office of Medicaid (MassHealth) – Review of Capitation Payments

June 28, 2023, 2022-1374-3M5, Office of the State Auditor

The Office of the State Auditor in Massachusetts conducted an audit of the Massachusetts Office of Medicaid (MassHealth). Auditors estimated MassHealth paid $85 million over almost four years for beneficiaries who were concurrently enrolled and resident in another state or territory.

Medicaid Residency

August 16, 2023, 40220035, Louisiana Legislative Auditor

The Louisiana Legislative Auditor's Office conducted an audit of the Louisiana Department of Health (LDH). Auditors estimated the state paid $112.6 million over six and a half years for beneficiaries who were concurrently enrolled and resident in another state.

The Cost of Concurrent Enrollment

March 2024, Ohio Auditor of State

The Ohio Auditor of State conducted an audit of the Ohio Department of Medicaid. Auditors estimated the state paid more than $209 million over four years for beneficiaries who were concurrently enrolled and resident in another state.

State of Rhode Island Medicaid Capitation Paid for Members Residing in Other States

March 2024, State of Rhode Island Auditor General

The Rhode Island Auditor General conducted an audit of Rhode Island Medicaid. Auditors estimated the state paid $38.4 million over three years for beneficiaries who were concurrently enrolled and resident in another state or territory.

"Our vision is to increase **trust** in government. We are the public's window into how tax money is spent."

– Pat McCarthy, State Auditor

Washington State Auditor's Office
P.O. Box 40031 Olympia WA 98504

www.sao.wa.gov

1-564-999-0950

Office of the Washington State Auditor
Pat McCarthy