COMMENTS ON THE OVERSIGHT DIVISION'S REPORT TO THE JOINT COMMITTEE ON LEGISLATIVE RESEARCH REGARDING THE "APPLICATION PROCESS AND ELIGIBILITY VERIFICATION OF MEDICAID"

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These comments respond to the Oversight Division's Report to the Committee on Legislative Research regarding "the "Application Process and Eligibility Verification of Medicaid."[1] Our primary concern is that the findings in the new report could result in new obstacles to health coverage in the Missouri Medicaid program that would cause Missouri's poor and most vulnerable residents to lose access to health care. In particular, the conclusions drawn by Oversight Division's investigative staff and their recommended changes in verification practices would almost certainly cause large numbers of *eligible* families to lose heath coverage. This loss of coverage would have severe negative consequences for the health of Missouri's low-income residents and our state. These consequences should be evaluated carefully before new administrative barriers or verification policies are imposed.

The Report of the Oversight Division (hereinafter, "Report") reviewed samples of Missouri Medicaid cases primarily to see if documentation was sufficient to establish Medicaid eligibility. In several instances, the Oversight Division staff determined that Family Support Division (FSD) verification practices were inadequate because specific types of documentation were not included in the case file or the investigators believed that FSD's policies were not specific enough in requiring particular documents to verify certain eligibility factors.

The investigators did not determine that significant numbers of individuals were receiving health insurance improperly in these cases or that anyone was fraudulently receiving Medicaid.[2] They did, however, make a set of recommendations based on their findings – recommendations that, if implemented, would have the probable effect of cutting large numbers of *eligible* people off of the program. At the same time, the Report appropriately found that the Agency could make better use of the HIPP program to coordinate Medicaid and other forms of health insurance coverage.

These comments review some of the Report's findings and the implications of the recommendations in the report.

I. THE ADOPTION OF NEW VERIFICATION PRACTICES OR PROCEDURAL REQUIREMENTS WILL HAVE A SUBSTANTIAL NEGATIVE IMPACT ON MEDICAID COVERAGE OF ELIGIBLE INDIVIDUALS AND FAMILIES, AND WILL COST THE STATE MONEY

The implementation of new verification requirements and other administrative barriers would have several unintended consequences that are not addressed in the Report. In

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[1] See *Program Evaluation: Application Process and Eligibility Verification of Medicaid*, Prepared for the Committee on Legislative Research by the Oversight Division.

[2] The Oversight Division staff raised questions about the ongoing eligibility of individuals who had not had a Medicaid reinvestigation and whose case files included outdated financial information. Report at 16-20. However, the Committee's findings and recommendations on additional verification of specific points of eligibility were not based on any clear showing that the Agency's current policies cause ineligible people to remain on the program.

particular, we are concerned that significant numbers of eligible families will lose coverage at the same time that the state agency is forced to spend scarce resources on new and unnecessary administrative requirements.

The Report did not address the chilling effect that new verification requirements would have on participation in health insurance coverage by *eligible* individuals and families, including elderly and disabled residents who would have to spend more time trying to meet new income and resource verification requirements. As a United Hospital Fund study noted: "An estimated one-third of uninsured Americans – or 14.1 million people in 2001 are eligible for public health insurance. **Complicated application and renewal processes for public health insurance programs are barriers to enrollment and thereby contribute to the large numbers of eligible but uninsured persons**."[3]

To the extent that any *new* verification requirements are imposed, the impact would surely be that greater numbers of eligible individuals are denied Medicaid coverage. There is substantial research that imposing additional procedural obstacles, such as new verification requirements, causes *eligible* people to lose Medicaid coverage and deters eligible families from applying in the first place.[4] Families with children *eligible* for Medicaid and SCHIP often cite requirements to produce significant amounts of verification as a major factor thwarting their efforts to obtain and retain coverage for their children.[5] "In a survey of parents with uninsured children who were eligible for Medicaid, one of the most frequently cited barriers to completing the enrollment process was "the difficulty in getting all required documentation (72 percent)."[6] This research certainly is consistent with our experience with Legal Services clients who are often denied coverage because of *existing* administrative and/or paperwork requirements even though they meet the financial eligibility requirements of the program. Imposing more of these types of burdens will make it even more difficult for these clients to establish their eligibility for Medicaid coverage.

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[3] Danielle Holohan and Elise Hulbert, *Lessons from States with Self-Declaration of Income Policies*, United Hospital Fund of New York, 2004 ("United Hospital Fund Report") at 1 (citations omitted).

[4] Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge, A 50 State Update on Eligibility, Enrollment, Renewal and Cost-sharing Practices in Medicaid and SCHIP*, July 2003 ("New Tensions") at 3; Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October, 2004 ("Beneath the Surface") at 5. Ellen O'Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003, at 9; Laura Cox, *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs*, Center on Budget and Policy Priorities, December 28, 2001.

[5] Cohen Ross and Cox, *New Tensions,* at 13-16.

[6] Cohen Ross and Cox, *Beneath the Surface,* at 5. This same report goes on to state that in Washington, new income verification rules helped lead to a caseload reduction of *40,000* children, many of whom were undoubtedly eligible for Medicaid benefits. Id. at 7.

This means that **more low-income Missourians will become uninsured if the verification process is made more stringent than it is now**. Moreover, additional verification requirements mean greater administrative burdens and greater costs to the state agency, including more staff time to process the additional paperwork and ask additional questions.[7] As a recent Kaiser report notes:

> While requiring families to comply with added paperwork and reporting procedures may save money by reducing the number of people participating in the programs, it should be noted that costs also are incurred as a result of making such changes **In addition to the large costs associated with uncompensated care when uninsured people seek needed medical attention, and the serious financial burdens low-income families must shoulder to pay for treatment on their own, there are expenses associated with the administrative tasks necessary to implement more labor-intensive procedures.** Where financial pressures have already resulted in state workforce reductions or hiring freezes, it is important to keep in mind that changes such as increasing reporting and verification requirements are likely to require more staff time.[8]

Other studies show that savings achieved through imposition of administrative barriers are inefficient because people are likely to overcome enrollment barriers when sick and have *greater* health expenses.[9]

Such costs should be factored into any analysis of the "savings" from new verification proposals.

Cutting Medicaid by increasing verification requirements will throw *eligible* people off of Medicaid, generating a number of severe consequences to the state and its most vulnerable residents, as indicated below.

II. CUTTING MEDICAID ELIGIBILITY HAS A NUMBER OF NEGATIVE CONSEQUENCES FOR LOW-INCOME MISSOURIANS AND THE STATE, WHETHER THE CUTS ARE IN THE FORM OF DIRECT CHANGES TO ELIGIBILITY REQUIREMENTS OR INDIRECT CUTS THROUGH MORE RESTRICTIVE VERIFICATION PRACTICES

There is no doubt that if new, more restrictive eligibility verification practices are adopted in response to the Report, thousands of Missouri Medicaid recipients will lose health coverage. More restrictive enrollment practices have led to substantial losses in

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[7] Cohen Ross and Cox, *New Tensions,* at 16.

[8] Id. (emphasis added).

[9] United Hospital Fund Report at 6.

enrollment in several states. For example, new procedural barriers caused enrollment of children to drop by more than 149,000 in the Texas SCHIP program.[10] The imposition of these types of barriers has had a similar impact in other states.[11] And as indicated above, many of those families who lose coverage when these barriers are imposed *still meet* the eligibility requirements for Medicaid coverage. This loss of insurance coverage would have an array of negative consequences for the health and well-being of low-income Missourians and for Missouri's health care system and its economy. Among these consequences are:

- The loss of Medicaid coverage will increase the number of uninsured in our state. Because of Medicaid and SCHIP, the percentage of uninsured children in the United States and Missouri has remained steady, despite the decline in employer-based coverage.[12] Census data show that Missouri's rate of uninsured would have been far worse if not for the role of Medicaid and SCHIP in responding to increased need during the recent recession.[13] For example, the Center on Budget and Policy Priorities found that **from 2000 to 2002, the percentage of uninsured low-income Missouri children fell from 12.2 percent to 7.2 percent – a rate reduction that was entirely attributable to children** being enrolled in Medicaid and SCHIP.[14] Thus, it is no accident that Missouri's rate of uninsurance is 4% below the national rate.[15] The Center also has noted, however, that Missouri's rate of low-income uninsured adults has increased over the last several years as a direct result of cuts to parent Medicaid eligibility in 2002.[16] Cutting Medicaid eligibility through restrictive verification practices will increase Missouri's rate of uninsured.

- **The loss of Medicaid will diminish access to health care and health outcomes** for the people who become uninsured due to excessive verification practices. It is well established that having health insurance through Medicaid improves access to health care and health outcomes for those who are insured through the

[10] Cohen Ross and Cox, *Beneath the Surface,* at 6-8.

[11] Id.

[12] See Robert Mills, *Health Insurance Coverage in the United States: 2002*, Current Population Reports P60-223, U.S. Census Bureau, September, 2003.

[13] For further discussion of Missouri-specific findings on the impact of Medicaid and SCHIP on Missouri's rate of uninsured, see Joel Ferber, *Economic and Health Benefits of Missouri Medicaid*, Missouri Foundation for Health, April 2004, ("MFH Report") and the citations therein.

[14] See MFH Report at 8-9.

[15] Missouri's rate of uninsured was 11.3% for 2002-2003 while the national rate was 15.4% for 2002-2003. Table 9 (Percentages of People Without Health Insurance Coverage by State Using 2- and 3-year Averages: 2001-2003 (available at www.census.gov/hhes/hlthins/hlthin03/hi03t9.pdf).

[16] Leighton Ku, Memorandum to Interested Parties, Center on Budget and Policy Priorities, December 7, 2004.

program.[17] Studies have found that Medicaid and SCHIP have had a number of positive effects on the health care of Missouri children, including reduced emergency room visits, reduced emergency room visits for asthma, a decline in preventable hospitalizations, and improved school attendance.[18] Access to health care and health outcomes are diminished for those who lose Medicaid coverage.[19]

- **A loss of Medicaid coverage will reduce the financial stability of low-income families, making them more likely to incur medical debt and unable to afford the cost of health care.** In addition to its positive impact on health, Medicaid promotes financial stability among low-income families by paying for the costs of their health care. It is well established that having health insurance, including Medicaid, improves families' financial well-being. "Families who are uninsured are at greater risk than the insured of high out–of pocket medical spending due to injury or illness and its consequences (e.g., risk of impoverishment, bankruptcy, inability to afford other necessities, such as rent, food, clothing and transportation)."[20]

- **The state's uncompensated care burden will increase, shifting costs of the terminated Medicaid recipients' care to everyone else, including hospitals, health provides, insurers, employers, and patients.** For example, the Missouri Hospital Association has previously estimated a cost shift of more than $144 million dollars if Missouri's rate of uninsured were comparable to the higher *national* rate of uninsured.[21] The loss of health insurance coverage increases the amount of "uncompensated care" -- care that is not paid for by private or public insurance. A **Kaiser study showed that emergency room visits increased by**

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[17] Ellen O'Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003. See also Katie Plax and Joel Ferber, *Medicaid and SCHIP Improve the Health of Missourians*, Washington University School of Medicine, April 20, 2004, for a more detailed review of the medical literature on Medicaid and SCHIP's impact on health. Regarding the impact of health insurance on health access and outcomes, see Kaiser Commission on the Future of Medicaid and the Uninsured, *The Uninsured and their Access to Health*, January 2003; Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured: Executive Summary*, The Kaiser Commission on Medicaid and the Uninsured, February 2003 (available at *www.kff.org/uninsured/20020510-index.cfm,*1*)*.

[18] Department of Social Services, State of Missouri, *Since MC+ Began*, February 10, 2003.

[19] See O'Brien and Mann; Pam Silberman et al., *The North Carolina Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families ("Enrollment Freeze")*, January 2003; Cindy Mann and Samantha Artiga, T*he Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program*, Kaiser Commission on Medicaid and the Uninsured, June 2004.

[20] O'Brien and Mann at 19 (and the citations therein).

[21] Missouri Hospital Association, *Missouri Medicaid Briefing*, House Interim Committee on Medicaid Cost and Containment, October 10, 2003, at 37. MHA's findings are consistent with other research on this issue. See also MFH Report at 11-12 (and citations therein).

17% in the three months after Medicaid cuts were implemented in the state of Oregon compared to the year before.[22] These uncompensated care costs are transferred to other parts of the health system, driving up costs and straining health resources for people who are not covered by the Medicaid program.

- Missouri will lose valuable federal funds that it receives for covering these individuals. **These lost federal funds will mean a loss of economic activity and a loss of Missouri jobs.** Medicaid and SCHIP have a substantial and positive economic impact on our state and local economies. Medicaid brings significant federal matching dollars into the state. State Medicaid funds generate federal matching funds at a 61% rate for most individuals and a 72% rate for SCHIP children. Missouri Medicaid spending generates almost $1.6 in federal matching funds for every state dollar spent while SCHIP spending generates nearly $2.7 in federal matching funds. These federal matching funds are an important source of funding for hospitals, doctors, pharmacists, and nursing homes in every part of the state -- funding which, in turn, leads to economic ripple effects as these health care providers pay rent, purchase food, pay taxes and so on. An analysis of economic data by economists at the St. Louis University's John Cook School of Business found that every $1 million that the state spends on Medicaid spending generates over $3 million in business activity and 42 jobs. Expenditures on SCHIP have even larger effects.[23]

As indicated in this discussion, there would likely be a number of unintended consequences that would result if more restrictive Medicaid verification requirements are adopted in response to the Oversight Division's Report. These consequences should be evaluated before new administrative barriers to Medicaid coverage are implemented.

III. COMMENTS ON SPECIFIC FINDINGS IN THE REPORT

- **Income Verification**

The Oversight Division finds that "Recipient Income is Not Adequately Verified." Report at 9. Yet the findings in the report do not support this conclusion.

The Oversight Division staff alleges that FSD policy allows the use of a single pay stub to verify earned income when the income information is not considered questionable. The report recommends that Division of Employment Security (ES) data be used to verify income.

In fact, FSD policy provides that FSD staff can use a variety of sources to verify income, *including* ES data, as well as pay stubs.[24] It is understandable why FSD might not rely on

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[22] Mann and Artiga at 15.

[23] MFH Report at 5-9, 14-16.

[24] Missouri Income Maintenance Manual, § 0110.025.00 ("Earned Income").

the ES data in every situation since the applicant may report a change of employment or income that is not reflected in the ES system. In those situations, the applicant's current pay stub might be more accurate than the ES data. Furthermore, in many instances, FSD uses an automated employment verification service of the TALX Corporation to verify detailed and current employment information. This service was not mentioned in the Report. Regardless, the investigators' preference for using the ES data does not demonstrate that "recipient income is not verified." And, it certainly does not show that *ineligible* people are receiving health insurance through Medicaid simply because the Agency uses pay stubs for verification of income in some circumstances.[25]

It is important to note that a significant number of states do *not* require families to produce *any* documents to substantiate the income stated on their application (as opposed to Missouri which *does* require verification of income), and studies show that very few ineligible people receive benefits in those states. A recent study of those states that do not require families to produce documents to substantiate the income stated on their application concluded that "self-declaration of income, with appropriate safeguards [such as third party verification and reliable data exchange systems], provides states with the opportunity to simplify enrollment procedures and increase enrollment of eligible individuals without jeopardizing program integrity."[26] State officials also report that ***"reduced documentation requirements* allowed workers to process applications more quickly and generally increased the speed of eligibility determination[s]."**[27] Moreover, excessive income verification can impose substantial burdens on families as well as caseworkers. As a United Hospital Fund study noted:

> **Documentation of income is a particularly difficult requirement for low-income individuals and families whose work is often informal and episodic. [citations omitted] In addition, the income documentation requirement creates challenges for eligibility workers because it often requires extensive follow-up with applicants.** Furthermore, as state and local agencies increase the use of technology, such as electronic applications, to improve efficiency in their public program procedures, the income documentation requirements limit the potential gains of these innovations because it continues to rely on paper records.[28]

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[25] The Oversight Division staff also stated that there was an improper "lock-in" process based on a single case in which the caseworker apparently froze eligibility at the lower income level to continue eligibility, rather than follow FSD policy for estimating variable income. Report at 9-10. In fact, the FSD Manual actually has specific rules for estimating variable income and includes no such "lock-in process." It is possible that the caseworker made an error in the *one* case in which this problem was found. However, if the case was a "Medicaid for Pregnant Women" case, then the case likely was handled correctly as pregnant women are covered until the second month after their child is born, as long as they are eligible for benefits in *any* month during that time. Missouri Income Maintenance Manual § 0925.025.00.

[26] Cohen Ross and Cox, *Beneath the Surface*, at 5, citing United Hospital Fund Report.

[27] United Hospital Fund Report at iv.

[28] Id. at 1.

An earlier GAO study similarly noted significant advantages to Michigan's policy of *not* requiring documentation of income:

> Medicaid and SCHIP officials in Michigan told us that they eliminated documentation requirements because they were a barrier to application and enrollment. Before the state eliminated the documentation requirements, Michigan officials reported that 75 percent of the applications received were incomplete because individuals failed to provide adequate documentation. Michigan eliminated income documentation for both programs and, as a result, the proportion of incomplete applications received for both programs dropped to below 20 percent.[29]

Michigan officials also reported low error rates under this policy.[30] Of course, Missouri already does require documentation of income. However, these kinds of considerations should be taken into account before more burdensome income verification requirements are imposed in Missouri.

- **Asset Verification**

The Report finds that "FSD does not have an adequate way of identifying recipients' assets." It notes that "[t]he manual requires the caseworker to identify applicant balances in savings and checking accounts and time deposits, for programs which have limits on applicant resources. The manual then describes procedures for 'verifying' these balances, including obtaining copies of current bank statements or other papers from the applicant." Alternatively, the manual suggests that verification can be obtained from the institution with the applicant's written permission. Report at 10-11.

The Report states: "**[w]e believe these statements are unlikely to provide *any* valid information, since an applicant could have funds in *other* banks or institutions."** Report at 11. This finding is problematic because one would generally assume that written verification from financial institutions on the amount of money in a particular account is valid information. Yet the Oversight Division staff find that this is not valid information, because the individual *could* have "other bank accounts" that he/she is not disclosing. There is no evidence that this practice is actually occurring (i.e., that elderly and disabled Medicaid recipients are not disclosing bank accounts and other similar

[29] United States General Accounting Office, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care,* Report to the Ranking Minority Member, Committee on Energy and Commerce House of Representatives, September 2001, GAO-01-8983, at 14.

[30] State audits showed error rates of 3 percent under the policy. Id.

resources).[31] Yet the Oversight Division's investigators seem to assume that this is a serious problem and therefore attack existing verification procedures as inadequate. **It would be difficult, burdensome, and expensive to require the Agency to obtain proof of resources that it has no reason to believe the applicants have**.[32] For example, it would be costly and time consuming for caseworkers to write to every bank in the state to determine whether every single applicant and recipient might have an account that the Agency has no reason to believe they have.[33] **It is also virtually impossible for a Medicaid applicant or recipient to prove the non-existence of a resource.[34]**

The Department indicates that it uses IRS data to determine whether there are other income-producing resources that an individual may not have claimed and is open to considering other ways to identify unreported resources. Response to Legislative Oversight Review of Medicaid Eligibility ("FSD Response") at 3.[35] However, there would clearly be an administrative burden in trying to prove the non-existence of assets for every claimant.[36]

- **Verifying Age and Relationship**

The Oversight Division staff would like the Agency to require *more birth records* than it does under current policy. Report at 5-6. The Agency's current policy is to require verification of birth records for individuals who were born in Missouri but to use social security numbers to verify the age of individuals who were born outside of the state and accept the client's statement on relationship in these instances.[37] FSD Response to

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[31] In fact, studies show that "[s]tate officials report that counting assets actually keeps few families from qualifying for Medicaid, since those with very low incomes generally do not have much in terms of savings and other resources." Cohen Ross and Cox, *Beneath the Surface,* at 13.

[32] Missouri officials have previously stated that eliminating the asset test in its family Medicaid programs saved time, money and resources. Vernon Smith et al., *Eliminating the Medicaid Assets Test for Families: A Review of State Experiences*, Kaiser Commission on Medicaid and the Uninsured, April 2001, at ii. These savings occurred because of the paperwork burdens involved in verifying assets.

[33] Banks are also unlikely to provide this service for free to FSD staff.

[34] At one point, the investigators suggest that Income Tax Returns be used to verify assets but in fact very high percentages of low-income people do not file a tax return and are not required to file a return because of their low-incomes. Requiring Medicaid applicants to produce a tax return would undoubtedly impose new burdens on families and caseworkers and would not be a very effective way to establish current assets.

[35] The Family Support Division's response can be found in the Appendix to the Report.

[36] The Oversight Division also expressed concerns about treatment of certain types of assets (e.g., life insurance, prepaid burial plans and real estate) and expressed a preference for more restrictive practices with regard to these assets. Report at 11-13. These comments do not address any errors by FSD but express policy preferences of the Oversight Division. As pointed out in the Family Support Division's Comments, these policies are based on federal and state laws that FSD is required to follow, and are not discretionary with FSD. FSD Response to Comment 3.

[37] Missouri Income Maintenance Manual, § 0110.010.00.

Comment 1. FSD can readily obtain birth records within Missouri but not from other states. The investigators gave no indication that there was a problem with the way FSD determines whether an individual is related to the child in need of Medicaid benefits. There is no indication that requiring additional birth verification in these instances is necessary or that such a change in verification policy would be cost-effective.

The Agency's current policy also makes sense because there is little to be gained by the imposition of further documentation of the relationship between the parent and the child. In fact, children for whom assistance is sought would be more likely to be eligible for coverage if the adult in the household is *not* related to the child, than if the caretaker is related. If the child's caretaker is someone other than the parent, then that person's income cannot be counted, which would result in *less* income being counted in determining the child's Medicaid eligibility.[38] There is no incentive for caretakers to be dishonest in claiming that they are related to the child for whom they seek benefits because the *lack of such a relationship will increase the likelihood of Medicaid eligibility.*

It is certainly possible, however, that *eligible* families, who have difficulty obtaining birth certificates, could be denied coverage even though they are financially eligible for health insurance through Medicaid.[39]

- **State Employees who Receive Medicaid**

The Report expressed concern about people receiving both state employment insurance and Medicaid. **There is nothing improper about these 325 people receiving both forms of health insurance.** Medicaid recipients are allowed to have other insurance (private, employer-sponsored or state-sponsored insurance). Medicaid, however, is the payer of last resort. [40] States are required to pursue other insurance before Medicaid pays for health care costs.[41] State employees only qualify for Medicaid if they are poor enough to meet the income eligibility requirements for that program. If they are receiving Medicaid, it means that their income from state employment is low enough for the family to meet Medicaid eligibility requirements. Many are likely to be on Transitional Medical Assistance (TMA), for which they are automatically eligible, when

[38] 42 C.F.R. § 435.602(a)(1).

[39] For example, many things can happen to create difficulties in obtaining birth certificates. These types of documents can be destroyed by fire or an act of God, lost through a physical move from one address to another, or stolen, along with other vital documents. In light of the many circumstances that can occur with physical documents, it does not make sense to create *additional* procedural barriers to obtaining crucial and potentially lifesaving medical assistance.

[40] 42 U.S.C. §§ 1396a(a)(25), 1396b(o).

[41] States are required to "take all reasonable measures to determine third parties (including ERISA plans and health maintenance organization) who are or may be liable to pay all of part other medical costs of injury, disease, or disability of a Medicaid applicant or recipient." 42 U.S.C. §1396a(a)(25). See 42 C.F.R. § 435.137-433.140. In most instances, Medicaid will pay benefits only to the extent that Medicaid payment exceeds the amount of third party liability. 42 U.S.C. § 1396a(a)(25)(C); 42 C.F.R. § 433.139.

they lose eligibility for Medical Assistance for Families (MAF) due to employment or increased earnings.[42]

The Report did *not* find that providers were getting paid twice for the same medical care, which *would* show a significant problem in the state's administrative procedures. The Report simply found that a small number of state employees had both forms of coverage.

State Medicaid programs are not allowed to deny health coverage to people who have other insurance, and other insurers (including the state employees' health plan) are not allowed to deny health insurance coverage to people because they have Medicaid.[43] The key is for the state to have administrative procedures in place to ensure that Medicaid only pays over and above what the other insurance covers, even when the additional coverage is the state employee health insurance plan.

The Report recommends that the state eliminate duplicate coverage if it is not advantageous to the state. Report at 24. While the state clearly needs to coordinate Medicaid and other health insurance coverage, this is far different from having a policy that would prohibit people from having two different forms of coverage when one of them is Medicaid. Of course such a policy would run afoul of various federal laws.

- **HIPP Program and Coordination of Benefits**

The Oversight Division recommended that that FSD develop procedures to improve the Health Insurance Premium Payment (HIPP) unit referral process and to evaluate the potential benefit and cost of developing an automated system. Report at 17-18. FSD indicated that it would explore ways to do this with the Division of Medical Services. FSD Response at 4.

The HIPP program is an appropriate and cost-effective way to use state resources. This program is one of the effective ways in which a state agency can coordinate Medicaid with private health insurance coverage. The Agency certainly should be evaluating whether it is cost-effective to enroll people in HIPP and should have sufficient resources to make these determinations. It is well worth exploring the possibility of making improvements in this area. It is also appropriate to refer state employees to this program for better coordination of their health care coverage. Having Medicaid pay for

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[42] There are also important policy reasons why the State would want to allow state employees to have both forms of coverage. For example, if a state employee were required to give up his or her state employment coverage because of Medicaid coverage, there could be gaps in health coverage when the Medicaid coverage runs out (e.g., because Transitional Medical Assistance ended). At that point, the recipient might have missed the open enrollment period for state employee coverage and might not be able to receive any health coverage at that time. Having both Medicaid and state employee coverage protects against the possibility that the individual will be uninsured when he or she loses Medicaid. In other instances, the person's low-income may preclude payment of deductibles or premiums required in the state employee's plan, or a person's special health needs may require greater coverage than the state employee's plan allows. In these instances, Medicaid can fill in the gaps in state employee health coverage.

[43] 42 U.S.C. §§ 1396a(a)(25)(D) and (G).

State employee health coverage through the HIPP program may well be appropriate in a number of cases when individuals are eligible for both programs.

- **Requiring Social Security Numbers from the Entire Family**

The Report expresses a concern that FSD policy does not require that everyone in the household provide a social security number. In fact, current FSD policy requires a social security number for every individual *applying* for Medicaid. As is noted in the Agency's comments, FSD cannot require a social security number for individuals who are *not* applying for Medicaid, under applicable federal regulations**.** See 42 C.F.R. §§ 435.910 and 435.920.[44]

The Oversight Division staff recommends that FSD require verification of Social Security numbers for "applicant family members." If the staff means that FSD should require verification of SSNs for people applying for benefits, then this procedure is what FSD already does and what they appeared to be doing in the cases that were reviewed. Under federal guidelines, FSD cannot require social security numbers of family members who are not applying for benefits nor should they have to require such verifications, although they almost always obtain this information anyway (See FSD Response to Comment 1). There is no clear need for any change in policy in this area.

FSD does have to verify income of certain individuals in the household whose income is countable for the purposes of determining eligibility. In those instances, there are a variety of ways to verify income besides requiring the production of a social security number. There is clearly no need for this information in the case of individuals who cannot be counted for Medicaid purposes, such as non-parent caretaker relatives of children applying for Medicaid/MC+ benefits.

The Oversight Division staff also recommended verification of birth dates for everyone in the family. This recommendation would be prohibitively burdensome for the state and the family and is totally unnecessary. **Age is not a relevant factor in most instances and is *never* a relevant factor for people who are not applying for Medicaid.** The Agency needs to know the age of children to determine whether they are eligible for MC+ and the appropriate category of MC+ eligibility, and it needs to know the age of people reaching 65 to determine eligibility for Medical Assistance. FSD verifies age in these instances.[45] Requiring birth verification in all of the other situations, in which it is clearly irrelevant to determining eligibility, would be wasteful and an inappropriate use of taxpayer funds. It would also be an especially onerous burden for low-income

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[44] Federal guidance provide that "[s]tates must require the disclosure of SSNs only for applicants and recipients of Medicaid benefits." Centers for Medicare and Medicaid Services, Policy Guidance Regarding Inquiries into Citizenship, Immigrant statues and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits, September 21, 2000, Questions and Answers, at 3. States may not deny benefits because the applicant did not provide the SSNs of person who were neither applicants for nor recipients of Medicaid or SCHIP (Medicaid expansion program) benefits. Id.

[45] Missouri Income Maintenance Manual, §§ 0110.000.00 and 1005.005.00.

families, many of whom would lose Medicaid even though they meet the financial eligibility requirements of the program.

- **Verification of Address**

The Oversight Division staff felt that more needed to be done to verify recipients' addresses, and they wanted address documentation in the files of all recipients. Report at 6. They disputed the Agency's policy of accepting the claimant's statement unless the address was questionable. Under this policy, there was understandably no address verification in a number of the files (45%), given that verification is not required.

The actual Medicaid eligibility requirement is that people *reside* in Missouri, not that they prove their actual address. There is no indication in the Committee staff's findings that the cases in which address was not verified *were questionable* or that it would be an efficacious use of limited state resources to require production of additional paperwork to prove addresses in every case. As indicated above, however, it is likely that eligible individuals would lose health coverage because they would not be able to keep up with additional paperwork requirements.

- **Out-of-State Residents**

The Oversight Division staff expressed concern that some individuals receiving Medicaid have addresses outside the State of Missouri They recommend that FSD verify recipients' residency status on at least an annual basis, especially in cases where recipients have mail routed to an out of state location. Report at 20-21.

FSD indicated that its policy is to verify residence when this information is questionable, and they agreed that having an "out-of-state" address is a reason to question residence in Missouri. FSD Response at 4-5. Thus, additional verification is required under the Agency's current policy in these circumstances. The Department also indicated that it is involved in a federal program to determine receipt of benefits in two different states and is looking into ways to better utilize the information.

It is not clear that there is anything insufficient in the Department's policies or practices with regard to verifying addresses in these situations.

- **Medicaid Reinvestigations ("Reverifications")**

The Report notes that the Agency is not completing reinvestigations in a high percentage of cases. The Agency is required to conduct annual reviews of Medicaid eligibility. However, the **Legislative Oversight Division has indicated previously that it would cost almost $14 million and require over 250 additional staff to conduct annual reinvestigations in all cases.**[46] One solution would be to provide the staff needed to

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[46] See Committee on Legislative Research, Oversight Division, Fiscal Note for HS for HCS for HB 1566, L.R. No.: 4719-07, March 17, 2004; *Department of Social Services Medicaid Eligibility, Performance*

conduct these reinvestigations and still comply with all of the agency's other responsibilities. There is nothing wrong with conducting annual reviews, provided they are conducted in a fair manner. It also makes sense, as the investigators suggest, to better utilize the information obtained from Food Stamp recertifications, as the Oversight staff have suggested. The Agency has indicated that it is in the process of automating its ability to use Food Stamp recertification information in performing Medicaid reinvestigations.

Again, it is worth noting that the investigators did not find that the failure to conduct these reviews caused large numbers of ineligible people to remain on Medicaid, just that these reviews were not conducted in a number of cases. In fact, the investigators noted that many of the Medicaid recipients whose cases they reviewed were eligible for food stamps and "concluded that **most of these recipients were *eligible* for Medicaid based on information in the Food Stamp reinvestigation**." Report at 15 (emphasis added).

Furthermore, the Report noted that many Medicaid recipients, especially the blind, the totally and permanently disabled and the elderly, would likely remain eligible for extended periods of time, and that **"there is very little risk that these individuals would receive inappropriate benefits because their situations are unlikely to change."** Report at 17. Thus, the failure to conduct reviews does not necessarily lead to significant numbers of ineligible people remaining on the program.

The Report recommends that FSD focus staff time on reinvestigation of those cases in which circumstances are most likely to change. Report at 17. Given limited staffing, it certainly makes sense for the Agency to prioritize its work on reinvestigations. Ultimately, it makes sense to ensure that FSD has sufficient staffing to conduct the reinvestigations. The Department of Social Services has previously reported that it is staffed at only 46% of need.[47]

Given the Report's finding regarding the failure to conduct Medicaid reinvestigations, it is not surprising that the Oversight Division staff also found that FSD continues benefits to recipients based on outdated information. Report at 7. The Oversight Division did not recalculate budgets or conduct additional investigations to determine whether any of the cases reviewed would have shown that people were actually ineligible for assistance because the Division staff found that this work "falls within the caseworkers' duties." It is not surprising that the failure to conduct reinvestigations would lead to files that do not contain updated information. Yet this finding does not show that all of the individuals who were not reinvestigated would have been financially ineligible for health care coverage. In fact, as indicated above, significant numbers of these recipients are still eligible because their financial circumstances are relatively stable or could have been found to remain eligible based on their ongoing food stamp eligibility.

Audit, from the Office of State Auditor Claire McCaskill, Report No. 2004-29 ("State Auditor's Report"), April 27, 2004 at 12.

[47] State Auditor's Report at 12.

- **Consolidation and Automation of Medicaid and Other Programs**

The Report recommends further integration of Medicaid and other programs in both its processes and computer systems. Coordinating and aligning programs are worthwhile ideas to consider. However, the Department has been engaged in the development of its FAMIS computer system and transition to that system for approximately fifteen years and is moving very slowly through that process. Only Food Stamps and Child Care have been converted to FAMIS at this point, and the Department is in the process of moving the Temporary Assistance program to FAMIS.

In our view, the transition to the FAMIS system has sometimes been a barrier to implementing improvements to various programs, and we are skeptical of the Agency's ability to better integrate its programs within its computer systems in light of its commitment to FAMIS and the slow pace at which changes to FAMIS are implemented. Because it does not appear that Medicaid will be transferred to FAMIS at any time in the near future, it will likely be difficult to integrate Medicaid with all of the other programs in the FSD computer system for the foreseeable future. FSD's comment about using FAMIS information to update Medicaid cases prior to the transition of Medicaid to FAMIS seems reasonable in light of the time it has taken to transition various programs to the FAMIS system.

- **Family Composition**

The Oversight Division staff expressed concern about the treatment of Family Composition in the cases that they reviewed. They recommend that FSD include financial information for all family members unless there are "legitimate, documented reasons for excluding these individuals." Report at 7. These decisions are not discretionary with the Family Support Division as there are specific legal rules that govern who must be in the assistance group and who must be excluded. There is no room for further policymaking by FSD on "reasons" for inclusion or exclusion of certain household members.

IV. ISSUES NOT ADDRESSED BY THE REPORT

It is important to recognize that there are a number of issues that the Report did not address that are important to evaluating the performance of the Medicaid program in meeting its legal requirements and its overall mission. These include the following issues:

- As indicated earlier, for the most part, the investigators did not review whether the individuals whose case files were found to have insufficient documentation were actually ineligible to receive health insurance through the Missouri Medicaid program. Moreover, there was no indication that the Agency's *current* verification policies allow significant numbers of ineligible individuals to receive Medicaid. The primary problem identified was the Agency's failure to conduct

timely reinvestigations which the Agency attributes to insufficient staff.[48] The Report did not directly address the staffing needed to conduct these reinvestigations consistent with federal requirements.

- **The investigators did not review cases in which Medicaid *was denied or terminated* to see if people were being *denied* health coverage improperly.** In our experience, the more common problem is that individuals and families who are in fact *eligible* for these programs are often improperly denied coverage. Only with legal representation are these improper denials and terminations corrected. On a daily basis, we help individuals and families who have been denied coverage based on misapplication of family composition, age, income, disability and other eligibility requirements.[49] These kinds of errors are *another* consequence of insufficient staffing and training combined with complex eligibility rules. These improper denials and terminations mean a loss of medically necessary health care for some of Missouri's most needy residents.

- There was no review of the cost-effectiveness or administrative efficacy of implementing new verification requirements. For example, **there was no review of the staff time involved in requiring additional verification** of various points of eligibility, such as verifying the *non-existence* of resources that the Agency has no reason to believe that claimants actually have or obtaining specific verification for individuals who are not applying for Medicaid. These issues are critical in light of ongoing staffing shortfalls in staffing at the Agency. As indicated earlier, the Agency reports that it is staffed at only 46% of need.

- There was no review of the impact of these proposals on access to health coverage by low-income people, and whether *eligible* individuals would lose coverage if new administrative burdens were imposed in the program. As indicated above, studies show that excessive verification requirements do cause eligible individuals to be denied health coverage through Medicaid.

- There was no review of how well the Medicaid program was performing in providing health care services to eligible families, either in terms of providing benefits to families in a timely manner or providing health care services to individuals enrolled in Medicaid managed care plans or in fee-for-service Medicaid. For example, the Oversight Division did not review recipients' access to health care providers or whether reimbursement rates are sufficient to meet the program's goals of providing health care to Missouri's poorest residents.[50]

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[48] Report at 15.

[49] Sometimes these errors cause widespread denials of coverage. For example, LSEM learned through one of its cases that the Agency erroneously suspended more than 4700 children from the Medicaid program because of the *complexity* of its system for providing Transitional Medical Assistance to children and parents in low-income working families.

[50] As the Report states, "[t]he goals of the Medicaid program are to promote good health, prevent illness and premature death, correct, or limit disability, treat illness, and provide rehabilitation to persons with

Many of these issues should be addressed when policy changes are contemplated in this area, while others should be reviewed to determine whether the Missouri Medicaid program is performing in accordance with legal requirements and its mission of providing health insurance to Missouri's low-income residents.

V. CONCLUSION

The Oversight Division's Report to the Joint Committee on Legislative Research includes a number of recommendations that would increase paperwork burdens on both the state agency and Medicaid applicants and recipients. As indicated above, the Oversight Division's findings do not justify many of the recommendations in the report. The Report did not document fraud or identify significant numbers of ineligible people receiving Medicaid. Nor did it attempt to review terminations and denials of Medical Assistance to address whether *eligible* people are being denied coverage. The Report did not address the *costs* of imposing new administrative burdens or the consequences of imposing such burdens on eligible families. The Report also appears to misconstrue third party liability provisions in its discussion of state employees receiving both Medicaid and state-employee coverage.

The Oversight Division *appropriately* expresses a need to evaluate more individuals for the HIPP Program and to better coordinate Medicaid and third party insurance coverage. The Report raises concerns with program alignment which may also be worth further study. Our primary concern is that the Report could lead to implementation of policies that will negatively affect the health of low-income Missourians and will have severe deleterious consequences for Missouri's health care system and its economy.

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disabilities. Certainly, there are an array of other important program policies and practices that could be evaluated to determine whether the State is meeting these goals, besides policies and practices that involve verification of eligibility. Report at 1.