

Report to the Governor and the General Assembly of Virginia

Eligibility Determination in Virginia's Medicaid Program

2015



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Director

Hal E. Greer

JLARC Staff for This Report

Nathalie Molliet-Ribet, Associate Director

Jeff Lunardi, Project Leader

Erik Beecroft

Chris Duncombe

Nia Harrison

Matt Johnson



COMMONWEALTH of VIRGINIA

Joint Legislative Audit and Review Commission
201 North 9th Street, General Assembly Building, Suite 1100
Richmond, Virginia 23219

Hal E. Greer
Director

(804) 786-1258

April 7, 2016

The Honorable John C. Watkins, Chair
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Watkins:

In 2015, the General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to review Virginia's Medicaid program (HJ637 and SJ268). As part of this study, the report *Eligibility Determination in Virginia's Medicaid Program* was briefed to the Commission and authorized for printing on November 9, 2015.

On behalf of Commission staff, I would like to express appreciation for the cooperation and assistance of the staff of the Departments of Medical Assistance Services and Social Services.

Sincerely,

A handwritten signature in cursive script that reads "Hal E. Greer".

Hal E. Greer
Director

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Abbreviations

Aged, blind, or disabled	ABD
Application Benefit Delivery Automation Project	ADAPT
Center for Medicare and Medicaid Services	CMS
Central processing unit	CPU
Department of Medical Assistance Services	DMAS
Department of Motor Vehicles	DMV
Department of Social Services	DSS
Federal Medical Assistance Percentage	FMAP
Government Accountability Office	GAO
Home and community based services	HCBS
Local department of social services	Local DSS
Medicaid Management Information System	MMIS
Modified adjusted gross income	MAGI
National Directory of New Hires	NDNH
Payment Error Rate Measurement	PERM
Supplemental Nutrition Assistance Program	SNAP
Temporary Assistance for Needy Families	TANF
Virginia Case Management System	VaCMS
Virginia Employment Commission	VEC

Summary: Eligibility Determination in Virginia's Medicaid Program

WHAT WE FOUND

Virginia policies do not ensure that all eligibility criteria are verified for all individuals

State policy does not require eligibility workers to search for either unreported income or unreported assets. Without complete information, Virginia is vulnerable to erroneously providing benefits to individuals who do not meet financial eligibility criteria for the Medicaid program. Virginia's policies were developed when information was verified manually and identifying unreported resources would have been difficult, but the state is increasingly able to verify eligibility criteria using electronic data sources.

A 2012 triennial federal review showed that Virginia's eligibility error rate had significantly improved since the previous review in 2009. Recent pilot reviews indicate a modest increase in errors, which may be curbed once the eligibility determination process reaches a steady state.

Late eligibility determinations may delay access to health care and result in spending on ineligible recipients

Local departments of social services (DSS) have struggled to determine eligibility for many Medicaid applications within prescribed time standards, which can delay access to health care for eligible applicants such as pregnant women. The number of overdue applications has decreased substantially in recent months, but it remains relatively high: one quarter of Medicaid applications submitted during the first quarter of 2015 were approved late.

Local offices have also been unable to renew the eligibility of some Medicaid recipients every 12 months as required, due to considerable changes to the eligibility determination process and a significantly increased workload. When renewals are performed late, Medicaid recipients who have become ineligible continue to receive benefits. In FY 2014, it is estimated that between \$21 million and \$38 million was

WHY WE DID THIS STUDY

The General Assembly directed JLARC to review the eligibility determination process for Medicaid benefits in Virginia. Medicaid eligibility determination in Virginia is undergoing significant changes, including new policies for most Medicaid applicants and a new information system used for all applicants. In the midst of these changes, eligibility determinations need to remain accurate and timely to ensure that only eligible applicants receive benefits.

ABOUT VIRGINIA'S MEDICAID PROGRAM

The Virginia Medicaid program provides medical, long-term care, and behavioral health services to more than one million individuals each year. The Department of Medical Assistance Services (DMAS), which administers the program, paid almost \$8 billion in state and federal funds for services in FY 2014.

DMAS and the federal government set Medicaid policy. The Virginia Department of Social Services oversees the implementation of eligibility policy, and local departments of social services (local DSS) carry out policy to determine the eligibility of individuals.

spent on benefits for ineligible recipients whose renewals were processed late. Half of these benefits were paid with state funds.

Half of all overdue renewals in Virginia in FY 2015 were concentrated in only six local offices. Five of these six offices also have some of the lowest staffing levels relative to caseload in the state, partly because the current method of allocating base administrative funds to local DSS offices is outdated and does not reflect current workload.

Virginia does not proactively identify assets that could be recovered to offset Medicaid expenses

Virginia does not proactively identify assets that could be recovered from the estates of deceased Medicaid recipients to reimburse the cost of the services they received. The state currently relies primarily on heirs and estate administrators to disclose or self-report the existence and value of assets, creating a conflict of interest because these individuals may stand to inherit the assets if they are not used to reimburse the state for Medicaid expenses. Virginia recovered just \$883,000 from 207 estates in FY 2014. Identifying assets for recovery was difficult before the availability of electronic data. The state's new eligibility determination system will soon contain information that could be used to identify which estates may have recoverable assets and prioritize those with the highest values.

WHAT WE RECOMMEND

Legislative action

- Direct DMAS to change Medicaid eligibility policy to require (i) checking electronic data sources when applicants report zero income and (ii) searching for unreported assets when applicants are subject to an asset limit.
- Direct VDSS to review and revise the current allocation methodology for state administrative funds for local departments of social services.
- Direct DMAS to proactively seek recovery from the estates of deceased Medicaid recipients.

Executive action

- DMAS should develop a proposal to the General Assembly for using the central processing unit to address the backlog of overdue renewals.

The complete list of recommendations is available on page iii.

Recommendations: Eligibility Determination in Virginia's Medicaid Program

RECOMMENDATION 1

The General Assembly may wish to consider amending the Code of Virginia to require all financial institutions doing business in Virginia to provide the Department of Medical Assistance Services with financial records for all accounts owned by Medicaid applicants and recipients whose financial resources are subject to an asset limit under Medicaid eligibility requirements (Chapter 2, page 15).

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to develop the capability to search for real estate assets through the Virginia Case Management System for all individuals whose assets are subject to an asset limit under Medicaid eligibility requirements (Chapter 2, page 16).

RECOMMENDATION 3

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to modify current policy to direct eligibility workers to apply the same protocols when verifying income for all individuals, including those who report no earned or unearned income (Chapter 2, page 20).

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act to direct the Departments of Medical Assistance Services and Social Services to implement a process for checking Virginia's new hire database for recent employment when data available from the Virginia Employment Commission at the time of Medicaid application or renewal does not identify wages. The Department of Medical Assistance Services should work with the Centers for Medicare and Medicaid Services to gain access to the National Directory of New Hires (Chapter 2, page 21).

RECOMMENDATION 5

The General Assembly may wish to consider including language in the Appropriation Act to direct the Departments of Medical Assistance Services and Social Services to implement a process for checking wage data from the Virginia Employment Commission six months after application or renewal, in cases where self-attestation was accepted at the time of application or renewal (Chapter 2, page 22).

RECOMMENDATION 6

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to modify current policy to direct eligibility workers to search for unreported assets using all available sources of electronic data, including local real estate property databases, the Department of Motor Vehicles, and Virginia's asset verification system, for all Medicaid applicants and recipients whose assets are subject to an asset limit under Medicaid eligibility requirements (Chapter 2, page 25).

RECOMMENDATION 7

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to make the necessary improvements to the Virginia Case Management System so that eligibility workers have the tools to manage their caseload and minimize the number of late applications (Chapter 3, page 36).

RECOMMENDATION 8

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to implement the necessary changes to the Virginia Case Management System so that eligibility can be determined at the time of renewal through an automated process (Chapter 3, page 37).

RECOMMENDATION 9

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to amend the Virginia Medicaid application, with approval from the Centers for Medicare and Medicaid Services, so that Medicaid applicants grant permission to use their federal tax returns to perform renewals, unless they opt out (Chapter 3, page 38).

RECOMMENDATION 10

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to amend the Virginia Medicaid application, with approval from the Centers for Medicare and Medicaid Services, so that additional information is provided on the advantages to recipients of granting access to their tax returns for the purpose of renewing their Medicaid eligibility, and so that the request for permission to use federal tax data for eligibility renewals is placed in a more prominent position on the form (Chapter 3, page 39).

RECOMMENDATION 11

The Department of Medical Assistance Services should conduct outreach to recipients who have not granted permission for electronic renewals, to explain the advantages of electronic renewals and provide a mechanism for recipients to grant permission (Chapter 3, page 39).

RECOMMENDATION 12

The Departments of Medical Assistance Services and Social Services should develop a plan for expanding the central processing unit, to reduce the backlog of overdue renewals as quickly as is practicable, and establish a target limit on the number of late renewals each month. The plan should be submitted to the House Appropriations and Senate Finance Committees by the beginning of the 2016 General Assembly session (Chapter 3, page 44).

RECOMMENDATION 13

The General Assembly may wish to consider appropriating necessary general funds to implement the plan presented by DMAS for expanding the central processing unit to reduce the backlog of overdue renewals (Chapter 3, page 44).

RECOMMENDATION 14

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to develop an objective and data-driven formula for the allocation of state administrative funding to local departments of social services that reflects workload, ability to pay, and other factors that affect performance (Chapter 3, page 46).

RECOMMENDATION 15

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to use data from the Virginia Case Management System to identify the reported assets of deceased Medicaid recipients and to initiate recovery from estates for which the value of the assets is likely to exceed the cost of recovery (Chapter 4, page 53).

RECOMMENDATION 16

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to use electronic data sources to search for unreported assets of deceased Medicaid recipients and to initiate recovery from estates for which the value of the assets is likely to exceed the cost of recovery (Chapter 4, page 54).

1 Medicaid Eligibility in Virginia

SUMMARY Virginia's Medicaid program provides benefits to children, parents, the aged, disabled individuals, and pregnant women who meet certain residency and financial criteria. The state spent \$7.9 billion to serve more than 1.2 million individuals, or nearly 15 percent of Virginians, enrolled in Medicaid during FY 2014. Determining eligibility for these individuals is a complex process involving multiple state and local agencies that establish and implement eligibility policy, as well as multiple data systems for eligibility verification. These policies, processes, and systems have undergone significant changes since Fall 2013, when eligibility criteria changed for most Medicaid applicants and the state implemented a new eligibility determination system.

In 2015 the General Assembly directed JLARC to review Virginia's Medicaid program. The mandate specifically called for a review of the eligibility determination process and whether appropriate services are provided in a cost-effective manner (Appendix A). This report presents research and findings related to the eligibility determination process for Medicaid in Virginia. Two other reports will be issued under the study mandate, addressing Medicaid non-emergency transportation services (December 2015) and the cost-effectiveness of Medicaid services (Fall 2016).

A variety of research activities were conducted to evaluate the eligibility determination process. Interviews were conducted with state agency staff who are responsible for setting and implementing eligibility policy, and with local agency staff who are responsible for determining eligibility for Medicaid benefits. Extensive analysis of data collected from multiple state agencies was performed to further understand the eligibility determination process (Appendix B).

Virginians must meet numerous criteria to be eligible for Medicaid

To be covered under the Medicaid program in Virginia, individuals must fall into one of five primary eligibility categories, as well as meet non-financial criteria, such as U.S. citizenship and Virginia residency. In addition, individuals must meet the financial criteria for their specific eligibility category.

Only certain categories of Virginians are eligible for Medicaid

In Virginia, individuals may be eligible for full Medicaid benefits if they fall into one of five primary eligibility categories:

- children (under age 19),
- parents or legal guardians of a dependent child,
- pregnant women,
- aged (65 or older), or
- disabled or blind.

Belonging to one of these categories does not in itself guarantee eligibility, but it is necessary to be enrolled in the program. Adults without children are not eligible for full Medicaid benefits unless they are aged, blind, or disabled. There are other partial benefit categories, including family planning services for adults and limited Medicare cost-sharing benefits for some Medicare-eligible applicants, for individuals who meet specific eligibility criteria.

All applicants must meet the same non-financial criteria but financial criteria vary depending on eligibility category

An individual who belongs to one of Virginia's primary Medicaid eligibility categories must also meet non-financial eligibility criteria. As required by federal regulation, each applicant's identity must be verified. The individual must either be a U.S. citizen or have a certain immigration status, and the individual must be a Virginia resident.

To be eligible for Medicaid, individuals must meet financial criteria that are specific to the corresponding eligibility category. Each recipient must have income below the appropriate percentage of the federal poverty level for their eligibility category (Table 1-1). The income thresholds in Virginia range from 24-48 percent of the federal poverty level for able-bodied parents to 143 percent of the federal poverty level for children and pregnant women. In 2015, the federal poverty level for a family of three was \$20,090. Both earned income, such as wages and salaries, and unearned income, such as social security and unemployment income, are assessed against the income threshold. For non-disabled children to be eligible, the income of their parent or guardian must be below the threshold.

In addition to the income threshold, there are asset limits for aged and disabled recipients: \$2,000 for individuals and \$3,000 for married couples. There is no asset limit for children, parents, or pregnant women. Typical assets that are counted include bank accounts, real estate, and vehicles. Homes are exempt if the applicant still lives in the home, and one vehicle is exempt for every applicant.

TABLE 1-1

Medicaid recipients must meet different financial criteria depending on their eligibility category

Primary eligibility category	Income threshold (% of federal poverty line)	Asset limit
Parents	24-48%	N/A
Children	143	N/A
Pregnant women	143	N/A
Aged	80	\$2,000/\$3,000
Disabled/Blind ^a	80	\$2,000/\$3,000

Source: JLARC staff analysis of DMAS regulations and Medicaid policy manuals.

Note: Income threshold for parents varies by locality.

^a Applicants for long-term care services are subject to higher income thresholds.

Virginia spent \$8 billion to provide Medicaid benefits in FY 2014

Virginia spent almost \$8 billion in state and federal funds to provide Medicaid benefits to 1.2 million Virginians in FY 2014. This represented more than 18 percent of total state appropriations in that year. Medicaid spending is shared between the state and federal governments based on each state's Federal Medical Assistance Percentage (FMAP). Virginia's FMAP is 50 percent, so the state pays for half the cost of Medicaid services.

Nearly 15 percent of Virginians were enrolled in Medicaid in FY 2014

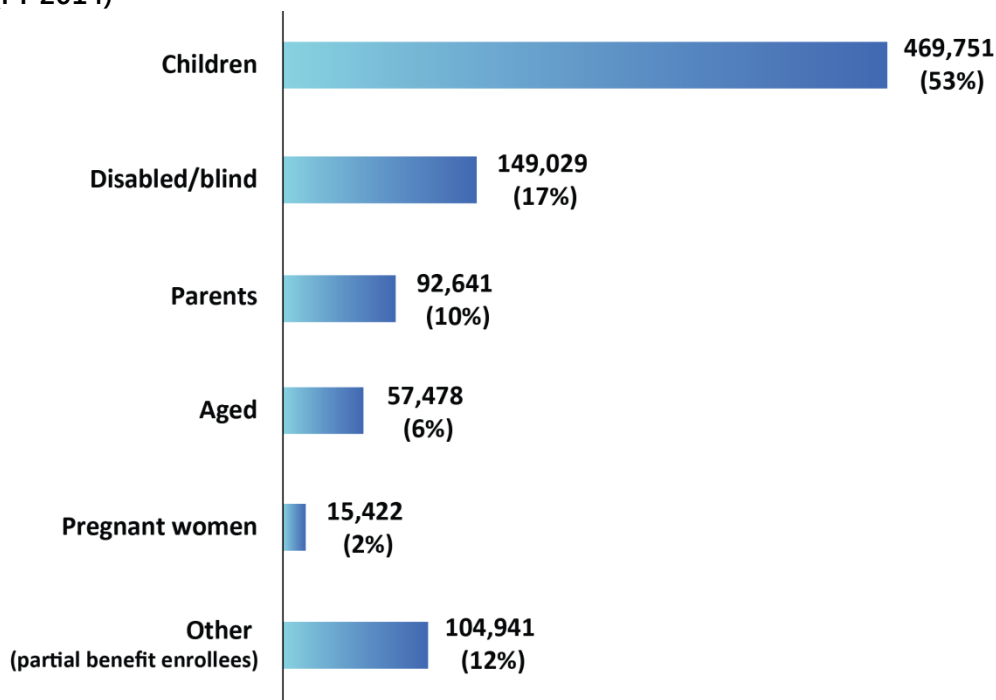
Almost 1.2 million Virginians were enrolled in Medicaid at some point during FY 2014, or 14.2 percent of Virginia's population of approximately 8.3 million people. On average, 889,000 individuals were enrolled in the program each month. Children comprised the majority (53 percent) of Medicaid enrollment (Figure 1-1). Disabled or blind enrollees (17 percent), parents (10 percent), and the aged (6 percent) collectively accounted for 34 percent of Medicaid enrollment. Pregnant women and other categories including mostly partial benefit enrollees make up the remaining 12 percent.

Cost per enrollee is highest for disabled and aged recipients

The Department of Medical Assistance Services (DMAS) paid \$7.9 billion in state and federal funds for Medicaid benefits on behalf of enrollees during FY 2014. Disabled or blind enrollees account for almost half (47 percent) of these expenditures. This is due to their high relative cost per enrollee of more than \$24,000 annually. Aged enrollees account for another 19 percent of expenditures. Children are

the least costly enrollees on average, with annual expenditures per enrollee of approximately \$3,500. Total expenditures for children accounted for just 22 percent of total spending even though these enrollees account for 53 percent of total enrollment (Figure 1-2).

FIGURE 1-1
Children accounted for more than half of monthly Medicaid enrollment
(FY 2014)

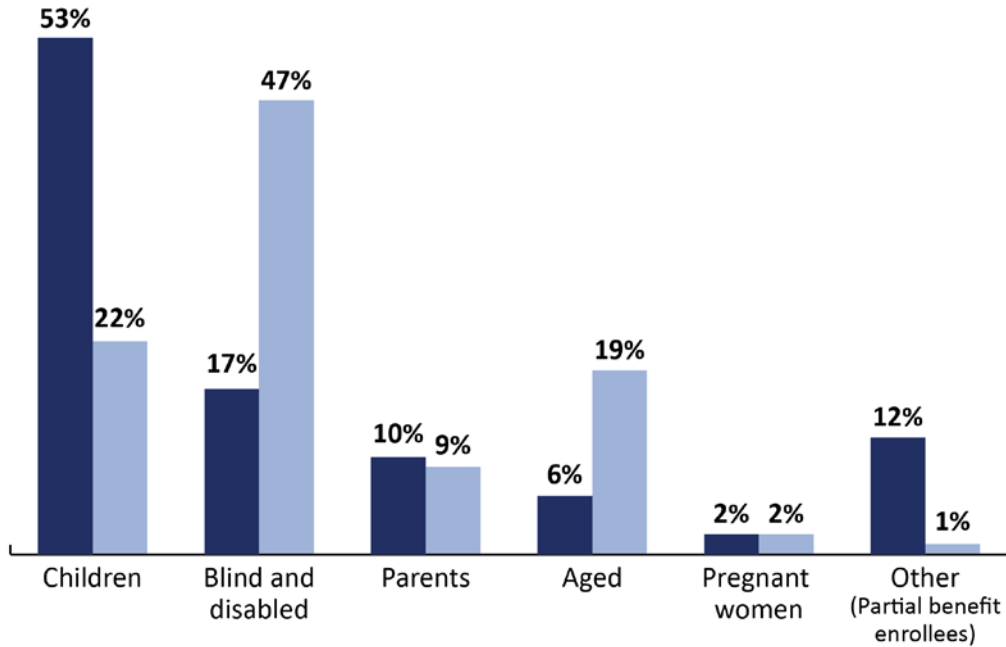


Source: JLARC staff analysis of DMAS data.

Note: "Children" includes foster care enrollees. Other partial benefit categories include Plan First enrollees who are eligible for family planning services and certain Medicare-eligible enrollees who only receive limited Medicare cost sharing benefits.

Medicaid pays for a variety of services, including acute care, long-term care, and behavioral health services. Acute care services accounted for a majority (52 percent) of total expenditures in FY 2014 (Figure 1-3). These services include all traditional health care, from hospital stays to physician visits and prescription drugs. Long-term care services make up nearly one-third (31 percent) of total spending, and include both traditional nursing facility care, where individuals live and receive necessary services in a nursing facility, as well as home- and community-based services, where individuals live at home and receive necessary services either at home or in the community where they live. Behavioral health is the smallest major service category (9 percent) and includes services provided in institutional settings as well as intensive in-home and day treatment therapies.

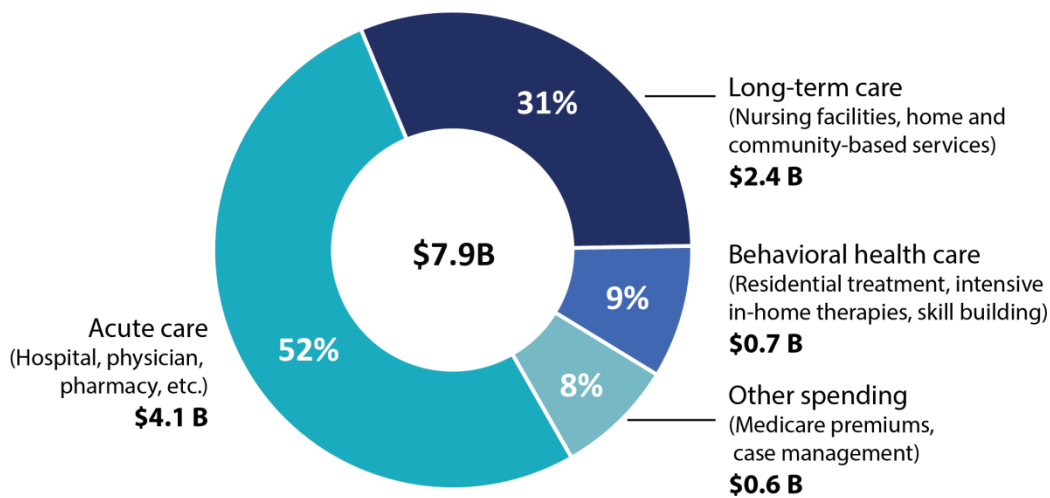
FIGURE 1-2
Disabled and aged enrollees accounted for a disproportionate amount of Medicaid expenditures (FY 2014)



Source: JLARC staff analysis of DMAS data.

Note: "Children" includes foster care enrollees. Other partial benefit categories include Plan First enrollees who are eligible for family planning services and certain Medicare-eligible enrollees who only receive limited Medicare cost sharing benefits.

FIGURE 1-3
Acute care services accounted for half of Medicaid spending in FY 2014



Source: JLARC staff analysis of DMAS data.

Eligibility determination process is complex and involves multiple federal, state, and local agencies

Several government agencies are involved in establishing and implementing Medicaid eligibility policy in Virginia. The federal Centers for Medicare and Medicaid Services (CMS) establishes standards within which all states set their eligibility criteria and policy. In Virginia, DMAS establishes eligibility policy and the Virginia Department of Social Services (VDSS) oversees its implementation. Eligibility determinations are made by 120 local departments of social services (local DSS) and a central processing unit (CPU). These agencies interact with a variety of federal, state, and local data systems to accurately determine eligibility in a timely manner.

Federal and state agencies set eligibility policy but local departments of social services determine eligibility

DMAS is responsible for setting Virginia's Medicaid eligibility determination policies within the federal guidelines established by CMS. State eligibility policies stipulate how the information reported by the applicant should be verified within federal standards, what data sources should be used to perform the verifications, and the time standards that should be met in performing initial applications and renewals. While Virginia's eligibility criteria are established through the regulatory process and codified in the Virginia Administrative Code, DMAS has broad discretion in setting eligibility determination policies, which are documented in state policy manuals but are not subject to the regulatory process. DMAS works with VDSS through a Memorandum of Understanding to implement these eligibility determination policies. VDSS is responsible for disseminating DMAS's policies to 120 locally controlled DSS offices and overseeing the eligibility determination process across the state.

Local DSS offices are responsible for determining eligibility for most Medicaid applications. Eligibility workers in local offices must review the information provided by applicants, verify all criteria in accordance with DMAS policy, and make eligibility determinations. Local eligibility workers determine eligibility for both the initial Medicaid applications and annual renewals. They also determine eligibility for benefit programs such as the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF) program.

In August 2014, DMAS established the CPU to assist local DSS offices with the Medicaid application caseload. The CPU started by determining eligibility for applications referred to Virginia from the federal marketplace. In April 2015, the CPU began determining eligibility for about two-thirds of the applications from Cover Virginia, a call center that allows individuals to apply for Medicaid benefits over the phone. Prior to August 2014, local offices processed every Medicaid application and renewal in Virginia.

Federal marketplace

Federal law established a website, healthcare.gov, for individuals to purchase private health insurance. When individuals apply for coverage they are screened for potential Medicaid eligibility and referred to their state's Medicaid program for an eligibility determination.

Federal regulations require that eligibility be determined within established time standards for all applications and renewals. Applications must be reviewed, and eligibility determined, within different standards depending on the eligibility category of the applicant (Table 1-2). Renewals must be completed every 12 months for all Medicaid recipients, except pregnant women, who are evaluated for eligibility in other Medicaid categories once they are no longer pregnant.

TABLE 1-2
Eligibility determination for applications and renewals should be completed within prescribed time standards

Primary eligibility category	Application time standard	Renewal time standard
Pregnant women	10 work days	N/A
Children	45 calendar days	12 months
Parents	45 calendar days	12 months
Aged	45 calendar days	12 months
Disabled/Blind	45-90 calendar days	12 months

Source: VDSS Medicaid eligibility policy manual.

Note: The time standard for disabled applicants is 90 days if a disability assessment is required. If the applicant has already been assessed, the standard is 45 days.

Eligibility determination process is complex

Determining eligibility for applications and renewals requires coordination between several state and local agencies and access to multiple data systems. Federal regulations require that states provide four methods for filing applications: on paper applications at local DSS offices; through CommonHelp, an online application portal for multiple benefit programs; through the Cover Virginia call center; and through the federal marketplace. Applications from all four sources are entered into the Virginia Case Management System (VaCMS), which is operated by VDSS, and assigned to the appropriate local DSS office or to the CPU.

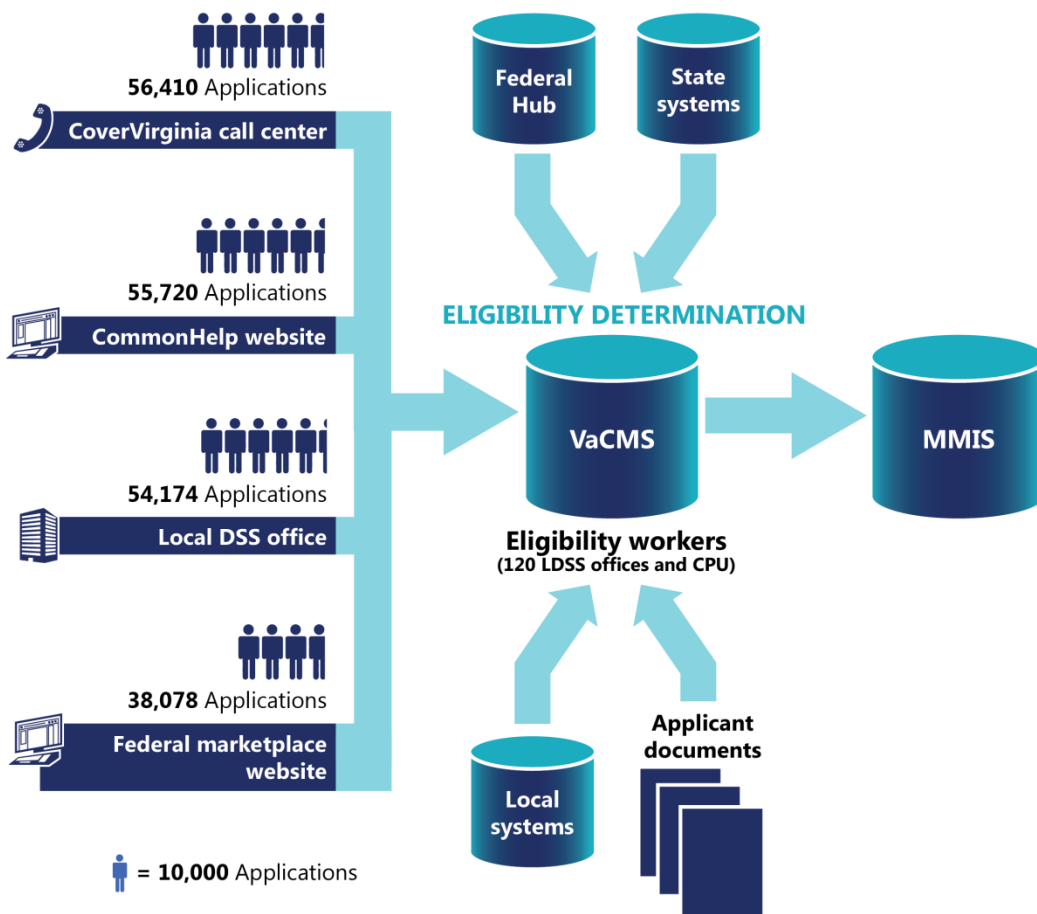
Eligibility workers must then use multiple electronic data sources, and in some instances paper documents, to determine whether applicants meet the eligibility criteria for Medicaid. Applications are checked against information in the federal hub, a new federal database that includes social security numbers, citizenship information, immigration status from the Department of Homeland Security, and income data from the Social Security Administration and applicants’ most recent federal tax returns.

If the information cannot be verified through the federal hub, eligibility workers can use records from state and local sources, including wage and unemployment insurance data from the Virginia Employment Commission, data from other benefit programs in which applicants may be participating, such as SNAP or TANF, and real estate records from local departments of revenue.

If eligibility cannot be determined by using the information available through these electronic data sources, eligibility workers may request that applicants present necessary documentation such as pay stubs to verify income or a driver’s license to verify identity (Figure 1-4).

Information from approved applications is then transferred from VaCMS to the DMAS Medicaid Management Information System (MMIS). Eligibility workers print and mail letters notifying applicants of their approval for Medicaid benefits. All of these processes must be performed correctly and on time, to ensure that only eligible recipients are approved for Medicaid benefits and that eligible individuals are able to access services.

FIGURE 1-4
Medicaid eligibility determination process requires coordination between multiple agencies and systems



Source: JLARC staff analysis of data provided by VDSS and interviews with VDSS and local DSS offices.
 Note: Application counts are all children, parents, and pregnant women applications received in VaCMS between October 1, 2013 and March 31, 2015. MMIS – Medicaid Management Information System.

Medicaid eligibility policies and processes are undergoing significant changes

Several aspects of Medicaid eligibility in Virginia have undergone significant changes in the past two years. Federal policy mandated a new method for evaluating financial eligibility for children, parents, and pregnant women, which went into effect in October 2013. Virginia is simultaneously in the process of implementing a new eligibility determination system (VaCMS) for Medicaid and other benefit programs. In addition to these policy and system changes, Virginia is experiencing an influx of applications, some of which are being referred from the federal marketplace.

Eligibility of children, parents, and pregnant women is now evaluated using Modified Adjusted Gross Income

The Affordable Care Act changed the financial eligibility criteria for children, parents, and pregnant women to a Modified Adjusted Gross Income (MAGI) standard. The change to the MAGI standard altered the income calculation for children, parents, and pregnant women, aligning the Medicaid income definition with the IRS MAGI definition. This required all eligibility workers to learn and implement the new policy, including what type of income is and is not counted and how household size is defined.

Virginia is currently implementing a new case management system for Medicaid and other social services programs

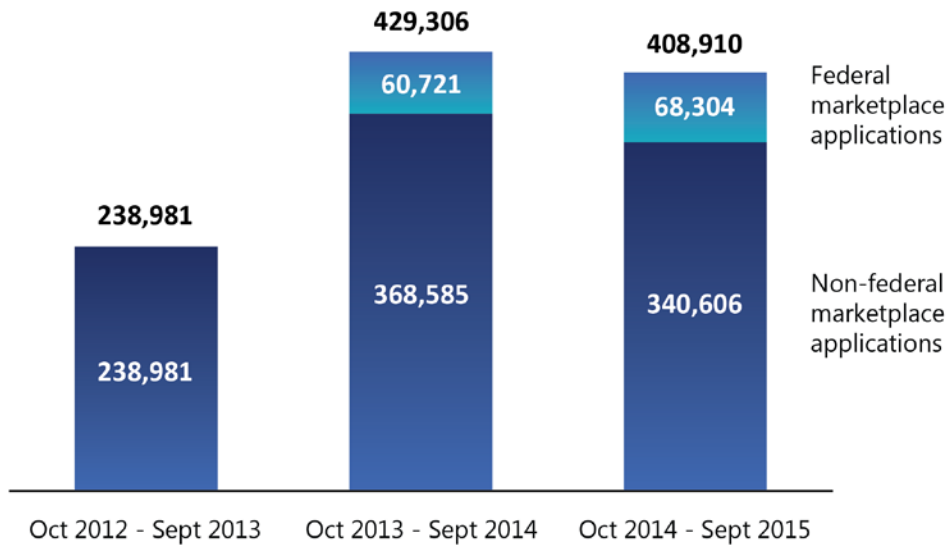
Virginia initiated a contract to develop VaCMS in December 2012 to meet a federal requirement that states have an eligibility system that can process applications for all health insurance affordability programs, including Medicaid. VaCMS implementation for the eligibility categories subject to the MAGI standard (children, parents, and pregnant women) started in October 2013. The aged, blind, and disabled eligibility groups started transitioning to VaCMS in September 2015, and the SNAP and TANF programs are scheduled to transition by the end of 2016. Until the SNAP and TANF programs have transitioned, eligibility workers will continue to work in two separate IT systems and perform separate eligibility determinations for clients who receive both Medicaid and other benefits.

VaCMS interfaces with new data sources that eligibility workers can leverage to determine eligibility. Notably, the federal hub can be used to electronically verify information reported by applicants. However, VaCMS also changed the process that eligibility workers use to determine eligibility, and the change necessitated retraining of eligibility workers statewide.

Changes in federal policy causing an increase in Medicaid applications

Virginia experienced an 80 percent increase in applications between October 2013 and September 2014, which was also the first year of VaCMS implementation (Figure 1-5). Part of this increase was due to increased awareness of the Medicaid program stemming from the implementation of the Affordable Care Act. Virginia is also receiving additional Medicaid applications referred from the federal marketplace. Individuals who apply for health insurance benefits through the federal marketplace, but may be eligible for Medicaid benefits, are referred to the appropriate state Medicaid program for an eligibility determination. Virginia received more than 60,000 applications from the federal marketplace during the first year of VaCMS implementation, significantly increasing the workload for eligibility workers. While the CPU was established to address the additional applications referred from the federal marketplace, DSS reported that no additional resources were provided to help local DSS offices handle the increased workload from non-federal marketplace sources. Applicants referred from the federal marketplace have a lower approval rate (35 percent) than other applicants (65 percent), but this does not diminish the workload. All applications must be evaluated by eligibility workers.

FIGURE 1-5
Application volume increased significantly at the same time as VaCMS implementation



Source: JLARC staff analysis of DSS summary application data.
 Note: Applications include all Medicaid and FAMIS applications.

2 Ensuring Eligibility Is Determined Accurately

SUMMARY State policies do not require eligibility workers to search for unreported income and assets. As a result, individuals who do not report any income or do not fully disclose their assets could be erroneously found eligible for Medicaid. Greater use of electronic data has enabled Virginia to obtain more complete and reliable information to verify the income that applicants do report. Searching available data sources for income and assets that may not have been reported would improve the state’s ability to ensure that only applicants who meet financial eligibility criteria receive Medicaid benefits. Ensuring that eligibility workers follow eligibility policies has been more challenging in the past few years because of several changes to the eligibility determination process and IT system. Recent federal reviews indicate a small increase in errors, which may be curbed once the eligibility determination process reaches a steady state.

Individuals must meet several financial and non-financial criteria to be eligible for Medicaid. In Virginia, local departments of social services (local DSS) are responsible for determining eligibility by verifying that individuals meet each of these criteria. While the federal government prescribes how to verify certain criteria, such as citizenship, states have flexibility in designing the policies and processes used to verify other criteria, such as income and assets. For states to accurately determine eligibility, complete and reliable information about applicants must be available to inform decisions; sound policies and processes must exist to properly evaluate available information against eligibility criteria; and workers must comply with policies and procedures to make consistent determinations.

Increased availability of electronic data sources providing access to more complete information

Recent technological advancements have enabled Virginia to make greater use of independent electronic data sources to verify Medicaid eligibility on many criteria. Since the implementation of VaCMS in 2013, earned income has been verified electronically nearly five times as often, and citizenship and immigration status can now be verified through an electronic data source at the time of application. Still, the electronic verification of assets remains limited. Using electronic data rather than paper documentation or self-attestation (sidebar) streamlines eligibility decisions, enhances the efficiency of eligibility workers, and provides more complete information to reduce the potential for error and fraud.

Self-attestation

Relying on the information provided by the applicant to verify eligibility. Applicants must sign the Medicaid application, attesting that the information provided is true to the best of their knowledge.

Use of electronic information for income and non-financial criteria has improved

Since the new VaCMS system was implemented, electronic data has been used more frequently to verify the information reported by applicants subject to the MAGI standard on all major income and non-financial criteria. Most notably, citizenship is now verified electronically at the time of application in the vast majority of cases, and immigration status in more than one quarter of cases (Figure 2-1). Prior to VaCMS, citizenship and immigration status could be verified electronically only after applicants had been granted conditional approval. The shift to electronic verification has likely enhanced the reliability of this information, which was previously verified through paper documents or self-attestation at the time of application. Earned income reported by applicants is verified electronically nearly 50 percent of the time, compared to seven percent before October 2013. VaCMS has only recently (as of September 2015) been used to determine eligibility for aged and disabled individuals. Use of electronic data sources through VaCMS with this population is likely to be similar to the current use with families and children.

The use of electronic verification has increased partly because of the functionality of the new VaCMS system but largely because of the creation of a federal hub (sidebar), which provides access to information from several data sources. The federal hub links VaCMS to tax data from the Internal Revenue Service, citizenship and benefits information from the Social Security Administration, immigration status from the Department of Homeland Security, and other information from federal and private sources. Prior to the implementation of VaCMS, the federal hub did not exist and the Application Benefit Delivery Automation Project (ADAPT) system relied instead on electronic data available from several state agencies and private vendors. These sources of data are not as complete as the federal hub and do not encompass all eligibility criteria, but they remain useful and in some cases provide more recent information than the federal hub. The state continues to use these sources when eligibility workers are unable to verify certain information through the federal hub.

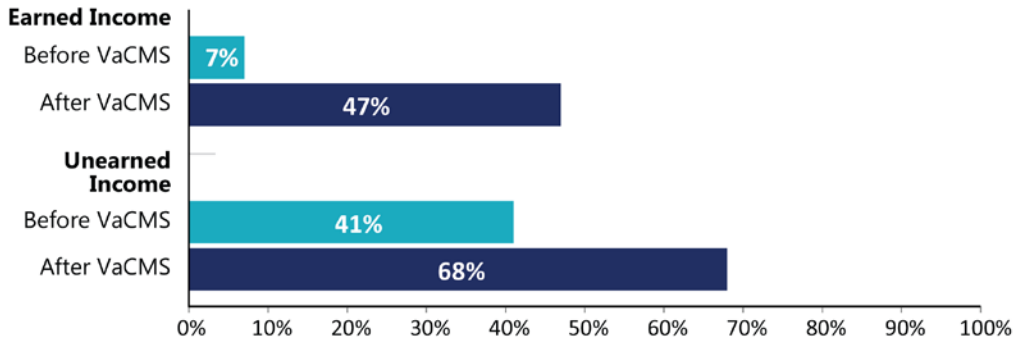
Federal hub

The 2010 Affordable Care Act directed the establishment of a more rigorous approach to verifying Medicaid eligibility. In FFY 2014, CMS implemented a tool called the Data Services Hub to compare the information provided by applicants to the information held by the IRS, Social Security Administration, Department of Homeland Security, and other agencies.

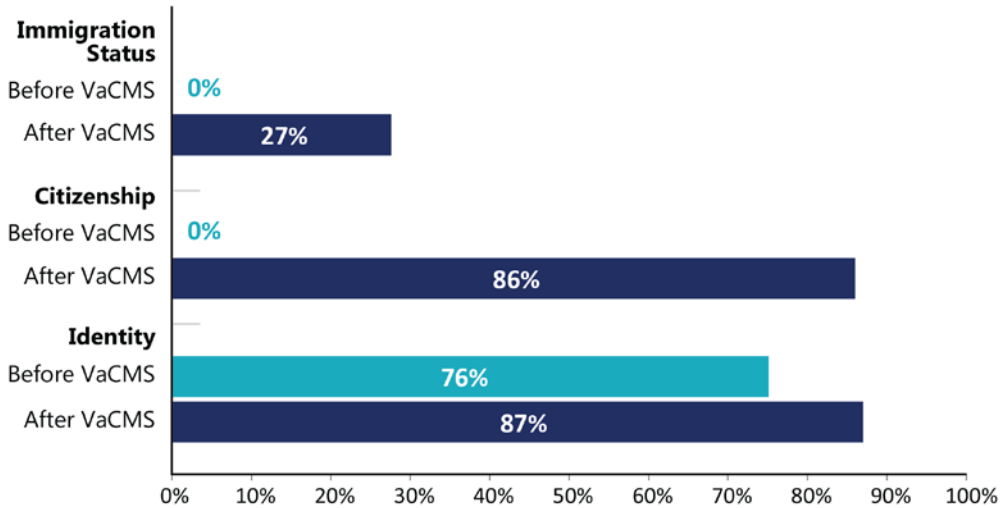
Using electronic data rather than paper documentation or self-attestation offers several benefits to the state and Medicaid recipients alike. The availability of information from an independent source reduces the potential for fraud by incorporating more complete information and reducing the need to rely on self-attestation. Information can also be obtained and processed much faster and more efficiently. Eligibility workers can process cases faster, helping to reduce the backlog of late renewals, which have financial costs to the state. (See Chapter 3 for more detail.) Faster processing also results in faster decisions for applicants, who currently experience delays in being notified. Obtaining information electronically also reduces the need for data entry, which is time-intensive and prone to error.

FIGURE 2-1
Information is verified electronically more frequently at the time of application since implementation of VaCMS (Fall 2013)

Income



Non-financial criteria



Source: JLARC staff analysis of VDSS individual-level data for applications processed in ADAPT (October 2012–September 2013) and in VaCMS (October 2013–March 2015).
 Note: Percentages for earned and unearned income include only individuals who reported income and were therefore subject to verification. Immigration status and citizenship could be verified electronically prior to VaCMS but through a monthly data match that occurred after applicants were granted conditional approval.

Asset verification for aged and disabled applicants could be strengthened through access to electronic information

The information available to verify the existence and value of assets reported by aged and disabled Medicaid applicants, who are subject to an asset limit, is not comprehensive and often not available electronically. The federal hub does not contain any data sources that can be used to verify assets, and information is often verified using paper documentation. In addition to being more burdensome for eligibility

workers and Medicaid applicants, the use of paper documentation necessitates extensive data entry, which is prone to error and can result in less reliable information. Only aged and disabled individuals are subject to asset limits, and although they represent a minority of Medicaid enrollees, these individuals incur the highest health care expenses, so eliminating error may produce cost savings.

The most commonly held assets include vehicles, homes, and bank accounts, according to staff at local DSS offices. Vehicle ownership in Virginia can easily be checked electronically through the Department of Motor Vehicles (DMV), and the value of those vehicles can be verified through another IT system available from a third-party vendor (NADA). In contrast, information on home ownership is not available statewide because real estate records, which are maintained locally, are not always available online. Similarly, electronic information about home ownership in other states is not available nationwide, although some private vendors have developed national databases of real estate records. In the absence of electronic information, property ownership is validated with paper documentation such as tax records and deeds.

CASE STUDY

Eligibility workers rely on multiple sources to verify reported assets

Eligibility workers in the local department of social services in Lexington/Rockbridge/Buena Vista use different sources to verify each type of asset reported by Medicaid applicants. They use centralized DMV and NADA electronic records to verify reported vehicles, but rely on a variety of sources to verify the ownership and value of real estate, depending upon the property's location. The City of Lexington and Rockbridge County both have online databases that are searchable by name or address. If these searches are unsuccessful or if the property is in the City of Buena Vista, which does not have an online database, eligibility workers obtain records from the appropriate commissioner of revenue. Eligibility workers use paper documents to verify all financial resources, such as bank accounts, life insurance policies, and retirement accounts. This often requires obtaining releases from applicants, contacting the financial institutions, and waiting to receive the documents via fax or mail.

Information on financial resources such as bank accounts, and retirement and investment accounts is not currently available electronically and has to be verified with statements. In December 2015, Virginia is planning to implement an asset verification system that will function as an electronic mechanism for contacting financial institutions to verify financial resources for Medicaid eligibility. The federal Supplemental Appropriation Act of 2008 required states to receive approval by the end of FFY 2013 for a state plan amendment to implement an asset verification system. Virginia met this deadline but, like many other states, has not yet implemented the system.

The new system will be useful in identifying unreported financial resources held at participating financial institutions, but its value may be limited if financial institutions choose not to participate. Under current law, financial institutions are not required to provide financial information for the state's asset verification system. A bill introduced during the 2015 session (HB 2372) would have imposed this requirement, but the legislation was amended to make participation by financial institutions voluntary. It is currently unknown how many financial institutions will participate and therefore how completely the financial resources of Medicaid applicants will be captured.

Mandating that financial institutions participate in the asset verification system is necessary to obtain complete and reliable information. At least three states—New Hampshire, Wisconsin, and Utah—have passed legislation requiring financial institutions to participate, and more may follow as states continue to implement their asset verification systems. Requiring participation by financial institutions in Virginia would be an efficient way to implement a robust process to identify each applicant's financial resources.

RECOMMENDATION 1

The General Assembly may wish to consider amending the Code of Virginia to require all financial institutions doing business in Virginia to provide the Department of Medical Assistance Services with financial records for all accounts owned by Medicaid applicants and recipients whose financial resources are subject to an asset limit under Medicaid eligibility requirements.

The asset verification system is designed to include information only on financial resources and to exclude real estate, which can be an individual's largest asset. Virginia currently makes no comprehensive effort to determine whether applicants have unreported real estate. Although an individual's primary residence is often excluded from their assets for purposes of eligibility determination (sidebar), the exclusion is capped (at \$543,000 in FY 2014) for individuals applying for long-term care services, and second homes are not excluded. Because electronic real estate records are not consistently available statewide or nationwide, verifying the value of a residence requires contacting local tax assessors, which can be time-intensive.

The state could substantially strengthen its eligibility verification process by purchasing access to a searchable national database of real estate assets. To maximize efficiency, eligibility workers should be able to search for real estate assets through VaCMS, either directly or through the Asset Verification System. At least one other state (Oregon) currently contracts with a private vendor to conduct real estate searches for asset recovery, and at least one more state is actively looking for a vendor that can develop an asset verification system for eligibility determination that includes real estate. By developing the capability to search for real estate through VaCMS, the state would reduce the burden on eligibility workers to check multiple sources.

Homes excluded from Medicaid asset limits

The equity value of a primary residence is excluded from the calculation of assets if either (1) the individual continues to reside in the home or (2) the individual's spouse, dependent child, or disabled adult child resides in the home.

Developing an interface between VaCMS and a searchable database of real estate assets will require implementation and ongoing operational costs. System implementation costs are currently eligible for an enhanced 90 percent match however, reducing the state's cost of improving the resources needed to accurately determine eligibility. The timing of the system changes necessary to develop this capability could also impact the scheduled deployment of VaCMS for the remaining Medicaid recipients as well as SNAP and TANF. The cost and implementation timing should be considered when developing the capability to search for real estate assets through VaCMS.

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to develop the capability to search for real estate assets through the Virginia Case Management System for all individuals whose assets are subject to an asset limit under Medicaid eligibility requirements.

Current policy does not ensure that eligibility is verified on all criteria for all individuals

State policies do not require eligibility workers to search for either unreported income or unreported assets. These policies render Virginia vulnerable to erroneously enrolling individuals who do not meet financial eligibility criteria for the Medicaid program. It may also result in different verification standards being applied to different applicants, depending on what they report. Currently, eligibility workers are not required to verify applicants' attestation that they earn zero income, nor do workers validate that aged or disabled individuals do not own more assets than those reported. These policies were implemented when electronic information was not widely available, and the absence of income or other assets could not be verified with paper documentation. As the availability of electronic data and the use of technology improve, policies need to evolve to use the most complete and reliable information available in eligibility determination decisions. Federal policy directs states to rely on electronic information to the maximum extent practicable to determine eligibility, and when information received electronically is not reasonably compatible with information reported by the applicant, states are directed to request additional information to determine eligibility.

Not verifying zero income creates vulnerability in eligibility determination process

State policy does not ensure that all individuals who are approved for Medicaid meet income eligibility limits and are therefore eligible for the program. In Virginia, when an applicant reports even a small amount of income, eligibility workers are required to independently verify the value of that income. In contrast, when an applicant reports zero income, this information is not subject to verification. Unreported earnings are likely to go undetected under this policy. According to a review of cases where individuals reported earning zero income, most individuals appear to report zero income accurately. Still, data suggests that a subset of individuals may have earned wages at the time of their application or renewal.

Policy does not require income verification when applicants report zero income

Eligibility workers are not directed to use electronic data sources to verify that individuals reporting zero income are in fact under the income threshold, unless they have reason to believe the information reported is inaccurate. The policy pertains to both earned income (such as wages, salaries, and tips) and unearned income (such as social security disability income and unemployment insurance benefits), and is used for new applicants as well as existing recipients, whose eligibility must be verified annually. In its use of this policy, Virginia is consistent with several other states.

Although policy does not require eligibility workers to validate zero income, it does not expressly preclude them from doing so. Staff in three of the seven localities visited for this study indicated that they *do* check existing electronic data sources for income, such as information from other benefit programs or the Virginia Employment Commission (VEC), even though policy does not require them to. Staff in the other four localities indicated that an applicant's statement of zero income is accepted unless the eligibility worker identifies other reasons to doubt the accuracy of their statement.

Current policy provides an incentive for individuals to report zero income if their true income exceeds the eligibility threshold, because they are unlikely to be caught unless their information raises a red flag. Federal and state eligibility reviews do not typically detect instances of unreported income, because their purpose is to check compliance with policy and not to verify the accuracy of the information reported. DMAS staff note that individuals who intentionally misrepresent their information do so under the penalty of perjury and are referred to the program integrity division when they are identified.

Current policy also subjects individuals to different verification standards. Individuals who report some income are held to different verification standards than those who report zero income. When an individual reports any income, even as little as \$1, state policy does not allow eligibility workers to accept self-attestation and directs them instead to verify the information using either electronic data sources or documentation requested from the individual.

Site visits to local DSS

In-depth site visits were conducted in seven of the 120 local DSS. Visits included structured interviews and observations. The purpose of the site visits was to understand how eligibility policy was implemented, identify challenges faced by local DSS offices, and develop potential solutions to address these challenges.

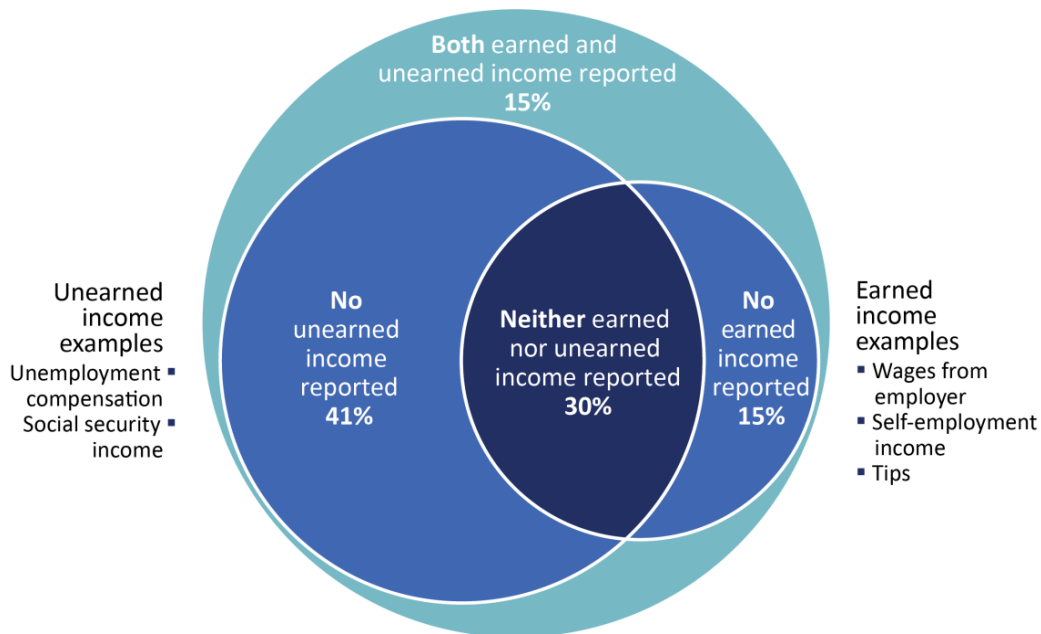
Almost one-third of approved applications subject to the MAGI standard reported zero income

Applications subject to MAGI standards usually include an adult of working age. Aged and disabled applicants, who may be less likely to earn income, are not included in this population, and the income of a child's parent or guardian is assessed for Medicaid eligibility.

Although many individuals rightfully did not have any income to report when they applied for Medicaid, some may have been earning wages around the time of application, according to a JLARC staff analysis. It is not known precisely how many individuals misrepresented their income and should have been found ineligible. However, the fact that many Medicaid applicants report zero income and some of them may be earning wages suggests that the state should use electronic data to detect potential income sources and to strengthen its eligibility determination process.

An analysis of wages information suggests that only a subset of Medicaid applicants who reported zero earnings may have been earning income when they applied for benefits. Applicants subject to the MAGI standard reported zero earned and zero unearned income in 30 percent of the approved applications processed in VaCMS between October 2013 and March 2015 (sidebar). During the same time period, an additional 15 percent of approved applications included zero earned income and some unearned income (Figure 2-2).

FIGURE 2-2
Approved Medicaid applicants subject to MAGI standard reported zero earned and zero unearned income in 30 percent of applications

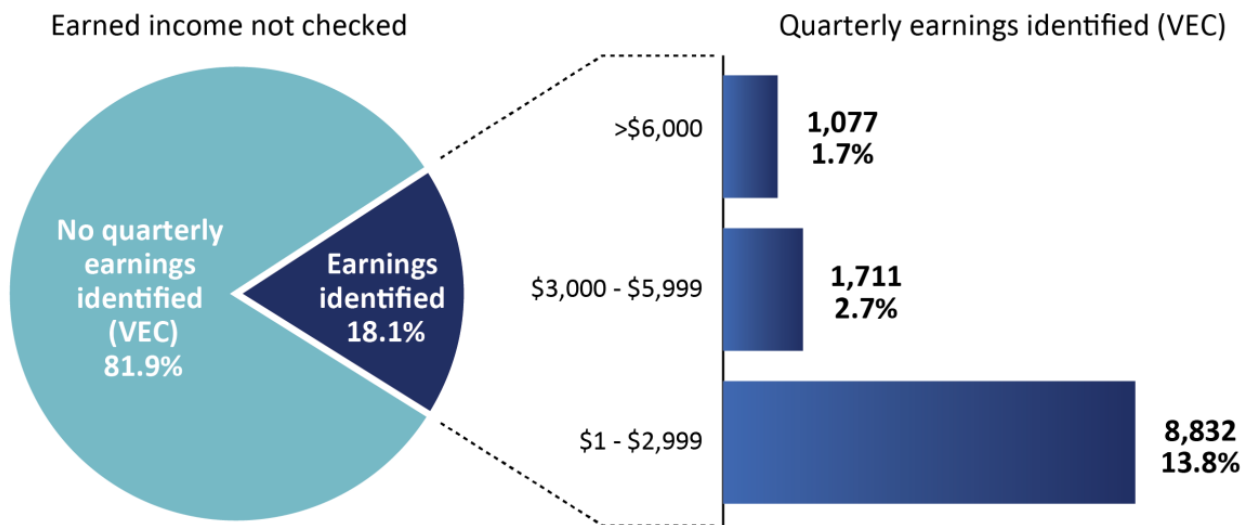


Source: JLARC staff analysis of VDSS application data.
 Note: Numbers may not add due to rounding. Analysis includes all applications processed in VaCMS between October 1, 2013 and March 31, 2015.

Of the applications that reported zero earned income and were not checked during the eligibility determination process, 18 percent included individuals who earned wages during the quarter they were approved. Most of the applications (76 percent) included individuals with earnings of less than \$3,000 during the quarter, which equates to less than \$12,000 annually (Figure 2-3).

About 20 percent of all approved applications that reported zero earned income were checked against the federal hub or through a document request, even though current policy does not direct workers to do so. This would typically occur because the eligibility worker identified a red flag and conducted additional checks, or because of a data entry error. These applications were excluded from the JLARC staff analysis because income appeared to have been verified.

FIGURE 2-3
Eighteen percent of approved applications with zero reported earned income did earn wages during the quarter they were approved



Source: JLARC staff analysis of DSS application and VEC earnings data.
 Note: Numbers may not add due to rounding.

The evidence of earned income does not necessarily mean that the applicants were ineligible for Medicaid benefits. Income for Medicaid eligibility is based on the most recent month of earnings, whereas earnings reported by VEC are aggregated at a quarterly level. It is possible that the earnings identified through VEC data were earned earlier in the quarter, and that the individual lost a job before applying for Medicaid. Additionally, applicants who earned wages may still have been eligible for Medicaid if their income was below the eligibility threshold, which varies according to several factors including eligibility category, household size, and locality.

State policy should require local offices to verify that individuals have zero income

Ohio verification of zero income

In Ohio, applications where zero income is reported are verified against the federal hub. If information from the hub does not confirm zero income, eligibility workers verify income using standard processes.

When standard sources of verification have been exhausted and the individual cannot provide the necessary documentation, eligibility workers may accept self-attestation on a case by case basis and only in rare circumstances.

Electronic data could be accessed to identify income that individuals who report zero income might be receiving. Although many states still follow the same policy as Virginia, at least one state (sidebar) has modified its process to reflect technological advances and to reduce the likelihood that applicants who do not meet eligibility criteria are enrolled in Medicaid. Electronic data may not detect every possible source of income, but it can be used to rule out the receipt of income from all sources checked for individuals who report income, such as wages, social security income, and unemployment benefits.

Checking for earned and unearned income when applicants report zero income will require a change in process and policy, but few system changes will be required because the electronic data sources already exist. The federal hub provides access to information from different sources of earned and unearned income, including federal tax returns and social security benefits, and the VEC makes available quarterly wage data and unemployment insurance payments. The information for earned income is not always current, but if the data sources identify earned income, eligibility workers can request further documentation from applicants to verify that they in fact earn zero income. Information for unearned income is current and could be used by eligibility workers to identify and evaluate applicants' income, if directed by state policy.

RECOMMENDATION 3

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to modify current policy to direct eligibility workers to apply the same protocols when verifying income for all individuals, including those who report no earned or unearned income.

The electronic data sources presently available to check for earned income may not be sufficiently current or comprehensive to ensure that eligibility workers have complete and reliable information. For example, earned income is most frequently verified through the federal hub, which receives its information from annual tax returns and could be outdated by more than two years, depending on the time of year. Wages data is available from the VEC but usually has a six-month lag time. Consequently, data from the VEC may confirm that individuals received no wages six months prior to applying for Medicaid, but they may now be earning wages if they were hired during the past six months.

To obtain more current and comprehensive information, Virginia should gain access to the National Directory of New Hires. Employers are required by federal and state law to report to their state all new hires and rehires within 20 days. Every state's information is then consolidated in a national database. The information provided in the new hire database is therefore both current (required within 20 days) and com-

prehensive (required of all employers nationwide and for all employees, including full-time, part-time, and temporary staff). When other electronic data sources indicate that an applicant earned zero income, the database could be used to verify that the applicant has not gained employment in recent months. One limitation of the data is that it does not include the amount of wages earned, but it would provide eligibility workers with a current and comprehensive source to identify if applicants were recently hired.

DMAS should begin checking Virginia's new hire database and work with CMS to gain access to the National Directory of New Hires to improve the state's ability to ensure that all approved Medicaid recipients meet income limits. The database was originally created to assist in the collection of child support payments, but its use has since been expanded to the administration of other programs, and at least 10 states use their statewide new hire database in the Medicaid eligibility determination process. VDSS pays an annual fee for access to the national database for use in Virginia's child support enforcement program.

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act to direct the Departments of Medical Assistance Services and Social Services to implement a process for checking Virginia's new hire database for recent employment when data available from the Virginia Employment Commission at the time of Medicaid application or renewal does not identify wages. The Department of Medical Assistance Services should work with the Centers for Medicare and Medicaid Services to gain access to the National Directory of New Hires.

Requiring verification of zero income will not eliminate the need to accept self-attestation for earned income in some cases. Eligibility workers may have to accept self-attestation when the information obtained electronically does not validate that the applicant earned zero income, and the applicant cannot provide documentation for their loss of income. This could occur when an applicant recently lost a job but did not receive documentation to that effect from the former employer. When electronic data sources do not identify any earned income in recent months, eligibility workers will also have to accept self-attestation that individuals are still earning zero income at the time of application.

Verifying income for all applicants would increase the workload of eligibility workers. When the information obtained electronically contradicts an individual's attestation of zero income, eligibility workers will have to reconcile the difference and determine which information should be used to determine eligibility. For example, a tax return accessed through the federal hub indicates that an individual earned wages in the prior year, but if the individual is no longer employed, current income may in fact be zero. Resolving these disparities will require additional time and effort, and adding to the workload of eligibility workers may slow the process of application and renewal. (See Chapter 3 for more detail.)

To mitigate the risk of accepting self-attestation and reduce some of the work required at the time of application, at least one state (Arizona) accepts self-attestation at the time of application or renewal for individuals who report zero income and then checks their wages six months later, once information is available electronically from the state's employment agency. Virginia should follow the same approach when self-attestation is accepted either because the loss of income is recent or because electronic data sources do not identify any earned income.

RECOMMENDATION 5

The General Assembly may wish to consider including language in the Appropriation Act to direct the Departments of Medical Assistance Services and Social Services to implement a process for checking wage data from the Virginia Employment Commission six months after application or renewal, in cases where self-attestation was accepted at the time of application or renewal.

Verifying income for all applicants, checking the National New Hire Database, and developing a process to check wage records six months after approval when self-attestation is accepted will require system and policy changes and additional staff time. VaCMS will have to be updated to develop an automated interface with VEC wage data to check for earned income. System implementation costs are currently eligible for an enhanced 90 percent federal match, but the timing of the update should be coordinated with the planned deployment of VaCMS for remaining Medicaid enrollees and other programs. Business rules will also have to be developed when checking VEC records six months after approval to determine under what circumstances enrollees will be subject to a full eligibility renewal. Eligibility workers will also have to perform additional work on some applications when electronic data contradicts the applicant's statement, and conduct additional renewals after six months when VEC data indicates that the enrollees may have earned income even though they reported zero income.

Not searching for unreported assets creates vulnerability to error in eligibility determinations for aged or disabled applicants

Current policy does not ensure that all assets are considered when determining the eligibility of aged or disabled Medicaid applicants. Eligibility workers are directed to verify the value of all reported assets, but policy does not require them to search for assets that individuals may not have disclosed. As a result, some aged or disabled applicants could be erroneously found eligible. Because aged or disabled Medicaid recipients can only retain \$2,000 in countable assets (\$3,000 for married couples), even small omissions can disqualify individuals from the program. Many other states appear to be more rigorous in searching for unreported assets, especially real estate. Although the prevalence of underreported assets is not well established, the state should change its policy to strengthen its eligibility determination process and to minimize the number of individuals who may be erroneously approved for Medicaid.

Policy does not ensure that all assets are considered for eligibility determinations subject to an asset limit

Eligibility workers are not directed by state policy to search for assets that individuals may have forgotten or failed to report. State policy requires eligibility workers to verify all countable, non-excludable assets for the aged, blind, and disabled population and for those applying for long-term care services, but does not specify that the verification process should entail searching for unreported assets. The consensus among staff at DMAS, VDSS, and local DSS offices is that eligibility workers should only search for unreported assets if they have reason to suspect that additional assets exist. Eligibility workers interviewed for this study reported periodically finding evidence of unreported assets while reviewing itemized bank statements, which are provided to verify the balance of reported bank accounts. For example, bank statements may show transfers to unreported bank accounts or payments for an unreported life insurance policy.

Although not required to do so, eligibility workers in two of the seven local offices visited for this study indicated that they proactively search for unreported vehicles when verifying eligibility. However, these efforts are not consistently applied across the state, and workers in all other offices visited reported using electronic data sources only to verify the value of reported vehicles and real estate. Practices appear to vary even among staff within the same local office.

Individuals with unreported assets could be ineligible for Medicaid

Identifying unreported assets could affect eligibility determinations because asset limits are fairly low. To be eligible for Medicaid, individuals who are aged, blind, or disabled and those applying for long-term care cannot have more than \$2,000 in countable assets (\$3,000 for couples). These limits could quickly be exceeded for individuals who have assets beyond their primary residence and one vehicle—which are typically excluded from asset limits—such as retirement plans or life insurance policies.

There is no reliable and current data in Virginia or from the research literature on the extent to which Medicaid recipients may underreport assets. Those eligibility workers who checked for unreported assets indicated that they found such assets in a minority of cases, and they were unsure how frequently these assets would have impacted eligibility determinations. These workers indicated that in most cases, the assets they identified had not been intentionally withheld, but rather that individuals had forgotten that they owned the assets. Examples included old vehicles no longer used by the individual, undeveloped land jointly owned with other parties, bank accounts with small balances, and life insurance policies from past employers. Assets that had been intentionally withheld usually included real estate, bank accounts, and vehicles.

State policy should require local offices to search for unreported assets

Virginia should direct eligibility workers to search for unreported assets, such as real estate, vehicles, and financial resources. Many states have more rigorous efforts to search for unreported assets than Virginia, particularly in reviewing real estate records. A study conducted by the Government Accountability Office (GAO) in 2012 suggests that Virginia lags behind in identifying such assets. Unlike Virginia, 16 states searched real estate records for all applications, regardless of whether real estate was reported. Fourteen states searched DMV records for all applications to identify unreported vehicles, and four states obtained information from financial institutions to check for unreported financial resources (Table 2-1). The GAO report expressed concern regarding Virginia’s ability to identify unreported real estate, stating that it was unclear how the state would “determine if an applicant owns a home that he or she failed to report, and the value of an applicant’s equity interest in the home.”

Virginia could focus efforts on searching for unreported assets that other states have had success identifying. Some states use electronic tax records, locally as well as nationwide, to search for unreported real estate. Oregon has contracted with a private vendor to facilitate nationwide real estate property searches during the asset recovery process, and representatives from that state indicate that the database has been a valuable tool in discovering unreported real estate. Eligibility workers in Virginia would have access to information to search for unreported real estate if nationwide real estate property records are made available in VaCMS (Recommendation 2).

TABLE 2-1
Other states conduct asset searches for all applicants whether or not assets are reported (2012)

Type of asset	States that conduct searches for all applicants				Number of states
Real estate	Alabama	Arizona	Georgia	Hawaii	16
	Kentucky	Maine	Montana	Nevada	
	New Hampshire	North Carolina	Oklahoma	Rhode Island	
	South Carolina	South Dakota	Washington	Wisconsin	
Vehicles	Connecticut	Delaware	Kentucky	Maine	14
	Maryland	Montana	Nebraska	New Mexico	
	South Dakota	Utah	Washington	West Virginia	
	Wisconsin	Wyoming			
Financial resources	Kentucky	New York	Rhode Island	Vermont	4

Source: JLARC staff analysis of GAO report “Medicaid Long-term Care: Information Obtained by States about Applicant’s Assets Varies and May Be Insufficient,” July 2012.

Eligibility workers should also be directed to use DMV records to search for unreported vehicles, and NADA records to verify the value of vehicles that may exist. These records are readily accessible today, but they are currently used only to verify the value of declared vehicles, and only when individuals report owning more than one vehicle. (The first vehicle is excluded when counting assets for Medicaid eligibility.) Instead, electronic DMV records could be used to identify all vehicles listed in an individual's name, including those that may not have been disclosed.

RECOMMENDATION 6

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to modify current policy to direct eligibility workers to search for unreported assets using all available sources of electronic data, including local real estate property databases, the Department of Motor Vehicles, and Virginia's asset verification system, for all Medicaid applicants and recipients whose assets are subject to an asset limit under Medicaid eligibility requirements.

Searching for unreported assets is necessary for a robust eligibility determination process that precludes ineligible individuals from enrolling in Medicaid. However, the additional searches will require more time and effort, and the additional workload could lead to additional delays in processing applications and renewals in some local DSS offices. This delay translates into delayed access to health care for eligible applicants and increased costs to the state. (See Chapter 3 for more detail.) DMAS and VDSS should consider these adverse impacts in implementing new policies to strengthen the state's ability to effectively determine eligibility while minimizing the impact on eligibility workers, eligible applicants, and the state budget.

Compliance with policy improved in 2012 but showed modest decline in recent reviews

Targeted reviews suggest that compliance with eligibility policy in a sample of cases has decreased since 2013, when new federal policies went into effect and Virginia implemented a new case management system. A 2012 triennial federal review indicated that Virginia's error rate in approving Medicaid applications had improved significantly compared to 2009 and was far better than the rest of the nation. However, information from more recent pilot reviews, while not generalizable to the entire Medicaid population, suggests that eligibility workers are making more errors, in part because they have been implementing new policies while learning a new system. The 2012 federal review and the more recent pilot reviews measure compliance with state policy and do not independently verify that eligibility determinations were correct. These reviews would not detect erroneous eligibility determinations that may occur when an applicant does not fully disclose assets or reports zero income.

Given the sweeping changes that have occurred along with higher caseloads, recent performance may not be reflective of what can be expected once eligibility workers and the VaCMS implementation reach a steady state. In fact, the federal government suspended the triennial review that would have updated Virginia's eligibility error rate in 2015, in recognition of the unusual circumstances faced in every state. Still, continuing to identify errors can help identify potential weaknesses in the processes and systems used by eligibility workers. Virginia should therefore closely monitor the frequency and types of eligibility determination errors until the transition to VaCMS has been completed in late 2016 and the next triennial federal review has been completed in 2018.

Eligibility workers closely adhered to policy in approving Medicaid cases in 2012

A 2012 federal review of Virginia's eligibility determination process indicates that eligibility workers generally adhered to state policy and committed relatively few errors when approving Medicaid cases. CMS conducts a Payment Error Rate Measurement (PERM) review every three years to verify the accuracy of eligibility determinations and renewals in Virginia by checking a random sample of Medicaid cases. The 2012 PERM assessment estimated that Virginia had a 0.5 percent error rate in approving eligibility, which is well below the national average of 3.3 percent (Table 2-2). When extrapolated to all cases approved in Virginia in FY 2012, the state's error rate could be measured as approximately \$32 million for specific services that should not have been covered even though they were delivered to eligible recipients (57 percent) or services that were provided to individuals who were ineligible (43 percent).

TABLE 2-2
2012 Virginia error rate in approving Medicaid eligibility was far lower than national average and 2009 performance

	Estimated error rate	
	2012	2009
Virginia	0.5%	16.9%
Nationwide	3.3%	7.6%

Source: JLARC staff analysis of CMS Virginia – PERM Medicaid FY 2012 Findings and CMS US – PERM Medicaid Findings FY 2011–FY 2013.

Nearly half of errors occurred because workers had not classified individuals in the proper eligibility category, such as disabled or elderly, and were therefore not checking eligibility against the relevant criteria. In other cases, the verification of assets was missing, the calculation of a recipient's income was inaccurate, or a recipient was found not to be a Virginia resident.

Virginia’s eligibility error rate improved substantially since the prior PERM review, which was conducted in FY 2009 and found that eligibility workers had made errors in approximately 17 percent of cases approved. The improvement between 2009 and 2012 is attributable in part to efforts to reduce the number of “undetermined” cases, which accounted for two-thirds of errors in 2009. Cases were labeled as “undetermined” when the information available in recipients’ case files was insufficient to either validate or disprove eligibility. For the 2012 PERM, DMAS hired a contractor that obtained all missing information necessary to establish recipients’ eligibility before the review began.

Recent eligibility review pilots indicate areas for improvement in applying policies

Virginia’s recent performance on federal eligibility review pilots identified errors in determining the eligibility of Medicaid applicants. According to three pilots, spanning October 2013 to March 2015, between 1.4 and 4.1 percent of cases reviewed contained errors (Table 2-3). Two more rounds of reviews are scheduled to take place during the latter part of 2016.

**TABLE 2-3
Percentage of cases with eligibility errors in pilot reviews has fluctuated since the implementation of VaCMS**

Percentage of cases with eligibility errors		
Round 1 Oct 2013–Mar 2014	Round 2 Apr 2014–Sep 2014	Round 3 Oct 2014–Mar 2015
4.1%	1.4%	2.7%

Source: JLARC staff analysis of Medicaid eligibility pilot review results, Rounds 1-3 from the Virginia Department of Social Services and Department of Medical Assistance Services.

CMS temporarily suspended PERM reviews nationwide in light of the significant changes made to the way states determine eligibility pursuant to the Affordable Care Act (sidebar), which prompted the redesign of many state processes and systems. Beginning in FY 2014, all states were required instead to participate in eligibility review pilots to provide targeted, timely information on the accuracy of new processes. Comparative information relative to the rest of the nation will be available in the CMS Agency Financial Report beginning FFY 2015.

Unlike the PERM review, eligibility pilots are not designed to be statistically representative and results cannot be projected to the universe of all eligibility determinations. Still, the information gathered through pilot reviews can help identify weaknesses in the state’s new eligibility determination processes and systems, especially those errors that can be attributed directly to the transition. For example, several of the errors identified in Round 1 occurred because the VaCMS system had not per-

Major effects of the Affordable Care Act on Medicaid eligibility

- Change in methodology to calculate income and household composition
- Use of a single application
- Increase in application numbers and sources
- Access to federal hub for verification

formed the proper calculations or eligibility workers misapplied policy. System changes and additional policy training were implemented shortly after the review to address these issues.

Still, many of the remaining errors are consistent with findings from prior PERM reviews, such as inaccurate data entry and missing verifications or documentation. These types of errors are likely not due to the changes that eligibility workers have faced in recent years, nor do they appear to have been corrected by the implementation of the new VaCMS system. As several local workers indicated, the system remains only as good as the information entered into it. The state should therefore continue to closely monitor the magnitude and nature of eligibility errors and identify corrective actions necessary to address both new and longstanding challenges.

3 Ensuring Eligibility Is Determined on Time

SUMMARY Local departments of social services are not meeting time standards in determining the initial eligibility of applicants or in renewing the eligibility of current recipients, partly due to changes in the eligibility determination process and understaffed offices. As a result, eligible applicants may be delaying needed medical care, and the state may have spent between \$21 million and \$38 million on ineligible Medicaid recipients in FY 2014. To address these problems, the new eligibility determination system can be improved to enhance efficiency by increasing automation and providing eligibility workers with better tools to manage their caseload. Increased efficiency may not be enough to improve performance in some local departments of social services with the highest workloads, and actions could be taken to reduce workload in these offices. The state could fund the Department of Medical Assistance Services central processing unit to assist with the renewal workload in the short term. Administrative funding for local offices may also play a role in the disproportionate workload at some offices, and the Department of Social Services could reassess the method it uses to allocate base administrative funds, which has not been updated in 25 years.

Local departments of social services (DSS) are required by state and federal regulations to determine and renew eligibility for the Medicaid program within certain time standards. These standards are important to ensure that eligible recipients have access to health care services and that ineligible recipients are promptly identified and disenrolled from the program.

Late eligibility determinations may delay access to care and extend coverage for ineligible recipients

Local DSS offices are often not meeting time standards in determining the initial eligibility of applicants or in renewing the eligibility of current recipients, which may have an adverse health effect on Medicaid applicants and a negative financial impact on the state. Amid significant changes to IT systems and an increased volume of applications, eligibility workers were able to process more applications between October 2013 and March 2015, but performance in meeting time standards declined.

Eligible applicants may have delayed necessary medical services, including prenatal care, while they waited for a decision. Because local offices are not consistently checking whether recipients remain eligible every 12 months as required by federal policy, the state may have spent between \$21 million and \$38 million on individuals no longer eligible for program coverage in FY 2014. The number of late applications

has decreased since the beginning of 2014, but the number of late renewals has increased by almost 500 percent.

Eligibility was determined late for more than 40 percent of applicants since fall 2013, delaying access to care

Local DSS offices have consistently not met time standards for determining the initial eligibility of applicants between October 2013 and March 2015. Applications submitted during this period were determined late for 40 percent of children, parents, and pregnant women. Approved applications were more likely to be determined on time than denied applications, however, as 31 percent of approved applications were determined late. Aware of these delays, the Centers for Medicare and Medicaid services identified Virginia for a focused review in August 2014 to determine the causes of the backlog and develop strategies to address it.

Eligibility was more likely to be determined on time for children and parents than for pregnant women. A total of 69 percent of approved applications were determined within the 45-calendar-day time standard, while 11 percent of applications took longer than 135 days to be approved for benefits (Figure 3-1). Late determinations can result in applicants delaying medical care and can lead to health concerns and more costly services once found eligible. National research indicates that more than half (54 percent) of the uninsured population has an unmet medical need because they cannot afford necessary health care services. Local DSS offices indicated that applicants sometimes call and inquire about the status of an eligibility determination. These applicants sometimes indicate that they are delaying treatment, waiting for Medicaid benefits to be approved before being treated for an urgent health care need.

About half (49 percent) of approved applications for pregnant women were determined within the 10-working-day time standard (Figure 3-2). Many applications took significantly longer than the requirement. More than 5,000 pregnant women (18 percent) received approval 30 or more working days (six calendar weeks) after submitting a Medicaid application. Late determinations for pregnant women are especially problematic because they increase the likelihood that a pregnant woman will delay prenatal care. High quality prenatal care helps identify risk factors that can lead to poor outcomes, such as low birth weight and infant mortality.

Local DSS offices have reduced the number of late Medicaid determinations, with assistance from the state's central processing unit (CPU), from a peak of 40,000 (58 percent) in the first quarter of 2014 to less than 12,000 (25 percent) in the first quarter of 2015 (Figure 3-3). At the direction of the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS), the CPU helped local offices process more than 57,000 applications that were referred from the federal marketplace, freeing up local DSS staff to focus on applications from other sources. Some applications from the federal marketplace were not referred to Virginia for several months, causing some applications to be late even before they were assigned to an eligibility worker for a determination.

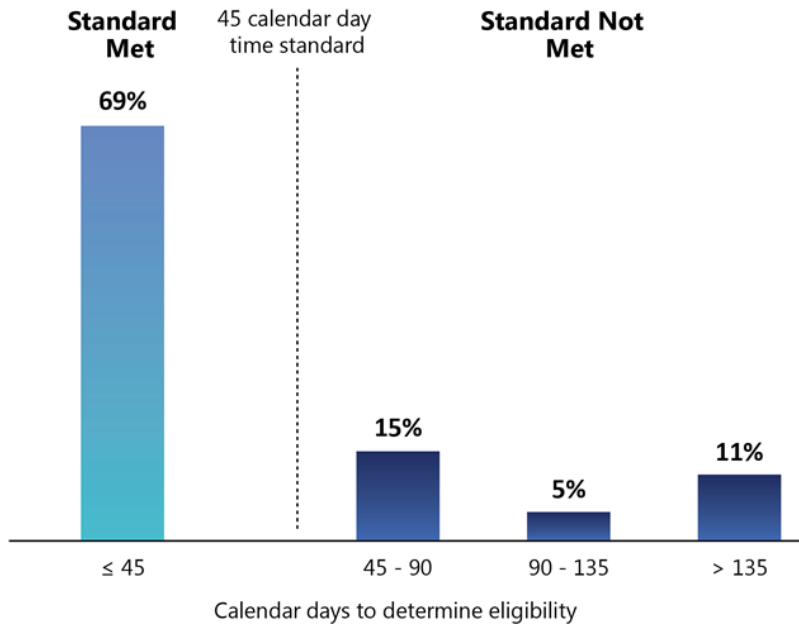
Central processing unit

DMAS contracts with a vendor to determine eligibility for applications referred from the federal marketplace and some applications submitted through the Cover Virginia call center.

Federal marketplace

Federal law established a website, healthcare.gov, for individuals to purchase private health insurance plans. When individuals apply for coverage they are screened for potential Medicaid eligibility and referred to their state's Medicaid program for an eligibility determination.

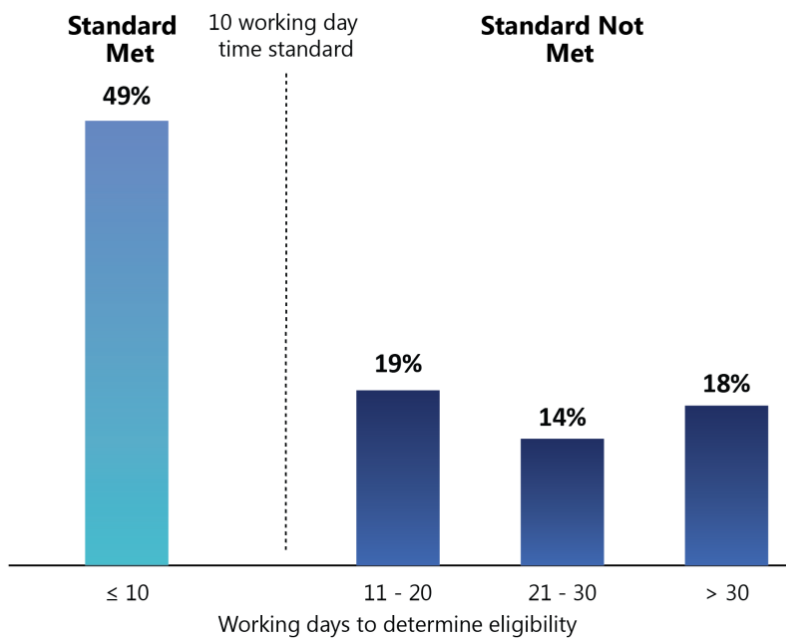
FIGURE 3-1
About 30 percent of children and parents received approval late



Source: JLARC staff analysis of VaCMS data.

Note: Includes all children and parents applying for Medicaid between October 1, 2013 and March 31, 2015.

FIGURE 3-2
About half of pregnant women received approval late

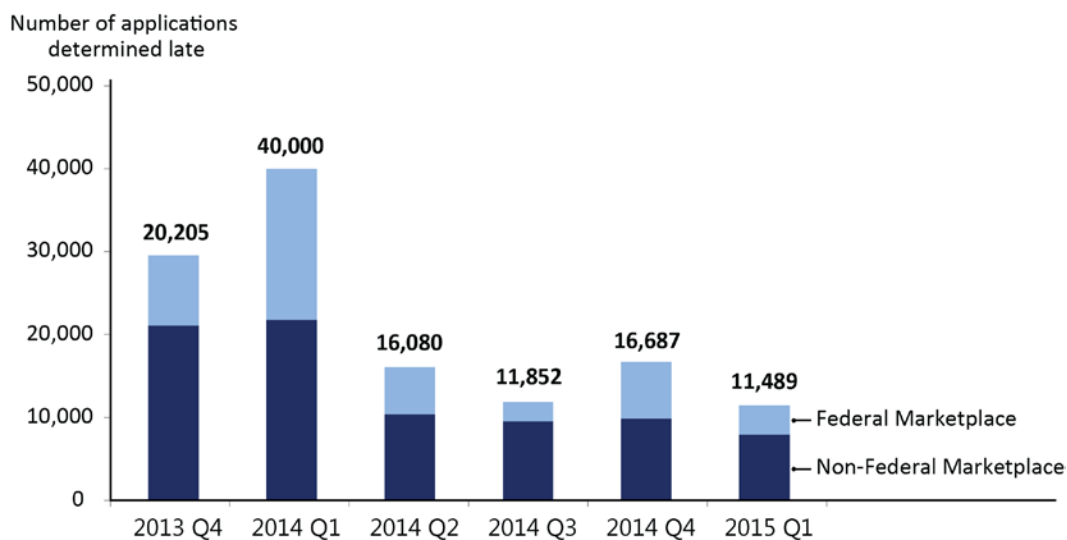


Source: JLARC staff analysis of VaCMS data.

Note: Includes all pregnant women applying for Medicaid between October 1, 2013 and March 31, 2015.

Staff at local offices indicated that the reduction in the number of late determinations from non-federal marketplace sources was due in part to an increased emphasis by local DSS offices on meeting time standards, which included working additional overtime. Late determinations from non-federal marketplace sources dropped from a high of almost 22,000 in the first quarter of 2014 to a low of 8,000 in the first quarter of 2015. In April 2015 the CPU’s role was expanded to include processing many of the applications submitted through the Cover Virginia call center, while applications associated with existing cases are still processed by local DSS offices. The CPU now handles approximately one-third of all applications subject to the MAGI standards, further reducing the workload of local DSS offices.

FIGURE 3-3
Volume of applications determined late was reduced significantly by CPU and local VDSS offices

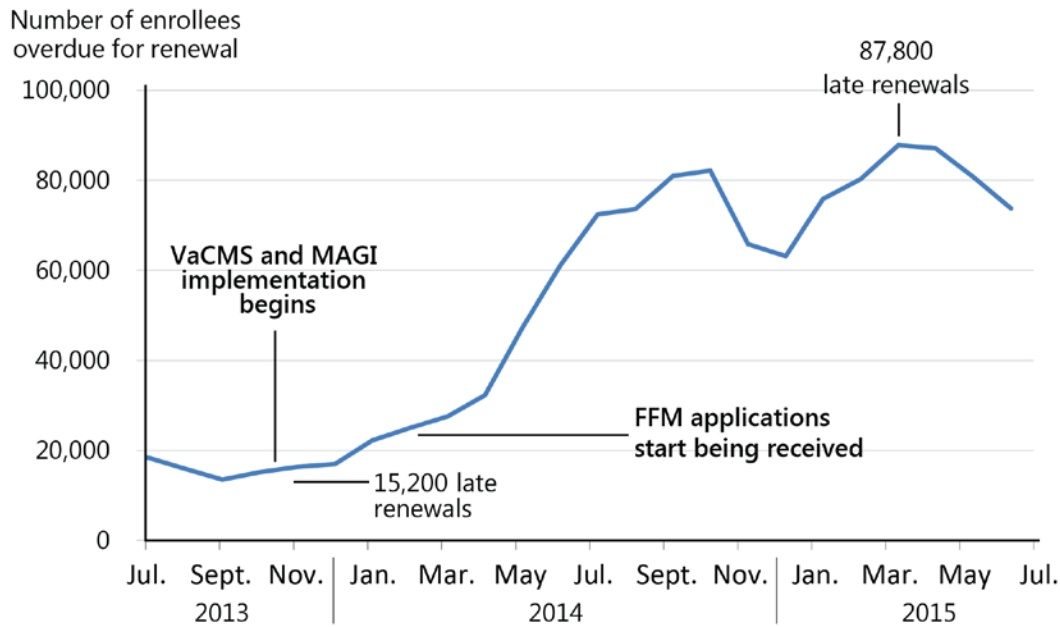


Source: JLARC staff analysis of VaCMS data provided by VDSS.
 Note: Applications are grouped by the quarter they were submitted. For applications from the federal marketplace, this is the date submitted to the federal marketplace, which may have been earlier than it was referred to Virginia.

Late renewals increased substantially since October 2013, resulting in payments made for ineligible recipients

The number of Medicaid enrollees who are overdue for their annual eligibility renewal increased by nearly 500 percent since VaCMS was implemented. The number of late Medicaid renewals increased from 15,183 in October 2013 to a peak of 87,792 in March 2015 (Figure 3-4). This indicates that the eligibility status of 8.8 percent of all Medicaid enrollees was uncertain as of March 2015. Some recipients who are overdue for renewal may no longer be eligible for Medicaid benefits due to changes in income, household size, or Virginia residency.

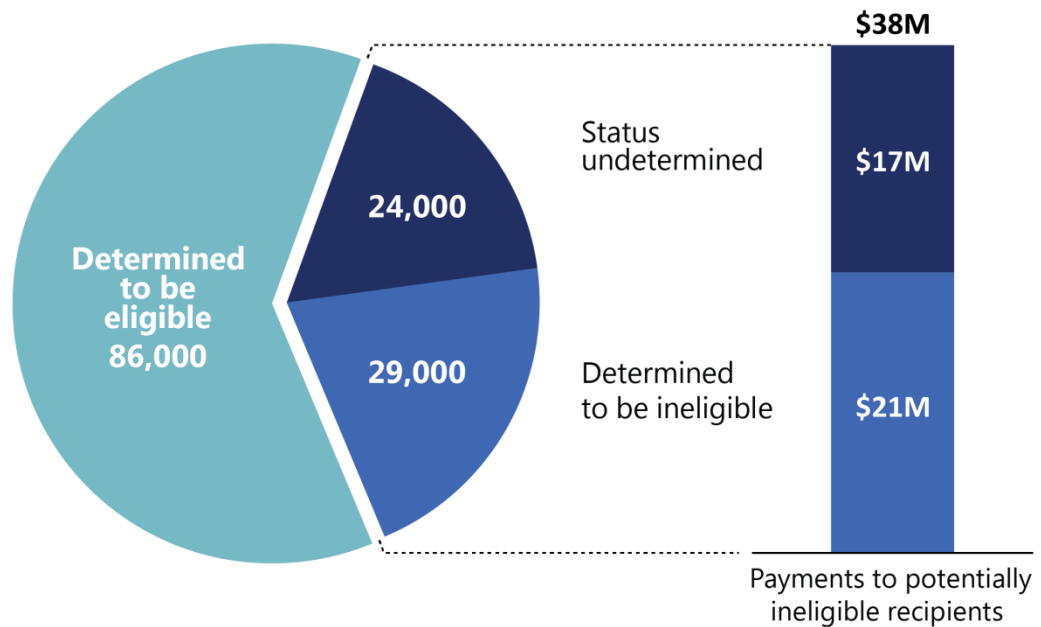
FIGURE 3-4
Late renewals increased by more than 72,000 between October 2013 and March 2015



Source: JLARC staff analysis of VDSS data of monthly counts of late Medicaid renewals.

Late renewals may have cost between \$21 million and \$38 million in state and federal funds in FY 2014. Renewals for about 139,000 enrollees were overdue at some point during FY 2014, and between 29,000 and 53,000 of these enrollees may have been ineligible while their decisions were overdue. About 29,000 individuals no longer met eligibility requirements when ultimately processed. Another 24,000 renewals were still pending at the end of FY 2015 or were closed because the applicant did not submit the renewal application. Benefits costing \$21 million were delivered to the 29,000 individuals who were waiting for an overdue eligibility determination and were ultimately found ineligible. Another \$17 million in benefits was provided to the 24,000 enrollees whose eligibility status was unknown as of the end of FY 2015. The resulting total is estimated to be as high as \$38 million in potentially improper benefit payments in FY 2014 (Figure 3-5). This amount would likely have been larger in FY 2015 because late renewals more than doubled.

FIGURE 3-5
Late renewals resulted in benefit payments for services to potentially ineligible recipients in FY 2014



Source: JLARC staff analysis of VDSS data of monthly overdue renewals and DMAS claims data.

Significant changes to eligibility policy, systems, and workload hindered ability to meet time standards

Federal policy created significant changes to Medicaid eligibility, requiring staff at local offices to learn a new system for processing eligibility determinations and new rules for determining eligibility, while the volume of applications simultaneously increased by 80 percent. Virginia implemented VaCMS to modernize the eligibility determination system for all public assistance programs and to accommodate federally-required changes to Medicaid eligibility policies and processes. The Affordable Care Act directed states to use a more streamlined income calculation, the Modified Adjusted Gross Income (MAGI) standard, for children, parents, and pregnant women. The Affordable Care Act also required states to provide individuals the option to apply for Medicaid benefits online. Eligibility workers were able to process more applications during the first year of VaCMS implementation than in the prior year but could not fully absorb the increase, leading to more late determinations.

Because of these changes to federal policy, the state received an influx of applications from the federal marketplace, resulting in 60,000 additional Medicaid applicants in the first year of VaCMS implementation. In describing the impact of these changes on eligibility workers, one local DSS supervisor said that it was as though all the eligibility workers started new jobs on October 1, 2013, implementing new policy, in a new system, with higher workloads.

In interviews, staff of local DSS offices identified some complications that compounded the difficulties of the transition to VaCMS: technical problems in the system, difficulties monitoring caseloads, and inadequate training. Some of the more severe technical challenges have already been addressed by the state. These problems included eligibility workers being disconnected from the system in the middle of processing cases; slow performance of the system during periods of high-volume usage; and trouble gaining access to the federal hub for quick verification of eligibility. Before these issues were addressed, they raised significant barriers to eligibility workers' ability to process applications and renewals on time. Some issues, such as the inability of eligibility workers to prioritize cases, still persist. The aged, blind, and disabled (ABD) population transitioned to VaCMS in September 2015, and state and local staff expressed concern that this transition would further impact the timeliness of both new applications and renewals.

VaCMS improvements could streamline processes and help local offices meet time standards

The functionality of VaCMS could be more fully utilized to help determine eligibility faster. Improved case management tools could help prioritize cases, particularly applications from pregnant women, and automating electronic renewals could help reduce the backlog of overdue renewals. Medicaid applicants can grant permission for the state to use their federal tax returns to electronically renew their eligibility for Medicaid in future years using an “ex parte” renewal process. The ex parte renewal process is underutilized and has not yet led to greater efficiency because of system limitations. Automating electronic renewals would reduce the effort of eligibility workers and improve their ability to process renewals on time.

The state contracted with a vendor in December 2012 to develop VaCMS, and the system was deployed for the population subject to the MAGI standard on October 1, 2013, to meet the federal deadline of January 2014. Under this nine-month timeline, the system did not initially have the proper functionality to facilitate efficient eligibility determinations.

Case management tools could help reduce backlog of applications by identifying priority cases in VaCMS

The current inability of eligibility workers to identify high priority applications in VaCMS likely exacerbates the ongoing delay and backlog. The VaCMS software interface does not allow workers to quickly identify applications that are overdue or will become overdue. It does not allow workers to quickly identify applications for pregnant women, which are subject to a strict time standard (10 working days); half of all applications for pregnant women are determined late. If eligibility workers had the capacity to readily identify high priority applications, they could better manage their caseload.

Providing an indicator for the type of application and the number of days overdue would improve eligibility workers' ability to prioritize cases. This improvement will become increasingly important now that eligibility determinations for the ABD population have transitioned to VaCMS, because applicants requiring an evaluation for disability also have a different time standard (90 calendar days) for determining eligibility. To help eligibility workers prioritize their caseload, VaCMS should include functionality to (i) identify the eligibility category under which each application was filed and (ii) calculate the due date for each application depending on the relevant time standard and number of days overdue. VDSS has indicated that recent updates to the system provided eligibility workers with additional reports to help prioritize cases, but it is not known whether the system updates fully address these issues.

RECOMMENDATION 7

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to make the necessary improvements to the Virginia Case Management System so that eligibility workers have the tools to manage their caseload and minimize the number of late applications.

Greater automation would expedite renewals by minimizing involvement of eligibility workers

Improvements are needed to take greater advantage of the option to renew eligibility electronically, because the current process is inefficient and underutilized. Few recipients have granted the state permission to access federal tax records, and site visits to local DSS offices indicated that electronic renewals are not being attempted using other data when permission is not granted. Even when recipients grant permission, the current electronic renewal process requires eligibility workers to manually process each part of the renewal in VaCMS. Automating electronic renewals and increasing the number of recipients who grant permission to access their federal tax returns would reduce the involvement of eligibility workers and increase the number of renewals performed on time.

Automating electronic renewals

Even when recipients grant permission to access their federal tax data for electronic renewals, eligibility workers still have to verify all criteria in VaCMS. The primary advantage of electronic renewal is that it eliminates the process of completing and submitting the renewal form. This advantage is not always realized, though, because recipients who have granted permission are not readily identifiable and because eligibility workers are not attempting electronic renewals with other data sources when they do not have permission to use federal tax data. Eligibility workers must click through each pending renewal to determine whether to initiate the process electronically or send the renewal form by mail and wait for it to be returned. Some local DSS

offices indicate that they send renewal forms to all recipients because it is easier and faster than identifying which cases can be attempted electronically.

Workload could be reduced if VaCMS automatically initiated electronic renewals. If all of the criteria can be validated and the individual continues to be eligible for benefits, then the eligibility worker would have only one task: to send the notice of renewed eligibility to the recipient. If some criteria cannot be validated, or if the new information indicates a change in eligibility status, the case would be sent to the eligibility worker for the appropriate action.

Electronic renewals in VaCMS would mirror the initial application process. When an individual first applies for Medicaid, VaCMS initiates an electronic eligibility determination through a “self-direct” process before sending the application to an eligibility worker. The self-direct process attempts to verify all of the eligibility criteria using the federal hub, and if the validated information indicates that the applicant is eligible, then the application is approved without any handling by an eligibility worker. Eligibility workers at local offices indicated that changing the VaCMS system rules to automatically initiate electronic renewals would save time and allow them to focus on the renewals that require their intervention. VDSS and DMAS have indicated that a system update scheduled for December 2015 is intended to automate the electronic renewal process.

RECOMMENDATION 8

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to implement the necessary changes to the Virginia Case Management System so that eligibility can be determined at the time of renewal through an automated process.

Obtaining recipients' permission for electronic renewals

Taking full advantage of electronic renewals would require the permission of more recipients. The majority of Medicaid recipients have not granted permission for eligibility workers to use their tax returns to renew their eligibility electronically. Only 27 percent of recipients opted for an electronic renewal between August 2014 and March 2015. There has been a steady increase in permissions over this time period, however, from 21 percent in August 2014 to 35 percent in March 2015. Still, the majority of recipients manually complete the 18-page renewal form, which is time-consuming for recipients and for eligibility workers, as they wait to receive the renewal form by mail. Additionally, the six localities with the highest percentage of overdue renewals in FY 2015 obtained fewer permissions for electronic renewal than the statewide average.

Applicants may not be granting permission for electronic renewal because they inadvertently skip over the permission section when completing the application. The permission for electronic renewal is located in the middle of a page that has a lot of other information on it, and applicants often leave the section blank (Appendix C). Local DSS staff indicated that when recipients were asked why they had not granted

permission, they often responded that they did not notice the permission section and therefore left it blank. Local staff suggested that the permission section be placed in a more prominent position on the form, and that it be a required section on electronic applications. Another way to address this issue would be to alter the language of the renewal application to require applicants to “opt out” of electronic renewal, rather than using the current “opt in” approach.

RECOMMENDATION 9

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to amend the Virginia Medicaid application, with approval from the Centers for Medicare and Medicaid Services, so that Medicaid applicants grant permission to use their federal tax returns to perform renewals, unless they opt out.

Applicants who do notice the section may still choose not to grant permission because the advantages are not clearly articulated. The form states that permission will make renewal easier, but it does not indicate that in the absence of permission, recipients will be required to complete an 18-page renewal form, and that failure to return that form on time will result in their disenrollment from the Medicaid program (Figure 3-6). The form also does not clarify that applicants will have the opportunity to provide documentation of their continued eligibility if the electronic renewal shows that they are ineligible.

FIGURE 3-6

Medicaid application provides limited information to applicants on advantages of granting permission to use tax returns for electronic renewals

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal. I understand that I can opt out at any time.

Yes, I consent to the use of electronic income data including information from tax returns to annually renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

Source: Virginia Medicaid application (2015).

DMAS should revise the current application to more clearly articulate the benefits to the recipient of granting permission for the state to use their tax returns for the purposes of electronically renewing Medicaid eligibility. In addition, the electronic renewal permission section should be placed in a prominent location. If an “opt out” approach is implemented, applicants should be made aware of their right to opt out.

RECOMMENDATION 10

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to amend the Virginia Medicaid application, with approval from the Centers for Medicare and Medicaid Services, so that additional information is provided on the advantages to recipients of granting access to their tax returns for the purpose of renewing their Medicaid eligibility, and so that the request for permission to use federal tax data for eligibility renewals is placed in a more prominent position on the form.

Obtaining approval from the Centers for Medicare and Medicaid Services to amend Virginia's Medicaid application may be a time-consuming process, and in the interim, DMAS should explore ways to further increase the percentage of recipients who grant permission for electronic renewals. Eligibility workers could conduct outreach by phone or email to recipients and explain the advantages of granting permission. Recipients could grant permission over the phone, if the call can be recorded, or be instructed to grant permission electronically through CommonHelp.

CommonHelp is an online portal where Virginians can apply for Medicaid and other benefit programs.

RECOMMENDATION 11

The Department of Medical Assistance Services should conduct outreach to recipients who have not granted permission for electronic renewals, to explain the advantages of electronic renewals and provide a mechanism for recipients to grant permission.

Aligning renewal due dates across benefit programs could improve efficiency for eligibility workers

Performing renewals simultaneously when recipients receive assistance from multiple programs would improve efficiency by reducing the total time required to perform the renewals. More than 60 percent of Medicaid recipients also receive benefits from either the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) program. Eligibility criteria are not identical, but all three programs require annual reviews during which eligibility workers verify the same type of information, such as income and household size. This means that eligibility workers have to work with each case multiple times during the year if the renewal due dates for the programs are different. VaCMS could facilitate the alignment of renewal dates across these programs once all cases are transitioned into the system. VDSS staff indicated that efforts are underway to develop a process to align renewal dates when possible. Eligibility workers would then be able to work with each case only once to review and verify eligibility criteria, reducing the overall workload in local DSS offices.

Additional staffing capacity needed to alleviate backlog of late determinations

High caseloads contributed to the growing backlog of renewal cases and will have to be addressed in order to meet statewide time standards. Five of the six local DSS offices with the most difficulty meeting time standards were among the offices with the highest caseloads, and they accounted for half of the outstanding late renewals statewide in FY 2015. These offices reported funding limitations and difficulties recruiting and retaining staff as reasons for being understaffed. Additional staffing capacity could be built in the short term by funding the CPU to assist local DSS offices in renewing Medicaid eligibility. Changing how administrative funds are allocated could help some understaffed offices in the long term.

High caseloads contributed to backlog of late renewals

Local DSS offices with disproportionately high caseloads appear unable to renew eligibility within established time standards. Those experiencing the greatest difficulty meeting time standards were also among those with the greatest staffing limitations. Five of the six local offices that accounted for half of overdue renewals in FY 2015 were among the offices with the highest caseloads (Table 3-1). Five of these offices had caseloads far higher than the state average of 598 recipients per worker. In Loudoun County and Chesterfield County, eligibility workers had caseloads of more than twice the state average.

TABLE 3-1
Local DSS offices with most difficulty meeting time standards among those with highest caseloads

Local agency	Indicators of on-time performance		Indicators of workload		Percent of all overdue renewals in VA (FY15)
	Percent of recipients with overdue renewal (FY15)	On-time renewal ranking in VA (out of 120)	Caseload per eligibility worker (FY14)	Caseload ranking in VA (out of 120)	
Loudoun	33%	120	1,221	119	7%
Chesterfield	32%	119	1,230	120	16%
Stafford	30	118	942	117	5%
Richmond City	27	117	731	106	17%
Petersburg City	25	116	562	63	3%
Shenandoah	23	115	881	114	2%
State average	8%		598		

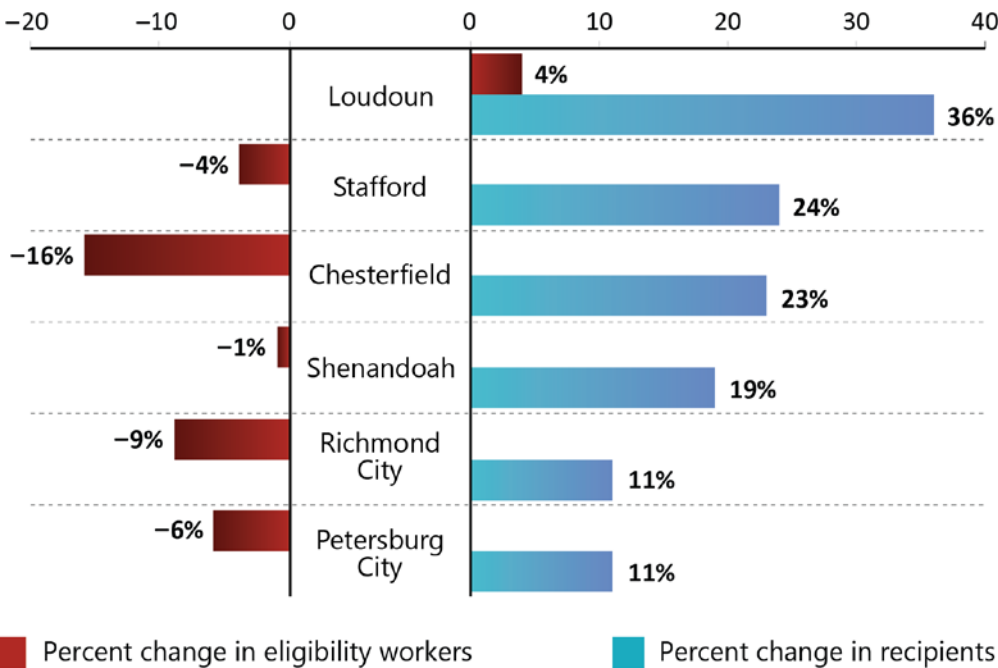
Source: JLARC staff analysis of VDSS data of monthly counts of late Medicaid renewals and benefit staff.

Note: Staffing ratios indicate number of unduplicated benefit clients across the Medicaid, SNAP, and TANF programs per benefit staff.

The six local DSS offices with the greatest percentage of late renewals in FY 2015 have experienced a significant increase in caseload—30 percent on average over the past five years. This increase resulted from a rise in the number of recipients combined with a decrease in the number of eligibility workers in five of the six localities (Figure 3-7). Only one locality, Loudoun County, marginally increased its number of eligibility workers, while the number of recipients increased by 36 percent in five years. The statewide increase was only 10 percent during the same period.

The correlation between high caseload and late renewals appears to be meaningful only for offices with very high caseloads. Many factors other than caseload—staff inexperience, high turnover, and organizational inefficiency—can explain problems with lateness in a particular office, but there appears to be a “threshold effect” for very high caseloads. For the top 10 percent of offices with very high caseloads, there is a strong positive correlation (0.73) between caseload and percentage of late renewals over the past five years. Above a certain caseload threshold, skilled staff and greater efficiency may not be sufficient to overcome the problems with lateness. For the lower 90 percent of offices, there is a much weaker correlation (0.14) between caseload and percentage of late renewals.

FIGURE 3-7
Number of recipients increased substantially in localities with largest numbers of late renewals as number of staff remained flat or decreased (FY 2010–FY 2014)



Source: JLARC staff analysis of VDSS renewal, enrollment, and staffing data.

Financial constraints, turnover, and difficulty recruiting candidates are the primary reasons why staffing did not keep up with the increase in recipients. Staff at several local offices reported that the transition to VaCMS resulted in significant turnover that impeded their ability to meet time standards. Many eligibility workers who were close to retirement did not want to learn the new eligibility determination system. Local DSS offices reported difficulty filling open positions. Loudoun County, for example, indicated that they had been operating at about 50 percent of their eligibility capacity because they have been unable to fill positions.

Several offices have received state funding for overtime to help manage their caseload, but they report that existing staff have reached capacity. Local DSS offices described workers as “exhausted,” often working late nights and weekends on a regular basis. Several offices indicated that the overtime requirements had resulted in further turnover. One office reported that their eligibility workers were leaving for better staffed offices.

Expanding the CPU could add short-term staffing capacity needed to reduce late determinations

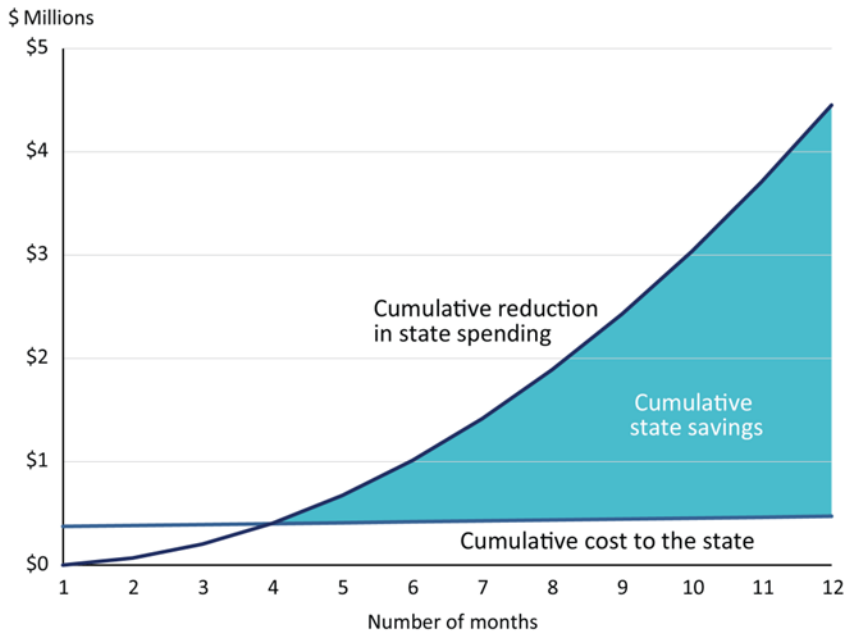
Expanding the CPU to perform renewals could create additional capacity to reduce the backlog of late renewals as well as applications. The state funded a contractor to operate the CPU in August 2014 to help reduce the backlog of late Medicaid applications, at an annual cost of approximately \$16.7 million (of which 25 percent are state funds). The CPU, in conjunction with local offices, was successful at reducing this backlog, such that the number of applications receiving a late determination fell from a high of 40,000 (58 percent) in the first quarter of 2014 to less than 12,000 (25 percent) in the first quarter of 2015. The CPU is staffed by contract employees and can therefore adjust its capacity more quickly than local DSS offices, increasing or decreasing capacity as necessary to handle its caseload.

Reducing the backlog of late renewals could save the state money by reducing the amount spent on services for ineligible recipients, and using the CPU to accomplish this goal quickly appears likely to be cost-effective. Late renewals are estimated to have cost between \$21 million and \$38 million in FY 2014 (Chapter 2). On average, each overdue renewal is estimated to cost between \$67 and \$121 for each month overdue in FY 2014. Half of these costs are incurred by the state, and the other half by the federal government. The transition of the ABD populations into the VaCMS system will likely exacerbate the backlog of late renewals, and the total cost associated with these recipients will continue to increase.

Using the CPU would cost an estimated \$20 per renewal, and expanding the capacity of the CPU would require one-time implementation costs of approximately \$3.5 million for additional space and necessary technology changes. However, the cost to the state would be far lower because 90 percent of implementation costs and 75 percent of ongoing operational costs would be paid with federal dollars.

The actual cost savings to the state resulting from this strategy will depend on the size of the backlog and the volume of renewals that can be performed by the CPU, but this strategy is likely to be cost-effective even if a small number of renewals are processed by the CPU. Performing just 200 renewals each month would allow the state to break even and recoup the state share of the CPU implementation costs within the first year. If the CPU performed 2,000 renewals per month, the state could save between \$4 million and \$8 million in the first year (Figure 3-8). Completely eliminating the backlog of overdue renewals—which was more than 73,000 as of June 2015—in 12 months would save the state between \$13 million and \$24 million. This would require more than 6,000 renewals by the CPU each month.

FIGURE 3-8
Expanding the CPU to perform 2,000 renewals per month could produce \$4 million in general fund savings in the first year



Source: JLARC staff analysis of VDSS overdue case data and DMAS cost data.
 Note: Estimated savings by month are based on an estimated monthly cost of \$67 for each overdue renewal.

In interviews, staff of VDSS and DMAS indicated that the number of overdue renewals has decreased since June 2015 and that multiple efforts are already underway to address the current backlog. These efforts include a one-time waiver from CMS to use SNAP income data for electronic renewals, a temporary increase in personnel and staff hours in local DSS offices, and improvements to VaCMS to help eligibility workers quickly identify upcoming renewals.

These initiatives are intended to reduce the backlog of late renewals, but it is unknown how effective they will be or how quickly they can be expected to eliminate the backlog, particularly given the concerns expressed by state and local staff that the transition of the ABD populations to VaCMS could exacerbate the backlog. The effectiveness of these initiatives and the current status of the backlog should be taken into consideration as a plan is developed to expand the CPU. Further, DMAS and VDSS should establish a benchmark for the acceptable level of late renewals in any given month, against which local DSS offices and VDSS will be measured. A certain number of renewals are likely to be late in any given month, but measuring performance against this benchmark would enhance accountability and help minimize the impact of late renewals.

RECOMMENDATION 12

The Departments of Medical Assistance Services and Social Services should develop a plan for expanding the central processing unit, to reduce the backlog of overdue renewals as quickly as is practicable, and establish a target limit on the number of late renewals each month. The plan should be submitted to the House Appropriations and Senate Finance Committees by the beginning of the 2016 General Assembly session.

RECOMMENDATION 13

The General Assembly may wish to consider appropriating necessary general funds to implement the plan presented by DMAS for expanding the central processing unit to reduce the backlog of overdue renewals.

Outdated allocation formula for local administration should be updated to address chronic staffing shortages in certain offices

The allocation formula used to distribute the state's base administrative funding among localities does not appear to accurately reflect local workloads and may be contributing to staffing shortages in some offices. Several offices with high case-loads—one indicator of high total workload—cited a lack of funding as a reason for their staffing shortages. State administrative funding is used primarily for staff salaries, yet the base allocation does not adequately take into account current workload. The allocation of state funds also drives how federal funds and a portion of local funds are allocated.

The state allocates base administrative funding to localities according to a model developed in FY 1991. DSS indicated that the allocation was based in part on localities' relative workload at that time, but the model has not been substantially updated since then. VDSS staff reported considering workload and other relevant factors in allocating new funding to local DSS offices, but the base administrative allocation remains the same each year. Demographic changes have caused significant shifts in

each locality's population over the past 25 years, resulting in different relative workloads in FY 2015 than in FY 1991.

Local funds can be used to better match staffing with workload. Localities may provide additional funding, which is eligible for a federal match, above the state administrative allocation; however, some localities are less able than others to contribute additional funds for staffing. Localities provided a total of \$184 million (33 percent) for local DSS administration in FY 2014, compared to \$112 million in state funds (22 percent). Another \$260 million (46 percent) was made available by the federal government.

The outdated state allocation method and the disparate ability of localities to provide additional funding results in wide variation in the level of administrative funding available per recipient in each locality. Local DSS offices received between \$30 and \$145 per recipient from the state in FY 2014. Including all funding sources, local DSS offices had between \$153 and \$873 in administrative funds per recipient.

Some localities receive disproportionately low levels of funding, given their high caseloads, and the low funding level is a contributing factor to poor performance. Among the six local DSS offices with the highest proportion of overdue renewals, four were among the localities receiving the lowest levels of state funding relative to caseload (Table 3-2). One locality (Loudoun County) provides significant local funds to increase their total funding per recipient above the state average, and reported that problems with recruiting, rather than funding, drove their staffing shortages. Another two offices received more administrative funding per recipient than the state average, but still had a high percentage of overdue renewals. This demonstrates that funding is just one of the factors that affect performance. Likewise, caseload is only one of the factors that affect total workload at local DSS offices. Other program responsibilities, such as foster care and adult protective services, contribute to total workload. VDSS indicated that benefit programs account for approximately half of total workload for local DSS offices.

The state should reassess its base administrative funding formula for local DSS offices, to adjust for shifting demographics and the resultant changes to workload. State administrative funding is not the only factor that affects performance, but maintaining the base funding allocation from FY 1991 ensures that funding will not adapt to shifting demographics. Localities have varying levels of local resources with which to supplement state funding, and local ability to pay for local DSS administration should also be considered in reviewing the administrative funding allocation.

TABLE 3-2

Local offices with highest proportion of late renewals tend to be those that receive less state administrative funding (FY 2014)

Local DSS offices with highest percent of overdue renewals (FY15)	State administrative funding per recipient	State administrative funding rank	Total administrative funding per recipient	Total administrative funding rank
Chesterfield	\$30	120	\$165	118
Loudoun	33	118	363	29
Stafford	36	115	192	109
Shenandoah	40	113	216	97
Petersburg City	86	23	289	53
Richmond City	98	13	337	32
State average	\$63		\$314	

Source: JLARC staff analysis of FY 2014 VDSS annual financial report and monthly counts of late Medicaid renewals. Note: Staffing ratios calculated using unduplicated enrollees across Medicaid, SNAP, and TANF per worker.

RECOMMENDATION 14

The General Assembly may wish to consider including language in the Appropriation Act to direct the Virginia Department of Social Services to develop an objective and data-driven formula for the allocation of state administrative funding to local departments of social services that reflects workload, ability to pay, and other factors that affect performance.

4 Estate Recoveries from Medicaid Recipients

SUMMARY The Department of Medical Assistance Services (DMAS) does not proactively identify assets that may be recoverable from the estates of deceased Medicaid recipients, limiting the state’s ability to seek reimbursement for the cost of Medicaid expenditures. In FY 2014, total recoveries were just \$883,000, split between state and federal funds. DMAS is successful at recovering funds when assets are identified through referrals, receiving payment from more than 87 percent of estates that were identified for recovery. The state’s eligibility determination system will soon have data that could be used to proactively identify estates with assets and to prioritize recovery from the estates with the highest values. External data sources exist that could help DMAS identify and recover additional assets that are not identified through the eligibility determination process.

Federal policy requires states to seek recovery from the estates of deceased Medicaid recipients over the age of 55 for the cost of providing long-term care and related hospital and prescription drug services, unless the individual is survived by a disabled child. When Medicaid recipients are survived by a spouse, recovery efforts are delayed until after the spouse’s death. Virginia also exercises the state option to seek recovery for all other Medicaid-funded services provided to recipients who are 55 or older upon their death, with the exception of Medicare premiums and cost-sharing benefits. Half of all funds recovered under this policy are returned to the state general fund, and the other half are returned to the federal government.

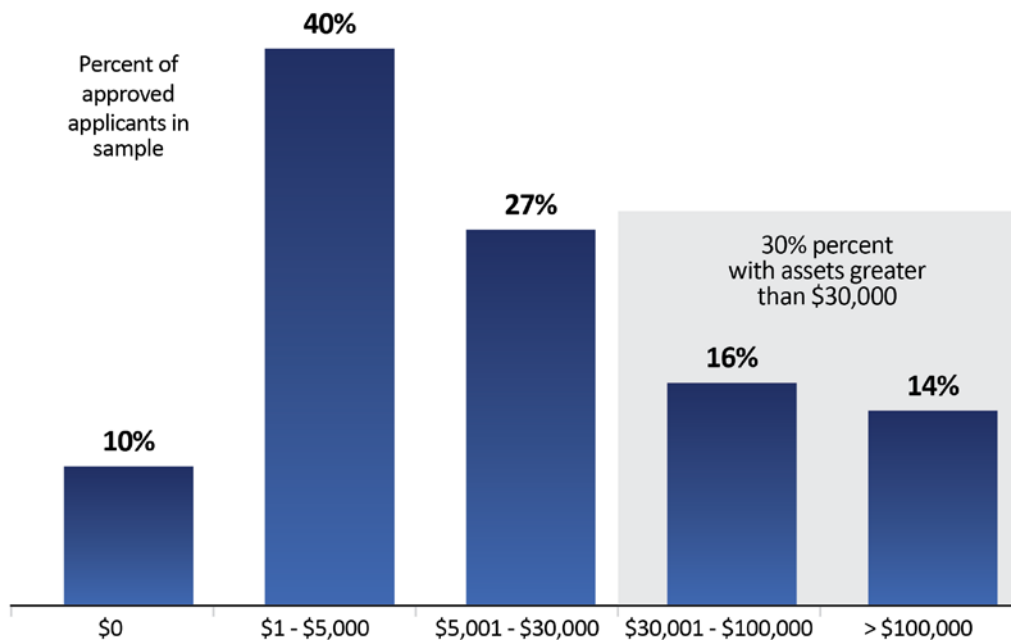
States are required to seek recovery for Medicaid-funded services under certain circumstances

Most Medicaid recipients whose estates are subject to asset recovery are aged recipients who cannot have more than \$2,000 in countable assets (\$3,000 for married recipients) to be eligible for the program. However, some Medicaid recipients may also own valuable assets that were exempt from being counted for eligibility purposes (sidebar), but are recoverable after the individual’s death to reimburse the state for Medicaid expenses. The most commonly held exempt assets are homes and vehicles, particularly for long-term care recipients who receive home and community-based services (HCBS) and often still reside in their homes. Other types of assets that may exist and are potentially recoverable are bank account balances that are below the asset threshold, certain types of trusts, and pre-need funeral contracts with excess balances after all funeral expenses have been paid.

Exempt assets
Virginia eligibility policy exempts the value of an individual’s primary residence as long as the person resides in the home. One vehicle is also exempt for each individual.

Information about the assets of recipients is not currently documented electronically in Virginia, so it is not known how many Medicaid recipients currently have exempt assets. A 2014 study of three states (not including Virginia) by the Government Accountability Office (GAO) found that about 90 percent of Medicaid recipients in their sample had assets, with about 30 percent owning more than \$30,000 in assets (Figure 4-1). Recipients can have assets with a value that exceeds the Medicaid eligibility limit, because several types of assets are exempt. GAO found that 74 percent of Medicaid recipients in their sample owned at least some exempt assets, with an average value of over \$80,000 and a range from zero to more than \$1.5 million. The most common exempt assets in the sample were prepaid burial and funeral contracts (39 percent), primary residences (31 percent), and vehicles (26 percent) (Table 4-1).

FIGURE 4-1
GAO study found 30 percent of recipients owned more than \$30,000 in total assets



Source: JLARC staff analysis of GAO report GAO-14-473.

TABLE 4-1
Some Medicaid recipients may have exempt assets with significant value

Type of asset	Percent owning asset in GAO sample	Typical treatment under Virginia eligibility policy
Financial (bank accounts)	95%	Countable
Prepaid burial contracts	39%	Exempt
Life insurance	34%	Countable (cash value)
Primary residence	31%	Exempt
Vehicle	26%	Exempt

Source: JLARC staff analysis of GAO report GAO-14-473 and DMAS Medicaid eligibility policy.
 Note: Findings based on sample of long-term care applications from four counties in three states.

Recoverable assets are not proactively identified in Virginia

Recoverable assets are not proactively identified and recovered from the estates of deceased Medicaid recipients, in part because of the absence of centralized, electronic information. DMAS relies on referrals to initiate the estate recovery process, limiting the state’s ability to recover the cost of providing Medicaid services to recipients who meet the criteria for estate recovery. In FY 2014 Virginia recovered \$883,000, while Oregon, which operates a smaller Medicaid program but has a more robust asset recovery process, recovered more than \$21.8 million. Electronic data will soon be available to help DMAS proactively identify estates with recoverable assets and prioritize them for recovery. To make use of electronic resources as they become available, DMAS will need to develop new processes.

Recoverable assets are currently identified through referrals

There is currently no process in place to identify whether the estate of a deceased Medicaid recipient has assets that could be recovered. DMAS instead relies on heirs and executors to report any assets that are subject to estate recovery, creating a potential conflict of interest. Heirs and executors may stand to inherit assets from estates if they are not used to reimburse the state for the decedent’s Medicaid expenses. Prior to 2015, referrals from estate attorneys, nursing facilities, and local DSS offices were Virginia’s only mechanisms to identify recoverable assets. In February 2015, DMAS started sending automated estate verification letters to the last address of deceased recipients whose estates met the criteria for recovery. The letter enumerates the federal and state recovery requirements and requests that the heir or estate administrator return an information form with the value of the estate and relevant information on the decedent’s family and the executor of the estate. It is too

Transition of ABD population to VaCMS

Beginning in September 2015, eligibility for aged and disabled applicants will be performed using VaCMS. By January 2016, information on all current aged and disabled recipients will be maintained in the centralized system.

early to tell whether this process will result in additional assets being identified and ultimately recovered.

The passiveness of this process significantly limits the state's ability to recover the cost of Medicaid services. More than 11,000 Medicaid recipients over the age of 55 died in FY 2014, but DMAS sought recovery from only 215 estates. This low number of attempted recoveries is due in large part to the fact that no central data source exists to identify the assets of Medicaid recipients. Prior to the use of VaCMS for the aged and disabled populations, records indicating the type and amount of assets for Medicaid recipients were maintained in paper files at each local DSS office. Obtaining information on the assets owned for each deceased recipient whose estate is eligible for asset recovery would place an additional burden on local eligibility workers. The additional work would in turn exacerbate the backlog of late applications and renewals. DMAS indicated that this limitation is the primary reason for its reliance on referrals to identify recoverable assets.

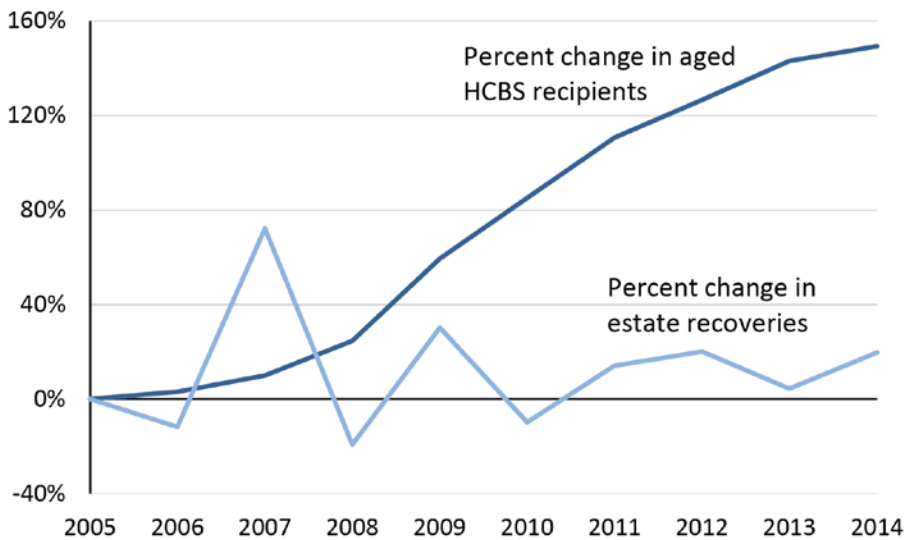
Recoverable assets likely growing but recoveries remaining flat

The number of deceased Medicaid recipients with potentially recoverable assets has likely increased significantly over the past decade, but estate recoveries have remained flat. Many recipients whose estates are subject to asset recovery are long-term care recipients who are increasingly living at home and receiving services through HCBS long-term care waivers. More than half of all long-term care recipients elect an HCBS option and retain their home as an exempt asset if it is their primary residence.

In contrast, the homes of nursing facility residents are considered countable assets six months after the move to a nursing facility, unless their spouse still resides in the home. Typically the nursing home resident either loses eligibility for Medicaid or sells the house to help pay for nursing facility care, so asset recovery upon death is not relevant.

The number of recipients who still own their homes at time of death is likely to increase as more recipients choose to stay in their homes and receive long-term care services in the community. The number of aged HCBS recipients has grown by almost 150 percent over the past 10 years, or an average of 16.5 percent annually. The amount of recoverable assets statewide has likely increased concurrently, but estate recoveries have been largely flat, increasing by just 2.2 percent annually from approximately \$735,000 in FY 2005 to just over \$880,000 in FY 2014, adjusted for inflation (Figure 4-2).

FIGURE 4-2
Growth in number of aged HCBS recipients who may own homes significantly outpaced estate recoveries (FY 2005–FY 2014)



Source: JLARC staff analysis of DMAS recipient and estate recovery data.
 Note: Percent change in estate recoveries is based on inflation-adjusted 2014 dollars.

Recovery efforts are generally successful when assets are identified

At least some payment was received from 87 percent of the 1,008 estates that were identified for asset recovery between FY 2011 and FY 2014. DMAS is largely successful at collecting payment from identified estates by filing a claim with the Commissioner of Accounts in the appropriate locality. The Commissioner of Accounts is responsible for ensuring that all claims against the estate, including claims for Medicaid reimbursement, are paid before the estate is closed. When payment is not received from the estate, it is usually because the estate’s heirs received a hardship waiver or because there were no funds left in the estate after taxes and other creditors were paid.

The total amount recovered from the 207 estates that made a payment to DMAS in FY 2014 was just over \$883,000, or \$4,622 per recovery. However, the average amount of Medicaid expenses that the state seeks to recover is more than \$35,000. This significant gap between the average amount claimed for reimbursement and the average amount recovered exists because most estates identified for recovery do not have significant assets remaining once taxes and other creditors have been paid. In fact, an average of just \$813 was collected from the smallest 182 estates in FY 2014. Many of these small recoveries occur when a recipient dies in a nursing facility and the nursing facility proactively disburses any funds remaining in the individual’s bank account to DMAS. These are typically small amounts; high balances would exceed

Hardship waiver

Heirs to an estate can request a hardship waiver if recovery from the estate would pose a significant hardship to the heirs or if a home subject to recovery is considered a homestead of modest value, defined as having a value below the median home price in the locality.

Order of precedence for estate disbursements

1. Costs of administration
 2. Family allowances
 3. Funeral expenses
 4. Federal debts/taxes
 5. Medical expenses for the last illness
 6. Virginia debts/taxes (including Medicaid)
-

the asset limits for Medicaid eligibility. Most of the amount recovered (83 percent) came from just 25 estates with larger assets (Table 4-2).

Electronic data sources will soon be available to identify recoverable assets

Multiple data sources exist to help proactively identify estates with recoverable assets. The VaCMS system will include information on all assets that are identified during the initial eligibility determination process and subsequent renewals, once the transition to the system is complete in January 2016. Additional data sources exist through private vendors that would enable searches for assets that are not identified through the eligibility determination process.

VaCMS will maintain data on assets identified during eligibility determination

When implemented for the aged and disabled population, VaCMS will provide a central electronic database that includes the type and value of assets owned by Medicaid recipients. All assets that are owned by recipients should be reported during the initial eligibility determination and annual renewal processes. Because eligibility workers assess eligibility based on all of the assets that are reported by the applicant, including homes and vehicles even if they are exempt, VaCMS will have records of all assets and their reported value at the time of the most recent determination.

Automatically gathering data from VaCMS for deceased Medicaid recipients will improve DMAS's ability to identify recoverable assets. It will remove the conflict of interest inherent in the current process, which relies on heirs and estate administrators to self-report the value of estates. Using data from VaCMS will also allow for greater prioritization in the recovery process. Many estates of deceased Medicaid recipients are very small, so prioritizing estates with larger assets would increase the average amount recovered and yield a greater return on investment than those with smaller values.

TABLE 4-2
Small number of high dollar recoveries accounted for majority of asset recovery revenue in FY 2014

	Number of recoveries	Average revenue from recoveries	Total revenue from recoveries
<\$500	96 (46%)	\$119	\$11,383 (1%)
\$500 - \$2,000	62 (30%)	\$1,069	\$66,272 (8%)
\$2,000 - \$5,000	24 (12%)	\$2,932	\$70,359 (8%)
≥\$5,000	25 (12%)	\$29,405	\$735,133 (83%)
Total	207	\$4,622	\$883,147

Source: JLARC staff analysis of DMAS asset recovery data.

DMAS may need to dedicate more staff to identifying, prioritizing, and processing recoveries if they are successful at identifying additional recoverable assets. There are only two staff members at DMAS who allocate a majority of their time to estate recoveries. At this level of staffing, DMAS was able to process an average of 248 recoveries per year over the past four years. If more recoverable assets are identified through VaCMS, the workload will increase, and two staff positions may not be enough.

RECOMMENDATION 15

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to use data from the Virginia Case Management System to identify the reported assets of deceased Medicaid recipients and to initiate recovery from estates for which the value of the assets is likely to exceed the cost of recovery.

Public and private data sources may contain assets that were not identified during eligibility determination

There are other data sources that could help DMAS identify recoverable assets not captured in VaCMS. VaCMS will document the type and value of assets that are identified during the eligibility determination, but in accordance with current policy, it would not include unreported assets. Unless current policy is changed as recommended (see Chapter 2), unreported assets would not be recorded in the VaCMS database and could not be identified for recovery. Other public and private databases exist that could provide DMAS staff with more information about recoverable assets.

DMAS should contract with a private vendor for access to data sources that can be searched for the unreported real estate assets of deceased Medicaid recipients. Other states are successfully using these data sources to identify and recover assets that are not documented during the eligibility determination process. For example, Oregon reported success using a vendor to search a nationwide property records database in a cost-effective way. Oregon reported paying \$1,000 per month on average for searches of the database. The financial impact of such a service, at a cost of \$12,000 annually, would be a net gain if it resulted in three additional recoveries, using the current average of \$4,600 per recovery.

DMAS could similarly search for unreported vehicles owned by deceased Medicaid recipients in Virginia's Department of Motor Vehicles (DMV) database. Vehicles that are reported during the eligibility determination process are verified using DMV records, but there is no check for unreported vehicles. This data is owned and stored by the state, so the cost of this type of search would be minimal.

RECOMMENDATION 16

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Medical Assistance Services to use electronic data sources to search for unreported assets of deceased Medicaid recipients and to initiate recovery from estates for which the value of the assets is likely to exceed the cost of recovery.

Additional staffing with legal expertise in property and estates and in Medicaid eligibility policy would be necessary to fully utilize these external data sources. Staff in Oregon indicated that legal expertise is often required to accurately identify and evaluate recoverable assets. Searches for unreported assets sometimes discover property that has been transferred to related parties, and in these cases, the asset transfer must be evaluated to determine if the transfer made the recipient ineligible for Medicaid and if the asset is potentially recoverable.

Appendix A: Study Mandates

HOUSE JOINT RESOLUTION NO. 637

and

SENATE JOINT RESOLUTION NO. 268

Directing the Joint Legislative Audit and Review Commission to study the Commonwealth's Medicaid program.

Agreed to by the Senate, February 27, 2015

Agreed to by the House of Delegates, February 27, 2015

WHEREAS, the Commonwealth's program of medical assistance services, also known as the Medicaid program, is the largest program in the Commonwealth's budget, accounting for more than \$8 billion in combined state and federal funds in fiscal year 2014; and

WHEREAS, the Commonwealth's Medicaid program has become increasingly complex as coverage has expanded to include services related to long-term care, behavioral health, and developmental disabilities; and

WHEREAS, elderly Virginians and Virginians with disabilities represent a minority of enrollees in the Medicaid program but account for the majority of expenditures for medical assistance services and generally receive services through a fee-for-service rather than a managed care system; and

WHEREAS, a review of the eligibility process, particularly for long-term care services, could lead to strategies that strengthen the integrity of the program, improve efficiencies, and ensure that limited financial resources are directed to the individuals and families who most require assistance; and

WHEREAS, in light of budgetary pressures facing states across the nation, promising models of care and administrative processes have been implemented to lower costs associated with medical assistance services while maintaining and improving patient outcomes; and

WHEREAS, a comprehensive and analytical review of the Medicaid program should build upon and not duplicate the knowledge and findings from completed studies; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to study the Commonwealth's Medicaid program. In conducting its study, the Joint Legislative Audit and Review Commission shall review (i) the processes used to determine eligibility, including the financial eligibility screening process for long-term care services, whether asset sheltering could be further prevented and asset recoveries improved, and the effectiveness of existing fraud and abuse detection and prevention efforts; (ii) whether the most appropriate services are provided in a cost-effective manner; (iii) evidence-based practices and strategies that have been successfully adopted in other states and could be used in the Commonwealth; and (iv) other relevant issues, and make recommendations as appropriate.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Office of the Secretary of Health and Human Resources and the Department of Medical Assistance Services. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2015, and for the second year by November 30, 2016, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B: Research Activities and Methods

JLARC staff conducted the following primary research activities:

- structured interviews with staff at multiple state agencies charged with setting Medicaid eligibility policy and overseeing the Medicaid eligibility determination process;
- structured interviews on-site at seven local departments of social services;
- quantitative analysis of Medicaid application and renewal data for the MAGI population (children, parents, and pregnant women);
- quantitative analysis of asset recovery data; and
- review of documents and research literature.

Structured interviews

JLARC staff conducted structured interviews to understand Medicaid eligibility policy, how the implementation of that policy is overseen and coordinated by state agencies, and how that policy is used to make eligibility determinations at local departments of social services. JLARC staff conducted structured interviews with staff at the Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS). Structured interviews were also conducted during site visits to seven LDSS offices.

Structured interviews of state agency staff

JLARC staff conducted structured interviews with eligibility policy and asset recovery staff at DMAS, and with staff at DSS responsible for implementing VaCMS and coordinating the eligibility determination process. Topics for these interviews included clarifying the intent of current eligibility policies, understanding the progress of the transition to VaCMS and the data available from the system, and identifying challenges that are currently facing these state agencies and the LDSS offices that they partner with.

Site visits to local departments of social services

JLARC staff conducted site visits to seven out of 120 local DSS offices to conduct structured interviews and observe the eligibility determination process. The purpose of these interviews and observations was to understand how eligibility policy was implemented by eligibility workers, identify any challenges being faced by local DSS offices across the state, and develop potential solutions to address these challenges. The structured interviews during the site visits focused on the initial eligibility determination and the annual renewal process for the MAGI population, including how criteria are verified currently and prior to VaCMS, and the policies and processes used to verify assets for the aged and disabled populations. JLARC staff selected seven local DSS offices based on their region, size, and relative performance in performing Medicaid renewals on time (Table B-1).

Table B-1 Local departments of social services selected for site visits

Locality	Region	Size	Timeliness performance
Danville, City of	Piedmont	Medium	High
Fairfax County	Northern	Large	High
Lexington/Rockbridge/ Buena Vista	Piedmont	Small	Low
Loudoun County	Northern	Medium	Low
Norfolk, City of	Eastern	Large	High
Richmond, City of	Central	Large	Low
Smyth County	Western	Small	High

Source: JLARC staff analysis of DSS data.

Quantitative analysis

JLARC staff analyzed data from DMAS, DSS, and the Virginia Employment Commission (VEC). JLARC staff used data on MAGI applications and renewals from VaCMS to:

- assess the extent to which VaCMS is improving eligibility workers' ability to electronically verify Medicaid eligibility criteria,
- assess the risk to the state of certain eligibility policies, and
- evaluate the timeliness of Medicaid eligibility determinations for both applications and renewals.

JLARC staff also obtained data from DSS on current and historical staffing and funding levels for LDSS offices to assess the relationship between staffing, funding, and performance. Data from DMAS on the assets identified for recovery and the assets recovered was used to assess the effectiveness of the current asset recovery process.

Electronic verification analysis (Chapter 2)

JLARC staff used data on all MAGI applications received in ADAPT from October 1, 2012 through September 30, 2013, and in VaCMS between October 1, 2013 and March 31, 2015 to assess the extent to which electronic resources were being used to verify eligibility criteria before and after VaCMS implementation (Table B-2). JLARC staff calculated how frequently certain eligibility criteria were verified electronically in ADAPT and VaCMS. This analysis focused on six eligibility criteria: earned income, unearned income, immigration status, citizenship, alien status, and identity (social security number).

TABLE B-2
Data from ADAPT and VaCMS was used for eligibility verification analysis

Data source	Description of data	Analysis performed
DSS	Source of eligibility verification for children, parents, and pregnant women applications in ADAPT 10/1/12–9/30/13	Percentage of each eligibility criterion verified electronically
DSS	Source of eligibility verification for children, parents, and pregnant women (MAGI) applications in VaCMS 10/1/13–3/31/15	Percentage of each eligibility criterion verified electronically

Source: JLARC staff analysis.

Unreported income analysis (Chapter 2)

JLARC staff used data from DSS and VEC to understand the risk to the state of the current policy to accept self-attestation of zero income for Medicaid eligibility (Table B-3). JLARC first identified all approved applications where no individual on the application reported any earned or unearned income. For those applications reporting zero earned income, JLARC identified if any individuals on that application had earnings reported to VEC during the quarter in which the application was approved.

TABLE B-3
Data from VaCMS and VEC was used for unreported income analysis

Data source	Description of data	Analysis performed
DSS	Children, parents, and pregnant women (MAGI) applications in VaCMS 10/1/13–3/31/15	Applications reporting either zero earned or unearned income, or both
VEC	Quarterly earnings, 2010–2015	Identified applications with VEC earnings reported in the approval quarter Calculated distribution of earnings for approved applications reporting zero earned income

Source: JLARC staff analysis.

Application and renewal timeliness (Chapter 3)

JLARC analyzed data from VaCMS and monthly overdue case data from DSS to assess the timeliness of the eligibility determination process for both applications and renewals. JLARC staff calculated the percent of MAGI applications that were determined late, and the number of days that they were late, by eligibility category. JLARC staff also calculated the percent of Medicaid enrollees who were overdue for a renewal. Both of these analyses was performed over time and by locality (Table B-4).

JLARC staff used DSS renewal data and DMAS Medicaid claims data to estimate the cost to the state and federal governments of overdue renewals. JLARC staff identified all enrollees who were overdue for a renewal at any point during FY 2014, and the months they were overdue in FY 2014. To determine which overdue months may have been ineligible months, JLARC staff examined whether an individual was subsequently closed or renewed at any point through the end of the following fiscal year (FY 2015), the last month of data available for the study. If an individual:

- Was subsequently renewed and determined to be eligible, none of their overdue months in FY 2014 were considered to be ineligible months.
- Was subsequently renewed and determined to be ineligible, all of their overdue months in FY 2014 were considered to be ineligible months, with some exceptions. Individuals who were ineligible because they did not return their renewal application, and who re-enrolled in Medicaid within three months, were considered to be continuously eligible.
- Failed to return the renewal application and had not returned to the Medicaid program by the end of FY 2015, their eligibility status during their overdue months in FY 2014 was unknown.
- Was still active and had not been renewed as the end of FY 2015, their eligibility status during their overdue months was unknown.

JLARC staff estimated the cost of late renewals by summing the detailed claims data for ineligible months. The upper bound was calculated assuming that the unknown months (the last two bullets above) were ineligible months.

JLARC staff also used additional data from DSS on LDSS staffing and funding levels to assess the relationship between staffing, funding, and performance at LDSS offices. JLARC staff calculated the workload of each LDSS office by comparing the number of unduplicated benefit clients across the Medicaid, SNAP, and TANF programs to the number of eligibility workers. JLARC also calculated the amount of federal, state, and local administration funding per benefit client in each LDSS office.

TABLE B-4
Data from DSS and DMAS was used to assess timeliness of eligibility determination process

Data source	Description of data	Analysis performed
DSS	Children, parents, and pregnant women (MAGI) applications 10/1/13–3/31/15	Length of time to perform initial eligibility determination, Days early/late for each application
	Recipients overdue for renewal FY 2014–FY 2015	Overdue recipients and cases by locality and month, Estimated number of recipients ineligible due to a late renewal, FY 2014 Estimated cost of recipients ineligible due to a late renewal, FY 2014
	LDSS benefit clients, staffing, and funding, FY 2010–FY 2014	Benefit clients per staff, FY 2010–FY 2014, Funding per benefit client, FY 2010–FY 2014
DMAS	Medicaid claims, FY 2014	Estimated cost of recipients ineligible due to a late renewal, FY 2014

Source: JLARC staff analysis.

Asset recovery analysis (Chapter 4)

JLARC staff used data on the invoices issued and recoveries received by DMAS to assess the effectiveness of the estate recovery process (Table B-5). JLARC staff calculated the number of estates from which recovery was sought each year by calculating the number of invoices created. JLARC staff also calculated the average amount that was invoiced for each estate. The number of invoices for which payment was received and the amount of payment received was also calculated for each year.

TABLE B-5
Data from DMAS was used to assess asset recovery process

Data source	Description of data	Analysis performed
DMAS	for FY 2011–FY 2014	for FY 2011–FY 2014
	Asset recovery invoices initiated	Number of invoices created
		Amount of invoices created
		Number of invoices where payment was collected
		Amount of payments for invoices where payment was collected
	for FY 2011–FY 2014	for FY 2011–FY 2014
	Asset recovery payments received	Number of invoices for which payment was received
		Amount of payments received per invoice

Source: JLARC staff analysis.

Review of research literature and documents

JLARC staff reviewed DMAS and DSS documents related to eligibility determination policy and VaCMS implementation. Specifically, JLARC staff reviewed Virginia’s Medicaid eligibility policy manual and related documents, such as Virginia’s Medicaid application, to understand the current policies.

JLARC staff reviewed research literature and policy documents from other states to compare Virginia’s eligibility policy and implementation to that of other states. Documents included reports by other state oversight agencies, the US Government Accountability Office, and nonprofit research organizations.

Appendix C: Signature Page for Virginia Medicaid Application

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration and billing services.
- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months.
- I know that I must tell the local Department of Social Services within 10 calendar days if anything changes and is different than what I wrote on this application. I can visit www.commonhelp to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal. I understand that I can opt out at any time.

Yes, I consent to the use of electronic income data including information from tax returns to annually renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think Medicaid, FAMIS or Plan First has made a mistake I can contact them at www.coverva.org or call 1-855-242-8282.

Instructions for filing an appeal will be included on my notice and are also available on the coverva.org website.

If I think the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-318-2596. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature _____	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
-----------------	---

STEP 6 Mail completed application.

Mail your signed application to:

The local Department of Social Services in the city or county in which you live



NEED HELP WITH YOUR APPLICATION? Visit the Cover Virginia website at coverva.org or call us at 1-855-242-8282. Para obtener una copia de este formulario en Español, llame 1-855-242-8282. If you need help in a language other than English, call 1-855-242-8282 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-888-221-1590.

10/15/14

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Appendix D: Agency Response

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report to the Secretary of Health and Human Resources and the Departments of Medical Assistance Services and Social Services. Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report.

This appendix includes response letters from the Secretary of Health and Human Resources and the Departments of Medical Assistance Services and Social Services.



COMMONWEALTH of VIRGINIA
Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

November 4, 2015

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
201 North 9th Street
General Assembly Building
Suite 1100
Richmond, Virginia 23219

Dear Mr. Greer:

Thank you for the opportunity to review your report on our eligibility system transformation. This has been a unique and complex undertaking and I appreciate the recognition that we are not yet finished. I would like to add a bit of perspective that may not be evident from the focus on the eligibility determination performance.

It is important to recognize the context of Virginia's decision to proceed with transformation of our eligibility system:

1. The existing system was built on outdated technology and could not be supported long term.
2. This system had known shortfalls and the state share of support for these services had declined since 2006.
3. Federal changes required the Commonwealth to prepare for MAGI.

These business drivers would have required new investment in old technologies.

The Commonwealth opted to follow a strategic approach to solution of the MAGI requirement and replacement of Virginia's eligibility system. When the federal government extended availability to access 90-10 funding through Medicaid this year, they specifically requested states to pause and rethink how the technology that they funded could be multitasked. Virginia embraced that vision from the start, opting to "buy once and reuse" the underlying technology. The downside of following this strategy was that the Commonwealth got a late start due to the timing of the decision to move ahead, and only one vendor bid on this project.

Health and Human Resources, in conjunction with the Secretary of Technology, the Department of Motor Vehicles and the Virginia Information Technologies Agency leadership, viewed this project as potentially transformative in several ways. Our goal was to enable a customer-centric approach to eligibility determination. By creating one system to support multiple programs, we would simultaneously make access simpler for the citizen and reduce the workload on our eligibility workers. As the remaining programs (SNAP, TANF and LIHEAP)

Hal E. Greer, Director

November 4, 2015

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come on line next year, the old system will be retired and our workers will be in one modern system. We have enabled centralized support via call center technology to support that which can be done routinely. Ideally, with the proper policy changes, much of this work can be automated. We also have begun to facilitate the process of going paperless at the local offices.

From the beginning, we knew that we were purchasing technology that could benefit agencies both inside and beyond Health and Human Resources. We also knew that any strategy as might be adopted by the Virginia Information Technologies Agency for its eventual re-compete of the Northrop Grumman relationship would be better supported by adoption of modern technology than by additional investment in stale technologies.

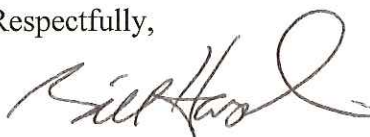
Today we now have a modern technology that, if we commit to utilize it collectively, will enable Virginia to modernize our approach to citizen services. It can cost effectively enable a single mobile platform for the Commonwealth. Data collection and analytics can be enhanced.

One realized example of how the technology can be of value is the death registry. This platform could allow the Virginia Department of Health to push notices to all agencies of a citizen's death. This would have significant implications for spending on benefits and the potential for voter fraud. The value will only be realized if agencies can connect to the system and this will require some up-front funding. Another example of a simple but valuable tool would be the ability to keep addresses and contact information current. If the Department of Motor Vehicles receives an address change, would tax not want to know about it?

One piece of the technology that we purchased was the underpinning of the Commonwealth Authentication System (CAS) which was entrusted to the Department of Motor Vehicles to develop. CAS can create a single credential for citizens who access Commonwealth services online. There are citizen convenience opportunities here, but also our system would be much more secure with fewer access points. Absent a commitment to support and disseminate this technology, it will be too expensive for a single agency, i.e., the Department of Social Services, to support.

The Department of Social Services, the Department of Medical Assistance Services, the Department of Motor Vehicles and the Virginia Information Technologies Agency worked exceptionally well together to get us to this point. Given the adage that "experience is what you have right after you needed it", there would be much to learn from a case study of the broader implementation and I would encourage the Joint Legislative and Audit Review Commission to consider undertaking such an evaluation. As a Commonwealth, we must move away from "agency centric" approaches to programs and services if we are to add value.

Respectfully,

A handwritten signature in black ink, appearing to read "Bill Hazel", written in a cursive style.

William A. Hazel, Jr., M.D.



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

October 28, 2015

Mr. Hal E. Greer, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
201 North 9th Street
Richmond, Virginia 23219

Dear Mr. Greer:

The Department of Medical Assistance Services would like to thank the staff of JLARC for their conscientious efforts to understand, evaluate and correctly communicate certain aspects of Virginia's Medicaid program in the preparation of this report. We particularly appreciate the opportunities we were afforded to meet with JLARC staff to discuss and clarify issues and to submit written comments prior to the report being finalized.

DMAS has reviewed the exposure draft of this report and agrees with the recommendations included therein. Most notably, we agree that with the growth in the availability of electronic data sources related to eligibility criteria, certain procedures should be updated in order to maximize the use of such databases. In fact, DMAS, in collaboration with the Department of Social Services (DSS), has already begun revising procedures to incorporate searches of available electronic data in certain types of cases addressed in this report. We hope to have the first phase of these new procedures in place prior to the end of the year.

However, while we agree that the recommendations contained in this report may help improve the accuracy of eligibility determinations and the recovery of certain assets owed the Commonwealth from the estate of deceased beneficiaries, we must also note that these changes would require funding to implement. Some of the electronic databases suggested in the report are for-profit enterprises and therefore require contracts with vendors and transaction fees to access. To incorporate searching of such databases as part of the automated real-time eligibility process through Virginia's new Eligibility & Enrollment system, VaCMS, it will also require modifications to that current contract and likely additional funding to implement. Finally, some

of these new processes, while automated in part, will also result in an increase in workload for local departments of social services and/or the central processing unit of Cover Virginia. For example, while the VaCMS system can be modified to check current electronic databases for earned and unearned income for those reporting 0 income (as the system currently does for those reporting some income), a certain number will be found to be inconsistent with the electronic sources. These cases will require manual intervention by an eligibility worker as the applicant must be afforded an opportunity to provide a “reasonable explanation” of the discrepancy and some follow-up will also be required resulting from post enrollment searches for income (recommendations 3, 4 and 5). While future enhancements to the VaCMS could reduce the impact on worker time (e.g., by providing a drop down box of potential explanations for 0 incomes embedded in the online application instead of requiring a worker inquiry), there would still be some workload impact in addition to the cost of system changes. DMAS and DSS will attempt to evaluate the initial cost of this change in procedure and compare this to the number of individuals denied eligibility based on discovered unreported income and the resulting savings to the Commonwealth.

In addition to funding, certain recommendations will also require that the General Assembly grant the necessary authority for DMAS to implement. For example, DMAS originally proposed legislation last year that would have mandated financial institutions to cooperate with the new electronic asset verification system (AVS). However, the language was ultimately changed to require only voluntary cooperation. Although it is currently unknown how effective such voluntary cooperation will be, recommendation #1 in this report suggests the legislature may wish to strengthen that requirement. Also, despite requests by DMAS and DSS last year to preserve the proposed funding for the CoverVirginia Central Processing Unit (CPU) and remove the language terminating all such funding as of the end of SFY 2016, the proposed funding was reduced by \$4 million and the language eliminating future funding remains in effect. Without these changes, recommendations 12 and 13 cannot be implemented and the support provided by the CPU will terminate next summer, negatively impacting the progress Virginia has made in processing applications in a timely manner.

While DMAS believes this report provides an accurate representation of current eligibility policies and practices and makes viable recommendations for improvements, we also want to clarify two important points for readers. This report documents that 30% of Medicaid enrollees reported 0 income on their application. To some, this could appear to represent a significant degree of fraud. However, there is no evidence to suggest applicants misrepresented their current circumstance. There are several reasons why almost a third of applicants might legitimately report no income. First, the federally approved Medicaid application cannot ask questions that are not directly relevant to a person’s eligibility and certain forms of unearned income are not relevant to a determination based on the Modified Adjusted Gross Income (MAGI) methodology prescribed in the Affordable Care Act. For example, child support cannot be counted, nor can SSI incomes or Veterans benefits. Therefore, the application does not

request information on income from these sources and, even if received by the applicant, the resulting countable household income would be reported as 0. Second, there are fairly common scenarios in which Medicaid applicants would have no countable income to report. For example, a significant number of grandparents or other relatives are raising children apart from their parents. In such families the grandparent/other relative income does not count toward a child's eligibility. Lastly, the electronic databases are not "real time" and the individual could have very recently lost their employment, including health benefits, and immediately applied for Medicaid – again accurately reporting no current income.

We would also like to note that according to the Urban Institute, the nationally recognized source of state participation rates in Medicaid, approximately 30% of Virginians eligible for the state's Medicaid program have no countable income. This data is not taken from applications but from national surveys and appears to validate the JLARC findings.

The last point DMAS would like to clarify is the degree of flexibility states have in setting eligibility policy. While every state's Medicaid program is different regarding services covered, delivery systems, and payment rates the Affordable Care Act increased the standardization of eligibility policy significantly. Federal regulations are now even more prescriptive on criteria used to determine eligibility for the MAGI population (most of Virginia's enrollees). Regulations prescribe who constitutes members of an applicant's household, whose income can be counted, what types of income counts, how states are to rely on electronic data for verification, how applications can be designed, how states must accept applications, and how and when renewals are to happen. Virginia's current Medicaid program operates within all these federal requirements. As JLARC notes in this report, there are some procedures where federal regulations are silent and states do have discretion, such as how to verify a report of 0 income. In these limited areas DMAS can and will make recommended improvements.

In closing, we wish to acknowledge that despite many challenges the Commonwealth has made great progress in the last two years in creating a new eligibility system and in redesigning processes and procedures. DMAS and DSS have worked in partnership to continuously improve the overall system and will continue to do so. We are confident that Virginia Medicaid is, and will continue to be, the high-quality program upon which over 1 million Virginians rely for their health care coverage.

Sincerely,



Cynthia B. Jones

c: The Honorable William A. Hazel – Secretary of Health and Human Resources
Ms. Margaret Schultze – Commissioner, Department of Social Services



COMMONWEALTH of VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
Office of the Commissioner

Margaret Ross Schultze
Commissioner

October 28, 2015

Mr. Hal E. Greer, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
201 North 9th Street
Richmond, Virginia 23219

Dear Mr. Greer:

Thank you for the opportunity to review and comment on the exposure draft of the Joint Legislative Audit and Review Commission (JLARC) report on the *Eligibility Determination in Virginia's Medicaid Program*. We appreciate the JLARC Team's competence and respect for the work that has been undertaken in the past several years to modernize the Commonwealth's eligibility determination system - VaCMS.

Virginia's Medicaid program is a complex one. The multi-faceted approach to establish client eligibility in this "state-supervised; locally-administered system" among the Department of Medical Assistance Services (DMAS), Department of Social Services (VDSS), and the local departments of social services (LDSS) contributes to the complexity of the process. We respect the time that JLARC staff took to understand the intricate nature of this work and the value that it brings to the clients and to Virginia's economy.

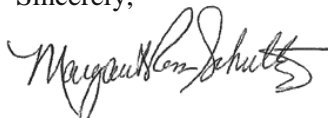
Thank you for the time that you and your staff provided for the exchange of clarifying information and data both in person and in writing. We believe these discussions contributed to the substance of the report and ultimately the recommendations. We acknowledge the consideration given to the recommendation related to the funding allocation for local departments. As indicated, VDSS considers workload as a primary component in the allocation of new funds provided for local staff and operations.

Mr. Hal E. Greer
October 28, 2015
Page 2

DMAS and VDSS reviewed the report both jointly and independently. Our collaborative review lead to general concurrence with the recommendations outlined in the report. Those recommendations that result in changes to VaCMS will lead to system improvements and enhance the integrity of the eligibility determination process. We must note, however, that these system modifications will require both time and money to accomplish. In 2013, VDSS undertook an effort to modernize the eligibility system for ALL public assistance programs. Medicaid was the first on VaCMS and the remaining programs TANF, SNAP and Energy Assistance will be transitioned in 2016. This schedule will impact our ability to implement those recommendations in the short term.

In the past two years, much has been accomplished – implementation of Medicaid policy changes as a result of the Affordable Care Act, development of the modernized eligibility system, training of local staff and managing the associated workflow changes at the LDSS level. This has been achieved despite a significant increase in application volume and with minimal additional financial resources provided. We appreciate the report's acknowledgement of the significant potential VaCMS will have once fully implemented.

Sincerely,

A handwritten signature in cursive script, appearing to read "Margaret Ross Schultze".

Margaret Ross Schultze

c: The Honorable William A. Hazel – Secretary of Health and Human Resources
Ms. Cynthia B. Jones – Director of the Department of Medical Assistance Services



JLARC.VIRGINIA.GOV

General Assembly Building
201 N. 9th Street, Suite 1100 Richmond, VA 23219