

Compliance Audit  
of the  
Commonwealth of Pennsylvania  
Department of Public Welfare  
Medicaid Eligibility  
*Clarion County Assistance Office*

Audit Period  
January 1, 2005 to June 8, 2007





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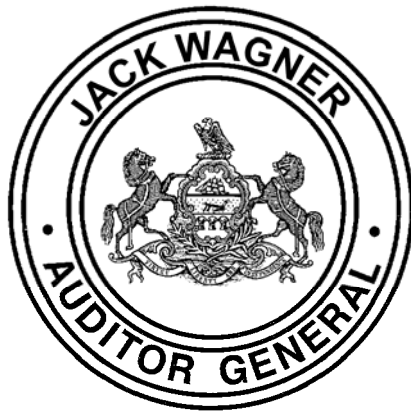
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## **Report of Independent Auditors on Compliance**

The Honorable Edward G. Rendell  
Governor  
Commonwealth Of Pennsylvania  
Harrisburg, Pennsylvania 17120

Dear Governor Rendell:

We have conducted a compliance audit of the Clarion County Assistance Office (CAO) pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code. The audit period was January 1, 2005 through June 8, 2007. The objectives of our audit were:

- 1) To determine whether the CAO made proper eligibility determinations for recipients of Medicaid based on Department of Public Welfare (DPW) policies and procedures, while evaluating the CAO's implementation of the Medicaid Eligibility Determination Automation (MEDA) system; and
- 2) To determine whether the CAO obtained and properly recorded all third-party liability in the Client Information System.

When recipients are not eligible for Medicaid, the cost to Pennsylvania taxpayers of the resulting improper payments could be significant. For individuals in a managed care organization (MCO), a set monthly capitation fee is paid to the MCO even if the recipient did not receive services during the period of ineligibility. For individuals not in a MCO, the amount of improper payments depends on the types of services, such as prescriptions, hospitalization, dental services, and other medical services received by individuals during periods of ineligibility. It should be noted that payments made on behalf of ineligible recipients cannot be recouped by the Commonwealth from the MCO or from individual providers.

Report of Independent Auditors on Compliance (Continued)

A burden of improper Medicaid payments to taxpayers also occurs when CAOs do not obtain and record sources of existing Third Party Liability (TPL) insurance into the system. Medicaid law states that Medicaid funds should not be paid for services covered by TPL insurance - in other words, Medicaid funds should only be paid as a last resort when other sources are not available. When CAOs do not obtain and record sources of existing TPL insurance into the system, DPW's Medicaid payment system is unaware of the TPL insurance and pays for services or pays capitation fees that should not be paid with Medicaid funds.

Our audit resulted in the following findings.

Finding No. 1 - Failure To Make Proper Medicaid Eligibility Determinations

Finding No. 2 - Failure To Obtain And/Or Properly Record All Third Party Liability On The Client Information System

Finding No. 3 - MEDA Inquiry Screen Information Does Not Match MEDA Action Screen Information

During the November 19, 2007 exit conference, we reviewed these findings, observation and recommendations with the Clarion CAO representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER  
Auditor General

May 7, 2008



**Commonwealth of Pennsylvania  
Department of Public Welfare  
Clarion County Assistance Office**

**BACKGROUND INFORMATION**

## ***Background Information***

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The Department of Public Welfare (DPW) is responsible for the administration of public assistance benefits to needy recipients in Pennsylvania. Benefits include cash assistance, food stamps and Medicaid. Cash assistance is grant money which falls into two categories: Temporary Assistance to Needy Families (TANF), a federally-funded program which provides money to families with dependent children who are needy because financial support is not available from one or both parents, and General Assistance (GA), a state-funded program which provides money primarily to single individuals and childless couples who do not have enough income to meet their basic needs and who do not qualify for TANF. The Food Stamp program is designed to offer assistance to low-income households in order to raise their level of nutrition. It is federally funded and operated jointly by the U.S. Department of Agriculture, Food and Nutrition Service, and DPW. Medicaid is the federal health care program for families and individuals with low income and resources. It is funded jointly by both the state and the federal government. DPW administers the program while the federal Centers for Medicare and Medicaid establishes requirements for service delivery, quality and eligibility standards.

Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance Handbook, Medicaid Eligibility Handbook and Supplemental Handbook contain the applicable state regulations.

Once an applicant is determined eligible for benefits, relevant information about the recipient is recorded and maintained in DPW's Client Information System (CIS), where benefit information is maintained based on eligibility status and category of aid. The CAO performs a "renewal", or annual review, to determine continued eligibility for benefits.

CAO personnel utilize DPW's Income Eligibility Verification System (IEVS) to compare income and resource information with income and resource information obtained from outside sources. IEVS is updated quarterly with information from several sources including wage information from the Social Security Administration, and tax and unearned income information from the Internal Revenue Service. CAO caseworkers are to review this information at the time of application, when the recipient submits his or her semi-annual report (SAR) and at the annual renewal. Caseworkers receive an alert when they are required to review wage information received between the application date, the SAR and the renewal. However, IEVS only sends caseworkers an alert when there is

## ***Background Information***

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wage information from a new or additional employer. IEVS does not provide caseworkers an alert when there is an increase in wages from ongoing employment even though the wage increase could affect a recipient's eligibility. Consequently, information that could affect a recipient's continued eligibility for Medicaid benefits is not reviewed until the recipient's SAR or annual review.

DPW recently implemented the Medicaid Eligibility Determination Automation (MEDA) system which was designed to automatically determine the level of Medicaid coverage based on demographic, resource and income information entered by the caseworker. Prior to this implementation, the caseworker made manual calculations to determine Medicaid eligibility.



**Commonwealth of Pennsylvania  
Department of Public Welfare  
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**OBJECTIVES, SCOPE AND METHODOLOGY**

## ***Objectives, Scope And Methodology***

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To achieve our audit objectives regarding eligibility we obtained a quarterly data file from the Department of Public Welfare of all recipients determined by the CAOs to be eligible for Medicaid benefits as of December 31, 2006. We selected a random sample of 138 cases from the 2,629 cases related to the Clarion CAO represented in the data file. Our audit period was January 1, 2005 to June 8, 2007, however in cases where we determined an ineligible individual was receiving Medicaid benefits, we expanded our test work through the last date of his or her ineligibility.

For each case selected in our sample, we tested certain aspects of eligibility and evaluated the CAO's examination and recording of third party liability to determine compliance with DPW regulations, governing laws, and administrative policies. We also tested cases that changed category when they were converted to MEDA to evaluate whether MEDA made the proper category determination.

The criteria we used to test cases in our sample included the Medicaid Eligibility Handbook, the Income Eligibility Verification System (IEVS) Manual, and the Client Information System Manual.

Due to the Internal Revenue Code paragraph 6103 regarding safeguarding of certain tax information, we are not authorized to have access to all information that contains wage and unearned income from the IRS. This scope limitation prevents us from confirming that all resources were included in calculating recipients' eligibility for benefits.

**Commonwealth of Pennsylvania  
Department of Public Welfare  
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**FINDINGS AND RECOMMENDATIONS**

## ***Findings and Recommendations***

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Our audit testing included 138 out of 2,629 Medicaid cases. Cases where a significant number of deficiencies occurred are discussed in the following findings:

### **Finding No. 1 - Failure To Make Proper Medicaid Eligibility Determinations**

During our audit we found that CAO personnel improperly determined recipient eligibility in 13 of the 138, or 9% of the cases we tested. Recipients in these cases were either over the income limit or did not meet other conditions of eligibility such as age limitation, citizenship, disability or family relationship requirements. In 4 of these cases, recipients were not eligible for Medicaid benefits, and in 5 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In these 9 cases, benefits were paid while the recipients were ineligible. As a result, improper payments of \$5,028 were issued to managed care organizations on behalf of recipients in the form of capitation payments<sup>1</sup>, as shown in Table 1 on page 11 of this report. Payments made on behalf of ineligible recipients cannot be recouped by the Commonwealth from MCOs or from individual providers. In addition, we found no evidence that recoveries for Medicaid are pursued by DPW or referred for collection to the Office of Inspector General. Consequently, it is important for DPW to monitor recipients' eligibility, immediately identify ineligible recipients, and stop payment of benefits on their behalf.

In an additional 4 cases, recipients were placed in the incorrect category of aid although they had no periods of ineligibility. Failure to place recipients in the proper category of aid could result in recipients receiving services for which they are not entitled, or being denied services for which they are entitled. Because we do not have access to all wage and unearned income information as noted in our scope limitation on page 8 of this report, we were not able to ascertain whether CAO personnel utilized all available wage and unearned income information to determine Medicaid eligibility. As a result, additional improper payments could have been made and not discovered during our audit.

The Medicaid Eligibility Handbook provides criteria to assist the CAO in making proper eligibility determinations.

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<sup>1</sup> In a fee-for-service environment providers are paid directly for services they provide to recipients. In a managed care environment, contracted managed care organizations are paid a set monthly capitation fee for all members of their organization whether or not members (recipients) received services. The managed care organization is then responsible to pay providers of services.

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## ***Findings and Recommendations***

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These improper determinations occurred because:

- The CAO management did not monitor to ensure that recipients met the age limitation requirements, were disabled and/or that they met the family relationship requirement.
- The CAO management did not monitor to ensure that citizenship and identity of recipients were verified during the application and renewal process.
- The CAO management did not monitor to ensure that income from IEVS alerts was timely and/or properly reconciled with reported income.
- The CAO management did not monitor to ensure that income from IEVS history was properly reconciled with reported income at application and renewals.
- DPW's policy does not require a review of all changes to income, including income from ongoing employment, when the information becomes available on IEVS. Instead, DPW's policy requires information regarding ongoing employment be reviewed only during a recipient's annual renewal or semi-annual review.

**Table 1**

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
1.	MA - 14	03/01/07	03/18/07	\$ 83.73
2.	MA - 15	04/05/05	05/22/05	1,082.82
3.	MA - 89	04/01/07	05/27/07	164.91
4.	MA - 96	08/07/06	07/19/07	2,166.66
5.	MA - 101	07/01/06	09/30/06	281.52
6.	MA - 106	02/12/07	07/10/07	222.60
7.	MA - 110	04/01/07	06/06/07	246.09
8.	MA - 111	12/01/06	02/14/07	164.49
9.	MA - 114	06/01/06	07/15/07	615.35
	<b>Total</b>			<b>\$5,028.17</b>

## ***Findings and Recommendations***

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### Recommendations

To ensure that proper eligibility determinations are made, we recommend that CAO management:

- Ensure that personnel are adequately trained to understand the eligibility requirements pertaining to age, disability and family relationship criteria for Medicaid categories.
- Ensure that personnel are adequately trained to verify citizenship and identity during the application and renewal process.
- Improve monitoring to ensure that caseworkers timely and/or properly reconcile reported income with IEVS alerts.
- Improve monitoring to ensure that caseworkers properly reconcile reported income with IEVS history at application and renewals.

We also recommend that DPW:

- Change its policy to require a review of all changes in income including income from ongoing employment when it becomes available.
- Follow up with the Office of Inspector General to see if overpayments made on behalf of recipients can be recouped.

### Management Response

In a February 28, 2008 electronic memorandum to this Department, the CAO management stated, in part, that they disagree that there were periods of ineligibility in seven of the cases in our finding, and in these seven cases recipients were eligible for another Medicaid category. The CAO management also stated that for recipients who were ineligible, payments would not have been made on their behalf if they did not access medical services.

## ***Findings and Recommendations***

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### Auditors Conclusion

We acknowledge that the seven recipients were eligible for another Medicaid category at some point during our audit period, but they were also ineligible to receive benefits for certain periods of time as reflected in our audit finding. In addition, DPW paid capitation fees on behalf of the ineligible recipients cited in our finding whether or not they accessed any medical services. Therefore, our finding remains as written, and we encourage CAO management to ensure that personnel are adequately trained and closely monitored to make proper eligibility determinations as noted in the above recommendation.

### **Finding No. 2 - Failure To Obtain And/Or Properly Record All Third Party Liability On The Client Information System**

During our audit we determined that in 24 of the cases we tested, or 17% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 18 of these cases, the recipient's case record included documentation of auto insurance which was not recorded in the Client Information System. In 4 of these cases, an auto was listed as a resource; however documentation of auto insurance was neither contained in the case record, nor listed on the Client Information System. We also determined that in 2 of the cases, the CAO failed to obtain documentation of health insurance from recipients who had health coverage under another plan.

DPW's claims processing system makes payments to providers based on information found on the Client Information System. If no other insurance information is recorded, it is possible that medical claims will be paid with Medicaid funds, including medical claims and the cost of hospitalization resulting from auto accidents.

The Medicaid Eligibility Handbook, Chapter 338.2, and CFR 433.138 and 433.139 provide criteria to assist the CAO in properly identifying and recording all third party resources.

These deficiencies occurred because:

- The CAO management did not monitor to ensure that third party insurance information was entered into the Client Information System even though this information was contained in the case record.

## ***Findings and Recommendations***

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- The CAO management did not monitor to ensure that third party insurance information was obtained during the application and renewal process.
- The CAO management did not monitor to ensure that auto insurance information was obtained and entered into the Client Information System, even though an auto was listed as a resource.

Failure to obtain and/or enter all third party liability resources into the Client Information System increases the likelihood that medical claims will be paid by Medicaid, which should be the payor of last resort.

### Recommendations

We recommend that CAO management ensure that caseworkers request all third party resources, including auto insurance, during the application and renewal processes and enter this information into the Client Information System. Also, DPW should revise current policy to require recipients to show evidence of auto insurance when an auto is listed as a resource.

### Management Response

In a February 28, 2008 electronic memorandum to this Department, the CAO management provided the following response:

We disagree with this finding in 22 cases based on PMA 13745340. Auto insurance information is no longer collected and no corrective action is possible for previously unrecorded information as it has been determined that auto insurance is not beneficial as a TPL resource.

We also disagree that in two cases the recipients had other health insurance that affected the Medicaid eligibility. Although the client is required to report the existence of third party resources, having a third party resource does not render the client ineligible.

In two cases, the TPL's were correctly entered and no period of ineligibility existed. The CAO disagrees with the audit findings in these two cases. This is supported by MAH 338.2, 303.22, and SH 915.12.

## ***Findings and Recommendations***

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### Auditors Conclusion

The Medicaid Eligibility Handbook, which is part of our audit criteria, was revised to reflect DPW's change in policy for auto insurance TPL after our audit period. In addition, even though the criteria no longer requires CAO caseworkers to enter available auto TPL into the Client Information System, doing so decreases the likelihood that medical claims resulting from auto accidents would automatically be paid with Medicaid funds, which should be the payor of last resort. Also, our finding does not conclude that a recipient is deemed ineligible because health insurance was not verified or obtained. It is the CAO's responsibility to obtain health insurance TPL and enter it into the Client Information System to again, ensure that medical claims are not paid with Medicaid funds. Therefore, our finding remains as written and we continue to recommend that CAO caseworkers request and enter all third party resources, including auto insurance, into the Client Information System.

### **Finding No. 3 - MEDA Inquiry Screen Information Does Not Match MEDA Action Screen Information**

We noted that in 26 of the 138 cases we tested, or 19% of our sample, information on the Client Information System screens should match and does not. Specifically, family relationship information on the inquiry screen does not match family relationship information on the action screen. Action screens are used to input information into the Client Information System, while inquiry screens are used only to reference information. No changes can be made in the system while in inquiry mode.

The Medicaid Eligibility Handbook, Chapter 310, provides regulations for CAOs to determine family relationships in a household for the issuing of Medicaid benefits. Family relationship information is entered into the Client Information System through action screens, and can later be accessed through inquiry screens. Accurate relationship information is essential in determining Medicaid benefits.

According to the CAO, failure of the inquiry screen to indicate correct relationship information may have been caused by a system logic problem with the Client Information and MEDA systems.

## ***Findings and Recommendations***

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If CAO personnel were to utilize the inquiry screen to gather family relationship information, improper eligibility determinations could result. Furthermore, if CAO personnel cannot rely on the inquiry screen information, they may need to refer to paper case records when household changes are reported.

### **Recommendations**

We recommend that DPW examine existing software for system logic problems. Furthermore, the CAO should establish additional procedures to help identify the inconsistencies between action screens and inquiry screens in MEDA.

### **Management Response**

In a February 28, 2008 electronic memorandum to this Department, the CAO management agrees that the 26 cases cited were not CAO errors but system errors.

## ***Audit Report Distribution List***

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This report was originally distributed to the following:

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