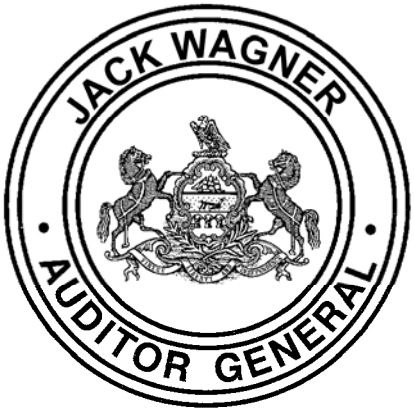
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Clinton County Assistance Office

Audit Period
January 1, 2006 to October 5, 2007



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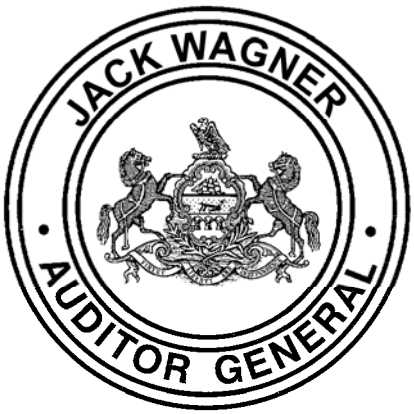
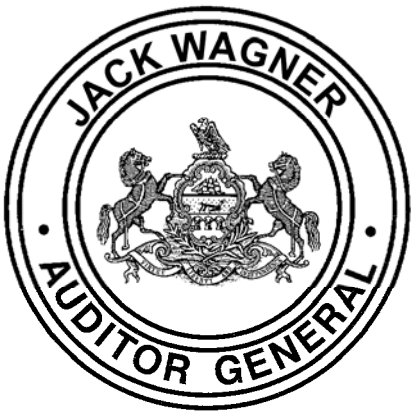

JACK WAGNER
AUDITOR GENERAL

CONTENTS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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 Clinton County Assistance Office (CAO) pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code. The audit period was January 1, 2006 through October 5, 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.

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

During the February 28, 2008 exit conference, we reviewed these findings and recommendations with the Clinton CAO representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

December 12, 2008

Commonwealth of Pennsylvania
Department of Public Welfare
Clinton County Assistance Office

BACKGROUND INFORMATION

Background Information

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.

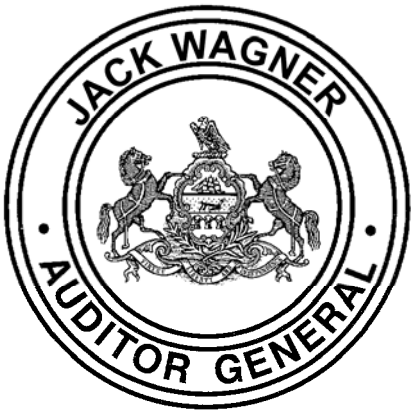
Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance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

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.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OBJECTIVES, SCOPE AND METHODOLOGY

Objectives, Scope And Methodology

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 March 31, 2007. We selected a random sample of 136 cases from the 2,562 cases related to the Clinton CAO represented in the data file. Our audit period was January 1, 2006 to October 5, 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
Clinton County Assistance Office

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations

Our audit testing included 136 out of 2,562 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 53 of the 136, or 39% 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 37 of these cases, recipients were not eligible for Medicaid benefits, and in 7 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 41 of these 44 cases, benefits were paid while the recipients were ineligible. As a result, improper payments of $31,016 were issued to both managed care organizations and individual providers on behalf of recipients,[1] as shown in Table 1, beginning on page 11 of this report. Specifically, $7,946 was issued to managed care organizations in the form of capitation payments and $23,070 was issued to providers in the form of medical claims paid. 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 9 of the 53 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.

[1] 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.

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

These improper determinations occurred because:

1. The CAO management did not monitor to ensure that citizenship and identity of recipients were verified during the application and renewal process.

2. 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.

3. The CAO management did not monitor to ensure that income from IEVS history was properly reconciled with reported income at application and renewals.

4. The CAO management did not monitor to ensure that income and/or resource amounts were properly entered on the Client Information System.

5. 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

		Ineligibility Period		Benefits
	Case Number	From	To	Paid
1.	MA-6	08/25/06	12/09/07	$ 710.98
2.	MA-10	01/01/06	10/07/07	294.67
3.	MA-22	07/01/06	03/31/07	205.89
		05/05/07	11/26/07	220.43
4.	MA-27	08/01/06	12/09/07	1,112.08
5.	MA-30	11/07/06	05/31/07	1,701.03
6.	MA-32	11/15/06	11/22/07	241.49

Table 1 (continued)

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
7.	MA-33	03/21/06	11/13/06	$ 75.00
		12/05/06	12/09/07	6,792.48
8.	MA-35	01/01/06	02/28/06	72.55
9.	MA-37	04/01/06	01/31/07	326.46
10.	MA-39	02/01/07	06/12/07	182.45
11.	MA-40	01/01/06	03/31/06	102.34
		07/01/06	09/30/06	14.04
		01/01/07	03/31/07	14.04
12.	MA-42	04/01/06	12/31/06	202.73
13.	MA-44	10/01/06	12/30/06	801.53
14.	MA-45	01/01/06	03/31/06	295.57
15.	MA-47	10/02/06	10/18/07	248.65
16.	MA-48	12/05/06	12/10/07	248.37
17.	MA-49	05/01/06	11/18/07	962.76
18.	MA-50	01/01/06	03/31/07	541.96
19.	MA-55	01/01/06	04/13/06	304.70
20.	MA-56	06/21/07	11/27/07	206.35
21.	MA-57	09/01/06	08/21/07	1,978.30
22.	MA-60	01/01/06	06/30/06	1,179.72
23.	MA-69	01/01/06	06/24/07	1,051.48
24.	MA-72	03/14/06	06/19/07	213.16
25.	MA-76	09/15/06	12/09/07	2,396.48
26.	MA-77	01/01/07	09/25/07	200.38
27.	MA-82	04/10/06	06/19/06	31.10
28.	MA-85	01/01/06	03/31/07	487.61
29.	MA-89	10/01/06	03/31/07	300.46
30.	MA-95	08/02/06	09/30/07	482.38
31.	MA-98	01/01/06	12/31/06	525.98
32.	MA-99	07/07/07	10/02/07	157.98
33.	MA-105	10/01/06	12/09/07	267.09
34.	MA-107	10/01/06	05/06/07	257.84
35.	MA-111	01/01/07	03/31/07	924.34
		08/17/07	12/04/07	113.83

Table 1 (continued)

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
36.	MA-113	08/01/06	12/31/06	$ 167.50
37.	MA-115	04/01/06	10/10/06	2,845.45
		01/10/07	12/09/07	908.13
38.	MA-122	10/01/06	04/22/07	420.01
39.	MA-124	04/17/07	12/09/07	202.28
40.	MA-126	09/26/06	01/15/07	7.02
41.	MA-132	01/08/07	06/13/07	18.72
	Total			**$31,015.79**

Recommendations

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

- Ensure that personnel are adequately trained to verify citizenship and identity during the application and renewal process.

- Ensure that personnel are adequately trained to understand the eligibility requirements pertaining to age, disability and family relationship criteria for Medicaid categories.

- Improve monitoring to ensure that caseworkers properly reconcile reported income with IEVS history at application and renewals.

- Ensure that personnel are trained to accurately enter income and/or resource information into the Client Information System.

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 July 15, 2008 letter to this Department, the CAO management provided the following response:

1. The CAO management did not monitor to ensure that citizenship and identity of recipients were verified during the application and renewal process.

   Case records are monitored monthly by IMCW Supervisors using the Comprehensive Supervisory Review criteria. In addition Targeted Supervisory Reviews (TSR) are completed periodically to target review criteria in case records to ensure proper procedures are followed and eligibility requirements are met. These reviews monitor for citizenship and identity, income and resources, and correct category.

2. 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.

   Case records are monitored monthly by IMCW Supervisors using the Comprehensive and Target Review criteria to ensure that recipients meet the age limitation, disability criteria and that the relationship requirements were met.

3. The CAO management did not monitor to ensure that income from IEVS history was properly reconciled with reported income at application and renewals.

   The Department's policy does not require a review except under certain circumstances including a change in income over $100 and for certain children and adults who are living with disabilities.

4. The CAO management did not monitor to ensure that income and/or resource amounts were properly entered on the Client Information System.

   Case Records are monitored monthly by IMCW Supervisors using the Comprehensive Supervisory Review and Targeted Review Criteria to ensure that income and resources are properly entered in the Client Information System.

5. 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.

   The above paragraph incorrectly summarizes the Department's procedures and DPW would like to take that this opportunity to clarify its policies and procedures in this area.

   Specifically, the Department's policies include several measures to help ensure that the Department is not authorizing benefits for those whose income makes them ineligible for medical coverage:

   - Income information is required to be reviewed during the semi-annual and annual review periods for Medicaid recipients.

   - Caseworkers are alerted to changes in income on a quarterly basis -- whether it is new or ongoing -- through the Department's Income Eligibility Verification System (IEVS) system and are required to act on the information provided in that system.

   - Increases are also required to be reported by recipients on their Semi-Annual Reporting (SAR) Form and applicants/recipients are advised of their responsibility to report interim changes within ten days following the month the change occurred.

   - The Department's policy does not require a review, however, under certain circumstances including a change in income over

$100 and for certain children and adults who are living with disabilities.

Please note that the Department is also in the midst of several steps which may have an impact on these policies:

- The Department is updating the IEVS internal system logic. The new system logic will require that changes in income must be reviewed and cleared by caseworkers for clients that remain at the same employer. This will address the issue of system cleared alerts in these circumstances. While this may result, in some duplication of work for the caseworker, the decision will further ensure that changes in income are identified and acted upon as quickly as is feasible.

Auditors Conclusion

We acknowledge Clinton CAO management's ongoing targeted supervisory reviews to reduce the number of improper Medicaid eligibility determinations. However, without improved monitoring payments will continue to be made on behalf of ineligible recipients. We also acknowledge that, according to CAO management, DPW is making efforts to review and possibly update the IEVS internal system logic, which may require a review of changes in income from ongoing employment. It should be noted, however, that the CAO management's response includes contradictory language. Specifically, the response includes one statement that DPW's policy does not require a review of IEVS history at application and renewals and another statement that it does. We agree that the review is required, and we perform our testing based on this requirement. In addition, the CAO states in the response that caseworkers are alerted to changes in income on a quarterly basis, whether it is new or ongoing (employment.) Our recommendation that DPW change its policy to require a review of income whether it is for new or ongoing employment is based on the fact that the caseworkers currently are not alerted when an increase in wages occurs from ongoing employment. Our finding remains as written and we continue to recommend improved monitoring by CAO management, and continue to recommend that DPW change its current policy to include a review of all changes in income.

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 60 of the cases we tested, or 44% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 23 of these cases, the recipient's case record included documentation of auto insurance and in 3 cases included medical insurance which was not recorded in the Client Information System. In 31 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. In 3 of these cases, the recipient's case record included documentation of both medical and auto insurance which was not included in the Client Information System.

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 auto insurance information was obtained and entered into the Client Information System, even though an auto was listed as a resource.

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

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.

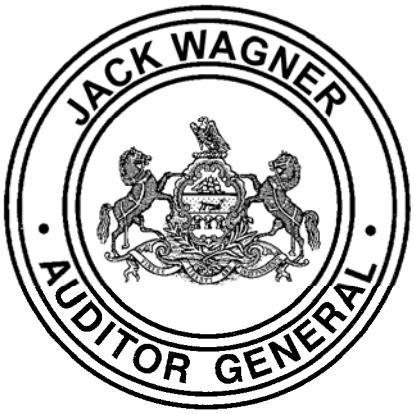
Management Response

In a July 15, 2008 letter to this Department, the CAO management provided the following response:

> DPW has reviewed the recommendation made by the Auditor General that CAO management follow the Medicaid Eligibility Handbook (MEH), Chapter 338.2 regarding third party liability to ensure that caseworkers request all third party resources during the application and renewal processes and enter this information into CIS.
>
> Based on Policy Clarification PMA13745340, the OIM and the Division of Third Party Liability (TPL) have determined that auto insurance is no longer beneficial as a TPL resource. PMA13745340 provided that information and instructed CAOs to close all auto insurance TPLs effective May 24, 2007.
>
> In accordance with 42 CFR 433.138 and 139, TPL is required to pursue claims with trauma diagnoses. This is far more effective than relying on the CAO and the client to provide updated auto insurance information. The trauma diagnoses process reveals many more trauma situations for investigation than just auto accidents.
>
> The MEH Chapter 338.2 has been revised to remove the requirement to record auto insurance in CIS. However, it has been reinforced to CAOs the need to add other third party resources to CIS. Every resource helps ensure Medical Assistance is the payer of last resort.

Auditors Conclusion

The Medicaid Eligibility Handbook, which is part of our audit criteria, was revised to reflect DPW's change in policy 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. 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.


JACK WAGNER
AUDITOR GENERAL

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