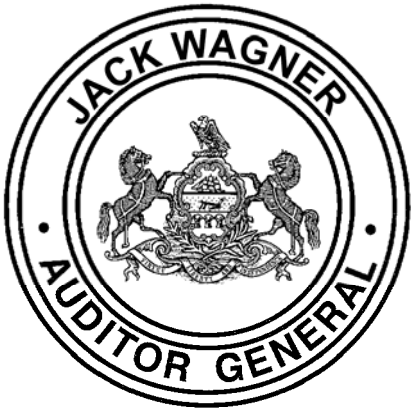
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Indiana County Assistance Office

Audit Period
January 1, 2005 to June 15, 2007



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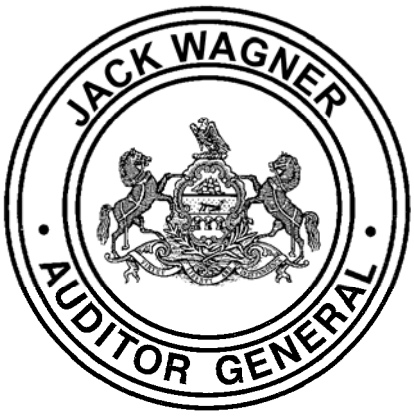
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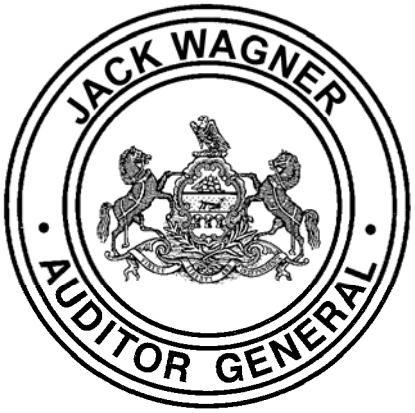
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Report of Independent Auditors on Compliance

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

Dear Governor Rendell:

We have conducted a compliance audit of the Indiana 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 15, 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 finding.

Finding - Failure To Make Proper Medicaid Eligibility Determinations

During the November 14, 2007 exit conference, we reviewed this finding and recommendations with the Indiana CAO representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

January 14, 2008

Commonwealth of Pennsylvania
Department of Public Welfare
Indiana 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.

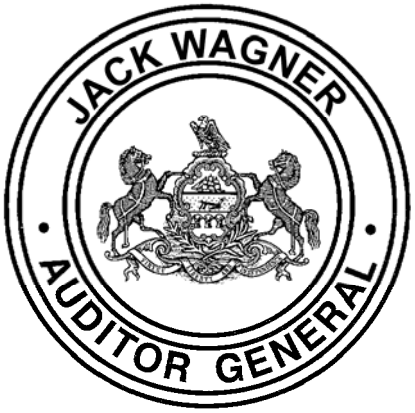
Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance 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 December 31, 2006. We selected a random sample of 143 cases from the 4,222 cases related to the Indiana CAO represented in the data file. Our audit period was January 1, 2005 to June 15, 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
Indiana County Assistance Office

FINDING AND RECOMMENDATIONS

Finding and Recommendations

Our audit testing included 143 out of 4,222 Medicaid cases. Cases where a significant number of deficiencies occurred are discussed in the following finding:

Finding - Failure To Make Proper Medicaid Eligibility Determinations

During our audit we found that CAO personnel improperly determined recipient eligibility in 14 of the 143, or 10% 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 10 of these cases, recipients were not eligible for Medicaid benefits. In these 10 cases, benefits were paid for recipients while they were ineligible. As a result, improper payments of $28,534 were issued to both managed care organizations and individual providers on behalf of recipients,[1] as shown in Table 1 on page 11 of this report. Specifically, $28,278 was issued to managed care organizations in the form of capitation payments and $256 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 4 of the 14 cases, the recipients were not in the proper Medicaid category of aid. 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.

[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.

These improper determinations occurred because:

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

- The CAO management did not monitor to ensure that income from IEVS alerts was timely and/or properly reconciled with reported income.

- 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
		From	To	Paid
1.	MA - 16	07/01/06	12/31/06	$ 1,471.75
2.	MA - 31	04/01/05	06/30/05	670.85
3.	MA - 32	04/01/06	06/30/06	638.67
4.	MA - 45	01/01/05	09/15/06	3,081.83
5.	MA - 46	04/01/05	12/31/06	8,975.74
6.	MA - 50	01/01/05	11/13/05	6,505.28
		01/01/06	10/31/06	2,535.05
7.	MA - 75	07/01/05	09/30/05	793.40
8.	MA - 77	01/04/06	12/31/06	1,809.88
9.	MA - 110	04/01/06	10/30/06	170.00
10.	MA - 123	01/13/06	09/04/06	1,881.35
	Totals			**$28,533.80**

Recommendations

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

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

- Improve monitoring to ensure that caseworkers timely and/or properly reconcile reported income with IEVS alerts.

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 December 27, 2007 electronic memorandum to this Department, the CAO Management provided the following response:

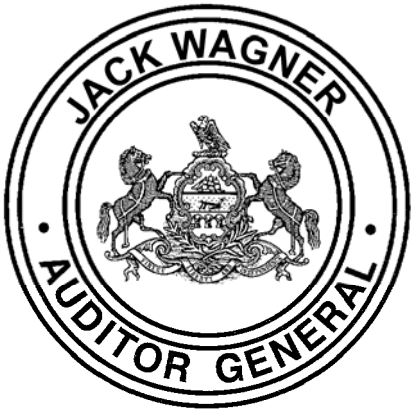
> "In determining if the cited deficiency was based upon the proper policy, the CAO requested to review the auditors' calculations as required by DPW policy, Supplemental Handbook 805.34. The calculations were not provided so our review could not be completed.
>
> In addition, CAO disagreed on 10 of the 14 deficiencies. The CAO cited the policy in Medical Assistance Eligibility Handbook 368 and on the IEVS/SAR Desk Guide outlined in PMA13791378 as their reference. The auditors disagreed with DPW interpretation of this policy. The cases challenged would result in a decrease of $28,533.80 by following the DPW policy interpretations in the previously cited manual references."

Auditors Conclusion

CAO Management disagreed with 10 of the 14 deficiencies, based on their internal policy clarification, specifically PMA 13791378, which was written after the deficiencies were submitted. The policy clarification did not change our audit criteria, specifically the Medical Assistance Eligibility Handbook. The CAO has available to them all information about a client's circumstances, such as income, resources and allowable medical expenses for ineligible periods in question. The deficiencies are based on income information obtained from IEVS and allowable deductions that are shown on the Client Information System. The CAO was given the sources of our information, and was provided with the methodology used to determine the ineligibility.

Our finding remains as written and we continue to recommend that CAO management improve monitoring of caseworkers' review of income to prevent erroneous eligibility determinations.

It should be noted that, if the CAO fails to take corrective action on these cases based on the deficiencies, monthly capitation payments will continue to be made for the ineligible recipients.


JACK WAGNER
AUDITOR GENERAL

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