Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Susquehanna County Assistance Office

Audit Period
January 1, 2005 to November 17, 2006

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JACK WAGNER

AUDITOR GENERAL

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JACK WAGNER

AUDITOR GENERAL

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 Susquehanna 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 November 17, 2006. 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.

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 May 24, 2007 exit conference, we reviewed these findings and recommendations with the Susquehanna CAO representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

January 9, 2008

Commonwealth of Pennsylvania
Department of Public Welfare
Susquehanna 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.

The CAO personnel utilize DPW's Income Eligibility Verification System (IEVS) to compare income and resource information on the application 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. This new information could affect a recipient's eligibility for benefits; however caseworkers are not always required to review it.

Background Information

Caseworkers are not required to review all new information until a recipient renews his/her application, which occurs annually. Caseworkers receive an alert when they are required to review new information. However, the only instance when caseworkers receive an alert is when wage information is sent from a new or additional employer. As a result, increases in income from ongoing employment are not required to be reviewed until the annual renewal date. Consequently, information that may affect eligibility is not considered in the majority of cases until the recipient's annual renewal is due.

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 June 30, 2006. We selected a random sample of 187 cases from the 2,628 cases related to the Susquehanna CAO represented in the data file. Our audit period was January 1, 2005 to November 17, 2006, 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
Susquehanna County Assistance Office

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations

Our audit testing included 187 out of 2,628 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 9 of the 187, or 5% 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 8 of these cases, recipients were not eligible for Medicaid benefits. In 7 of these 8 cases, benefits were paid for recipients while they were ineligible. As a result, improper payments of $12,767 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, $188 was issued to managed care organizations in the form of capitation payments and $12,579 was issued to providers in the form of medical claims paid.

In 1 of the 9 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.

These improper determinations occurred because:

- DPW's policy does not require a review of all changes to income, including income from ongoing employment, when the information becomes available

[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.

on IEVS. Instead, DPW's policy requires information regarding ongoing employment be reviewed only during a recipient's annual review.

- 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 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 income from IEVS history was properly reconciled with reported income at application and renewals.

Table 1

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
1.	MA-1	05/28/04	04/27/06	$2,522.45
2.	MA-72	06/18/06	10/24/06	18.72
3.	MA-75	10/16/06	11/13/06	4.68
4.	MA-85	01/01/05	10/07/06	933.27
5.	MA-89	11/14/05	09/07/06	1,413.95
6.	MA-102	09/27/05	10/31/06	7,855.53
7.	MA-189	07/28/06	11/26/06	18.72
	Total			**$12,767.32**

Recommendations

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

- Change its policy to require a review of all changes in income including income from ongoing employment when it becomes available, since the majority of improper eligibility determinations are a result of this deficiency.

- Adjust future capitation payments to managed care organizations to recoup payments made for ineligible recipients. In addition, DPW should follow up with the Office of Inspector General to see if overpayments made on behalf of recipients can be recouped.

We also recommend that CAO Management:

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

- 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.

Management Response

The CAO Management agreed with the finding as presented at the exit conference and will take action to comply with the recommendations.

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 16 of the cases we tested, or 9% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 9 of these cases, the recipient's case record included documentation of auto insurance which was not recorded in the Client Information System. In 6 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 1 of these cases, the recipient's case record included documentation of health insurance information which was not recorded 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 third party insurance information was entered into the Client Information System even though this information was contained in the case record.

- 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 documentation of 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 follow the Medicaid Eligibility Handbook, 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 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

The CAO Management agreed with the finding as presented at the exit conference and will take action to comply with the recommendations.

JACK WAGNER

AUDITOR GENERAL

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