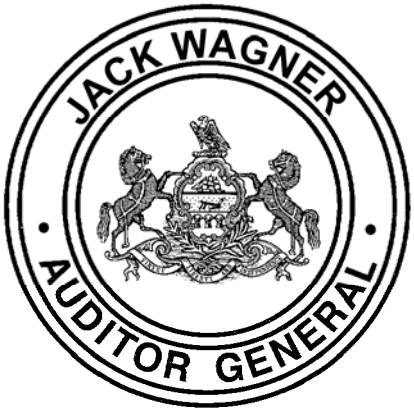
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Washington County Assistance Office
Washington District

Audit Period
January 1, 2005 to May 18, 2007



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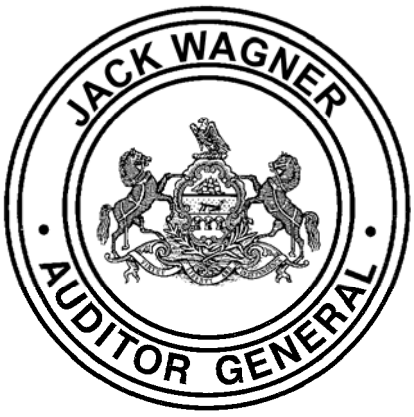
JACK WAGNER
AUDITOR GENERAL

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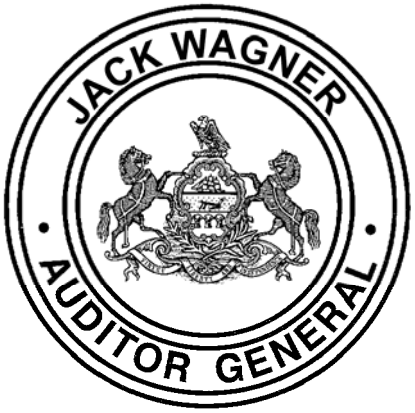

JACK WAGNER
AUDITOR GENERAL

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 Washington County Assistance Office (CAO), Washington District, pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code. The audit period was January 1, 2005 through May 18, 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 November 8, 2007 exit conference, we reviewed these findings and recommendations with the Washington CAO, Washington District, representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

May 2, 2008

Commonwealth of Pennsylvania
Department of Public Welfare
Washington County Assistance Office
Washington District

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.

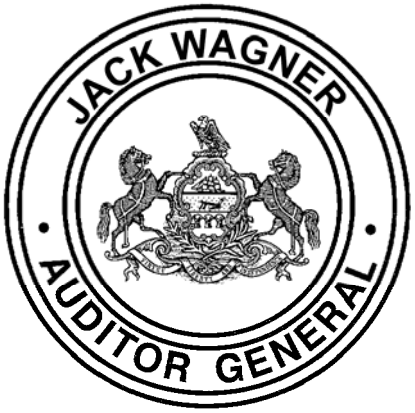
Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance 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 September 30, 2006. We selected a random sample of 148 cases from the 7,574 cases related to the Washington CAO, Washington District, represented in the data file. Our audit period was January 1, 2005 to May 18, 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
Washington County Assistance Office
Washington District

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations

Our audit testing included 148 out of 7,574 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 33 of the 148, or 22% 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 25 of these cases, recipients were not eligible for Medicaid benefits, and in 1 additional case the recipient had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 24 of these 26 cases, benefits were paid while the recipients were ineligible. As a result, improper payments of $61,739 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, $61,547 was issued to managed care organizations in the form of capitation payments and $192 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 an additional 7 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:

- 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 the annual renewals and/or semi-annual reviews took place on the date they should have been done.
- 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 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 alerts was timely and/or properly reconciled with reported income.

Table 1

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
1.	MA - 9	05/22/06	03/29/07	$ 6,577.38
2.	MA - 18	07/01/05	10/01/05	1,662.90
3.	MA - 29	10/01/05	06/30/06	2,069.07
4.	MA - 36	10/01/05	10/31/05	904.08
		12/01/05	01/31/06	1,828.40
5.	MA - 42	03/10/07	05/10/07	289.04
6.	MA - 62	01/18/07	04/08/07	703.94
7.	MA - 68	04/01/05	09/01/05	5,521.26
8.	MA - 71	01/01/05	03/30/05	629.01
		10/01/05	09/21/06	2,765.07
		02/22/07	06/21/07	1,050.00

Table 1 (Continued)

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
9.	MA - 72	04/01/06	07/01/06	$ 921.77
10.	MA - 73	01/01/05	03/31/05	649.34
		07/01/05	06/30/06	2,690.73
11.	MA - 74	10/03/06	05/07/07	3,669.76
12.	MA - 79	05/15/06	06/03/07	11,336.92
13.	MA - 82	04/01/06	07/01/06	975.61
14.	MA - 84	04/01/05	09/11/06	4,131.73
15.	MA - 85	04/01/06	07/03/06	861.59
16.	MA - 89	02/28/07	05/29/07	639.88
17.	MA - 98	03/28/07	05/29/07	425.55
18.	MA - 100	01/31/07	05/31/07	1,043.07
19.	MA - 103	01/31/07	05/01/07	1,455.30
20.	MA - 110	12/23/06	06/03/07	1,633.71
21.	MA - 111	10/24/05	12/31/05	327.20
22.	MA - 120	03/31/07	05/28/07	2,301.26
23.	MA - 125	11/30/06	05/24/07	1,407.54
24.	MA - 148	12/10/06	05/21/07	3,267.99
	Total			**$61,739.10**

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 perform annual renewals and/or semi-annual reviews in a timely manner.

- 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 timely and/or properly reconcile reported income with IEVS alerts.

We also recommend that DPW:

- Follow up with the Office of Inspector General to see if overpayments made on behalf of recipients can be recouped.

Management Response

In a March 11, 2008 memorandum to this Department, the CAO management provided the following response:

> During the period which the Auditor General's review covers, January 1, 2005 to May 18, 2007, a number of circumstances occurred which contributed to the findings put forth in this audit. As with many CAOs, loss of staff positions has had an effect, and this condition was exacerbated by absences during this period due to death, maternity leave, military leave, retirements, dismissals, and the creation of a Change Center in our office. We had to assign six (6) experienced staff members from our Income Maintenance Worker complement to the State Call Change Center.
>
> Operations Memorandum OPS060705, Verifying Citizenship and Identity for Medicaid, was issued 07/21/06, the middle of the audit period. This memorandum created new requirements for the verification process which are part of the review addressed in the audit. As new requirements, it took some time for all workers to get trained and to become acclimated to the new processes and we feel that this transition contributed to some of our deficiencies. In addition to veteran staff having to learn the new procedures while managing large caseloads, we had a large number of trainees who were learning these new procedures along with all of the other regulations involved in doing the job. Now that we're through this transition phase, the verification process will not be an issue. We have

added as part of our CSR/TSR reviews that supervisors check to verify that citizenship and identity are addressed in reviewed cases.

During the Audit review the CAO was told that there would be no period of ineligibility established or overpayment determined. The 'Notice of Deficiencies' did not solicit CAO rebuttal of either the period or amount of any overpayments identified by the AG. We have review Table 1 in finding No. 1 and have a number of questions on the cases listed in "Table 1."

Auditors Conclusion

The audit objective is to determine whether the CAO made proper eligibility determinations for Medicaid recipients. The notices of deficiency submitted to the CAO during field work reflected the eligibility criteria that were not met and the periods of ineligibility. This information was provided to the CAO at the time of our audit. Our emphasis is on improper eligibility determinations. Dollar values of benefits paid on behalf of ineligible recipients, which are obtained from DPW's claims payment system, further demonstrate the cost to taxpayers of these improper determinations. With regard to CAO management's comments that loss of staff has contributed to these deficiencies, procedures should to be established so that proper eligibility determinations are made without interruption.

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 17 of the cases we tested, or 11% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 5 of these cases, the recipient's case record included documentation of auto insurance which was not recorded in the Client Information System. In 11 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 the cases, the CAO failed to obtain

documentation of health insurance from a recipient 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.

- 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 March 11, 2008 memorandum to this Department, the CAO management provided the following response:

> CAO Management stated at the exit conference that they partially disagree with this finding. Specifically, CAO Management stated that they are no longer required per Clarification PMA 13745340 dated 06/01/07 and revised 06/27/07 from DPW Bureau of Policy to enter auto insurance information with third party liability (TPL) into the Client Information System (CIS). DPW Bureau of Policy states in clarification PMA 13745340, "The Office of Income Maintenance and Third Party Liability (TPL) has determined that auto insurance is no longer beneficial as a TPL resource."
>
> It should also be noted that since our exit conference section 338.2 of the Medicaid Handbook has been revised to state "Automobile insurance is not considered a third party liability resource."

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 on 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.

Audit Report Distribution List

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