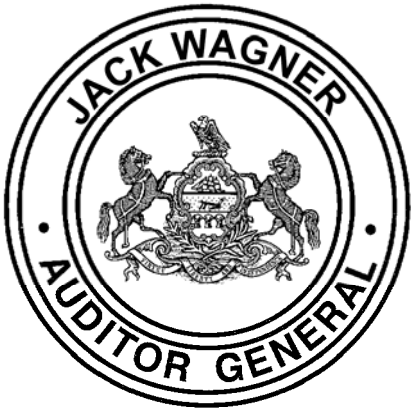
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Westmoreland County Assistance Office
Alle-Kiski District

Audit Period
January 1, 2005 to February 2, 2007



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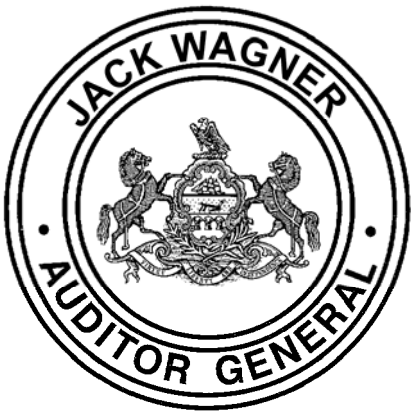
JACK WAGNER
AUDITOR GENERAL

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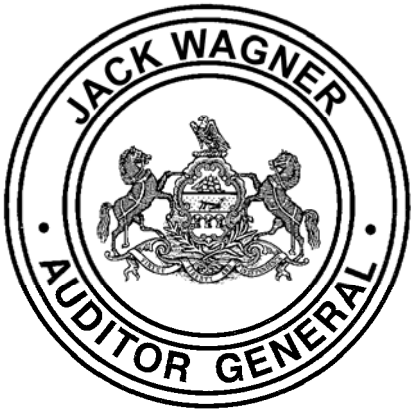
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Report of Independent Auditors on Compliance

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

Dear Governor Rendell:

We have conducted a compliance audit of the Westmoreland County Assistance Office (CAO), Alle-Kiski District, pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code. The audit period was January 1, 2005 through February 2, 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.

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 June 11, 2007 exit conference, we reviewed these findings and recommendations with the Westmoreland CAO, Alle-Kiski District, representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

January 8, 2008

Commonwealth of Pennsylvania
Department of Public Welfare
Westmoreland County Assistance Office
Alle-Kiski 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.

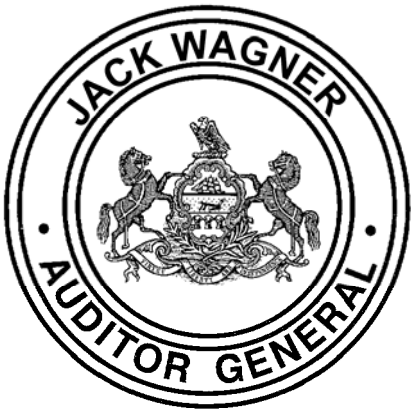
Once an applicant is determined eligible for benefits, relevant information about the recipient is recorded and maintained in DPW's Client Information System (CIS), where benefit information is maintained based on eligibility status and category of aid. The CAO performs a "renewal", or annual review,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

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 156 cases from the 3,426 cases related to the Westmoreland CAO, Alle-Kiski District, represented in the data file. Our audit period was January 1, 2005 to February 2, 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
Westmoreland County Assistance Office
Alle-Kiski District

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations

Our audit testing included 156 out of 3,426 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 12 of the 156, or 8% 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 7 of these cases, recipients were not eligible for Medicaid benefits. In these 7 cases, benefits were paid for recipients while they were ineligible. As a result, improper payments of $13,560 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, $13,535 was issued to managed care organizations in the form of capitation payments and $25 was issued to providers in the form of medical claims paid.

In 5 of the 12 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:

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

[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 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.

- 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 review.

Table 1

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
1.	MA - 52	10/01/05	03/12/06	$ 1,407.30
2.	MA - 81	09/01/05	12/31/05	1,297.80
3.	MA - 84	01/01/05	04/26/06	4,196.44
4.	MA - 90	03/01/05	09/25/05	3,021.98
5.	MA - 130	01/01/06	04/31/06	979.81
6.	MA - 150	04/01/05	10/01/05	836.74
		04/01/06	07/01/06	24.78
7.	MA - 151	09/01/05	11/30/05	1,591.54
		05/01/06	05/31/06	203.80
	Totals			**$13,560.19**

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.

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

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, 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.

Management Response

The CAO Management stated during the exit conference that they disagree with the Department of the Auditor General's computation for Medically Needy Only (MNO) medical categories concerning the use of work and personal expenses. CAO staff was told that once a new calculation of MNO benefits was performed that they were able to remove previous work paper calculations from the case record. Without the work paper verifications of the work and personal expenses, they disagree with three cases that were included in this finding.

Auditors Conclusion

The Auditor General reviews CAOs' determinations of eligibility for MNO cases according to DPW policy regarding deductions for verified expenses found in the MEH, Sections 378.31 and 361.2. At the time of our audit, we found no evidence of verified expenses in the case records mentioned above. Therefore, we applied the standard income deduction allowable for MNO cases based on the MEH 361.2. Additionally, DPW's Operation's Memorandum 06-11-02, *Record Retention Guidelines,* requires CAOs to narrate in "...sufficient detail about CAO's actions...why eligibility decisions and/or changes were or were not made." Due to the CAO's lack of eligibility documentation, we continue to maintain our position with this finding as previously stated.

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 23 of the cases we tested, or 15% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 12 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.

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 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 stated that they agree with the finding as presented at the exit conference and will take corrective action to comply with the recommendations.

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

We noted that in 23 of the 156 cases we tested, or 15% 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.

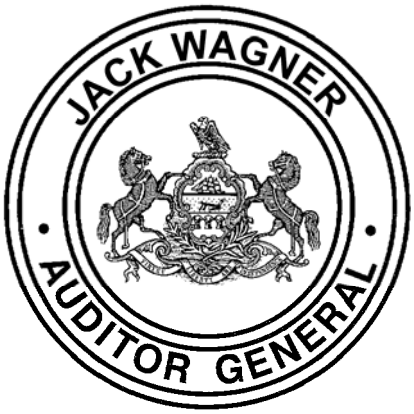
If CAO personnel were to utilize the inquiry screen to gather family relationship information, improper eligibility determinations could result. Furthermore, if CAO personnel cannot rely on the inquiry screen information, they may need to refer to paper case records when household changes are reported.

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

The CAO Management stated that they agree 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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