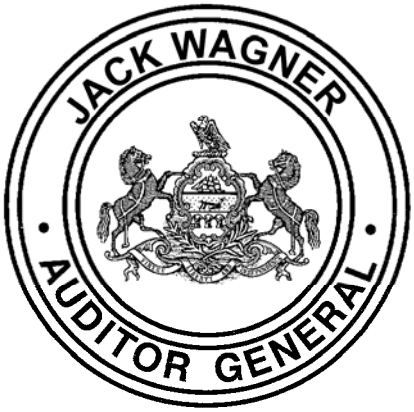
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

# *Jefferson County Assistance Office*

Audit Period
September 1, 2006 to June 13, 2008

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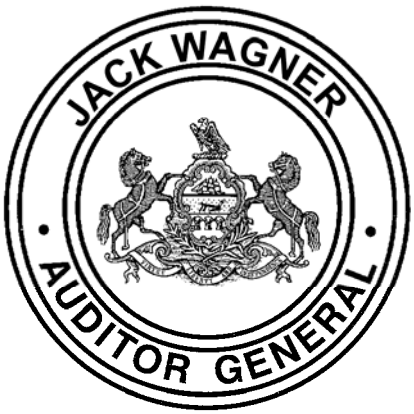
JACK WAGNER
AUDITOR GENERAL

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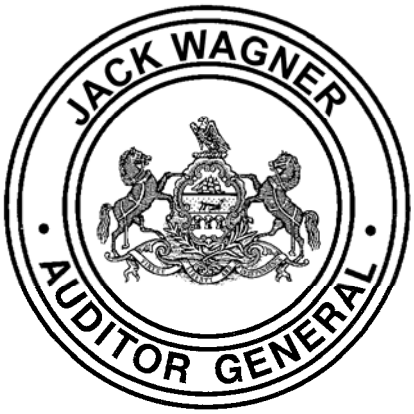

JACK WAGNER
AUDITOR GENERAL

## 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 Jefferson County Assistance Office (CAO) pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code and P.S. §402 and §403 of the Fiscal Code. The audit period was September 1, 2006 through June 13, 2008. 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 an 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 Verify, Investigate, And Refer Potential Fraudulent Activity To The Office Of Inspector General

During the November 18, 2008 exit conference, we reviewed these findings and recommendations with the Jefferson CAO management. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

December 30, 2009

**Commonwealth of Pennsylvania**
**Department of Public Welfare**
**Jefferson 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 Services establishes requirements for service delivery, quality and eligibility standards.

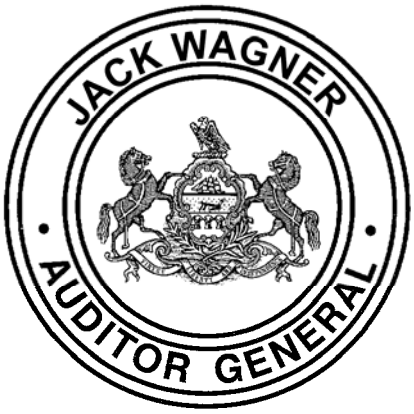
Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance 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 on a regular basis with information from several sources including wage information from the Department of Labor and Industry, benefit information from the SSA, and tax and unearned income information from the Internal Revenue Service. CAO caseworkers are required to review this information at the time of application, when the recipient submits their semi-annual reporting (SAR) form and at the annual renewal. Caseworkers receive an alert when they are required to review new wage information received between the application date, the SAR and at the time of the

annual 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. Consequently, information that could affect a recipient's continued eligibility for benefits is not reviewed until the recipient's SAR or the annual renewal.

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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**Department of Public Welfare**
**Jefferson County Assistance Office**

# ***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, 2007. We selected a random sample of 136 cases from the 3,352 cases related to the Jefferson CAO represented in the data file. Our audit period was September 1, 2006 to June 13, 2008, 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.

It is DPW's position that the Department of the Auditor General is 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**
**Jefferson County Assistance Office**

# ***FINDINGS AND RECOMMENDATIONS***

## *Findings and Recommendations*

Our audit testing included 136 out of 3,352 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 37 of the 136, or 27% 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 22 of these cases, recipients were not eligible for Medicaid benefits, and in 3 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 24 of these 25 cases, benefits were paid while the recipients were ineligible. As a result, improper payments of $43,686 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, $23,921 was issued to managed care organizations in the form of capitation payments and $19,765 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 12 of the 37 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.

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:

- 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.

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

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

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

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

- 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.

- 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.

**Table 1**

| | | Ineligibility Period | | Benefits |
|---|---|---|---|---|
| | Case Number | From | To | Paid |
| 1. | MA - 3 | 07/01/07 | 07/23/07 | $87.36 |
| 2. | MA - 7 | 08/01/07 | 03/08/08 | 685.90 |
| 3. | MA - 16 | 05/01/07 | 10/02/07 | 1,046.64 |
| 4. | MA - 30 | 11/01/06 | 02/07/07 | 932.38 |
| 5. | MA - 31 | 09/01/06 | 12/31/06 | 391.50 |
| 6. | MA - 37 | 06/12/07 | 05/11/08 | 2,448.74 |

**Table 1 (Continued)**

| | Case Number | Ineligibility Period | | Benefits Paid |
|---|---|---|---|---|
| | | From | To | |
| 7. | MA - 38 | 09/01/06 | 06/02/08 | $3,272.06 |
| 8. | MA - 56 | 01/01/07 | 04/27/08 | 7,784.35 |
| 9. | MA - 58 | 04/18/07 | 05/15/08 | 1,529.96 |
| 10. | MA - 60 | 10/01/07 | 06/30/08 | 1,655.34 |
| 11. | MA - 73 | 04/29/08 | 05/23/08 | 286.83 |
| 12. | MA - 74 | 01/01/07 | 03/31/07 | 243.54 |
| | | 07/01/07 | 12/31/07 | 518.40 |
| 13. | MA - 89 | 09/01/06 | 01/18/07 | 84.16 |
| 14. | MA - 90 | 02/01/08 | 03/18/08 | 244.80 |
| 15. | MA - 104 | 01/01/07 | 12/31/07 | 1,105.72 |
| 16. | MA - 105 | 04/01/07 | 12/31/07 | 1,981.86 |
| 17. | MA - 107 | 09/01/06 | 12/12/06 | 1,164.44 |
| | | 06/01/07 | 06/14/08 | 7,012.25 |
| 18. | MA - 112 | 04/01/08 | 04/13/08 | 84.07 |
| 19. | MA - 123 | 11/01/07 | 12/31/07 | 171.77 |
| 20. | MA - 124 | 04/01/07 | 12/31/07 | 476.02 |
| 21. | MA - 125 | 01/01/07 | 07/24/07 | 7,349.95 |
| 22. | MA - 127 | 05/01/07 | 03/25/08 | 198.30 |
| 23. | MA - 134 | 07/01/07 | 02/24/08 | 1,800.38 |
| 24. | MA - 137 | 01/28/08 | 07/06/08 | 1,129.22 |
| | **Total** | | | **$43,685.94** |

Recommendations

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

- 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.

- 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.

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

- Improve monitoring to ensure that caseworkers perform annual renewals and/or semi-annual reviews in a timely manner.

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 determine if payments made on behalf of ineligible recipients can be recouped.

Management Response

In a March 18, 2009 letter to the Department of the Auditor General, DPW management provided the following response:

> This letter provides our comments regarding the finding "Failure to Make Proper Medicaid Eligibility Determinations" . . . contained in the draft audit report on Medicaid Eligibility of the Jefferson County Assistance Office (CAO) for the period September 1, 2006 to June 13, 2008.
>
> Prior to addressing the recommendations listed, the Department of Public Welfare (DPW) would like to comment on the findings in the report. The Department believes that many of the conclusions incorrectly summarize our procedures and thus the Department would like to take the opportunity to clarify its policies and procedures.
>
> The report states that the County Assistance Office (CAO) management did not monitor to ensure that the citizenship and identity of recipients

were verified during the application and renewal process. The Department continues to take steps to ensure citizenship and identification compliance is met by conducting monthly targeted reviews of cases and internal audits. The Department's policies include several measures to help ensure that we are properly authorizing benefits to eligible individuals only.

The Department's policies include several measures to help ensure that benefits are not being authorized for those whose income makes them ineligible for medical coverage. Information is reviewed during the semi-annual and annual reviews of benefits and recipients are required to report any increase in income on their Semi-Annual Reporting (SAR) form.

In addition, the Department is continuing to take the necessary steps to enhance controls by updating the Income Eligibility Verification System (IEVS) internal system logic. The new system logic will require that changes in income be reviewed and cleared by caseworkers for clients that remain at the same employer. 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 quickly.

The Department secured the services of a forensic accounting firm to review its eligibility processes, including those regarding income determinations and will make appropriate changes based on identification of any deficiencies in the Department's policy.

The Department has reviewed the 136 case files that the Auditor General's Office drew for its audit sample. The results of the review show that the Department made an overpayment in 37 of the 136 cases.

To address the finding, CAO managers will re-emphasize to caseworkers the need to follow the established eligibility determination procedures and will take a more active role in case review through mandated automated reviews which are tracked by computer software. In addition, the Department is reviewing its eligibility determination procedures, including those regarding changes in income and collection of citizenship and identification documents, to determine if its policies and procedures can be improved. Any overpayments made on behalf of recipients due to

improper Medicaid eligibility determinations will be referred to the Office of Inspector General (OIG) for possible recoupment.

We agree with the recommendation to follow up with the OIG to determine whether or not overpayments made on behalf of recipients can be recouped from the recipients, Managed Care Organizations (MCO) or individual providers. The audit report was shared with staff from the OIG and a joint workgroup is being formed to research and appropriately improve the current collection process for overpayments in Medical Assistance categories.

Auditors' Conclusion

Our audit determined that eligibility was improperly determined in 37 of the 136 cases we tested. As a result, improper payments of $43,686 were made on behalf of ineligible recipients. These facts indicate that DPW's oversight of the Medicaid program and it's monitoring of conditions of eligibility is inadequate and needs to be improved. Therefore, our finding remains as written.

**Finding No. 2 - Failure To Verify, Investigate, And Refer Potential Fraudulent Activity To The Office Of Inspector General**

In 1 of the 37 cases noted in Finding 1, we performed additional testing because we believe resources were erroneously stated on the recipients' application for Medicaid benefits. We found information from the Recorder of Deeds office that the recipients purchased 2 parcels of land in 2007 worth $62,500 each. Based on this discovery, we expanded our scope prior to the beginning of the audit period and found additional information on a Personal Financial Statement dated January 5, 2003, that was part of a bank loan application, showing the recipients reported annual income in the amount of $18,800. This income exceeds the amount allowable for any Medicaid category of aid and is inconsistent with documentation the recipients provided to the CAO. This documentation showed income of $383 per month ($4,596 annually) for the period May 2001 through May 2002 and $279 per month ($3,348 annually) for the period May 2003 through April 2004. This conflicting information caused us to question whether income was accurately reported to the CAO and to request that the Office of Inspector General (OIG) investigate. Other information on the loan application indicates the following:

- Net worth: $638,979
- Real estate investments: $1,008,000

Income tax returns for 2006 and 2007 indicate the following:

| | | |
|---|---|---|
| • 2006 | Gross receipts | $322,295 |
| | Depreciable assets | $246,912 |
| | Partners' capital account | $182,674 |
| • 2007 | Gross receipts | $417,813 |
| | Depreciable assets | $231,850 |
| | Partners' capital account | $191,335 |

We requested that the CAO refer the case to the OIG to investigate for possible fraudulent activity, specifically, whether false information was knowingly provided to the CAO. However, at the time of the exit conference on November 18, 2008, the CAO could not provide the auditors with evidence that it did, in fact, refer the case to the OIG.

The responsibilities of the CAO to verify suspected fraudulent activity can be found in the Medical Assistance Eligibility Handbook, Chapter 378. The CAO responsibilities for investigating and referring suspected fraudulent activity to the OIG can be found in the Supplemental Handbook, Chapter 910.

The failure of the CAO to follow up on this information was caused by the CAO's weak internal controls. The CAO failed to:

- obtain documentation to substantiate information received from recipients;
- verify eligibility information;
- ensure that CAO personnel are properly trained on the Field Investigation Procedures and utilization of the OIG-12 referral form.

As a result, benefits were paid on behalf of the recipients while they were ineligible during the audit period, and possibly as far back as May 1997, the date of their original Medicaid application.

We recommend that CAO management implement adequate internal controls to help identify and take appropriate action on potential fraud. We also recommend that DPW strengthen its controls at the CAO level to ensure that suspected fraudulent activity is properly referred to the OIG.

Management Response

In a March 18, 2009 letter to the Department of the Auditor General, DPW management provided the following response:

> This letter provides our comments regarding the finding . . ."Failure to Verify, Investigate and Refer Potential Fraudulent Activity to the Office of Inspector General" contained in the draft audit report on Medicaid Eligibility of the Jefferson County Assistance Office (CAO) for the period September 1, 2006 to June 13, 2008.
>
> The Department maintains that procedures to verify Medical Assistance (MA) eligibility were followed, and that this potential fraudulent activity was referred to the OIG. This case concerns the purchase of land by a Limited Liability Corporation (LLC) that employs the MA recipients in question. The recipient allegedly claimed income in a loan application

> which is greater than the allowable limits reported to the CAO for MA eligibility determination. It should be noted that your office also employed a Special Investigator to look further into this case and recommended referral to the OIG.
>
> In response to this audit, a meeting was held with the recipient on July 14, 2008, in which they produced all documents related to the LLC, including tax returns, proof of assets owned by the LLC, and personal assets. The gross proceeds from the LLC, their net income as reported from the LLC, and their personal tax returns were consistent with the information that had been verified by the CAO in the application and renewal process. DPW Office of General Counsel also reviewed the tax forms produced by the recipients and concurred that they were done correctly. In addition, the parents in this case qualified for TD ("Medically Needy Only") until the child turned 21 years of age. According to 55 PA Code 178.1, resources are excluded for applicants/recipients with a natural or adoptive child under the age of 21 years and living in the household; thus, this is a categorically "Medically Needy Only" case and the resources of the couple would not have come into question during the audit period.
>
> In the enclosed letter, the OIG confirms that the Jefferson CAO lacked a basis to refer this matter to the OIG, and that the application to the bank is "outside the scope of the OIG's jurisdiction."

In a January 9, 2009 letter to the Department of the Auditor General, OIG management provided the following response:

> During a Department of Auditor General audit in the Jefferson County Assistance last summer, it was discovered that the recipients had a potential overpayment based on their alleged ownership of a [business] with income and assets. The Jefferson County Assistance Office requested additional information from the recipients and, after reviewing the documents that the recipients provided, determined that under Department of Public Welfare regulations an overpayment did not exist based on income. A period of ineligibility may have existed due to an incorrect determination based on categorical eligibility, but this would have resulted from an administrative error and, in accordance with the

> Pennsylvania Code, would not be recoverable. Absent an overpayment, the Jefferson County Assistance Office lacked a basis to refer this matter to the OIG's Bureau of Fraud Prevention and Prosecution for further investigation.
>
> Although the basis for an overpayment referral did not exist, the Department of Auditor General requested that the Jefferson County Assistance Office consider a referral of this matter to investigate whether a bank fraud had occurred. Apparently, the documents that the recipients provided to the Jefferson County Assistance Office suggest the recipients misrepresented their income on a loan application to the . . . bank.
>
> Under Executive Order 1987-7, the OIG has jurisdiction to deter, detect, prevent and eradicate fraud waste, misconduct, and abuse in the programs, operations, and contracting of executive agencies of the Commonwealth. An investigation of a loan application to a bank is outside the scope of the OIG's jurisdiction.
>
> According to the OIG's Office of Chief Counsel, the confidentiality provisions of the Public Welfare Code preclude the OIG's referral of the allegedly fraudulent bank loan to any other agency for investigation.

Auditors' Conclusion

The recipients in this case own the LLC and are not merely employees of the LLC. Therefore, they were not eligible for Medicaid benefits because they did not meet the key eligibility requirements for self-employed persons.

Although we recommended that the CAO refer this case to the OIG to investigate for possible Medicaid fraud, as of November 19, 2008, the date of the exit conference, the CAO had not referred the case to the OIG to investigate as we recommended. In fact, the OIG is misstating our recommendation by saying that we recommended that it perform an investigation in order to determine whether a bank fraud occurred, which we clearly did not. Nor did we recommend that it refer the matter of a bank fraud to any other agency for further investigation. We merely wanted the OIG to consider evidence we found in an investigation of possible Medicaid fraud. We contend that OIG has a responsibility to investigate whether the recipients in this case provided inaccurate information to the CAO in order to be eligible for benefits.

It is our position that any time that Medicaid funds are paid on behalf of recipients who are ineligible, an improper payment has been made. DPW does not consider an improper payment to be an overpayment when it is the result of an error or failure by DPW. We disagree. Regardless of the cause, when Medicaid funds are paid on behalf of an ineligible recipient, DPW should consider it an overpayment. DPW should improve its management of the Medicaid program in order to prevent improper payments to ineligible recipients. Furthermore, DPW should follow up with the OIG to determine whether payments made on behalf of ineligible recipients can be recouped.

Therefore, our finding remains as written and we continue to recommend that the OIG investigate this case.

## *Audit Report Distribution List*

This report was originally distributed to the following:

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