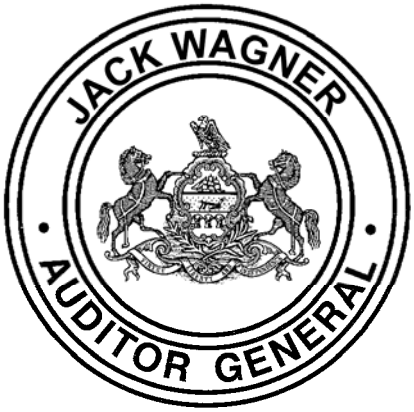
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Montour County Assistance Office

Audit Period
December 1, 2005 to September 7, 2007



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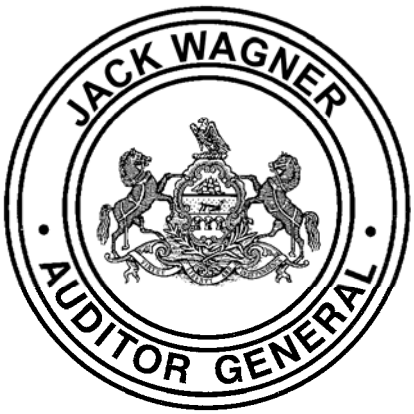
JACK WAGNER
AUDITOR GENERAL

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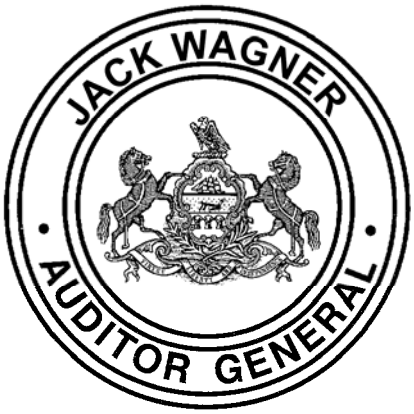
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AUDITOR GENERAL

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 Montour County Assistance Office (CAO) pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code. The audit period was December 1, 2005 through September 7, 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 January 30, 2008 exit conference, we reviewed these findings and recommendations with the Montour CAO representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

December 30, 2008

Commonwealth of Pennsylvania
Department of Public Welfare
Montour 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.

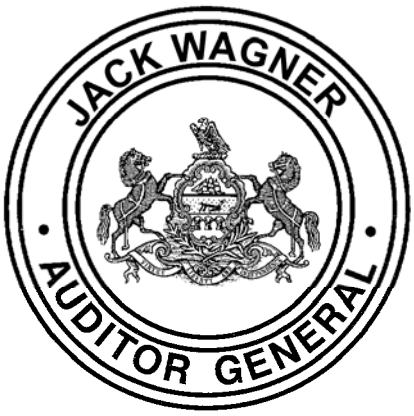
Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance 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 March 31, 2007. We selected a random sample of 116 cases from the 848 cases related to the Montour CAO represented in the data file. Our audit period was December 1, 2005 to September 7, 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
Montour County Assistance Office

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations

Our audit testing included 116 out of 848 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 22 of the 116, or 19% 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, and in 4 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 7 of these 11 cases, benefits were paid while the recipients were ineligible. As a result, improper payments of $10,519 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, $578 was issued to managed care organizations in the form of capitation payments and $9,941 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 11 of the 22 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 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 and/or resource amounts were properly entered on the Client Information System.

- 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.

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

- 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

		Ineligibility Period		Benefits
	Case Number	**From**	**To**	**Paid**
1.	MA-27	05/01/06	05/07/07	$1,286.60
2.	MA-48	10/20/06	07/08/07	4,033.59
3.	MA-77	12/01/05	03/31/06	11.28
4.	MA-78	06/01/06	07/31/06	3,436.18
		11/01/06	11/30/06	395.53
5.	MA-79	08/03/06	08/31/06	85.42
6.	MA-87	10/01/06	12/31/06	692.72
7.	MA-109	08/02/06	07/08/07	578.04
	Total			**$10,519.36**

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.

- Ensure that personnel are trained to accurately enter income and/or resource information into the Client Information System.

- 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 verify citizenship and identity during the application and renewal process.

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 May 5, 2008 letter to this Department, the CAO management provided the following response:

> The Montour CAO acknowledges the finding Failure to Make Proper Medicaid Eligibility Determinations. However, in one (MA-78) of the seven (7) cases listed as ineligible for Medicaid benefits, the CAO adhered

to the policy outlined in OPS 05-07-06 when applying new income to the MA budget. Policy states "To be consistent with current policy for FS households enrolled in SAR, all TANF, GA, Medicaid, and Non-SAR FS recipients are required to report changes by the 10th of the month following the month of the change with the following exception." In this case when the CAO applies the policy to income that starts and stops, there is no MA ineligibility during the suggested deficiency timeframe.

The remaining six (6) cases, benefits were paid while the recipients were ineligible. As a result, improper payments of $6,687 were issued to both managed care organizations and individual providers on behalf of recipients. Specifically, $578 was issued to managed care organizations in the form of capitation payments and $6,109 was issued to providers in the form of medical claims paid.

The deficiencies cited in this audit do not indicate a trend in similar errors to warrant retraining of policy. The deficiencies were discussed at a staff meeting with all IMW employees.

Auditors Conclusion

CAO management disagreed with 1 of the 7 cases in our finding where recipients were totally ineligible for Medicaid benefits. In this case, we found that the CAO failed to properly review IEVS information at the time of the recipients' renewal, therefore failing to discover that the recipient was over the income limit and no longer eligible for benefits. This was also the reason why several recipients remained in categories of aid for which they were no longer eligible. In fact, three of the cases in our finding had recipients assigned to categories with more benefits (dental, vision and prescription) than the recipients were entitled to receive. In one case, the recipient would have been eligible for additional benefits. As noted in our finding, deficiencies occurred in 22, or 19%, of the cases we sampled, not just the 7 the CAO addressed, which is significant. Therefore, our finding remains as written and we continue to recommend that the CAO personnel are more closely monitored and adequately trained to make proper eligibility determinations.

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 18 of the cases we tested, or 16% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 4 of these cases, the recipient's case record included documentation of auto insurance which was not recorded in the Client Information System. In 9 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. In 2 of these cases, the recipient's case record included both documentation of medical and auto insurance which was not included in the Client Information System. We also determined that in 3 of the cases, the CAO failed to obtain documentation of health insurance information from recipients 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 documentation of auto insurance information was obtained and entered into the Client Information System, even though an auto was listed as a resource.

- The CAO management did not monitor to ensure that third party insurance information was entered into the Client Information System even though this documentation 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.

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 May 5, 2008 letter to this Department, the CAO management provided the following response:

> The Montour CAO acknowledges the finding of Failure to Obtain and/or Properly Record All Third Party Liability on the Client Information System. Of the 18 cases cited with deficiencies in which the CAO failed to obtain and/or properly record all third party liability (TPL) into the Client Information System (CIS), only five (5) cases were the result of failure to record health insurance information. The remaining 13 cases were due to failure to record auto insurance. According to Medicaid Eligibility Handbook policy 338.2 and Policy Clarification PMA13745340, automobile insurance is not considered a third party liability resource. Caseworkers are not required to capture and enter automobile insurance as a TPL resource.
>
> The CAO reviewed with IMW staff the importance of securing and adding medical insurance into the TPL system.

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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