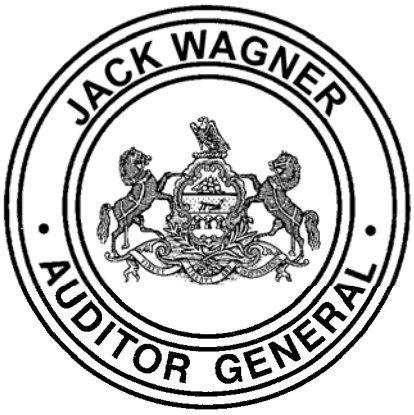
Commonwealth of Pennsylvania
Department of Public Welfare's
Medicaid Program

Philadelphia County Assistance Office
Girard District

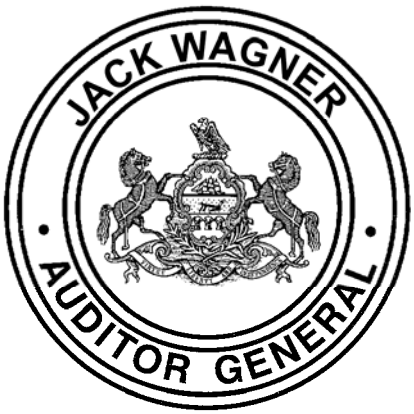
Audit Report for the Period
March 3, 2007 to November 5, 2010



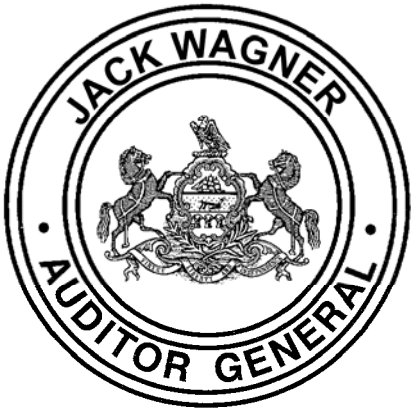
Commonwealth of Pennsylvania
Department of Public Welfare's
Medicaid Program

Philadelphia County Assistance Office
Girard District

Audit Report for the Period
March 3, 2007 to November 5, 2010


JACK WAGNER
AUDITOR GENERAL

CONTENTS


JACK WAGNER
AUDITOR GENERAL

Report of Independent Auditors

The Honorable Tom Corbett
Governor
Commonwealth of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Corbett:

We have conducted an audit of the Philadelphia County Assistance Office (CAO), Girard District, pursuant to Section 109.1 of Title 55 of the Pennsylvania Code and Sections 402 and 403 of the Fiscal Code. Philadelphia County, Girard District, falls under The Department of Public Welfare's (DPW's) HealthChoices mandatory managed care program. The audit period was March 3, 2007 through November 5, 2010. The objective of our audit was to determine whether the CAO made proper eligibility determinations for recipients of Medicaid.

When recipients are not eligible for Medicaid, the cost to Pennsylvania taxpayers of the resulting improper payments could be significant. For individuals receiving health care services through 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 cost of services received by individuals during periods of ineligibility.

Our audit resulted in the following finding.

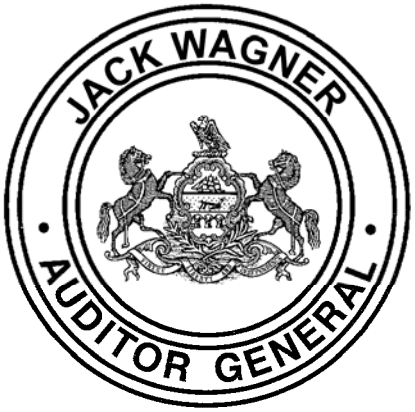
Finding - Failure To Make Proper Medicaid Eligibility Determinations

During the exit conference, we reviewed this finding and recommendations with the Philadelphia CAO, Girard District, management. We have included the CAO and DPW management comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

October 22, 2012


JACK WAGNER
AUDITOR GENERAL

Commonwealth of Pennsylvania
Department of Public Welfare
Philadelphia County Assistance Office
Girard District

BACKGROUND INFORMATION

Background Information

Medicaid, also known as DPW's medical assistance program is the federal health care program for families and individuals with low income and resources. It is funded jointly by the state and the federal governments. DPW administers the program while the federal Centers for Medicare and Medicaid (CMS) 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 contains the applicable state regulations.

Relevant information about recipients is recorded and maintained in DPW's Client Information System (CIS). This information is used to determine eligibility status and category of aid. The CAO updates information on CIS when new information becomes available.

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 Social Security Administration, and tax and unearned income information from the Internal Revenue Service (IRS). CAO caseworkers are required to review this information at the time of application, when the recipient submits his/her semi-annual reporting (SAR) form and at the annual renewal. Caseworkers receive alerts when they are required to review certain information between the application date, the SAR and at the time of the annual renewal.

Commonwealth of Pennsylvania
Department of Public Welfare
Philadelphia County Assistance Office
Girard District

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 CAO to be eligible for Medicaid benefits as of March 31, 2010. We selected a random sample of 139 cases from the 9,944 cases related to our audit objectives for the Philadelphia CAO, Girard District represented in the data file. Our audit period was March 3, 2007 to November 5, 2010; however, in cases where we determined that 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, including income, disability, citizenship and identity, and other non-financial eligibility requirements to determine compliance with DPW regulations and administrative policies.

The criteria we used to test cases in our sample include the Code of Federal Regulations and the Pennsylvania Code, Title 55.

It is DPW's position that current law does not allow DPW to provide all federal and state wage and unearned income information to the Department of the Auditor General. DPW provided us with most, but not all, federal and state wage and unearned income information. DPW did not give us access to IRS-reported wage and income data. This scope limitation prevents us from confirming that all available resources were included in calculating recipients' eligibility for benefits.

Commonwealth of Pennsylvania
Department of Public Welfare
Philadelphia County Assistance Office
Girard District

FINDING AND RECOMMENDATIONS

Finding and Recommendations

The random sample contained 139 out of 9,944 Medicaid cases. The following finding addresses areas where deficiencies occurred:

Finding - Failure To Make Proper Medicaid Eligibility Determinations

During our audit we found that CAO management failed to ensure that eligibility requirements were met in 55 of the 139, or 40% 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, time limitation, citizenship and identity, and disability requirements. In 24 of these cases, recipients were not eligible for Medicaid benefits, and in 23 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 42 of these 47 cases, benefits were paid while the recipients were ineligible. As a result, improper payments of $190,411 were issued to both managed care organizations and individual providers on behalf of recipients,[1] as shown in Table 1, beginning on page 10 of this report. Specifically, improper payments of $139,652 were issued to managed care organizations in the form of monthly capitation fees and $50,759 was paid to providers for medical claims submitted on behalf of recipients. Payments made on behalf of ineligible recipients cannot be recouped by the Commonwealth from MCOs, due to contractual obligations, or from individual providers, who billed the Commonwealth in good faith. Therefore, it is important for DPW to monitor recipients' eligibility, immediately identify ineligible recipients, and stop payment of benefits on their behalf. The lack of proper monitoring increases the risk of payment to an ineligible recipient and creates an atmosphere that could result in potential fraud.

In 8 of the 55 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. Also, because capitation payment amounts vary depending on the category of aid, MCOs could be receiving erroneous capitation payments as a result of a recipient not being placed in the proper category of aid.

[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.

Finding and Recommendations

Because we do not have access to all wage and unearned income information as noted in our scope limitation described on page 6 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 eligibility determinations occurred because:

- CAO management did not monitor to ensure that income from IEVS alerts was timely 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 recipients met the age, time limitation, and disability requirements.

- CAO management did not monitor to ensure that the SAR was received or that the annual renewal was performed timely.

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

Table 1

	Audit Sample Number	Ineligibility Period		Benefits Paid
		From	To	
1.	MA-3	03/20/09	05/31/09	$483.76
		12/17/09	04/30/10	4,841.83
2.	MA-9	03/01/08	09/30/08	1,862.94
		08/08/10	10/26/10	15,547.37
3.	MA-12	01/08/10	07/26/10	2,748.01
4.	MA-13	11/01/09	08/26/10	2,273.65
5.	MA-16	04/01/08	04/30/08	260.76
6.	MA-19	03/15/09	04/13/10	7,068.38
7.	MA-22	12/01/07	01/31/08	270.63
		07/01/08	10/31/08	1,499.03
		01/01/09	02/28/09	572.54
		07/01/09	07/31/09	239.57
		01/01/10	02/28/10	2,503.46
		04/01/10	04/30/10	1,276.80
8.	MA-28	07/01/07	09/30/07	396.07
9.	MA-29	01/01/08	03/31/08	785.94
		10/01/08	12/31/08	813.59
		01/01/10	10/26/10	11,161.01
10.	MA-32	08/01/09	08/31/09	239.16
		05/09/10	11/04/10	4,105.87
11.	MA-34	03/03/07	03/31/10	3,391.61
12.	MA-44	03/03/07	05/31/07	774.66
13.	MA-45	04/08/10	08/25/10	1,860.84
14.	MA-47	04/01/08	05/11/08	133.92
15.	MA-48	07/01/07	12/31/07	1,613.39
		03/01/08	12/31/08	49.15
		05/01/09	10/31/09	1,024.02
16.	MA-50	01/01/08	02/28/08	479.46
		10/01/09	12/31/09	1,398.51
17.	MA-51	03/01/08	12/31/08	2,673.91
18.	MA-54	06/01/08	07/23/08	235.74
		02/09/09	08/25/10	2,559.92

Table 1 (Continued)

	Audit Sample Number	Ineligibility Period		Benefits Paid
		From	To	
19.	MA-57	10/01/09	03/31/10	$842.94
20.	MA-60	05/01/09	05/31/09	218.39
21.	MA-61	02/01/09	03/31/09	378.39
22.	MA-63	07/01/08	02/28/09	1,431.10
		07/01/09	12/31/09	2,104.58
23.	MA-65	01/01/08	03/31/08	785.94
24.	MA-76	06/01/08	07/18/08	260.76
25.	MA-78	11/01/08	10/21/10	7,553.60
26.	MA-87	04/01/08	06/30/08	785.83
27.	MA-90	06/01/10	10/26/10	940.56
28.	MA-91	12/10/08	06/29/09	961.25
29.	MA-94	02/18/08	09/02/10	4,785.32
30.	MA-95	09/01/09	01/29/09	1,218.76
31.	MA-99	04/01/10	08/31/10	13,056.92
32.	MA-101	07/09/09	10/26/10	10,475.17
33.	MA-104	08/16/09	10/30/09	4,790.90
		04/01/10	06/30/10	745.61
34.	MA-109	01/01/09	03/31/09	649.49
		07/01/09	07/31/09	239.78
		09/01/09	03/31/10	1,569.85
35.	MA-113	04/16/09	11/05/10	36,731.33
36.	MA-118	12/01/08	05/31/09	1,462.70
37.	MA-119	08/08/10	10/29/10	332.10
38.	MA-120	07/01/08	12/31/09	4,983.17
39.	MA-127	06/01/09	12/31/09	7,119.63
40.	MA-131	03/01/09	09/30/09	4,145.41
		12/01/09	02/28/10	3,736.02
41.	MA-134	10/01/09	12/31/09	522.97
42.	MA-139	04/30/10	10/30/10	2,437.20
	Totals			**$190,411.17**

We recommend that:

- CAO management ensure that caseworkers timely or properly reconcile reported income with IEVS alerts.

- CAO management ensure that caseworkers properly reconcile reported income with IEVS history at application and renewals.

- CAO management ensure that personnel understand the eligibility requirements pertaining to age, time limitation, and disability requirements.

- CAO management ensure that SARs are received and that the annual renewal is performed timely.

- CAO management ensure that personnel verify citizenship and identity during the application and renewal process.

DPW's Management Response

DPW disagrees with this finding. DPW, along with the CAO, reviewed the cases that the auditor cited as deficiencies and does not agree with all the exceptions cited as deficiencies for the individual cases. When DPW evaluates for Medicaid, it also evaluates for state-funded General Assistance (GA)-related MA categories. Although the procedures in place during the audit period (which extends back to March 3, 2007) worked well and were effective, it should be noted that since that time additional procedures have been implemented to make the monitoring even better and to further ensure that recipients are meeting eligibility requirements. The following responses to the issues identified by the AG support DPW's position on this finding.

Reconciliation of IEVS is reviewed by CAO management when individual cases are transferred, sent to the closed file, or selected for Targeted Supervisory Review (TSR). New caseworkers are required to complete an Introduction to IEVS e-learning module which reviews how to view IEVS and when they should be reviewed. During September of 2008, with the implementation of Workload Dashboard, training was provided to

caseworkers that included an extensive review of the IEVS processing procedures. With Workload Dashboard, CAO management is better able to screen IEVS reviews and ensure that IEVS alerts are addressed timely.

Alerts are created when a recipient turns age 1, 6, 19, 21, or 65, notifying the caseworkers that action must be taken on a case with regards to age. CAO management has the ability to monitor these alerts through the Workload Dashboard. CAOs monitor the age alerts related to recipients turning age 21 to ensure that ineligible recipients do not receive benefits.

Extended Medical Coverage (EMC) is an up to twelve month long medical category available to Temporary Assistance for Needy Families (TANF) or Non-Money Payment for the Family (NMP-F) recipients who become ineligible due to an increase in earned income. The budget group must have received TANF or NMP-F in at least three of the six months immediately prior to the month TANF or NMP-F ended and have a child who meets the TANF age requirements. The CAO conducts reviews of EMC in months four and seven. The review in month four is to verify that a TANF qualified child is still in the budget group. The review in month seven is to verify continued employment and that the earned income is within the EMC limit, which is 185% of the Federal Poverty Income Guideline (FPIG). After the seventh month, it is the client's responsibility to report any changes in circumstances to have the proper action taken. If EMC ends for any reason, the caseworker using Client Information System (CIS) re-evaluates budget group members for continuing benefits under the federally-funded Medicaid or state-funded MA categories. With the addition of Workload Dashboard, CAO management is able to monitor alerts related to EMC reviews received by staff to ensure they are addressed timely. Additionally, the Semi-Annual Reporting (SAR) form is used as the seven month review to verify the household's composition and income. Under a planned system enhancement to automate closing of benefits, if the SAR is not received by the extended due date, an advance notice will automatically be issued and the recipient's benefits will close.

When the Medical Review Team (MRT) certifies a client disabled, the disability continues as long as the MRT has certified the disability. If the client reports a change in medical condition, another MRT determination is needed to re-evaluate the client's condition. The MRT determination

can be found using the AppMap system, or the MRT may provide a hard copy for the case file (MA Handbook Section 305.25). Alerts are created when a disability end date is set to expire on the CADISB screen. CAO management has the ability to monitor these alerts through the Workload Dashboard.

DPW is working on a system enhancement to automate benefit closings if the SAR or Renewal is not completed timely. When implemented, the Client Information System (CIS) will automatically close benefits based on the appropriate Advance Notice following the SAR extended due date. Additionally, CIS will automatically issue the appropriate advance notice once a Renewal due date has passed and close the benefits the last day of the month following the due date. Under current policy, caseworkers and CAO management monitor cases in SAR (MA Handbook Section 376.4) and Renewal (MA Handbook Section 376.2) and take appropriate action when they are due. To help CAOs effectively monitor SAR processing, a Targeted Supervisory Review (TSR) was also added to the case review system in the Fall of 2011 to allow CAO management to review specific elements related to SAR processing.

Under current policy, anyone applying for or receiving medical benefits, whether federally-funded or state-funded, must verify identity (MA Handbook Section 320.1) and anyone applying for or receiving medical benefits, whether federally-funded or state-funded, must verify citizenship status (MA Handbook Section 322.1). Only those requesting or receiving medical benefits must provide the verification; other household members who do not wish to receive medical benefits or do not meet criteria for medical benefits do not have to provide verification. If an individual does not have or cannot obtain satisfactory verification of identity or citizenship, proof that the client is attempting to obtain the verification is sufficient. System upgrades were made on June 7, 2010 on the Client Information System (CIS) to automatically verify citizenship and identity by linking to the Social Security Administration (SSA) through the Master Client Index (MCI). Per Operations Memorandum 100602, when a case initiation is completed on a new application, a request for electronic verification is sent out and a response is received in two or three days. The CAO must verify, through the Systematic Alien Verification for Entitlements (SAVE) Program, the immigration status of all aliens who

receive cash assistance, Supplemental Nutrition Assistance Program (SNAP), or medical assistance (Supplemental Handbook Section 740.1). If citizenship or identity verification is needed for a newborn, it is requested at the Annual Renewal (MA Handbook Section 322.11). If during a renewal the caseworker notices that identify or citizenship has not been verified, they will request the verification. If the client fails to provide the requested verification or provide proof that they are attempting to secure verification, the caseworker discontinues the client's benefits.

Workload Dashboard was introduced during September of 2008, providing Income Maintenance Caseworkers (IMCWs) and CAO management with a system that more easily allows for tracking of applications and maintenance requirements on case records.

Supervisors are required to review three records per worker every month to ensure that all factors of eligibility are addressed. Management will ensure that reviews occur and areas of concern are addressed.

Supervisors hold monthly meetings to review findings from previous audits and to review policy with IMCWs to ensure that the audit findings are addressed. Supervisors also hold individual monthly conferences to review each worker's Comprehensive Supervisory Review (CSR) results and to offer additional individual training to ensure that compliance with policy is maintained.

CAO management has placed more emphasis on scanning/imaging of all documentation in an attempt to cut down on misplaced or repetitive verification. This also allows IMCWs at different CAOs to view verification that may have previously been submitted in another county.

Desk guides are available for caseworkers and OIM staff on the following:
-Reporting requirements (Semi-Annual Reporting) for all budgets
-Income and Eligibility Verification System (IEVS) desk guide
-U.S. Citizenship and Identity desk guide
-Medical Eligibility Determination Automation (MEDA) desk references

Auditors' Conclusion

We acknowledge DPW's efforts to review and revise procedures to ensure proper eligibility determinations are made. During our next audit we will examine the implementation of DPW's additional procedures, including the Workload Dashboard and Data Exchange Targeting Enhancements, to determine whether or not those procedures address the deficiencies noted in this report.

It is clear that the procedures in place during the audit period were not adequate to ensure proper eligibility determinations were consistently made. It is also clear that payments to managed care organizations or medical providers on behalf of recipients did not cease when some recipients were no longer eligible.

The creation of alerts to prompt action on a case does not ensure that the action is taken. For example, when a recipient turns 19, he or she is no longer a child and therefore is ineligible for medical assistance as a child. An alert by a DPW system to the CAO on the recipient's 19th birthday does not ensure the CAO takes action to reassess the individual's eligibility and stop payment of benefits on behalf of the recipient who is no longer eligible for benefits unless the recipient has experienced a life changing event such as a pregnancy or a serious medical condition. Similarly, in a MA case in which Extended Medical Coverage (EMC) is provided for the 12 month maximum, an alert by a DPW system to the CAO that the 12th month of EMC has ended does not ensure that eligibility for EMC will end and payments for the coverage will also end.

Deficiencies we detected related to MRT typically involved children who are eligible for a specific category of medical coverage. These children need medical coverage and they are eligible for coverage. In these cases the children were provided medical coverage under a SSI related or Healthy Horizons category which have higher capitation fees when the children should have been provided coverage under a Money Payment or Healthy Beginnings category which have lower capitation fees.

Lastly, proof of identity and citizenship for those requesting and receiving medical benefits was not always present in the case records. When proof of identity or citizenship was missing from a case record we provided an opportunity for it to be produced. When proof was not provided we determined the recipient was not eligible and that benefits should not have been paid on their behalf.

Audit Report Distribution List

This report was originally distributed to the following:

Commonwealth of Pennsylvania

The Honorable Tom Corbett
Governor

The Honorable Gary Alexander
Secretary
Department of Public Welfare

The Honorable Charles Zogby
Secretary
Office of the Budget

Alex Matolyak, Director
Division of Audit & Review
Bureau of Financial Operations
Department of Public Welfare

John Kaschak, Director
Bureau of Audits
Office of the Budget

The Honorable Robert McCord
State Treasurer

The Honorable Kenya Mann Faulkner
Inspector General

Lourdes Padilla, Deputy Secretary
Office of Income Maintenance
Department of Public Welfare

Rich Wallace, Acting Director
Bureau of Operations
Office of Income Maintenance
Department of Public Welfare

County Assistance Office

Dionisio Mignacca, Executive Director
Philadelphia County Assistance Office

This report is a matter of public record. Copies of this report may be obtained from the Pennsylvania Department of the Auditor General, Office of Communications, 318 Finance Building, Harrisburg, PA 17120. If you have any questions regarding this report or any other matter, you may contact the Department by accessing our website at www.auditorgen.state.pa.us.