STATE OF WEST VIRGINIA

FULL PERFORMANCE EVALUATION OF THE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAID ELIGIBILITY

Eligibility Decision Error Rate

OFFICE OF LEGISLATIVE AUDITOR
Performance Evaluation and Research Division
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WEST VIRGINIA LEGISLATURE

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December 14, 1997

The Honorable Billy Wayne Bailey
State Senate
Drawer A
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The Honorable Vicki Douglas
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Building 1, Room E-213
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0470

Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Full Performance Evaluation of the Department of Health and Human Resources - Medicaid Eligibility, which will be presented to the Joint Committee on Government Operations on Sunday, December 14, 1997. The issue covered herein is "Eligibility Decision Error Rate."

Sincerely,

Antonio E. Jones

AEJ/wsc

Enclosure

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EXECUTIVE SUMMARY

Medicaid was created in 1965 as Title XIX of the Social Security Act . It is a federal/state program administered by states and funded from federal, state and in some states, local revenues. One in five West Virginians receives health care benefits through the Medicaid program. It is a *$1.4 billion* program with an approximately *$322 million state match*, serving approximately *431,000 citizens.* Given the size and cost of the State Medicaid program, it is important to know the accuracy with which Medicaid eligibility determinations are made.

ISSUE AREA: Of the Cases Reviewed, Medicaid Eligibility Policy and Procedures were not Followed in 16.5% of the Cases

To determine whether eligibility decisions are being made correctly, a sample of 455 cases was taken from those eligible to receive benefits on October 31, 1995. These cases were evaluated based on Federal and State guidelines used by Department of Health and Human Resources field staff, compiled in the ***Income Maintenance Manual. This Manual serves as the authority for all eligibility decisions.*** Of the 455 cases sampled, ***75 cases (or 16.5%) were found to contain errors*** as follows: ***incorrect eligibility decisions*** (9 cases representing 12% of the total errors); ***lack of verification such that a proper determination of eligibility could not be made*** (52 cases representing 69.3% of the total errors); ***or the entire file or relevant application/reapplication had been lost*** (14 cases representing 18.7% of the total errors).

Summary of Errors by Type		
Type of Error	**Number of Cases**	**% of the 455 Cases Sampled**
No verification of client reported income	7	1.5%
No verification of client reported bank accounts	43	9.5%
Client's income exceeded program limits	6	1.3%
File or relevant application was lost or missing	14	3.1%
Miscellaneous errors	5	1.1%
Total Errors	**75**	**16.5%**

Expenditures for cases determined to be in **error** totaled **$146,343,** accounting for about 12% of expenditures for cases in the sample. Insufficient training, a complex reference manual and insufficient supervisory case review combine to cause errors in Medicaid eligibility decisions.

Summary of Outlays for Eligibility Sample		
Type of Case	**Total Number of Cases**	**Dollars Consumed**
Correct Cases	376	$1,092,577
Miscoded Cases	4	$980
Total for Correct Cases	**380**	**$1,093,557**
No Verification of Income	7	$3,914
No Verification of Assets	43	$86,552
Client Over Income	6	$9,845
Lost File, Application, or Review	14	$26,420
Miscellaneous Errors	5	$19,612
Total for Error Cases	**75**	**$146,343**
Total Expenditures	**455**	**$1,239,900**

Because many of the errors identified in this study were verification errors, to accurately determine dollars in error would have required investigation of personal bank accounts, and other similar inquiries. The Legislative Auditor's Office made no attempt to carry this study to such an extreme. Thus, some verification errors may have no impact in dollars, because had the information been verified some individuals may have been positively determined to be eligible. However, nine cases identified in the study were found to be clearly ineligible. These cases accounted for $18,832 in expenditures. Projected to the total population of 106,439 from which the sample was drawn, over $4.4 million was spent erroneously. If one was to make the unreasonable assumption that all errors resulted in ineligible recipient consumption, the projected dollars in error would be $34 million. The Legislative Auditor's Office has no basis to determine the effect of verification errors, but can offer the range of $4.4 to $34 million with reasonable certainty, for the amount that was spent to provide coverage for those who were ineligible but extended coverage on October 31, 1995.

BACKGROUND, OBJECTIVE, SCOPE AND METHODOLOGY

Medicaid was created in 1965 as Title XIX of the Social Security Act of 1965. It is a federal/state program administered by states and funded from federal, state and in some states, local revenues. Federal funds are made available contingent on a state match that varies among states from year to year. West Virginia has the second most favorable match rate in the nation, at an approximate 74 percent federal and 26 percent state. The match rate is determined by a formula that takes into account the State's per capita income compared to the national average. After rising steadily between 1980 and 1992, the match rate began to decline in 1993. The decrease in the match rate alone required State funding increases of $11 million in State Fiscal Year (SFY) 1995 and $16 million in SFY 1996. Medicaid covered 36 million people on any given day in 1995, representing about 13 percent of all Americans. Even with this substantial coverage, an estimated 43 million Americans remained uninsured. Today, one in five West Virginians receives health care benefits through the Medicaid program. It is a $1.4 billion program, with an approximate $322 million state match, serving approximately 431,000 citizens.

Health care services for the aged and disabled account for nearly two-thirds of all Medicaid expenditures. Medicaid and Medicare together have an enormous economic impact in West Virginia. Almost seventy per cent of nursing home revenue is attributable to Medicaid and more than 60 percent of all hospital revenue in West Virginia is attributable to these two programs.

Nationally, the Medicaid program consumed nearly 20 per cent of state expenditures in 1995, up from an average of 10 percent in 1987. In West Virginia, Medicaid consumed 15.2 percent of the state budget for fiscal year 1995. Medicaid is essentially three programs in one: first, it is a ***health insurance program for low income parents and children***; secondly, ***it is a long-term care program for the elderly***; and lastly, ***it is a funding source for services to people with disabilities***. Medicaid is one of the largest expenditures within the Department of Health and Human Resources.

The Department of Health and Human Resources is one of the seven Cabinet-level departments of state government created under legislation enacted in 1989. As its name indicates, the Department brings together health-related programs and human resource programs, which include public assistance and social service programs. Although the Department provides services to individuals in institutional settings, emphasis is placed on community-based service delivery programs within the Department that are categorized by similarity of service and function into five bureaus:

Bureau for Children and Families. This Bureau manages public assistance programs, social service programs, and child support enforcement and collections. A citizen might have contact with this Bureau's programs in such matters as eligibility determination for Temporary Assistance to Needy Families, Food Stamps and Medicaid, subsidized work programs, child and adult abuse concerns, and child day care, foster care and adoptions.

Bureau for Child Support Enforcement This Bureau's mission is to improve the quality of life for children by locating non-custodial parents; establishing paternity; establishing, modifying and enforcing support orders; collecting and distributing child support; and educating the public about

the Bureau's services.

Bureau for Community Support. This Bureau provides health and behavioral health services to vulnerable citizens with a particular focus on adults and the aging. Services are provided in the home, community, hospitals, residential facilities and long-term care facilities operated by the state or by other providers.

Bureau for Medical Services. This Bureau is the single state agency charged with administering the state's Medicaid program, which provides medical coverage for eligible clients. The Bureau provides administration and reimbursement for medical services to eligible individuals, such as inpatient and outpatient hospital care, physician services, laboratory, x-ray, behavioral health services, prescription drugs, nursing home care and several in-home services which keep individuals out of institutional services.

Bureau for Public Health. This Bureau administers and coordinates programs that protect the health of the public and promotes "Healthy People in Healthy Communities." These programs include: emergency health services, environmental health services, specialized laboratory services, enforcement of licensure and certifications for hospital and long-term care facilities, and the state's medical examiner. A citizen might have contact with this Bureau's programs in such matters as county health department concerns, maternal and child health programs, information about communicable or sexually-transmitted diseases, birth and death certificates, emergency ambulance service, food service sanitation or water and sewage permits, community tobacco coalitions, family planning or services to children with special needs.

As stated above, the *Bureau for Medical Services* is responsible for the overall administration of the Medicaid program. The *Bureau for Children and Families* manages public assistance programs, social service programs and child support enforcement and collection. Each of the county offices falls under the supervision of the Bureau for Children and Families.

The county offices have two distinct branches: Economic Services and Social Services. Social Services is responsible for child and adult abuse concerns, child day care, foster care and adoptions. Economic Services is responsible for public assistance. Public assistance services provide access to financial assistance for eligible West Virginians to help meet their basic needs and reach a level of self-sufficiency and well-being.

Public assistance services include eligibility determination, case management and other client services for Aid to Families with Dependent Children (AFDC), Food Stamps, Job Opportunities and Basic Skills (JOBS), Medicaid, Title IV-A Emergency Assistance, Low-Income Energy Assistance Program (LIEAP), Indigent Burial Program, Transportation Remuneration Incentive Program (TRIP), and the Donated Foods Program.

Congressional proposals in 1995 and 1996 to make substantial changes to Medicaid stimulated debate at all levels of society and government. A variety of proposals received serious consideration, but key congressional leaders and the President could not reach a compromise for any major program changes. Key proposals that shaped the debate and may serve as foundations for future deliberations

include the "Medigrant" bill that passed Congress and was vetoed by the President in December 1995; the Clinton administration proposal; the proposal adopted by the National Governors' Association in February 1996; and the Medicaid Restructuring Act of 1996. The National Conference of State Legislatures also has several policies related to reforming Medicaid.

The recent welfare reform legislation (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996), signed August 22, 1996, affects Medicaid in several ways:

- Eliminates the Aid to Families with Dependent Children (AFDC) program, to which Medicaid has automatic eligibility ties;
- Freezes certain Medicaid eligibility criteria, subject to modification;
- Modifies eligibility standards for Supplemental Security Income (SSI) for children, a program that also has automatic Medicaid ties; and
- Restricts Medicaid coverage for legal immigrants.

This report contains references to Aid to Families with Dependant Children (AFDC) and its links to Medicaid eligibility. In general, however, people who meet AFDC eligibility criteria that were in effect on and prior to July 16, 1996 will be eligible for Medicaid. Accordingly, references to AFDC in this report should be read as references to the "frozen" July 1996 AFDC criteria.

Federal statutes and regulations largely dictate who is eligible for coverage in the Medicaid program. Over the past thirty years Medicaid eligibility standards have been progressively broadened to cover the medical costs of more groups of individuals who are aged, blind, or disabled, and members of low-income families with dependent children. Federal regulations specify a broad range of groups that must be covered (coverage groups) by the Medicaid program if the state chooses to participate in the Medicaid program. A few groups may be included or excluded at state option. The basis for Medicaid coverage is classified as either Categorical Need or Medical Need.

The groups referred to as the Categorically Needy include:

- AFDC recipients and children;
- Low-income pregnant women and children;
- Supplemental Security Income (SSI) recipients or certain individuals eligible for SSI; and,
- Low-income Medicare beneficiaries.

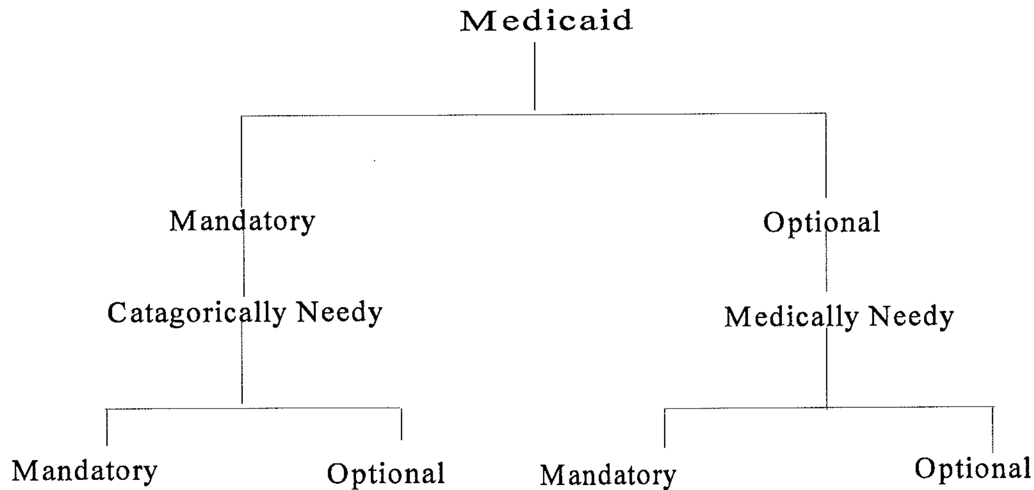
Those classified as Medically Needy would be eligible for AFDC or SSI except that their income or assets are too high. They receive Medicaid because they cannot afford to pay their medical expenses. Medically Needy groups include:

- Children who would be eligible for AFDC except for their income or asset levels;
- Newborns whose mothers are Medically Needy;
- Aged, blind, or disabled individuals who would be eligible for SSI except for their income or asset levels; and,
- Relatives taking care of children who are Medically Needy.

Within both the Categorically Needy and Medically Needy categories, some coverage groups are

mandatory and others are optional (Medicaid categories are discussed in greater detail in Appendix A).

More than 261,000 West Virginians received Medicaid benefits in January 1995. Among these



recipients, about 245,000 (94%) were classified as Categorically Needy. The remaining six percent (6%) are classified as Medically Needy. The State of West Virginia has provided the optional Medicaid coverage to the Medically Needy group since 1976.

Starting in 1988, federal mandates began requiring states to expand coverage to include new classes of eligible individuals. For federal fiscal year (FFY) 1994, there were 47,800 recipients (thirteen percent (13%) of the total recipients) who were covered under the federally mandated expansions since 1988. Of this total, over 27,400 were either caretaker relatives of covered recipients or pregnant women. The cost to provide care to this group for FFY 1994 was $203.7 million, or sixteen percent (16%) of the total $1.3 billion budget.

This full performance evaluation of the state Medicaid Program within the Department of Health and Human Resources was conducted in accordance with the West Virginia Sunset Law, Chapter 4, Article 10, Section 11 of the West Virginia *Code* as amended. The objective of this review was to determine if the Department of Health and Human Resources effectively administers the Medicaid program. The evaluation will help the Joint Committee on Government Operations determine the following:

- if the agency was created to resolve a problem or provide a service;
- if the problem has been solved or the service provided;
- the extent to which past agency activities and accomplishments, current projects and operations

and planned activities and goals are or have been effective;

- if the agency is operating efficiently and effectively in performing its tasks;
- the extent to which there would be significant and discernable adverse effects on the public health, safety or welfare if the program were abolished;
- if the conditions that led to the creation of the agency have changed;
- the extent to which the agency operates in the public interest;
- whether or not the operation of the agency is impeded or enhanced by existing statutes, rules, procedures, practices or any other circumstances bearing upon the agency's capacity or authority to operate in the public interest, including budgetary, resource and personal matters;
- the extent to which administrative and/or statutory changes are necessary to improve agency operations or to enhance the public interest;
- whether or not the benefits derived from the activities of the agency outweigh the costs;
- whether or not the activities of the agency duplicate or overlap with those of other agencies, and if so, how the activities could be consolidated;
- whether or not the agency causes an unnecessary burden on any citizen by its decisions and activities;
- what the impact will be in terms of federal intervention or loss of federal funds if the agency is abolished.

The scope of this report focuses on the Department's accuracy in making eligibility determinations for new cases and for reevaluating continuing cases. The Evaluation included a planning process and the development of audit steps necessary to collect competent, sufficient and relevant evidence to answer the audit objectives. Physical, documentary, testimonial and analytical evidence used in the evaluation were collected through interviews, reviews of records and site visitations. The evaluation was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States.

As related to the specific issue addressed in this report, a sample of 455 active Medicaid cases were taken from recipients deemed eligible to receive benefits on October 31, 1995. The date was chosen because it predates initial RAPIDS implementation. This guaranteed that case files would be available for review in paper form. Certain eligibility categories were excluded from the study because the eligibility decision is not made by an economic services caseworker in the county office. Aged, blind and disabled SSI cases were excluded because the eligibility determinations are made at the federal level. Boarding Care or Foster Children cases were excluded because the decision is made by social service caseworkers. Cases with the deprivation factor of Not Medical (NM) were excluded because these cases do not actually receive a medical card, this designation is a bookkeeping code used under the OBRA system.

The cases were evaluated based on Federal guidelines as set forth in the *Income Maintenance Manual*. Eligibility was distilled into three basic components: characteristics; income; and assets. Characteristics are the causal elements which qualify an individual for aid. Characteristics include, but are not limited to, age, absence, disability and pregnancy. Income refers to the applicable income limits for specific coverage groups. Assets refer to the applicable asset limit for specific coverage groups which require an asset test.

The Office of Quality Assurance, within the Department of Health and Human Resources, conducts internal evaluations of the Medicaid program and calculates the sanction rate. Quality Assurance bases the sanction rate on the amount of dollars in error, while this study examines ***cases in error***. This means that if a case reviewed by Quality Assurance is in error, but the client has not consumed benefits, then the error is not reflected in the sanction rate. However, this study was developed to test the accuracy with which eligibility rules are followed at the county level, not to impose federal sanctions. Therefore, all cases in which errors were made in the eligibility determination are included in the results. Quality Assurance has the legal authority to investigate Medicaid cases in greater detail. Unlike the Legislative Auditor, they have the authority to make visitations to the homes of recipients and examine bank records, in order to verify eligibility.

The 455 case files were obtained from county offices and reviewed to determine if the eligibility decision, which rendered the recipient eligible to receive benefits on October 31, 1995, was correct. The determination was made with an instrument designed by the Legislative Auditor to test cases for compliance with state, federal and program guidelines. Audit staff attended Kanawha County eligibility training sessions. These sessions are the standard instructions provided to county caseworkers. Case reviews conducted in county offices were discussed with supervisors.

Interviews were conducted with Department of Health and Human Resources staff. Direct observations of staff were made on a county level. Eligibility rules, standards and manuals were studied and reviewed. To examine the practices and attitudes of caseworkers on the country level, the Legislative Auditor developed a survey in conjunction with Department staff.

ISSUE AREA: Of the Cases Reviewed, Medicaid Eligibility Policy and Procedures were not Followed in 16.5% of the Cases

West Virginia maintains a consolidated eligibility manual which contains the policy and procedures for the State's public assistance programs. The Manual was consolidated in the late 1970's as the *Economic Services Manual.* In 1995, the entire Manual was rewritten and titled the *Income Maintenance Manual.* ***This Manual serves as the authority for all Medicaid eligibility decisions.*** It is updated periodically as required by changes in federal or state laws, clarifications, and other administrative modifications.

To determine whether Medicaid eligibility decisions are made correctly, a sample of 455 cases was drawn from cases eligible to receive benefits on October 31, 1995. Therefore, the cases were evaluated based on policy that was in place prior to the passage of TANF (Temporary Assistance for Needy Families) and West Virginia Works Programs. These cases were evaluated based on Federal and State guidelines as contained in the *Income Maintenance Manual.* Medicaid eligibility can be distilled into three basic components: ***characteristics, income and assets.*** ***Characteristics*** are the properties that qualify someone to receive benefits. These characteristics include, but are not limited to, absence of spouse, age, disability, unemployment and pregnancy. ***Income*** refers to the applicable income limits for each coverage group. ***Assets*** refer to the applicable asset limit for each coverage group (for coverage groups with an asset test).

Of the 455 cases sampled, 75 cases (or 16.5%) were found to contain errors. Errors include: ***incorrect eligibility decisions*** (9 cases representing 12% of the total errors); ***lack of verification such that a proper determination of eligibility could not be made*** (52 cases representing 69.3% of the total errors); ***or the entire file or relevant application/reapplication had been lost*** (14 cases representing 18.7% of the total errors; for a complete list of errors see Appendix B). In cases where an incorrect eligibility decision was made, the most common mistake was that the client's income exceeded the allowable income limit. The remainder of cases which make up this type of error are listed as miscellaneous errors and include: the client's review completed late; client not completing the application; the client moving out of state and the case was not closed on time; and the client not satisfying the necessary qualifications for a particular aid category.

The errors characterized by lack of verification include, 1.) no verification of client's reported income, and the largest error type, 2.) no verification of client's reported assets. The rest of the errors include missing files, applications, or sections of the case record. Of the 75 errors contained in the sample, 81 per cent or 61 cases were the result of a misapplication of eligibility policy (all errors except for lost cases; see Table 1).

Table 1 Summary of Errors by Type		
Type of Error	**Number of Cases**	**% of the 455 Cases Sampled**
No verification of client reported income	7	1.5%
No verification of client reported bank accounts	43	9.5%
Client's income exceeded program limits	6	1.3%
File or relevant application was lost or missing	14	3.1%
Miscellaneous errors	5	1.1%
Total Errors	**75**	**16.5%**

EFFECT

The effect of misapplied policies and procedures is that funds are spent incorrectly. For the 455 cases in the sample, the total expenditures were **$1,239,900**. Cases that contained a correct eligibility decision accounted for **88.20%** of all expenditures or **$1,093,557**. This includes four cases which were miscoded by the worker. Several of these miscoded cases were cases in which the clients income was excessive for the program that the worker placed them in, but their incomes were not excessive for other programs. Therefore, these clients would have still been eligible despite being placed in the wrong category. ***Total expenditures for sampled cases determined to be in error were $146,343 accounting for 11.8% of total sample outlays*** (see Table 2).

Because many of the errors identified in this study were verification errors, to accurately determine dollars in error would have required investigation of personal bank accounts, and other similar inquiries. The Legislative Auditor's Office made no attempt to carry this study to such an extreme. Thus, some verification errors may have no impact in dollars, because had the information been verified the individual may have been positively determined to be eligible. However, nine cases identified in the study were found to be clearly ineligible. These cases accounted for $18,832 in expenditures. Projected to the total population of 106,439 from which the sample was drawn, over $4.4 million was spent erroneously. If one was to make the unreasonable assumption that all errors resulted in ineligible recipient consumption, the projected dollars in error would be $34 million. The Legislative Auditor's Office has no basis to determine the effect of verification errors, but can offer the range of $4.4 to $34 million with reasonable certainty, for the amount that was spent to provide coverage for those who were ineligible but extended coverage on October 31, 1995.

Table 2 Summary of Outlays for Eligibility Sample		
Type of Case	**Total Number of Cases**	**Dollars Consumed**
Correct Cases	376	$1,092,577
Miscoded Cases	4	$980
Total for Correct Cases	**380**	**$1,093,557**
No Verification of Income	7	$3,914
No Verification of Assets	43	$86,552
Client Over Income	6	$9,845
Lost File, Application, or Review	14	$26,420
Miscellaneous Errors	5	$19,612
Total for Error Cases	**75**	**$146,343**
Total Expenditures	**455**	**$1,239,900**

CAUSAL FACTORS

Decentralized and Inconsistent Policy Training

Errors in the sample such as no verification of income, no verification of assets or the client was over income, may be the direct result of insufficient training, especially when each worker is required to handle such a large number of cases. In a letter from the former Acting Commissioner of the Bureau for Children and Families, policy knowledge of the field staff was addressed. The former Commissioner stated that "***there has been a lack of centralized, consistent policy training offered to field staff*** over several years that has created an additional burden on field supervisors."

One reason why training is inconsistent is the lack of a statewide consolidated training manual. Each trainer would have instructed each worker with their own interpretation of the *Income Maintenance Manual.* In 1995 two regional trainers were in place. Region I has had a regional trainer since 1992, Region II since 1991. For the remaining two regions, Region III and Region IV, ***each of the supervisors*** were responsible for training in their respective offices. Since training was the responsibility of individual supervisors, over twenty-seven (27) different people (two regional trainers and 25 supervisors for Regions III and IV) would have been charged with the training of their staffs. In 1995 there were 468 workers. This means that each individual would have been in charge of training an average of 17 individuals, each instructor teaching a different format of the 35

entrances into the Medicaid program. Interpretation of the *Income Maintenance Manual* varies from supervisor to supervisor. A policy survey was conducted among the Economic Service Supervisors. This survey was faxed to each of the supervisors in the county offices. The survey contained a question regarding the verification of assets (the single largest source of errors). The question dealt with the necessity of verifying bank accounts. The policy states that for programs which have an asset test, all bank accounts must be verified at application and when a change is reported. This is regardless of the amount contained in the bank account. Of the 39 supervisors responding to the survey **14 (36%)** posted responses that were inconsistent with policy. Table 3 contains a sample of responses to the survey questionnaire.

Table 3 **Supervisor's Responses from Policy Survey**
"We do not verify bank accounts reported to be below $100."
"Unless there are other assets beside checking and savings we normally do not verify the assets if the customer states that these accounts are for depositing their monthly checks and for paying their monthly bills and the current balance is below $100."
"Verification of assets is being done at the workers discretion depending on the amount and the client involved. The workers verify all questionable assets."
"If the combined assets are near the maximum asset level and the worker questions the amount in the bank accounts, it can be verified."
"Bank accounts of this nature are not routinely verified. However, if the worker believes there may be a problem then verification is requested. Also if there are other assets involved which are near the asset maximum, then bank verification may be needed."
"We verify the bank accounts if the assets are close to the countable assets for the program for which they are applying. We verify all Nursing Home bank accounts and Medicaid Waiver bank accounts."
"We have always verified any information that we question. We have verified bank accounts much lower than $100 if we question the validity of a customer's statements."
"For medical coverage groups with an asset test and a small bank account may need verified because if it puts the case over the asset limit then the case would be ineligible and the customer would not get the benefit of the Medical help."

Income Maintenance Manual difficult to understand

Errors in the sample such as no verification of income, no verification of assets or income over the allowable limit, may be caused by a confusing reference tool. Medicaid policies are inherently complex and difficult to understand. This was one reason why the *Income Maintenance Manual* was

compiled in 1995. The *Income Maintenance Manual* is designed to be a ready-reference tool. This Manual is two volumes and 23 chapters. Each volume is three inches thick. It has had 75 updates since 1995. The former Director of the Policy Unit stated that the Manual needs to be updated whenever eligibility changes are required due to changes in laws, clarifications, or other administrative modifications.

The policy contained in the *Income Maintenance Manual* is not in a format that is user friendly. To determine if someone would have been eligible for AFDC, one would need to refer to the following chapters:

- Chapter 8 - this chapter contains the common eligibility requirements for AFDC/U, Food Stamps, and Medicaid.
- Chapter 15 - this chapter contains the specific requirements for AFDC/U. This chapter explains the necessary deprivation factors.
- Chapter 9 - this chapter explains whose income to count, who to included in the benefit group, and what the family size should be.
- Chapter 10 - this chapter explains what to count as income and applicable income limits.
- Chapter 11 - this chapter explains what counts as an asset and applicable asset limits.
- Chapter 4 - this chapter explains what should be verified.

This needs to be done at intake and does not take into account whether or not the person is eligible for Food Stamps. It also does not take into account whether the person would have to quarterly report nor does it account for any other aspect of the case maintenance process.

The *Income Maintenance Manual* is difficult to understand because it contains both policies and procedures. Many of these procedures are now performed automatically by RAPIDS. This issue is now being addressed by the RAPIDS team and the Policy Unit who plan on putting the Manual completely on-line on RAPIDS. The Director of the RAPIDS project offered the following comments:

> *One of the issues yet to be resolved is the detail to be included in the on-line manual. The present Income Maintenance Manual is a policy and procedure manual. The decision has not yet been made as to the necessity of having procedures in the on-line manual other than those procedures that are carried out external to the system. Once that decision is made, the process of putting the material together to up-load to RAPIDS will begin. The target for the new manual development has been moved back to January, 1998 due to the necessary work for both the Policy Unit and RAPIDS team relating to welfare reform.*

However, simply extracting the procedure portion from the Manual will not solve the problem. Once you have located the applicable policy, the difficulty is not over. Consider the following excerpt from the Manual:

The Social Security Act provides for the crediting of quarters of coverage based on yearly earnings including deemed military wages (the amount of deemed military wages must be determined by the SSA) divided by the amount required to qualify a calendar quarter as a quarter of coverage. ...However, special treatment is required if the individual is self-employed. If the taxable year is a calendar year, or begins with or during a calendar year, and ends with or during the same calendar year, the self-employment income will be credited to that calendar year. If the taxable year is not a calendar year, the self-employment income will be allocated proportionately to the two calendar years, of which portions are included in the taxable year, on the basis of the number of months which are included completely within the taxable year.

The current format of the Income Maintenance Manual serves only to provide the information without regard to the reader's circumstances. Although Medicaid policy is complex, it is no more inherently complex than tax law, yet a tax form is constructed so that most citizens can complete it without previous tax training. A tax form is designed to guide the user, not just distribute information. Consider the previous example of quarters of coverage in a new format:

Quarters of Coverage: Is the applicant self employed? If **yes,** go to Section B, if **no,** go to Section A.

Section A:
Step 1 - Add Yearly Earnings ***plus*** deemed military wages (as determined by the SSA).
Step 2 - Take the amount from step 1 and ***divide by*** the amount required to qualify a calender quarter as a quarter of coverage.
Quarter of Coverage = (yearly earnings + deemed military wages) ÷amount required to qualify a calender quarter as a quarter of coverage

Section B:
step 1- Is the taxable year a calendar year? If **yes**, go to step 3, if **no**, proceed to step 2.
step 2- Is the taxable year fall completely within a calendar year? If **yes**, go to step 3, if **no**, go to Section C.
step 3- Consider the self-employment income to be yearly earnings and go to step 4.
step 4 - Add Yearly Earnings ***plus*** deemed military wages (as determined by the SSA).
step 5 - Take the amount from step 4 and ***divide by*** the amount required to qualify a calender quarter as a quarter of coverage.
Quarter of Coverage = (yearly earnings + deemed military wages) ÷amount required to qualify a calender quarter as a quarter of coverage

Section C: Allocate the self employment income to the two years covered using the following formula:
Year 1
step 1 - Divide the number of months worked during the first calender year by 12.
step 2 - Multiply the self-employment income by the number from step 1. This is the yearly earnings

for year 1.
step 3 - Add Yearly Earnings ***plus*** deemed military wages (as determined by the SSA).
step 4 - Take the amount from step 3 and ***divide by*** the amount required to qualify a calender quarter as a quarter of coverage.
Quarter of Coverage for year 1 = (yearly earnings + deemed military wages) ÷amount required to qualify a calender quarter as a quarter of coverage

Year 2
step 1 - Divide the number of months worked during the second calender year by 12.
step 2 - Multiply the self-employment income by the number from step 1. This is the yearly earnings for year 2.
step 3 - Add Yearly Earnings ***plus*** deemed military wages (as determined by the SSA).
step 4 - Take the amount from step 3 and ***divide by*** the amount required to qualify a calender quarter as a quarter of coverage.
Quarter of Coverage for year 2 = (yearly earnings + deemed military wages) ÷amount required to qualify a calender quarter as a quarter of coverage

This revision would save the caseworker time in two ways. First, it limits the text that needs to be read to only portions of the policy that apply. Second, it eliminates the time it would take the reader to determine what policy needed to be applied. If an online manual were developed in this manner, it could produce on-line prompts which would save more time and increase accuracy by telling the reader exactly which information to supply or insert.

Levels of supervisor case review insufficient

Errors in the sample such as no verification of income, no verification of assets or the client was over income, may be the direct result of lack of supervisor case review. In an environment where policy is complex and always changing, knowledge levels are suspect, supervisor review is even more essential. However, in a letter from the Secretary of the Department of Health and Human Resources, the Secretary stated that "from 1994 through February 1996 mandatory supervisory reviews required the review of *5* ***Medicaid cases by every supervisor every month***. The supervisors were instructed to review cases that in their judgement were error prone." In 1995 there were 42 Economic Service Supervisors. If each supervisor reviewed 5 Medicaid cases a month, then the total number of Medicaid cases reviewed would have been 210 cases per month. Assuming that each supervisor reviewed different cases each month, then the total number of Medicaid cases reviewed during the year would have been 2,520 cases. In 1995 the total number of Non-Assistance (medical assistance only) Medicaid cases was 125,837. ***This means that the supervisors were required to review two per cent (2%) of Medicaid cases*** (see Table 4).

Table 4 **Summary of Medicaid Cases Reviewed for 1995**	
Total Number of Economic Service Supervisors	42
Number of Cases Reviewed in One Year (assuming no case was reviewed twice in the same year)	2,520
Total Number of Medicaid Cases for SFY 1995	125,837
Percentage of Cases Reviewed	**2%**

In addition to the five Medicaid cases, each supervisor was to review 20 AFDC cases. Applying the same analysis techniques found above yields slightly different numbers. If each supervisor reviewed 25 public assistance cases a month (5 Medicaid and 20 AFDC), then the total number of public assistance cases reviewed would have been 1,050 cases per month. Assuming that each supervisor reviewed different cases each month, then the total number of public assistance cases (Medical Assistance Only and AFDC) reviewed during the year would have been 12,600 cases. In 1995 the total number of public assistance cases was 263,907. ***This means that the supervisors were required to review less than five per cent (5%) of all public assistance cases*** (see Table 5).

Table 5 Summary of Public Assistance Cases Reviewed for 1995 (Medical Assistance Only and AFDC)	
Total Number of Economic Service Supervisors	42
Number of Cases Reviewed in One Year (assuming no case was reviewed twice in the same year)	12,600
Total Number of Medicaid Cases for SFY 1995	263,907
Percentage of Cases Reviewed	**5%**

However, in a letter dated June 1, 1995 the Director of the Office of Family Support wrote the following:

> *It has come to my attention through conversation with my staff and from a recent USDA Corrective Action Monitoring Report* ***that not all Supervisors are completing the reviews or are completing less than the required number****. I would like to remind you that this activity is considered mandatory for all Supervisory Staff that supervise line staff directly. If the time factor is a problem, we recommend that only the error prone elements listed be checked. These elements account for 66% of the dollar errors in the Food Stamp Program. We are looking for optimum results for*

*the time involved....**I am sure you would agree that consistent and uniform application of basic corrective action is the key to successful reduction in the error rate in West Virginia.***

The Secretary further stated that "the Department of Health and Human Resources ***discontinued*** mandatory case record reviews when RAPIDS was implemented. These reviews became obsolete as the paper record now contains old information." There are two regions currently implementing experimental case reviews in RAPIDS. Due to the newness of each of these methods of supervisor review, there is no data currently available as to their effectiveness.

Lost Cases

Another factor contributing to the error rate is the number of lost cases. Nineteen per cent (19%) of the error cases are cases where either the file was lost, a particular application was lost or sections of the case record were lost. In one instance, one of the DHHR offices had recently changed locations and some of the case records were lost. Another possible explanation is that some of the older material contained in the case records had been purged. Some of the recipients may have moved from county to county and the case records were lost in the transfer. The final possible explanation is the sheer bulk of case records on hand makes it difficult to store the records properly.

Other Potential Causes

One potential cause is caseload. In March 1993 the Department of Health and Human Resources (DHHR) established a caseload standard. ***The caseload standard was set at 360 cases.*** In 1994 the average number of cases per worker per county, based on allocated positions, ***exceeded the standard by 218 cases.*** In 1995, the average number of cases per worker per county ***exceeded the standard by 166 cases*** (see Table 6). In 1996 the county offices began converting cases to RAPIDS. Since RAPIDS does not track recipients the same way as the C-219 and M-219 eligibility systems, current caseload information was not available.

Table 6 Summary of Caseload Data		
Year	**1994**	**1995**
Total Number of Allocated Positions	487	516
Total Number of Cases	243,929	263,907
Average Number of Cases per Worker per County	565	513
Caseload Standard	360	360
Average Number of cases in excess of standard	218	166
Source: *Department of Health and Human Resources, Office of Audit Research and Analysis*		

To help manage the caseload, the Department has developed a new data system that will automate much of the case maintenance process. This will allow the case worker to handle a larger caseload. Also, welfare reform will work to lower the caseload that each worker has by removing recipients from the welfare role.

In addition to the causes above, there may be additional causes for errors which there is currently no evidence to support. For example, there may be cases where the client is over income by some small amount and the caseworker simply overlooked the excess income. There may also be circumstances when a caseworker looks upon a task with apathy. This could affect cases where the client claimed a bank account with a very small balance and the caseworker did not think that it would affect the client's eligibility.

CONCLUSION

This study found 75 of 455 sampled cases to be in error representing 16.5% of the cases examined and 11.8% of the spending identified in the sample. Dollars in error are projected to range between $4.4 and $34 million for those who were ineligible but extended coverage on October 31, 1995. The lower end of the range is more likely. Given the ever present threat of withdrawal of federal support, depleted Medicaid Trust Fund and escalation of medical costs the Department and the State must work to eliminate this waste. The Medicaid program can little afford to provide coverage for ineligibles.

Recommendation 1:

The Department of Health and Human Resources should conduct a needs assessment to measure where training is lacking in both preservice and in service. Training modules should be developed to fill the training gaps and standardize training for basic operations.

Recommendation 2:

The Department of Health and Human Resources should develop a stepwise policy manual with a decision tree format that will eliminate interpretation differences and facilitate easy reference.

Recommendation 3:

The Department of Health and Human Resources should develop a new method of supervisor case review and ensure that the level of review is sufficient.

APPENDIX A
MEDICAID CATEGORIES

APPENDIX A MEDICAID COVERAGE GROUPS	
Categorical Mandatory	
AFDC Recipients	All individuals whose needs are included in an AFDC payment.
Deemed AFDC recipients	People who do not receive a cash payment solely because the amount would be less than $10. Families which lose AFDC eligibility as a result of receiving child or spousal support must receive Medicaid for four months if they received AFDC in at least three of the previous six months. Children covered under Title IV-E Adoption Assistance or Title IV-E Foster Care payments.
Transitional Medicaid	Provides Medicaid coverage for families that lost AFDC eligibility because of an increase in or beginning of earned income, an increase in the number of hours the caretaker relative works, or loss of earned income disregards. Medicaid benefits are automatically extended for six months. The family continues to be eligible for up to six additional months as long as the total, gross, monthly income is less than 185% of the Federal Poverty Level (FPL). To qualify the family had to have received AFDC in at least three of the last six months prior to the change.
Pregnant Women and Infants	Pregnant women and infants under the age of one with family income at or below 150% FPL.
Qualified Children	Children under age 19, but born on or after 10/1/83 if the child would qualify for the AFDC based solely on the income test. Waivers allow West Virginia to waive an asset test and to disregard all income between the AFDC payment level and 100% FPL +$1.
Poverty Level Children Ages 1-5	Children at least age one but not yet six who were born on or after 10/1/83 and whose family income does not exceed 133% FPL.
Poverty Level Children Ages 6-18	Children at least age six but not yet 19 who were born on or after 10/1/83 and whose family income does not exceed 100% FPL.
Newborn Children	Children born to women who are eligible for and receiving categorically needy Medicaid on the date of the child's birth and are deemed eligible (or would remain eligible if pregnant) and the child remains in the household with the mother. Changes in the mother's income do not affect the infant's eligibility because if the mother were still pregnant, the mother would remain eligible.

SSI Recipients	All individuals who receive a Supplemental Security Income (SSI) check, including those pending a final determination of disability or blindness or pending disposal of excess property under agreement with SSA.
Deemed SSI Recipients	Disabled adult children are individuals at least 18 years old who lost SSI eligibility by becoming eligible for RSDI benefits or for an increase in those benefits due to blindness or a disability that began before they reached age 22. Individuals who are under age 65 and severely disabled who are gainfully employed and who lose eligibility for SSI due to earnings. Essential spouses are individuals who were eligible for SSI Medicaid in December 1973 as essential spouses and who continue to live with the SSI recipient. The recipient must continue to meet the December 1973 eligibility requirements and the spouse must continue to meet the December 1973 requirements for having his or her needs included in computing the SSI check amount. Pass-Through individuals are those who would be eligible for SSI except for the 20% increase in RSDI which occurred in 1972. They must have been eligible for and received an RSDI payment August 1972. This includes individuals who would have been eligible for an RSDI check in August 1972 if they had applied or if they had not been in a medical institution. Another group of pass-through individuals is referred to as "Pickles." These are individuals who receive RSDI, but who lost SSI eligibility following the cost of living (COLA) increases received after April 1977. They would still be eligible for SSI if all the COLA increases were deducted from income, regardless of the reason they lost SSI eligibility. Disabled widows and widowers are individuals who would be eligible for SSI except for the increase in RSDI benefits resulting from the elimination factor in 1983. In addition, they were entitled to RSDI in December 1983 and received disabled widows' benefits and SSI in January 1984. They must have applied for this coverage no later than July 1, 1988. Disabled widows and widowers and disabled, unmarried, divorced spouses (married for at least 10 years if they are at least age 50) must be eligible for Medicaid when they: receive RSDI; lost SSI eligibility as a result of RSDI benefits; receive SSI in the month before RSDI benefits started; would be eligible for SSI if RSDI payments were not counted as income; and, they are not eligible for Medicare, Part A.
Qualified Medicare Beneficiaries (QMB)	Aged (65) or disabled individuals who qualify for Medicare Part A, whose income does not exceed 100% of the FPL and whose assets do not exceed $4,000. Coverage is limited to Medicare cost-sharing expenses. A special yellow medical card is issued to limit coverage.

Specified Low-Income Medicare Beneficiaries (SLIMB)	Individuals who would be eligible for Medicaid as a QMB except for income. Their income must not exceed 110% of FPL in 1993 and 1994 and 120% of FPL in subsequent years. Coverage is limited to payment of Part B Medicare premiums. No medical card is issued.
Qualified Disabled and Working Individuals	Individuals who are disabled but employed and who are entitled to enroll in Medicare Part A. Their income cannot exceed 200% of FPL. Their resources must not exceed $4,000 and they must not be eligible for Medicaid under any other coverage group. Coverage is limited to the payment of the Medicare Part A premium. No medical card is issued.
Categorical Optional	
Individuals Receiving Home and Community-Based Services	Individuals who would be eligible for Medicaid if institutionalized and who would require institutionalization if not for home and community-based services. Individuals may be elderly/disabled or mentally retarded/developmentally disabled. Must be cost-effective as an alternative to institutionalization.
Adoption Assistance Other than Title IV-E	Special needs children under age 21 who have state adoption assistance agreements in effect (other than Title IV-E) and who cannot be placed for adoption without Medicaid.
Children with Disabilities Community Services (formerly TEFRA)	Children (18 or younger) who qualify as disabled under SSI and who would qualify for Medicaid if they were in an institution. They must require a level of care provided in a hospital, nursing facility or ICF/MR and it must be appropriate to provide care at home. The cost of care at home must not exceed the cost of care in an institution.
Medicaid Expansion	Children made eligible for Medicaid under WV H.B. 5008 are optional under federal law. As of FFY '95 children 12-18 whose income does not exceed 100% FPL.
Medically Needy Mandatory Coverage	
Children under 18	Children under 18 (or under 19 if still in school and expected to graduate before 19th birthday) who meet all eligibility requirements for AFDC except that income/assets are excessive. If countable income is below the Medically Needy Income Level (MNIL), there is no spend down to become eligible.

Newborns	Newborns of women who are eligible for and receiving Medically Needy coverage on the date the child is born. The child is deemed to have filed an application and been found eligible on the date of birth and remains eligible for one year as long as he is in his mother's household, and the woman remains eligible, or would remain eligible if still pregnant.
Aged, Blind or Disabled Individuals	Aged, blind or disabled individuals who meet all eligibility requirements for SSI except that income is excessive. If countable income is between the AFDC/U payment level and the MNIL, there is no spend down. If countable income exceeds the MNIL, the client must spend down to become eligible.
Medically Needy Optional Coverage	
Caretaker Relative	The caretaker relatives of the children under 19 described under Medically Needy Mandatory.
SOURCE:	Program Descriptions from the Bureau for Medical Services, Department of Health and Human Resources.

APPENDIX B
DESCRIPTION OF IDENTIFIED WORKER ERRORS

APPENDIX B Description of Identified Worker Errors	
Index #	**Description of Error**
35	On the November 1994 application the client reported $1,620 in monthly income and this amount was not verified by the caseworker.
17	On the September 1995 application the client reported $600 in monthly income and this amount was not verified by the caseworker.
133	On the March 1995 application, client reported $609 in Social Security income and this amount was not verified by the caseworker.
188	On June 1995 application, client reported $450 in earned income and this amount was not verified by the caseworker.
31	On June 1995 application, client reported a checking and savings account and these were not verified by the caseworker.
378	On August 1995 application, client did not circle yes or no for checking account and the caseworker neglected to have the information completed.
236	On November 1994 application, client reported a checking account and it was not verified by the caseworker.
246	On April 1995 application, client reported a checking account and it was not verified by the caseworker.
40	On January 1995 application, client reported a checking account and it was not verified by the caseworker.
303	On April 1995 application, client reported a checking account and it was not verified by the caseworker.
71	On June 1995 application, client reported a savings account and it was not verified by the caseworker.
272	On April 1995 application, client reported a checking account and it was not verified by the caseworker.
261	On April 1995 application, client reported a checking account and it was not verified by the caseworker.
169	On July 1995 application, client reported a checking and savings account and these were not verified by the caseworker.
6	On December 1994 application, client reported a checking account and it was not verified by the caseworker.

262	On June 1995 application, client reported a checking account and it was not verified by the caseworker.
258	On August 1995 application, client reported a checking account and it was not verified by the caseworker.
403	On August 1995 application, client reported a checking and savings account and these were not verified by the caseworker.
13	On January 1995 application, client reported a checking account and it was not verified by the caseworker.
289	On August 1995 application, client reported a checking and savings account and these were not verified by the caseworker.
103	Caseworker failed to put client in phase two of transitional Medicaid as of June 1995. Income report form not sent in resulting in recipient being ineligible from September 1995 to December 1995.
239	On May 1995 application, client reported no income. Two months later, client reported $2,386 in projected income and the QC case was not re-evaluated. This amount of income would have exceeded the maximum allowable limit making the client ineligible for any program.
267	On April 1995 application, client reported earned income of $1,397 and unearned income of $147. If you deduct the $90 work allowance this leaves an income of $1,454 which exceeds the maximum allowable limit making the client ineligible for any program.
406	Client's two month postpartem period ended in September 1995 and her re-evaluation was not done until November 1995 making the client ineligible for a period of two months.
300	Client reported moving out of state in August 1995 and case was not closed until May 1996.
109	Client reported that she receives SSI making the client ineligible for the PS aid category since one requirement is not receiving SSI.
367	On August 1995 application, client reported a savings account and it was not verified by the caseworker.
448	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
601	On April 1995 application, client reported a savings account and it was not verified by the caseworker

604	On March 1995 application, client reported a checking account and it was not verified by the caseworker
608	On August 1995 application, client reported a checking account and it was not verified by the caseworker
617	On April 1995 application, client reported a checking account and it was not verified by the caseworker
623	On June 1995 application, client reported a checking account and it was not verified by the caseworker
626	On a November 1994 application, client reported a checking account and it was not verified by the caseworker
641	On June 1995 application, client reported a savings account and it was not verified by the caseworker
652	On an August 1995 application, client reported a checking account and it was not verified by the caseworker
655	On an August 1995 application, client reported a checking and a savings account and it was not verified by the caseworker
662	On a September 1995 application, client reported a checking account and these were not verified by the caseworker
665	The client had an AFDC case open with absence as the deprivation factor. On September 1994 the client reported that her husband moved back into the home and the workers closed her AFDC case and opened a QC case and never verified the father's income.
686	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
703	The client was receiving services based on poverty level pregnancy and there was no verification of pregnancy.
705	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
718	On a February 1995 application, client reported a bank account and it was not verified by the caseworker
720	On a September 1995 application, client reported a savings account and it was not verified by the caseworker
726	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.

729	On a July 1995 application, the client's income was calculated to be $1,056.68. If you combine this with $148 in child support for that child, then the client was over the income limit of $1,050.
730	On an August 1995 application, client reported a checking account and it was not verified by the caseworker
758	On a June 1995 application, client reported a checking account and it was not verified by the caseworker
762	On a September 1995 application, client reported a checking and savings account and it was not verified by the caseworker
763	On an October 1995 application, client reported a checking account and it was not verified by the caseworker
770	On an August 1995 application, client reported a checking account and it was not verified by the caseworker
774	On a June 1995 application, client reported a checking account and it was not verified by the caseworker
776	On a June 1995 application, client reported a bank account and it was not verified by the caseworker
777	On the client's November 1994 application, the information relating to earned and unearned income was left blank and the worker failed to require the applicant to complete it.
782	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
785	On a December 1994 application, client reported a bank account and it was not verified by the caseworker
799	On an August 1995 application, the client reported $300 weekly in earned income and this amount was not verified.
808	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
817	On a September 1995 application, client reported a checking and savings account and these were not verified by the caseworker
818	On a January 1995 application, client reported a checking account and it was not verified by the caseworker
819	On a January 1995 application, the client reported that she was working and her income was not verified.

826	On a May 1995 application, client reported a checking account and it was not verified by the caseworker
836	On a June 1995 application, the client's income was calculated to be $1,625.40 which is greater than the allowable limit of $1,263.
856	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
857	On a February 1995 application, client reported a bank account and it was not verified by the caseworker
859	On a May 1995 application, the client's income was calculated to be $2,530 which is greater than the allowable amount of $1,894.
866	On a September 1995 application, client reported a bank account and it was not verified by the caseworker
874	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
876	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
877	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
879	On a July 1995 application, client reported a checking account and it was not verified by the caseworker
880	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
881	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
882	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.
889	Either the entire file was lost or the relevant application was lost preventing a correct evaluation from being made.

APPENDIX C
MEDICAID CASE REVIEW INSTRUMENT

Individual's Data (from MMIS printout)

Name____
SS# (indicate if none) ____
Recipient #____
Certificate # (from file log # should match Recipient #) ___________________
Date of Birth_________________________
Gender______________________________
Application Date_____________________
Beginning Date______________________
End Date____________________________
Cancellation Reason__________________
County File Kept in _________________

Which system is data under(will determine which code appendix to use)?
C219(10) _____ .... M219(20)_____

Aid Category_______________
Aid Category Description_______________________________
Category under which recipient is eligible. Compare MMIS Aid Category found in Appendix F and the alpha prefix of the Certificate # found in the Income Maintenance Manual Ch.23. If they are different note below

____

____

____

Deprivation Code ______________
Deprivation Code Description____________________________
(reason for eligibility)

What are the category requirements (see Requirements column of Appendix HES)

Which of these requirements did the recipient meet (see case file)? See Income Maintenance Manual 4.2. for required verification. Indicate whether the answer was in the negative and therefore did not require verification.

Requirement	Required Verification	Verification Obtained

Income

In the table below provide information for the income group (HES Appendix), applicable income deductions (HES Appendix), needs group and FPL. Also, attach applicable worksheets.

Requirement	Actual	Verification

Assets

What are the asset requirements for this category of aid (see assets Appendix HES)?

What is the applicant's asset level?

See Income Maintenance Manual 4.2 and case file.

Required verification	Verification that was in file

Was the eligibility decision correct? Yes______ No_______

Describe why the eligibility decision was incorrect.

____

____

____

____

Identify any errors that did not affect the eligibility decision.

____

____

____

____

APPENDIX D
AGENCY RESPONSE

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Secretary
State Capitol Complex, Building 3, Room 206
Charleston, West Virginia 25305
Telephone: (304) 558-0684 Fax: (304) 558-1130

Cecil H. Underwood
Governor

Joan E. Ohl
Secretary

December 10, 1997

RECEIVED
DEC 10 1997
RESEARCH AND PERFORMANCE EVALUATION DIVISION

Antonio E. Jones, Ph.D.
Office of Legislative Auditor
Performance Evaluation and Research Division
Building 1, Room 314W
Charleston, West Virginia 25305

Dear Dr. Jones:

In general, we agree with the methodology and findings of the Full Performance Evaluation of the Department of Health and Human Resources - Medicaid, dated December 1997. We appreciate the opportunity to respond to the report.

The suggestion that the error rate may translate from $4.4 million to $34 million is well explained in the report, but we want to emphasize that the higher figure would occur if every technical error that was found produced an ineligible case. Actually, our experience assures us that the income errors noted as the basis for the extrapolation amounting to $4.4 million is an appropriate assumption. The other technical errors that cause the extrapolation to range to $34 million are not the basis for a reasonable assumption. Those errors rarely cause ineligibility in cases.

DHHR has a very effective Quality Assurance Program that samples all cases with a thorough review by staff devoted solely to that responsibility. The detected errors are analyzed and considered by a Corrective Action Panel (CAP) comprised of state office and field staff. The CAP makes recommendations for policy and procedural changes based on the members' collective skill and experience, as well as the analyses. The problems noted by the PERD in its review of the status of 1995 Medicaid eligibility decisions generally reflect the same problems found by DHHR Quality Assurance staff for that same period.

Addressing each of the findings of the PERD Report, we offer the following comments:

<u>Finding 1</u>: **Workers are not verifying income and/or assets. If they are verifying they are not documenting this information in the case record.**

<u>Response:</u> *This problem is one that has been cited in Error Review Committee meetings because the Quality Assurance reviewers have indicated that workers are not completing case recordings that indicate how they have arrived at a decision. At the Corrective Action Panel meeting, this issue also was discussed because workers are not using the Case Comments section in RAPIDS. A recommendation has been made to make Case Comments a mandatory entry in RAPIDS.*

Finding 2: The Income Maintenance Manual is complex and should be simplified.

Response: *We agree. The review period was particularly troublesome in that regard because the manual was completely redeveloped in 1995.*

Finding 3: Staff training needs to be improved.

Response: *We agree and are working to improve that situation.*

Finding 4: Supervisory review process needs to be expanded.

Response: *We also agree and plan to emphasize not only the error detection process, but the process of using supervisory review to obtain indicators of training and management needs.*

Summary of findings:

Most of the cases found in error by PERD were due to lack of verification and this issue will be addressed by DHHR by issuing a notice to field staff that the verification requirements listed in the manual must be followed. Workers also need to document the cases by using Case Comments and following established verification requirements.

The report also discussed missing case records. This could have occurred due to purging of records, county transfers, natural disasters such as the flood, and offices moving to a different location. With the implementation of RAPIDS and the interactive interview, this problem will be reduced.

In response to their recommendations, the following is provided:

Recommendation 1: The Department of Health and Human Resources should conduct a needs assessment to measure where training is lacking in both preservice and inservice. Training modules should be developed to fill the training gaps and standardize training for basic operations.

Response: *Each region now employs a regional trainer. These trainers work together to develop training agendas that meet the needs of the employee, program requirements and payment accuracy goals.*

Recommendation 2: The Department of Health and Human Resources should develop a stepwise policy manual with a decision tree format that will eliminate interpretation differences and facilitate easy reference.

Response: *The recommendation about the Income Maintenance Manual format will be evaluated. Conversion to the new automated eligibility determination system, RAPIDS, should reduce this problem. The policy manual was recently revised with the intent of providing field staff with a better reference guide. Unfortunately, the federal regulations governing the Medicaid program are very complicated and cannot be easily interpreted. We do solicit input from local offices and manual users on suggestions for improvements in the policy manual.*

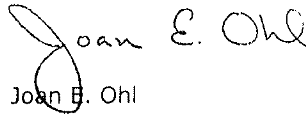
<u>Recommendation 3</u>: **The Department of Health and Human Resources should develop a new method of supervisor case review and ensure that the level of review is sufficient.**

<u>Response:</u> The Department is currently evaluating procedures to revise the supervisory review process including the number of cases to be reviewed, content of the review and other relevant factors.

In order to correct the error cases cited in the report, the PERD needs to identify the cases by name and county rather than the control number used by PERD.

Thank you for the opportunity to review the report and provide comments.

Sincerely,



Joan E. Ohl
Secretary

JEO:cms

FULL PERFORMANCE EVALUATIONS FOLLOWING COMPLIANCE MONITORING AN FURTHER INQUIRY

Division of Personnel
Division of Rehabilitation Services