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NEWS RELEASE

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FOR RELEASE March 8, 2010

Auditor of State David A. Vaudt today released a report on the eligibility requirements for the Medicaid program administered by the Department of Human Services (DHS) for the period July 1, 2006 through December 31, 2008. The review was conducted in conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa* to determine whether Medicaid eligibility is properly evaluated under the Family and Child Medical Assistance programs within Medicaid and whether changes in recipients' eligibility are properly monitored and documented.

The Medicaid program is under the direction of the Iowa Medicaid Enterprise within DHS (DHS-IME). Medicaid is a state administered program which provides medical assistance for families and individuals with low incomes and resources. According to the DHS Medicaid Manual, the State of Iowa has 28 eligibility groups, each with its own eligibility requirements. This review focused on the Family Medical Assistance Program (FMAP) and the Child Medical Assistance Program (CMAP). FMAP is a program available to parents or specified relatives who have a dependent child living in the household in need of medical expense assistance. CMAP is a program for children under 21 years of age who are income eligible for FMAP but do not meet the FMAP requirements of living with a parent or specified relative.

DHS-IME provided a database of all FMAP and CMAP recipients from which certain recipients were selected for review. The related case files were reviewed to determine if income eligibility requirements were being properly evaluated. Vaudt reported the recipients tested complied with the income eligibility requirements and income limits were properly calculated.

Vaudt also reported personnel from 8 DHS County Offices were interviewed to obtain an understanding of the income eligibility evaluation process and to determine if standardized procedures were in place. Vaudt reported the review identified DHS County Offices are relying on Medicaid recipients to accurately report information affecting income eligibility, such as marital status, household size, bank accounts and employment status, on the initial application and/or annual review form and as any changes to the reported information occur. Because there are no independent verification procedures established, if an individual reported inaccurate information, the individual would more than likely receive Medicaid assistance for which he/she is not eligible. In addition, because no verification is performed at a recipient's annual review, the ineligible recipient

could continue to receive benefits for an extended period of time. Also, Vaudt reported standardized procedures are not used to evaluate income and perform reviews at the DHS County Offices.

The report includes recommendations to strengthen DHS-IME's internal controls to ensure income reported by Medicaid recipients is independently verified to determine accuracy and to ensure DHS County Offices follow standardized procedures.

A copy of the report is available for review in the Office of Auditor of State and on the Auditor of State's web site at http://auditor.iowa.gov/specials/index.html.

# # #

A REVIEW OF ELIGIBILITY REQUIREMENTS FOR THE FAMILY AND CHILD MEDICAL ASSISTANCE PROGRAMS UNDER THE MEDICAID PROGRAM ADMINISTERED BY THE DEPARTMENT OF HUMAN SERVICES

FOR THE PERIOD
JULY 1, 2006 THROUGH DECEMBER 31, 2008

0960-4010-BOP5

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Auditor's Transmittal Letter

To the Governor, Members of the General Assembly and the
Director of the Department of Human Services:

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*, we have conducted a review of the compliance with eligibility requirements established by the Iowa Medicaid Enterprise (IME) within the Department of Human Services (DHS) for the period July 1, 2006 through December 31, 2008. Specifically, we determined whether selected recipients of the Family Medical Assistance Program (FMAP) and the Child Medical Assistance Program (CMAP) were eligible for coverage and whether recipients' case files were properly maintained. We also determined whether DHS sufficiently monitored recipient cases for income changes affecting eligibility and whether any overpayments occurred due to income changes affecting eligibility which were not identified by DHS. In conducting our review, we performed the following procedures:

(1) Interviewed personnel from DHS to gain an understanding of the FMAP and CMAP Medicaid programs and the Medicaid eligibility requirements for those programs.

(2) Reviewed applicable laws, rules and guidelines.

(3) Obtained a database from DHS-IME listing all FMAP and CMAP recipients to judgmentally select individuals to test eligibility requirements for the period July 1, 2006 through December 31, 2008.

(4) Reviewed the recipients' case files to determine the income reported on the applications and any other notifications of income changes for the recipients' households.

(5) Reviewed the recipients' case files to determine if wage reports, pay stubs, employee earnings reports or income tax forms were properly included.

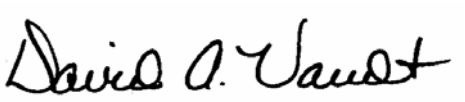
(6) Compared total income from each recipient's household to the Medicaid income eligibility requirements to determine if assistance was properly received.

(7) Reviewed the recipients' case files to determine if DHS sufficiently monitored recipient cases for income changes affecting eligibility and if assistance was properly modified based on any changes occurring.

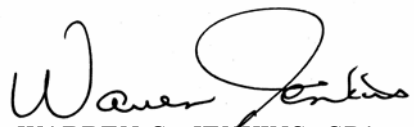
(8) Interviewed personnel from select DHS County Offices to gain an understanding of income eligibility requirements and verification procedures and to determine if all DHS County Offices follow standardized procedures.

Based on these procedures, we identified certain internal control weaknesses at the DHS County Offices, including reliance on the Medicaid recipients to accurately report information affecting income eligibility, such as marital status, household size, bank accounts and employment status. Procedures are not in place which provide independent verification of the information provided. We also identified inconsistency in the implementation of reviews and recalculation of income. We have developed certain recommendations and other relevant information we believe should be considered by officials of the Department of Human Services.

We extend our appreciation to the management and staff of the Department of Human Services for the courtesy, cooperation and assistance provided to us during this review.



DAVID A. VAUDT, CPA
Auditor of State



WARREN G. JENKINS, CPA
Chief Deputy Auditor of State

October 21, 2009

Background

Title XIX of the Social Security Act is the legal basis for Medicaid. Medicaid is a state administered program which provides medical assistance for families and individuals with low incomes and resources.

The Medicaid program is funded with Federal and State appropriations, as well as other revenue sources. **Table 1** summarizes the amount received by the Department of Human Services (DHS) for the Medicaid program by fiscal year.

Table 1

Revenue Type	Fiscal Year Ended June 30, 2007	2008	2009	Total
Federal	$1,469,520,642	1,605,710,001	1,889,037,520	4,964,268,163
State	664,811,610	631,593,774	593,302,330	1,889,707,714
Other*	491,143,725	604,755,749	636,075,680	1,731,975,154
Total	$2,625,475,977	2,842,059,524	3,118,415,530	8,585,951,031

* - Includes revenue from local governments, transfers from other agencies, interest, fees and licenses, refunds and reimbursements and other sales.

As part of the Social Security Act, each state establishes its own guidelines regarding eligibility and services. For Iowa, DHS is responsible for administration of the Medicaid program. Therefore, DHS determines the guidelines regarding eligibility and services for Medicaid.

DHS has determined individuals within the following groups are eligible for Medicaid if they also meet the additional criteria stated below:

- A child under the age of 21,
- A parent living with a child under the age of 18,
- A woman who is pregnant,
- A woman who needs treatment for breast or cervical cancer and who has been diagnosed through the Breast and Cervical Cancer Early Detection Program,
- A person over the age of 65,
- A person who is blind or disabled,
- Certain Medicare beneficiaries or
- A person who is disabled and working.

Individuals within the groups identified above must also:

- Be a U.S. citizen or a legal qualified alien,
- Live in Iowa,
- Provide a social security number or proof of application for a social security number,
- Meet income and resources limits which vary by program and
- Provide all information needed to determine eligibility and benefit level.

Individuals seeking Medicaid assistance complete applications available at their local DHS County Office. The DHS office personnel then use the completed applications along with any additional supporting documentation regarding income and resource levels, such as W-2s and pay stubs, to determine if the individuals are eligible to receive Medicaid assistance. Once individuals have been identified as eligible for Medicaid assistance, that eligibility may be

applied retroactively up to 3 months before the month of application if the individuals have either paid or unpaid medical expenses for covered medical services incurred during the 3 months prior to applying for assistance. In addition, the individuals must meet the eligibility criteria for those 3 months as if they had applied for Medicaid.

In 2003, DHS separated the State Medicaid System into the following 9 components under the direction of the Iowa Medicaid Enterprise within DHS (DHS-IME).

- Provider Services – Enrolls health care professionals as participating providers and offers assistance for billing services through routine training seminars and telephone assistance.
- Member Services – Operates a statewide telephone call center to assist Medicaid members in accessing services or explaining how services can be provided. The hotline staff will assist members in enrolling in managed care, when applicable.
- Provider Audit and Rate Setting – Helps policy staff develop payment rates which are consistent and appropriate for services provided to members, including rates for physicians and hospitals, among others, using various methodologies.
- Core Services – Performs multiple functions, including claims processing and payment, mail handling and reporting. This unit also provides and updates the automated eligibility verification system.
- Medical Services – Consists of medical professionals and affiliated staff which provide medical opinions on specific areas, such as coverage and benefits, as well as assisting with opinions on exceptions to policy and appeals.
- Pharmacy Medical Services – Oversees the operation of the Preferred Drug List (PDL) and Prior Authorization (PA) for prescription drugs. The development and updating of the PDL allows the Medicaid program to optimize the funds spent for prescription drugs. PAs are performed along with medical professionals who evaluate each request for the use of a number of drugs.
- Surveillance and Utilization Review (SURS) – Routinely inspects claims submitted to ensure Medicaid is paying only for covered services.
- Pharmacy Point of Sale System – A real-time system used by pharmacies to submit prescription drug claims for Medicaid members and receive a timely determination regarding payment.
- Revenue Collections Unit – Provides for capture of payments made to the Medicaid program through other sources, such as third-party insurance, estate recovery and liens.

DHS-IME staff utilizes 3 different computer systems:

- Medicaid Management Information System (MMIS),
- Iowa Automated Benefits Calculation (IABC) and
- OnBase.

These computer systems will be discussed in more detail in the Program Administration and Eligibility Requirements sections of this report.

This review focused on the income eligibility requirements for the Family Medical Assistance Program (FMAP) and the Child Medical Assistance Program (CMAP) under Medicaid. FMAP is a program available to parents or specified relatives who have a dependent child living in the household in need of medical expense assistance. CMAP is a program for children under 21 years of age who are income eligible for FMAP but do not meet the FMAP requirements of living with a parent or specified relative.

Table 2 summarizes the total expenditures for the FMAP and CMAP program for fiscal years 2007 through 2009 (through December 31, 2008). As shown below, FMAP and CMAP programs account for $796,357,518 of Medicaid expenditures over this 2½ year period.

Table 2

Fiscal Year	Expenditures for FMAP	Expenditures for CMAP	Total
2007	$ 243,760,882	53,894,051	297,654,933
2008	270,957,613	57,356,061	328,313,674
2009*	139,522,848	30,866,063	170,388,911
Total	$ 654,241,343	142,116,175	796,357,518

* - Includes expenditures for July through December 2008.

More detailed information regarding the eligibility requirements is provided in a later section of this report.

Report Overview

The remainder of this report is organized as presented in **Table 3**.

Table 3

Report Section	Description
Objectives, Scope and Methodology	Summary of the review's focus, scope and methodology.
Program Administration	Summary of the Medicaid system processes.
Eligibility Requirements	Summary of methodology used to document findings.
Findings and Recommendations	Summary and detailed examples of findings and related recommendations for improving compliance with Medicaid income eligibility requirements.

During our review, we identified certain internal control weaknesses at the DHS County Offices, including reliance on the Medicaid recipients to accurately report information affecting income eligibility, such as marital status, household size, bank accounts or employment status. Procedures are not in place which provide independent verification of the information provided. We also identified inconsistency in the implementation of reviews and evaluation of income.

The results and recommendations included in this report will enhance administration of the Medicaid program. DHS-IME should:

- implement standardized procedures for determining income eligibility at the County Offices.
- implement procedures to ensure information reported by recipients is independently verified or supported by sufficient documentation for marital status, household size, bank accounts and employment status to prevent ineligible individuals from receiving assistance.

Objectives, Scope and Methodology

Objectives

Our review was conducted to determine if:

- recipients of FMAP and CMAP were eligible for coverage based on applicable State and Federal regulations regarding income eligibility,
- applications for eligibility and recipients' case files were complete and contained sufficient documentation,
- DHS sufficiently monitored recipients for income changes affecting eligibility and
- any overpayments occurred due to income changes affecting eligibility which were not identified by DHS.

Scope and Methodology

We reviewed DHS-IME's program operations and monitoring of Medicaid income eligibility requirements. We also tested compliance with significant laws, rules and guidelines. In addition, we reviewed selected Medicaid recipients from FMAP and CMAP to test income eligibility requirements for the period July 1, 2006 through December 31, 2008.

To gain an understanding of program operations, procedures and controls related to Medicaid income eligibility requirements, we interviewed personnel from DHS-IME and the DHS County Offices and reviewed significant laws, rules, policies and procedures and program information obtained from DHS.

To determine if DHS provided Medicaid assistance to individuals who did not meet the eligibility requirements, we obtained a database from DHS-IME listing all individuals receiving FMAP and/or CMAP for the period July 1, 2006 through December 31, 2008. We judgmentally selected 100 recipients for testing based on the number of recipients in each program. We prorated the recipients tested between FMAP and CMAP. As a result, we selected 84 FMAP recipients and 16 CMAP recipients. We compiled a list of the recipients selected, which was provided to DHS to obtain the recipients' case files for our review.

For each recipient selected, we compared the household income documented in the case file to the established income and resource limit for the household size to determine if the recipient was in compliance with the income eligibility requirements for FMAP and CMAP.

Program Administration

As previously stated, DHS-IME was created to be responsible for the State of Iowa Medicaid program. In this section of the report, the processes implemented by DHS-IME to determine and verify recipients' income eligibility are discussed in detail.

Medicaid Eligibility

The Medicaid program provides assistance for covered medical and health care costs for certain individuals meeting established income and resource limits. According to the DHS Medicaid Manual, the State of Iowa has identified 28 different eligibility groups, each with its own eligibility requirements. Our review focused on the income eligibility requirements for the FMAP and CMAP programs.

To obtain Medicaid assistance, individuals from all eligibility groups must complete a Health Service Application. However, if also applying for other public assistance benefits, individuals may complete the Health and Financial Support Application. Information required for the application includes:

- full names and social security numbers (SSNs) for all individuals within the household,
- all income to the home from any household member, including child support and alimony,
- household assets, such as investments, vehicles and bank accounts, and
- household expenses.

DHS also requests documentation of citizenship, pay stubs for the last 30 days for employed individuals or Federal income tax records for self-employed individuals, bank statements and proof of the expenses listed on the application.

The application is submitted to and processed by the DHS County Office in the applicant's county of residence. Once an individual applies for Medicaid assistance, the assigned DHS case worker determines the appropriate eligibility group based on the applicant's income, needed services and household composition. In addition, information provided on the application is reviewed and verified by the assigned case worker using pay stubs for the last 30 days, Employer's Statement of Earnings, Federal income tax returns or employment ledgers for self-employed workers.

As part of the DHS case worker's review, all personal information, including SSNs, are entered in DHS' Iowa Automated Benefits Calculation (IABC) system. IABC automatically queries the Social Security Administration database to ensure the names provided match the SSNs and birthdates included on the applications. If any information is incorrect, the DHS case worker receives an error report and follows up with the applicant.

If the applicant does not provide pay stubs with the application, the DHS case worker verifies the income reported by accessing Iowa Workforce Development's database using the SSNs of the household members. Once reported income is verified, a Notice of Decision is sent to the applicant within 30 days notifying him/her whether coverage was granted. As previously stated, coverage may be granted retroactively up to 3 months prior to the application date if the applicant had medical expenses for covered services incurred within that period. All Medicaid recipients are instructed to contact the assigned DHS case worker within 5 working days if their income changes. However, DHS case workers do not periodically contact the recipients to verify if any changes have occurred.

Also, DHS established the Payment Error Rate Measurement (PERM) to review and verify eligibility requirements. According to a DHS representative, PERM selects a Medicaid program to target for specific testing for a particular year and each month of that year a sample of recipients is selected to verify eligibility. For example, DHS may call neighbors of recipients or relatives to verify household size. However, the FMAP and CMAP programs have not been tested in the last ten years and documentation is not available prior to that.

Eligibility Requirements

As previously stated, this review focused on the income eligibility requirements for FMAP and CMAP, which are discussed in more detail in the following paragraphs.

Family Medical Assistance Program (FMAP)

FMAP was established for parents or other specified relatives and dependent children 0 through 17 years of age (through 18 years of age if enrolled in high school). Parents or other specified relatives must have a dependent child in their care to be eligible. Individuals not eligible to receive coverage under FMAP are as follows:

- children not living with a specified relative,
- children over 18 years of age,

- adults who do not have a dependent child in their care,
- adults who are not specified relatives and
- pregnant women with no children other than the unborn child.

The eligibility group for FMAP consists of individuals meeting certain requirements who reside together, which is considered the household size. In addition, household size may include individuals not eligible to receive benefits but who reside in the household. All unearned (i.e., alimony, child support, etc.) and earned income is considered when determining both initial and continuing FMAP eligibility unless the income is specifically exempted, disregarded, deducted or diverted. Income specified as exempt includes settlement payments, food stamps and grants. In addition, income derived from an ineligible child living in the home and Supplemental Security Income (SSI) are disregarded when evaluating income eligibility. The FMAP program also allows deductions, such as 20% from earned income, adult or child care expenses and a 58% work incentive deduction. Diversions, such as alimony and child support, are deducted for people not living in the home.

FMAP income eligibility requirements address both income and resource limits. DHS-IME uses a 3-step process to determine "countable" income to compare against the established income limit. The first test is the 185% Eligibility Test. To meet this limitation, gross income must not exceed 185% of the Standard of Need limit, which is based on household size. If the applicant's gross income exceeds 185% of the Standard of Need, the application is immediately denied. If gross income falls below the limit, the DHS case worker performs the second test.

The second test is the Standard of Need Eligibility Test, which subtracts allowable deductions from gross income to determine if the applicant qualifies for the third test. Allowable deductions include a 20% earned income deduction, intended to encompass all work-related expenses (i.e., taxes, transportation, uniforms, etc.), adult or child care expenses up to $175 per month ($200 per month for children under 2 years of age) and child support paid for children not residing with the applicant. If the net amount remaining after applying the allowable deductions is less than the established limitation given the household size, the DHS case worker performs the third, and final, test.

For the third test, the Benefit Standard Test, the DHS case worker applies a 58% work incentive deduction to the net of the Standard of Need Eligibility Test. The net amount remaining, referred to as "countable" income, is compared to the limitation established for that test. If "countable" income does not exceed the maximum amount allowed and the applicant meets all non-financial requirements as discussed above, the application is approved. When determining continued eligibility, only the third test is performed.

Table 4 summarizes the applicable monthly limits per household size, effective August 3, 2007, for all 3 income eligibility tests as presented in the DHS Employee Manual, Title 8, Chapter E.

Table 4

	Household Size						
Tests	**1**	**2**	**3**	**4**	**5**	**6**	**7**
185% Eligibility	$ 675.25	1,330.15	1,570.65	1,824.10	2,020.20	2,249.60	2,469.75
Standard of Need Eligibility	365.00	719.00	849.00	986.00	1,092.00	1,216.00	1,335.00
Benefit Standard	183.00	361.00	426.00	495.00	548.00	610.00	670.00

As previously stated, FMAP eligibility requirements address both income and resource limits, such as the cash balance in a recipient's checking account or the cash value of a life insurance policy held by the recipient. For a household filing a new FMAP application, the

resource limit is $2,000.00, while the resource limit for a household already receiving FMAP is $5,000.00.

If an individual receiving FMAP experiences an income change which results in earned income exceeding the limits shown in **Table 4**, the individual may continue to receive FMAP for up to 12 months. This 12-month period is referred to as Transitional Medicaid. If the income change is the result of an increase in child support, FMAP only continues for up to 4 months.

As previously stated, for the period July 1, 2006 through December 31, 2008, we judgmentally selected 84 recipients to determine if income eligibility was evaluated properly. Based on our testing, all 84 recipients were eligible for FMAP and their income eligibility was evaluated properly based on the 3 tests described above, assuming the information provided by the recipient was accurate.

Child Medical Assistance Program (CMAP)

CMAP is available to individuals under 21 years of age who meet all FMAP eligibility requirements, except age, living with a specified relative and resource limits. In addition, unborn children are counted as a member when determining household size if the pregnancy has been verified.

When evaluating income for CMAP, FMAP policies and procedures are followed and the same 3 eligibility tests are applied, except as follows:

- According to Iowa Administrative Code 75.1(15)a(2), a "man-in-the-house" who is not married to a pregnant woman is not considered a member of the unborn child's family for the purpose of establishing household size. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the pregnant woman by the "man-in-the-house" shall be considered in determining her eligibility. DHS personnel rely on the pregnant woman to accurately report any amounts received from the "man-in-the-house." Because reporting such income could result in the determination the pregnant woman is ineligible, there is no incentive for her to accurately report that income.
- The earned income deduction is allowed for individuals not included in the FMAP eligible group if their income is considered in establishing eligibility or if their needs would be included in the FMAP eligible group if there was FMAP eligibility. For example, a 17-year old male living independently cannot receive FMAP. Therefore, CMAP eligibility is determined as though the individual meets the FMAP definition of a dependent child.

As previously stated, for the period July 1, 2006 through December 31, 2008, we judgmentally selected 16 individuals to determine if income eligibility was evaluated properly. Based on our test, all 16 recipients were eligible for CMAP and their income eligibility was evaluated properly based on the 3 tests described above, assuming the information provided by the recipient was accurate.

DHS County Offices

In addition to reviewing the case files for the 100 selected recipients, we interviewed personnel from 8 DHS County Offices to determine what procedures are used to evaluate income eligibility and to determine if standardized procedures are used by each office. Examples of the questions asked of the DHS County Office personnel include:

1. When an individual completes an application for Medicaid assistance, what documentation is required to verify the income reported?
2. If an individual changes a job or loses a job, how are DHS County Offices notified? Are the changes verified?

3. Are any face-to-face meetings with the recipient conducted to review income? If so, how often and what is reviewed?

Based on our discussions with DHS County Office personnel, we determined DHS case workers are not independently verifying the information reported by recipients affecting income eligibility but are relying on the recipients to accurately provide that information. Also, we determined different procedures are performed from office to office. For example, 1 office interviewed conducts 6-month reviews while the other offices interviewed do only annual reviews. In addition, we determined 1 office evaluates income based on the total of earned income and unemployment income reported if the recipient did not properly notify the DHS case worker he/she lost employment. This would increase the recipient's income, which could cause the recipient to become ineligible, thereby losing assistance.

Also, we interviewed case workers from 3 of the 8 DHS County Offices to determine what procedures are used to verify information provided by the recipient verbally, such as household size, marital status and number of jobs held. Examples of the questions asked of the DHS case workers include:

1. Do DHS case workers perform home visits on a periodic basis to ensure the household size reported by the recipient is accurate?
2. If a female recipient completes the Medical assistance application for herself and her children but does not properly report her marital status or the income of her spouse, does the DHS case worker review and verify her marital status?
3. If a recipient has 3 bank accounts but only reports 1, does the DHS case worker rely on the information provided by the recipient or are other procedures performed to determine if other bank accounts exist?

Based on our discussions with the case workers from the selected DHS County Offices, we determined the case workers are not independently verifying the marital status, household size, bank accounts or employment status reported on either the application or annual review forms. According to the case workers interviewed, verification procedures are only performed if a recipient's actions or information reported causes concern or if a recipient's reported expenses and income are disproportionate to each other. For example, if a recipient reports rent expense of $1,000 per month but income of only $400 per month, further review and verification would be performed, such as obtaining vehicle registration information to determine the owners of the vehicle and the corresponding address.

According to DHS personnel, should an individual determined to be eligible for assistance display any behavior which causes concern for the DHS case worker, the case is referred to the Department of Inspections and Appeals (DIA) Medicaid Fraud Control Unit through DHS-IME. In addition, DIA has established a hotline to receive anonymous tips if a private citizen has a concern regarding a Medicaid recipient. It is DIA's responsibility to perform further investigation and the results of their investigation are provided to DHS-IME to take appropriate action.

Overall, based on our review of FMAP and CMAP, DHS-IME has implemented some strong controls within the eligibility process in order to provide assistance to those in need. However, we have identified certain areas in which improvement could be made and have developed recommendations accordingly.

Findings and Recommendations

For the period July 1, 2006 through December 31, 2008, we reviewed the income eligibility requirements for FMAP and CMAP under Medicaid to determine if recipients were in compliance with the applicable State and Federal regulations. We also determined if the applications for assistance and recipients' case files were complete and included sufficient supporting documentation. In addition, we reviewed DHS' monitoring procedures to determine if any changes affecting eligibility were properly identified and if any overpayments occurred due to income changes which were not identified. As a result, we identified certain findings and recommendations relating to internal control weaknesses, such as verification of income and standardization of procedures at the DHS County Offices, which should be considered by DHS-IME.

FINDING A – Consistency of Procedures

Based on discussions with DHS County Office personnel, we determined the procedures used to evaluate income eligibility have not been standardized for all offices. For example, 1 office interviewed conducts 6-month reviews while the other offices interviewed perform only annual reviews. In addition, we determined 1 office evaluates income based on the total of earned income and unemployment income reported if the recipient did not properly notify the DHS case worker he/she lost employment.

Recommendation – DHS-IME should implement standardized procedures for determining income eligibility for all DHS County Offices.

FINDING B – Verification Procedures

DHS case workers rely on Medicaid recipients to accurately report information affecting income eligibility, such as marital status, household size, bank accounts and employment status, on the initial application and/or annual review form and as any changes to the reported information occur. For example, a pregnant woman is responsible for reporting any income received from a "man-in-the-house" to whom she is not married.

Also, while PERM reviews eligibility requirements for Medicaid programs it has not been used to review FMAP or CMAP in the last ten years.

Because independent verification is not performed, if an individual reported inaccurate information, the individual would more than likely receive Medicaid assistance for which he/she is not eligible. In addition, because no verification is performed at the recipient's annual review, the ineligible recipient could continue to receive benefits for an extended period of time.

By relying on information provided by the applicant, DHS-IME risks determining eligibility based on:

- Inaccurate or incomplete income amounts,
- Undisclosed sources of income,
- Inaccurate identification of resources and/or assets,
- Undisclosed resources and/or assets,
- Undisclosed asset transfers,
- Improper identification of the members living in the household,
- Failure to report the existence of third party insurance (perhaps provided by an employer) and
- Residential status (i.e. non-Iowa resident).

In addition, the information provided is used to determine eligibility for all other assistance programs offered by DHS-IME, not just FMAP and CMAP. Therefore, an ineligible individual could receive assistance under multiple programs based on the inaccurate information.

Recommendation – DHS-IME should implement procedures to ensure the information reported on the initial application, annual review form and as changes occur which affect income eligibility, such as marital status, household size, bank accounts and employment status, is either independently verified or supported by sufficient documentation to prevent an ineligible individual from receiving Medicaid assistance.

Staff

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