REPORT DIGEST

PERFORMANCE AUDIT OF THE

MEDICAL ASSISTANCE PROGRAM – LONG TERM CARE ELIGIBILITY DETERMINATION

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State of Illinois
Office of the Auditor General

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SYNOPSIS

House Resolution 1295 directed the Auditor General to audit the Medical Assistance Program jointly administered by the Departments of Healthcare and Family Services and Human Services with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the client's financial resources and financial liability.

In their response to the audit report, the agency directors acknowledged that: **"The policies, procedures and systems reviewed are highly complex and confusing."** As auditors, we are accustomed to dealing with complex and confusing processes. However, the real significance of, and difficulty with, this statement lies with the elderly and vulnerable population who ultimately must deal with these highly complex and confusing policies on a regular basis.

Among the issues auditors noted were:

- **The eligibility determination process**, specifically the processes used by both Departments related to determining how much income a client with a community spouse (a spouse residing in the community) must pay to the long term care facility, **is complex, cumbersome, and confusing**.
- **Auditors identified significant and pervasive problems in the processes and data used** by the Departments which resulted in long term care clients with community spouses being overcharged for their nursing home care.
- The most significant problem was that **the Departments automatically add the annual Social Security cost of living increase to the client's group care credit** (the amount that the client and the client's community spouse have to pay monthly for nursing home care).
- This automatic cost of living adjustment **almost always results in the new group care credit being incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care.
- **In 7 of 23 cases** we reviewed, there were **14 instances** where more than **two months passed before the group care credit was manually corrected by the caseworker. In 3 of 23 cases,** the group care credits **were not corrected for two years.** In these cases, **the clients were overcharged $9,204, $1,056, and $1,012,** for their care**.**
- The Departments send two notices within a two week period to long term care clients that **provide conflicting, or at best confusing, information** regarding the handling of the clients' Social Security increases.

REPORT CONCLUSIONS

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

The responsibility for administering the long term care program is shared primarily by two agencies, HFS and DHS. DHS is responsible for eligibility determination for all Medicaid programs. HFS pays for Medicaid long term care. According to the HFS website, its Bureau of Long Term Care administers the program that reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In Fiscal Year 2007, Healthcare and Family Services paid $1.5 billion for long term care.

DHS is responsible for determining the initial eligibility of long term care applicants. DHS is also responsible for redetermination of clients' eligibility. The current Illinois Medicaid State Plan requires redetermination of eligibility for all recipients on an annual basis. This determination and redetermination process is handled by caseworkers at the Department's approximately 100 Family Community Resource Centers located throughout Illinois.

In cases where a long term care client has a spouse residing in the community, federal and State law allow clients to give some or all of their income to the community spouse, up to a set amount (called the maintenance needs allowance, which was $2,610 per month in 2008). The purpose of allowing nursing home clients to give all or a portion of their income to a spouse residing in the community is to prevent the spouse from becoming impoverished.

SOCIAL SECURITY ADJUSTMENTS

The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living adjustments (COLA) received by clients with community spouses. Effective January of each year, most clients receive an annual Social Security cost of living increase. Rather than making a determination as to how much of the increase can be given to the community spouse at the time the amount of the Social Security increase is known, the Departments

automatically add the cost of living increase to the client's group care credit (the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS (Medicaid Management Information System).

This automatic adjustment almost always results in the new group care credit being **incorrect,** since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care. We reviewed 23 cases where the long term client had a community spouse. This included a review of detailed timelines which the agencies prepared for the 23 cases. Although the auditors requested "Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services," DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the clients were paying the long term care facility. Consequently, auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.

CLIENT LIABILITY

In many of the long term care cases we reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client was required to pay. In 7 of 23 cases we reviewed during the audit, we identified **14 instances** where more than two months passed before the group care credit was manually corrected by the caseworker. **In 3 of the 23 cases, the group care credits were not corrected for two years; in 3 other cases, they were not corrected for 11 to 13 months**. In the three cases where the group care credits were not corrected for two years, **the clients were overcharged $9,204, $1,056, and $1,012, respectively, for their long term care.** *The audit recommends that the agencies discontinue automatically adding Social Security increases to the group care credits of clients with community spouses and rather, calculate the group care credit on a case by case basis.*

In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two notices within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the clients' Social Security increases. In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact DHS. About two weeks later, the agencies send another letter to the client which contains the specific dollar amount of the Social Security increase and states that **"You must pay this money directly to the facility** [emphasis added]." This letter is sent to all long term care clients, both those with community spouses and those without. Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is **no mention** in the second letter of the client's ability to give the increase to his or her community spouse.

In the cases where DHS determined that clients had overpaid the long term care facility for their care, DHS retroactively reduced the amount that the client was required to pay to the facility and increased the State's payment to the long term care facility to cover the amount overpaid by the client. Department officials stated that then the long term care facility may be responsible for refunding the money to the client.

Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases we reviewed. The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show the HFS nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted. *The audit recommends that the Departments implement a control to ensure that any overpayments made by a client as a result of the Departments' eligibility determination process are repaid to the client by the long term care facility.*

DATA RELIABILITY

Auditors had significant concerns regarding the reliability and validity of the electronic data provided by the Departments. Both DHS and HFS operate their own data systems which process data related to long term care. The DHS system is largely a case management system, while the HFS MMIS system is used to process payments to providers. *The*

audit recommends that the agencies take the necessary actions to assure that the data contained in their systems is consistent, reliable, and timely updated.

OTHER ISSUES IMPACTING ELIGIBILITY DETERMINATIONS

During the course of the audit, we identified other issues which impact the accuracy of the eligibility determination process, as well as the general processing of long term care cases. These issues included the following:

- Some DHS local field office caseworkers were not completing annual facility visits as required by the Policy Manual.

- The redetermination process is designed to update case information and check eligibility. Due to variations in how long term care cases are coded by the various DHS offices, the "Overdue for Redetermination" report is not being used effectively by the central office to monitor the timeliness of long term care case redeterminations.

- Supervisors are not routinely reviewing DHS caseworkers' eligibility determinations.

HFS has not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes related to eligibility determinations for Medicaid long term care clients.

BACKGROUND

House Resolution 1295 directed the Auditor General to audit the Medical Assistance Program jointly administered by the Illinois Departments of Healthcare and Family Services (HFS) and Human Services (DHS) with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the financial resources and financial liability of the applicants and recipients.

The federal statute, Title XIX of the Social Security Act (42 USC 1396a *et seq*.), the Code of Federal Regulations (42 CFR 430 *et seq*.), the Illinois Public Aid Code (305 ILCS 5), and the Illinois Administrative Code (89 Ill. Adm. Code 120.1 through 120.550) guide the Illinois Medical Assistance or Medicaid program.

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and State governments jointly fund and administer the Medicaid program. At the federal level, the Centers for Medicare and Medicaid Services administers the program. Each State runs its Medicaid program in accordance with a Centers-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements. HFS administers the State's Medicaid program in Illinois. According to the HFS website, its Bureau of Long Term Care administers the program that reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In Fiscal Year 2007, Healthcare and Family Services paid $1.5 billion for long term care out of a total spent for medical assistance of $11.3 billion.

HFS and DHS entered into an Interagency Agreement in 2000 regarding the administration of the medical programs and the child support enforcement program. HFS has sole responsibility for developing and establishing policy with regard to medical programs' eligibility. HFS is to consult with DHS in the development, dissemination, and implementation of policy. The parties are to jointly incorporate policy and procedure in manuals and other publications. HFS shall have final approval of all policies regarding medical programs. DHS is to accept applications and make timely eligibility determinations and redeterminations, including spenddown requirements, for individuals applying for benefits under the medical programs. (pages 6-7)

MEDICAID LONG TERM CARE PROBLEMS

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

Auditors identified significant and pervasive problems in the processes and data used by HFS and DHS which resulted in long term care clients, with spouses residing in the community, being overcharged for their nursing home care.

This audit was initiated based on a case where the State had data problems related to the nursing home group care credit of a client. The group care credit is the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care. The client had been in a nursing home since 2005. His wife was still

living in the community and was making a monthly contribution to his care. The problem was identified when the amount the client's wife was required to pay toward the client's care tripled when her income had not changed significantly. The State has an income-based formula to determine how much of a co-payment Medicaid long term care patients are charged. When there is a spouse in the community, there are additional calculations that must be done.

Eventually DHS acknowledged the error. DHS recalculated the charge and said she owed nothing for 2008. According to DHS/HFS officials, the nursing home reimbursed the community spouse for amounts overcharged in 2006 and 2007. According to a newspaper article, when DHS was asked if other seniors had been overcharged, DHS officials said they had no way of knowing.

When auditors reviewed the case file, based on the Department's rules and procedures, the spouse should not have had to pay anything for the nursing home care from the very beginning. Because there was a spouse still living in the community, the client's income and assets should all have been transferred to the community spouse.

Electronic Data Concerns

Auditors had significant concerns regarding the reliability and validity of the electronic data provided by the Departments.

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Healthcare and Family Services Data

Because the case files did not allow us to find out what the HFS system showed as the amount the community spouse was actually supposed to pay, we requested electronic data from HFS. Because HFS pays the nursing homes, it needs to receive from DHS the correct amount the spouse should pay, so that HFS can know the portion the State should pay.

We requested data for all nursing home cases that had a community spouse. That data was to include what, if anything, the community spouse was supposed to pay. We received the requested data from HFS in December 2008. The data provided by HFS included 2,756 cases. We had previously requested from DHS a count of cases with a community spouse and it had reported that there were 3,552 in 2008.

Human Services Data

Because there was a discrepancy of 796 cases (29 percent) between the number of cases with community spouses reported by HFS (2,756) and DHS (3,552), we requested the same detailed data from DHS for the same time period (December 2008) to better understand the discrepancies in the data. We received the requested data from DHS in January 2009. The data provided by DHS included 3,866 cases. That meant that there was a discrepancy of 1,110 cases in numbers provided by HFS and DHS; DHS data included **40 percent more cases**. There were 2,169 cases that appeared in both data sets. We also identified 13 cases which were duplicates within the HFS data set and one case that was duplicated within the DHS data.

To attempt to identify why there were such discrepancies, we analyzed the 2,169 cases that appeared in both data sets to see if the amount that the client or spouse was supposed to pay agreed. When we compared the group care credit for the 2,169 cases, there were **only 319 cases, or less than 15 percent,** where the dollar amount agreed. In over 85 percent of the cases the amount that the client's spouse was supposed to pay **did not agree** between the two agencies.

Revised Data from Agencies

After auditors analyzed the data and concluded there were significant problems, we shared our concerns regarding the data limitations with HFS and DHS. In a joint meeting with both agencies on April 22, 2009, HFS and DHS officials noted that they thought the differences in amounts and differences in populations were attributable to the criteria they used to select the data and to timing differences in the data. HFS and DHS officials stated that each agency would produce a new data set that would cover the same time period and use the same criteria, which would result in a better match of both the universe of cases and group care credits.

The next day, April 23, 2009, the agencies asked to meet again. At that meeting HFS and DHS officials said that they would not be able to each produce a data set because the two data sets would still not agree. A DHS official noted that their system was not updated automatically when the HFS system is updated. Officials stated the DHS caseworker uses the HFS MMIS system to update financial data, including updating the group care credit, and not the DHS system. Consequently, the data in the DHS system is outdated. HFS and DHS noted that they would need to collaborate and do one data set. Auditors noted that they did not have any confidence in the data being reliable, given the documented inconsistencies between DHS data, HFS data, and case files.

Agencies noted that automatic Social Security adjustments were the reason for many of the differences between the case files and the electronic data. They also noted several limitations and weaknesses in their systems but expressed confidence in the accuracy of the data. Among the weaknesses that the agencies noted were:

- When explaining their inability to produce a new data set, as promised in April 2009, the agencies stated, ". . . I believe we overemphasized the need to coordinate the timing of our data pulls without fully taking into account the **limitations of MMIS and CIS [Client Information System] in presenting directly comparable documentation of patient care credits** [emphasis added]."

The agencies noted: "Both the age and long since obsolete programming language of the CIS have prevented DHS from quickly pulling data in ways other than the on-going processes of determining eligibility."

- The agencies noted that the CIS program was written in Autocoder **in the 1970's**. "Both the age and long since obsolete programming language of the CIS have prevented DHS from quickly pulling data in ways other than the on-going processes of determining eligibility."

- Patient care credits, as represented in the HFS MMIS system, are the final result of a caseworker's calculations which are recorded on a 2500 form [LTC Resource Calculation Form] for each payment or patient credit modification. "**Entry of this patient credit data into the CIS system would be a duplication of effort for DHS staff** [emphasis added]." **Consequently, the DHS group care credit information is not reliable.**

- There are limitations on using automated data to replicate largely manual processes, where not all data elements are entered into both data systems. Officials noted, "**While the current system is inefficient and obviously difficult to audit**, we are still confident that the systems work [emphasis added]."

In June 2009, we offered the agencies one more opportunity to attempt to address the serious concerns we had regarding the accuracy and reliability of their data. Auditors requested a reconciliation of the total number of cases in the universes provided by HFS in December 2008 and by DHS in January 2009 discussed earlier. DHS and HFS **did not provide the requested reconciliation**, but instead provided new data files that only included case identification numbers.

Both agencies used data as of June 4, 2009. In this comparison, DHS had 2,910 cases while HFS had 3,447. The agencies noted that 581 of the HFS cases included spousal diversion codes (referred to as "670" codes) that have been closed by DHS, but not reflected in HFS' Data

Warehouse. Agency officials noted that other discrepancies were due to up to a two day lag between DHS extracting the data and HFS loading the Data Warehouse.

Although the total universes, with explanations and adjustments, are closer than before, they still did not match. In addition, the new data runs did not include group care credit amounts, the most important information for this audit, so no assessment of their reliability could be attempted. (pages 7-11)

Review of Sampled Cases

The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living increases received by clients with community spouses. Effective January of each year, most clients receive an annual Social Security cost of living increase. Rather than making a determination as to how much of the increase can be given to the community spouse at the time the amount of the Social Security increase is known, the Departments **automatically add** the cost of living increase to the client's group care credit (the amount of money the client is required to pay the long term care facility). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS system.

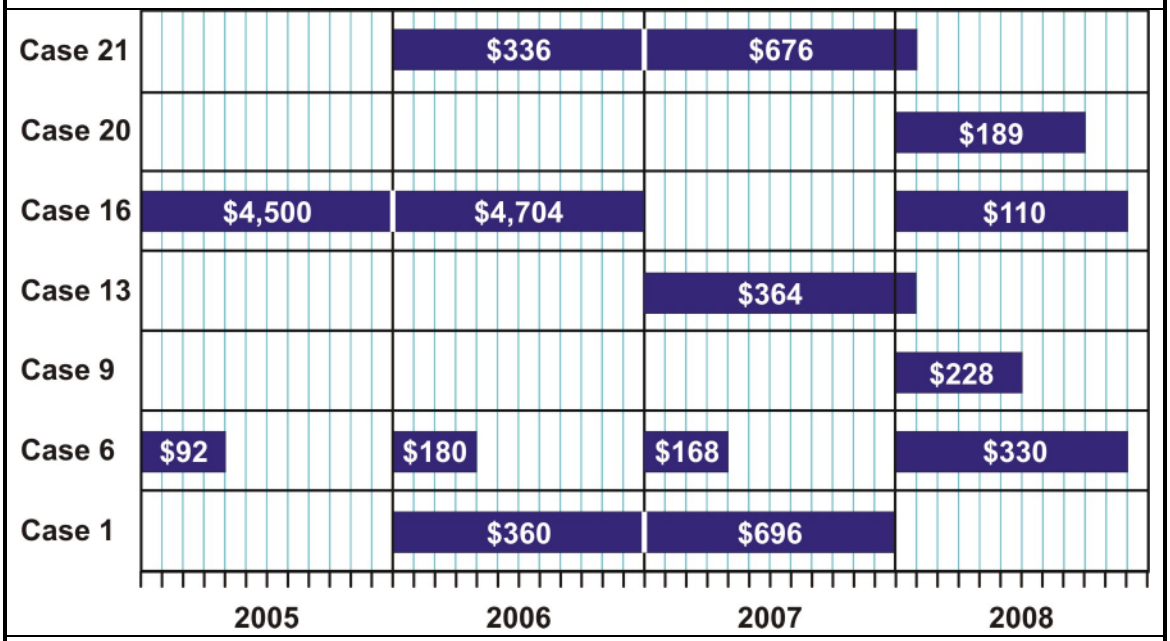
This automatic adjustment almost always results in the new group care credit being **incorrect,** since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care. Although the auditors requested "Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services," DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the clients were paying the long term care facility. Consequently, auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.

This automatic adjustment almost always results in the new group care credit being <u>incorrect</u>.

Our review of the detailed documentation provided by DHS and HFS for the 23 cases sample identified the following deficiencies:

- **Incorrect/Overstated Group Care Credits:** In many of the long term care cases we reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client is required to pay. In most cases, at least one or two months passed before the automatic increase in the group care credit due to the Social Security cost of living increase was corrected. There were, however, **14 instances** in 7 of the 23 cases auditors examined where the clients' group care credits were incorrect **for more than a two month period.** In these cases, the State's payment to the long term care facility would have been reduced by the amount of the COLA and the client would be responsible to pay that amount to the facility. In the 14 instances where this occurred, the amount that the clients' group care credits were overstated **totaled $12,933**. Digest Exhibit 1 summarizes these 14 instances. In all but one of the instances, once the State retroactively corrected the group care credit amount, it paid the long term care facility the adjusted amount. As discussed below, the State does not then verify to ensure that the long term care facility passed the reimbursement of the overpayment on to the client.

Digest Exhibit 1
MONTHS ELAPSED FROM SOCIAL SECURITY COLA UPDATE UNTIL GROUP CARE CREDIT AMOUNT CORRECTED, AND AMOUNTS CLIENT WAS OVERCHARGED
(Greater than 2 Months)



Source: DHS and HFS data summarized by OAG.

- **Delays in Entering Changes into HFS MMIS System:** In several cases, changes made by caseworkers to correct the client's group care credit were not timely entered into the HFS MMIS system, which is the system used to pay the long term care facilities. For example:

  The timeline provided for one case showed the caseworker conducted a redetermination in May 2008 and reduced the client's group care credit to $0. However, the timeline shows the group care credit was **not changed** to $0 in the HFS MMIS system until October 2008, when it was made retroactive to January 2008. Consequently, for the period May through October 2008, the payments made by HFS to the long term care facility were incorrectly based on the client contributing income toward his care, which should have been going to the community spouse.

  The timeline for another case showed a redetermination was completed in December 2006 and the group care credit was determined to be $0. The client's group care credit during 2006 had been $28 per month. However, the timeline shows that the revised group care credit amount of $0 was **never entered** into HFS' MMIS system. Rather, the group care credit was further **increased** by the 2007 Social Security cost of living increase to $52 per month. Finally, in February 2008, **13 months after** the December 2006 redetermination had been completed that showed the group care credit was $0, another redetermination was completed which again showed the group care credit should be $0. That same month, the HFS MMIS system was updated to reflect the $0 group care credit, and it was made retroactive to January 2007. However, the group care credit was not made retroactive to 2006 during which the client also had an erroneous $28 per month group care credit.

- **Medicare Premium:** In one case the Medicare premium was not netted out of the client's income in 2008, thereby overstating the amount the client had to pay toward his care.

- **Spouse Death:** In one case, a spouse died in November 2008, but the client was still in DHS' system as having a community spouse case in December.

In addition, there are instances where the information provided by the Department to the auditors did not contain adequate documentation to support the changes made to the group care credit amounts. After auditors noted the significant differences in the group care credit amounts in the DHS case files, the DHS electronic data, and the HFS electronic data, the Departments requested an opportunity to provide detailed timelines that would show why the amounts differed among the three sources. While in many instances the timelines and supporting documentation explained

such differences, in others, questions remain why certain changes to the group care credits were made. For example:

- In one case**,** the client's group care credit was $0 from the time of admission in 2007 until January 2009. In January 2009, the group care credit increased to $64 as a result of the Social Security cost of living increase, but the DHS caseworker changed it back to $0 in March 2009. The timeline provided by the Departments then shows the group care credit **increasing to $329** on May 18, 2009, **but did not contain a report or other support** for this adjustment. As such, auditors could not examine the basis for or validity of this change. In the agencies' written response to the audit they noted: ". . . the $329 was a typo in the submitted timelines."
- In another case, the client's group care credit was $0 through October 2007. Beginning in November the group care credit began to increase significantly, up to $1,164 as of January 2009. We inquired of DHS officials as to why the significant increase in the group care credit occurred. DHS officials stated that the community spouse entered a long term care facility in October 2007, thus there was no more diversion of the client's income to the community spouse, and the client's group care credit increased accordingly. However, the case file did not document this reason and, in fact, contained documentation to the contrary, including a March 2009 DHS "Authorization of Assistance Action" form with $1,088 designated as income to be diverted to a community spouse. Also, the Departments sent the December "Notice to Long Term Care Residents Giving Income to Family," which is sent out to cases where income is diverted to a community spouse. This case again raises concerns regarding the validity and reliability of the data the agencies provided since the case was in the universe of cases with community spouses provided by both DHS and HFS, which it should not have been if the community spouse entered a nursing home.
- In another case, a client's group care credit amount automatically increased in December 2007 (effective January 1, 2008) from $0 to $30 due to the annual COLA increase. The timeline and the case file both document that in February 2008 a caseworker completed a LTC Resource Calculation Form changing the group care credit amount back to $0. Like the previous example, the timeline shows the revised group care credit amount of $0 was **never entered** into HFS' MMIS system. Then a year later in December 2008 (effective January 1, 2009) the group care credit increased again from $30 to $116 due to the annual COLA increase. Later in December 2008, the group care credit was changed from $116 back to $0 for all of 2008.
- In another case, the client had a group care credit of $382 in 2008, which increased to $427 in January 2009 due to the 2009 Social

Security increase. However, in February 2009, the timeline provided by the Departments showed that the DHS caseworker changed the group care credit to $0. The change was made **retroactive to 2007**. Although the provided timeline contains a notation that information was received from the long term care facility, neither the case file nor other documentation provided support this adjustment. However, **one month later**, in March 2009, the DHS caseworker again changed the group care credit back to $382 for 2008 and to $299 for 2009. Finally, the 2009 group care credit was **changed again** to $329 **one month later** in April 2009 by a DHS caseworker.

- In another case, the client had a group care credit of $357 beginning in July 2003 which had increased to $406 as of January 2007. In February 2007, a redetermination was completed for the period beginning June 2006, which concluded the client had a group care credit of $0. The group care credit of $0 was made retroactive to June 2006. However, based on the client's and community spouse's income documented in the case file, the auditors questioned whether the client should have been assessed **any** group care credit during the period July 2003 through May 2006.

The incorrect group care credits, many of which went uncorrected for extended periods of time, demonstrate the need for both Departments to undertake a review of all cases involving clients in long term care facilities with community spouses.

The incorrect group care credits, many of which went uncorrected for extended periods of time, demonstrate the need for both Departments to undertake a review of all cases involving clients in long term care facilities with community spouses. Leaving group care credit amounts uncorrected results in community spouses not getting the income to which they are entitled and increases the risk of them becoming impoverished. (pages 16-19)

Conflicting Notices Sent to Clients and Community Spouses

The Departments' notices provide conflicting, or at best confusing, information regarding the handling of the client's Social Security increases.

In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two letters within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the client's Social Security increases. Copies of both notices are included in Appendix B of this report.

In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact their DHS caseworker. The second notice, which is mailed within two weeks of the first, tells the client the total amount of their new Social

Security and the amount which is available each month to pay to the nursing home. The notice says: "**You must pay this money directly to the facility** [emphasis added]." Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is **no mention** in the second letter of the client's ability to give the increase to his or her community spouse. (page 21)

Controls over Client Liability

Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases we reviewed. The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show HFS' nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted. (page 26)

POLICY ISSUES

The Departments of Healthcare and Family Services (HFS) and Human Services (DHS) have policies that were not current or were not clear. Those problems may be negatively affecting the long term care eligibility determination process. In addition, some of DHS's local field offices were not operating according to the Policy Manual.

DHS had weaknesses in management oversight of the Medicaid long term care program. These weaknesses included Overdue for Redetermination reports not being used and a lack of supervisory review of caseworkers at DHS. In addition, there were computer system oversight issues and policy coordination issues that are the shared responsibility of HFS and DHS.

HFS has not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes concerning eligibility determinations for Medicaid long term care clients. (pages 29-42)

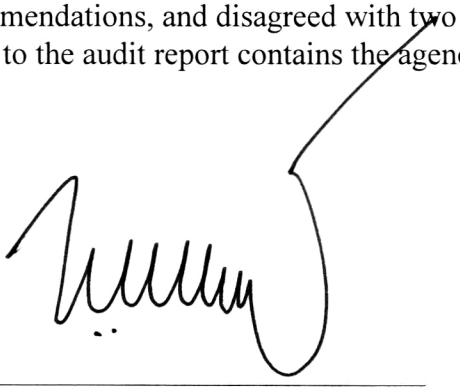
RECOMMENDATIONS

The audit report contains nine recommendations. Six recommendations are addressed to both the Department of Human Services and the Department of Healthcare and Family Services. Two

recommendations are addressed to just the Department of Human Services and one recommendation is addressed to just the Department of Healthcare and Family Services.

The Departments provided a joint response to the audit report. In their response to the audit report, the agency directors acknowledged that: **"The policies, procedures and systems reviewed are highly complex and confusing."** As auditors, we are accustomed to dealing with complex and confusing processes. However, the real significance of, and difficulty with, this statement lies with the elderly and vulnerable population who ultimately must deal with these highly complex and confusing policies on a regular basis.

The Departments agreed with three of the recommendations, partially agreed with four recommendations, and disagreed with two of the recommendations. Appendix C to the audit report contains the agencies' complete responses.



WILLIAM G. HOLLAND
Auditor General

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September 2009