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UNITED STATES GENERAL ACCOUNTING OFFICE
REGIONAL OFFICE
ROOM 403, U.S. CUSTOMHOUSE, 610 SOUTH CANAL STREET
CHICAGO, ILLINOIS 60607

OCT 9 1970

Mr. Donald F. Simpson, Regional Commissioner
Social and Rehabilitation Service
Department of Health, Education, and Welfare
Room 808 - 433 W. Van Buren Street
Chicago, Illinois 60607



Dear Mr. Simpson:

As part of our continuing examination into the manner in which the Department of Health, Education, and Welfare (HEW) is discharging its responsibilities relative to the federally assisted medical assistance program - Medicaid - the General Accounting Office has examined into the controls over payments made on behalf of certain Medicaid recipients who have an obligation to pay for a portion of their medical care. In your region, we examined into the adequacy of such administrative controls at all levels (Federal, State, and local) as applied to the Medicaid program conducted in Illinois, and particularly in Cook County. Our review covered a total of 259 cases.

Similar reviews have been conducted in California and Massachusetts and a consolidated report to the Congress is planned. The purpose of this letter is to bring to your attention certain matters which may not be included in the consolidated report.

NEED TO EXCLUDE FEDERAL PARTICIPATION
IN COSTS OF PROVIDING MEDICAID SERVICES
TO PERSONS WHO WERE ELIGIBLE FOR BUY-IN
MEDICARE COVERAGE

Until January 1, 1970, States could "buy in"--that is, they could enter into agreements to pay the premium charges under Part B of Medicare and provide coverage for all Medicaid recipients 65 and over. After January 1, 1970, Federal matching would not be available for any expenditures for Medicaid services that would have been provided to an individual by Medicare if the individual involved had been enrolled in the insurance program.

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Illinois decided not to "buy in" for the medically needy group. Therefore, since January 1, 1970, Federal participation was prohibited for that portion of Medicaid payments which would have been covered by the Medicare program under the "buy in" agreement.

Illinois had not segregated such costs in their statement of expenditures submitted to HEW for Federal participation for the 3-month period ending March 31, 1970.

We have pointed out to both State officials and members of your staff the need for the adjustment. Members of your staff subsequently informed us that they are in the process of making arrangements with the State for making the proper adjustment and for excluding such costs from Federal participation in the future.

NEED FOR STATE TO PERFORM
EXAMINATIONS OF LOCAL OFFICES

The Illinois State Plan provides for regular planned examination and evaluation of operations in local offices by regularly assigned State staff, including regular visits by such staff. We found that such evaluations had not been performed.

In the Cook County districts that we visited, we found inconsistencies in practices relating to:

1. Establishment of collection accounts.
2. Determination of monthly payments required to be made in the 6-month eligibility period.
3. Requirement that overpayments be refunded to recipients.
4. Determination of medical needs of applicants.
5. Determination of financial eligibility of applicants.
6. Treatment of nonexempt liquid assets above the protected level.
7. Requirement to liquidate other nonexempt assets.

8. Establishment of separate cases for a family unit of two or more persons with resultant effect of splitting the income, increasing the aggregate maintenance allowance, and reducing the recipients' share of medical costs.
9. Redetermination of eligibility upon a change in recipient's resources or medical needs.
10. Responsibility of spouse for cost of medical care of a recipient.

We believe that performance of regularly scheduled examinations and evaluation of local offices as set forth in the State plan would contribute toward the elimination of these inconsistencies and promote more effective administration of the Medicaid program.

COLLECTION ACCOUNTS MAY NEED REVIEW TO
DETERMINE IF OVERPAYMENTS ARE OCCURRING

Medicaid recipients who receive assistance other than for hospitalization or nursing home care and have a share of cost, are to make six equal monthly payments into a collection account established by the local welfare office. The total of the monthly payments represents the recipients share of cost for the 6-month eligibility period. The State in turn, pays all the recipients medical bills incurred during the eligibility period.

State instructions provide that any overpayment should be refunded to the recipient or credited toward his share of cost for subsequent eligibility periods. However, the State does not review accounting records to identify overpayments unless a recipient alleges that his monthly payments exceeded the medical bills paid by the State.

In several cases we noted that collections from recipients exceeded medical payments recorded by the State. Because of the time interval in processing and paying bills, however, we could not determine whether the State had yet paid all bills incurred during the eligibility period.

State officials informed us that they would look into this matter to determine whether overpayments by recipients are occurring and whether the establishment of routine procedures to detect overpayments and make refunds, is warranted. Members of

your staff stated that the State should provide a means of assuring equitable treatment of all recipients and that they would follow up this matter with the State.

IMPROVEMENT NEEDED IN
ADMINISTRATION OF CASE FILES

Many of the case files we examined did not contain sufficient data to clearly support decisions made on recipients' eligibility, as well as their share of cost. We often found that required documents were missing or incomplete. The State manual (4003.1) requires that the case record show how each factor of eligibility is established. However, case files generally did not contain dollar estimates of medical needs, or if estimates were included, did not contain the basis of the estimate or the source of information.

We also noted that case files were frequently unorganized and lacked tabbing to facilitate reference to basic documents.

We believe that the County and State should give increased attention to the case files so that (1) supervisory personnel will have a sound basis for reviewing and evaluating caseworker's determinations and performance, and (2) meaningful quality control reviews can be performed.

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The matters presented in this report have been discussed with your Deputy Regional Commissioner and with the Associate Regional Commissioner of the medical services staff. We shall appreciate receiving your comments and advice as to any action taken or planned on these matters.

Copies of this report are being sent to the Assistant Secretary, Comptroller; the Administrator, Social and Rehabilitation Service; and the Regional Audit Director, for their information.

Sincerely yours,

M. S. Mosher

FOR M. R. Wolfson
Regional Manager