STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

June 8, 1983

All County Welfare Directors Letter No 83-44

QUALITY CONTROL (QC) ERRORS AND SUGGESTED COUNTY ACTION

This is the second in a series of letters which addresses Medi-Cal Quality Control (QC) errors. The first was the Deprivation Training Package which accompanied All County Welfare Directors Letter No. 82-67.

The Department of Health Services' (DHS) Quality Control and Evaluation Branch reviews the eligibility of approximately 180 approved Medi-Cal-only cases and the denial/discontinuance of approximately 40 Medi-Cal-only cases every month. Claims data is gathered for all approved cases. These reviews are summarized in six-month review periods as required by federal QC procedures. QC staff uses the data developed from this random sample to extrapolate a statewide dollar error rate and case error rate and to identify specific error concentrations. Eligibility Branch staff are responsible for developing initiatives designed to reduce such eligibility errors.

This letter is to provide you with the following:

- A brief review of federal QC errors for the October 1981 - March 1982 review period.
- A comparison of this review period with the 36-month period April 1979 - March 1982 together with suggested corrective actions.

I. BRIEF REVIEW OF FEDERAL QC ERRORS FOR THE OCTOBER 1981 - MARCH 1982 REVIEW PERIOD

The Department of Health Services' Quality Control and Evaluation Branch reports that, for the period October 1, 1981 through March 31, 1982, the Medi-Cal Only (MAO) case error rate for federally eligible groups was 16.79 percent and the MAO dollar error rate (misspent dollars) was 3.14 percent. It was estimated that, due to MAO errors, $34,498,794 dollars were misspent for Medi-Cal services for persons who were either federally ineligible or who had an understated share of cost (SOC).

A. Dollar Errors

During this period, over 57 percent of all dollar errors was attributed to agency action or inaction. The estimated annual cost of misspent dollars due to agency error was $19,899,980. Agency errors were caused primarily by the county disregarding or not applying information or by failing to follow-up on impending changes.

It should be pointed out that, although agency error includes both county action/inaction, it does not include errors relating to the implementation of the quarterly share of cost (QSOC) provisions of

AB 251. Since counties were instructed to implement QSOC effective April 1, 1982, QC reviewed to monthly share of cost until that date.

Errors in the Basic Requirements component (e.g., age, citizenship, living arrangement, deprivation, disability) accounted for over half of the dollar errors, while errors in the Income component contributed one-third of the total.

B. Case Errors

Beneficiaries caused over 58 percent of all case errors while the agency was responsible for the remainder. The majority of beneficiary errors were caused by failure to report changes in earned or unearned income.

Over half of all case errors were in the Income component, with earned income errors again accounting for about half of all errors in income and for one-fourth of all case errors.

II. COMPARISON OF CURRENT REVIEW PERIOD WITH 36 MONTH PERIOD AVERAGE OF APRIL 1979 THROUGH MARCH 1982

This section will provide analyses of: A) the primary source of liability/eligibility dollar errors; B) Basic Requirement errors; C) Resource errors; and D) Income errors and will include general suggestions for corrective action in each area.

A. Primary Source of Eligibility/Liability Dollar Error

1. Table

	Percent of Dollar Error			
	36-Month Average	Current	36-Month High	36-Month Low
AGENCY				
Failure to Act	32.2	52.8	52.8	6.8
TOTAL	49.1	57.6	68.7	14.5
BENEFICIARY				
Failure to Report	31.4	34.4	36	26.0
TOTAL	50.9	42.4	85.5	31.3

2. Discussion

Although beneficiary errors account for approximately two-thirds of the case error rate, dollar errors are much more evenly distributed. Over the 36-month period reviewed for this report, <u>county/agency error accounted for almost one-half the dollar error</u>. This means that reducing errors for federal QC sanction purposes is well within the control of the county/state.

B. <u>Basic Requirements</u>

1. Table

Factor	Percent of Cases in Error (1)		Percent of Misspent Dollars (2)	
	36-month Average	Current	36-month Average	Current
Age	1.5	4.7	3.3	19.2
Citizen-ship/ Alienage	1.1	1.2	.9	4.2
Living Arrangement	7.3	8.1	4.1	4.0
Deprivation	7.5	6.4	22.7	5.7
Blind/ Disability	.9	1.7	2.7	15.9
Total Basic Requirements	19.0	22.7	34.2	51.3

Formulas: (1) Cases with factor in error ÷ total cases in error.

(2) Misspent dollars due to factor ÷ total misspent dollars.

2. Discussion

Basic Requirements factors are: age, citizenship/alienage, residency, living arrangements, deprivation and blindness/disability determination. Errors in Basic Requirements usually result in some or all of the persons in the case being ineligible for Medi-Cal; thus, benefits were provided to which the ineligible person(s) were not entitled. For example, in the current period, eight people were not shifted out of a federal program category (MI child or AFDC/MN child) at age 21. These eight errors created a projected annual cost of $6,616,869. Failure to use the appropriate standards in establishing disability/blindness resulted in three people being granted eligibility erroneously. Medi-Cal services for these three people caused a projected annual cost of $5,471,509.

These errors are attributed solely to county failure to take appropriate action.

Living Arrangement errors occur when the child who has provided linkage to the AFDC program either leaves home or becomes 21. Errors caused by incorrect determination of these factors may result in program ineligibility for the entire family.

Most of these errors were caused by beneficiary failure to report that the child left home.

Deprivation errors occur when the case is set up as AFDC/MN but linkage to the AFDC program does not exist. For example, if the unemployed parent upon whom a child's deprivation is based is <u>not</u> the primary wage earner or if the unemployed parent does not meet connection to the labor force criteria, linkage does not exist. In general, the children continue to be eligible for Medi-Cal even if linkage does not exist. However, in most cases, the adults in the case are not eligible for Medi-Cal under any program. The same applies to cases where absence, incapacity, death or disability are erroneously identified as the linkage factor.

Four-fifths of the errors in this factor are attributed to the counties' failure to take appropriate action or follow correct policy.

3. Suggested Corrective Actions

a. Age Errors

Although the MEDS/CID systems have age/aid code edits for MI children which prevent state issuance of a Medi-Cal card for persons 21 and over, these persons still must be sent a timely discontinuance notice of action.

Many counties have automated systems which provide a listing of persons who will be 21 in the following month. The county should verify that these listings are being used properly and that timely action is taken. MEDS/CID age/aid code edit error listings provide management with a tool to identify problems.

Counties which do not have such a system should ensure that a tickler system is developed which identifies persons who will be 21 in the following month.

b. Disability/Blindness

Title 22, California Administrative Code (22 CAC), Section 50167, requires that blindness/disability be verified <u>prior to</u> granting Medi-Cal eligibility. Medi-Cal Eligibility Manual Procedures Section 4A "County Procedures, Disability Determination Referrals" provides specific instructions for counties to follow. The county should take whatever actions are necessary to ensure that these procedures are followed in all cases.

c. Living Arrangement

County staff should emphasize to beneficiaries the importance of reporting when a child moves in or out of the home. Counties should ensure that workers understand that parents over 21 who are neither aged, blind nor disabled are <u>not eligible</u> for Medi-Cal if there is no eligible child in the home.

d. Deprivation

Medi-Cal Eligibility Branch sent counties a Deprivation Training Package in All County Welfare Directors Letter No. 82-67. The county should ensure that workers receive training in deprivation factors, including connection to the labor force and identification of primary wage earner in Unemployed Parent linked cases.

C. Resources

1. Table

Factor	a. Percent of Cases in Error		b. Percent of Misspent Dollars		c. Percent of Cases Containing Factor		d. Percent of Cases in "c" Which are in Error	
	36 month	current	36 month	current	36 month	current	36 month	current
Liquid Assets	4.4	3.5	14.0	2.0	54.9	54.6	1.3	1.1
Other Personal Property	1.1	0	12.6	0	37.2	45.1	.4	0
Total Resource*	7.6	5.2	33.2	3.6				

Formulas:

a. Cases with factor in error ÷ total cases in error (e.g., 6 ÷ 172 = 3.5%)

b. Misspent dollars due to factor ÷ total misspent dollars (e.g., $182 ÷ $8,980 = 2.0%)

c. Cases containing factor ÷ total cases (e.g., 559 ÷ 1,024 = 54.6%)

d. Cases with factor in error ÷ total cases with factor (e.g., 6 ÷ 559 = 1.1%)

*Includes other resource errors

2. Discussion

Eligibility workers can expect over half of Medi-Cal applicants and beneficiaries to have liquid assets, including checking and savings accounts. Over one-third will have other personal property including nonexempt cars, boats, jewelry, etc.

Although resource errors were not a significant factor in either case error or dollar error in the current review period, in four of the past six review periods, resource errors contributed significantly to the dollar error rate. Most of these errors can be attributed to the beneficiaries failure to report all resources.

3. Suggested Corrective Action

The intent of regulations requiring preverification of income and resources is to reduce errors in this area. Counties can increase the effectiveness of these regulations by:

a. Reemphasizing to county staff the importance of verifying the value of resources <u>before</u> granting eligibility.

b. Instructing workers to question applicants and beneficiaries who report no checking or savings, no cash on hand, etc., but who indicate they either pay rent or are purchasing a home, as to how they meet their living expenses. This should improve the probability that all resources are reported.

c. Ensuring that, during redetermination, county staff compare the most recent Statement of Facts, MC 210, with prior MC 210s in the case. Many QC errors in this area could have been prevented by a review of prior information. Staff should question beneficiaries or their authorized representatives about any discrepancies.

D. Income

1. Table

Factor	a. Percent of Cases in Error		b. Percent of Misspent Dollars		c. Percent of Cases Containing Factor		d. Percent of Cases in "c" Which are in Error	
	36 month	current	36 month	current	36 month	current	36 month	current
Earned Income	24.7	24.4	11.8	15.7	25	26	15.4	15.7
RSDI	21.8	17.4	3.5	4	50	48	6.9	6.1
Other Govt. Program Benefits	7.2	9.3	5.2	11.6	24.5	25.9	4.6	6
Pensions	6.8	6.4	1.6	2.7	7.4	7.2	14.4	14.9
Total* Income	61.0	55.2	25.3	35.6				

Formulas:

a. Cases with factor in error ÷ total cases in error (e.g., 42 ÷ 172 = 24.4%)

b. Misspent dollars due to factor ÷ total misspent dollars (e.g., $1,413 ÷ $8,980 = 15.7%)

c. Cases with factor ÷ total cases (e.g., 267 ÷ 1,024 = 26%)

d. Cases with factor in error ÷ total cases with factor (e.g., 42 ÷ 267 = 15.7%)

*Includes all income errors. A case may contain more than one type of income error.

2. Discussion

Income errors, that is, beneficiary failure to report income changes or agency failure to act timely on anticipated or reported income changes, remain a significant source of dollar error. Approximately one-fourth of all MAO cases contain earned income, and an average of fifteen percent of cases with earned income will be in error. Another significant dollar error source is in Other Governmental Program Benefits. This factor includes unemployment benefits (UIB), disability benefits (DIB), veterans' benefits, etc.

Social Security Retirement, Survivors, Disability Insurance (RSDI) benefits are present in about fifty percent of all cases. The most frequent errors in this factor relate to Buy-In and cost of living adjustments (COLA).

3. Suggested Corrective Actions

a. Earned Income, Other Governmental Program Benefits

Beneficiary failure to report changes in earnings from employment and in UIB/DIB income and county failure to act timely on reported changes account for most of the errors in this area. Counties are encouraged to develop procedures to identify and more closely monitor these cases.

When beneficiaries report increased income, but the report is not timely, the county should determine the share of cost which should have been met in each month. If the beneficiary should have met a share of cost for one or more months, the amount totals $50 or more for the entire overpayment period, and Medi-Cal cards were issued either by the State or the County, the County is to report the overpayment to DHS in accordance with Title 22, Article 16.

Instructions on overpayment reporting also were provided in All County Welfare Directors Letter No. 82-19, and in the instructions for completing Medi-Cal Notice of Action, Overpayment, MC 239E.

Overpayment referrals are to be sent to:

Department of Health Services
General Collection Section
714/744 P Street
Sacramento, CA 95814

It is expected that this action will allow the State to not only recover misspent dollars but will also reduce the future incidence of untimely reporting of income changes.

b. RSDI

Failure to follow up on Medicare Buy-In and failure to make adjustments to the Medi-Cal share of cost at the time of the annual Social Security COLA increases are the two most frequent errors in this income category.

(1) Buy-In

The Department of Health Services' Buy-In Unit, Recovery Branch has developed a State Buy-In manual which is available to county staff upon request. In addition, staff from Buy-In Unit will provide training on the Buy-In process to county department staff. Counties should ensure that all appropriate staff are trained in Buy-In procedures. For further information, please contact:

Byron T. Moss, Chief
Other Coverage Section
Department of Health Services
714/744 P Street
Sacramento, CA 95814

Counties should have in place either an EDP or manual tickler system to follow-up on changes to the share of cost once Buy-In has occurred and the Medicare premium is no longer being paid by the beneficiary. In addition, counties should use the monthly Master Activity Report No. 1 and County Response Report No. 2, which are provided by the Buy-In Unit, to verify that Buy-In has occurred.

(2) Cost of Living Adjustments Excluding Title II Disregard Persons

DHS routinely sends counties advance notice of the percentage of Title II COLAs with the understanding that this information will be used to determine the new income amount. It appears that this information has not always been used as intended.

Each case containing a person who receives Social Security income should be flagged with a manual or EDP indicator. This activity can be performed over

the next several months during routine case maintenance. When the county is informed of the effective date and the percent of COLA increase to RSDI income, these cases should be pulled and necessary work should be performed. The county should <u>not</u> wait to be informed by the beneficiary of the increase in income.

Please note: Persons eligible for Title II Disregard status will not be affected by these increases. These instructions are in addition to those contained in All County Welfare Directors Letter No. 83-38.

Counties with EDP systems capable of making mass automated income changes in Medi-Cal cases are encouraged to investigate the feasibility of developing such programs. Because of the Social Security reform measure recently passed by Congress, Social Security COLAs will be moved to December. Since maintenance need changes occur in July, counties will have to recompute the share of cost for members of this population at least twice yearly. An automated system would reduce both county staff workload and QC errors.

We urge you to review county Medi-Cal program operations in light of the information and suggestions provided in this letter. We also request that you notify us of specific areas in which state developed training materials would be useful. It is our hope that together we can increase the accuracy of the Medi-Cal eligibility determination process and thus save taxpayer funds and avoid federal fiscal sanctions.

Copies of the QC analysis and federal Medicaid QC tables are available upon request.

If you have any questions or wish a copy of the analysis and tables, please contact Marlene Ratner of my staff at (916) 445-1912.

Sincerely,

ORIGINAL SIGNED BY

Jo Ann Wray
Acting Deputy Director
Health Care Policy and
Standards Division

cc: County Liaisons
Medi-Cal Program Consultants