GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF THE ELIGIBILITY DETERMINATION PROCESS FOR ALLIANCE AND MEDICAID PARTICIPANTS

BLANCHE L. BRUCE
INTERIM INSPECTOR GENERAL

OIG No. 10-1-16HT(a) **September 19, 2014**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

September 19, 2014

Deborah Carroll, Esq.
Interim Director
Department of Human Services
64 New York Avenue, N.E., 6th Floor
Washington, D.C. 20002

Dear Ms. Carroll:

Enclosed is our final report summarizing the results of the Office of the Inspector General's (OIG's) Audit of the Eligibility Determination Process for Alliance and Medicaid Participants (OIG No. 10-1-16HT(a)). This audit was included in our Fiscal Year 2014 Audit and Inspection Plan.

As a result of our audit, we directed 12 recommendations to the Department of Human Services (DHS) for actions we consider necessary to correct described deficiencies. On August 25, 2014, DHS provided a written response to a draft of this report. DHS agreed with the report's finding and conclusions and concurred with all 12 recommendations. DHS's actions planned or taken are considered responsive and meet the intent of the recommendations. The full text of the DHS response is included at Exhibit B.

We appreciate the cooperation and courtesies extended to our staff by the DHS personnel. If you have questions, please contact me or Ronald W. King, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Blanche L. Bruce
Interim Inspector General

BLB/caw

Enclosure

cc: See Distribution List

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ACRONYMS

ACEDS	Automated Client Eligibility Determination System
AFDC	Aid to Families with Dependent Children
CY	Calendar Year
DCAS	DC Access System
DHCF	Department of Health Care Finance
DHS	Department of Human Services
DIMS	Document Imaging Management System
ESA	Economic Security Administration
FPL	Federal Poverty Level
FY	Fiscal Year
ID	Identification
MA	Medical Assistance
MAR	Management Alert Report
MMIS	Medicaid Management Information System
MRDD	Mental Retardation and Developmental Disabilities
OCFO	Office of the Chief Financial Officer
OIG	Office of the Inspector General
OPRS	Office of Pay and Retirement Services
OTR	Office of Tax and Revenue
PI	Primary Informant
QI-1	Qualified Individual
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low Income Medicare Beneficiary

ACRONYMS (continued)

SSD	Social Security Disability
SSI	Supplemental Security Income
SSN	Social Security Number
SSR	Social Services Representative
TANF	Temporary Assistance to Needy Families

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EXECUTIVE DIGEST

OVERVIEW

This report summarizes the results of the Office of the Inspector General's (OIG) Audit of the Eligibility Determination Process for Alliance and Medicaid Participants (OIG No. 10-1-16HT(a)). This is the second and final report addressing the District's medical assistance eligibility determination process. This audit was included in our Fiscal Year (FY) 2014 Annual Audit and Inspection Plan and is part of our continuing review of the District's Medicaid program.

The objective of this audit was to determine whether Alliance and Medicaid participants met eligibility requirements. This audit is one of several Medicaid program audits that we will perform on an ongoing basis, as Medicaid is a major risk area and a significant portion of the District's annual budget.

PERSPECTIVE

During the verification stage of the audit, we identified District employees listed as eligible recipients in the Automated Client Eligibility Determination System (ACEDS) whose 2010 income exceeded income thresholds for their respective medical assistance programs or who were non-District residents in 2010. We concluded that the Department of Human Services (DHS) needed to address the improper claims payments, made on behalf of these potentially ineligible District employee participants, prior to issuing our audit report.

As a result, the OIG issued a Management Alert Report (MAR No. 14-A-01) to DHS on March 27, 2014, recommending that DHS take immediate action to further review the case files and investigate whether the identified employees misrepresented their income or residency in order to obtain eligibility for the District's medical assistance programs. DHS was responsive in implementing our recommendations and took immediate action to determine whether these employees met eligibility requirements based on the third-party information we provided and DHS's subsequent review of the case files. The finding and recommendations from the MAR are included within this report.

CONCLUSIONS

We found that 2,861 ineligible and potentially ineligible Alliance and Medicaid participants received medical assistance benefits from 2010-2012. According to the DHS Economic Security Administration (ESA), these participants were eligible to receive benefits; however, information regarding their respective income, identity, or residency was inconsistent with the independent third-party data verification we performed. Some of the participants were also District employees who either underreported, or failed to report, their District government income to ESA according to our comparison of the ACEDS data file and other District agency data files. Moreover, some of the employees who received medical assistance benefits from 2010-2012

EXECUTIVE DIGEST

were non-District residents. Lastly, we found deficiencies within the verification processes ESA employees and managers use to administer the Alliance and Medicaid programs.

We concluded that these conditions most likely occurred because: (1) Alliance and Medicaid participants provided false statements of income, identity, and residency to the DHS ESA; and (2) DHS was ineffective in preventing or detecting eligibility authorization errors.

As a result, we identified improper claims payments totaling $22.4M made by the Department of Health Care Finance (DHCF) on behalf of Alliance and Medicaid participants who did not meet income or residency eligibility requirements. Additionally, we found $11.5M in questionable costs where the participants may have been ineligible to receive medical assistance benefits. Moreover, the conditions found during this audit further revealed that DHS is at risk of recipient fraud due to inadequate income, identity, and residency verification methods and inefficient operations related to the medical assistance eligibility determination process. These matters requiring management's attention are detailed in the Finding and Recommendations section of this report.

SUMMARY OF RECOMMENDATIONS

We directed 12 recommendations to DHS that we believe are necessary to address deficiencies identified during the audit. The recommendations focus on: (1) determining whether the Alliance and Medicaid participants identified were ineligible, received medical assistance benefits improperly, and provided false eligibility criteria to ESA; (2) ensuring appropriate actions are taken to address fraud and ineligibility; (3) promoting compliance to ensure only eligible participants receive medical assistance benefits; and (4) improving the eligibility criteria verification process.

A summary of the potential benefits resulting from this audit is included at Exhibit A.

MANAGEMENT RESPONSES AND OIG COMMENT

On August 25, 2014, DHS provided a written response to a draft of this report. DHS agreed with the report's finding and conclusions and concurred with all 12 recommendations. DHS's actions planned or taken are considered responsive and meet the intent of the recommendations. The full text of the DHS response is included at Exhibit B.

INTRODUCTION

BACKGROUND

This audit was included in the Office of the Inspector General's (OIG's) Fiscal Year 2014 Audit and Inspection Plan. The purpose of the audit was to determine whether DC Healthcare Alliance (Alliance) and Medicaid participants met eligibility requirements.

The mission of the Department of Human Services (DHS) is to assist low-income individuals and families maximize their potential for economic security and self-sufficiency. Under DHS, the Economic Security Administration (ESA) determines District residents' eligibility for public assistance benefits, including, but not limited to, medical assistance.

Applicants who qualify for medical assistance are generally provided healthcare coverage through Medicaid, funded in part by the federal government or through the locally funded Alliance program. Once approved, ESA communicates eligibility for benefits to the Department of Health Care Finance (DHCF), which in turn pays healthcare providers for medical assistance received. In September 2010, the Medicaid and Alliance programs had 156,312 and 25,463 members, respectively. Payments for healthcare coverage for these two programs totaled approximately $1.9 billion in fiscal year (FY) 2010. As of September 2012, there were 165,592 Medicaid and 23,041 Alliance members, and payments for both programs totaled $2.2 billion in FY 2012.

Enrollment of applicants occurs at ESA headquarters, five decentralized service centers, and various outstations located in low-income neighborhoods throughout the city. The enrollment and recertification processes are completed using the Automated Client Eligibility Determination System (ACEDS). ACEDS is a flexible[1] system that allows the user to determine a customer's eligibility for public assistance benefits or just conduct a search query to determine a person's eligibility status.

ESA is responsible for enrolling District residents into various medical assistance programs available to mainly low-income individuals. In order to receive these benefits, applicants must provide certain information to show that they qualify to receive assistance. Specifically, an applicant must provide proof of identity, District residency, citizenship status, and income. The process for determining eligibility includes meeting with ESA Social Service Representatives (SSRs), who request and collect proof of eligibility and enter supported data into ACEDS. SSRs also create client case files of supporting documentation and authorize eligibility.

Another important ESA function is recertification of eligibility. The recertification process involves recipients providing updated information to have their program eligibility recertified or redetermined by ESA for additional time periods, which vary by program. Recipients are responsible for reporting all nonfinancial and financial changes by the 10th day of the month following the month of the change. Medical assistance recertifications are done by mail. Not all

[1] ACEDS processing is driven by tables that can be modified to incorporate policy changes.

INTRODUCTION

groups are required to recertify for medical assistance (e.g., "Categorically Eligible"[2] groups are not required to recertify).

ESA also performs monitoring, quality control, and reporting functions required by federal law. In addition to the SSRs' supervisors, there are two divisions responsible for detecting eligibility authorization errors: the Division of Monitoring and Quality Assurance within ESA, and the Office of Program Review Monitoring and Investigation within DHS. See Figure 1 on page 3 for a pictorial representation of the ESA organizational structure.

DHS is in the process of implementing the DC Access System (DCAS), a new Medicaid and Human Services eligibility, enrollment, and integrated case management system. DCAS will replace the legacy system, ACEDS, and will be developed in three phases or "Releases," to be consistent with all required Affordable Care Act functionality. Release I occurred on October 1, 2013, and DHS plans to issue Releases II and III on October 1, 2014, and September 1, 2015, respectively.[3] Releases II and III will expand existing functionality for other federal and local health and human services programs. DCAS will employ key functionality, such as establishing unique identifications (IDs) for users; perform matching and synchronization of IDs already existing in the system and across other District systems; implement procedures and processes to detect and deter fraud; and terminate coverage as a result of detection of fraud by a customer.

DHCF administers the Medicaid Management Information System (MMIS), which processes Medicaid claims but does not perform eligibility determinations. Eligibility and enrollment information is provided daily to the MMIS by the existing ACEDS platform. It is envisioned that DCAS will interface directly with the MMIS when ACEDS is retired as part of Release II.

[2] In medical assistance programs, being "categorically eligible" means that the group does not have to be tested against asset and income limits.
[3] The District will continue to operate ACEDS through the completion of Release II of the project.

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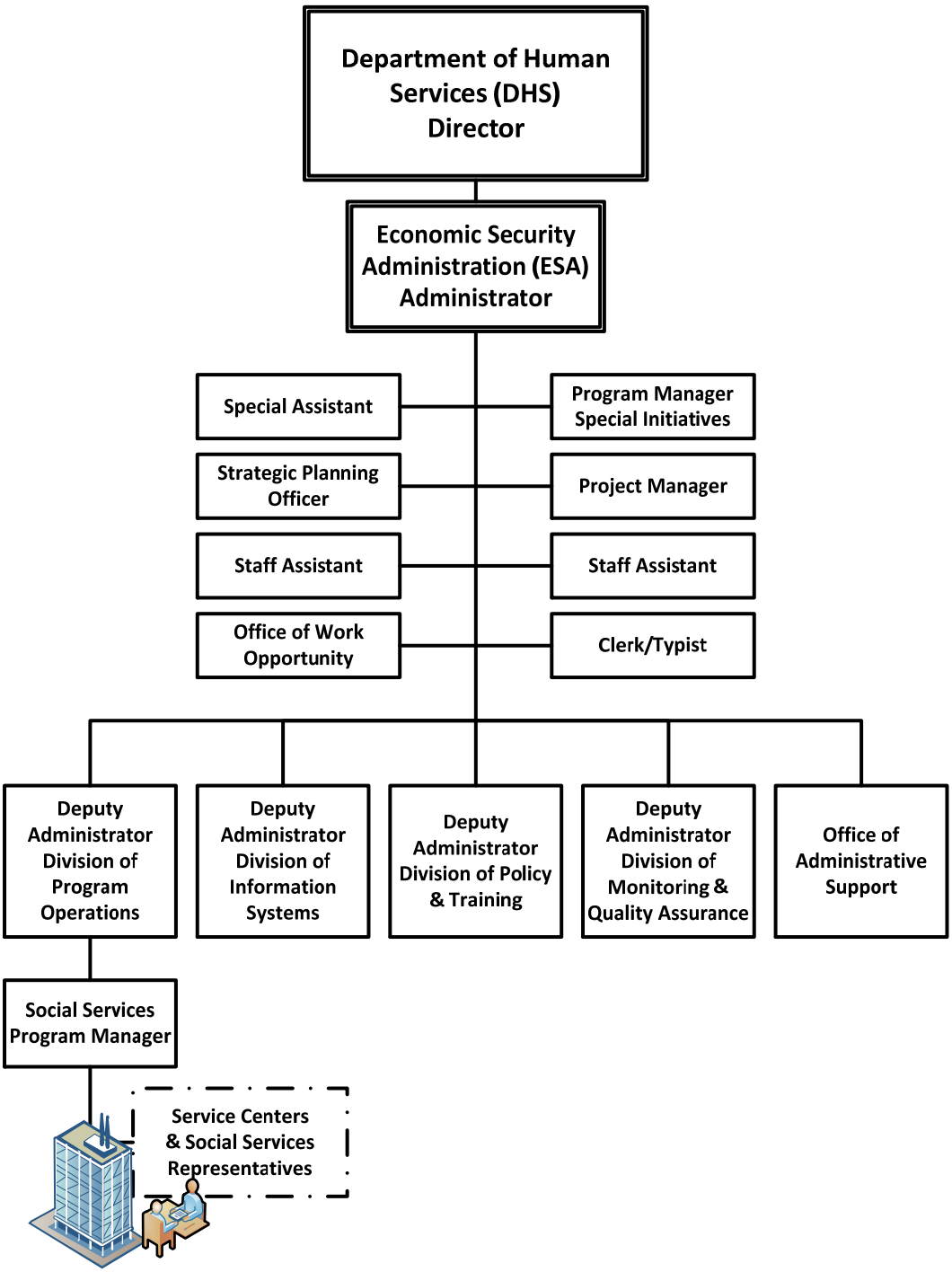
Figure 1. Excerpt of the Department of Human Services Organizational Chart Relative to the Economic Security Administration



INTRODUCTION

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objective was to determine whether Alliance and Medicaid participants met eligibility requirements. To accomplish our objective, we reviewed applicable laws, policies, and procedures related to eligibility determinations for medical assistance benefits. We submitted an internal controls questionnaire to ESA, conducted interviews with ESA employees and other District agency officials, used data mining methods, and performed a sample case file review. We also used data mining techniques to compare independent third-party data to the ACEDS eligibility file and formed conclusions about the accuracy of the information participants provided to ESA when applying for, or recertifying, medical assistance benefits.

We obtained a data file from ESA, which contained all eligible primary informants[4] in ACEDS for fiscal year (FY) 2010. We compared this file to various District agency data sources to validate eligibility information in ACEDS. We performed a sample ACEDS case file review that included information from calendar years (CYs) 2010-2012. The data we obtained from DHCF contained paid claims in CYs 2010-2012. We then used data mining techniques to compare and classify the information into several eligibility criteria[5] categories. When we identified participants who did not meet the eligibility criteria, we totaled the amount of the claims DHCF paid on their behalf. We then submitted this information to DHS for further investigation.

We relied on computer-processed data to verify eligibility criteria including participant's income, family size, employer, program type, identity, and residency. However, we did not assess the reliability of the ACEDS data because the Division of Information Systems within ESA was unavailable until after October 1, 2013, due to the Health Information Exchange deadline required by the Affordable Care Act. The OIG used the ACEDS data file obtained from ESA during the prior OIG audit,[6] and we based our conclusions on the analysis of the information in that file. Also, we based our analysis and conclusions on third-party data verifications of the information in the ACEDS data file, and the 26 ACEDS case files reviewed.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

[4] "Informants" are persons in the primary position for a group, e.g., head of household.
[5] ESA Policy Manual: http://dhs.dc.gov/page/esa-policy-manual (last visited on Nov. 18, 2013) and the Medicaid Maximum Monthly Countable Income Levels for Children and Families in Medicaid (Effective February 1, 2009).
[6] In March 2013, the OIG issued a report entitled *Audit of the Eligibility Determination Process for Alliance and Medicaid Participants* (OIG No. 10-1-16HT).

INTRODUCTION

RESULTS OF PRIOR AUDIT

In March 2013, we issued a report entitled *Audit of the Eligibility Determination Process for Alliance and Medicaid Participants* (OIG No. 10-1-16HT), which documented control deficiencies in the eligibility process. The deficiencies included: (1) inadequate supporting documentation used by ESA to substantiate eligibility criteria; (2) a lack of standard operating procedures detailing the type and quality of documents required to substantiate eligibility; and (3) untimely processing of eligibility recertification. At the onset of this audit, one prior recommendation remained unresolved; we recommended that the Director, DHS develop a set of standard operating procedures to ensure applicant information is accurate and verifiable during both initial and recertification eligibility processing.

FINDING AND RECOMMENDATIONS

FINDING: DISTRICT ALLIANCE AND MEDICAID PARTICIPANTS ELIGIBILITY VERIFICATION

SYNOPSIS

We found participants, including District employees, who were listed as eligible recipients in ACEDS and receiving medical assistance benefits although they had income that exceeded eligibility thresholds for their respective medical assistance programs. Alliance and Medicaid participants are required to accurately report and substantiate their income, residency, and identity when applying for, or recertifying, their eligibility for medical assistance. Based on our identity verification procedures, we found 24 participants who used false identities, 4 of which were for deceased persons. Additionally, we found participants, including District employees, who did not reside in the District of Columbia according to official records from the Office of the Chief Financial Officer (OCFO), Office of Tax and Revenue (OTR) and the Office of Pay and Retirement Services (OPRS); however, these individuals were listed as eligible recipients in ACEDS for the District's medical assistance programs. Finally, we reviewed a sample of ACEDS case files for District employees and found that not all residency and income information agreed with the independent third-party data we collected, and we found that DHCF made claims payments on behalf of some ineligible participants.

We concluded that these conditions most likely occurred because participants provided false statements of income and residency to ESA and DHS was ineffective in preventing or detecting eligibility authorization errors; as a result, DHCF improperly paid medical assistance claims on behalf of ineligible participants. Specifically, we identified improper claims payments totaling $21.6M, and $9.7M in potentially improper claims payments, that DHCF issued on behalf of 2,557 participants whose income exceeded, or may have exceeded, eligibility thresholds for their respective medical assistance programs. Additionally, we found 60 participants whose identities were inaccurate based on OTR's data verification, with claims payments totaling $424,949. Finally, we identified 244 participants who were non-District residents; for this group, DHCF improperly paid claims totaling $816,749 and may have improperly paid claims totaling an additional $1.3M.

DISCUSSION

We identified several categories of ineligible and potentially ineligible Alliance and Medicaid participants, some of whom were also District government employees at some point in CY 2010. In addition, we obtained claims information from DHCF to measure the amount of questionable payments made on behalf of some of these participants. The audit details for these conclusions are provided in the following sections.

FINDING AND RECOMMENDATIONS

District Employee Income Verification

We matched the eligible primary informants for FY 2010 listed in the ACEDS Alliance and Medicaid data file (received from ESA) with OPRS 2010 District employee income data. We then used data mining techniques to compare the data and classified the information into several categories. These categories consist of District government employees who: (1) reported no income to ESA when they earned income as District employees; (2) underreported their income to ESA; or (3) reported additional income to ESA beyond what they earned as District employees. These categories are detailed in Table 1 below.

Table 1. Comparison of ACEDS Income Data to District Employment Income

Income Categories	Totals	Percentages
Reported No Income to ESA But Had Income	950	44%
Underreported Income to ESA	671	31%
Reported Additional Income[7] to ESA	551	25%
Total	2,172	100%

The match resulted in a population of 2,172 individuals employed by the District government in CY 2010, who were also in the FY 2010 ACEDS file. We determined that 950 (or 44 percent) of these employees reported to ESA that they had no income when applying for or recertifying their medical assistance benefits in FY 2010, but OPRS records indicated that they had earned income from District government employment in CY 2010. We also determined that 671 (or 31 percent) of the population underreported their income to ESA. The remaining 551 employees (or 25 percent of the population) reported additional income to ESA in excess of the amount they were paid through their District government employment.

These results indicate that 75 percent of these participants may have misrepresented their eligibility criteria to ESA in order to improperly obtain medical assistance benefits. DHS should carefully review the original application or recertification documentation, along with the third-party data, for each of these participants to determine whether further investigation is warranted. The impact of potentially ineligible participants in the Medicaid and Alliance programs is especially significant because these cases consist of District employees whose actions affect District government integrity. As a result of insufficiently verifying the income of some of these District employees, DHS may have enabled ineligible participants to receive medical assistance benefits.

Tax Return Verification

We collaborated with OTR to identify potential anomalies in income and residency data reported to ESA. OTR grouped the participants based on certain attributes, which showed that ESA did not receive the same information OTR received via the participants' District 2010 tax returns.

[7] ACEDS case files contained higher reported income figures than the OPRS District employee income file, which can be explained by additional income from secondary jobs, household income, or unearned income that did not derive from District government employment.

FINDING AND RECOMMENDATIONS

Additionally, we matched official OPRS electronic records of employees who worked for the District government at some point during CY 2010 to the OTR identified group of participants with income, based on their family size, in excess of 300 percent of the Federal Poverty Level (FPL), the maximum income eligibility threshold for some of the medical assistance programs. For example, a family of four's monthly income threshold to qualify for benefits under the DC Healthy Families Program in FY 2010 was $5,512.50, equivalent to $66,150 annually. Table 2 below gives a description of the matched population.

	Table 2. Population Descriptions for Participants With 2010 Income Exceeding 300 Percent of the FPL	
	Totals	**Population Descriptions**
1	162,473	Participant case file records in the ACEDS data file
2	141,989	Participants with Social Security Numbers
3	2,935	Participants with income exceeding 300 percent of the FPL
4	2,557	Number of participants within the previous population (row 3) with paid claims
5	189	Number of District employees in this population (row 4) with paid claims

We obtained claims data from DHCF for participants whose 2010 tax return data showed income exceeding 300 percent of the FPL for their respective household size. The DHCF data included claims with dates of service from CYs 2010-2012. The claims data for these participants included the medical assistance (MA) codes, which we used to determine the income threshold eligibility criteria. Tables 3 and 4, on the next page, show the categories we used to determine whether there were potentially ineligible participants in the Alliance and Medicaid medical assistance programs based on income thresholds.

Our analysis determined that in 2,693[8] cases, participants exceeded clearly defined income thresholds for their respective medical assistance programs (see Table 3). In an additional 845[9] cases, the applicable income criteria were more complex and we could not determine whether these participants were ineligible based solely on income data (see Table 4). The total number of participants with 2010 income in excess of 300 percent of the FPL and paid claims was 2,557, as shown in Table 2 above. The total number of recipients listed in Tables 3 and 4 is greater (3,538) because some individuals participated in multiple programs during CYs 2010-2012.

[8] We note that 205 of these cases pertain to District employees. Accordingly, we issued a Management Alert Report (MAR) on March 31, 2014, that notified DHS about the employees found in this population.
[9] Seventy-six of these cases pertain to District employees. As noted above, we notified DHS about these employees via a MAR issued on March 31, 2014.

FINDING AND RECOMMENDATIONS

Table 3. Paid Medicaid/Alliance Claims for Participants Whose 2010 Tax Year Income Exceeded 300 Percent of the FPL With Clearly Defined Eligibility Income Thresholds			
Number of Recipients	**MA Code Program Type Descriptions**	**Income Thresholds**	**Claims Totals CYs 2010-12**
122	Medically Needy or Disabled	50% FPL	$681,938
645	Alliance	200% FPL	$1,135,912
114	Pregnant, Aged or Disabled (Title XIX)	100%-185% FPL	$805,667
1,335	Childless Adult Medicaid	200% FPL	$10,475,257
477	Medical Expansion for Parents of Eligible Children & MRDD[10]	200%-300% FPL	$8,472,358
2,693*	Totals		$21,571,132

*Total number of recipients is 3,538 because some individuals participated in multiple programs.

Table 4. Paid Medicaid Claims for Participants Whose 2010 Tax Year Income Exceeded 300 Percent of the FPL and May Have Exceeded Applicable Eligibility Income Thresholds			
Number of Recipients	**MA Code Program Type Descriptions**	**Income Thresholds**	**Claims Totals CYs 2010-12**
61	QMB, SLMB, QI-1[11]	Varies	$73,686
282	Categorically Eligible	SSD or SSI[12] Eligible	$5,276,757
21	Spend Down (500 Series)	Medical Bills Reduce Countable Income	$106,869
12	Spend Down (600 Series)	Medical Bills Reduce Countable Income	$3,611
38	Aged or Medically Needy; Not Receiving SSI	SSI Payment Level	$352,630
294	AFDC/TANF[13] Adult	SSI Payment Level	$1,392,071
137	Medically Needy or Medicare; Not Receiving SSI	SSI Payment Level	$2,517,052
845*	Totals		$9,722,676

[10] "MRDD" stands for Mental Retardation and Developmental Disabilities.
[11] "QMB" stands for Qualified Medicare Beneficiary, "SLMB" stands for Specified Low Income Medicare Beneficiary, and "QI-1" stands for Qualified Individual.
[12] "SSD" stands for Social Security Disability and "SSI" stands for Supplemental Security Income.
[13] "AFDC" stands for Aid to Families with Dependent Children and "TANF" stands for Temporary Assistance to Needy Families.

FINDING AND RECOMMENDATIONS

Identity Verification

Through our collaboration with OTR, we identified another irregularity within the ACEDS data file: participants whose identities did not match official tax records. OTR identified 60 participants whose Social Security Numbers (SSNs) did not match the SSNs on these individual's respective 2010 tax returns. The claims total for this population for CYs 2010-2012 totaled $424,949. These participants may have provided misinformation to ESA when applying for benefits in order to improperly obtain eligibility for the District's medical assistance programs.

We used software that searched through public and private data sources to verify and validate the identities of the 60 participants and determine the reason(s) why these participants had incorrect, or nonmatching SSNs on file with OTR versus the SSNs in ACEDS. We found that 18 (or 30 percent) of participants in this group had SSNs recorded in ACEDS that appeared to be typos because the SSN in ACEDS was close enough to the information from the identity validation that there appeared to be a mistake (e.g., transposition or one-digit off). We also found that 18 (or 30 percent) of the participants in this population matched the identities we found during our identity verification procedures. Some reasons these participants' identities may not have matched OTR records were the participant used a different name, such as a maiden name, or the names and addresses in ACEDS were too dissimilar for the OTR match to be successful.

The remaining 24 participants' files (or 40 percent) contained various irregularities related to identity verification that DHS should further investigate. Our identify verification determined that four of these participants are deceased. Three participants showed some likeness to the identity in ACEDS, but there was a distinct variation in the person's name or address, which may explain why OTR did not obtain a successful match. Two participants had SSNs that were connected to multiple[14] identities. Finally, the identities of the other 15 participants could not be linked in any way to the identities found using the verification software.

We believe that there are additional identity validation methods available that could assist DHS in effectively verifying the identities of applicants for public assistance programs. These methods would assist the SSRs in assessing the validity of support documentation applicants provide to substantiate their identities. As a result of inadequately verifying the identities of some Alliance and Medicaid participants, DHS may have enabled ineligible participants to receive medical assistance benefits.

[14] There were more than three identities connected to each of these two SSNs.

FINDING AND RECOMMENDATIONS

Residency Verification

According to the ESA Policy Manual, Alliance and Medicaid participants must reside in the District of Columbia to be eligible to receive District Alliance or Medicaid medical assistance benefits. OTR provided us a list of participants from the ACEDS data file who submitted 2010 D-40B District tax returns. The D-40B is a tax return in which a nonresident attests that he/she did not live in the District for any part of the applicable tax year, but for some reason, had District income taxes withheld from his/her wages. The purpose of this return is for the non-District resident to receive a full refund of all District income taxes paid.

We identified 255[15] Alliance and Medicaid participants who attested on a D-40B return that they did not live in the District of Columbia at any time during CY 2010. Therefore, we concluded that any claims payments made on their behalf during that year were improper because they did not meet eligibility criteria to receive District medical assistance benefits. We obtained paid claims information from DHCF for these participants for CYs 2010-2012. Of the 255 participants identified, 244 had improper claims payments totaling $816,749 in CY 2010. We also noted that some of these participants also had claims payments, totaling $1.3M, for the period of CYs 2011-2012, which represent potentially improper payments if these participants continued to reside outside the District. Table 5 below details the participant totals and their respective paid claims' totals by calendar year.

Table 5. Participants Who Filed Nonresident District Tax Returns and Their Respective Paid Claims' Totals for CYs 2010-2012

Calendar Year	Participant Totals	Claims Totals
2010	244	$816,749
2011	216	$719,168
2012	135	$611,901
2010-2012 Claims Total		$2,147,818

We used identity verification software to further verify residency for the six District employees/participants who filed 2010 D-40B tax returns. Table 6 on the next page shows each employee's respective CY 2010 residency information obtained from OPRS, OTR, and the identity verification, compared to ESA's FY 2010 residency data.

[15] Six of these participants were District employees. We notified DHS about the employees found in this population, via the previously mentioned MAR, on March 31, 2014.

FINDING AND RECOMMENDATIONS

Table 6. Third-Party Data Verification of Residency Results						
Employee	**ESA**	**OPRS**	**OTR**	**Identity Verification**	**Driver's License State**	**Summary**
1	District	Maryland	Non-Resident	Maryland	District	Maryland address verified based on third-party data. No connection to District address found.
2	District	District	Non-Resident	Maryland	District	Maryland address verified based on third-party data. District address appears to be parents' address.
3	District	Maryland	Non-Resident	Maryland/ District	District	Dual residency. Maryland address most likely primary address due to OTR filing.
4	District	Maryland	Non-Resident	Maryland/ District	None	Dual residency. Maryland address most likely primary address due to OTR filing.
5	District	Maryland	Non-Resident	Maryland/ District	District	Dual residency. Maryland address most likely primary address due to OTR filing.
6	District	District	Non-Resident	Maryland	None	Maryland address verified. District address only verified for 1 month, March 2011.

Our authentication results confirmed that all six participants were non-District residents in CY 2010 whereas ESA's records showed that they were District residents. This discrepancy indicates potential misstatements by applicants in order to establish eligibility for District medical assistance programs. We observed that all participants with a driver's license had a District driver's license while they were likely Maryland residents. According to the ESA Policy Manual, a driver's license is a valid form of identification the SSRs use to verify an applicant's identity and residency. Therefore, assuming SSRs required applicants to produce a driver's license, additional identity verification methods may be useful to detect applicant misstatements and prevent ineligible applicants from obtaining District medical assistance benefits.

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In addition to residency verification through OTR and identity verification data queries, we matched CY 2010 address data from the OPRS employee data file to participant residency information in the ACEDS data file. We determined that of the 2,172 District employees eligible for medical assistance benefits, 82 lived outside the District at some point during CY 2010 (75 of 82 were Maryland residents).

This data mining method identified all nonresidents who were District employees, not just the D-40B tax filers. Of the 6 D-40B tax filers shown in Table 6, 4 were also found within the ACEDS data file (see Table 7 below). In total, we identified 84[16] nonresident District employees in the ACEDS data file. Stronger internal controls should be implemented to verify residency for medical assistance applicants because current verification methods are not effectively preventing nonresidents from obtaining eligibility.

Table 7. Nonresident District Employees in ACEDS

State of Residency	State Totals
Maryland	75
Virginia	5
Arizona	1
Georgia	1
District of Columbia (Nonresident Return/D-40B Filers)	2
Total	84

District Employee Case File Review

Lastly, we selected and reviewed a sample of ACEDS case files, which included participants who underreported their income to ESA based on comparisons with OTR's 2010 tax return information. These participants also were identified by OPRS as having been an employee of the District government at some point during CY 2010. Specifically, we reviewed 26 ACEDS case file histories from CYs 2010-2012 for reported income, employer information, income support documentation, other health insurance information, and recertification dates. The purpose of reviewing the case files was to determine what information was in ACEDS; whether the data reconciled with the source documents; whether it contradicted OPRS and OTR data; and why any inaccuracies were not detected and corrected by ESA.

We compared the information obtained from the case file review to the OPRS District employee income data, and noted the income exceptions shown in Table 8 (on the next page). We found income exceptions, and other errors, in 22 of the 26 (85 percent) case files reviewed. We noted

[16] We notified DHS about the employees found in this population, via the previously mentioned MAR, on March 31, 2014.

that DHCF made improper claims payments on behalf of those employees in CYs 2010-2012 totaling $164,213.[17]

Table 8. District Employee Case File Review Income Exceptions		
Income Exception Descriptions	**Total Case Files**	**Percentage of Total Sample***
No District government income reported to ESA	18	69%
Underreported District government income to ESA	3	12%
ESA incorrectly recorded District government income in ACEDS	1	4%
Totals	22	85%

*Sample Size = 26 Medical Assistance Case Files

Internal Controls

Generally Accepted Government Auditing Standards establish that internal control "comprises the plans, policies, methods, and procedures used to meet the organization's mission, goals, and objectives. Internal control includes the processes and procedures for planning, organizing, directing, and controlling program operations, and management's system for measuring, reporting, and monitoring program performance."[18] Management is responsible for developing, implementing, and monitoring internal controls. Ultimately, internal controls provide reasonable, but not absolute assurance, that the organization's goals will be achieved.

During this audit, we reviewed ESA's list of ACEDS key controls, which indicated that ESA is proactive in implementing internal controls to protect the integrity of the eligibility enrollment process. However, we found during our case file review that some of the key controls related to income, identity, and residency verification are inadequate. A significant challenge presented by eligibility determinations is that the application process is largely based on self-reporting. Therefore, it is critical that corroborating support documentation and interfacing data checks are obtained and performed, carefully reviewed, and applied timely and consistently when determining eligibility.

Table 9, on the next page, shows a listing of the types of errors or irregularities we found while performing the case file reviews of 26 employees whose income exceeded 300 percent of the FPL in CY 2010. We found a number of issues when performing random eligibility compliance testing on the 26 case files.

[17] These paid claims are included in the $31.3M monetary benefit referred to in Exhibit A, Recommendation 1.
[18] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GOVERNMENT AUDITING STANDARDS 18-19, § 2.11, GAO-12-331G (2011 Rev.).

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Table 9. District Employee Case File Review Results		
Irregularity Descriptions	**Number of Irregularities**	**Percentage of Total Sample***
Base Wage[19] interface shows prior income when participant reported none.	2	8%
No end date entered into eligibility through date field.	2	8%
Incorrect eligibility through date/recertification date entered.	1	4%
Paystub frequency keying error.	1	4%
Missing or nonmatching paystub support documentation.	3	12%
Missing support documentation for income disregarded.	2	8%
Information in system does not qualify recipient for medical assistance program.	4	15%
Reported unemployment income to ESA while employed by District government.	5	19%
Other health insurance in 2010.[20]	8	31%

*Sample Size = 26 Medical Assistance Case Files

We performed a random sampling of eligibility criteria due to our inability to audit all the source documentation for the sampled case files. During our audit, there were problems retrieving electronic records within DHS's Document Imaging Management System (DIMS). For example, when we requested that the SSR locate specific documents in DIMS, the SSR was unable to retrieve the correct documents in a timely manner. In some instances the SSR was unable to find the correct document at all. According to the SSR, the reason for the retrieval problems we experienced is that DIMS is often times unable to capture the date stamp accurately.

We observed during our case file review, long continuous listings of documents, sorted by date, that were associated with the participants' case files, some spanning multiple years. We found eligibility support documentation, without an accurate date stamp, difficult and sometimes impossible to locate for the relevant timeframe. We observed numerous instances where DIMS logged an electronic default date of 01/01/1900, when the system was unable to read the manual date stamp. Each electronic document with the electronic default date must then be opened and reviewed to determine whether it is the correct one. This made it impossible to timely review the

[19] An ACEDS interface query, used for income verification, which shows how much income an applicant earns if their employer reports and submits quarterly income taxes to the District on behalf of their employee.
[20] According to ESA, it is permissible to have other health insurance while in a Medicaid program but it is prohibited for Alliance eligibility.

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case files to determine whether the eligibility criteria, manually keyed into ACEDS, accurately reflects the source documentation submitted by the medical assistance applicant.

According to the ESA Policy Manual, Part VIII – Case Maintenance, Chapter 1.1 − Case Record Documentation Standards:

> All program records should be labeled and retained in an organized fashion for audit and review purposes including[, but not limited to]:
>
> - Application, re-certification forms, and related documents; [and]
> - Verification documentation submitted by the applicant/recipient[.]

ACEDS interfaces with several databases to verify income for applicants. One of the interfaces is called Base Wage, which only captures income from employers that report employee earnings on a W-2 form. During the case file review, the SSR advised that the Base Wage verification must be performed during the application and recertification processes. The SSR must perform the Base Wage query, print the query, and send it for imaging to be included as part of the applicant's case file. However, we found no recent evidence reflecting that the SSRs performed this verification check beyond placing an occasional notation in the system.

Additionally, the Base Wage data is not current because it consists of income reported by the applicant's employer when paying quarterly income taxes and can be up to 90 days old. Therefore, this key control is inadequate because it is not being performed consistently and the information provided is not current. The SSRs are required to collect the prior 30 days of income information from the applicant; however, if the applicant reports no income, it is difficult to verify something that does not exist. The agency is too reliant upon the applicant to provide accurate income information at the time of application and notifying ESA of any changes thereafter.

The income verification issue we found may be corrected by performing a "look back" income verification. The check would consist of generating a daily report of applicants that obtained eligibility during the previous 2 to 3 months. The SSR would conduct a Base Wage data check on those applicants to verify whether the income information provided at the time of application or recertification was accurate. If not, then either: (1) the SSR would bring the discrepancy to management's attention for further investigation; or (2) the system would generate and send an automatic letter to the applicant advising of the discrepancy and that a face-to-face interview is required to resolve the potential misstatement in income. We believe this added step could be the solution to the issues of income self-reporting and lack of real-time interface data. Further, we believe the resources necessary to perform this check already exist at ESA and may be cost-effective. Rather than finding out that an applicant is ineligible at the point of recertification (usually 12 months after enrollment), ESA could determine that a possible misstatement occurred within 2 to 3 months of enrollment and the District would avoid paying medical assistance benefits for the ineligible participant for an additional 9 to 10 months. This could be a temporary solution until the real-time independent data verification becomes a reality.

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CONCLUSIONS

Based on our analysis, it appears that Alliance and Medicaid participants provided incorrect information to ESA in regard to their income and residency, which did not agree with the third-party data we reviewed from other District agencies. We identified $21.6M in improper claims payments and $9.7M in potentially improper claims payments on behalf of 2,557 participants whose income exceeded, or may have exceeded, eligibility thresholds for their respective medical assistance programs. Moreover, we found 60 participants whose identities were inaccurate based on OTR's identity verification, with claims payments totaling $424,949. Lastly, we found 244 participants who were non-District residents with improper claims payments totaling $816,749 for CY 2010 and an additional $1.3M in potentially improper payments for CYs 2011-2012.

There is a significant risk that these medical assistance participants misstated their income, identity, and residency to ESA. Further investigation is required to determine whether these participants knowingly provided incorrect information to improperly obtain eligibility for the District's medical assistance programs. We strongly believe that DHS should strengthen its internal controls, to include encouraging staff to follow existing policies and procedures, and modify existing controls to prevent such acts from occurring going forward. DHS can improve the income, residency, and identity verification processes by using third-party data and data mining methods to identify participants who may have misrepresented their eligibility criteria. By taking appropriate actions, DHS can proactively identify potential misrepresentations of eligibility criteria to ensure only eligible participants receive medical assistance benefits through the District's Alliance and Medicaid programs.

RECOMMENDATIONS, MANAGEMENT RESPONSES, AND OIG COMMENTS

Based on our audit results, we recommend that the Director, DHS:

1. Determine whether any of the 2,368[21] participants received or are continuing to receive medical assistance benefits incorrectly based on the income verification we performed using OTR data; investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Attorney General for appropriate action.

DHS RESPONSE

DHS agreed with the recommendation and expects to at least substantially complete their investigation by November 30, 2015. DHS stated that as part of its ongoing quality assurance reviews, it will conduct an inquiry regarding the current District employees identified in our audit. DHS has developed a detailed strategic approach for conducting their investigation of the validated employees.

[21] This represents the number of participants identified within the report (2,557) less the District employees (189) referenced in Recommendation 2.

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OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

2. Determine whether any of the 189 District employees received or are continuing to receive medical assistance benefits incorrectly based on the income verification we performed using OPRS and OTR data; investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Inspector General for appropriate action.

DHS RESPONSE

DHS agreed and stated that it will give this recommendation priority attention. DHS stated that it will review the identified employees' eligibility for the period in question based on third party income information. DHS expects to at least substantially conclude its investigation by January 26, 2015.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

3. Determine whether any of the 60 participants received or are continuing to receive medical assistance benefits incorrectly based on the identity verification we performed; correct the data entry errors and/or investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Attorney General for appropriate action.

DHS RESPONSE

DHS agreed with the recommendation. DHS stated that the Office of Program Review, Monitoring and Investigation will conduct the investigation, which will be prioritized and is slated to be at least substantially completed by November 30, 2015. As appropriate, DHS will refer substantiated cases to the D.C. Office of the Attorney General.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

4. Determine the cost-effectiveness of using another identity verification method to detect discrepancies between the applicant's reported identity and a possible false persona, as well as independently verify residency information.

DHS RESPONSE

DHS agreed with the recommendation, and is giving it priority attention. DHS expects to achieve at least substantial completion by November 30, 2015. DHS stated that it will obtain

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necessary data from OPRS and OTR and explore other cost-effective methods to verify identity and residency information.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

5. Determine whether any of the 244 participants received or are continuing to receive medical assistance benefits incorrectly based on the residency verification we performed using OTR data; investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Attorney General for appropriate action.

DHS RESPONSE

DHS agreed with the recommendation and expects to achieve at least substantial completion of its investigation by November 30, 2015. DHS stated that it will review the identified participants' eligibility for the period in question based on third party residency information.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

6. Determine whether any of the 84 District employees received or are continuing to receive medical assistance benefits incorrectly based on the residency verification we performed using OPRS and OTR data; investigate to determine whether recipient fraud exists; and refer the cases to the Office of the Inspector General for appropriate action.

DHS RESPONSE

DHS agreed with the recommendation and has assigned priority attention to its completion. DHS targets completion of its review by November 30, 2014. DHS provided a detailed strategic approach for conducting its review of the validated employees.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

7. Determine whether any ineligible participants are still eligible in ACEDS or DHCF's claims system; correct their eligibility status in both systems; and discontinue improper claims payments.

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DHS RESPONSE

DHS agreed with the recommendation and expects to at least substantially conclude their investigation by November 30, 2015. DHS stated that it will conduct this investigation as part of its ongoing quality assurance reviews. As appropriate, DHS will notate the system with the investigative outcomes so that corrective actions regarding receipt or termination of benefits can be taken.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

8. Improve the income and residency verification processes by using data mining methods in conjunction with third-party data, such as OPRS employee data, to identify employees in Medicaid or Alliance that may have misrepresented their income and state of residency to obtain eligibility.

DHS RESPONSE

DHS agreed with the recommendation and plans to enhance the current verification process by gaining access to OPRS employee data by November 30, 2015.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

9. Verify that errors and anomalies identified in the 22 District employee case files have been resolved.

DHS RESPONSE

DHS agreed with the recommendation and assigned priority to its completion. DHS' target date for its review of the employees in this category (e.g., those with income exceptions) is November 30, 2014.

OIG COMMENT

Actions planned by DHS are responsive and meet the intent of the recommendation.

10. Retrain staff and perform more frequent supervisory case file reviews to ensure compliance with existing laws, rules, regulations, and policies and procedures to promote consistent and accurate eligibility verification processing.

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DHS RESPONSE

DHS responded that staff is retrained annually or more frequently as needed. Additionally, DHS stated that staff is retrained when policy or procedural changes occur. DHS also plans to fully implement an enhanced Selected Supervisory Case Review process by October 31, 2014.

OIG COMMENT

Actions planned and taken by DHS are responsive and meet the intent of the recommendation.

11. Comply with the ESA Policy Manual and correct the date-stamping issue in DIMS to ensure all source documents are recorded electronically with an accurate date to make them easily accessible for audits, supervisory oversight, and operational efficiency.

DHS RESPONSE

DHS maintains that the date stamping issue we observed resulted from a past conversion of legacy case files and, therefore, does not occur within the current document scanning process. However, DHS will reissue memorandum to all staff stressing the importance of date stamping.

OIG COMMENT

Actions taken by DHS are responsive and meet the intent of the recommendation.

12. Implement a procedure to use Base Wage data verification in a timely manner by adopting a "look back" check to verify whether the applicant provided accurate income data at the time of application or recertification.

DHS RESPONSE

DHS stated that they perform a "look back" procedure at the point of recertification and also review current paystubs. Additionally, DHS indicated they are in the midst of a major system upgrade whereby they expect to be able to create reports and leverage information from local data hubs in the future. This recommendation is expected to be completed by November 30, 2015.

OIG COMMENT

In consideration of the system upgrade, which is expected to enhance the eligibility verification process, we consider the actions planned and taken by DHS to be responsive and meet the intent of the recommendation.

EXHIBIT A: SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendations				
No.	**Description of Benefit**	**Amount and Type of Benefit**	**Estimated Completion Date**	**Status[22]**
1	**Compliance.** Ensures that only eligible participants receive medical assistance benefits.	Monetary $31.3 Million	11/30/2015	Open
2	**Compliance.** Ensures that only eligible District employee participants receive medical assistance benefits.	Monetary $1.2 Million (Included in Recommendation 1)	1/26/2015	Open
3	**Compliance.** Ensures that only eligible participants receive medical assistance benefits.	Monetary $424,949	11/30/2015	Open
4	**Internal Control and Economy and Efficiency.** Reduces the risk of errors and fraud affecting Alliance and Medicaid programs during the eligibility determination process.	Non-Monetary	11/30/2015	Open
5	**Compliance.** Ensures that only eligible participants receive medical assistance benefits.	Monetary $2.1 Million	11/30/2015	Open
6	**Compliance.** Ensures that only eligible District employee participants receive medical assistance benefits.	Monetary Undetermined	11/30/2014	Open
7	**Compliance and Internal Control.** Ensures that only eligible participants receive medical assistance benefits.	Monetary Undetermined	11/30/2015	Open

[22] This column provides the status of a recommendation as of the report date. For final reports, **"Open"** means management and the OIG are in agreement on the action to be taken, but action is not complete. **"Closed"** means management has advised that the action necessary to correct the condition is complete. If a completion date was not provided, the date of management's response is used. **"Unresolved"** means that management has neither agreed to take the recommended action nor proposed satisfactory alternative actions to correct the condition.

EXHIBIT A: SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendations (continued)				
No.	**Description of Benefit**	**Amount and Type of Benefit**	**Estimated Completion Date**	**Status**
8	**Economy and Efficiency.** Increases fraud detection capabilities related to income and residency verification.	Monetary Undetermined	11/30/2015	Open
9	**Compliance and Internal Control.** Ensures compliance with income requirements for the District medical assistance program and information accuracy in ACEDS.	Monetary $164,213 (Included in Recommendation 1)	11/30/2014	Open
10	**Compliance and Economy and Efficiency.** Ensures compliance with District medical assistance program requirements, consistency in program operations, and reduces the risk of eligibility authorization errors.	Non-Monetary	10/31/2014	Open
11	**Compliance, Internal Control, and Economy and Efficiency.** Ensures compliance with ESA policy and timely accessibility of ACEDS electronic source documentation.	Non-Monetary	08/25/2014	Closed
12	**Internal Control and Economy and Efficiency.** Increases ESA's ability to timely detect fraudulent income information and prevent improper claims payments to ineligible program participants.	Non-Monetary	11/30/2015	Open

EXHIBIT B: DHS RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Office of the Director

August 25, 2014

Blanche Bruce
Interim Inspector General
DC Office of the Inspector General
717 14th Street, NW
Washington, DC 20005

RE: Department of Human Services Response to the Office of the Inspector General (OIG) No. 10-1-16HT (a)

Dear Interim Inspector Bruce:

This is in response to the July 22, 2014, OIG "Draft Audit of the Eligibility Determination Process for Alliance and Medicaid Participants" report. The Department of Human Services (DHS) is responding to the findings and recommendations of this report in conjunction with responses to the OIG Management Alert Report (MAR-14-A-01).

As you are aware, DHS submitted a preliminary response to MAR-14-A-01, on April 30, 2014, with projected plans to conduct and conclude an internal investigation into the issues cited in the MAR by the fourth quarter of FY 2014. However, given the significant issues associated with alleged or suggested employee fraud and other equally serious fraudulent/criminal activities, DHS has prioritized its approach to the recommendations of both reports (MAR-14-A-01 and No. 10-1-16HT (a)) and the resulting case/customer review. Hence, because the findings and recommendations in MAR-14-A-01 are also in this report, and given that the data sources and strategies for investigating customers identified in both reports are the same, we propose to simultaneously review and investigate all cases appropriately identified as improper. To that end, please note that OIG Recommendations 2, 3,4,5,6, and 9 are being given priority attention, with case reviews relative to issues in these recommendations being implemented within the next week, and with full investigations being slated for completion or substantial completion by November 2015.

As indicated, DHS has developed a strategic approach for investigating those cases identified as possibly fraudulent. DHS' validation process will include assessing the identified cases by program type, household size and the properly applied Federal Poverty Level (FPL) for each case for the initial fiscal year in question. Based on those findings, DHS will conduct a more comprehensive review, including interviews of the validated/identified "fraud" cases

EXHIBIT B: DHS RESPONSE

Therefore, DHS' proposed investigative approach includes but is not limited to:

- Reviewing the OPRS and OTR income verification data the OIG's office used to calculate the 2010 income for the validated/identified District employees.
- Check ACEDS for validated/identified District employees, (This requires, at a minimum, review of 8 different ACEDS screens for all 5 years.);
- Conduct credit reports for all validated/identified District employees; Check sources for all possible addresses for all validated/identified District employees;
- Check DIMS for all validated/identified District employees and retrieve all pertinent documents for 2010, 2011, 2012, 2013 and 2014;
- Create and send out appointment letters to all known addresses for all validated/identified District employees, specifying information and documents to be brought to the meeting;
- Conduct mass interviewing for the validated/identified District employees on multiple Saturdays; and
- Update and perform Medicaid eligibility using the new information to assess whether the identified employees were correctly approved for Medicaid.

With this strategic approach in mind, DHS answers to OIG recommendations are as follows:

1. OIG Recommendation

Determine whether any of the 2,368 participants received or are continuing to receive medical assistance benefits incorrectly based on the income verification we performed using OTR data; investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Attorney General for appropriate action.

1. DHS Response

The review of the validated 2,368 (current) DC employees would be conducted as part of DHS' ongoing quality assurance reviews. We would sample a set number of validated/identified employees each quarter as opposed to trying to re-determine eligibility at once for all. The investigation will comport with the previously stated strategy and DHS will refer cases deemed fraudulent to the Office of Attorney General for appropriate action.

2. OIG Recommendation

Determine whether any of the 189 District employees received or are continuing to receive medical assistance benefits incorrectly based on the income verification we performed using OPRS and OTR data; investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Inspector General for appropriate action.

2. DHS Response

Previously responded to in MAR-14-A-01 and accepted by OIG.

EXHIBIT B: DHS RESPONSE

More specifically, once validated, effective September 8, 2014, appointment letters will be sent to the identified employees requiring them to attend a Saturday interview (tentatively on 9/27/14), to review their eligibility for the period in question based on third party information. Because the OIG Investigator accessed and used ACEDS information, this gives us a greater opportunity to assess the information and the methodology used by the OIG Investigator. The target for completing this review is 120 days.

3. OIG Recommendation

Determine whether any of the 60 participants received or are continuing to receive medical assistance benefits incorrectly based on the income verification we performed; correct the data entry errors and/or investigate to determine whether recipient fraud exist; and refer substantiated cases to the Office of the Attorney General for appropriate action.

3. DHS Response

This recommendation which involves identity issues will receive priority consideration. The validated/identified cases will be investigated by the Office of Program Review, Monitoring and Investigation (OPRMI), which functions under the immediate direction of the DHS Director and is responsible for managing allegations and incidents of fraud, abuse, and waste in DHS programs by investigating and referring customers and/or employees for criminal prosecution, program disqualification or other actions. Upon completion of investigation of these cases, as appropriate, OPRMI will make direct referrals to the Office of Attorney General (OAG) for action.

4. OIG Recommendation

Determine the cost-effectiveness of using another identify verification method to detect discrepancies between the applicant's reported identify and a possible false persona, as well as independently verify residency information.

4. DHS Response

DHS believes that gaining access to the Office of Pay and Retirement Services (OPRS) and Office of Tax and Revenue (OTR) will be the first and most immediate step in achieving a cost-effective means of verifying identity and residency information. Should the OIG be unable to provide DHS the data it used from OPRS and OTR, DHS will connect with both offices to work out a process for DHS to access the necessary data. However, DHS will explore other cost effective methods for validating identity and residency and determine the feasibility of implementing the most viable methods. Further, validated cases will be investigated for identity and residency issues by OPRMI. Upon completion of investigation of these cases, as appropriate, OPRMI will make direct referrals to the Office of Attorney General (OAG) for action.

EXHIBIT B: DHS RESPONSE

5. OIG Recommendation

Determine whether any of the 244 participants received or are continuing to receive medical assistance benefits incorrectly based on the residency verification we performed using OTR data; investigate to determine whether recipient fraud exists; and refer substantiated cases to the Office of the Attorney General for appropriate action.

5. DHS Response

The same methodology referenced in response to OIG Recommendation 2 will be employed for this issue of residency for 244 participants. DHS will issue appointment letters to the validated/identified participants no later than 9/17/14 for interviews on 9/27/14. Again, the use of ACEDS data as the foundation for this recommendation creates accessible data to be reviewed.

6. OIG Recommendation

Determine whether any of the 84 District employees received or are continuing to receive medical assistance benefits incorrectly based on the residency verification we performed using OPRS and OTR data; investigate to determine whether recipient fraud exists; and refer the cases to the Office of the Inspector General for appropriate action.

6. DHS Response

Previously responded to in MAR-14-A-01 and accepted by OIG.
The first priority review will be of those validated/identified employees among the 84 employees identified by the OIG. Appointment letters for all validated/identified employees will be issued by 9/8/14 and aggressively scheduled interviews will begin 9/27/14. The target for completion of review of these cases is 60 days.

7. OIG Recommendation

Determine whether any ineligible participants are still eligible in ACEDS or DHCF's claims system; correct their eligibility status in both systems; and discontinue improper claims payments.

7. DHS Response

Previously responded to in MAR-14-A-01 and accepted by OIG.

The same strategy outlined in response to Recommendation 1 will be employed, in that participants deemed ineligible for services will be subject to the ongoing quality assurance reviews. A set number of identified employees will be sampled and reviewed each quarter. Should outcomes of reviews create new information or confirmation, DHS will notate the system accordingly, so that correct actions regarding receipt or termination of benefits can be taken.

EXHIBIT B: DHS RESPONSE

8. OIG Recommendation

Improve the income and residency verification processes by using data mining methods in conjunction with third-party data, such as OPRS employee data, to identify employees in Medicaid or Alliance that may have misrepresented their income and state of residency to obtain eligibility.

8. DHS Response
Previously responded to in MAR-14-A-01 and accepted by OIG.

9. OIG Recommendation
Verify that errors and anomalies identified in the 22 District employee case files have been resolved.

9. DHS Response

These income exceptions for the validated/identified DC employees in this category will be part of the first wave of priority cases reviewed. To retrieve data, DHS will access current systems, including documents retrieved via the Case Records Management Unit (CRMU). DHS will review the errors and anomalies associated with the income exceptions identified for these District employee cases and make the appropriate corrections in ACEDS. Target for completion of the review is 60 days.

10. OIG Recommendation
Retrain staff and perform more frequent supervisory case file reviews to ensure compliance with existing laws, rules, regulations, and policies and procedures to promote consistent and accurate eligibility verification processing.

10. DHS Response

Staff retraining occurs annually and more often as needed or required due to policy/procedural changes. Moreover, an enhanced Selected Supervisory Case Review process is being implemented. Full implementation is expected within the next 45 days. This tool enables supervisors and managers under the leadership of the Chief of the ESA, Office of Quality Assurance and Analysis (OQAA), to address deficiencies in all program efforts. Special attention in this roll-out will be accorded Medicaid. In addition, DHS expects the real time DC Health Link interface with local and federal data hubs to eliminate opportunities for human errors.

11. OIG Recommendation

Comply with the ESA Policy Manual and correct the date-stamping issue in DIMS to ensure all source documents are recorded electronically with an accurate date to make them easily accessible for audits, supervisory oversight, and operational efficiency.

EXHIBIT B: DHS RESPONSE

11. DHS Response

Protocols dictate that date stamping is to occur during the initial recipient interview. On occasions that documents might arrive at the Case Records Management Unit (CRMU) without a date listed, CRMU staff will attempt to identify dates and when the actual date of arrival to the agency is determined CRMU staff will enter the date. Further, DHS will reissue memorandum to all staff stressing the importance of date stamping.

With respect to the OIG's observance that "DIMS logged an electronic default date of "01/01/1900, when the system was unable to read the manual date stamp", the agency purposefully created the date of 01/01/1901 as a default date during the conversion scanning of legacy case files. During this process when the document did not include a date and did not fall into the date criteria, the default date was instituted. During "conversion" scanning each document required the date field to be completed. 1901 was a date that would not return; therefore it was used as the default date. This 1901 date has nothing to do with the current scanning process/procedure.

12. OIG Recommendation

Implement a procedure to use Base Wage data verification in a timely manner by adopting a "look back" check to verify whether the applicant provided accurate income data at the time of application or recertification.

12. DHS Response

At the point of recertification of benefits, the agency does a "look back" and has the advantage of reviewing current pay stubs. In addition, the DHS is in the midst of a major system upgrade and functionality development. We expect a major outcome will include the capacity to create reports that leverage data from the local data hubs.

Finally, we would request a "point of contact" in your office who would be available to our investigative lead, [redacted], for questions and concerns as we work through the data already provided by you. In this way our investigation of the 2,861 individuals identified in the above named draft report would be aided by access to a person with complimentary investigative approach. Ms. [redacted] contact information is [redacted]@dc.gov, at [redacted].

All things considered, to conduct a comprehensive review and investigation of the identified cases, DHS proposes to act on all OIG recommendations and conclude this investigation by November 2015.

You and your staff have been very considerate of the multi-tasking and multiple challenges DHS has been facing as we attempt to incorporate tasks necessary to address the OIG recommendations and reports, and all accommodations are appreciated. Please contact me at (202) 698-3906, should you have questions or concerns.

EXHIBIT B: DHS RESPONSE

Sincerely,

Deborah A. Carroll

Deborah A. Carroll
Interim Director

cc: [redacted] Acting Administrator, Economic Security Administration
[redacted] Chief Accountability Officer, DHS

DAC/den