REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

ELIGIBILITY ABUSES AND DEFICIENCIES IN CALIFORNIA PUBLIC ASSISTANCE PROGRAMS

MARCH 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

MIKE CULLEN
CHAIRMAN

March 24, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report on eligibility abuses and deficiencies in California Public Assistance Programs.

By matching the Medi-Cal eligibility file of the Department of Health against paid claims for February 1976, the Auditor General estimates that at least $84 million was paid for services to ineligible recipients during 1976. Similar audit findings were made during the previous Administration by the Director of Finance in January 1974.

A computer-assisted analysis for the nine months preceding October 1976 has revealed over 100,000 recipients declared eligible for benefits for one or more months in at least two counties concurrently. One million eligibility records contained invalid Social Security numbers and could not be analyzed.

In summary, the Auditor General's discovery required 65 auditor-days and $7,100 in computer charges. The Chief Executive of the State of California will be well advised to ascertain which state employees in the Departments of Health and Benefit Payments are inept in their present exempt and civil service positions and to transfer them to employment in other positions more suitable to their capabilities.

By copy of this letter, the Department is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department.

The auditors are Kurt R. Sjoberg, Manager; Gary S. Ross and Dennis C. Reinholtsen.

Respectfully submitted,

MIKE CULLEN
Chairman

SUITE 750 • 925 L STREET • SACRAMENTO 95814 • (916) 445-0255

AUDITOR GENERAL'S INTRODUCTORY COMMENTS

The Medi-Cal program has been in existence for over ten years in California; other public assistance programs which are described in this report have been in existence longer in various forms. The public has a right to expect that any public program, especially those which disburse billions of dollars annually, will be carefully monitored and controlled. Unfortunately, this is not the case in California.

In 1976 alone, we found that California paid more than $84 million for services rendered to recipients of the Medi-Cal program who were not eligible to receive that assistance. The controls we found lacking which allowed this to occur did not break down—they simply never existed. Accordingly, the loss to Californians, which we discovered for the year 1976, is exemplary of losses which have been occurring for years.

Our auditors also found that in 1976 over 100,000 California recipients of public assistance were improperly eligible in multiple locations. Eligibility in multiple locations results both from fraudulent activities by the recipient and from administrative errors by county offices and the responsible state departments. There is no system in existence to detect these circumstances. The proportions of this potential drain on the State Treasury exceed $30 million for the relatively small sample period we examined.

Our examinations which led to discovering these adversities should not be interpreted to mean that the maximum extent of the losses for 1976 was $84 million and $30 million, respectively. The scope of our work was hindered significantly by the departments responsible for these programs. Consequently, the results presented in this report demonstrate program losses only to the extent of the limited scope of our review.

What is more important, however, is that these public assistance programs funded heavily by the Federal Government are not limited to California; they exist nationwide. We are not aware to what extent similar program control deficiencies may exist in the 49 other states. If such deficiencies do exist in other states, nationwide program losses could approach billions of dollars annually.

On March 9, 1977, the Secretary of California's Health and Welfare Agency testified before a joint Congressional committee that California would not tolerate welfare program abuses. Moreover, he stated that "strike forces" were being formed to "crack down on the cheaters" and bring them to justice. I applaud the Secretary's position; however, I believe the approach only treats the symptoms rather than the cause. Abuses of public monies has become a commonplace event—from outright fraud to the more subtle abuses stemming from inattentive or improper management of public funds. While program abuses cannot be tolerated, and must be curtailed, a more important issue must also be addressed; that issue is inefficient, uneconomical and ineffective human service program management.

Fraud and questionable practices by recipients and providers of public assistance services are but symptoms of a larger problem and account for only a relatively small portion of excessive program costs. Yet, because of public outrage, such circumstances receive perhaps the greatest attention, and the more important causes of such problems remain veiled in the bureaucracy and perpetuate.

I concur with the Secretary's "strike force" concept; however, far greater benefits will result from complementing that approach with an aggressive, introspective examination of the system's weaknesses which foster abuses of public programs. This report addresses those weaknesses and provides means for consideration to correct them.

JOHN H. WILLIAMS
Auditor General

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SUMMARY

The State of California's Medi-Cal program is administered by the Departments of Health and Benefit Payments. The integrity of all state-administered public assistance programs is the responsibility of the Health and Welfare Agency.

Medi-Cal benefits are provided automatically to recipients of public assistance. The responsibility for determining eligibility rests with the county welfare departments for family aid and the Social Security Administration for adult aid recipients.

Weaknesses in the present eligibility system have caused numerous problems which impact significantly on the public assistance program in California. We found that:

- $84 million was paid for Medi-Cal services rendered to recipients with no record of eligibility during 1976 (page 7).

- Over 100,000 persons were eligible for benefits in two or more counties at the same time improperly. The potential dollar impact of this system weakness is $30 million if all of these benefits had been utilized (page 13).

- The system which produces the monthly Medi-Cal identification card for each recipient is costly and does not control Medi-Cal eligibility and benefits (page 19).

We also found that material essential to establishing eligibility was lacking in a sample of three counties reviewed (page 25) and that the earnings clearance system used to verify recipient earnings was inadequate (page 29).

We did find, however, that the determination of the medically needy and medically indigent's liability was being performed in a timely and accurate manner (page 31).

On page 33 we recommend that a new eligibility system be implemented. We also provide a proposed eligibility system which will accomplish the necessary control (page 33).

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee, we have reviewed the present system for determining eligibility for Medi-Cal benefits.

This report, the third in a series on Medi-Cal,* provides an analysis of the existing eligibility system and the results of various audit tests performed to determine the effectiveness of the system. A recommendation for an improved system for managing Medi-Cal eligibility is included on page 33 of the report.

The budgeted monthly caseload for Medi-Cal during fiscal year 1976–77 is approximately 2.7 million recipients. This total is comprised of:

		Percentage of Total
Aged, blind and disabled	693,700	25.3
Aid to families with dependent children	1,525,300	55.7
Medically needy	246,700	9.0
Medically indigent	273,200	10.0
Total	2,738,900	100.0

Program expenditures budgeted for Medi-Cal in fiscal year 1976–77 total about $2.4 billion, which is comprised of 43 percent federal, 42 percent state and 15 percent county funding.

* See Costs and Revenues of the Medi-Cal Claims Processing Subcontract (286.1), dated January 1977; and A Management Analysis of the Third Party Liability and Other Health Coverage Programs (286.2), dated March 1977.

The Social Security Administration assumed responsibility for administrating the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program for aged, blind and disabled persons on January 1, 1974. Effective with this change the Social Security Administration also assumed responsibility for determining Medi-Cal eligibility for SSI/SSP recipients.

County welfare departments are responsible for determining Medi-Cal eligibility for recipients receiving Aid to Families with Dependent Children (AFDC) and Medically Indigent/Medically Needy individuals. The counties will receive approximately $127 million during fiscal year 1976–77 to finance their Medi-Cal eligibility function.

The State Department of Health is responsible for coordinating, clarifying and implementing procedures to assure that eligibility is determined accurately and on a timely basis by the county welfare departments. The Department is also responsible for reviewing the entire eligibility operation in California to ensure it is in compliance with federal Medicaid regulations and acts as an arbiter for fair hearings between recipients and county welfare departments. Of the annual total of $38.2 million to be expended during 1976–77 on Medi-Cal administration by the Department of Health, we estimated that $3.3 million will be directly related to the Department's role in eligibility activities.

The Department of Benefit Payments has responsibility for audits of the Medi-Cal program to ensure fiscal compliance with state laws and regulations. This Department will receive about $5 million in fiscal year 1976–77 for this activity.

Scope of the Review

Our investigation of the eligibility function included two main subject areas.

The first audit area consisted of a review of eligibility determination activities in three counties. A random sample of case files was reviewed at each county to determine if applicable federal and state regulations were being followed in granting Medi-Cal eligibility.

The second phase of the audit included a review of the State's central identification system which is used to issue identification cards to Medi-Cal recipients. Using computer-assisted techniques, we designed and performed a series of audit tests on the Medi-Cal eligibility files. These tests were designed to determine:

- If claims were being paid for services rendered to recipients who were ineligible for Medi-Cal.

- If it was possible for a recipient to receive more than one valid Medi-Cal card in a given month.

- If it would be possible to use the Medi-Cal history file (EHF file) to detect those beneficiaries who were receiving Medi-Cal benefits and cash grant aid in two or more counties at the same time.

The EHF file was provided by the Department of Health and our office paid $7,100 for computer assistance used in the analysis.

Although the audit was directed at a review of the Medi-Cal eligibility function which is under the overall direction of the Department of Health, a significant finding deals with widespread abuse in the public assistance program, which is the responsibility of the Department of Benefit Payments.

We would have preferred to perform additional analyses to learn whether the findings we present in this report are only a part of a larger problem, but the denial of access to records under Welfare and Institutions Code Section 10850 precluded further work.

AUDIT RESULTS

$84 MILLION WAS PAID FOR MEDI-CAL SERVICES RENDERED TO RECIPIENTS WITH NO RECORD OF ELIGIBILITY DURING 1976

By matching the Department of Health's own Medi-Cal eligibility file against paid claims for the month of February 1976, we estimate that at least $84 million was paid for services provided in 1976 to recipients with no departmental record of Medi-Cal eligibility.

The present Medi-Cal claims payment system does not interface with the State's central identification (CID) system which contains recipient eligibility data. Without an interface between the two systems, ineligible recipients receive Medi-Cal benefits without detection.

To determine the extent of Medi-Cal services provided to beneficiaries with no record of eligibility, we performed a computer match of paid claims and eligibility data. The paid claims data included all paid Medi-Cal claims with a February 1976 date of service. The eligibility data were drawn from two sources in an effort to ensure an objective analysis. A complete description of the data used in the analysis follows:

Paid Claims History Data

A file of 2,689,260 paid Medi-Cal claims with a February 1976 date of service was extracted from the paid claims history file maintained by the fiscal intermediary. These data became the constant against which the two files of eligibility information were applied.

Eligibility History Data

Two separate sources of eligibility data were used to determine if Medi-Cal benefits were being paid for services provided to recipients with no Medi-Cal eligibility. The two sources were the CID file and the EHF file. Each of these files was supplied by the Department of Health. A description of the two files follows:

CID Eligibility File

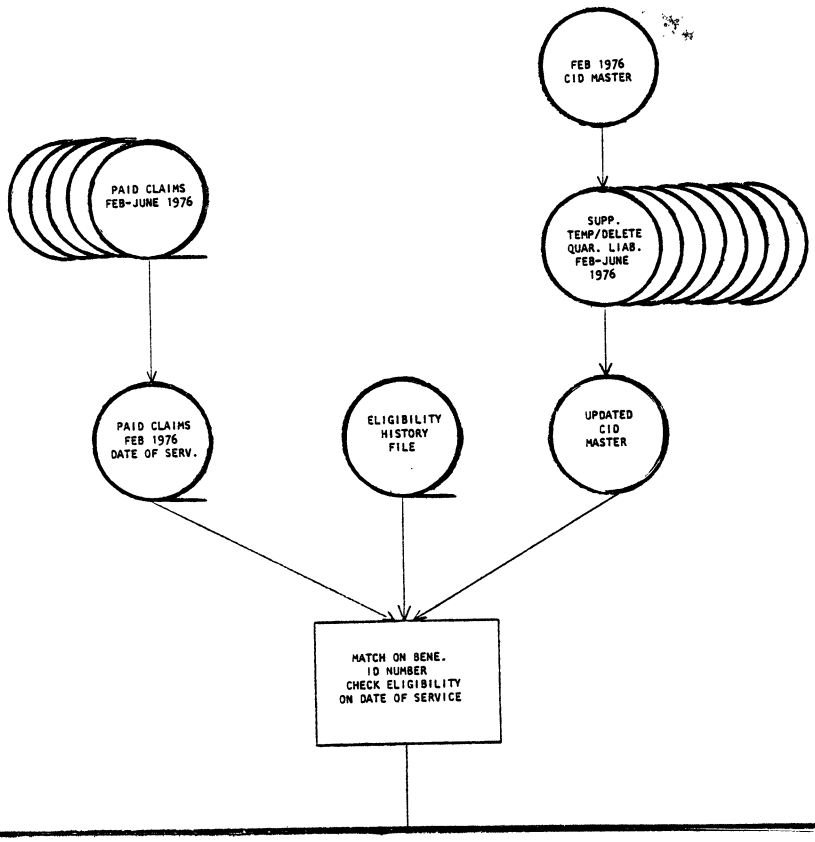
The February 1976 primary file, with 2,353,789 valid beneficiary records, was used as a starting point. All subsequent supplemental, temporary/delete and quarterly liability records for the period of Feburary through June 1976 were processed against the primary file to apply any retroactive transactions which affected those services rendered in February.

Eligibility History File (EHF)

The EHF file which contained eligibility data for the nine months from January through September 1976 was used as a second source of eligibility verification data. This information was first produced in

November 1975 by the Department of Health to aid their fiscal intermediaries in clarifying the eligibility of Medi-Cal beneficiaries. This file is to eventually contain 18 months of eligibility data for every beneficiary in the Medi-Cal program.

A flow chart of the match of paid claims versus eligibility is shown on the next page with sample reports which were produced for each county and the statewide total. The match of paid claims against the EHF file produced a total of approximately $7 million in payments to beneficiaries with no record of eligibility for the month of February 1976. Since this month is actually a below average claims month, the annual total of such payments in 1976 would exceed $84 million.



FEBRUARY 1976 PAID CLAIMS ANALYSIS ORANGE

AID	MATCHED CLAIMS CID FILE	MATCHED CLAIMS CONSOLIDATED	MATCHED DOLLARS CID FILE	MATCHED DOLLARS CONSOLIDATED	NOT MATCHED CLAIMS CID FILE	NOT MATCHED CLAIMS CONSOLIDATED	NOT MATCHED DOLLARS CID FILE	NOT MATCHED DOLLARS CONSOLIDATED
38	16	16	269	269	8	8	147	147
40	970	973	38,421	38,451	179	176	5,620	5,590
42	0	0	0	0	0	0	0	0

FEBRUARY 1976 PAID CLAIMS ANALYSIS STATE TOTAL

AID	MATCHED CLAIMS CID FILE	MATCHED CLAIMS CONSOLIDATED	MATCHED DOLLARS CID FILE	MATCHED DOLLARS CONSOLIDATED	NOT MATCHED CLAIMS CID FILE	NOT MATCHED CLAIMS CONSOLIDATED	NOT MATCHED DOLLARS CID FILE	NOT MATCHED DOLLARS CONSOLIDATED
38	1,239	1,248	53,468	53,646	113	104	7,361	7,183
40	18,822	18,922	663,075	674,473	2,361	2,061	92,006	80,608
42	3,823	3,915	125,710	128,352	709	117	9,029	6,386
43	44	51	11,246	12,547	23	16	1,691	390
44	12	16	3,391	3,414	8	5	366	343
45	2,055	2,110	80,433	86,578	157	102	11,661	5,516
46	1	1	39	39	5	5	71	71
47	88	109	3,233	3,684	34	13	2,484	2,033
50	127	136	4,056	4,132	55	46	3,994	3,918
56	0	0	0	0	2	2	11	11
58	0	0	0	0	1	1	9	9
60	495,785	506,612	21,302,983	21,829,046	23,509	12,772	1,429,756	963,693
62	0	0	0	0	0	0	0	0
63	19,191	19,894	2,054,728	2,133,450	1,303	600	160,014	81,292
64	874	917	42,276	43,876	135	92	10,651	9,051
65	392	450	17,727	19,612	96	38	3,719	1,834
66	111	138	2,158	2,894	31	4	810	73
67	13,503	14,859	1,092,562	1,188,299	1,934	599	183,538	87,801
68	1,801	1,823	87,324	88,799	196	174	10,173	8,698
74	0	0	0	0	0	0	0	0
75	0	0	0	0	0	0	0	0
82	36,151	37,376	1,416,452	1,464,706	6,597	5,372	469,510	421,253
83	1,566	1,612	295,040	295,209	249	243	42,554	42,394
84	167,711	171,834	8,052,500	8,237,824	19,276	15,153	1,794,452	1,609,129
85	4,381	4,405	869,871	874,231	391	367	57,076	52,716
86	12,327	12,651	773,177	801,810	1,744	1,180	161,224	132,592
89	221	222	37,217	37,227	29	28	2,609	2,603
99	0	0	0	0	0	0	0	0
TOTAL	2,525,349	2,595,330	103,077,844	105,919,107	160,911	93,926	9,938,883	6,997,619

* Full-scale copies are provided on Appendices C and D.

Although this figure is significant and indicates a serious lack of control in the Medi-Cal program, the Department of Health has been aware of this condition since 1974. The Department of Finance performed an audit similar to ours in January 1974, and even though they sampled only 24.2 percent of the month's paid claims as opposed to our total sample, the results were similar. Based upon their sample the Department of Finance projected that Medi-Cal paid $9,720,500 in benefits to ineligible beneficiaries in January 1974. The annual total of such erroneous payments would have exceeded $116 million. In a follow-up study analyzing the results of the Finance audit, the Department of Health concluded that approximately one-tenth of one percent of Medi-Cal claims paid per month actually represented payments for ineligible persons. At the program expenditure rates then in effect, this translated to $140,000 per month in erroneous payments. We have no means to verify the validity of these 1974 results.

During our review of the county eligibility determination function, we noted a substantial number of cases where eligibility was granted and later retroactively canceled when necessary verification could not be obtained. Section 50610, Title 22, California Administrative Code on overpayment states:

> Overpayment occurs when medical assistance is paid and there is no entitlement. Any such overpayment must be recovered within a period reasonable to the circumstances, either by direct repayment or a collection plan.

The Department of Benefit Payments' Health Recovery Bureau and the Department of Health's Investigation Unit are primarily responsible for collecting beneficiary overpayments. For fiscal year 1975–76 the Health Recovery Bureau has only collected $816,584 from beneficiaries, and the Investigation Unit has collected $588,977.

We have prepared a complete computer analysis of the erroneous payments by county and aid code and will provide this to the Department of Health upon request.

OVER 100,000 PERSONS WERE ELIGIBLE FOR BENEFITS IN TWO OR MORE COUNTIES AT THE SAME TIME IMPROPERLY

We analyzed the Eligibility History File (EHF) to determine if it contained any records of recipients who were eligible for benefits in more than one county during the nine months of January through September 1976. This resulted in the discovery of over 100,000 recipients who had been eligible for one or more months in at least two counties simultaneously. Due to this system weakness, a potential of $30 million in duplicate benefits was available in cash grants and services to Medi-Cal eligibles. Because of limitations to our access to records under Welfare and Institutions Code Section 10850, we could not test the amount of the benefits actually utilized by recipients. A Department of Benefit Payments analysis of the Sacramento AFDC duplicates concluded that only six percent of the cases should be referred to the county for further investigation. We did not verify the accuracy of this report, but present it only as the Department's position.

In a public hearing before the Assembly Committee on Human Resources on December 8, 1975, the Acting Deputy Director of the Department of Benefit Payments stated that "available data indicates that the incidence of welfare fraud is very small and that the existing systems for detecting welfare fraud cost more than the amount of money actually recovered."

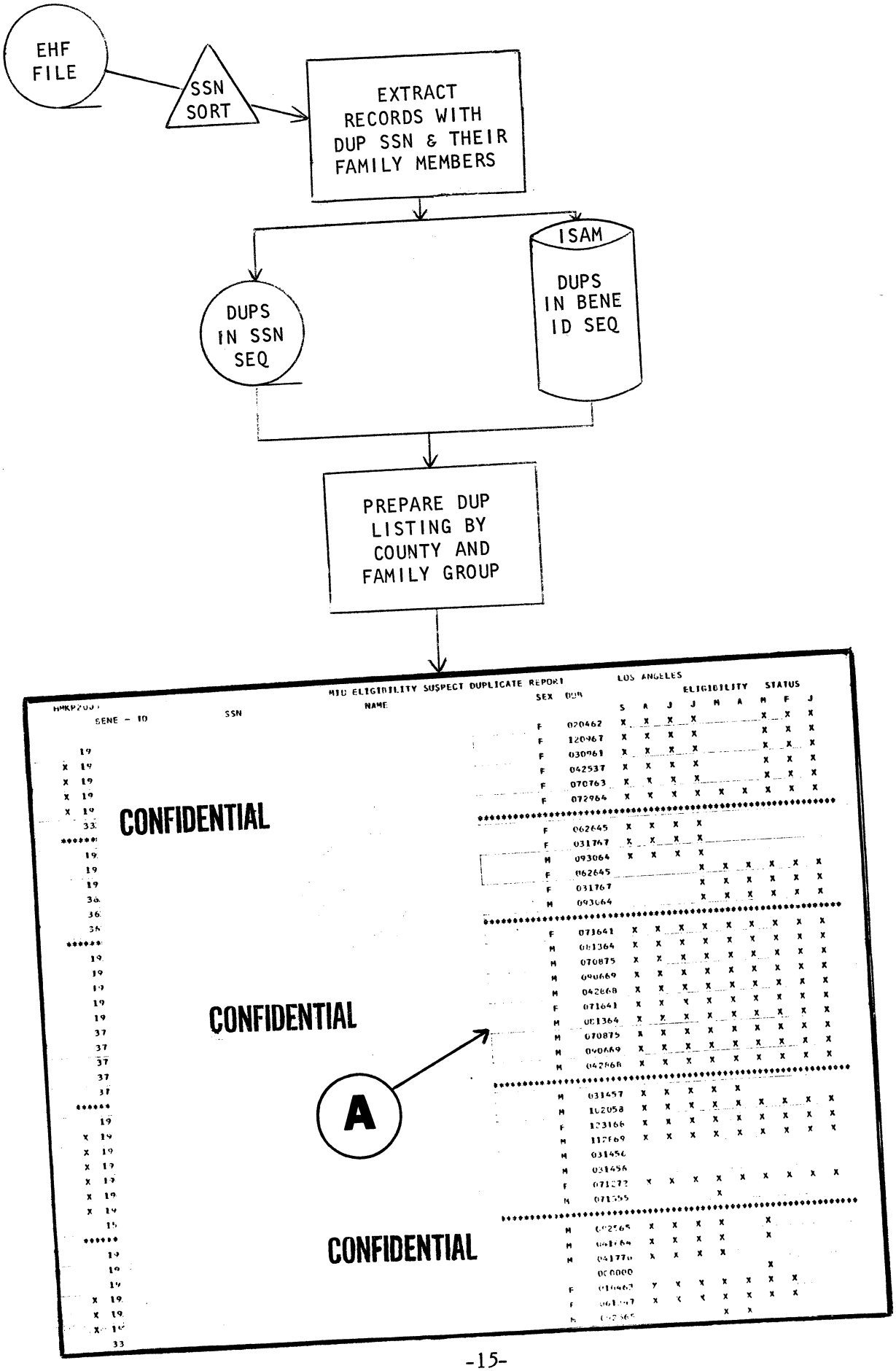
Public aid recipients have been able to apply for and receive benefits in two or more counties at the same time because no statewide system to detect such abuse exists. On Feburary 8, 1977, a Deputy

Director of the Department of Benefit Payments told us that it was possible under the present system for a recipient to apply for and receive aid undetected in all 58 counties simultaneously.

The present Medi-Cal eligibility system uses the individual county welfare case number for beneficiary identification rather than the recipient's Social Security number, although the latter is included in the record.

Using computer-assisted audit techniques, we searched the EHF for recipients who had improper eligibility in two or more counties during any of the months of January through September 1976. We used SSNs as match criteria for duplicates. The EHF contains a total of 4,868,311 beneficiary records of which 1,139,590 contain no Social Security numbers and were of no value in the search for duplicates. The balance of the file (over 3.5 million records) was processed and the result showed that approximately 100,000 names were shown to be in two or more counties during one or more months in the test period. Some recipients were found to have simultaneous eligibility in as many as four counties.

The systems chart on the following page provides a brief description of the process and the report prepared. The sample data shown is actual; however, identifying information has been removed. In the family group identified "A," note the full nine months of eligibility overlap in counties 19 (Los Angeles) and 37 (San Diego) and the fact that their birth dates and sex are identical. The name and Social Security number (removed for confidentiality) were also identical. An enlargement of the data is on Appendix B.


EHF FILE
SSN SORT
EXTRACT RECORDS WITH DUP SSN & THEIR FAMILY MEMBERS
ISAM
DUPS IN BENE ID SEQ
DUPS IN SSN SEQ
PREPARE DUP LISTING BY COUNTY AND FAMILY GROUP
MID ELIGIBILITY SUSPECT DUPLICATE REPORT
LOS ANGELES
BENE - ID
SSN
NAME
SEX
DOB
ELIGIBILITY STATUS
CONFIDENTIAL
CONFIDENTIAL
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A

We were concerned that Social Security numbers may have been a questionable match criteria because of honest errors in recall and transposition; however, a report issued by the Department of Benefit Payments in September 1976 appears to minimize this concern. The report states that, in a sample of 1,206 aid cases which were processed through the Earnings Clearance System, only 1.1 percent had erroneous Social Security numbers. It appears from this, that using Social Security numbers for duplicate eligibility checking is valid.

Over 80 percent of the Medi-Cal recipients also receive cash grant aid; therefore, if a person was eligible for Medi-Cal benefits in two or more counties, the person may also be receiving duplicate cash grants which are far more significant in amount.

The next step in the audit was performed by the Department of Benefit Payments (DBP) using data which we developed in our search for duplicates in Sacramento County and provided to them on January 7, 1977 (see Appendix A).

DBP analyzed 1,300 suspected duplicates receiving Aid to Families with Dependent Children (AFDC) grants in Sacramento County with the following results:

AFDC cases which included the above duplicates	922
Cases where both counties made payments	391
Cases which DBP referred for investigation	55
Percent of cases which DBP felt warranted investigation	6%

It is noteworthy that, in the Sacramento sample of 922 suspected duplicate aid cases, checks were printed in two or more counties for an identical Social Security number in 391 cases, or 42 percent of the sample. We have not reviewed the reasons for DBP's decision to investigate only 55 of the duplicate aid cases.

The DBP maintains statewide error statistics for the AFDC program for the 15 largest counties. The report for July through December 1976 shows Sacramento County to have a zero eligibility error rate while other counties have rates as high as 5.26 percent. Considering the results of the analysis of the duplicate eligibility data for Sacramento County which according to DBP statistics has an excellent error history, the results of an analysis of suspected duplicate aid cases in those counties with a history of eligibility abuses should be greater. A more complete analysis of duplicate eligibility data was suspended when DBP raised questions concerning our access to welfare records under Welfare and Institutions Code Section 10850.

Our $30 million estimate of the system impact of cash grant payments and Medi-Cal services rendered to the recipients drawing aid in two or more counties was computed using average costs; however, the following actual program payment standards were in effect on July 1, 1976.

Program	Number of Persons in Family	Monthly Grant Dollars
Aged	1	276
Disabled	1	276
Blind	1	313
AFDC	1	157
AFDC	2	258
AFDC	3	319
AFDC	4	379
AFDC	5	433
AFDC	6	487

On February 3, 1977, DBP announced, "a stepped up use of computers to track down welfare fraud" and a plan which included, "designing a new computer program to identify people who try to receive payments from more than one county simultaneously." The news release failed to mention that the Auditor General's Office had already developed such a system and had in fact supplied the data for the investigation DBP had just completed in Sacramento County (Appendix A).

The resources we expended to develop our system and to use it to examine the Medi-Cal eligibility files for all 58 counties totaled 65 man-days and $7,100 in computer charges. Considering the potential value of our system in detecting welfare abuse and the minimal amount of resources expended in its development, we believe the DBP should develop this capability immediately.

THE MEDI-CAL CARD IDENTIFICATION SYSTEM IS INEFFECTIVE AND EXPENSIVE AND DOES NOT PROVIDE POSITIVE CONTROL OVER PAYMENT FOR MEDI-CAL BENEFITS

The Medi-Cal Reform Act of 1971 transferred the responsibility for issuance of Medi-Cal cards from the counties to the State Department of Health Care Services. The CID system is essentially a high-speed "printing press" for Medi-Cal cards and, in our opinion, does not function as an eligibility control mechanism.

System Description

The CID system produces a monthly identification card for each of the 2.7 million Medi-Cal recipients. Input to the system is provided on magnetic tape from 46 counties and the Social Security Administration (SSA), and on hard copy from the 12 "paper counties" which do not use electronic data processing equipment.

The nonfederal portion of the CID file is recreated in total every month, whereas the federal portion of the CID file is updated with input provided by the SSA.

The Medi-Cal identification cards are printed by the Department of Benefit Payments and then processed by the Mail Unit of the Department of Health. The Mail Unit employs about 34 equivalent full-time positions to sort, stuff and batch the cards for delivery to the Postal Service for mailing. Approximately 75,000 cards are "handpulled"

from the system each month before mailing due to the death or address change of the recipient. Estimated expenditures for the CID operation for 1976–77 are as follows:

		Estimated Expenditure
Gross Salaries and Wages		$ 205,426
Man-Years	18	
Temporary Help		141,312
Man-Years	16.2	
Total—Salaries and Wages		346,738
Man-Years	34.2	
Salary Savings		(13,266)
Net Total Salaries and Wages		333,472
Staff Benefits		73,030
Total Personal Services		406,502
Duplication and Xerox		4,932
General Expense		30,652
Printing		481,159
Communication (postage)		2,328,647
Rent		10,594
Equipment		88,544
Total Operating Expense and Equipment		2,944,528
Total Estimated Expenditures		$3,351,030

The largest single item expenditure is for communications, which represents first class postage for 1.4 million pieces of mail per month at 13 cents each.

Most of the activity in the CID function occurs during the last ten days of the month in order that recipients receive their cards by the first of the following month. The "sticky labels" which are included on the identification cards are then peeled off and attached to the claims submitted by providers for medical services rendered to the beneficiaries. When the fiscal intermediary receives the claim for payment, a visual check must be made to ensure that a sticky label, valid for the month of service, is attached to the claim.

Deficiencies

Beneficiary Identification Number

The beneficiary identification number used by CID consists of 14 digits which represent county of residence, aid category, county case, family budget unit and person number. Whenever a recipient moves to a new county or changes his aid category within a single county, he is assigned a new beneficiary identification number.

To check recipient eligibility for benefits, the CID system uses the beneficiary identification number as a record key to check prior claims history. Medi-Cal benefits provided the recipient in a different county or under a different aid category are not included in the claims history data. This would allow a recipient to receive benefits which exceed allowable limits.

Monthly Issuance

In 1973, the Department of Finance found that 43.6 percent of all Medi-Cal recipients (over 70 percent of adult aid recipients) were eligible for 11 months or more. Issuing eligibility cards monthly to people such as aged, blind and disabled is questionable because the likelihood of change in their circumstances, which provided the original eligibility, appears remote. Another major segment of the Medi-Cal recipient group receive Aid to Families with Dependent Children (AFDC), many of these families remain on Medi-Cal until the children reach the age of majority (or longer if they remain in school) or until the family income exceeds allowable limits. Even when the family income exceeds the allowable limit, the family is allowed a four-month adjustment period before Medi-Cal is terminated. Issuing monthly cards in these cases also seems impractical.

Controls

The fiscal intermediary must rely on a visual check by claims examiners to verify that a valid Medi-Cal label is attached to each claim; that the label has been issued to the patient on the claim; and that it is valid for the date of service. A system of this volume that depends so heavily on human efforts is subject to error. As an example of the type of error that can occur, we found a Medi-Cal claim that had been paid for services rendered to a young woman who was not on Medi-Cal but whose young child was a legitimate recipient. The child's case file gave the mother's imprisonment as justification for eligibility.

Utilization

Originally, the major intent of the CID system was to limit the monthly benefits provided to recipients. The "sticky label" limited the beneficiaries to a specific number of services per month without prior approval. In July 1975 the limitation on services was abandoned; therefore, when a recipient exhausts his or her allocation of labels, they need only make a photocopy of a portion of the identification card to attach to the claim. Since services are no longer limited, it would appear that the primary justification for the CID system in its present form has been eliminated, yet it continues in use.

CASE FILES OF MEDI-CAL RECIPIENTS IN THREE SAMPLE COUNTIES LACKED DOCUMENTS TO SUPPORT APPLICANTS' ELIGIBILITY

We reviewed a statistically valid sample of case files in Alameda, Fresno and San Benito Counties to determine if they contained sufficient documentation to establish an applicant's Medi-Cal eligibility.

The eligibility factors reviewed for 552 cases and the error rates developed for each are as follows:

Eligibility Factors	Number of Errors	Percentage in Error
Family relationship	44	7.97
Marital relationship	8	1.45
Death verification	1	.20
Income verification	98	17.75
Residency	13	2.35
Citizenship	23	4.18
Absent parent status	11	1.99
Correct income calculation	34	6.16

NOTE: The error rates for the individual counties were substantially the same.

The results of our sample show that based on information available in the case files the counties are not completely verifying many of the eight areas tested. One hundred sixty-six cases out of the total cases reviewed (552) contained one or more exceptions. The counties' high turnover rate in eligibility workers may cause some of these errors.

In our opinion, the applicable state statutes do little to clarify the requirements for written verification of the factors for eligibility; instead, they appear to hinder establishment of objective practices. For instance, Section 11000 of Division 9 of the Welfare and Institutions Code states:

> The provisions of law relating to a public assistance program shall be liberally construed to effect the stated objects and purposes of the program.

Three of the subject areas we considered important to the establishment of eligibility are not required to be verified prior to granting eligibility. They are:

(1) residency

(2) income

(3) work-related expenses and special deductions, etc.

Income and the related deductions and expenses must be verified within 60 days of application, but not necessarily prior to approval of eligibility and the payment of aid. If verification cannot be made within 60 days, a sworn statement by the recipient or his responsible representative will be accepted as necessary verification.

The regulations further restrict the counties by allowing additional verification of facts only if a specific case warrants it. County welfare offices cannot examine bank records without the applicant's permission and cannot ask for permission unless the applicant gives a clear impression they have unreported assets.

A related problem in accurately determining eligibility for Medi-Cal involves verifying an applicant's lawful presence in this country. Under current regulations, if a person cannot document his lawful presence in the country, he has two options. He can:

(1) provide affidavits from two U.S. citizens attesting to the alien's continuous residency in the U.S. for five years or more, or

(2) complete an Alien Status Verification Form (WR–6) for forwarding to the Federal Immigration and Naturalization Service (INS).

An alien is considered to be lawfully present in the United States until the INS informs the county otherwise. Aliens receive benefits in the interim, and in the event they are determined to be ineligible, no claim is made for the return of the benefits paid.

During our fieldwork we noted that very few completed WR–6 forms were returned by the INS. Discussions with welfare officials in Fresno and San Benito disclosed that processing time for a WR–6 may be from six months to more than a year and that many forms are never returned. Benefits are paid throughout this period.

THE EARNINGS CLEARANCE SYSTEM USED TO VERIFY EARNINGS OF RECIPIENTS IS INADEQUATE

The Earnings Clearance System is intended to verify the earnings of aid recipients using the recipient's Social Security number as a match key to search the Base Wage File maintained by the Employment Development Department. Our review of the Earnings Clearance System revealed the following significant deficiencies:

- The system verifies earnings for only a portion of public assistance recipients which means that at least 45 percent of aid recipients are not verified through EDD.

- A total of 1,139,590 records on the Eligibility History File contained "0" in the Social Security number field and cannot be used in the Earnings Clearance System.

  Additional eligibility records carry invalid SSNs such as 123456789. All of these situations make the detection of unreported earnings for a particular recipient impossible.

- The Base Wage File used by the Earnings Clearance System includes only employees covered by unemployment or disability insurance programs. This means earnings of government workers and self-employed people are not checked; therefore, such persons could be fully employed and continue to draw aid.

- Due to the time lag allowed employers in filing quarterly wage reports and the processing cycle for the system, earnings data is five to seven months old when it is used. Therefore, a recipient could work full-time and receive a large salary for five to seven months without being detected.

- Counties are not required to use the Earnings Clearance System and are given an option to set a maximum allowable quarterly earnings limit over which only exceptions will be reported. The quarterly earnings limits are $1, $501 and $901. In effect, at the highest limit, recipients are allowed to earn up to $300 per month without "flagging" these earnings for review by the eligibility worker.

- Until March 1, 1977, the Earnings Clearance System did not determine whether an aid recipient was also drawing unemployment or disability benefits. An individual applying for aid is required to state all sources of income including such payments; however, until recently the accuracy of the statement of earnings from unemployment or disability insurance proceeds was not checked.

In summary, the Earnings Clearance System has serious weaknesses which severely limit its effectiveness. Recent actions by the Department of Benefit Payments to improve the system indicate they share our concern and are taking some corrective action to at least lessen some of the deficiencies.

THE DETERMINATION OF MEDICALLY NEEDY AND MEDICALLY INDIGENT LIABILITY IS BEING PERFORMED IN A TIMELY AND ACCURATE MANNER

To establish eligibility for Medi-Cal a Medically Needy (MN) or Medically Indigent (MI) recipient must have first met his liability for medical benefits received during the service period. The Department of Health's Benefits Review Unit is responsible for determining that this liability has been met and, in doing so, performs the following functions:

- Verifies that counties have correctly computed a recipient's liability.

- Verifies that the recipient has met his liability for the service period.

- Approves claims for payment received prior to a recipient's certification date.

We performed an audit on a statistically valid sample* to determine if the Benefits Review Unit was properly determining the liability of MN and MI recipients. The results of our sample showed that the actual error rate was within acceptable limits and had met the processing time requirements.

* Confidence level—95 percent; reliability ±3 percent.

CONCLUSION

Millions of Medi-Cal benefits are being paid to ineligible beneficiaries, and many thousands of recipients are erroneously and/or fraudulently eligible for public assistance in two or more counties. Furthermore, the lack of specific direction in determining eligibility has contributed to increased eligibility errors.

RECOMMENDATIONS

We recommend that the Department of Health provide specific direction to the counties on eligibility determination to ensure that the errors we found are corrected. In addition, the Department should implement an improved eligibility system for Medi-Cal which provides adequate controls.

The following system design is provided as one alternative. Many configurations and systems should be studied to obtain the most cost effective solution to the problem. The advent of a national health insurance plan and its potential impact on the entire Medi-Cal program must be considered in making the final decision.

PROPOSED ELIGIBILITY SYSTEM

Beneficiary Identification Numbers

The Social Security number is the only viable choice for a statewide identifier for Medi-Cal recipients. Federal legislation, effective January 1, 1977, made the possession of a

Social Security number or proof of application for it a mandatory condition for eligibility for Medi-Cal benefits. Recipients who change aid categories or move to a different county will retain the same identifier so utilization controls which depend upon accurate claims history can function effectively. Each recipient will have a unique identifier that will permanently identify him.

Identification Card

Our proposed eligibility system would replace the present sticky label with an imprinting type plastic card. The card would include as a minimum the following data on each Medi-Cal recipient:

(1) Social Security number
(2) Name in a specified format
(3) Address
(4) Sex
(5) Date of birth
(6) Date of beginning eligibility
(7) Date of ending eligibility
(8) County case number.

The cards would be issued annually to aged, blind and disabled; quarterly to recipients of Aid to Families with Dependent Children; and monthly to Medically Needy/Medically Indigent.

The annual production of cards for the aged, blind and disabled could be contracted to a vendor; the remaining cards would be produced by the counties. The Department of Health would have no direct role in producing identification cards but would continue to monitor and supervise county compliance through the Medi-Cal quality assurance effort conducted by the Department of Benefit Payments.

The cards for the county-administered programs would be prepared at the county welfare office using a typewriter-like device that sells for approximately $2,500. The plastic cards would be embossed with a special design that would make counterfeiting relatively difficult. After the card is prepared and before it is given to the recipient, it would be used to imprint a notice of eligibility which would be mailed to the fiscal intermediary for use in updating the eligibility file.

Provider Services

The plastic identification card would be used like a bank or gasoline credit card in obtaining Medi-Cal services. Each provider would have an imprinter which would be used to transfer the data from the card to the claim form. The descriptive data on the card concerning age and sex would help to ensure that only the authorized beneficiary was obtaining the benefits. When the claim was received at the fiscal intermediary, the beneficiary identification number (the

claimant's Social Security number) would be entered into the system to determine if the recipient was eligible for benefits on the date of service.

Fiscal Intermediary Operations

The new system would require a new on-line file of eligibility data which would be similar in format to the existing Eligibility History File. The record key would be the Social Security number and should contain at least 15 months of eligibility data. The recipient's address would be necessary in the file if the Department of Health plans to begin sending the Beneficiary Explanation of Medi-Cal Benefits (BEOMB). Retroactive eligibility could be handled easily in the new system because the file record would contain beginning and ending dates of eligibility. The ending date of eligibility would be included on all identification cards when issued and on the eligibility file so that eligibility would cease for recipients unless extended by positive action on the part of the responsible eligibility granting agency.

A further check would be available by matching the file against itself on fields such as birth date of family members, similarity of name and variations of these methods to detect recipients who apply for aid in more than one county using different Social Security numbers.

Medically Needy (MN) or Medically Indigent (MI) Liability

The proposed system would make the counties responsible for MN/MI liability determination. The present system requires that the recipient mail proof of having met his monthly liability for medical costs before a Medi-Cal card is issued. The recipient often receives his card late in the month with only a few days remaining before it becomes invalid. The new system would place the entire operation at one location (the county welfare office) so that the recipient could show his case worker the required documentation and receive his new Medi-Cal card at the same time.

Audit and Surveillance Activity

Since the proposed eligibility system would include an on-line file with the Social Security number as a record key, duplicate eligibility records using a common Social Security number would be immediately detected.

Additional safeguards could be performed such as matching the entire eligibility file against the Earnings Clearance System quarterly and notifying the responsible county authorities of any irregularities.

Cost

The cost of the proposed system would be less than the amount spent on the present CID system which does not provide adequate control. Estimated initial start-up costs would include:

1 year supply of plastic cards @2.8¢ ea.	$ 356,824
120 card embossing machines @$2,446 ea.	293,520
contractor preparation of 2.7 million ID cards @16¢ ea.	435,360
Total first year costs	$1,085,704

The cost of the imprinter would be paid by those providers who do not already possess one; however, the cost is less than $15 per provider.

The data processing contractor for the fiscal intermediary (EDSF Corporation) has offered to design and implement the necessary file structure for the proposed system at no cost.

Advantages of the Proposed System

The proposed system would provide the following benefits:

- Greater control over eligibility for Medi-Cal benefits.

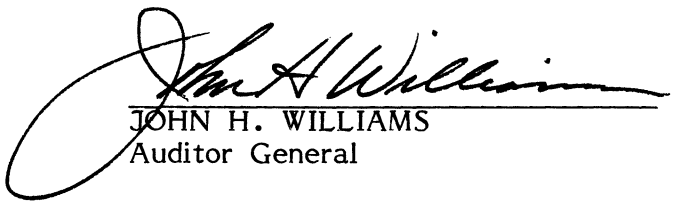
- A central index of public aid recipients to prevent the possibility of a recipient having eligibility in two or more counties at the same time for any type of assistance.

- Simplification of liability provisions for Medically Needy/Medically Indigent cases.

- Faster payment of provider bills through greater automation of eligibility verification processes at the fiscal intermediary level.

- Increased contact between welfare workers and AFDC and MN/MI recipients resulting from required monthly or quarterly visit to the welfare office by the recipient to obtain new Medi-Cal cards.

Respectfully submitted,



JOHN H. WILLIAMS
Auditor General

Date: March 21, 1977

Staff: Kurt R. Sjoberg, Manager
Gary S. Ross
Dennis C. Reinholtsen

STATE OF CALIFORNIA
EDMUND G. BROWN JR., *Governor*

HEALTH and WELFARE AGENCY
OFFICE OF THE SECRETARY
915 CAPITOL MALL, ROOM 200
Sacramento, California 95814
(916) 445-6951

Maria G. Oklodo
SECRETARY

James W. Conner
DEPUTY SECRETARY

Patsy G. Fulcher
DEPUTY ASST. SECRETARY

March 23, 1977

Mr. John H. Williams
Auditor General
925 L Street, Suite 750
Sacramento, CA 95814

Dear Mr. Williams:

On March 21, 1977, you sent this office a draft report on "Eligibility Abuses and Deficiencies in California Public Assistance Programs" and asked for the State Health and Welfare Agency's response by 8:30 a.m. on March 24, 1977. Attached is a point-by-point response which states our concerns about your draft report. We take exceptions to many items in your report, as reflected in the attachments. There are two matters, however, to which we must register very grave exceptions because there are statements in the report which are misleading.

First, the draft report indicates that over $84 million was paid for Medi-Cal services rendered to recipients with no record of eligibility during 1976. Although your report identifies deficiencies in the master eligibility file, the inference that this resulted in $84 million in payments to persons not eligible is without foundation. An earlier audit by the Department of Finance in 1974 reached similar conclusions that you now draw regarding the maintenance of the master eligibility file. However, a follow-up study of the earlier audit conducted by the Department of Health, utilizing a statistically valid sample, showed that less than one-tenth of one percent of Medi-Cal claims could be considered paid on behalf of ineligible persons. Because of the similarity in the audit procedures and the factors involved, we estimate the amount paid to ineligible persons to be less than $2 million during 1976.

Second, we must strongly disagree with your statement that: "Over 100,000 people were eligible for benefits in two or more counties improperly at the same time." The Department of Benefit Payments conducted a sample review of AFDC cases in one county to which you refer and concluded that 97 percent of those cases surveyed did not receive duplicate aid. Although your report recognizes this, nevertheless, it includes an unsubstantiated projected potential loss based on the 100,000 numbers of $30 million if these benefits had been utilized.

In our discussion with the Auditor General, the purpose of the audit was to improve systems in departments of the Health and Welfare Agency. Though we agree with this objective, we nevertheless believe that the references to the dollar impact are inflammatory and are not in keeping with the spirit of accomplishing this objective.

Sincerely,

MARIO G. OBLEDO
Secretary

Attachments

State of California **Department of Health**

Memorandum

To : Mario G. Obledo
Secretary
Health and Welfare Agency

Date : March 23, 1977

Subject : Auditor General's
Draft Report

From : Jerome A. Lackner, M.D.
Director

Attached is the Department of Health's response to the March, 1977 draft of the Auditor General's report entitled "Eligibility Abuses and Deficiencies in California Public Assistance Programs (number 286.3)." We have responded to the significant errors in the draft and would be happy to discuss our comments with you or the Auditor General's staff when mutually convenient.

Attachment

Summary Response to Draft Auditor General's Report No. 286.3

This is a summary response by the Department of Health to the draft report, "Eligibility Abuses and Deficiencies in California Public Assistance Programs" (March 1977).

This response identifies report findings which the Department should take action on. It also points out report premises, methodologies or conclusions which are erroneous or questionable.

I. Services Rendered to Ineligibles: pp. 7-11

The draft finds a weakness in the Medi-Cal computer processing, which causes some Medi-Cal patients not to appear on the Department's Files of Medi-Cal eligibles. This finding is correct. The Department is working to make systems improvements that will cause all Medi-Cal eligibles to show on its files each month.

We emphasize that the $84 million paid claims figure cited in the report does not represent payments for ineligible persons. The patients who were not on the Department's eligibility files were still Medi-Cal eligibles in all but a minute percentage of cases. We base this on a detailed followup of the same type of audit the Department of Finance did in 1974. In the followup, the actual eligibility status was determined for a statistically valid sample of unmatched patients from the Finance audit. The followup shows that less than one-tenth of 1 percent of the Medi-Cal claims for the sample month could be considered paid on behalf of ineligible persons. This is an acceptable rate of administrative processing errors. The US Department of HEW apparently agrees; a Federal funding withdrawal based on the Finance study has been indefinitely suspended because of the followup study cited here.

II. Persons Eligible in Two Counties at the Same Time: pp. 13-18

The draft contends that, using Social Security account numbers as match criteria, a test run of the Medi-Cal Eligibility History File showed that over 100,000 persons were eligible for benefits in more than one county at the same time over a nine-month period.

The basic issues in this area have been addressed by the Department of Benefit Payments. Virtually all the 12,000 cases on the listing provided to the Departments of Health and Benefit Payments represent persons who transferred from one county to another, with an apparent one-month overlap in Medi-Cal coverage. The fiscal impact of such overlap on the Medi-Cal program would be miniscule. Specifically, dual coverage does not mean that Medi-Cal services are provided to ineligible persons. In most cases, it does not mean that a person has received a service he or she would not otherwise have received.

III. Cost and Limitation of Medi-Cal ID Card System: pp. 19-23

The draft contends the CID Medi-Cal card eligibility system is basically a cardprinting operation without eligibility control features.

This is not true. Control processing in the CID system includes:

1. Use of CID eligibility data to confirm entitlement to enrollment of prepaid health plan (PHP) enrollees, prior to the first of each month.

2. Preparation of PHP enrollment lists and files for use by PHP's in giving services and for use by the Department of Health in paying monthly capitation fees.

3. Suppression of Medi-Cal cards for confirmed PHP enrollees for the coming month or creation of restricted cards for the enrollees.

4. Identification on Medi-Cal cards of persons who are Medicare-entitled and who providers should, therefore, bill the Medicare intermediary, instead of the Medi-Cal intermediary.

The CID card production is itself a control process, since the Medi-Cal card is the means to limit provision of Medi-Cal services to Medi-Cal eligibles; and since the two "MEDI" labels on monthly CID cards are utilization control devices.

The draft contends that monthly issuance of Medi-Cal cards is questionable from a cost-effectiveness standpoint because of the stability of the Medi-Cal population. This contention ignores the probability that providing longer-term cards could enable some persons to continue to receive Medi-Cal services after losing eligibility, possibly at substantial cost to the program.

IV. Incomplete Data in County Case Files: pp. 24-26

The draft contends that eligibility determination data was lacking in certain of the sample county Medi-Cal eligibility case files reviewed. Determination errors are made in Medi-Cal, as they are in all large public social service programs. However, over the 21-month life of the Medi-Cal quality control program to date, the average rate of erroneous Medi-Cal determinations statewide is projected at less than 3.5 percent. While short of perfection, this is a superior record, well within the 5 percent tolerance DHEW applied for AFDC cash grant cases.

The draft implies that eight different eligibility factors should be verified for each case. This contradicts the intent of the W & I Code generally and the specific provision of Section 14011 that the statements of a Medi-Cal-only applicant be accepted as evidence unless the county judges that more investigation is needed. Further, several eligibility factors are not reasonably subject to verification, particularly in light of court decisions on due process. Four such factors are: family relationship, residency, citizenship and absent parent status.

Report Conclusions: p. 30

The draft conclusion repeats two contentions. The first is that a large population receives Medi-Cal services without having been determined as eligible. This conclusion is unsupported by evidence, as previously stated. The second is that thousands of persons receive two sets of Medi-Cal benefits in two or more counties simultaneously. As stated previously, a major proportion of these persons are temporary carryovers who have moved from one county to another. Dual coverage does not mean services are provided ineligible persons. Nor does it mean that a person has received a service he or she would not otherwise have received.

The conclusion states one new contention: that there is a lack of specific direction to counties on determining Medi-Cal eligibility. This contention is contrary to Department of Health experience and belief. The Medi-Cal Eligibility Manual, in use in all counties since January 1, is a detailed description of Medi-Cal eligibility criteria and procedures, including a complete rewriting of Medi-Cal eligibility regulations done jointly by Department of Health and county welfare staff. These regulations give specific guidelines to counties on Medi-Cal eligibility while allowing counties to make judgmental decisions that are necessary when applying criteria to some 4 million eligibles per year.

V. Proposed Eligibility System: pp. 30-36

The Department of Health has committed extensive resources to a review and redesign of the current eligibility and claims processing system. Many of the proposed changes suggested in the draft either do not correct related problems or create new ones.

Examples:

--- Social Security number has drawbacks if it is the only Medi-Cal ID number assigned to a person. It does not lend itself to processing people as members of families or multi-person cases.
We believe use of both a county-assigned ID number and SSN for an eligible, using each number for selected functions, is a more viable approach.

--- A plastic ID card also poses problems. It cannot allow an eligible to receive and the provider to be paid for two unrestricted services per month, as required by State law. The plastic card is about twice as expensive as the current card stock.

--- Requiring counties to issue all non-SSI/SSP Medi-Cal cards would require 42 separate computerized processes to be maintained and modified as needed, instead of one central process.

State of California **Health and Welfare Agency**

Memorandum

To : MARIO G. OBLEDO, Secretary
Health and Welfare Agency
Room 200, 915 Capitol Mall

Date : March 23, 1977

Subject :

From : **Department of Benefit Payments**

Following are the comments of the Department of Benefit Payments to the Auditor General's draft report released to the Health and Welfare Agency for comment on March 21, 1977. The Department finds the report to be misleading and to contain considerable inaccurate and incomplete information.

In its essence, the report constitutes an exercise in taking a single phenomenon - the existence of duplicate social security numbers in public assistance computer files - and moving wholesale to an array of untested, unwarranted assumptions and projections.

The Auditor General's Assertion That 100,000 People Were Eligible For Duplicate Benefits is False. One key concern of this department is the report's assertion that 100,000 "people" were eligible for duplicate aid payments or benefits. The Auditor General's list of 100,000 relates only to duplicate Social Security numbers. The list is not indicative of duplicate aid payments made or received.

While the Auditor General made his "duplicate benefit" finding from a projection based on raw data, Benefit Payments has taken a sample of this data, subjected it to detailed case-by-case analysis, and found that 97 percent of the "duplicate social security number" cases examined did not in fact receive duplicate cash grants. This department received from the Auditor General a list of 12,000 duplicate Social Security numbers associated with the Aid to Families with Dependent Children. Our careful review clearly showed the Auditor General's assertion that all had received duplicate payments to be false. Further, the Auditor General states on page 17 of his report that we investigated only 55 cases in our sample review. In fact, Benefit Payments investigated all cases and found that in all but 34 cases there had been no receipt of duplicate payments. The 34 cases were referred for further investigation to Sacramento County and it was subsequently determined that all but 16 of these cases did not receive duplicate payments. Eighteen are still under investigation and no determination of duplicate aid has been made. At this point, only two cases have contained sufficient evidence to merit referral to the District Attorney's Office for possible prosecution. (See attachment I)

Even though specifically informed of our investigation and the results above, the Auditor General nevertheless chose to project a potential $30 million program loss without any basis in fact.

The Auditor General's Statement That He Is "Not Aware" of Benefit Payments' Review Process is a Fabrication.

As stated, Benefit Payments investigated every case in the sample including the 391 cases the Auditor General implies were ignored. The Auditor General's staff was made aware of the detailed methodology and criteria used to determine if duplicate aid could have been paid. This information and the reasons for referral to the county were shared at a February 8, 1977 meeting with the Auditor General's staff (Attachments II and III). Our stance is in stark contrast to the refusal of the Auditor General's staff to allow Benefit Payments' staff to examine the Auditor General's working papers in our attempt to discover his rationale for the conclusions reached in his draft report.

The Auditor General Has Misrepresented His Reason for Suspending His Analysis of Duplicate Social Security Number Data.

The Auditor General has implicitly charged that the Health and Welfare Agency denied access to data which precluded his further work. In fact, his staff's activity from the initial stage on has been in clear violation of a confidentiality law the Legislature enacted in 1975. That law (Welfare and Institutions Code Section 10850) makes it a misdemeanor for any "committee or Legislature" to obtain or possess information on individual public assistance recipients.

In a memorandum on March 10, 1977, I reminded the Auditor General that some material used in the preparation of his report was obtained illegally. (See Attachment IV). I also asked the Auditor General to return the illegally obtained material as soon as possible, and make no further use of it. As of the time this response is being prepared, this confidential information remains in the Auditor General's possession. It is our understanding that the Legislative Counsel also provided the Auditor General with an opinion that his office is prohibited from using this information.

The Auditor General Has Naively Claimed Development of a System to Detect Duplicate Benefits.

The Auditor General states on page 18 of the report that his office developed a system to identify recipients receiving aid in more than one county. However, the "system" was no more than a list of raw data on recipients. This list was not a "system" by any means and was far too bulky and inaccurate to be utilized in an ongoing management operation.

This Department has designed a system to screen and array the needed data in a manner that can be used effectively by county welfare departments. This system will, on April 15, 1977, begin to provide the counties with more manageable lists of duplicate Social Security numbers.

It is naive to assume that the raw computer match provided Benefit Payments by the Auditor General constitutes the development of a "system."

The Auditor General Has Completely Distorted Benefit Payments' Responsibility to Recover Funds for Benefits Provided to Ineligible Persons.

The Auditor General has matched an inflated estimate of erroneous overpayments with our Health Recovery Bureau's collections for fiscal year 1975-76 to imply that the department, through administrative inaction, failed to recover Medi-Cal overpayments to beneficiaries.

In fact, state legislation (W & I Code § 11004) does not permit our collecting overpayments in all but the relatively small percentage of cases where there has been willful misrepresentation by a recipient. In these cases, the Department's Health Recovery Bureau has actively and effectively pursued collection.

The Auditor General Has Made Totally Inaccurate Statements on the Operation of the Earnings Clearance System.

The Auditor General's evident lack of basic understanding of the Earnings Clearance System (ECS) limits the usefulness of his commentary in the report. His report indicates a belief the ECS is, for some reason, deficient in not verifying income for all aid categories.

What the Auditor General interprets as deficiency is, in fact, efficiency. The Earnings Clearance System is used in those program areas where it has been determined to be most cost-efficient.

The system was designed to provide county welfare departments with a report which allows them to concentrate on the specific types of earnings information most likely to be reported incorrectly. The report also contains false statements regarding program requirements. For example, the report states on page 28, "Counties are not required to use the Earnings Clearance System". Specific mandate for the use of, and procedures for, ECS data by the counties are included in the Eligibility and Assistance Standards Manual Section 20-005.23.

The Department recognizes that the ECS is not a perfect system. We have already taken steps to improve its effectiveness, some of which are noted in the Auditor General's report. The Department has found the ECS to be a valuable tool in the correction and prevention of overpayments in the AFDC program. We intend to continue efforts to improve it, and are exploring the cost benefit of expanding the verification to other employment groups and aid programs.

In conclusion, the report as it pertains to the Department of Benefit Payments, does a disservice to the Auditor General's Office and the programs they purport to review. To release a report containing such inaccuracies, misleading implications and unsupported or refuted assumptions raises some serious questions concerning the integrity of the Auditor General's Office.

for MARION J. WOODS
Director

Attachments

ATTACHMENT I

Status of 55 cases referred to Sacramento County SIU for investigation as of 3/22/77:

I. Number of cases determined not to have received duplicate aid	16
II. Number of cases referred to local District Attorney for prosecution	2
III. Number of cases determined to have received duplicate payments	14
IV. Number of cases still under investigation	18
TOTAL	55

Attachment II*

DUPLICATE SOCIAL SECURITY NUMBER FINDINGS

I.	Total persons in Sacramento County which were identified as having the same SSN also in another county	1,300
II.	Total number of AFDC cases which included the above 1,300 persons (total number of cases is less because two or more of these persons were in the same AFDC case).	922
III.	Total number of cases which the review determined from aid payrolls as not receiving aid payments in both counties.	531
IV.	Total number of cases which both counties identified aid payments be made under same social security number (this does not mean same person).	391
V.	Total number of Item IV cases selected for purpose of onsite case review to determine if case record indicated that the persons were probably the same in both counties.	391
VI.	Total number of cases where the case review determined that the persons are possibly the same in both counties and should be referred to the county for investigation.	55

Summary

Total Number of Duplicate Cases (Item II)	922
Findings (Item VI)	55
Percent of cases warranting investigation (55 ÷ 922)	6%

*Provided to the Auditor General February 8, 1977

V. Methodology

The following is a description of the combined procedures employed by the AG team and DBP review team to identify and resolve the status of potential duplicate aid cases from the DOH Eligibility History File (EHF):

A. EHF Dump of Potential Duplicate Aid Persons

The EHF was first produced about November, 1975 by DOH to aid their fiscal intermediaries in clarifying the Medi-Cal eligibility of persons rendered services by health care providers. Although the EHF is intended to provide an 18 month Medi-Cal eligibility history, it only contained the nine months of January through September, 1976 on file as of the AG team review date.

The AG team requested a dump or printout of all persons on the EHF who had a 'thirty' series aid code (AFDC) and the same SSN and appeared as eligible in two or more counties for one or more of the same months. A later examination of the dump shows all AFDC cases who met the other selection criteria were printed out, not just cash grant eligibile AFDC cases. The program called for each such case to be printed out with the county, aid and case number plus specified months of eligibility in each county

*Provided to the Auditor General February 8, 1977

simultaneously. This produced a list of approximately 1,300 persons who had been simultaneously issued warrants in Sacramento and at least one other county during the EHF history.

The review staff hypothesized that some case circumstances would prove useful in analyzing case review results and corrective actions. All Sacramento cases were therefore sorted into three groups:

- Group I - Cases with the same name and SSN which appeared to have been simultaneously issued warrants in two counties for a maximum of two months.
- Group II - Cases with the same name and SSN which appeared to have been simultaneously issued warrants in two counties for 3 or more months.
- Group III - Cases with different names but the same SSN which appeared to have been simultaneously issued warrants in two counties for any months (1 through 9).

After the group sort, all persons were sequentially sorted within groups by their individual case numbers. Persons with the same case

along with all other persons sharing that case number who were ostensibly members of the same qualifying AFDC family budget unit. The AG team states this program resulted in approximately 20,000 total names statewide being printed out.

After the Sacramento County special inquiry of 20 selected cases showed three possible fraud cases, the AG team brought the matter to the DBP's attention and released the 20,000 person printout to DBP for the review which is being reported here.

B. DBP Sort of EHF Dump

DBP determined a preliminary review of a sample of cases prior to a full review of the entire EHF dump was necessary. Since Sacramento County had already reviewed some of their own cases and volunteered to work with the DBP on additional reviews, Sacramento was selected as the 'host' county for the preliminary review.

All counties are numerically coded on each recipient's individual county, aid and case number. Sacramento County is county number 34. DBP first sorted the EHD dump into all persons who showed up in county 34 as one of the two or more counties they were ostensibly aided in

number were placed together, regardless of their individual SSNs.

After this series of manual sorts, during which the EHF printout had been cut into pieces for sorting purposes, all Sacramento County EHF printout cases were pasted together by group and cases within group. These three group listings were then relayed to another group for a duplicate aid warrant check.

C. DBP Aid Warrant Register Check

A data sheet was prepared for each set of corresponding host and companion county cases. The information on the data sheet included each counties case number, the case names and the common Social Security number from the listings. The DBP aid warrant register was checked for both Sacramento and the companion county cases.

The aid warrant register is a monthly listing provided DBP by each county listing the warrants that county issued to each of their cases during the month. If the aid warrant register indicated an aid warrant was issued by one county only, the notation "not in payroll' was placed next to the county listed on the data sheet not issuing an aid warrant.

The data sheet was then coded "non-duplicate" and placed in the non-duplicate stack. If the aid warrant register indicated aid warrants were issued by both counties during the same month, each county's warrant information was documented on the data sheet, and the sheet was coded "duplicate" and placed in the duplicate stack. There were 381 duplicate and 531 non-duplicate data sheets for a total of 922 cases.

D. Case Review Sample Selection

A random sample of 47 non-duplicate data sheets were drawn from the universe of 531 non-duplicate data sheets by numbering each non-duplicate sheet sequentially from 1 to 531. Starting with the sheet numbered 10, every tenth sheet was selected until 47 sheets had been drawn. This became the non-duplicate sample.

Individual samples for groups I, II and III were drawn from the duplicate data sheets universe of 391 sheets. In Group I, each Sacramento case was numbered sequentially from 1 through 133 and starting from the case numbered 2, every third case was selected until 45 cases had been

selected. In Group II, the first 18 Sacramento cases received from the universe of 20 Group II cases were arbitrarily selected for review. For Group III, each group three Sacramento case was numbered sequentially from 1 through 206, and starting with the case numbered 2, every third case was selected until 69 cases had been selected.

The three individual duplicate samples combined totaled 132 cases. Group I cases with a maximum of 2 months potential aid overlap, had 45 of 133 cases selected. Group II cases with potential overlaps of 3 or more months had 18 of 20 cases selected. Group III cases of differently named persons with the same SSN regardless of months of overlap, had 69 of 206 cases selected. The inordinately large sample of Group II cases with the highest potential for possible fraud may have skewed the sample results to a larger incidence of possible fraud than the total EHF printout may show.

E. Case Review Procedures

The sample of 47 non-duplicate cases were reviewed via a case file reading by trained and qualified DBP Quality Control analysts. For all sample cases, quality control reviewers were assigned to determine why the case appeared on the AG's printout as a possible dual aid case. A Non-Duplicate Aid Worksheet (Attachment 2) was completed by the analyst from data found in the case file. Pertinent data was usually found on the WR-2 covering the reported dual aid period, the ABCD 278 L and ABCD 278 LM documents (or their equivalents) and the ABCD 215, Notifications of Transfer. The three samples of 132 duplicate cases were also read by the same team of trained and qualified Quality Control analysts in both the host and companion counties whereever possible. A two-part Duplicate Aid Worksheet (Attachment 1) was prepared with the Sacramento county 'host' case data documented on the left side and the 'companion' county case data documented on the right side. This data was usually found on the WR-2 covering the suspected dual aid period, the ABCD 278L and ABCD 278LM documents, (or their equivalents) and the ABCD 215, Notification of Transfer. For both the non-duplicate and duplicate sample cases, the small, more distant companion counties were contacted by telephone and CWD personnel rad the cases over the telephone to the DBP analyst. The

same information was gathered and documented whether the case was read directly by the analyst or over the telephone by CWD personnel. In all cases, DBP analysts determined why the cases erroneously appeared as duplicate cases or decided the cases were actually possible fraud.

F. Decision Process and Categorization

In analyzing the non-duplicate worksheets, several decisions were made resulting in the placement of a case into one of five categories. These included comparing the SSNs in the case with the duplicate SSN listed on the AG printout; the dates of approval and discontinuance, if applicable; and the dates of any inter-county transfers in the file. The DBP analysts made a judgment based on the data documented on the Non-Duplicate worksheet and placed the case in one of the five following categories:

Category 1	Input of incorrect social security number to the CID file.
Category 2	Those discontinued cases remaining on the CID file, after the effective date of discontinuance.
Cateogry 3	Those cases transferred between two counties, and the transferring county data remains on the CID file after the discontinuance date.
Category 4	Those cases involving two recipients independently

using the smae social security number in different counties.

Category 5 — Those persons receiving Medi-Cal Post-Entitlement from one county, and a cash grant from another county. Po Entitlement recipients who were discontinued because of increased hours or earnings.

Duplicate aid cases were analyzed based upon criteria developed jointly by the quality control analysts and experienced investigators to identify those cases with the highest potential of possible fraud. This criteria included the comparison of data on the Duplicate Aid Worksheet including the corresponding names, social security numbers, birthdates, places of birth, and gender from the host and companion county cases. If many of these factors in the judgment of the analysts, appeared to be the same, that case was placed in category 7. In those cases where the analyst determined the recipients to be the same person, and an inter-county transfer between the host and companion county existed

during the period of suspected dual aid, the case was placed in category 6. Categories 6 and 7 were classified as possible fraud cases which should be referred to qualified investigators for further development.

The remaining five categories were not classified as possible fraud. They involved the following: SSN input error; systems problems in updating the CID file; two eligible recipients independently using the same SSN in different counties; and a recipient on Medi-Cal Post-Entitlement in one county, while receiving a cash grant in other county. The duplicate categories were as follows:

Category 1 — Input of incorrect social security number to the CID file.

Category 2 — Social security number does not match case record date in either county.

Category 3 — Those cases transferred between two counties, and the transferring county data remains on the CID file, after the discontinuance date.

Category 4 Those cases involving two recipients independently using the same social security number in different coutneis.

Category 5 Those persons discontinued from the FBU in one county and remaining on the CID file, while receiving aid in another county.

Catetory 6 Those cases transferred between two counties, with aid paid by both counties during one or more months.

C-tegory 7 Those cases where it was dtermined that the same person was receiving aid in two counties at the same time, and not placed in category 6.

Attachment IV

744 P Street, Sacramento, CA 95814
Telephone: (916) 445-2077

March 10, 1977

Mr. John H. Williams
Auditor General
925 L Street, Suite 750
Sacramento, California 95814

Dear Mr. Williams:

As Clint Whitney, Chief Deputy Director of this Department, explained in earlier conversations with you, the confidentiality provisions in the State Welfare and Institutions Code specifically prohibit release of information identifying welfare recipients to legislative committees. The problem arises because in addition to the general confidentiality provisions prohibiting release of information on applicants or recipients for aid or services, Welfare and Institutions Code § 10850 was amended in 1975 to specifically prohibit release of certain information to the legislature. The amendment provides that "the disclosure of any information which identifies by name or address any applicant for or recipient of such grants in aid to any committee or legislature is prohibited." Federal law requires that our state plan provide safeguards which "shall prohibit disclosure to any committee or a legislative body, of any information which identifies by name or address any such applicant or recipient." (42 USC 602.)

The Joint Legislative Audit Committee is established in Government Code § 10500 and is given authority to appoint an Auditor General. The Auditor General's staff are clearly employees of the legislature. Thus your office falls within the prohibition of Welfare and Institutions Code § 10850. As you indicated to Clint Whitney, Legislative Counsel apparently concurs with our opinion on this issue.

As it has come to our attention that you have been given information of this type, and are currently in possession of such information, it is incumbent upon us to inform you of the relevant restrictions and penalties in state law. Not only does Welfare and Institutions Code § 10850 forbid disclosure of the information, it provides that "any person, including every public officer and employee, who knowingly secures or possesses, other than in the course of official

duty, and official list or a list compiled from official sources, published or disclosed in violation of this section, of persons who have applied for or who have been granted any form of public social services for which state or federal funds are made available to the counties is guilty of a misdemeanor."

The above statutory provisions clearly prohibit the disclosure and possession of this information. Similarly, it would appear that the use of this information, if improperly obtained, would be prohibited. Therefore, in order to avoid a continuing violation of a statutory prohibition, return of this information to appropriate sources should be accomplished as soon as possible. Further, there should be no reference to or reliance upon this information in the future.

It is regrettable that this could have an adverse effect on any report you may be preparing. However, we believe that strict compliance with statutory provisions is necessary to protect the privacy of individual recipients. As in the past we remain available to provide, within relevant statutory constraints, any information necessary to pursue your objective.

Sincerely,

Original Signed by
Marion J. Woods
MARION J. WOODS
Director

cc: Jerome A. Lackner, M.D.

January 12, 1977

Mr. Mario G. Obledo, Secretary
Health and Welfare Agency
915 Capitol Mall, Suite 200
Sacramento, California 95814

Dear Mr. Obledo:

During the course of an audit we are performing of the Medi-Cal eligibility system, we have identified a condition which requires your immediate attention. Specifically, a computer test run revealed a significant number of potential welfare fraud cases.

An examination of duplicate Social Security numbers on the statewide AFDC eligibility file disclosed more than 12,000 recipients who appear to be drawing AFDC benefits in more than one county for one month or more during the first nine months of 1976. We estimate that the total number of duplicate records in all aid categories (Supplemental Security Income types) will exceed 125,000.

During the last week of December, in an effort to determine if any of the duplicates were the result of fraudulent activities on the part of recipients, we contacted the welfare fraud units in seven counties. Each selected a few duplicates in their counties for review. Although Sacramento County is the only unit to have completed their investigation to date, the results are serious. Of the 20 duplicates they chose, three resulted from apparent fraud on the part of the recipients. Based on this result, we are going to draw a statewide random sample of duplicates in all aid codes and review their case files to determine the extent that overpayment occurred, how it occurred, and its cost impact. We discussed this situation with Mr. James Connor and Mr. Ray Procunier at a meeting in my office on January 5th. Mr. Connor agreed to take immediate investigatory action, and we agreed to provide the Department of Benefit Payments with the methodology we developed for isolating these cases so that they could proceed.

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We recommend that they immediately forward the fraud cases we have identified to the Attorney General for appropriate action and, as additional cases are identified, they too should be forwarded to the Attorney General without delay.

If you have any questions, please call me.

Sincerely,

Wesley E. Voss
Assistant Auditor General

for

John H. Williams
Auditor General

JHW:KRS:lc

cc: Honorable Edmund G. Brown, Jr.
Governor of California
State Capitol
Sacramento, California 95814

HMKP200J MID ELIGIBILITY SUSPECT DUPLICATE REPORT LOS ANGELES

BENE - ID	SSN	NAME	SEX	DOB	ELIGIBILITY STATUS S	A	J	J	M	A	M	F	J
19			F	020462	X	X	X	X			X	X	X
X 19			F	120967	X	X	X	X			X	X	X
X 19			F	030961	X	X	X	X			X	X	X
X 19			F	042537	X	X	X	X			X	X	X
X 19			F	070763	X	X	X	X			X	X	X
33			F	072964	X	X	X	X	X	X	X	X	X
*******													
19			F	062645	X	X	X	X					
19			F	031767	X	X	X	X					
19			M	093064	X	X	X	X					
36			F	062645				X	X	X	X	X	X
36			F	031767				X	X	X	X	X	X
36			M	093064				X	X	X	X	X	X
*******													
19			F	071641	X	X	X	X	X	X	X	X	X
19			M	081364	X	X	X	X	X	X	X	X	X
19			M	070875	X	X	X	X	X	X	X	X	X
19			M	090669	X	X	X	X	X	X	X	X	X
19			M	042868	X	X	X	X	X	X	X	X	X
37			F	071641	X	X	X	X	X	X	X	X	X
37			M	081364	X	X	X	X	X	X	X	X	X
37			M	070875	X	X	X	X	X	X	X	X	X
37			M	090669	X	X	X	X	X	X	X	X	X
37			M	042868	X	X	X	X	X	X	X	X	X
******													
19			M	031457	X	X	X	X	X				
X 19			M	102058	X	X	X	X	X	X	X	X	X
X 19			F	123166	X	X	X	X	X	X	X	X	X
X 19			M	112869	X	X	X	X	X	X	X	X	X
X 19			M	031456									
X 19			M	031456									
X 19			F	071272	X	X	X	X	X	X	X	X	X
15			M	071555				X					
******													
19			M	092565	X	X	X	X		X			
19			M	041764	X	X	X	X		X			
19			M	041776	X	X	X	X					
X 19				000000						X			
X 19			F	010463	X	X	X	X	X	X	X		
X 19			F	061047	X	X	X	X	X	X	X		
33			M	092565				X	X				

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FEBRUARY 1976 PAID CLAIMS ANALYSIS ORANGE

AID	MATCHED CLAIMS CID FILE	MATCHED CLAIMS CONSOLIDATED	MATCHED DOLLARS CID FILE	MATCHED DOLLARS CONSOLIDATED	NOT MATCHED CLAIMS CID FILE	NOT MATCHED CLAIMS CONSOLIDATED	NOT MATCHED DOLLARS CID FILE	NOT MATCHED DOLLARS CONSOLIDATED
38	16	16	269	269	8	8	147	147
40	970	973	38,421	38,451	179	176	5,620	5,590
42	0	0	0	0	0	0	0	0
43	0	0	0	0	0	0	0	0
44	0	0	0	0	1	1	31	31
45	114	114	3,436	3,436	13	13	397	397
46	0	0	0	0	0	0	0	0
47	0	0	0	0	0	0	0	0
50	8	8	1,066	1,066	0	0	0	0
56	0	0	0	0	0	0	0	0
58	0	0	0	0	0	0	0	0
60	16,643	16,648	914,963	915,095	537	532	34,469	34,337
62	0	0	0	0	0	0	0	0
63	1,321	1,322	138,628	139,082	51	50	9,764	9,310
64	154	154	6,900	6,900	5	5	175	175
65	25	25	4,070	4,070	6	6	59	59
66	0	0	0	0	0	0	0	0
67	1,112	1,163	83,259	86,884	183	132	17,829	14,204
68	114	114	10,166	10,166	2	2	2,461	2,461
74	0	0	0	0	0	0	0	0
75	0	0	0	0	0	0	0	0
82	1,114	1,114	45,181	45,181	639	639	83,532	83,532
83	108	108	25,846	25,846	3	3	93	93
84	3,694	3,694	207,358	207,358	1,753	1,753	232,811	232,811
85	266	266	35,137	35,137	11	11	1,242	1,242
86	459	459	29,424	29,424	176	176	24,871	24,871
89	13	13	249	249	0	0	0	0
99	0	0	0	0	0	0	0	0
TOTAL	88,969	89,111	4,330,371	4,387,963	9,237	9,094	839,170	831,578

FEBRUARY 1976 PAID CLAIMS ANALYSIS — STATE TOTAL

AID	MATCHED CLAIMS CID FILE	MATCHED CLAIMS CONSOLIDATED	MATCHED DOLLARS CID FILE	MATCHED DOLLARS CONSOLIDATED	NOT MATCHED CLAIMS CID FILE	NOT MATCHED CLAIMS CONSOLIDATED	NOT MATCHED DOLLARS CID FILE	NOT MATCHED DOLLARS CONSOLIDATED
038	1,239	1,248	53,468	53,646	113	104	7,361	7,183
040	18,622	18,922	663,075	674,473	2,361	2,061	92,006	80,608
042	3,823	3,915	125,710	128,352	209	117	9,029	6,386
043 T	44	51	11,246	12,547	23	16	1,691	390
044	13	16	3,391	3,414	8	5	366	343
045	2,055	2,110	80,433	86,578	157	102	11,661	5,516
046	1	1	39	39	5	5	71	71
047 T	88	109	3,233	3,684	34	13	2,484	2,033
050	127	136	4,056	4,132	55	46	3,994	3,918
056	0	0	0	0	2	2	11	11
058	0	0	0	0	1	1	9	9
060	495,735	506,612	21,362,983	21,829,046	23,599	12,772	1,429,756	963,693
062	0	0	0	0	0	0	0	0
063 T	19,191	19,894	2,054,728	2,133,450	1,303	600	160,014	81,292
064	874	917	42,276	43,876	135	92	10,651	9,051
065	392	450	17,727	19,612	96	38	3,719	1,834
066	111	138	2,158	2,894	31	4	810	73
067 T	13,503	14,858	1,092,562	1,188,299	1,934	599	183,538	87,801
068	1,801	1,823	87,324	88,799	196	174	10,173	8,698
074	0	0	0	0	0	0	0	0
075	0	0	0	0	0	0	0	0
082	36,151	37,376	1,416,452	1,464,708	6,597	5,372	469,510	421,253
083	1,566	1,572	295,048	295,209	249	243	42,554	42,394
084	167,711	171,834	8,052,500	8,237,824	19,276	15,153	1,794,452	1,609,129
085	4,381	4,405	869,871	874,231	391	367	57,076	52,716
086	12,327	12,691	773,177	801,810	1,744	1,180	161,224	132,592
089	221	222	37,217	37,223	29	28	2,609	2,603
99	0	0	0	0	0	0	0	0
TOTAL	2,525,349	2,595,334	103,077,844	105,919,107	160,911	93,926	9,938,883	6,997,619

Feb claims / 2528349. + 160911. + 2689260. *I

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps