

STATE OF CONNECTICUT

**PERFORMANCE AUDIT
DEPARTMENT OF ADMINISTRATIVE SERVICES
BILLING AND COLLECTION SERVICES**

July 11, 2003

**AUDITORS OF PUBLIC ACCOUNTS
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TABLE OF CONTENTS

EXECUTIVE SUMMARY	<i>i-v</i>
BACKGROUND	1
Department of Administrative Services.....	1
Department of Mental Retardation.....	2
Department of Mental Health and Addiction Services	3
Department of Children and Families	4
Department of Veterans Affairs	4
Department of Social Services	5
AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY	6
NOTEWORTHY ACCOMPLISHMENTS.....	7
AREAS REQUIRING FURTHER REVIEW	8
RESULTS OF REVIEW	9
Item No. 1 - Department of Mental Retardation Targeted Case Management Billings	9
Item No. 2 - Department of Mental Retardation's Delayed Submittal of Monthly Attendance.....	13
Item No. 3 - Probate Recoveries	16
Item No. 4 - School-Based Child Health	18
Item No. 5 - Medicaid Claim Rejections	21
Item No. 6 - Reconciliation of Service and Billing Data	25
Item No. 7 - Department of Administrative Services' Billing, Collection, and Reporting System	28
RECOMMENDATIONS.....	30
CONCLUSION	34
EXHIBITS:	
DMR Residential Service Attendance form	A
Form PC-200	B

EXECUTIVE SUMMARY

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes and Generally Accepted Government Auditing Standards, we have conducted a performance audit of certain aspects of the billing and collection processes of the Department of Administrative Services. This audit encompassed collection and reporting of service and attendance data to the Department for billing purposes by the Department of Mental Retardation. We also looked at certain aspects of programs administered by the Department of Social Services and the Department of Mental Health and Addiction Services, which also provide services that are billed by the Department of Administrative Services.

The conditions noted during the audit, along with our recommendations, are summarized below. Our findings are discussed in further detail in the “Results of Review” section of this report.

Service Data for DMR’s Targeted Case Management

The Department of Mental Retardation is, by far, the largest of the Department of Administrative Services’ clients for Medicaid claims processing. One of the Department of Mental Retardation’s services is targeted case management. This is a service provided by the Department whereby a client’s case manager ensures that the client is receiving necessary services. If a case manager provides case management services once in a calendar quarter, the Department of Mental Retardation, through the Department of Administrative Services, can bill Medicaid for each day in that calendar quarter. The Department of Mental Retardation did not supply complete data for billable services for this program to the Department of Administrative Services in our test period. Losses for the quarter we tested amounted to \$137,012 for our sample. This equates to an estimated loss of \$1,014,904 as extrapolated to the entire population for the quarter. On an annualized basis, lost billing could total \$4,059,616. The Medicaid reimbursement is equal to 50 percent of the total amount billed.

As a result of our audit, the Department of Mental Retardation has taken steps to identify and correct the system and data entry problems that resulted in un-billed services.

Although the Department of Mental Retardation has located and resolved the coding error in its client/service information system, we recommend that it implement procedures to review the Targeted Case Management Billing Entry Report to ensure that all targeted case management services have been billed. This billing should be reviewed periodically to ensure that service contact by the case manager results in billing for each day in the quarter. In addition,

although the Department of Mental Retardation is in the process of computerizing the reporting of targeted case management services by case managers, personnel should monitor the process to ensure all targeted case management services are entered into the client/service information system. (See Item 1.)

**Submittal of
Monthly
Attendance
Data**

The Department of Mental Retardation contracts with various entities for residential habilitation services, offered by Private Community Living Arrangement and Community Training Home providers. Our testing revealed that the monthly census reports, due by the fifth of the following month per the terms of the contract, were not always submitted on time. The Community Living Arrangement attendance reports are completed and submitted by the providers, whereas the Community Training Home attendance is reported to Agency personnel who then complete and submit the attendance reports. The delays ranged from 61 to 210 days for the tardy Community Living Arrangement providers and 64 to 213 days for the tardy Community Training Home providers. As these reports form the basis for the Department of Administrative Services billing, the delayed reports mean delayed billing and collection. The Department of Mental Retardation pays the providers one twelfth of the annual contract amount each month, regardless of whether the providers have reported on their services.

The Department of Mental Retardation should implement a policy making contract payments to Community Living Arrangement service providers contingent upon the receipt of monthly attendance sheets.

In addition, the Department of Mental Retardation should re-evaluate and modify its Community Training Home attendance-keeping practices to ensure that these attendance reports are promptly submitted to the central office (See Item 2.)

**Probate
Recoveries**

The Department of Administrative Services has worked in cooperation with the Probate Court Administrator to obtain, on a voluntary basis, all information on estates opened in the State annually. The Probate Court Administrator issued an internal document in July 2000, TR 00-506, requesting that all probate courts submit all their probate applications to the Department of Administrative Services. This information is essential in recovering the cost of prior services, such as financial assistance or Medicaid, that the State has provided to decedent and inheriting parties. The probate courts are not required to forward all estate application forms

to the Department, though many do. The voluntary and cooperative effort between the Department of Administrative Services and the Probate Courts has resulted in a 93.7 percent increase in total collections, from \$5,795,819 to \$11,226,687, for the 12-month period of April 1, 2001 through March 31 2002. Recoveries for the six-month period of April 2002 through September 2002 show a 38.3 percent increase over the same time period in the prior year. If the Department of Administrative Services received all forms from all the probate courts, we estimate that personnel could increase recovery of the cost of prior State services by approximately \$3,000,000 over the current level, each year. We have recommended to the Connecticut General Assembly in our 2002 Annual Report that legislation be enacted requiring all probate courts to supply copies of the necessary probate application forms to the Department of Administrative Services.

Personnel in the Probate Recoveries unit of the Department of Administrative Services Financial Services Center should continue their efforts to encourage probate courts to submit information on all estates when the probate application is filed. (See Item 3.)

**School-Based
Child Health**

Each local or regional board of education must provide services for children requiring special education. The Department of Social Services administers a program, the School-Based Child Health program, whereby a school district may receive Medicaid reimbursement for the cost of certain services for Medicaid-eligible students with special education needs. The school districts receive 60 percent of the resulting Medicaid reimbursement, and the State retains 40 percent for administrative costs. Many schools participate, including those schools that have the most to gain financially from the program. However, for the schools that do not participate, we estimate that they lose approximately \$2,395,000 annually. This estimate is based on a comparison of the special education populations of participating and non-participating school districts within similar socio-economic groups. The estimated loss of revenue to the State is about \$1,594,000 annually. Mandatory participation in the program, for those school districts that would benefit from participation, would require legislative action. We have recommended in our 2002 Annual Report that the Connecticut General Assembly enact legislation making participation in the School-Based Child Health program mandatory, unless school districts can provide evidence that participation would not adequately compensate for the cost of administering the program.

In addition, two State-run school districts/systems are non-participating. These are the Department of Children and Families' Unified School District #2, and the State Department of Education's Vocational-Technical school system. We could not ascertain the reasons for their non-participation, and personnel at the Department of Children and Families, the State Department of Education and the Department of Social Services could not provide a rationale for non-participation.

We recommend that the Department of Social Services review the program participation requirements, benefits, and costs with officials from the Department of Children and Families and the State Department of Education to determine if these school systems are eligible to participate in the School-Based Child Health program, and if participation would be cost effective. (See Item 4.)

**Medicaid
Claim
Rejections**

Most of the claims submitted to the Department of Administrative Services for Medicaid billing must be submitted to Electronic Data Systems Corp., Connecticut's medical programs fiscal agent, within one year of the date(s) of service. We found 12 claims, out of a sample of 63 claims, 19 percent, that were submitted past this one-year filing limit. We also noted that eight claims, out of a sample of 64 claims, 12.5 percent, were rejected for diagnosis code deficiencies. These were all from the Department of Mental Health and Addiction Services' targeted case management program. The causes for these deficiencies are varied. The Department of Mental Health and Addiction Services does not have a systematic process for submitting or editing claims from private non-profit providers; the Department of Administrative Services does not consistently provide the originating agencies with remittance advice data for review of rejected claims; there is no process in place for reviewing rejected diagnosis-code related claims when they are made available to the Agency; some diagnosis codes are not yet approved by the State's Medicaid agency (the Department of Social Services); providers do not always include a diagnosis code in the claim submission; and the Department of Administrative Services' billing system sometimes alters claims when they are resubmitted.

The Department of Mental Health and Addiction Services should take steps to institute a system for processing and editing claims data from private non-profit providers. In addition, the Agency should continue its efforts to update the approved diagnosis codes for Medicaid billing and to instruct providers in the appropriate use of diagnosis codes, as well as other billing and documentation matters, such as timely filing. Furthermore, the Department should look into the allowability of resubmitting diagnosis-code related rejected claims, where it is known

that the service provided is appropriate for an approved diagnosis, in those cases where it appears that the diagnosis code was entered incorrectly.

We recommend that the Department of Administrative Services take steps to resolve the billing and collection system deficiencies that cause changes in the data when it is resubmitted. Also, the Department of Administrative Services should provide the Medicaid remittance advices to the originating service agencies on a systematic basis, rather than upon request. Personnel at those agencies should develop a process for reviewing and/or querying the remittance advice database in a manner designed to maximize opportunities to identify, and where appropriate, correct and re-submit rejected Medicaid claims. (See Item 5.)

**Reconciliation
of Billing and
Service Data**

Our testing of the January 2002 service data provided by the Department of Mental Retardation disclosed that the Department of Administrative Services failed to bill two service months for Southbury Training School attendance and one month of a private non-profit provider's day service. Furthermore, the Department of Mental Retardation failed to detect these billing omissions, and ensure that they were resolved, because of a lack of controls for verifying that service data submitted to the Department of Administrative Services is actually billed.

The Department of Administrative Services and its client agencies should develop controls that would provide reasonable assurance that all billable service data submitted to the Department by those client agencies is actually billed. (See Item 6.)

**DAS Computer
System for
Billing,
Collections, and
Reporting**

The Department's billing and collections data system is not yet fully operational. The billing function is in place, but the remittance portion is not yet operating as intended. Until the remittance advice portion is in place, the reporting function is, by default, also incomplete. The implementation of the billing, collection, and record-keeping system has been fraught with errors and delays. Agency personnel continue to work with the vendor, but the problems with the system have made it necessary for the Department to divert resources, reprocess claims, and devise compensating methods to meet its data processing needs.

The Department of Administrative Services should continue its efforts to bring the billing, remittance, and reporting system to full implementation. (See Item 7.)

Background

The Department of Administrative Services:

The Department of Administrative Services (DAS) is responsible for billing and collection for services rendered to persons aided, cared for or treated in a State humane institution, per Section 4a-12 of the Connecticut General Statutes. “Humane institution” means and includes State mental hospitals, community mental health centers, treatment facilities for children and adolescents, or any other facility or program administered by the Departments of Mental Health and Addiction Services, Mental Retardation, or Children and Families. In addition to billing and collection services for these State agencies, DAS also provides billing and collection services for certain programs of the Department of Veterans Affairs and the Department of Social Services.

The Department underwent reorganization in 1999 that dissolved the former Bureau of Collection Services and transferred the functions of that Bureau to the Financial Services Center. Through the Financial Services Center, DAS provides a variety of financial services for itself and for other State agencies. These functions include billing and collection.

The Financial Services Center is divided into three units. These three units perform the following functions, regarding billing and collection:

- The Fiscal Management Unit oversees the collection of delinquent accounts owed to the State.
- The Information Intake and Input Unit investigates billing and collection for services provided by the Department of Mental Retardation and the Department of Mental Health and Addiction Services. It also provides billing and collection services for the Department of Social Services’ School Based Child Health program and inpatient and outpatient claims processing for the Department of Veterans Affairs.
- The Recovery Unit functions primarily to obtain reimbursement of public assistance benefits paid by the Department of Social Services, and investigation, billing, and collection for inpatient services provided by the Department of Mental Health and Addiction Services and the Department of Children and Families.

The guarantor, or payer, with the greatest number and value of claims is Medicaid. The Department of Administrative Services is responsible to bill the total rate of the Medicaid claim, and the Department of Social Services draws down the Medicaid funds. The State receives Medicaid funding at a rate of 50 percent of the total amount billed for these programs.

The Agency for which DAS bills the most in Medicaid claims is the Department of Mental Retardation.

The Department of Mental Retardation:

The Department of Mental Retardation (DMR) provides support and services to people with mental retardation, through a network of public and private providers. Services may include various types of residential services, employment and day programs, inpatient programs in intermediate care facilities, case management services, educational services for children under the age of three, respite care, recreation and leisure activities, advocacy, or assistive technology, such as communication boards, for individuals who are unable to speak, and hearing aids. Certain of these services qualify for Federal financial participation through the Medicaid program.

The Department of Administrative Services performs the billing function for the DMR programs, billing for

- In-patient programs at public intermediate care facilities
These intermediate care facilities are State-owned, and all services are included in one daily rate for billing. The public intermediate care facilities are the Hartford Regional Center, the Lower Fairfield Center in Norwalk, the Meriden Center, the Ella Grasso Center in Stratford, the Northwest Center in Torrington, and the Southbury Training School. Admissions to the Southbury Training School closed in 1986, but the remaining five intermediate care facilities admit new clients when a bed becomes available.
- Day and Residential Habilitative services in the DMR Waiver Program
Under the DMR Waiver Program, the Department provides home and community-based services for persons with mental retardation, who would otherwise receive care in an intermediate care facility. These services are covered through a waiver of the statutory Medicaid requirements, which is necessary because the services provided are not normally included in Medicaid coverage. Waiver services in addition to Day Habilitative Services and Residential Habilitative Services include Environmental Modification Services, Family Training Services, Respite Care Services, Supportive Employment, Pre-vocational Services, and Specialized Medical Equipment and Supplies.
- Targeted Case Management services
Targeted case management services are state-sponsored case management services reimbursed under the Connecticut Medical Assistance Program. Covered services are those provided to eligible persons who are members of a "target" group. An individual case manager provides services for the purpose of enabling an eligible person to gain access to needed medical, social, educational, clinical or other services. The target group includes those eligible persons specified by DMR to receive case management services, based on a variety of criteria.
- Birth to Three program.
Birth to Three services are diagnostic, evaluative, and rehabilitation treatment services provided to children between the ages of newborn to three who are experiencing developmental delays. The Department of Administrative Services bills Medicaid only for those services provided by the DMR regional offices.

Additional information for some of these programs is provided in the “Results of Review” section of this report.

The Department of Mental Health and Addiction Services:

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatments throughout the State.

While DMHAS provides prevention services to all Connecticut citizens, its mandate is to serve adults with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. The Department also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance abusing pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse and mental illness, and clients transitioning out of the Department of Children and Families who need mental health services as adults. The Department of Mental Health and Addiction Services provides its services in both outpatient and inpatient settings, though it is the philosophy of the Agency that its clients can best be served in community settings, and that inpatient treatment should be used only when absolutely necessary to meet its clients’ needs.

The Department of Administrative Services provides billing and collection services for DMHAS activities and programs as follows:

- In-patient facilities
These include the Connecticut Mental Health Center, the Southwestern Connecticut Mental Health Center, the Connecticut Valley Hospital, and Cedarcrest Regional Hospital.
- Out-patient services
These services include medically billable outpatient services, which may be covered by Medicaid, Medicare, or an independent insurance plan.
- Targeted Case Management services
Targeted case management services are state-sponsored case management services reimbursed under the Connecticut Medical Assistance Program. Covered services are those provided to eligible persons who are members of a “target” group. Services are performed by an individual case manager for the purpose of enabling an eligible person to gain access to needed medical, social, educational, clinical or other services. The target group means those persons who are part of DMHAS’ target population, as defined in DMHAS’ policy.

Certain matters relating to the targeted case management program are discussed further in the “Results of Review” section of the report.

Department of Children and Families:

The Department of Children and Families (DCF) is a multi-service agency with a goal of helping to meet the needs of children and youth in Connecticut. It is responsible for planning, developing, administering and evaluating a comprehensive program of services, including preventive services for children and youth whose behavior does not conform to the law or acceptable community standards, or who are mentally ill, emotionally disturbed, delinquent, abused, neglected or uncared for. These include all children and youth that are committed to it by any court or voluntarily admitted to the Department for service of any kind.

The Department of Administrative Services bills for DCF's services at the Riverview Hospital for Children and Youth in Middletown. This psychiatric facility is an acute care inpatient hospital for children. The services may be covered by Medicaid, a managed-care organization, or other private insurance. The Department of Administrative Services is charged with the responsibility for billing and collecting from these guarantors. A very small percentage of the cost of care is collected from clients' legally liable relatives.

Other services provided by DCF include Children's Protective and Family Services, Substance Abuse Services, Juvenile Justice Services, Mental Health Services, Medical and Health Services, and a Wilderness School. For each of these services, DAS tries to determine the clients' legally liable relatives' ability to pay for the cost of the program. If a client's legally liable relative can contribute to the cost of care, based on a prescribed formula, DAS bills for the amount allowed, and endeavors to collect. If there is a pre-existing child support order specifically for the client, or some recurring benefit such as Social Security benefits, the amount due based on these criteria supercedes the amount due based on the DAS formula.

Department of Veterans' Affairs:

The Department of Veterans' Affairs (DVA) offers a variety of healthcare, social and rehabilitative services to Connecticut's veterans. In addition to medicine and nursing, specialty areas include dental, physical, occupational, speech, and recreational therapy, laboratory, radiology, cardiopulmonary, pharmacy and social work.

During the 2001-02 fiscal year, the Department also entered into an agreement making the University of Connecticut Health Center the sole source for specialty medical treatment and care for the Agency's patients and residents. In the past, patients were transported to several hospitals in the area for special treatment. Under the new agreement, all patients are treated at the Health Center in Farmington.

The DVA hospital, in the Veterans' Health Services program, is licensed by the Department of Public Health for 300 chronic disease beds. The programs in the hospital include: general medical care, Alzheimer's and related dementias, hospice care, pain-management, respite care, detox, and long-term substance abuse rehabilitation. Furthermore, primary care clinics are available in-house for domicile and hospital patients.

The Residential and Rehabilitative Services program features the Veterans' Improvement Program (VIP). This residential program provides veterans with a continuum of rehabilitation designed to, ultimately, return veterans to independent living in the community. The components of the program include room and board, substance abuse treatment, a patient work program, an interagency work experience program, vocational testing and counseling services, social work services, a transitional living program, an alternative living program, and various educational programs.

The Department of Administrative Services bills Medicare and Medicaid for the billable services of eligible patients. Services delivered to clients at the University of Connecticut Health Center are billed and collected by that entity.

Department of Social Services:

The Department of Social Services (DSS) provides a broad range of services to the elderly, persons with disabilities, families, and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. It administers over 90 legislatively authorized programs and accounts for approximately one-third of the State budget. By statute, it is the State agency responsible for administering a number of programs under Federal legislation, including the Rehabilitation Act, the Food Stamp Act, the Older Americans Act, and the Social Security Act. The Department is also designated as a public housing agency for the purpose of administering the Section 8 program under the Federal Housing Act.

Although DSS operates over 90 programs, DAS bills Medicaid for only one of these programs, the School-Based Child Health Program. Each local or regional board of education must provide services for children requiring special education. A school district may elect to participate in the School-Based Child Health Program. This program covers eligible diagnostic, evaluative and rehabilitative treatment services provided to Medicaid-eligible special education students. Each participating school district collects and submits service data to DAS for Medicaid-eligible special education students. The Department of Administrative Services bills Medicaid, and DSS subsequently pays the participating school districts 60 percent of the Medicaid reimbursement collected. We comment on this program in the "Results of Review" section of this report.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditors of Public Accounts, in accordance with Section 2-90 of the Connecticut General Statutes, are responsible for examining the performance of State entities to determine their effectiveness in achieving expressed legislative purposes.

We conducted this performance audit of billing and collection services at the Department of Administrative Services (DAS) in accordance with Generally Accepted Government Auditing Standards issued by the Comptroller General of the United States. This audit encompassed effectiveness and efficiency issues, both of which are types of performance audits.

Our objectives were to determine if:

- all services rendered by the originating service agencies are recorded and submitted to DAS for billing.
- the DAS billing process includes all clients and services included in the data submitted by the originating agency.
- appropriate action is taken for all claims that are rejected for Medicaid payment.
- all estates filed in Connecticut in our audited period have been submitted to DAS for review.

To accomplish our objectives, we conducted interviews with staff at the DAS Financial Services Center, as well as personnel from the Department's various client agencies. These include the Department of Mental Retardation, the Department of Mental Health and Addiction Services, the Department of Veterans' Affairs, the Department of Children and Families, and the Department of Social Services. We documented policies and procedures governing various billing and collection processes administered by DAS.

We reviewed in depth the process for resolving Medicaid claim rejections for services originating with the Department of Mental Retardation, the Department of Mental Health and Addiction Services, and the Department of Social Services, based on a random sample of rejections. In addition, we audited the data collection and reporting process for the Department of Mental Retardation, which is DAS' largest Medicaid client, to determine if that Agency's procedures are sufficient to ensure collection and reporting for billing of all billable service data.

We also reviewed DAS' process for recovering the cost of prior State services, provided to decedents and their heirs, through probate recoveries.

To achieve our audit objectives, we relied on computer-processed data produced by DAS' billing and collections system. The Agency has had some difficulty in fully implementing this system, as discussed in Item No. 7, and referenced in Item No. 5. One database was copied and supplied to us so that we could query and manipulate the data ourselves for testing. Although some of the records were incomplete, the information we needed for testing was available. In some instances, we found that the data was affected by processing flaws. But as this data was used to test Agency practices and procedures, we found the data to be useable for achieving our audit objectives.

NOTEWORTHY ACCOMPLISHMENTS

The Department of Administrative Services is responsible for trying to recover the costs of certain prior State services in cases where current or former recipients have an estate to be probated or are heirs to an estate. Until July 2000, the probate courts operated according to Section 45a-355 of the Connecticut General Statutes, requiring the Application for Administration or Probate of Will to be forwarded to DAS when the applicant indicated on the form that the decedent and/or his or her heirs was a recipient of State assistance. Of the approximately 10,000 to 12,000 annual probate applications (Form PC-200), DAS generally received only about 3,500 annually.

In July 2000, DAS and the Probate Court Administrator launched a joint cooperative effort whereby the probate courts should send all forms PC-200 to DAS for its research and, if warranted, recovery action.

This voluntary and cooperative effort has resulted in total collections of \$11,226,687 for the 12-month period of April 1, 2001 through March 31, 2002. (April 2001 was the first month that showed the positive results of this endeavor.) This is a remarkable 93.7 percent increase over probate recoveries for the preceding 12-month period, which were \$5,795,819. Recoveries for the six-month period of April 2002 through September 2002 show a 38.3 percent increase over the same time period in the prior year.

AREAS REQUIRING FURTHER REVIEW

In our review of probate recoveries managed by DAS, we learned that the Department of Veterans' Affairs also has a statutory responsibility to recover, through the probate system, the cost of care for decedents who received services from that Agency. We did not review the Department of Veterans Affairs' probate recovery process, as it was beyond the scope of this audit. However, a question arises concerning the efficiency of similar recovery needs and processes being handled in two separate agencies. Additional review is necessary to address this matter.

RESULTS OF REVIEW

Item No. 1 – Department of Mental Retardation Targeted Case Management Billings:

Background:

The Department of Mental Retardation (DMR) has a long history of providing case management services. However, it was not until 1991 that the Agency was authorized to bill Medicaid separately for targeted case management services. Section 17-134d-82 subsection (e) of the Regulations for Connecticut State Agencies, identifies those services that qualify as targeted case management services for eligible clients. These include advocacy, collaborating in developing and maintaining a plan of services, coordinating or attending meetings regarding the plan of services, coordinating a plan of services, reviewing and maintaining a plan of services, arranging for client assessments, monitoring a client's services, and providing information and referral. All Medicaid-eligible clients that reside in a non-institutional setting are eligible for targeted case management services. There are approximately 8,650 such clients.

Criteria:

The Department of Mental Retardation can bill Medicaid for targeted case management services for each day in a calendar quarter for any eligible client whose case manager provides one of the services outlined in Section 17-134d-82, subsection (e) of the Regulations for Connecticut State Agencies. Targeted case management services are billed each month. Using the client and case manager data from the Connecticut Automated Mental Retardation Information System (CAMRIS), the Department's central office prepares a list of all eligible targeted case management clients, by case manager. Each case manager receives a listing of his or her clients each month. The case manager records client contact on the list and returns it to the central office where the service data is entered into CAMRIS. The daily rate for State fiscal year 2001-2002 was \$6.56. The Department can bill targeted case management services for the entire quarter for each client as long as the case manager has contact with the client at least once per quarter, either in person or by phone. Therefore, if a case manager provides service to a client in February, the Department can bill for services from January 1 through March 31.

The Connecticut Medical Assistance Program Manual, Chapter 5, subsection 5, states that "it is the provider's responsibility to

ensure that all claims for services provided to a client are submitted within one (1) year from the actual date of service.”

Condition:

During our review, we found that, as of November 1, 2002, not all targeted case management costs were billed for services rendered during our test period, January through March 2002.

We obtained a list of all active case managers by region for this quarter. We statistically selected a sample of 37 case managers to review. This represents 13.5 percent of the population of 275 active case managers. One case manager’s records had not been submitted until we requested the records in October 2002; therefore, this case manager’s targeted case management services were not included in the review. The 36 case managers whose records we did review served 735 clients in the first quarter of calendar year 2002.

For our sample, we requested copies of each case manager’s reports for January through March 2002. In addition, we requested a copy of the Targeted Case Management Billing Entry Report for each month in our test period. This report lists all targeted case management services to be billed for a given month; it is the hard copy of the electronic data sent to DAS for Medicaid billing. We compared the case manager reports to the Targeted Case Management Billing Entry reports to ascertain if all services were billed for the entire quarter for all clients served during the quarter.

Of the 37 case managers in our sample, we discovered that 28 case managers had provided client services that were not billed for the entire quarter, for 174 clients. Of these 28, twelve represented case managers whose services were not billed at all for the quarter, eight represented case managers whose services were only partially billed for the quarter, and eight represented case managers with a combination of services not billed at all for the quarter and services only partially billed for the quarter.

Effect:

For our sample, targeted case management services for which DMR did not bill Medicaid, but should have, totaled \$137,012. Of this amount, \$101,555 represents targeted case management services that were not billed at all for the quarter; \$35,457 represents targeted case management services that had been only partially billed for the quarter. Projected to the entire case manager population for our test period, we estimate a loss of \$1,014,904 that should have been billed for the quarter. This would equal a loss of \$4,059,616 in billings on an annual basis if

the exception rate and volume of services detected in the first quarter remains constant. It should be noted that the Federal financial participation for Medicaid is 50 percent of costs, which means that the reimbursement to the State is 50 percent of the billings indicated.

Exacerbating the problem, DMR has to consider the one-year Medicaid claim-filing limit. The State cannot bill Medicaid for targeted case management services if a year has lapsed from the time of service. This means that January 2002 service records must be submitted to DAS by early January 2003, or the billings will not be submitted in time to be processed. The CAMRIS system and the existing procedures for processing the targeted case management billings have been in place since the early 1990's, when the Department began billing for targeted case management. There are no means to determine how much the State has lost in reimbursements since that time, but it is probable that the loss is in the millions.

Cause:

Per agency personnel, the CAMRIS system that processes the data, which is forwarded to the DAS Financial Services Center for billing, contained a coding weakness that was not recognized until we notified DMR of the deficiencies. Department personnel assumed that CAMRIS automatically billed for targeted case management services for an entire quarter when one service was entered for the quarter. If service was rendered during the first month of the quarter, the system should automatically submit billing data in the second and third months when it is time to bill for these months. If service was rendered during the second month of the quarter, the system should also automatically bill for the first month at the same time, and submit billing data in the third month when it is time to bill for that month. If service was rendered during the third month of the quarter, the system should also automatically bill for the first and second months at the same time. This process did not consistently work as intended, resulting in the partial billings.

In addition, Department personnel report that it is possible that errors in the data entry process may have caused an entire quarter's targeted case management billings to not be processed at all. This deficiency resulted in various case managers' services not being billed at all for the quarter.

Additionally, after the quarter is closed administratively, the system does not allow for submission of service data that may have been sent to the central office for processing too late. This means

that even if the data is submitted before the one-year Medicaid filing limit, DMR's system will not allow it to be processed and, therefore, will not allow it to be billed.

Recommendation: Although the Department of Mental Retardation has located and resolved the coding error in its client/service information system, we recommend that it implement procedures to review the Targeted Case Management Billing Entry Report to ensure that all targeted case management services have been billed. This billing should be reviewed periodically to ensure that service contact by the case manager results in billing for each day in the quarter. In addition, although the Department of Mental Retardation is in the process of computerizing the reporting of targeted case management services by case managers, personnel should monitor the process to ensure all targeted case management services are entered into the client/service information system. (See Recommendation 1.)

Agency Response: "The Department has reviewed the "exploding" of the service data, and the computerized program that processes these claims has been corrected. This computer programming error only affected some billings in unique circumstances. A corrected billing for the period January through September 30, 2002 has been processed with Medicaid. It resulted in \$1.25 million in paid claims of which \$625,000 was recovered by the State from Medicaid. In addition, a corrected billing retroactive to July 1, 1995 will be submitted to the Medicaid Program for the periods prior to January 1, 2002.

The data entry "missed billings" issue has been reviewed by the Department. As reported by the Auditors, a computerized reporting and billing system is being developed that will allow direct entry by the Department's Regional case managers. The new billing system will allow review at both the DMR Regional and Central Office levels. The Department's review of the Auditor's findings disclosed the "missed billings" error rate for the one quarter reviewed and sampled by the Auditors does not appear to be the error rate applicable for the remaining three quarters that the Auditors have projected their findings. The actual error rate, and the potential billings and recoveries by the State appear to be lower than the amounts projected by the Auditors. These recoveries will not be known until after the corrected billing has been processed by Medicaid.

The Department is currently manually reviewing these missed billings to identify potential targeted case management services for re-billing to the Medicaid Program. Corrected billings will be

processed, and subject to the anticipated results for each year, the re-billings may be retroactive to July 1, 1995. At the request of the Department of Social Services, the Medicaid State Agency, in order to accommodate the claims processing for the prior periods, the prior periods will be processed in one submission.”

Auditors’ Concluding Comments:

In a subsequent discussion with DMR personnel, we learned that the Agency, through DAS, had requested and obtained special approval from the Department of Social Services to retroactively submit these claims.

Item No. 2 – Department of Mental Retardation’s Delayed Submittal of Monthly Attendance

Background:

Residential habilitation services, offered by Private Community Living Arrangement and Community Training Home providers, give clients assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable an individual to reside in a non-institutional setting. At the beginning of each fiscal year, DMR awards a new contract to each of its service providers. The provider is paid one-twelfth of the total contract amount each month. In CAMRIS, the Department maintains the list of clients that reside in each facility. At the end of each service month, the Department’s central office prepares a preprinted attendance sheet for each provider listing the provider’s client(s). (See Exhibit A.) The attendance sheet is forwarded to the Community Living Arrangement providers to complete, noting actual attendance during the month, including when a client left and returned to the facility. The attendance sheet is then returned to DMR’s central office where the receipt of the monthly attendance is logged into the access database. The attendance sheets are then sent to the Financial Services Center at DAS for billing.

The process is different for Community Training Home providers. Those attendance sheets are provided to regional DMR personnel to complete. The responsible DMR party is supposed to call the Community Training Home providers each month to obtain the attendance data. The information should then be submitted to the central office.

Criteria:

Per Attachment A of the Department’s Human Service Contract awarded to Private Community Living Arrangement and

Community Training Home providers, monthly residential attendance is due at the Department's central office by the fifth of each month.

Condition:

For the period of December 2001 through May 2002, we obtained a list of active Private Community Living Arrangement and Community Training Home providers using the attendance logs, printed in August 2002, which are maintained by the Department's central office. In addition, we tested DMR-operated Community Living Arrangements and DMR regional campuses, because their attendance-keeping and reporting processes are the same as for the Private Community Living Arrangement and Community Training Home providers. We statistically determined to test 43 provider months out of the 5,553 provider months in our test period. (One provider would have six provider months during the test period, one for each month). For the providers selected for testing, we reviewed DMR's central office logs to determine if all monthly attendance forms had been submitted. During our review, we noted instances in which attendance sheets for Private Community Living Arrangement and Community Training Home providers, for the period of December 2001 through May 2002, were not submitted in a timely manner.

- a) Per our review of the log of Private Community Living Arrangement provider census reports, printed on August 5, 2002, there were 90 census reports that were not submitted as of that date, or 2.83 percent of the 3,180 total provider months in our sample. These reports were an average of 107 days late (ranging from 61 to 210 days) at August 5, 2002.
- b) Per our review of the log of Community Training Home census reports, printed on August 8, 2002, there were 267 census reports that were not submitted as of that date, or 16.9 percent of the 1,305 total provider months in our sample. As of August 8, 2002, these reports were an average of 128 days late (ranging from 64 to 213 days).

Effect:

When attendance sheets are not submitted by the provider on a monthly basis, there exists a risk that DMR could make payments to a Private Community Living Arrangement or Community Training Home provider that is no longer serving clients eligible under this program. Furthermore, the State is disbursing funds to the providers for services, but is not able to submit the related billing data to DAS for reimbursement on a timely basis.

Cause:

Under current practices, private service providers, including the Private Community Living Arrangement providers, are paid on a monthly basis per their approved contracts. No penalty is applied

to the provider when monthly attendance sheets are not submitted. Therefore, there is no incentive for the provider to submit these attendance records on a timely basis.

We could not determine a satisfactory reason for the delinquent filing of Community Training Home attendance records, which are reported to be under the control of the regional offices.

Recommendation: The Department of Mental Retardation should implement a policy making contract payments to service providers contingent upon the receipt of monthly attendance sheets.

In addition, DMR should re-evaluate and modify its Community Training Home attendance-keeping practices to ensure that these attendance reports are promptly submitted to the central office. (See Recommendation 2.)

Agency Response: “The Department of Mental Retardation has procedures that effectively monitor the submission of attendance by CLA and CTH providers. This system allows the Department to track attendance to ensure billings are made to recover revenues under the Home and Community Based Waiver Program. The Auditors have not reported any lost revenues that have resulted from the late attendance reports, therefore, the Department believes its monitoring of attendance procedures appears to be effective.

As reported by the Auditors, based upon their sampling of CLAs the late attendance filings were only 2.83%, and 16.9% for the CTH program. Annually the CLA program billings total upwards of \$308 million, and the CTH program billings only total upwards of \$5 million. While there is a 16.9% late billing for the CTH program, this is a relatively small residential program provided by individual families in the community who provide residential care on a daily basis. CTH providers are individuals and their families, not large private agencies with administrative staff available to submit the attendance forms.

CLA and CTH providers are funded based upon needs of the residents, based upon the rates applicable to resident needs as appropriate for each of these residential programs, and based upon the contractual requirements. Making the contract payments contingent upon receiving monthly attendance sheets would jeopardize the long-term continuation of residential programs for the individuals the Department of Mental Retardation serves, particularly residents in the CTH Program. Since there is no lost revenue from late attendance filings, and based upon the high

percentage of timely attendance combined for these two programs, the Department believes this recommendation would be detrimental particularly to the CTH program.”

Auditors’ Concluding Comments:

A good system of internal controls includes measures for timeliness. Even though lost revenue has not been reported, delayed billing of services rendered, in some cases up to seven months as observed in our testing, represents poor control. And there is an unrecorded loss based on the time value of money. Furthermore, it is not unreasonable to expect the providers to comply with the terms of their agreements, which include filing deadlines. Pre-printed attendance forms are sent to the providers to ease the administrative burden. Submitting these pre-printed forms months after the fact not only delays recovery from Medicaid, but increases the chance for error if the forms are not completed concurrently with provision of service, or soon thereafter. We maintain that the forms should be prepared and submitted in a timely manner, and that DMR has a responsibility to ensure that this is accomplished.

Item No. 3 –Probate Recoveries:

Background:

In addition to billing and collecting for residential and behavioral health care services provided to individuals through the State’s various humane institutions and programs, DAS is responsible for collecting money due the State for recovery of various types of public assistance, as provided for in Section 17b-95 of the Connecticut General Statutes.

Criteria:

The Probate Court Administrator issued a directive in July 2000 requesting that all probate districts cooperate with DAS by forwarding copies of all Forms-200, the Application for the Administration or Probate of Will, to that agency on a weekly or monthly basis. The Department of Administrative Services has responsibility and authority to determine what, if any, assistance the deceased or his or her heir(s) has received from the State, and to recover the cost of that assistance from the estate.

The directive from the Office of the Probate Court Administrator is dated July 2000. Until that time, in compliance with Section 45a-355 of the Connecticut General Statutes, the courts submitted to DAS only those Forms PC-200 for parties who had received some form of State assistance, as indicated by the applicant on the form. Applicants indicate recipient status by placing a checkmark or “x” in the appropriate box on the form. (See Exhibit B.)

Condition: The probate courts have not achieved 100 percent compliance with the directive from the Office of the Probate Court Administrator. For calendar year 2001, the courts submitted only 7,636 PC-200 forms out of 11,180 total probate cases opened in the courts for that year. This is a compliance rate of only 68.3 percent overall. It appears that 37 of the probate districts were 100 percent compliant with the requirement (including 3 that did not have any probate cases for the year). Of the remaining 96 non-compliant probate districts, the compliance rate was only 54.7 percent (representing submission of 4,275 of the requested 7,819 documents). The level of compliance among those districts varied significantly.

Effect: The probate courts' non-compliance with the Probate Court Administrator's July 2000 directive hampers effective recovery of funds due the State. The Department of Administrative Services is not supplied with the data it needs to pursue assets in repayment of prior assistance provided to the decedent and/or his or her heir(s).

There is evidence that the probate court system's efforts to provide the forms to DAS have had significant results. Probate recoveries have increased 44 percent from State fiscal year 1999-2000 (\$8,087,803) through State fiscal year 2001-2002 (\$11,643,574). The Department of Administrative Services projects an increase from 1999-2000 through fiscal year 2002-2003 that would equal 90.2 percent (\$15,384,536). This final projection is based on actual FY 2003 collections for only three months.

It has been only 18 months since DAS could see positive results from the Office of the Probate Court Administrator's cooperative effort to supply all forms PC-200 to DAS. The directive was issued in July 2000, and probate recoveries began to increase beginning in April 2001. The first year of probate recoveries resulting from this cooperative effort (April 2001 through March 2002) showed a dramatic 93.7 percent increase over collections for the preceding 12-month period. Recoveries totaled \$11,226,687 for the 12-month period of April 1, 2001 through March 31, 2002. From April 2002 through September 2002, collections totaled \$7,073,449; annualized, the projected total for April 2002 through March 2003 is \$14,146,898. This would be a 38.3 percent increase over collections for the prior year.

If probate court cooperation increased to the expected 100 percent, collections could increase an estimated \$3,100,000 for the period of April 2003 through March 2004. This estimate is based on an observed relationship between an increase in forms submitted in

one calendar year with the amount of collections beginning several months after that calendar year. It is also based on the following assumptions: That liability of decedents and heirs is relatively constant, and, as this is a labor-intensive process, that DAS has adequate personnel to accommodate an increased caseload.

Cause: Although the Probate Court Administrator has requested that the courts send copies of all forms PC-200 to DAS, there is no statutory requirement for the courts to do so. Most of the probate courts do not submit all of their required forms PC-200.

We have included a recommendation in our 2002 Annual Report to the Connecticut General Assembly that submittal of all forms PC-200 to DAS be required by statute.

Recommendation: Personnel in the Probate Recoveries unit of the Department of Administrative Services Financial Services Center should continue their efforts to encourage probate courts to submit information on all estates when the probate application is filed. (See Recommendation 3.)

Agency Response: “We agree with the finding and the projected increase in the recovery monies based on the assumptions indicated.”

Item No. 4 – School Based Child Health

Criteria: Section 10-76d of the Connecticut General Statutes, subsection (a), requires the Department of Social Services (DSS) to make grant payments to local or regional boards of education for Medicaid-eligible students who receive special education and related services in the school district. Medicaid can be billed the accepted rate for eligible students who have an individualized education plan. Section 9 of Public Act 98-239 (not codified) states that a town’s participation in the program is to be voluntary.

Medicaid reimburses the State 50 percent of the amount billed through this program. The Department is required to remit 60 percent of the Medicaid reimbursement to the school districts, and therefore, the State retains 40 percent of the reimbursement for administrative costs.

Condition: For the 2001-2002 school year, only 65 of the State’s 169 school districts participated in the School-Based Child Health program. Among the 104 non-participating school districts are the Department of Correction’s Unified School District #1 and the Department of Children and Families’ Unified School District #2,

as well as the State Department of Education's Vocational Technical School system.

It is unlikely that the Department of Correction's Unified School District #1 could participate in the School-Based Child Health program because of restrictions on Medicaid coverage for inmates of public institutions, referenced in Section 1905(a) (A) of the Social Security Act. However, the Department of Children and Families' Unified School District #2 and the State Department of Education's Vocational Technical schools may be able to participate. It appears that neither of these two potentially eligible Agencies, nor DSS, have analyzed the participation requirements and the cost/benefit data to determine if participation is desirable.

Effect:

The State may be missing opportunities for increased Medicaid recoveries because of the non-participation of the Department of Children and Families' Unified School District #2 and the State Department of Education's Vocational Technical School System.

We also note that the State's local and regional school districts that did not participate lost an opportunity to recover an estimated \$2,391,000 because of their election to not participate in the program. This equates to about \$1,594,000 in lost recoveries for the State (40 percent of the resulting Medicaid receipts). These estimates are based on comparisons of school districts in similar Education Reference Groups. We compared special education needs statistics of non-participating school districts with those of participating school districts. Our estimates are based on the minimum recovery of similar participating school districts.

An Education Reference Group is a classification system in which districts that have public school students with similar socio-economic status and need are grouped together. Grouping like districts together is useful in making legitimate comparisons among districts.

These estimates do not include school districts in Education Reference Group A, as there was no comparative data on which to base the estimate. (None of the school districts in Education Reference Group A participates in this program, so we could not compare the statistics of participating school districts with those of non-participating school districts.) Neither do they include data from Unified School Districts #1 or #2, nor the Vocational Technical Schools.

We must also note that there are administrative and training costs associated with program participation, which we did not analyze. Program personnel at DSS have indicated that school districts with the largest populations of students requiring special education services are already participating. For these school districts, the financial return far exceeds the cost of administering the program. However, for some school districts, the amount received may not offset the associated costs.

We have included in our 2002 Annual Report to the Connecticut General Assembly a recommendation that the statutes be amended to require participation in the program unless a subject school district can show that the program would not provide adequate financial reward for the cost of administering the program.

Cause: A school district's participation in the program is voluntary. This applies to the Department of Children and Families' Unified School District #2 and the State Department of Education's Vocational Technical Schools, as well as to the non-State school districts. However, personnel at the relevant agencies were not able to identify any specific reason for non-participation.

Recommendation: We recommend that the Department of Social Services review the program participation requirements, benefits, and costs with officials from the Department of Children and Families and the State Department of Education to determine if these school systems are eligible to participate in the School-Based Child Health program, and if participation would be cost effective. (See Recommendation 4.)

Agency Response: "We appreciate the opportunity to comment on Item No. 4 of your audit of the Department of Administrative Services, which covered the number and type of school districts participating in the School Based Child Health Program (SBCH), a program administered by the Department of Social Services.

We believe that participation in this program should remain voluntary. Currently 65 out of the 186 school districts (169 public and 17 regional school systems) in the state are participating. These 65 school districts are located throughout the state and include approximately 90% of the Medicaid eligible students. Many of the smaller school districts would not make enough money to really benefit their town given the additional staffing, training, and supplies required.

We are currently reviewing whether or not various other schools including the Department of Children and Families' Unified School District and the State Department of Education's Vocational Technical Schools would benefit from participating in this program. At this point about half of the DCF Unified School District's children appear to be ineligible for this program because they are either "incarcerated", and thus ineligible for Medicaid, or their medical costs have already been included in other reimbursement methodologies. This review is part of an ongoing process to maximize participation in this program."

Auditors' Concluding Comments:

The recommendation included in the Auditors of Public Accounts 2002 Annual Report to the Connecticut General Assembly, released January 31, 2003, takes into account that not all school districts will benefit from participation in the School-Based Child Health Program. We agree that such school districts should not be required to participate in the program, and this is clearly stated in the recommendation.

Regarding the number of school districts, we note here that our estimate is based on the statistical data provided by the State Department of Education. This information included a "count of students with disabilities (Pre-Kindergarten – 12)" by school district for the 2001-2002 school year. Fiscally responsible school districts are required to report statistics for students with special education needs in compliance with the Individuals with Disabilities Education Act (IDEA). The IDEA-compliant data includes 149 local school districts, 17 regional school districts, and 3 State-run school districts/systems. The 186 school districts referred to by DSS include the school districts in relation to the 169 Connecticut municipalities and the 17 regional school districts. The three State-run school districts/systems were not included in this number, nor did we include them in our estimate.

Item No. 5 – Medicaid Claim Rejections:

Background:

All claims submitted to Medicaid for payment must contain information relevant to the claim. The information required may vary for different types of service. One of the information components needed for a claim is a diagnosis code, based on the codes identified and defined in the International Classification of Diseases, Clinical Modification (ICD-9-CM). This is the classification used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization in the United States.

For Medicaid to approve and pay a claim, the diagnosis code must be among those approved by the Department of Social Services, which is the State’s Medicaid Agency.

Criteria: Prudent business practice dictates that reasonable efforts be made to collect funds due the State.

Condition: Claims with invalid or missing diagnosis codes are sometimes submitted for Medicaid payment, always resulting in rejection. Claims that are rejected for this reason are not reviewed for correction and subsequent resubmission. We found eight instances of diagnosis-code related claim rejections out of a sample of 64 rejected Medicaid claims. These are described in the table below.

<u>Number of claims</u>	<u>Reason for Rejection</u>
2	Incorrectly entered at the originating agency, with one additional digit in the code
2	Submitted with the correct code, rejected for another unrelated reason, resubmitted and rejected because the diagnosis codes did not forward to the resubmitted claims
2	Submitted without diagnosis codes
2	Diagnosis codes are not yet on the list of approved codes

In addition, we found 12 instances of claims submitted to DAS too late for processing within the one-year filing limit. The sample for this test consisted of 63 Medicaid claims rejected because they were past the time limit for filing the claim.

All of these rejected claims originated with the Department of Mental Health and Addiction Services (DMHAS) targeted case management program.

Effect: The State is missing opportunities to recover part of the cost of the DMHAS targeted case management program. We identified lost billings of \$4,301.41 in a six-month period in our two samples alone, which equates to a loss to the State of \$2,150.70 (50 percent Federal financial participation). We did not project total potential lost billing to the population of rejected claims, as sometimes a claim may be submitted more than once. Although this may be the result of perfectly normal and acceptable claims processing, it distorts the number of unduplicated claims, and we did not

differentiate between original and duplicate claims that comprised our population.

Cause: Personnel at DMHAS report that some of the diagnosis codes used by professional staff at DMHAS and its providers are not yet approved for Medicaid billing. Anytime an unapproved diagnosis code is used in a claim to Medicaid, the claim will be rejected. Agency personnel report that the Agency is taking steps to update the approved diagnosis codes with the Department of Social Services.

In addition, some of the private non-profit providers do not diagnose the clients, and therefore, do not include a diagnosis code in the claim documentation. These automatically result in rejected Medicaid claims.

Neither DAS nor DMHAS reviews Medicaid claim rejections related to diagnosis codes for the purpose of correcting and resubmitting them. The Department of Administrative Services cannot change a diagnosis code, and DMHAS uses the information on diagnosis claim rejections as a matter for training on billing and documentation for future claims; there is no process for identifying matters that could be corrected on a current basis. This appears to have been a factor for four of the diagnosis-code related rejected items. The Department of Mental Health and Addiction Services reports that two claims had an extra digit (a zero) in the diagnosis code and two were rejected because the correctly reported diagnosis codes did not forward to the related resubmitted claims. The problem with these last two claims stems from deficiencies with DAS' billing and collection system that the Agency is still trying to resolve. (See Item No. 7.)

Compounding the problem, DMHAS does not have a systematic process for submitting claims from the private non-profit targeted case management providers. This would include editing claims data before it is submitted to DAS for billing. Such a process could help to ensure timely filing as well as identifying coding errors that result in claims being rejected.

Personnel at DAS provide the originating service providers with the Medicaid remittance advices upon request, but not on a regular basis. The originating service providers do not review the remittance data consistently.

Recommendation: The Department of Mental Health and Addiction Services should take steps to institute a system for processing and editing claims

data from private non-profit providers. In addition, the Agency should continue its efforts to update the approved diagnosis codes for Medicaid billing and to instruct providers in the appropriate use of diagnosis codes, as well as other billing and documentation matters, such as timely filing. Furthermore, the Department of Mental Health and Addiction Services should look into the allowability of resubmitting diagnosis-code related rejected claims, where it is known that the service provided is appropriate for an approved diagnosis, in those cases where it appears that the diagnosis code was entered incorrectly.

We recommend that the Department of Administrative Services take steps to resolve the billing and collection system deficiencies that cause changes in the data when it is resubmitted. Also, the Department of Administrative Services should provide the Medicaid remittance advices to the originating service agencies on a systematic basis, rather than upon request. Personnel at those agencies should develop a process for reviewing and/or querying the remittance advice database in a manner designed to maximize opportunities to identify, and where appropriate, correct and re-submit rejected Medicaid claims. (See Recommendation 5.)

Agency Response:

The Department of Mental Health and Addiction Services:
“DMHAS concurs with the audit findings and recommendations, and has initiated a number of efforts to improve collections under the targeted case management program.

- A committee has been established to systematically address these problematic areas focusing on education and training of targeted case management services’ documentation and claim requirements as well as improved monitoring of information in a timely manner.
- DMHAS has been working with DSS to update and increase the selection of diagnosis codes available under the TCM program.
- DMHAS has proposed an amendment to the state regulations that govern the TCM program to expand the definition of TCM to include those individuals served with a diagnosis of substance use disorders. Currently, targeted case management covers only psychiatric disabilities.
- As of June 2002 service data that is submitted to DMHAS by private non-profit [PNP] providers greater than one year from the date of service is no longer being sent to DAS. This insures accurate claim data and identifies those providers that are not in compliance with their contract obligations. Future enhancements to DMHAS’ system will include collecting data from the PNP community with some up front editing and

direct feedback by not allowing inactive, incorrect or missing diagnoses to be entered as well as insure the integrity of all the data being submitted for payment.”

The Department of Administrative Services:

“We agree with this finding. We wish to point out that all services for targeted case management are sent to DAS electronically as is the diagnosis. We do not change it. The issue is that Medicaid will only pay on the two procedure codes in conjunction with specific diagnosis. If the diagnosis is not on the approved list, it should be identified at DMHAS when the file is created. A decision should be made then as to whether to correct the code or request DSS to include it on the approved list. As part of the [system] implementation, each agency will have access to the remittance advice for their agency to review diagnostic related rejections.

The [system] related issue with diagnostic codes not being forwarded with resubmissions has been corrected.”

Item No. 6 – Reconciliation of Service and Billing Data

Criteria: Good business practice dictates that reasonable efforts be made to collect promptly all funds that are due. In addition, it is necessary that the agencies involved in the delivery of and billing for services establish and maintain controls to provide reasonable assurance that program objectives – in this case, billing and collection – are achieved.

Condition: The Department of Administrative Services failed to bill two service months for Southbury Training School attendance and one month (21 days) of private day service from the January 2002 service data provided by the Department of Mental Retardation (DMR). This represents a .5 percent error rate for the 664 items in our judgmentally selected test group. Furthermore, DMR failed to detect these billing omissions, and ensure that they were resolved, because of a lack of controls for verifying that service data submitted to DAS is actually billed.

Effect: For one Southbury Training School client, delayed Medicaid-covered claims for the month of January 2002 amounted to \$17,307. The Department of Administrative Services found that it did not bill for one Southbury Training School client since October 2001, due to an error that carried forward an incorrect leave designation from the old system to the new system. Total delayed billing for that client through November 2002 amounted to

perform the reconciliation and monitoring controls recommended by the Auditors.”

Auditors’ Concluding Comments:

Processing information is certainly easier, and usually provides more consistent results, when it can be done electronically. And it may be easier to effect controls over the processing. However, manual processing also needs controls to ensure that the desired results are achieved. Control totals may be useful, such as the total number of clients submitted for billing, the total units of service submitted for billing, or the total expected billing. This information, compared with actual billing results, may provide useful data in detecting errors that would hinder the State from achieving the desired results of the billing and collection process. The reconciliation need not entail an item-by-item comparison, which would be too time-consuming to yield beneficial results.

And regardless of which agency would ultimately assume responsibility for reconciling data submitted with data actually billed, both the originating service agency and DAS will be providing some of the data. Therefore, both agencies will have a role in the process.

Agency Response:

Department of Administrative Services:

“From the Auditors test data for both the number of days and the number of patients, the error ratio is about the same at a little over .02% or a correct rate of 99.98 %. We believe that this type ratio provides more than reasonable assurance that program objectives of billing and collection are achieved.

We are able to produce system reports from Avatar if requested by DMR that would show services, the value of these services, what was billed and collected. It should be noted that a process for matching these reports against paper records would be labor prohibitive. For example, for January 2003, DAS inputted over 581,000 individual services for DMR.

We wish to emphasize that no monies were lost to the State of Connecticut for three billing omissions.”

Auditors’ Concluding Comments:

We do not dispute that the error rate for our judgmental test group is very low. However, we reiterate that absent controls for reconciling service data submitted with service data billed, neither DAS nor its client agencies can be reasonably sure that all service data submitted to DAS for billing is, in fact, billed. This would be

equally true for a higher error rate. Furthermore, the fact that one billing omission continued undetected for a period of 14 months, irrespective of a low error rate, is indicative of the need for controls to obtain reasonable assurance that billable service data submitted to DAS is actually billed.

Item No. 7 – Department of Administrative Services’ Billing, Collection, and Reporting System

Criteria: The Department of Administrative Services has contracted with a vendor for a data system for billing, collecting and reporting, that replaces DAS’ former systems. The target date for full system implementation was October 1, 2001.

Condition: The Department’s billing, collection and reporting system is still not fully operational.

At April 14, 2000, DAS contracted for the purchase, installation and implementation of a system to accommodate DAS’ billing, collecting, and reporting needs. Department personnel described three components that were necessary to complete a full processing cycle. These are billing, remittances, and reporting. The Agency submits billing data from its client agencies to guarantors, such as insurance companies, Medicare, or Medicaid, for payment. The system needs to receive and account for remittances from the guarantors, and finally, DAS personnel need to be able to extract data from the system via reports.

Originally scheduled for implementation by July 2001, the schedule was revised, and the system was to have been fully implemented by October 1, 2001. At that time, DAS began the process for billing the guarantors. However, due to various problems with the system, Agency personnel report that the first billings were not actually submitted to the guarantors until January 2002. Even then, the process did not operate as intended. Agency personnel report that there were problems that had to be corrected, which was noted during our review.

At December 2002, the remittance component of the system was not fully functioning, and therefore, the reporting function was also not available. Remittance data has been warehoused on the system, so that it is available, but could not be integrated into the records of accounts. Department personnel report that the billing component is fully operational, that Medicaid remittances have been loaded through August 2002, and that personnel are currently working on loading September 2002 remittances.

- Effect:* The Department of Administrative Services has had to devote resources to correcting the problems in the system. Data errors that have resulted in claim rejections have had to be reprocessed, increasing the number of claims presented to the Medicaid fiscal agent for processing. Processes that would expedite recording and reporting data are not available, so that DAS personnel must use compensating methods to achieve the goals of the Agency.
- Cause:* At this point, DAS maintains that the contractor has not delivered and implemented the product as specified in the contract. At December 17, 2002, DAS was withholding payment of \$329,521.63, of the \$2,227,155 contract, from the vendor, to encourage the contractor to complete a full billing-remittance-reporting cycle.
- Recommendation:* The Department of Administrative Services should continue its efforts to bring the billing and collection system to full implementation. (See Recommendation 7.)
- Agency Response:* “We agree with the finding. We always have intended to hold the vendor responsible for a fully functional data system. As for Medicaid remittance processing, it is current as of calendar year end- 2002.”

RECOMMENDATIONS

1. **Although the Department of Mental Retardation has located and resolved the coding error in its client/service information system, we recommend that it implement procedures to review the Targeted Case Management Billing Entry Report to ensure that all targeted case management services have been billed. This billing should be reviewed periodically to ensure that service contact by the case manager results in billing for each day in the quarter. In addition, although the Department of Mental Retardation is in the process of computerizing the reporting of targeted case management services by case managers, personnel should monitor the process to ensure all targeted case management services are entered into the client/service information system.**

Comment:

The Department of Mental Retardation has not been submitting all targeted case management services to the Department of Administrative Services for Medicaid billing due to a programming deficiency in its Connecticut Automated Mental Retardation Information System. This has resulted in partial billing of services provided in a quarter. A data entry weakness has resulted in service information being completely omitted for an entire quarter in some instances.

2. **The Department of Mental Retardation should implement a policy making contract payments to service providers contingent upon the receipt of monthly attendance sheets.**

In addition, the Department of Mental Retardation should re-evaluate and modify its Community Training Home attendance-keeping practices to ensure that these attendance reports are submitted promptly to the central office.

Comment:

Private non-profit Community Living Arrangement providers do not always submit service data within the contractual time limits. We noted delays of up to seven months. Regardless of this fact, the Department of Mental Retardation pays these providers 1/12 of their respective contract totals each month for their services. Personnel from the regional offices are responsible for collecting and reporting service data to the central office for Community Training Home providers. This information is often not filed on a timely basis, with delays of seven months for reporting these services as well.

3. **Personnel in the Probate Recoveries unit of the Department of Administrative Services Financial Services Center should continue their efforts to encourage probate courts to submit information on all estates when the probate application is filed.**

Comment:

The Department of Administrative Services' probate recoveries team in the Financial Services Center has worked in cooperation with the Office of the Probate Court Administrator to obtain all information on estates opened in the State annually. The Probate Court Administrator has requested that all probate courts submit all their probate applications to the Department of Administrative Services, per document TR 00-506. The probate courts are not required to forward all estate application forms to the Department of Administrative Services, though many do. If the Department received all forms from all the probate courts, we estimate that personnel could increase recovery of the cost of prior State services by approximately \$3,000,000 over the current level, each year.

4. **We recommend that the Department of Social Services review the program participation requirements, benefits, and costs with officials from the Department of Children and Families and the State Department of Education to determine if these school systems are eligible to participate in the School-Based Child Health program, and if participation would be cost effective.**

Comment:

Two State-wide school districts do not currently participate in the School-Based Child Health program. These are the Department of Children and Families' Unified School District #2, and the State Department of Education's Vocational-Technical schools. We could not ascertain the reasons for their non-participation, and personnel at the Department of Children and Families, the State Department of Education and the Department Social Services could not provide a rationale for non-participation. As a result, the State may be missing opportunities to increase Medicaid recoveries.

In addition, Connecticut's local and regional school districts have an opportunity to participate in the School Based Child Health Program, which makes them eligible to submit certain special education costs for Medicaid reimbursement. The school districts receive 60 percent of the resulting Medicaid reimbursement, and the State retains 40 percent for administrative costs. For the schools that do not participate, we estimate that they lose approximately \$2,391,000 annually. The estimated loss of revenue to the State is about \$1,594,000 annually. Mandatory participation in the program, for those school districts that would benefit from participation, would require legislative action.

5. **The Department of Mental Health and Addiction Services should take steps to institute a system for processing and editing claims data from private non-profit providers. In addition, the Agency should continue its efforts to update the approved diagnosis codes for Medicaid billing and to instruct providers in the appropriate use of diagnosis codes, as well as other billing**

and documentation matters, such as timely filing. Furthermore, the Department of Mental Health and Addiction Services should look into the allowability of resubmitting diagnosis-code related rejected claims, where it is known that the service provided is appropriate for an approved diagnosis, in those cases where it appears that the diagnosis code was entered incorrectly.

We recommend that the Department of Administrative Services take steps to resolve the billing and collection system deficiencies that cause changes in the data when it is resubmitted. Also, the Department of Administrative Services should provide the Medicaid remittance advices to the originating service agencies on a systematic basis, rather than upon request. Personnel at those agencies should develop a process for reviewing and/or querying the remittance advice database in a manner designed to maximize opportunities to identify, and where appropriate, correct and re-submit rejected Medicaid claims.

Comment:

Twelve claims, out of a sample of 63 claims, were submitted past the one-year filing limit. Eight claims, out of a sample of 64 claims, were rejected for diagnosis code deficiencies. These were all from the Department of Mental Health and Addiction Services targeted case management program. The causes for these deficiencies are varied. The Department does not have a systematic process for submitting or editing claims from private non-profit providers; the Department of Administrative Services does not consistently provide the originating agencies with remittance advice data; there is no process in place for reviewing rejected diagnosis-code related claim rejections when they are available; some diagnosis codes are not yet approved by the State's Medicaid agency (the Department of Social Services); providers do not always include a diagnosis code in the claim submission; the Department of Administrative Services' billing system sometimes alters rejected claims when they are resubmitted.

6. **The Department of Administrative Services and its client agencies should develop controls that would provide reasonable assurance that all billable service data submitted to the Department by those client agencies is actually billed.**

Comment:

The Department of Administrative Services failed to bill two service months for Southbury Training School attendance and one month (21 days) of private day service from the January 2002 service data provided by the Department of Mental Retardation. This represents a .5 percent error rate for the 664 judgmentally selected test group. Furthermore, the Department of Mental Retardation failed to

detect these billing omissions, and ensure that they were resolved, because of a lack of controls for verifying that service data submitted to the Department of Administrative Services is actually billed.

7. **The Department of Administrative Services should continue its efforts to bring the billing and collection system to full implementation.**

Comment:

The Department's billing and collections data system is not yet fully operational. The billing function is in place, but the remittance portion is not yet operating as intended. Until the remittance portion is totally in place, the reporting function is, by default, also incomplete. Problems with the system have made it necessary for the Department to divert resources, reprocess claims, and devise compensating methods to meet its data processing needs.

CONCLUSION

In conclusion, we wish to express our appreciation for the cooperation and courtesies extended to our representatives by the officials and staff of the Department of Administrative Services, the Department of Mental Retardation, the Department of Mental Health and Addiction Services, the Department of Veterans Affairs and the Department of Social Services.

Laura Rogers
Associate Auditor

Approved:

Kevin P. Johnston
Auditor of Public Accounts

Robert G. Jaekle
Auditor of Public Accounts

**APPLICATION
ADMINISTRATION OR
PROBATE OF WILL**
PC-200 (BBS) REV. 10/99

**STATE OF CONNECTICUT
COURT OF PROBATE**

RECORDED:

[Type or print in black ink. File in **duplicate**.]
[Use Second Sheet, PC-180, for additional data.]

TO: COURT OF PROBATE, DISTRICT OF	DISTRICT NO.	DATE OF APPLICATION
ESTATE OF [Include all names and initials under which any asset was held.]	SOCIAL SECURITY NO.	DATE OF DEATH
DECEDENT'S RESIDENCE AT TIME OF DEATH [Include full address.]	<input type="checkbox"/> WRONGFUL DEATH CLAIM	
JURISDICTION BASED ON: <input type="checkbox"/> Domicile in District [If domicile is different than residence, please explain.] <input type="checkbox"/> Other [Please explain other jurisdictional basis.] Use Second Sheet, PC-180, for explanation.		
PETITIONER [Name, address, and zip code]	SURVIVING SPOUSE [Name, address, and zip code. If there is no surviving spouse, so state.]	

HEIRS, NEXT OF KIN, BENEFICIARIES, AND TRUSTEES, if any. [Give names, addresses, zip codes, and relationships.] **If heir, indicate ancestor through whom heir takes. If beneficiary, indicate paragraph of will where interest is stated or may arise. For all minors listed, give date of birth. Indicate any person who is under legal disability or in the military service. C.G.S §§45a-436; 45a-438; 45a-439.**

THE PETITIONER REPRESENTS that:

- Decedent left a will and *codicil(s)* herewith presented for probate, dated _____
 - Decedent, after making said will and *codicil(s)*, had a child born, or adopted a minor child, or married, or had his or her marriage dissolved by divorce or annulment. C.G.S. §§ 257a - 257f. [Explain any checked boxes on Second Sheet, PC-180.]
 - The proposed fiduciary named below is **not** the primary executor named in said will or *codicil*. [Explain on Second Sheet, PC-180.]
 - Decedent left no will.
 - One or more of the children listed above or on Second Sheet, PC-180, are **not** also the children of the surviving spouse.
 - Decedent owned an interest in real property other than in survivorship in Connecticut at the time of death.
- Decedent, or spouse or children of the decedent, *did* *did not* ever receive aid or care from the State of Connecticut.
 [If affirmative, check appropriate box(es).] State of Connecticut Department of Veterans' Affairs C.G.S. §45a-355.
- The estimated value of (a) personal property is \$ _____ (b) gross taxable estate is \$ _____
 (c) wrongful death claim is \$ _____

All the foregoing data is true and complete to the best of his or her knowledge and belief, and he or she has used all proper diligence to ascertain the names and addresses of all heirs and beneficiaries. Any additional data given on Second Sheet, PC-180, is made a part hereof.

WHEREFORE, THE PETITIONER REQUESTS that said will and *codicils*, if any, be approved and admitted to probate and that either letters testamentary be issued or letters of administration be granted to the below-named proposed fiduciary.

The representations contained herein are made under the penalties of false statement.

Date _____

Petitioner's Signature

PROPOSED FIDUCIARY

IF APPOINTED, I WILL ACCEPT SAID POSITION OF TRUST.

Signature _____
[Type or print name under signature.]

Address with zip code _____

Fiduciary is is not a resident of the State of Connecticut.

Fiduciary is is not a resident of the State of Connecticut.

Telephone number _____

Telephone number _____

ATTORNEY FOR PROPOSED FIDUCIARY [Name, address, zip code, telephone number, and Conn. Bar Juris No.]

Each of the undersigned represents that he or she has examined the application and related documents and hereby **WAIVES NOTICE OF HEARING** upon said application and has **NO OBJECTION** to the granting and approval thereof. [If space is insufficient, use General Waiver, PC-181. Please also type or print name.]