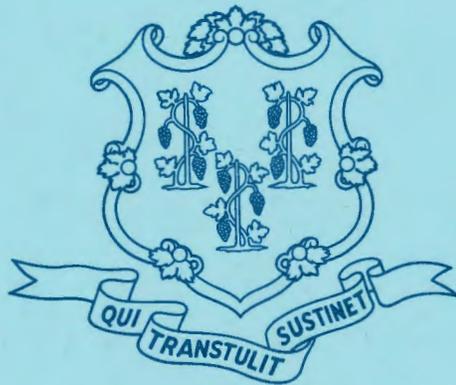


Connecticut General Assembly



Legislative Program Review and Investigations Committee

CONTAINING MEDICAID COSTS IN CONNECTICUT

September, 1976

CONNECTICUT GENERAL ASSEMBLY
PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, standing committee of the Connecticut General Assembly. It was established in 1972 as the Legislative Program Review Committee to evaluate the efficiency and effectiveness of selected state programs and to recommend improvements where indicated (Public Act 72-90). In 1975 the General Assembly expanded the Committee's mandate to include investigations and changed its name to the Legislative Program Review and Investigations Committee (Public Act 75-388).

The Committee is composed of twelve members (listed below), three each appointed by the Senate President Pro Tempore and Minority Leader, and the Speaker of the House and Minority Leader.

A list of the studies completed by the Committee to date appears at the end of this Report.

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LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

CONTAINING MEDICAID COSTS IN CONNECTICUT

SUMMARY

CHAPTER I. PURPOSE AND SCOPE

The Legislative Program Review and Investigations Committee issued a "Preliminary Review of Selected Medicaid Issues in Connecticut," in March, 1976. The preliminary report made some two dozen important recommendations, many of which have already been implemented (p. 1).

The purpose of this report is to provide an in-depth analysis of the state's Medicaid program, to identify problems and to recommend solutions designed to improve performance and reduce the rate of growth in program costs (pp. 1-2). Medicaid expenditures in Connecticut have been increasing at an average annual rate of more than 15% since FY 1971, and are expected to exceed \$200 million in FY 1977.

The scope of the study included four main types of cost controls--eligibility controls, price controls, utilization controls, and expenditure controls (p. 2).

Data were gathered from numerous sources, including documents and reports, more than one hundred interviews, a survey of eligibility workers, field visits and a public hearing (p. 2). Approximately 28 person months were consumed by the Committee's multidisciplinary staff in collecting and analyzing the data presented in this report. Some four dozen recommendations are made on ways to improve Department of Social Services (DSS) operations and to contain Medicaid program costs. Some of these recommendations require relatively small increases in appropriations for administration in order to save large sums of misspent funds due to inadequate controls. Further, many of the recommendations will have spillover benefits of reducing other welfare program costs through improved administrative controls (pp. 3-4).

CHAPTER II. INTRODUCTION TO MEDICAID

Title XIX of the Social Security Amendments of 1965, provides for grants to states for medical assistance (Medicaid). In Connecticut, the Department of Social Services (DSS) administers the Medicaid program together with other state welfare programs (p. 5).

Two groups of persons may be covered under Medicaid: the "Categorically Needy," such as AFDC recipients, and the "Medically Needy," who receive no cash assistance (p. 5). States are required by federal law to provide medical assistance to persons receiving cash assistance under any of the federal categorical programs (Categorically Needy). States may elect, as Connecticut has, to provide medical assistance to an intermediate group (Medically Needy) whose income and assets exclude them from cash assistance, but who are unable to afford necessary medical care (pp. 5-6).

Federal law provides a comprehensive list of services that a state Medicaid plan may include. Of these, certain services must be provided, and others are optional. Connecticut provides the full range of optional medical services (p. 7).

While the number of Medicaid recipients has only doubled from about 90,000 in 1967 to about 180,000 in 1976, Medicaid expenditures were six times higher in 1976 (\$188 million) than in 1967 (\$32 million).

A major cause of Medicaid cost increases in Connecticut is the imbalance in levels of care provided by the nursing home industry. Connecticut spends nearly half of its Medicaid budget on expensive skilled nursing care, while other states average only 20%. Conversely, other states average about 16% of Medicaid budgets for lower cost intermediate care, while Connecticut spends only 4% (pp. 9-11). Chapter VIII is devoted to an in-depth examination of nursing home problems and proposals for correcting the imbalance in levels of care available.

CHAPTER III ELIGIBILITY CONTROLS

DSS efforts to ensure that only those eligible for program aid receive it are discussed in this chapter. The most recent Quality Control Report (July-December, 1975) shows that 20% of AFDC cases are either overpaid or ineligible (p. 13). Misspent funds (cash and medical assistance) due to errors in the AFDC program alone are estimated at \$15.5 million annually. This does not include medical payments for ineligible Medically Needy recipients (p. 14).

While an increasing proportion of errors in the AFDC caseload are attributed to clients rather than the agency,

LPR&IC analysis suggests that some of these may result from agency inaccessibility. Improvements, especially in telephone service, are recommended.

As part of its latest corrective action plan, DSS proposes to study expansion of a pilot project (High Risk Unit) which has been successful in reducing errors in earned income cases (p. 17). It is recommended that DSS expand the High Risk Unit statewide if justified by a cost-benefit study. It is also recommended that the Department make better use of Quality Control Reports in the district offices by scheduling more frequent meetings with district directors on Quality Control findings and corrective action plans (pp. 18-20).

Verification of recipient resources are attempted only when income or assets are reported by the client. In addition, the system for verifying the presence of children and absence of fathers in AFDC homes is weak and does not include home visits. It is recommended that home visits be made on a sample of cases or when fraud is suspected (p. 21).

A redetermination of eligibility is required on all AFDC cases every six months and on all Medically Needy cases annually. While timely AFDC redeterminations are being done, Medically Needy redeterminations are not being accomplished as required. Because a pilot project in the Hartford district office shows that substantial savings could be made by reexamining the eligibility of Medically Needy cases, it is recommended that Medically Needy redeterminations be performed annually as required by federal law and that the General Assembly fund the additional staff necessary to perform this important cost-saving function (p. 24).

DSS administrative structure for managing caseloads is separated into three main units: eligibility services, income maintenance, and social services. Because workers in eligibility services and income maintenance perform similar tasks, it is recommended that the two units be combined (p. 26).

The system for managing caseloads is a "bank" approach in which cases are serviced by workers randomly or alphabetically. This system has major weaknesses since it is difficult to assign responsibility for particular actions or errors to particular workers. Therefore, it is recommended that the Department study the feasibility of

moving to a "caseload" system in which specific cases are assigned to each worker for long-range service (p. 27).

Adopting a caseload system may require other changes. For example, it was found that some workers lack basic skills needed to perform their jobs. It is recommended that the specifications for the entry level position of "welfare aide" be revised to require passing a job-related competency test (p. 28).

The workload and financial responsibility (excluding adult and CAMAD cases) of eligibility workers in DSS is incommensurate with qualifications and salary. On average, each worker handles cases totalling over \$1 million annually in cash assistance and medical aid and which account for over \$100,000 per year in errors (pp. 28-29).

It is recommended that the Department study more thoroughly the process time for case actions so that reasonable workloads can be developed for workers. In addition, because work output is monitored poorly in some work units, it is recommended that the Department develop performance standards by which workers can be evaluated (p. 29).

It was found that management practices and application of policy varies, sometimes considerably, from one district office to the next. To improve program administration, it is recommended that DSS interpret policy clearly at the central office and apply policy uniformly in the districts. Furthermore, staff/workload ratios should be equalized and uniform management guidelines should be implemented state-wide (p. 30).

A survey of eligibility workers was conducted to determine worker attitudes toward their training, working conditions, and morale. Workers reported that training was inadequate, and that they were dissatisfied with working conditions, salary, and opportunities for career development offered by DSS. It is recommended that an effective and meaningful training program for workers be implemented, and that training of supervisors be improved. It is also recommended that working conditions be upgraded in the district offices. It is suggested that the state personnel system be reviewed to determine if changes are needed to make the system more responsive to state manpower needs. A suggestion is also made that the Departments of Personnel and Finance and Control, the State Personnel Policy Board, and the Legislature cooperate with DSS efforts to implement a flexible career ladder for employees (pp. 30-39).

The chapter concludes with a discussion of recipient fraud. AFDC Quality Control Reports suggest that willful misrepresentation by clients may cost the state as much as \$9.2 million in AFDC cash assistance and \$1.5 million in Medicaid services. Further, the number of "client errors" is increasing at an alarming rate (p. 41).

Fraud referrals from DSS to the Department of Finance and Control may be reviewed as many as six times and take three months or more to process. In spite of this, 50-75% of the fraud referrals contain inadequate information, according to Finance and Control investigators. It is recommended that the fraud referral procedure be simplified and that Connecticut statutes be amended to require DSS to refer to Finance and Control only those cases in which recipient overpayment exceeds \$500. It is also recommended that resource unit supervisors in the district offices serve as fraud referral specialists and act as liaison to the Central Collections Unit in the Department of Finance and Control. In addition, it is recommended that DSS publicize its public fraud referral program (P.O. Box 567) (pp. 40-41).

Most data on recipients is not checked by DSS unless specific information is supplied by clients. Because an increasing number of recipients fail to report information or report inaccurate information, it is recommended that DSS evaluate the feasibility of cross matching eligibility files with records at the Departments of Labor and Motor Vehicles, Court Registries and school districts (p. 44).

To recover child support payments from absent parents, LPR&IC supports full compliance with the federal Title IV-D program. It is recommended that a separate line-item be contained in the budget to facilitate oversight of this program (p. 45).

CHAPTER IV. PRICE CONTROLS

In Connecticut there are five rate-setting bodies, each having jurisdiction over particular types of vendors (p. 47).

Hospitals. The Commission on Hospitals and Health Care (CHHC) sets private rates for hospitals and long-term care facilities. Based on CHHC rates and other factors, the Committee on State Payments to Hospitals establishes Medicaid reimbursement rates for these services (p. 49). In the case

of inpatient hospital services, interim rates are set in advance, payment is made at the interim rates, and year-end adjustment is made to reflect utilization and actual costs (p. 52). The retrospective adjustment for cost increases substantially undermines the potential effectiveness of the "prospective" rates.

Outpatient clinics and emergency room rates are based on data 21 months out of date. A time lag adjustment is made, but it appears inadequate. In addition, statutory caps on rates are too low and should be removed to allow CHHC more flexibility. Multi-purpose, community-based outpatient clinics are an important resource, and their growth should be fostered in needed areas (pp. 52-53).

Nursing homes. Long-term care accounted for 53% of Connecticut Medicaid expenditures in FY 1976. Numerous abuses nationwide have prompted HEW to require a strict cost-related reimbursement system (pp. 55-56).

While a new system was being developed, an interim reimbursement system was put into effect. The system was based on 1974 costs plus a 5% adjustment for inflation. Many nursing homes in Connecticut have reported significant financial losses as a result of the interim rates. Therefore, LPR&IC recommends that the Committee on State Payments accept and expedite rate appeals from homes able to fully document such losses.

Connecticut's proposed cost-related reimbursement system was not implemented on July 1, 1976 as planned, due to numerous objections from the industry including the failure of the Committee on State Payments to comply with the Uniform Administrative Procedures Act. Although LPR&IC endorses the proposed system, adequate information has not been provided to explain how the reported data will be used to establish rates. It is therefore recommended that the Committee on State Payments issue a handbook specifically describing the rate determination process (pp. 56-57).

Each facility's audited costs will be separated into controlled cost centers, uncontrolled cost centers and asset valuation. Because there is widespread concern that the asset valuation method of the proposed system will severely jeopardize the future of the nursing home industry in Connecticut, it is recommended that the Committee on

State Payments contract for an independent examination of the Fair Rental Value System of asset valuation for its long-range impact on the nursing home industry (p. 59).

To induce efficiency, financial incentives will be offered to homes meeting certain criteria. However, it is recommended that the incentives be reviewed to determine if they should be made more attractive (p. 60).

Drugs. Connecticut presently employs a cost plus professional fee method for reimbursing pharmacies. Although this appears appropriate for walk-in customers, an estimated \$900,000 could be saved if pharmaceutical services were provided to nursing homes on a low bid contract system. It is recommended that the Department of Social Services examine reinstatement of the bid system for providing pharmaceutical services to nursing homes (p. 62).

Doctors. Reimbursement for physician services is based on a "Relative Value Scale," which assigns units of value to each medical procedure according to time and complexity. A single unit is reimbursed at the rate of \$4.50 for basic medical services and \$5.00 for surgery and radiology (p. 63). These rates have not been updated since 1973.

Ambulances. Recent increases in ambulance rates were based on unaudited costs presented at a public hearing. It is recommended that the Department of Health provide the Office of Emergency Medical Service the use of a financial analyst for the ambulance rate determination process (p. 66).

Equipment. Until recently the state stocked durable medical equipment (wheelchairs, crutches, braces) to be dispensed upon DSS authorization. This procedure resulted in many problems, and the state will soon contract out for this service (pp. 66-67).

CHAPTER V. UTILIZATION REVIEW

Utilization review (UR) is a system used to determine the appropriateness of medical care provided and to identify and prevent overutilization of medical services (p. 68).

Most non-emergency medical services provided in Connecticut require prior authorization from the DSS Medical Review Team (MRT). This team is composed of several part-time specialists and a Medical Director. The workload is such that an average of six minutes can be spent on each

prior authorization request. Because policy communication with providers is essential, because an effective prior authorization system is a deterrent to overutilization, and because MRT positions are 75% federally reimbursed, it is recommended that DSS expand its Medical Review Team to include one or more additional full-time consultants and a full-time Medical Director (p. 69).

The Department has considered decentralizing its MRT staff to the various district offices. The Committee recommends that the MRT operation remain in the Central Office (p. 69).

DSS has no formal regulations that effectively control the use of non-emergency ambulance service. It is recommended that a procedure be established for the daily reporting and sample auditing of ambulance claims. In addition, welfare recipients should be made aware of alternative types of medical transportation available to them (p. 70).

Connecticut spends nearly \$3 million annually on elective surgery, one-third of which the Department estimates as being unnecessary. DSS intended to implement a second medical opinion requirement for six surgical procedures by January 1, 1976. Because of administrative delays and failure to adopt formal regulations, the plan has not yet taken effect. As much as \$1 million may already have been lost in calendar 1976 (pp. 70-71).

In FY 1975, drug utilization per Medicaid recipient rose at the alarming rate of 18%. DSS pharmaceutical reviewers should periodically review a sample of pharmacy billings to determine whether departmental policy is being followed with regard to drug quantity, refills and narcotic and alcoholic drugs. Further, DSS should reduce its restriction on the number of refills allowed for birth control prescriptions.

Federal regulations require that pharmaceutical services provided at a skilled nursing facility be under the supervision of a qualified pharmaceutical consultant. Many such consultants provide these services without fee, but usually when they also provide upwards of 70% of the drugs used in the home. Uncontrolled, these financial arrangements have the potential of creating a direct conflict of interest. It is recommended that the State Pharmacy Commission and State Department of Health promulgate regulations which will

effectively control the professional services provided by nursing home pharmaceutical consultants. All pharmaceutical consultants should be paid on a fee basis (pp. 74-75).

As a means of safeguarding against unnecessary surgery and other excessive treatments, the federal government has mandated states to establish local "Professional Standards Review Organizations" (PSRO's). Connecticut has four PSRO's which have begun limited operations. PSRO's will perform hospital length of stay (LOS) reviews by patient age and diagnosis for each Medicaid beneficiary (pp. 75-77).

CHAPTER VI EXPENDITURE CONTROLS

The Medicaid fee-for-service payment system is examined in detail. The Medical Payments Section, which is responsible for manual review and preparation for computer processing of all Medicaid claims, was found to be understaffed. LPR&IC recommends that existing vacancies be filled and that Medical Payments Section positions be reviewed for possible reclassification to attract and retain staff qualified to perform the important and complex manual review operations (pp. 78-83).

A separate "Suspended Payments Unit" also is recommended to relieve the Medical Payments Section of some of its current workload, to increase accuracy in the payment system, and to improve provider relations (p. 84).

The Department's lack of adequate staffing and effectiveness data on which to base cost-benefit analyses, as well as the lack of written instructions and formal training of personnel are noted. The LPR&IC recommends that a systematic study of claims processing be undertaken, and that appropriate detailed staff instructions be developed, along with the development of pre-service and in-service training program (pp. 85-87).

The Medicaid program must be the payor of last resort. Yet, the Department's system for holding other "third parties" (private insurers, Medicare) liable is weak. The LPR&IC recommends that a separate "claims recovery" unit be established to follow-up insurance and accident liability. With proper organization and training, this unit could recover significant amounts of erroneous Medicaid payments. Additionally, it is recommended that the Department explore

the use of a private contractor, as the Departments of Health and Mental Health have, to recover Medicaid payments where the Medicare program had primary liability (pp. 87-90).

The Post-Payment Audit Group is also understaffed, limiting their capability to effectively make use of the available post audit reports. The LPR&IC recommends that the staff of this section be augmented to increase the detection and recoupment of overpayments. An automated claims recovery system is also suggested which would allow the Department to withhold payments to vendors until overpayment balances are recouped (pp. 90-93).

To control rising drug costs, and fully realize projected savings of the drug substitution law (P.A. 76-166) the LPR&IC recommends that DSS implement a policy which will reimburse pharmacists only for the lowest cost generic equivalent (p. 95).

DSS conducts a very limited review of drug bills using a pharmaceutical reviewer and a computer edit routine which suspends only those line-items which exceed \$16. It has been demonstrated in other states that some private contractors have pharmaceutical cost auditing and utilization control systems which would cost significantly less to operate and would generate additional savings through cost and utilization controls. The LPR&IC recommends that formal bids be solicited for such a system (p. 96).

Vendor fraud is a topic of growing national concern. HEW has recently established a Medicaid Fraud and Abuse Unit and LPR&IC recommends that DSS seek this unit's assistance in establishing a vendor fraud and abuse unit for Connecticut (pp. 96-98). The Department has not promulgated regulations regarding vendor fraud as required by P.A. 76-242. Since very few (approximately one per year) vendor fraud cases are prosecuted, regulations should be issued to facilitate the prosecution of vendor fraud cases.

CHAPTER VII MEDICAID MANAGEMENT INFORMATION SYSTEM

HEW has developed a computerized system (MMIS) to help states contain Medicaid costs by reducing processing errors and facilitating control of misuse and abuse of the program (p. 101).

HEW grants financial assistance for 90% of development costs to states which develop an approved MMIS. When the system becomes fully operational, HEW increases the federal reimbursement for its operation from 50% to 75% (pp. 103-104).

Although the Department's MMIS development staff have been able to identify the problems of the existing system and to propose an appropriate solution, they have had problems implementing it.

Unless, management of the MMIS project is improved, the project will not meet its scheduled two-year completion date. Therefore, LPR&IC recommends that DSS recruit a full-time director to assume responsibility for the MMIS project. To aid project managers in controlling, monitoring, and reporting on the progress of the MMIS project, LPR&IC recommends that the Department of Finance and Control's State Data Processing Division make available to the Department of Social Services a project management system (p. 109).

To help plan for the transition from the old system to the new, LPR&IC recommends that the Department of Social Services include, as part of the organizational analysis required for MMIS development, a Personnel Resource Impact Statement. It should identify all changes in agency staffing required for the new system, including staff increases or decreases (p. 109).

Unless Connecticut takes an aggressive approach in following up its surveillance and utilization reports to recoup overpayments and to refer fraud cases, it will not realize the full potential savings from MMIS. The computer can only generate information which must be interpreted and followed up with investigatory work and, in some cases, court action. It is essential that DSS plan ahead for different staffing needs after MMIS is implemented if maximum benefits are to be experienced (p. 110).

CHAPTER VIII INSTITUTIONAL PROVIDERS OF LONG-TERM CARE

The high percentage of Connecticut's Medicaid funds spent on skilled nursing facility care warranted in-depth discussion of the reasons why so many elderly Medicaid patients are placed in skilled nursing homes and what can be done to reduce nursing home costs.

While the new cost-related reimbursement system (Chapter IV) will go far to improve nursing home accountability and assure that Medicaid only pays legitimate costs, other changes are needed to correct the current imbalance in levels of care provided and to assure that patients are appropriately placed. As many as 20-50% of Medicaid patients in long-term care facilities may be inappropriately placed in skilled nursing homes at an excess cost of at least \$6 million for FY 1977. New federal regulations require appropriate placement of Medicaid patients and non-compliance could mean substantial loss of federal funds to the state (pp. 111-112). The Committee recommends that the Department of Social Services establish a policy that skilled nursing facilities caring for reclassified (ICF) Medicaid patients either accept ICF reimbursement or the patient will be transferred to a facility that will accept the ICF reimbursement (p. 112).

Providers of long-term care are described and the problems of limited information about Medicaid convalescent population is discussed (pp. 112-117). It is recommended that DSS analyze general convalescent characteristics and trends to aid in planning and budgeting (p. 117).

Determining appropriateness of Medicaid long-term care is the function of two federally-required utilization review groups--Utilization Review Committees (URC's) and DSS Patient Review Teams (PRT's). PRT effectiveness in controlling overutilization of skilled nursing homes has been hindered by staff shortages and insufficient training (pp. 117-121). The Committee recommends that DSS seek funds for additional PRT staff and improved training to improve effectiveness in this important cost control area (p. 121).

Appropriate and timely discharge planning and patient placement is recognized as still another means of controlling overutilization and reducing long-term care costs. Suggested improvements in long-term care planning include a recommendation to increase the number and training of district office adult service workers who are responsible for arranging care and services for elderly clients (pp. 121-123).

Needed revision of the state's outdated Public Health Cost to facilitate development of a broader continuum of long-term care, multi-level facilities able to adjust care to patient needs, and compliance with federal regulations is outlined (p. 124). The Committee recommends amendment of

the Code to establish two levels of intermediate care. In addition, a recommendation is made for statutory annual review of the Code to insure its continued relevance (pp. 124-125).

The relation of quality of care to the revision of standards and costs is briefly discussed. While LPR&IC is not in a position to issue a definition of quality care, the Governor's Blue Ribbon Committee is studying the relation of quality to standards. It is recommended that the findings of this important Committee be fully considered during Code revision (pp. 125-126).

Weaknesses in the federally-financed Medicare program are presented. Many older persons require care (other than skilled nursing) which is not covered by Medicare. As a result, the Medicaid program has had to assume increasing responsibility for long-term care of the elderly. Since revisions in Medicare and Medicaid legislation are now being considered by Congress, it is recommended that DSS prepare and submit to the Connecticut Congressional Delegation, a document outlining current deficiencies and recommending specific changes (pp. 126-127).

CHAPTER IX ALTERNATIVES TO INSTITUTIONALIZATION

In Chapter IX, the role of alternatives to institutionalization in the continuum of long-term care for the elderly is discussed. The many existing services--home health care programs, adult day care, elderly foster homes, the Triage program and a proposed home care demonstration project--are described.

It is suggested that home health care, a Medicaid reimbursable service, is not being utilized to its full potential despite the possible cost-savings (p. 128). Utilization of home care, like other alternatives, is hampered by confusion over Medicaid reimbursement, an institutional bias, and the difficulties in coordinating an appropriate alternative care plan (pp. 132).

While savings cannot be accurately estimated, the State Department on Aging (DOA) is conducting studies to determine the cost-effectiveness of alternative care (pp. 132).







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APPENDICES

I. PURPOSE AND SCOPE

In February, 1976, the Legislative Program Review and Investigations Committee began its work on a study of Medicaid in Connecticut. In accordance with the Committee's request, the staff prepared a "Preliminary Review of Selected Medicaid Issues in Connecticut" focusing on pending legislation and budgeting, especially the Department of Social Services appropriation for Medicaid.

The report endorsed six pieces of legislation, all of which have subsequently become law. Most notable among these were a generic drug substitution bill, a vendor fraud bill, and a bill to establish uniform applications and reports in the General Assistance program. Also recommended and passed were the addition of a budget line-item for \$308,250 for needed staff on the Medicaid Management Information System (MMIS) project, and a reduction of \$3 million for reduced nursing care.

Recommended, but still unimplemented by DSS, are (1) a second medical opinion on elective (nonemergency) surgery, (2) filling a vacancy for a second pharmaceutical reviewer, and (3) stepped up recoupment efforts from Medicare and other third party payors.

Purpose

The purpose of this larger study was to conduct a review of the Medicaid program as a whole--to identify problems and recommend solutions in the areas of program performance, accountability and cost.

Inefficiencies in paper flow, manual claims processing, and caseload management have been analyzed. DSS ineffectiveness in reducing eligibility error rates, in controlling overutilization of services, and in auditing claims for payment are also addressed. Failure to comply with federal law (Medicaid redeterminations, reducing reimbursement for ICF patients in SNF's) and state law on several occasions are noted. Many of these problems are due to insufficient and inadequately trained staff. Recommendations are made throughout for upgrading administrative capabilities. Other problems may be solved by the implementation of MMIS (which is having its own problems--see Chapter VII). There can be

no disagreement that increased administrative expenditures will not guarantee improved performance. When administrative resources fall below some critical level, however, it becomes impossible to comply with federal and state regulations. By reducing administrative overhead as a means of controlling Medicaid (and welfare in general) costs, the state may have been "penny-wise and pound-foolish."

Scope

The scope of this study is as broad as Medicaid in Connecticut. It examines four main types of cost controls: (1) eligibility controls, (2) price controls, (3) utilization controls, and (4) expenditure controls. In addition, Appendices II-1 and II-2 review the medical costs of General Assistance (local welfare), which is 90% state funded and CAMAD, which is 100% state funded.

Sources

Data were gathered from a variety of sources, including the Departments of Social Services, Health, Aging, Finance and Control and the legislative Offices of Fiscal Analysis, Legislative Research, and Public Health and Safety Committee staff. In addition, a public hearing was held at which some two dozen private sector "experts" were invited to testify. Representatives from the Connecticut Pharmaceutical Association, the Connecticut Hospital Association, Connecticut Association of Non-Profit Facilities for the Aged, Connecticut Association of Health Care Facilities, Health Application Systems, the Connecticut State Medical Society, and numerous others have been generous with their time.

The Program Review and Investigations Committee staff interviewed more than one hundred people during the course of this study. Field teams visited four of the six DSS district offices, and one suboffice. A survey was sent to all DSS employees regularly assigned to recipient eligibility. Documents were reviewed from numerous sources including academic institutions, HEW, GAO, private consultants, and audit and review agencies in other states.

The research consumed 28 person-months, involving staff with advanced training and experience in operations research, public systems analysis, information systems,

accounting and auditing, economics, law, psychology, sociology, and government.

Organization

The report is divided into nine chapters, this being the first. Chapter II provides an overview to Title XIX (Medicaid)--the relationship between state and federal governments, eligibility, benefits, and program growth over its ten-year history. Chapter III examines eligibility controls in detail for both "Categorical" and "Medically Needy" programs. Drawing heavily on DSS Quality Control Reports and LPR&IC survey and interview data, numerous important recommendations are made. Chapter IV thoroughly examines the means by which all vendor reimbursement rates are controlled, and the significant results Connecticut has achieved in inpatient hospital rates. Some reimbursement methods need improvement, however, and alternatives are suggested. Chapter V examines utilization controls--prior authorization, PSROs, pharmaceutical utilization--and finds shortcomings. Expenditure controls are addressed in Chapter VI--how claims processing pre-and post-auditing, and bill paying is handled in DSS. This chapter stresses the heavy reliance on manual operations, which is costly, inefficient, and less effective than a comprehensive computerized system. The next chapter (VII) examines attempts to solve utilization and expenditure control problems with a new information system (MMIS); and, since nursing homes account for 53% of Medicaid expenditures, a full chapter (VIII) was devoted to long-term care. One possible solution to high nursing home expenditures is "alternative" care (noninstitutional support such as home health care, day care, Meals on Wheels) and the last chapter (IX) describes these options.

A glossary of terms and abbreviations is provided in Appendix I-1. Appendix I-2 contains agency response to this report. Other appendices provide detail for the interested reader on other state funded welfare programs (CAMAD and General Assistance), research methodology, state and federal regulations, program budgets, and LPR&IC survey response.

Some four dozen recommendations are made on ways to improve DSS operations and to contain Medicaid costs. Some of these recommendations require relatively small increases in appropriations for administration in order to save large

sums of misspent funds due to inadequate controls. Further, many of the recommendations will have spillover benefits of reducing other welfare program costs through improved administrative controls (pp. 3-4). Estimated costs and savings are reported in gross figures, which will be shared 50% each by state and federal governments.

The Program Review and Investigations Committee wishes to sincerely thank the dozens of busy people who cooperated in making this report possible. The careful review and detailed comments given by the Commissioner of Social Services and his staff are especially appreciated. Finally, the Committee wishes to thank Ms. Candy Barton for her care and patience in preparing the final report for publication.

II. AN INTRODUCTION TO MEDICAID (TITLE XIX)

Title XIX of the Social Security Amendments of 1965 (P.L. 89-97), provides for grants to states for medical assistance programs. In Connecticut, the single state agency authorized to administer the Medicaid program is the Department of Social Services. The purpose of Title XIX is to assist states in providing (1) necessary medical services to families with dependent children, the aged, blind and disabled, whose income and resources are insufficient to meet the cost of such services, and (2) rehabilitation and other services to help individuals attain or retain capability for independence.

Eligibility

Each state is required to provide medical assistance to all persons who are "Categorically Needy." This group includes persons receiving cash assistance under one of the categorical programs--Aid to Families with Dependent Children (AFDC), or Aid to the Blind, Aged or Disabled (AABD--adult cases). In addition, Connecticut has opted to provide medical assistance to an intermediate group called "Medically Needy." "Medically Needy" refers to persons who have dependent children, are aged, blind or disabled, and whose income and assets exclude them from cash assistance, but are insufficient to cover medical expenses, including insurance. These recipients are also called "Title XIX only" recipients because they receive Medicaid coverage but not cash assistance. All persons in this group would be eligible for cash assistance under AFDC or AABD if they had less income.¹

To be eligible for Title XIX medical assistance in Connecticut, a "Categorically Needy" individual must not

¹ Very low income individuals who are not aged, blind or disabled and are not in a family with dependent children depend on local welfare (General Assistance) for cash and medical assistance (see Appendix II-1). In addition, disabled residents who do not qualify for federal benefits may apply for Connecticut Aid and Medical Assistance to the Disabled (CAMAD). See Appendix II-2 for a description of this program.

have enough income to meet basic living costs such as food, clothing and shelter and must:

- (1) be a resident of Connecticut (a state may not require a period of durational residency);
- (2) not be in a public institution;
- (3) not have more than \$250 in personal property, excluding a \$600 burial reserve;
- (4) not own real property other than for personal occupancy;
- (5) not own a car unless deemed necessary for transportation (shopping, medical care, job hunting);
- (6) not have transferred property in the last seven years without receiving fair value; and
- (7) agree to turn over to the Commissioner of Social Services any proceeds on any pending claim excluding Social Security, Supplemental Security Income, Unemployment Compensation or Veteran's benefits.

Applicants who are applying as "Medically Needy" must also meet certain income and personal property resource limits established by the Commissioner of Social Services (Regulation 17-134d-3). The current Connecticut Public Assistance Handbook limits annual gross income (minus employment expenses) to \$2300 per year for one person or \$2900 for two people. Connecticut's current poverty level for two elderly persons is about \$3500, yet those who receive more than \$2900 from Social Security or other benefits are ineligible for Medicaid. The alternative available to such couples is to separate or divorce in order for each to qualify for the \$2300 (single person) income limit, and thus be able to have income up to \$4600.

Because these income levels are lower than those required under federal regulations,¹ and because such levels

¹ Based on U.S. Bureau of Labor Statistics poverty levels, regionally adjusted.

implicitly discriminate against Connecticut's married elderly, DSS should request an increase in its Title XIX appropriation to reflect increased living costs as determined by HEW. DSS estimates that if income allowances were increased to federally mandated levels, it may cost an additional \$5-6 million annually in Medicaid benefits, due to increased eligibility.

Benefits

Federal law provides a comprehensive list of services that a state Medicaid plan may include (Appendix II-3). Of these, certain services must be provided. These services are: (1) inpatient hospital, (2) outpatient hospital, (3) physician, (4) X-ray and laboratory, (5) skilled nursing, (6) early and periodic screening, diagnosis and treatment of children under 21, (7) family planning, and (8) transportation for necessary medical care.

In addition, Connecticut provides the full range of optional medical services, including: (See Regulation 17-134d-2)

- (1) home health care,
- (2) private duty nursing,
- (3) clinic services,
- (4) dental care,
- (5) prescribed drugs, dentures and prosthetic devices, prescription eyeglasses, and
- (6) any other medical care recognized under Connecticut law including special therapy, oxygen and podiatry.

Federal Reimbursement

Federal reimbursement to states for Medicaid is determined by a statutory formula which is based solely upon per capita income (see Title 42, Section 1396). Reimbursement includes administrative costs, and can range from 50% to 83%. Connecticut, with one of the highest per capita incomes in the nation, is, with minor exceptions, reimbursed for 50% of costs--the lowest possible rate.

Table II-1. Medicaid expenditures by vendor type, Fiscal Years 1972-1976.

<u>Vendor</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976¹</u>
Hospitals	\$ 23,375,699	\$ 22,836,239	\$ 24,944,656	\$ 31,915,900	\$ 38,740,134
Hospital Clinics	4,836,087	5,807,816	6,424,157	8,410,796	10,205,633
Long-term Care	51,422,568	60,245,777	70,369,461	81,790,975	99,298,568
Physicians	10,047,015	9,672,540	9,317,626	11,852,396	14,389,192
Dental Services	2,089,100	1,952,343	2,046,527	3,316,815	4,033,476
Optometrists	765,261	740,596	723,554	1,133,162	1,369,505
Drugs	5,927,538	6,060,127	7,021,600	9,127,406	11,087,370
Ambulances	471,293	642,260	705,670	980,356	1,181,902
Appliances	662,011	799,199	752,828	1,194,753	1,444,547
Private Clinics and Labs	847,494	1,181,196	1,640,633	2,662,235	3,226,781
Visiting Nurses	624,099	643,658	831,734	1,414,055	1,725,952
All Other Services	797,896	746,041	771,153	731,439	900,497
Vendor Payments Total	\$101,866,061	\$111,327,792	\$125,549,599	\$154,530,288	\$187,603,557

¹ Breakdown by vendor type estimated; total vendor payments actual.

Source: Department of Social Services

Program Growth

Costs. Medicaid expenditures in Connecticut have expanded from \$32.4 million in FY 1967 to \$187.6 million in FY 1976. While the rate of growth in Medicaid expenditures is budgeted at only 4.0% for FY 1977, the average annual increase for each of the five previous fiscal years has exceeded 15% (see Table II-1).

Caseload. Similarly, the number of Medicaid recipients has grown from less than 90,000 in 1967 to over 180,000 in 1976. Table II-2 shows caseload and Medicaid expenditures for Categorically Needy and Medically Needy recipients for FY 1975. Interestingly, AFDC cash recipients comprise nearly three-quarters of the state's Medicaid eligibles, but consume only one-quarter of its Medicaid budget. Conversely, the optional Medically Needy program enrolls 20% of Connecticut Medicaid eligibles, but consumes 65% of its Medicaid expenditures (see below).

Table II-2. Medicaid caseload and expenditures, FY 1975.

<u>Categorically Needy</u>	<u>Caseload (Eligible Recipients)</u>	<u>Percent of Total Medicaid Eligibles</u>	<u>Medicaid Expenditures (millions)</u>	<u>Percent of Total Medicaid Expenditures</u>
AFDC	128,074	74.1%	\$39.7	25.7%
Aged	3,767	2.2	2.6	1.7
Blind	116	0.1	0.2	0.0
Disabled	6,026	3.5	11.0	7.1
Total	<u>137,983</u>	<u>79.9%</u>	<u>\$53.5</u>	<u>34.5%</u>
<u>Medically Needy</u>				
AFDC	7,837	4.5%	N/A ¹	N/A ¹
Aged	16,606	9.6	N/A	N/A
Blind	167	0.1	N/A	N/A
Disabled	10,155	5.9	N/A	N/A
Total	<u>34,765</u>	<u>20.1%</u>	<u>\$101.0</u>	<u>65.5%</u>
	<u>172,748</u>	<u>100.0%</u>	<u>\$154.5</u>	<u>100.0%</u>

¹ Breakdown of Medically Needy expenditures not available by related category.

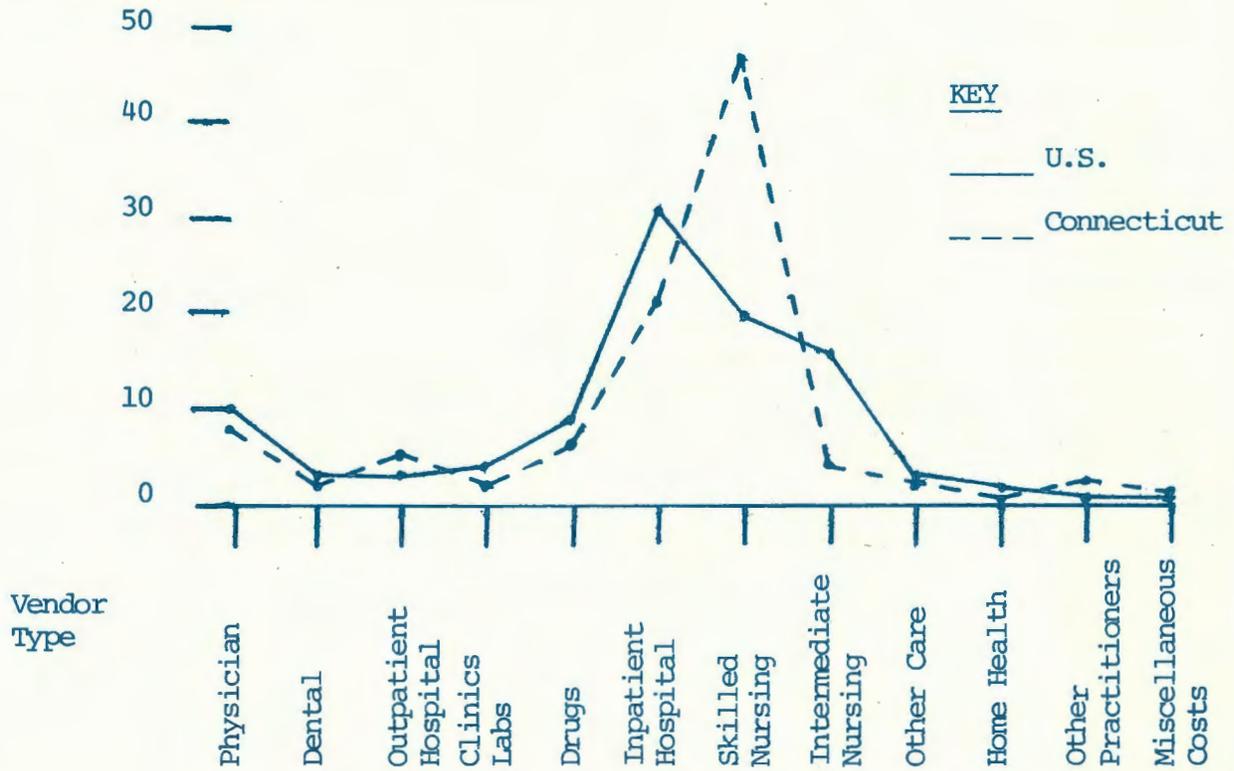
Sources: Office of Legislative Research and Department of Social Services

National Comparisons

Connecticut Medicaid eligibles comprise approximately six percent of the state's population, compared with a national average of about 10%. In 1975 Medicaid expenditures per recipient averaged about \$1,790 in Connecticut and \$1,456 in the nation as a whole. Further, average payments for Medicaid recipients aged 65 and over reached nearly \$3,600 in Connecticut, compared to about \$2,400 nationally (see Appendix II-4 for a breakdown for all states). This is primarily because Connecticut is oversupplied with expensive skilled nursing facility (SNF) beds and undersupplied with intermediate care facility (ICF) beds. Ninety percent of all nursing home beds in Connecticut are in SNF's even though various estimates suggest that up to half of SNF patients only require intermediate (ICF) care. Accordingly, Figure II-1 shows that Connecticut spent nearly half of its Medicaid expenditures on skilled care in 1975, while the national average is only 20%. Other states averaged 16% for lower cost intermediate nursing care as compared to Connecticut's 4%. Chapter VIII analyses the problems associated with the nursing home industry in Connecticut and proposes solutions for correcting the imbalance in levels of care.

Figure II-1. Medicaid expenditures by vendor type, Connecticut and the Nation, FY 1975.

Percent of Medicaid Expenditures



Sources: National Pharmaceutical Council and Department of Social Services

III. ELIGIBILITY CONTROLS

A major goal of welfare programs is to see that public assistance is provided to those, and only those, who meet specified eligibility criteria. The operational objective of DSS eligibility units, therefore, is to make payments at the appropriate levels to eligible recipients, and to aggressively seek to eliminate ineligibles from the rolls.

In this chapter, the system for establishing and controlling eligibility of recipients is reviewed. Eligibility error rates and quality control findings are examined, as well as agency efforts to reduce errors. In addition, progress in conducting periodic redeterminations of eligibility for Title XIX (including AFDC) is discussed. Agency administration and management of case-loads, staffing, training of workers, and employee morale are analyzed with respect to impact on work productivity and efficiency. The chapter concludes with a discussion of the problem of recipient fraud.

Because all categorical (cash) recipients (AFDC, Aid to the Aged, Blind and Disabled) are automatically eligible for medical assistance under Title XIX, the eligibility system for the largest of these, AFDC (93% of all categorical recipients), will be emphasized in this analysis.

Quality Control Review

The U.S. Department of Health, Education, and Welfare (HEW) monitors each state's eligibility and cash payment error rates through its Quality Control (QC) Review System. Federal regulations require AFDC and Medically Needy QC Reports every six months. To meet federal requirements, the Department of Social Services maintains a Quality Control Unit staffed with 36 employees who continuously check the work of Department eligibility workers.

QC review involves full field investigation of a statistically reliable sample of cases to verify eligibility, amounts of award, and compliance with policy. Error rates and excess cash payments can be projected for the entire caseload from errors found in the QC sample. In an

effort to ensure the validity and reliability of sample findings, HEW mandates that states follow a carefully prescribed sampling technique and investigative methodology for both AFDC (45 CFR 205.40) and Medically Needy (45 CFR 250.25) QC reviews. As a further check, the federal government assesses QC systems for compliance with standards by periodically re-reviewing for accuracy a sub-sample of cases (AFDC) and claims (Medically Needy) reviewed in the state sample. According to HEW, Connecticut's QC review system meets federal standards.

While Quality Control reviews for AFDC have been conducted for several years, the Medically Needy QC review is new. The first six-month review of Medically Needy paid claims covers the period from October, 1975 to March, 1976. The report is scheduled for release in late September and therefore was not available in time for analysis in this study.

AFDC error rates and analysis of errors. There are three basic types of errors which can be made in cash assistance programs: (1) to pay an ineligible person, (2) to overpay an eligible person, and (3) to underpay and eligible person.

These errors can be caused by the agency or by the client. Table III-1 reports agency and client error rates and the estimated cost of these errors for the most recent reporting period, July-December, 1975. As shown, 6.4% of AFDC cases were ineligible, 13.4% were overpaid and 4.2% were underpaid.

Table III-1. AFDC error rates and estimated cost (cash and medical assistance), July-December 1975.

	<u>Ineligible</u>	<u>Overpaid</u>	<u>Underpaid</u>	<u>Total</u>	<u>Estimated Annual Cost¹</u>
Agency Errors	1.6%	7.8%	3.1%	12.5%	\$4,000,000
Client Errors	4.8	5.5	1.2	11.5	11,500,000
Total	6.4%	13.4% ²	4.2% ²	24.0%	\$15,500,000

¹ Ineligibility and overpayment errors combined.

² Numbers do not total due to rounding.

Source: DSS Quality Control Report, July-December 1975.

Though somewhat below the national average¹ of 26.7%, Connecticut's 24% AFDC error rate accounted for an estimated \$15.5 million in misspent cash and medical assistance for FY 1976. This does not include the cost of errors in the Medically Needy or "adult" caseloads. Agency errors in AFDC cost an estimated \$4 million for the year. Client errors cost an estimated \$11.5 million annually (see page 39 for a discussion of recipient fraud). Although the overall error rate decreased slightly in 1974-75, the cost of errors has been increasing (see Appendix III-2). While it would be impossible to eliminate errors completely and recover the full amount lost, substantial savings could be realized if error rates were reduced.

Agency vs. client errors. During the most recent sample period, agency errors accounted for more than half (52%) of total errors while clients were considered responsible for the remaining 48%. The proportion of client errors has been growing since 1974.

The distinction between agency and client errors is not always clear. Generally, agency errors involve mistakes in administration and processing; whereas, client errors refer to failure of recipients to report information or to supply accurate information. According to one federal official, "client error" is difficult to analyze and control. Program policy and procedures must be clear so that recipients know what to report. Furthermore, the agency must facilitate reporting by clients by making its offices accessible. For example, clients may attempt to report information, but fail to do so because they cannot get through on the telephone.

The possibility of this occurring in Connecticut was confirmed by an LPR&IC staff study of calls made to the Hartford district office. Between June 6 and June 23, 1976, ten calls were made during normal business hours to the number provided to recipients for reporting information. Four of the ten calls were answered, but only after an

¹ Appendix III-1 lists AFDC QC error rates for all other states.

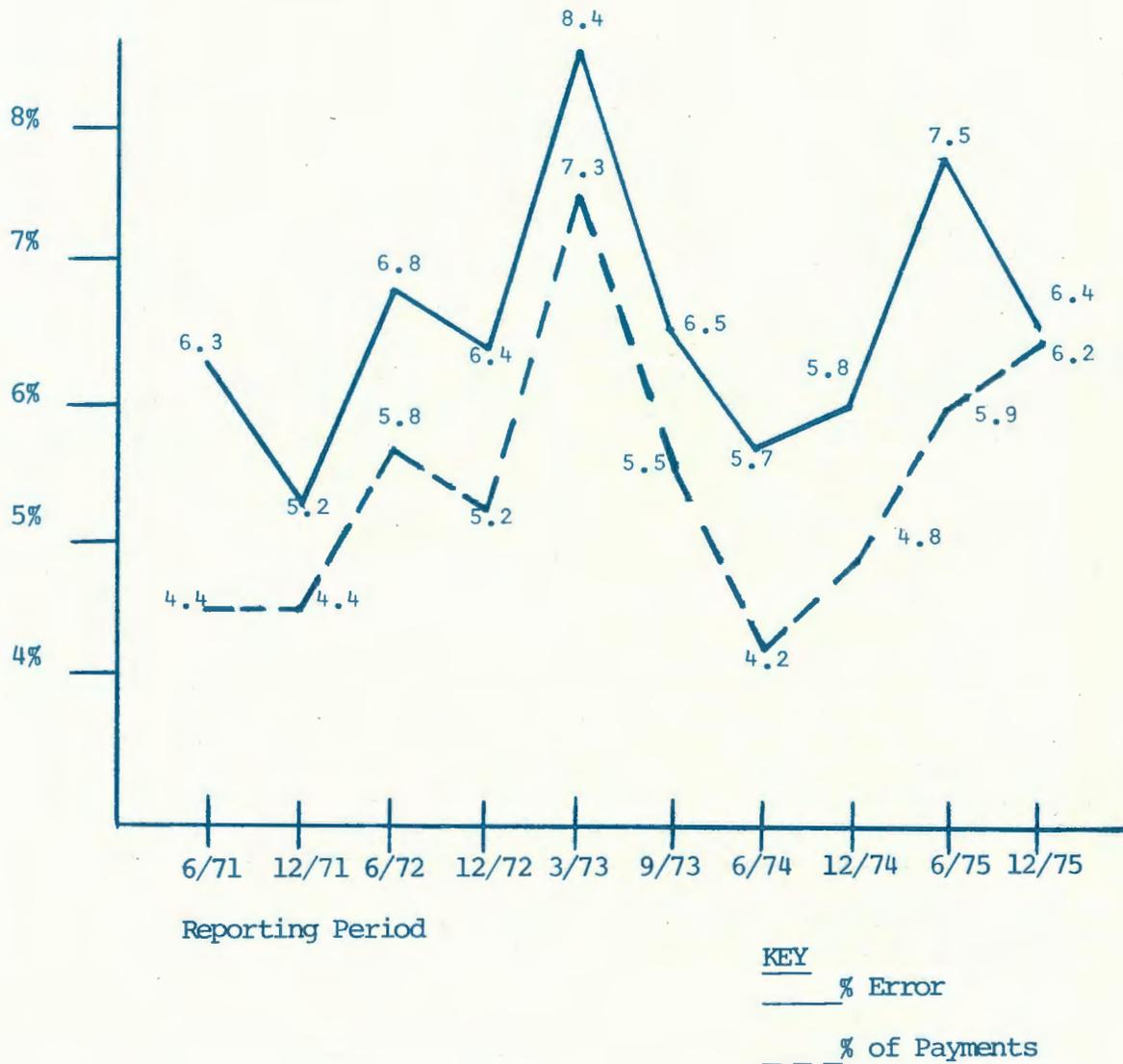
average of 10 rings. On the other six occasions, the phone was either busy (3 calls) or was not answered after 15 or more rings (3 calls). In one case, the phone was not answered after 51 rings. Thus, clients may attempt to report information but give up when their calls are unanswered. Because of the costly growth in client errors, it is recommended that the Department of Social Services monitor, and improve where necessary, its telephone service to clients. While classified as a client error if new information is not reported, it may actually be the Department's fault if the client has made a reasonable effort.

Major types of agency errors. In excess error cases (ineligible and overpayment cases only) sampled during the July-December 1975 period, the most frequent types of agency errors involved: (1) earned income and the treatment of income, (2) shelter (computing rent allowances), and (3) WIN program (Work Incentive) registration. In two district offices, Hartford and New Haven, significant errors were also found involving life insurance. The most costly and consistent agency error during recent reporting periods involves earned income and treatment of income. The agency error rate involving earned income during the July-December, 1975 period would cost the state more than three-quarters of a million dollars on an annual basis.

During the July-December, 1975 period, the most frequent client errors involved: (1) presence of the "absent" parent in the home (see p. 41), (2) earned income, (3) residence of specified children in the home, and (4) shelter.

Eligibility errors. As indicated in Figure III-1, eligibility error rates have varied erratically over the previous five years. The highest ineligibility error rate, 8.4%, was reported for the period ending March 31, 1973, while the lowest rate, 5.2%, was reported for December 31, 1971. While there is no distinct trend in eligibility error rates over the past two years, the cost of excess payments due to ineligibility errors has been steadily rising.

Figure III-1. Percent of AFDC cases ineligible and percent of dollars paid to ineligible cases (agency and client errors combined).



Source: DSS Quality Control Reports

Connecticut's ineligibility error rate for the July-December, 1975 reporting period equals the national average of 6.4% (see Appendix III-1). Connecticut compares favorably to New York and Massachusetts, which have higher error rates, but is not doing as well as Rhode Island which reports an error rate of only 3.6%. Four states, Indiana, Nevada, North Dakota, and Wisconsin had ineligibility rates ranging from 1.1% to 1.7%. As a guideline for possible imposition of fiscal sanctions, HEW attempted to establish an ineligibility error tolerance level of 3%. Only eleven states were at or below 3% during any part of calendar year 1975. Widespread protest by states that the 3% figure was arbitrary led to a court decision against HEW. Debate over tolerance levels and fiscal sanctions continues, however. Some officials argue that changes in the federal quality control system are needed because present policy ignores the relationship between error rates and administrative costs. Increasing administrative costs to reduce errors may cost more than it saves.

Agency eligibility errors stemmed primarily from failure to take indicated action on a case. Over the four recent reporting periods, errors resulted from failure to verify information where required by agency policy, and failure to follow-up on "impending changes" (e.g., child reaching age 18). In addition, errors occurred because workers disregarded or failed to apply reported information. Other errors resulted because policy was incorrectly applied.

Corrective Action Plans

The federal government requires that states develop, based on Quality Control findings, a corrective action plan to reduce error rates. Connecticut's most recent plan, forwarded to HEW in May, calls for the following action:

- (1) Reporting and analysis of errors by district office;
- (2) Exploring the possibility of hiring training staff for district offices;
- (3) Evaluation of the "High Risk" unit working on earned income cases in the Waterbury district for possible expansion statewide;

- (4) Revision of policy on ownership of motor vehicles;
- (5) Special study of cases listed as ineligible because of absent parent's presence in the home; and
- (6) A management study of work flow and techniques in the income maintenance system.

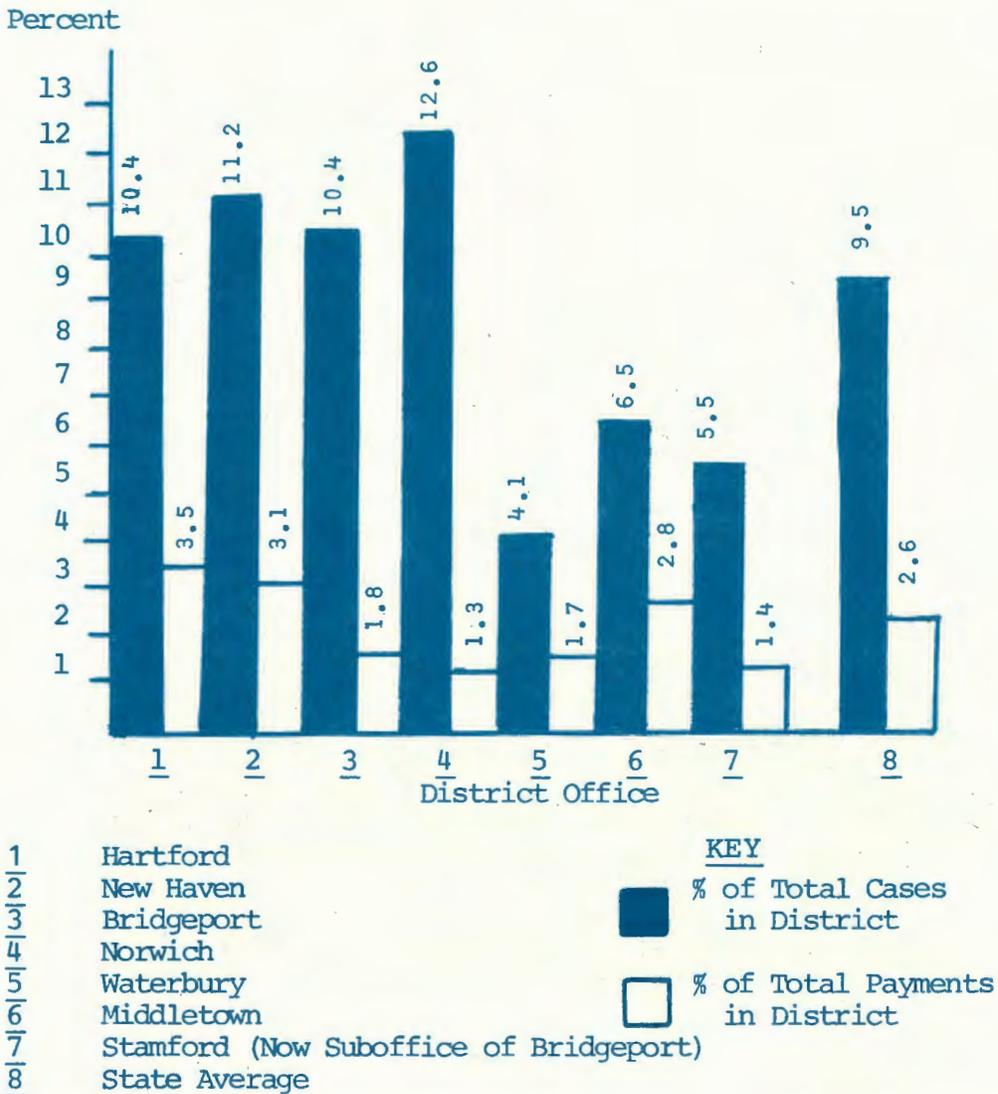
District office error rates. The December, 1975 QC report, for the first time, lists ineligible and overpayment error rates and types of error for each district office. As Figure III-2 indicates, agency error rates (ineligibility and overpayment) vary widely from district to district. The Norwich district reports the highest error rate, 12.6%, while the lowest rate, 4.1%, was found in the Waterbury district. The highest error costs, however, are reported for the Hartford and New Haven district offices.

Beyond identifying specific error cases, the Quality Control reporting system is of limited use to the districts. District directors and supervisors interviewed by LPR&IC staff indicated that QC reports are not always clear in their implications with respect to program administration and staff training. It is therefore recommended that the Central Office of the Department of Social Services, to help districts better understand and utilize Quality Control results, improve QC technical assistance to the district offices. Further the Central Office Research Staff reports that district directors and supervisors rarely call to discuss QC findings. It is also recommended that district directors and supervisors meet at least quarterly with the Central Office Research Staff to discuss Quality Control findings and corrective action in their districts.

The High Risk Unit

In September, 1975, the Department of Social Services began a pilot project in Waterbury to determine the extent to which more qualified and better trained staff could reduce errors in the most error-prone cases--those with earned income. Five college graduates, selected from the State Personnel Department's Connecticut Careers Trainee list, underwent an intensive five-day training session prior to placement in the Waterbury district office. All

Figure III-2. Agency caused errors by district office (eligibility and overpayment errors combined) July-December 1975.



Source: DSS Quality Control Report

AFDC cases with actual or potential income were assigned to this group, known as the "High Risk Unit" (HRU). This Unit handled an initial caseload of 591 cases, distributed among the five workers on an alphabetical basis. By January, 1976, the Unit was expected to handle all actions on assigned cases including redeterminations of eligibility. HRU workers have serviced an average of 120 cases per worker, a caseload considered reasonable by the Department.

To evaluate the effectiveness of the project, the Department compared, over a 15-week period, actions made by the HRU to actions of a work group in the Hartford district office. Results showed that the HRU averaged 150 actions per worker per week, twice as many as the Hartford workers. In addition, HRU workers made more referrals to the Resources and Support Units to investigate recipient income, assets, and liable parents.

The Department of Social Services qualified the evaluation results by pointing out that the Hartford workers have a much heavier workload than that of the specialized HRU. Nevertheless, the HRU has demonstrated how changes in caseload management, training and supervision can improve actions taken on cases.

Because of the apparent success of the HRU, LPR&IC recommends that the Department of Social Services expand the High Risk Unit statewide if justified by a cost-benefit study. Such a study should compare increased staffing and training costs to projected savings. Since the Department did not conduct the pilot project with adequate controls for comparative purposes, the cost-benefit analysis must be based on estimates.

Verifying Information

The latest corrective action plan does not call for any changes in policy and procedure for verifying basic information. At initial application for AFDC and Title XIX, and again at redeterminations of eligibility, agency policy requires verification of information supplied by the client with respect to income, employment, third-party insurance coverage, and liable parents. In the case of AFDC families, the presence of specified children in the home is also to be verified. However, if no information is supplied, under penalty of false statement,

no verifications are initiated, in spite of the fact that QC reports show that an increasing number of clients are failing to supply required information.

Income and assets. If the client reports earnings, a verification request is sent to the client's employer. Similarly, banks are requested to confirm deposits, and insurance coverage is checked with the carrier. If none of these assets are reported, however, no verification attempt is made.

The Department plans to periodically check employment information by crossmatching names and social security numbers with Department of Labor records. This procedure will be implemented when more staff is available, according to a Department official. Recommendations on additional crossmatching procedures are made in subsequent sections of this chapter.

Home visits. To confirm the presence of children in the AFDC home, the Department requires that clients produce birth certificates. School aged children are checked through school systems, although some school districts have at times been uncooperative. According to Department officials, verification of child dependency through birth certificates, is not foolproof. Eligibility workers and program administrators in the districts emphasize that home visits are the best way to verify residence of children. They contend, however, that this procedure would not be possible in all cases under the present case management system and workload.

However, because home visits are necessary to verify residence of children as well as presence of the "absent" parent, (see pp. 41-42) it is recommended that home visits be made periodically on a sample of cases or in cases where fraud is suspected. Successful implementation of home visits in all family cases may require changes in the system of caseload management to be discussed in subsequent sections.

Redeterminations of Eligibility

According to federal regulations, eligibility of all AFDC cases must be redetermined every six months and eligibility of all Medically Needy (Title XIX only) cases

annually (45 CFR 206.10(9)(3)). In Connecticut, AFDC redeterminations have been conducted on an automated basis since June, 1974. Client appointments are scheduled by computer and failure to comply with re-determination requirements, results in discontinuation of assistance. Redeterminations of the Medically Needy are not yet being systematically conducted on a state-wide basis, although some district offices have worked on them from time to time. The Department blames staff shortages for the failure to meet the Medically Needy redetermination requirement.

AFDC. Currently, almost all (98.8%) AFDC cases are being redetermined every six months, as required. In 1974 by comparison, 31.3% of cases sampled had not been acted on for seven months or more. Half of those had not been acted on for one year or more.

While timely AFDC reviews were being done by June, 1975, the work was not necessarily thorough and accurate. According to the July-December, 1975 QC report, 27% of agency errors occurred at the time of the redetermination.

Workers interviewed in the districts agreed that the quality of redetermination reviews is sometimes poor. One worker disclosed that instructions were given to "skim over" the verification procedures in order to complete the quota of reviews. According to one DSS official, district personnel are "shellshocked" due to staff shortages and the heavy workload.

Medically Needy. The DSS plans to implement annual eligibility review of all Medically Needy cases, as mandated by federal law, whenever more staff become available. Results of a pilot redetermination project conducted in Hartford appear to indicate that funding of such reviews would be amply cost-justified.

The pilot project in Hartford was initiated in January, 1976 with a mailing to 3,687 Medically Needy cases, all overdue for annual review. The project, staffed by 17 temporary employees and costing about \$50,000, included a desk review of convalescent cases.

As of July, 1976, 11.5% of the 3,086 cases reviewed had been discontinued, as shown in Table III-2. Most

cases were removed from eligibility because no response was made, the address was unknown, or income, assets, or other resources exceeded allowable limits. In 36 cases, the client was no longer living.

Table III-2. Medically Needy cases discontinued in Hartford.

Sample Size: 3,086
 Discontinued: 354 (11.5%)

<u>Reason</u>	<u>Number</u>	<u>Percent of Discontinuations</u>	<u>Percent of Sample</u>
No response to mailout	84	23.7%	2.7%
Address unknown	82	23.2	2.7
Excess income, asset, or resources	76	21.5	2.5
Deceased	36	10.2	1.2
Failure to supply information to establish eligibility	22	6.2	0.7
In public institutions	16	4.5	0.5
Client request	11	3.1	0.3
Out of state	8	2.2	0.3
Child over 21	6	1.7	0.2
Other	13	3.7	0.4
Total	<u>354</u>	<u>100.0%</u>	<u>11.5%</u>

Source: DSS Report, July 14, 1976.

To estimate the cost of Medically Needy ineligibility, the Department computed payments made in FY 1976 for the first 122 cases discontinued. Payments were found in 58 cases totaling \$70,797. In the remaining 64 cases, no payments had been made. Projecting these results to the 354 cases discontinued, the Department estimated over-expenditures of \$200,000 last year in Hartford alone.

Assuming an 11.5% ineligibility rate and similar costs statewide, projecting these results for the entire Medically

Needy caseload (over 35,000) suggests that as much as \$2,290,000 could be saved through annual redeterminations of the Medically Needy. DSS estimates that this would require 56 additional employees at an annual cost of \$435,000. Thus, every \$1 invested in these redeterminations could be expected to save more than \$5 in payments to ineligibles in the Medically Needy program. It is therefore recommended that redeterminations of the Medically Needy caseload receive high priority and that the General Assembly fund the necessary staff. More will be said about number, quality, and training of DSS staff later in this chapter.

Management and Administration

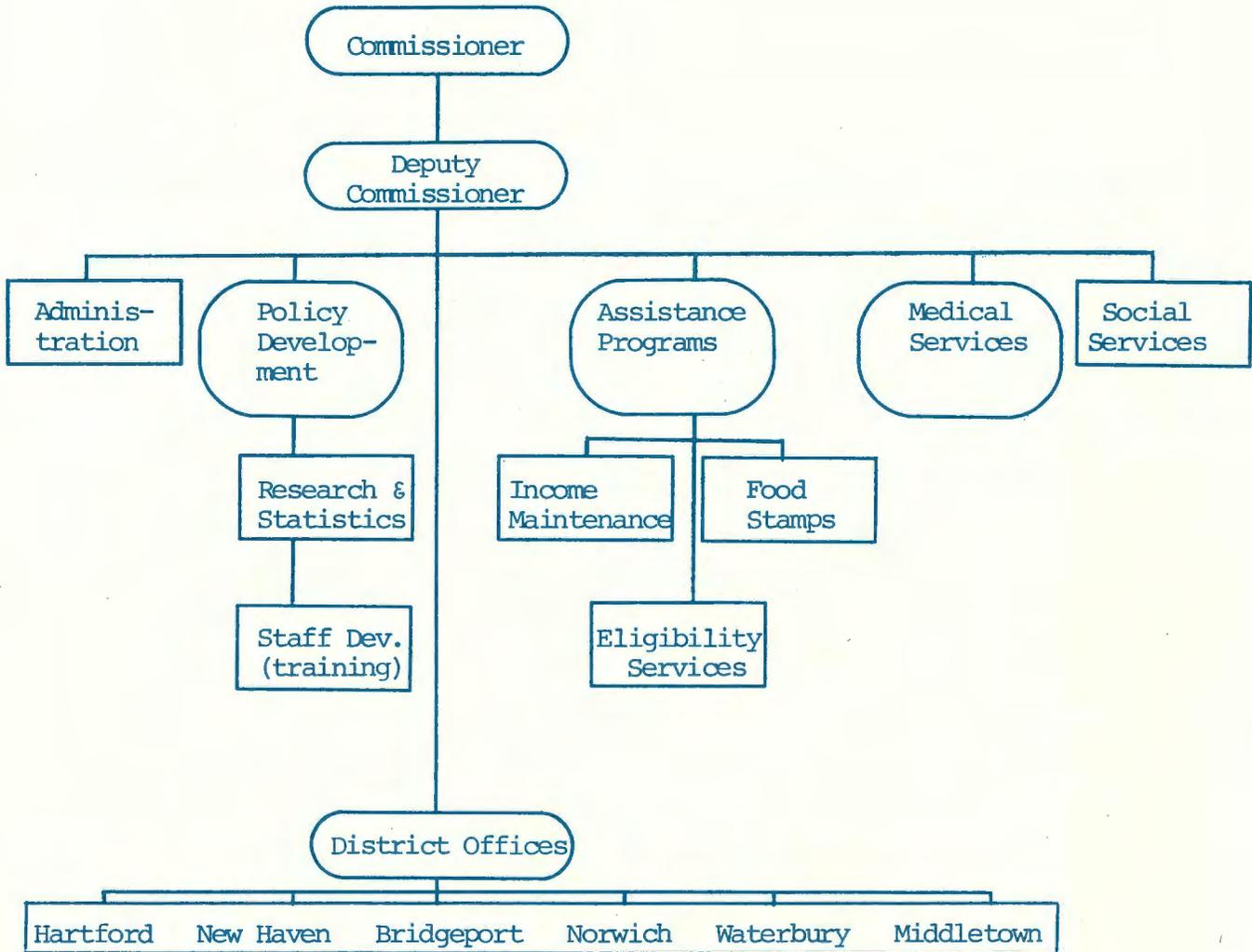
Efficient administration of large caseloads requires good organization and management. Most DSS administrative staff and district officials interviewed conceded that existing systems and procedures for managing caseloads could be improved considerably.

The Department recently received a grant from HEW to study AFDC administration and management. Specific problem areas to be examined include administrative structure, staffing, governmental regulation, and agency systems and procedures. The Legislative Program Review and Investigations Committee is hopeful that this study, being conducted simultaneously in California and Texas, will find ways to significantly improve DSS efficiency and effectiveness.

Agency Structure

Under the present system of caseload management (Figure III-3), the Department operates three primary but separate administrative functions: eligibility services, income maintenance, and social services. The chiefs of all three units report to the Deputy Commissioner. In addition, district directors, responsible for implementing agency policy and managing all operations in the district offices, also report to the Deputy Commissioner. The Department currently operates district offices in Hartford, New Haven, Bridgeport, Norwich, Waterbury, and Middletown with suboffices in other towns throughout the state.

Figure III-3. Department of Social Services organizational structure.



Source: Department of Social Services Organizational Chart

The Eligibility Services unit, staffed primarily by "Investigators," conducts resources and support investigations and establishes eligibility at initial application for program assistance. The Income Maintenance unit is staffed primarily by "Welfare Aides" and "Eligibility Technicians," and is responsible for cash assistance to active cases and recertifications of eligibility (redeterminations). Special social service needs are referred to a separate unit staffed by social workers.

The administrative separation of Eligibility Services and Income Maintenance is of dubious value. Intake workers making eligibility determinations and income maintenance workers doing eligibility redeterminations perform essentially the same task. Identical agency policy applies to initial and redetermined eligibility. Both units sometimes require investigations of client resources and support. Therefore, to streamline agency administration, it is recommended that the Eligibility Services and Income Maintenance units be combined. This should improve communication and promote more efficient utilization of agency resources.

Caseload Management

Two main functions are operated in the Income Maintenance unit: "interim activity" and "redetermination." Case modifications, considered "interim activity," are processed when clients report changes by telephone or visits to the district office. Redeterminations of eligibility are scheduled by computer and conducted by Eligibility Technicians who interview clients in the district offices. In both interim activity and redeterminations, cases may be assigned to workers either randomly or alphabetically. This approach, the "bank" system, replaced the pre-1971 system in which a specified caseload was assigned to each worker.

While some defend the existing system, most officials interviewed pointed to serious weaknesses. Because a single case may be handled by a series of workers, accountability for specific actions and overall service is poor. In some cases, responsibility for action on a case, or for failure to take action, is impossible to pinpoint. This problem is particularly troublesome in

interim activity where the employee initially in contact with the client is not necessarily the person who follows through on case changes. For example, the telephone operator in contact with a client reporting an address change may send a message to another worker who will follow through on the change.

Moreover, many workers and supervisors in the district offices claim that the present system does not inspire pride or job satisfaction. Workers cannot follow cases on a continuing basis, nor become involved in a diversity of tasks. As a result, employee morale, efficiency and effectiveness suffer.

According to some officials, a return to the caseload system would not be possible because the present workload is too heavy, the caliber of some personnel is too low, and cases would be left unattended when workers were absent. Other Department officials, however, favor changing the existing system. They believe a workable modification of the caseload system could be developed and implemented with present personnel and workloads.

Returning to a caseload system should improve administrative efficiency and employee morale. Workers would perform the same actions on cases but would be responsible for a designated set of cases. Thus, all actions on cases would be handled by the same workers who could become more familiar with case records. Fewer workers would handle the same case files. As a result, errors should be reduced and productivity should increase. It is recommended that DSS study the feasibility of implementing a system of caseload management in which a specified caseload is assigned to each worker or to a team of workers.

Quality of Staff

When the Department implemented the present management system in late 1971, the classification of personnel working in Income Maintenance was downgraded. Welfare Aides, starting at \$6,412 annually, and Eligibility Technicians, starting at \$7,509, began to handle work previously done by social workers.

The position of "Welfare Aide" is a classified but noncompetitive position requiring no prior related experience or education. The position of "Eligibility Technician I," classified and competitive, requires two years of college or related experience.

While the LPR&IC was impressed by the ability and dedication of most income maintenance workers, the demanding, dynamic nature of work in the Department of Social Services requires well qualified and able employees in all positions. Several district directors and supervisors, stressing the complexity and the important responsibilities involved, complained that some workers lack basic skills (arithmetic and writing ability) necessary to perform their jobs. Therefore, it is recommended that the job specifications for the entry level position of Welfare Aide be revised to require candidates to pass a job-related competence test to become eligible for hire.

In addition, because DSS plans to modernize work systems and technical support in the district offices, it is suggested that the Department anticipate and prepare for these changes by evaluating its future manpower needs. In the future, for example, one worker of a higher classification and salary grade may be able to equal or exceed the present output of two or more workers (see Chapter VII).

Staffing Levels and Workload

Staffing levels and work volume also affect the efficiency and effectiveness of case management. According to the Department, present staffing levels are insufficient to meet existing workload and service needs. While the Department indeed appears understaffed, the actual extent of understaffing needs to be better assessed.

According to the roster of positions issued by DSS in April, about 267 income maintenance workers are assigned to case management statewide. This represents a theoretical ratio of one worker to every 148 AFDC cases and every 133 Medically Needy cases. Thus, each worker would be responsible for well over \$1 million

annually in AFDC and Medicaid payments. Assuming a 10% error payment rate (AFDC is 9.5%), over \$100,000 is paid in error annually to each worker's "caseload." This workload and financial responsibility (which does not include adult and CAMAD cases) is unreasonable given the low level of staff compensation.

To compute staffing needs in Income Maintenance, the Department has developed fixed ratios of work for each employee. A work sheet issued in May, 1976 calls for 700 AFDC, Medically Needy or adult (SSI) redeterminations per worker per year. Workers must average 16 reviews per week to meet this quota. Interim workers are expected to handle 600 AFDC or Title XIX cases each per year or 1200 adult (SSI) cases. Based on these ratios, the Department has identified a need for about 143 additional income maintenance workers. Updated figures developed in August report a need for 194 additional eligibility workers.

The fixed ratios developed by the Department may be neither realistic nor reasonable. The ratios were based on a study conducted in 1974. Although somewhat systematic and carefully planned, the study did not involve a thorough and comprehensive measurement of actual worker output in the district offices.

To develop reasonable workloads for employees, it is recommended that the Department of Social Services conduct an empirical study of the process time for each type of case action. Only in this way, can realistic work ratios be developed and staffing needs accurately identified and assessed. In addition, work ratios developed by the Department should be periodically reviewed and adjusted to reflect changes in procedures or improvements in worker productivity.

The Department also needs to develop, especially in interim activity, workload expectations and performance standards by which employees can be evaluated. At the present time, in some districts, the output of employees is not adequately measured or monitored. Therefore, to improve management and control, it is recommended that the Department develop performance standards (quantitative and qualitative) and monitor output in all work units.

District Administration

The six district offices, though responsible to the DSS central office, are operated semi-autonomously by the local district office directors. As a result, management practices, application of policy, and workload are not uniform from district to district.

The March, 1976 DSS management report shows, for example, that income maintenance workers in the Norwich district average 434 cases per worker; whereas, workers in the Middletown district average 280 cases each. In some districts, supervisors rarely have unit meetings with workers; whereas, in other districts unit meetings are held every two or three weeks. Management ability and style of district directors and program supervisors also varies from district to district.

While some divergence in program administration is appropriate and desirable at the district level, lack of uniformity in interpretation and application of policy creates confusion and errors. Moreover, unequal workloads compound administrative problems. Therefore, to improve district administration, it is recommended that the Department of Social Services interpret policy clearly at the Central Office and apply policy uniformly in the districts. Furthermore, staff/workload ratios should be equalized and uniform management guidelines should be implemented statewide. An executive development training program should be designed for all district directors and program supervisors managing operations in the district offices. District management is the kind of problem which can and should be addressed aggressively. While "middle management" staff in DSS is relatively small in number, its impact on program administration is substantial.

Employee Training, Morale and Productivity

Training and motivation of employees has a critical impact on agency efficiency. One district director estimates that improvements in employee morale and working conditions could increase productivity in his office by 25%.

Survey. To assess employee job satisfaction and attitudes toward training, working conditions, and supervision, a survey of DSS eligibility workers was conducted.

Questionnaires were mailed to all Welfare Aides, Eligibility Technicians, Investigators, and Career Trainees employed in Eligibility Services and case management.

Response was overwhelming. Two hundred and twenty-eight (53%) of the 427 workers who received the survey, completed and returned it, although not every worker responded to every question. Many questionnaires were returned with extensive comments and requests for personal interviews. Because of the volume of response and time limitations, however, it was not possible to accommodate everyone who requested an interview. See Appendix III-4 for a copy of the survey and further details on methodology.

Training. Survey respondents were asked to describe and evaluate their initial and in-service training. Only 32% of workers said they participated in a formal training session when they were first hired. Likewise, only 34% reported participation in in-service sessions (see Appendix III-4, Tables 1 and 2). Almost half of those (46%) said formal sessions were held infrequently, once a year or less.

When asked to assess the quality of their training, only 25% said their initial training was adequate, and only 24% said their in-service training was adequate (see Tables III-3 and III-4). Analysis by job class showed that Investigators in the Eligibility Services unit were significantly more dissatisfied with their initial and in-service training than Eligibility Technicians and Welfare Aides.

A worker in one district office summarized the feelings of many toward their training:

Most workers do not receive any type of training. We are thrown into the job to "sink" or "swim." If not for the superior quality of many present state workers, due to the condition of the labor market, we would not be able to do the usually excellent job we do. We learn by asking questions of fellow workers, asking our supervisors, and learning as we go along. It is a deplorable situation which probably accounts for low employee morale and errors when an employee first begins. The same statement holds true for in-service training. It simply does not exist.

Table III-3. Adequacy of training: "How adequate do you think your training was in preparing you to do your job?"

	Investigators ¹ N=79	Technicians ² N=95	Aides ³ N=40	Total ⁴ N=214
Very adequate	14%	14%	23%	15%
Adequate	11	8	10	10
Unsure	19	39	38	31
Inadequate	27	22	15	22
Very inadequate	29	17	15	21

¹ Investigator I, Investigator II, Investigator III - Eligibility Services Unit.

² Eligibility Technician I, Eligibility Technician II, Welfare Eligibility Supervisor - Income Maintenance Unit

³ Welfare Aides - Income Maintenance Unit

⁴ Total does not include Career Trainees (12) who responded to the survey

Source: LPR&IC Survey of Department of Social Services Eligibility Workers

Table III-4. Adequacy of in-service training: "How adequate do you think your in-service training is in helping to improve or update your skills?"

	Investigators N=76	Technicians N=94	Aides N=35	Total N=205
Very adequate	9%	11%	26%	13%
Adequate	11	12	11	11
Unsure	20	35	26	28
Inadequate	13	19	23	18
Very inadequate	47	23	14	31

Source: LPR&IC Survey of Department of Social Services Eligibility Workers

Another worker described the frustrations suffered by some employees because of poor training:

After my three days "training," I was on my own in that no one taught me anything. It was up to me to ask questions to anyone whom I could get to help me. Worst of all, no one seemed to know the right answer. Asking any one question to 4 different district office supervisors, I invariably got 4 different answers.

Currently, the DSS training staff consists of one person in the central office. Over the past two years, the Department has contracted for training services with the University of Connecticut School of Social Work. Training provided to Eligibility and Income Maintenance workers under the contract has been minimal. During the first year of the contract (FY 1975) sessions were held exclusively for the Social Services staff. In the second year of the contract, sessions were held for eligibility workers. The sessions, however, focused primarily on interviewing techniques and client relations rather than specific policies and procedures.

Inadequate staff training is one of the most serious deficiencies in the Department. Both formal training for new employees and more frequent, in-service training are needed in the district offices. Therefore, it is recommended that the Department develop a meaningful and effective training program in the district offices, making maximum use of experienced and knowledgeable career employees already working for the Department. The legislature should provide sufficient funds to implement this training program. As one district director commented, "An investment in training must be made to get your money's worth out of your employees...."

Supervision

According to job specifications, supervisors are responsible for training workers and reviewing their output. According to LPR&IC survey results, most workers (62%) report satisfaction with the quality of their supervision (see Appendix III-4, Table 3).

A significant number of workers (21%), however, responded that their supervision was either poor or very poor. While some workers pointed to the heavy workload burdening supervisors, others criticized lack of training. One worker offered the following analysis:

Supervisors are not taught how to handle or motivate subordinates in order to obtain an adequate work flow with top efficiency from their staffs.

Because supervisors play a critical role in training and motivating workers, it is recommended that the Department of Social Services develop and implement a formal training program for district supervisors. In developing the program, maximum utilization should be made of existing resources in the Department and in other state agencies.

Another worker criticized management practices and personnel policies which adversely affect the quality of supervision:

One certainly has to question the personnel procedure which bases supervisory appointment decisions solely on ... test scores with no consideration given to job performance, experience, leadership qualities, and the ability to get along with others.... We have just lost our supervisor (a person superbly qualified for the position), who had been appointed provisionally. He brought to the position vast knowledge of policy and experience, and has handled the job with skill, efficiency, evenness of temper and consideration for those in subordinate positions. He has gained the respect of all who have worked with him. The loss to the agency in not appointing this man as permanent supervisor is immeasurable, and the injustice of the situation has left many of us with feelings of anger and frustration.

It was repeatedly noted in interviews throughout the Department of Social Services that state personnel policies impose many burdensome constraints with which the Department, and every other state agency, must contend. Individuals

who perform well on tests do not necessarily make the best workers or supervisors. The state personnel system should be evaluated to determine if changes are required to make the system more responsive to state manpower needs.

Job Satisfaction and Capability

DSS employee morale is very low. When asked to rate their job satisfaction, only 29% of survey respondents said they were happy with their jobs. As shown in Table III-5, Investigators expressed more dissatisfaction than Technicians and Aides.

Table III-5. Job satisfaction: "In general, how happy are you with your job?"

	<u>Investigators</u> <u>N=77</u>	<u>Technicians</u> <u>N=94</u>	<u>Aides</u> <u>N=41</u>	<u>Total</u> <u>N=212</u>
Very happy	7%	13%	10%	10%
Happy	17	23	15	19
Unsure	29	40	51	38
Unhappy	27	11	10	17
Very unhappy	21	13	15	16

Source: LPR&IC Survey of Department of Social Service Eligibility Workers

Three major reasons for dissatisfaction are poor working conditions, low salaries, and the lack of opportunity for career advancement. Table III-6 reports the amount of satisfaction with the work environment for each district office. As shown, the majority of workers in Hartford and New Haven are very dissatisfied with their offices. Workers in other offices, however, are almost as displeased. Only 20% of survey respondents statewide were happy with their working conditions.

Site visits by LPR&IC staff to four of the six district offices confirmed the validity of many worker complaints.

Table III-6. Work "space" satisfaction by district office: "How satisfied are you with your work "space" or the environment and atmosphere in your office?"

	District					
	Hartford N=47	New Haven N=31	Bridgeport N=42	Norwich N=26	Waterbury N=29	Middletown N=30
Very satisfied	2%	0%	5%	8%	7%	17%
Satisfied	4	7	12	12	10	3
Unsure	19	19	24	27	31	27
Unsatisfied	11	23	17	19	10	10
Very unsatisfied	64	52	43	35	41	43

Source: Legislative Program Review & Investigations Committee's Survey of Department of Social Service Eligibility Workers

Conditions in the Hartford district office (2550 Main Street) were a disgrace to the Department and the state.

DSS moved the Hartford district office in September, 1976. However, conditions in other offices visited also need improvement. Case records are stored in open cardboard boxes in Waterbury and Norwich, for example. The work environment in Norwich is crowded and noisy because of poor partitioning and sound-proofing. Facilities for interviewing clients are inadequate in Bridgeport and Norwich. It is recommended that wherever feasible, the Department should work to upgrade working conditions in the district offices. In some offices, a more creative allocation of space and equipment could result in substantial improvement at minimal cost. In addition, workers lack basic desk equipment. For example, provision of pocket calculators to eligibility workers would save time and improve accuracy.

A chronic complaint by survey respondents was that DSS offers little opportunity for career development. Table III-7 shows that only 10% of employees believe there is opportunity for advancement in the Department. This is a serious problem, since better educated and more able employees are more likely to leave when general employment conditions improve. Many workers, seeing themselves in "dead end" jobs with no future, are looking for other employment outside the Department.

Table III-7. Career development: "In your present position, how much opportunity do you feel there is for career development?"

	Investigators N=79	Technicians N=92	Aides N=39	Total N=210
Very much	1%	5%	5%	4%
Much	1	8	10	6
Unsure	5	15	21	12
Little	11	30	21	21
Very little	81	41	44	57

Source: LPR&IC Survey of Department of Social Services Eligibility Workers

To be efficient and effective, DSS must maintain a competent work force, offering employees a flexible career ladder and opportunities for promotion. The Departments of Personnel and Finance and Control, the State Personnel Policy Board, and the Legislature should cooperate with and assist DSS to accomplish this goal.

Summary and Conclusion

Many employee morale problems could be reduced if the Department implemented a caseload system. Workers would have an opportunity to perform a diversity of tasks, rather than doing the same monotonous job day after day. Employees could assume responsibilities in a variety of program areas and could learn operations now assigned to other work units. In addition, workers could specialize in programs or caseloads suited to their interests and abilities. For example, some workers may want to work with family cases while others may prefer an adult or convalescent caseload. Whenever possible, employees should have an opportunity to participate in decisions about their job assignments and program specializations.

Implementation of a caseload system will require related changes recommended in this chapter. The quality of some staff needs to be upgraded as does the training workers receive. Reasonable workloads and performance standards to monitor worker output need to be developed.

Modifications in administration and management are also recommended to facilitate switching to a caseload system. The Eligibility Services and Income Maintenance units should be combined in the central office. Policy needs to be interpreted clearly in the central office and uniformly applied in the districts. Uniform management guidelines should be implemented statewide. District directors and supervisors need specialized management training.

Most workers who responded to the survey said they were capable of handling their jobs at the present time. Only 12% reported that they could not cope with their responsibilities (see Appendix III-4, Table 4). Reasons cited for poor job performance are reported in Table III-8. Nearly a third of the workers (31%) mentioned that their

workload is too heavy, while 14% said their training, management, and supervision is poor.

Table III-8. Reasons for inability to do job: "If you do not feel capable of handling your job, is this because (of):"

	<u>Investigators</u> N=78	<u>Technicians</u> N=95	<u>Aides</u> N=41	<u>Total</u> N=214
Lack of ability on my part	1%	0%	0%	1%
Workload is too heavy	33	34	20	31
My training was poor	23	12	2	14
Management and supervision is poor	17	13	10	14
Other	12	9	2	9

Source: LPR&IC Survey of Department of Social Service Eligibility Workers

Workers in the Department feel that they could do an excellent job if adequate training, reasonable workloads, and proper supervision and management are provided. If workers are even partially right, then an investment in administrative improvements should result in savings to the state through reduction in program errors and increased worker productivity.

Recipient Fraud

Recipient fraud is defined by the Department of Social Services as "a false statement by denial or misrepresentation...with an awareness of the true facts on the part of the person making it at the time." (DSS Manual Vol. 1, Chapter III, 385.3). Penalties for recipient fraud are further defined by Connecticut General Statutes sections 17-82j and 17-83i.

According to the DSS Manual, the Division of Central Collections of the Department of Finance and Control has

statutory responsibility for presenting to the appropriate prosecutor all available evidence relative to any action on the part of a recipient which constitutes a presumption of fraud. The Department of Social Services has statutory responsibility for referring to the Division of Central Collections of the Department of Finance and Control all cases (regardless of dollar amount) in which a recipient receives a money payment in excess of that to which he is entitled (Section 17-82m). Upon referral by Finance and Control, the state's prosecutor then makes a decision whether or not to prosecute on a charge of fraud. The LPR&IC recommends an amendment to Connecticut General Statutes, Section 17-82m that would require the Department of Social Services to refer to the Division of Central Collections, Department of Finance and Control, only those cases of recipient overpayment amounting to \$500 or more (see Appendix III-5).

Overpayments may occur through unintentional reporting errors by recipients, fraudulent action by recipients or through agency error. A referring worker (intake investigator or eligibility technician) obtains and develops the initial information necessary to explain an overpayment. Each district office has a resource unit available to conduct field investigations and verifications. In cases of suspected fraud, the referring worker is required to complete, in triplicate, form W-262. After being reviewed as many as six times, form W-262 is transmitted to Central Collections and the DSS director of Eligibility Services. This fraud referral process may take three months or more to complete. The Committee staff reviewed one case of alleged fraud, involving over \$10,000 in which the district office referral form was not sent to Central Collections.

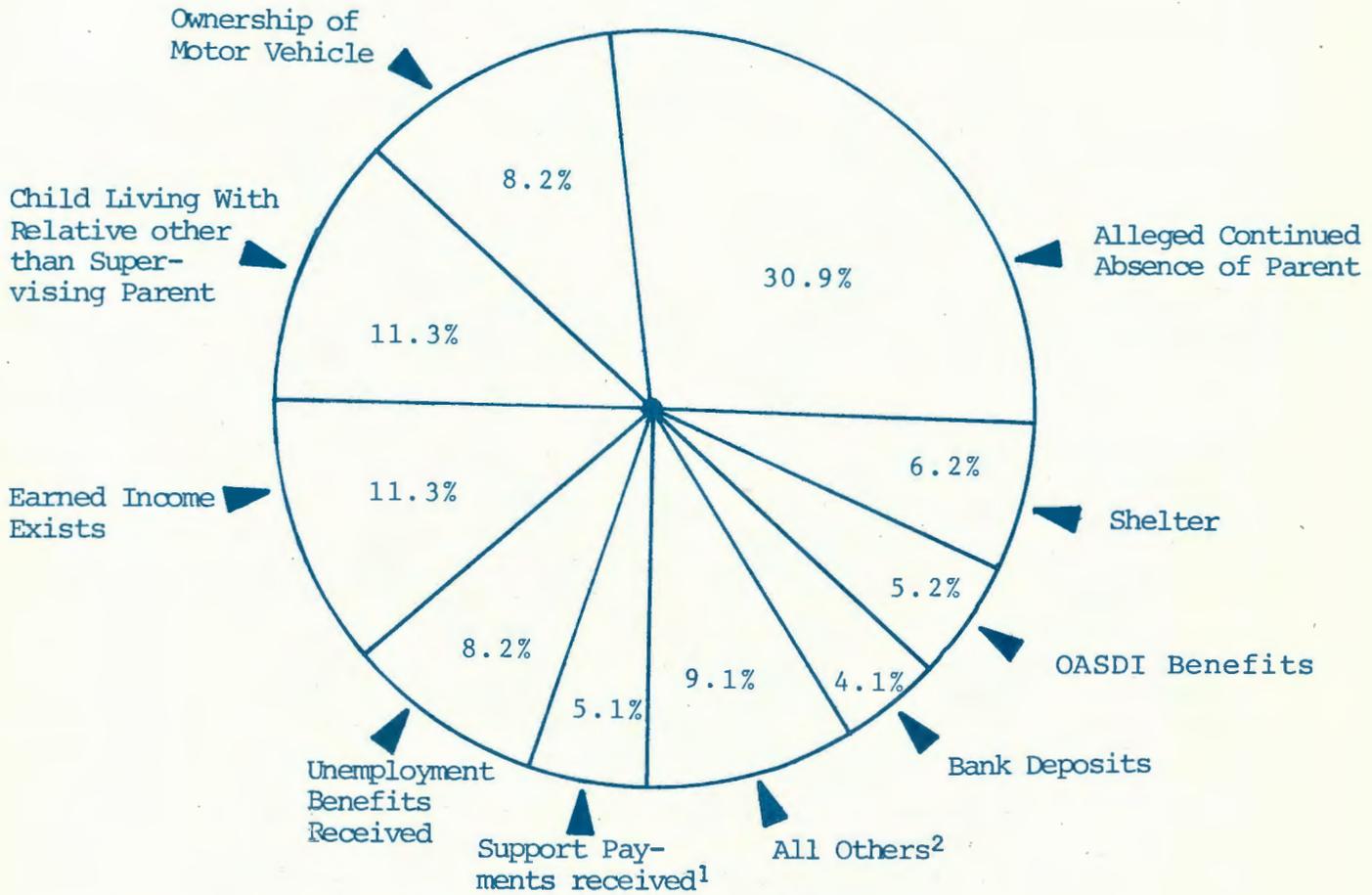
Furthermore, several special investigators for the Department of Finance and Control claim that over half of the district office fraud referrals contain incorrect or insufficient data on which to base a valid investigation. It is therefore recommended that each district office Resource Unit Supervisor shall: (a) review fraud referrals making necessary corrections and additions to W-262 forms, and (b) act as a liaison with the special investigator assigned to that district office by Central Collections.

In addition to initiating their own fraud referrals, the Department of Social Services has instituted a program which seeks fraud referrals from private citizens. It has made available P.O. Box 567, Hartford, to which citizens may forward, anonymously, any allegation of welfare abuse or fraud. This program has led to the investigations and conviction of several welfare recipients. However, it has not received sufficient public awareness to maximize its potential effectiveness. It is therefore recommended that the Public Relations Officer of the Department of Social Services develop a statewide publicity program to insure public awareness of the state's existing (P.O. Box 567) fraud referral program.

Recipient fraud controls. Because the Department of Social Services has only recently begun redeterminations of Medically Needy recipients, it is difficult to ascertain the degree of recipient fraud in this program. This is further complicated by the fact that the first Medically Needy Quality Control report has not yet been released.

The July-December 1975, federal AFDC Quality Control Report indicated that "the single largest client excess error element is continued absence...and every one of these involving misrepresentation of facts.... A review of past error findings in this high dollar error element shows and alarming increase over the past two years." According to this report, approximately 31% of all client "errors" involve instances where a liable parent resides in the home, but does not report this to DSS (see Figure III-4). The Department of Social Services has no effective method to detect this type of fraud: it can only verify information if it is reported by the client (see pp. 20-21). If a client claims that she is unemployed, has no bank deposits, is deserted by a liable spouse, or has no other assets or income, the Department will approve AFDC eligibility without an investigation. Approximately 80% of all client caused errors are due to a recipient's failure to report required information (see Table III-9).

Figure III-4. Types of Willful Misrepresentations



¹Court Ordered Support 3.1%
 Voluntary Support 2.0%

²W.I.N. Program 2.0%
 Residence 1.0%
 Real Property 1.0%
 Life Insurance 1.0%
 Workman's Comp. 1.0%
 Other 3.1%

Source: Department of Social Services, AFDC Quality Control Report July-December 1975.

Table III-9. AFDC client-caused errors July-December, 1975.

<u>Type of Error</u>	<u>Percent of all Client Errors</u>
Information not reported	79.9%
Information is incorrect	14.4
Information is incomplete	5.8
	<u>100.1</u>

Source: AFDC Quality Control Report, July-December, 1975.

In the remaining 20% of errors, the information is either incorrectly supplied or incomplete. In these instances, the Department attempts to verify the accuracy of what is reported; although, due to staff shortages, even this basic investigative function is not being performed adequately.

Implementation of a computerized control system could drastically reduce AFDC and Medicaid costs. According to the most recent Quality Control Report, willful misrepresentation on the part of clients existed in 8% of cases reviewed, and accounted for 6.2% of total expenditures. Projecting to the FY 1977 AFDC budget, willful misrepresentation by clients may cost the state nearly \$9.2 million next year in cash assistance alone. In addition, nearly one half (4%) of these cases of alleged fraud would be ineligible for Medicaid benefits for another \$1.5 million.

A related area of concern in fraud detection is the AFDC cash assistance distribution process. AFDC checks are issued on the first and sixteenth of each month. Approximately 1800-2000 (5% of the total) checks from each mailing are returned to DSS as undeliverable. Departmental policy has been violated in numerous instances by allowing recipients to "phone in" for their checks without further investigation or verification. To reduce potential fraud resulting from this practice, the Department of Social Services should require recipients to appear in person to receive any assistance check which was returned as undeliverable.

Recipients should then be informed of their statutory duty to report to their district office, within 15 days, any change of information which necessitated the return of their checks. District office directors should assure that such changes are completely and accurately verified and any willful misrepresentation is properly forwarded to Central Collections. Whenever a recipient's check remains outstanding for more than 30 days, the Department should investigate the case for potential fraud.

During FY 1975, the Department of Social Services made 1,336 fraud referrals to the Division of Central Collections. These referrals led to the arrest of 471 recipients and involved 629 criminal charges. Only one recipient was acquitted on all charges. Few guilty verdicts result in jail sentences however, see Appendix III-6 for a summary of fraud investigations and activities. Because fines or recoupment are virtually impossible, jail sentences are the only effective weapon against welfare abuse. (This lack of an effective deterrent has had a demoralizing effect upon the Special Investigations Unit of Central Collections and the staff in the various district offices.)

Pending the implementation of MMIS, the LPR&IC recommends that DSS evaluate the feasibility of periodically crossmatching eligibility files with records at the Department of Motor Vehicles, various Court Registries, School Districts, and the Department of Labor to verify information supplied by recipients and to detect misrepresentations of income, assets, and family membership.

Absent parents: Title IV-D. Federal law (Title XIX, S 1396a(25)) requires that each state plan for Medical Assistance under the Social Security Act must provide "reasonable measures" to ascertain the legal liability of relatives and their appropriate support based upon their ability to pay. Title IV-D (Public Law 93-647), would attempt to increase the ability, effort and effectiveness of states in collecting support for AFDC families from absent parents. The cost of this new program is 75% reimbursable. However, if a state does not show by January 1, 1977 a good faith effort to implement Title IV-D, 5% of the federal financial participation in AFDC grants will be withheld. If this sanction were imposed in Connecticut, the loss to the state could be as much as \$2 million for the last half of FY 1977 alone (January 1 through June 30, 1977).

Federal regulations permit a state to make recoveries from both recipients and absent parents. According to the latest DSS Annual Report, Connecticut is first among all states in the percentage of AFDC support payments (7.73%) recovered from recipients and absent parents.

However, the Department estimates that approximately 35% of all absent parents fail to inform the state of a change in address and consequently fail to fulfill their legal obligation.

The General Assembly enacted legislation (P.A. 76-334) to facilitate compliance with the federal child support provisions of Title IV-D. Furthermore, the Department has received approval for 68 Title IV-D positions and estimates an increase in collections of \$2.2 million for fiscal 1977. After deducting one-time incentive payments to recipients, personnel costs, and federal reimbursement, the net financial gain to the state is expected to be \$464,500. The Department of Social Services has established a special fund from which it will utilize federal monies advanced for IV-D as a method of funding Connecticut's child support program. The LPR&IC recommends that DSS cooperate fully with the Judicial Department, the Department of Finance and Control, and the Attorney General's Office in implementing Title IV-D. It is further recommended that DSS submit a separate Title IV-D budget for direct state appropriation, rather than utilizing a special fund system, so that legislative oversight can be provided.

IV. PRICE CONTROLS

Three factors combine to account for increasing costs in Medicaid: (1) increasing caseloads, (2) increasing utilization of medical services, and (3) increasing prices. The purpose of this chapter is to show the direction State efforts have taken to control price inflation in Medicaid costs through various reimbursement techniques.

Overview of Medical Price Increases, 1965-1975

The cost of medical care has been inflating at a rate significantly higher than that of most other consumer goods and services. In some instances this has been as much as 20% per year for a given category of service. Several factors contribute to this rapid rise. First, the health care industry is labor intensive and therefore highly sensitive to wage increases. Second, medical technology tends to raise costs rather than lower them. Third, physicians now tend to overtreat patients due to the increasing number of malpractice suits. These factors affect the prices paid by all consumers of medical care.

Within this context, it is not surprising that Medicaid expenditures nationwide have soared over the past decade--from \$1.6 billion in 1965 to a projected \$17 billion in 1977 (a 950% increase).

In an effort to keep burgeoning costs down, some states have restricted eligibility requirements while others have eliminated coverage for certain optional services. In Connecticut, for example, the Governor last year proposed to eliminate coverage of such services as adult dental care, chiropractic, and eyeglasses. Improving efficiency and controlling price increases represent alternative approaches to cost containment which do not require reductions in eligibility or coverage.

State Efforts at Price Control

Medical practitioners who provide services to persons eligible for Medicaid are reimbursed by the state. (The state is ultimately reimbursed by the federal government for half of the costs of covered services.) As a means of discouraging providers from billing the state

excessive charges, Medicaid reimbursement rates for each type of service are set in advance by various rate regulating bodies.

The fundamental goal in establishing reimbursement rates for all types of medical care is to find the minimum price necessary to pay for quality care. While high rates do not assure quality care, rates that are too low prevent it. The reimbursement problem is compounded by the fact that rates should also reward efficiency and be administratively simple.

Rate-setting bodies. In Connecticut, there are five distinct rate-setting bodies each having jurisdiction over particular types of medical vendors. The Commission on Hospitals and Health Care (CHHC), while not setting Medicaid reimbursement rates directly, attempts to control price increases in hospitals and nursing homes by reviewing budgets annually¹ and establishing basic rates for private patients. The Committee on State Payments to Hospitals determines Medicaid reimbursement rates for hospitals and nursing homes.

A Professional Policy Committee sets rates for physician services and pharmaceuticals. The Department of Health Emergency Medical Services Unit sets reimbursements rates for ambulances, and the Department of Finance and Control sets rates for durable medical equipment, such as braces, wheelchairs and special beds. Each of these bodies and the rate-setting methods they use are described below.

Commission on Hospitals and Health Care (CHHC)

In 1973, the General Assembly established the Commission on Hospitals and Health Care to regulate costs of hospitals and long-term care facilities for private patients (P.A. 73-117).

CHHC was designed to be similar to public utility authorities in that it would review rates, analyze costs,

¹ In the case of nursing homes, budgets are only reviewed when a home requests authorization to increase private patient rates.

and approve capital expenditures and annual operating budgets. Private patient rates for all hospitals and long-term care facilities must not exceed those approved by CHHC. The fifteen members of the Commission include industry representation, as shown below:

10 persons are appointed by the Governor of whom

- 1 shall be a hospital administrator nominated by the Connecticut Hospital Association,
- 1 shall be a nursing home administrator nominated by the nursing home industry,
- 1 shall be a practicing, licensed physician nominated by the Medical Society,
- 1 shall be a practicing registered nurse,
- 6 public members, geographically representative, without health care industry affiliation for at least three years,
- 2 public members are appointed, one each by the Speaker of the House and the President Pro Tempore of the Senate, and
- 3 members are ex officio: the Commissioners of Health, Mental Health and Insurance.

From the public members, the Governor selects a chairman and vice-chairman for a term of two years. The Commission hires an executive director, who manages the daily operation of the agency, which has been administratively under the Department of Health since 1975.

The statute (C.G.S. 334A, Section 19-73) authorizing the Commission is specific as to its powers and duties:

- All hospitals and such other health care facilities as the Commission designates must submit proposed operating and capital budgets annually to the Commission for review.
- The Commission must hold public hearings to approve, disapprove or modify any hospital proposal to change service charges by more than 6% over a 12-month period or 10% over a 24-month period; or nursing home rate increases of 4% over a 12-month period or 6% over a 24-month period.

- For proposed rate increases of 2% or more, but less than that shown above, the Commission may or may not require a public hearing.
- Proposals from health care facilities or institutions to expend capital of \$100,000 or more require approval and public hearings; proposals for expenditures of \$25,000 to \$100,000 require Commission approval, but do not require public hearings.
- The Commission shall carry out a continuing statewide health care facilities utilization review, recommend improvements in procedures, formulate a statewide program to improve service delivery, recommend legislation, and report annually to the Governor and the General Assembly on efficiency, costs, coordination and availability of health care throughout the State.
- The Commission may make regulations to carry out its duties.
- The Commission has authority to conduct investigations and subpoena power.

The Commission is organized into two divisions--Health Care Planning and Health Care Finances. The Planning Division reviews requests for capital expenditures and issues certificates of need. The Finance Division is responsible for rate setting.

Committee on State Payments to Hospitals

This Committee is composed of the Commissioner of Social Services (chairman), the Commissioner of Finance and Control, the Comptroller, and the Chairman and Vice Chairman of the Commission on Hospitals and Health Care (CHHC). As noted above, it sets Medicaid reimbursement rates for hospitals and nursing homes. The Committee is staffed by one person from CHHC's staff.

As are all regulating bodies, the Committee on State Payments to Hospitals is bound by the Uniform Administrative Procedures Act. Failure to follow the processes

mandated by this Act can result in court action, nullifying the Committee's work. Legal advice is provided to the Committee and to the Department of Social Services by the Attorney General's office. In the recent past a number of Medicaid regulations, including the proposed cost-related reimbursement method for nursing homes, have not been implemented on time due to a failure to follow the Administrative Procedures Act. Since such delays, as well as the court action itself, are costly to the state, a review of the legal services provided to the Committee and to DSS seems clearly in order.

Hospitals

In Connecticut there are thirty-six acute care centers or hospitals, all are non-profit institutions. Of these, only the newly-opened John Dempsey Hospital at the University of Connecticut Health Center does not come under the jurisdiction of the Commission on Hospitals and Health Care. Since Dempsey Hospital is operated by the University of Connecticut and is partially funded by the General Assembly, regulation by the CHHC might result in a conflict of authority.

During FY 1975, hospitals and clinics accounted for 26% of Medicaid expenditures, or \$40.3 million. As Table IV-1 shows, Medicaid expenditures for hospitals and clinics have quadrupled since 1968.

Table IV-1. Medicaid expenditures for hospitals and clinics, FY 1968-75.

<u>Fiscal Year</u>	<u>Hospitals</u>	<u>Clinics</u>	<u>Total</u>
1968	\$ 8,903,478	\$1,322,201	\$10,225,679
1969	11,058,493	1,648,750	12,707,243
1970	16,282,297	2,953,761	19,236,058
1971	20,978,836	3,911,794	24,890,630
1972	23,375,699	4,836,087	28,211,786
1973	22,836,239	5,807,816	28,644,055
1974	24,944,656	6,424,157	31,368,813
1975	31,915,900	8,410,769	40,326,669

Source: Department of Social Services

The increase in Medicaid expenditures for hospitals, however, is not caused by unduly long hospitalizations. The average length of stay for Medicaid patients has decreased from 7.7 days in 1973 to 6.5 days in 1975 (compared with a constant 7.6 days for private patients). During the same period, however, utilization of hospitals by Medicaid recipients increased by nearly 39,000 days and discharges have increased by nearly 8,000. Medicaid recipients are being hospitalized more frequently, but for shorter stays, than in 1973.

Hospital budget review. The Commission on Hospitals and Health Care reviews hospital budgets and attempts to control total revenues and total expenditures. Taking into account the fiscal impact of anticipated increases in volume, a schedule of fees is established that will generate the needed revenue. Table IV-2 shows Connecticut's experience in containing hospital price increases, compared with nearby states and the nation as a whole.

Table IV-2. Percentage increase in average daily hospital rates.

	<u>1969-1971</u> ¹	<u>1971-1972</u>	<u>1972-1973</u>	<u>1973-1974</u>
Connecticut	33.3%	12.5%	11.2%	8.9% ²
Massachusetts	36.0	11.6	9.7	14.2
New Jersey ³	29.6	10.2	12.7	11.0
New York	30.4	14.3	9.1	9.9
Pennsylvania	34.8	14.5	10.2	10.6
UNITED STATES	32.0	13.8	9.0	11.6

¹Total increase over the two-year period

²First year of CHHC's operation

³These figures are prior to rate setting program

Source: Presented in Health Insurance Association of America, Viewpoint, December 1975, from material originally prepared by the American Hospital Association.

The Committee on State Payments to Hospitals establishes Medicaid rates for each of four types of hospital services: inpatient, outpatient, emergency room, and special services.

Inpatient rates. Interim rates for inpatient hospital care of Medicaid patients are established by the Committee on State Payments to Hospitals based on CHHC's rates and previous utilization experience. The state pays this interim rate for each Medicaid recipient regardless of treatment actually provided. At the end of the year, hospitals submit actual bills minus payment received for each Medicaid recipient to the Committee. If a hospital received too much from DSS, a check is enclosed and vice versa.

The "actual bills" reflect not only patient utilization of special services, but also the hospitals actual costs of providing all services, independent of CHHC's rate restrictions. Although hospital cost reports are fully audited to insure that cost increases claimed by the hospitals were actually incurred, no control is exercised to prevent or minimize such increases. Connecticut's Medicaid rate-setting procedure for inpatient hospital care is therefore not truly "prospective."

The state is exploring ways by which equitable rates can be set in advance that will not be subject to year end adjustment for price increases.

Outpatient clinics. Connecticut has 26 outpatient clinics providing fast and efficient medical service to individuals who are ambulatory and do not require emergency treatment. Specialized services such as prenatal care and treatment of venereal disease are often provided, as well as general health care information and services. These clinics are an important resource and should be fostered.

The method for reimbursing outpatient clinics, however, is stifling rather than fostering them. The major problem is that reimbursement is based on costs 21 months out of date. A time lag adjustment is made, based on average cost increases over the preceeding three years. In addition, by statutory mandate, rates must not exceed 150% of the combined average fee of a general practitioner and a specialist for an office visit.

Because outpatient clinics can provide more comprehensive care than individual physicians at less cost than hospitals, they should be encouraged to expand in areas where they are needed. The present reimbursement method is apparently causing hardships on existing clinics and preventing expansion of this useful service. It is therefore recommended that the Committee on State Payments to Hospitals carefully review its rate setting procedure for outpatient clinics giving special attention to the time lag between rates and the data on which they are based.

It is further recommended that the statutory limit on clinic visit rates (C.G.S. 17-312d) be deleted. This would give the Commission on Hospitals and Health Care and the Committee on State Payments to Hospitals the flexibility needed to determine reasonable rates that would foster the growth of community-based, multi-purpose clinics where needed.

Emergency rooms. Mandated to set rates which are "reasonable," the Committee on State Payments separates emergency room service into two categories: that which requires the services of hospital staff and that which requires use of facility only, as in the case of personal physician treatment. Similar problems exist in the rate setting procedure for emergency rooms as in outpatient clinics. Cost data are 21 months behind rates and the time lag adjustment is inadequate. The cap on emergency room rates is set by statute at the sixty-seventh percentile of costs. Again it is suggested that this rate setting mechanism be reviewed and that the arbitrary cap be eliminated to give CHHC more flexibility.

Outpatient special services. Hospital outpatient special services, all of which require DSS prior authorization for Medicaid reimbursement, include:

- autopsies and lab analyses (basic lab tests do not require prior authorization)
- radiology therapy
- renal dialysis
- occupational and physical therapy
- psychological therapy
- speech and hearing therapy

Rates for reimbursing each service at each hospital are determined in advance and are used by DSS to adjust each bill before payment is made (since hospital charges may vary from costs, a predeveloped "ratio of costs to charges" is used for adjustment purposes). Together with the prior authorization requirement, this method is effective in controlling utilization and payment and should therefore be retained.

Long-Term Care Facilities

Costs. Long-term care (over 30 days) accounted for 53% of Medicaid expenditures in Connecticut in 1975. Long-term care facilities include nursing homes (skilled nursing facilities and intermediate care facilities) and chronic disease hospitals.

In recent years nursing homes have become a major issue among federal and state agencies seeking to control the precipitous rise in Medicaid costs. As Table IV-3 shows, Medicaid expenditures for long-term care in Connecticut rose from \$24 million in 1968 to \$82 million in 1975.

Table IV-3. Medicaid expenditures for long-term care, 1968-1975.

<u>Year</u>	<u>Convalescent Care¹</u>	<u>Chronic Disease Hospitals²</u>	<u>Total</u>
1968	\$22,216,717	\$ 938,660	\$23,155,377
1969	29,550,703	1,214,402	30,765,105
1970	35,521,868	1,416,724	36,938,592
1971	44,536,323	1,655,898	46,192,221
1972	49,484,946	1,937,622	51,422,568
1973	57,972,570	2,273,207	60,245,777
1974	67,875,407	2,494,054	70,369,461
1975	78,361,010	3,429,965	81,790,975

¹Includes skilled nursing facilities and intermediate care facilities.

²Excludes the three state-operated chronic disease hospitals which are separately funded and ineligible for Medicaid reimbursement.

Source: Department of Social Services

Abuses and federal reform. By 1972, it was apparent to federal officials monitoring the rise in Medicaid expenditures that many of the reimbursement systems utilized by states for nursing homes were inviting fraud and overpayment of funds. This belief was reinforced by investigations performed in various states. In New York, as the Moreland Commission pointed out, and in Texas, Ohio and other states nursing homes were found guilty of substantial financial abuse. Medicaid rate structures generally failed to reimburse homes on the basis of reasonable costs for quality care.

Various systems allowed owners to include for reimbursement the following:

- refinancing of assets, including interest charges;

- payment of large salaries to corporate owners under the guise of consulting or administration;
- submission of unaudited costs;
- overstatement of actual costs;
- sale of homes among corporate officers to raise the mortgage value; and
- inclusion of significant amounts of land around the home held for investment purposes as part of the home's mortgage.

Extensive evidence, documented from state to state, made revisions in federal policy for Medicaid reimbursement of nursing homes necessary.

Recent amendments to the Social Security Act will soon take effect, forcing the states to adopt a "reasonable cost-related methodology." States will be mandated to "provide such methods and procedures relating to the payment for care and services available under the plan,... as may be necessary to...assure that payments...are not in excess of reasonable charges consistent with efficiency, economy and quality of care." In Connecticut and in most other states, this has resulted in a significant departure from former reimbursement methods.

Long-term care reimbursement in Connecticut. Until recently, Connecticut used a point system of reimbursement, whereby a home could qualify for a higher classification and a higher reimbursement level by providing services beyond Health Code standards. This system resulted in general upgrading of institutions, but not necessarily care. There was no rational relationship between points for classification and costs. Homes had an incentive to provide "services"--sometimes unrelated to patient needs--and many of them did.

On November 5, 1975, a temporary system was implemented using interim rates to bridge the gap between the demise of the point system and institution of the new cost-related system. The interim rates, which are still in effect, were based on 1974 costs, plus 5% for inflation. Although unaudited, cost reports were accepted as accurate for purposes of setting an interim rate. At the time of their implementation, late in 1975, the expectation was that the federally mandated cost-related reimbursement system would be approved by July 1, 1976. Implementation problems across the country caused

HEW to postpone the date to January 1, 1978. Because of industry objections to process as well as substance, Connecticut's proposed system will not go into effect until November 1976 at the earliest. In the meantime, many homes in Connecticut report significant financial losses due to the outdated interim rate. Although the new system will apply retroactively to July 1, 1976, some adjustment on an individual basis may be needed. LPR&IC recommends that the Committee on State Payments accept and expedite appeals from nursing homes able to document, using standard accounting and auditing principles, significant losses due to Medicaid rates. It is not in the public interest for the state to impose undue financial hardships on nursing homes with high Medicaid enrollments.

The proposed cost-related reimbursement system. In the fall of 1975, the Department of Social Services hired two full-time consultants to develop the required cost-related system for nursing home reimbursement. The proposed system, which addresses in detail the types of abuses previously outlined,¹ has recently become public. LPR&IC endorses the proposed system which addresses the major problems and abuses associated with the prior reimbursement methodology. However, as with any new system that radically changes former practices, a careful monitoring of the system's effects is required. The Committee on State Payments to Hospitals should proceed to implement the new cost-related system, but should also assess its effects over time on the nursing home industry. Particular attention should be given to homes which incur losses under the new system.

The proposed cost-related reimbursement system is based on the breakdown of costs and assets at each home as follows:

¹ A major drawback faced in Connecticut has been the limited documentation of actual financial abuse in this state. It is difficult to decide how much to spend on deterring abuse without knowing how much the alleged abuse is already costing. To address this and other problems, the Governor recently convened a Blue Ribbon Committee, chaired by former Speaker William Ratchford, to investigate the nursing home industry. The report of this important committee, due for release in November 1976, should go far in documenting the need for change in nursing home regulation in Connecticut.

- A. Controlled Cost Centers
 - 1. Dietary
 - 2. Nursing
 - 3. Laundry
 - 4. Housekeeping

- B. Uncontrolled Costs
 - 1. Management Services (reviewed for reasonableness)
 - 2. Utilities
 - 3. Accounting Fees
 - 4. Other

- C. Asset Valuation
 - 1. Building
 - 2. Land
 - 3. Appurtenances

The annual reporting form. In addition to using the Uniform Chart of Accounts, all long-term care facilities seeking Medicaid reimbursement will be required to submit to the Committee on State Payments an annual report by December 31 of each year. The form for this report is 43 pages long.

An instruction booklet has been prepared, which together with the report form information will be used to determine per diem rates, but not how that rate will actually be computed. The result has been a significant amount of legal and technical confusion over the proposed rate determining process. It is therefore recommended that the Committee on State Payments issue a handbook describing specifically how the reported data will be used in the rate determination process.

Auditing. Based on the detailed annual report, desk auditors will determine an interim rate for each facility. After independent field auditors verify the information provided, the interim rate (with adjustments, if indicated) will become the actual rate for that year.

The Committee on State Payments, which now has little audit capacity, must substantially strengthen its staff to meet the auditing requirements of the proposed system. For the first two years of operation, an independent accounting firm was selected by competitive bid to perform these functions. In the meantime, the state will develop a staff of qualified auditors which will ultimately assume

these responsibilities. To expedite the auditing process, all facilities will be required to maintain accounts on an accrual method and to meet "generally accepted accounting principles," as determined by the American Institute of Certified Public Accountants.

Controlled cost centers. As shown above, the Committee on State Payments to Hospitals has identified four "controlled cost centers,"--dietary, laundry, housekeeping, and nursing. Homes, profit and nonprofit together, will be grouped by size and class, and rank ordered by costs in each of the controlled cost centers. Costs, up to the 80th percentile, for each size and class in each cost center will be fully reimbursed. The most expensive homes (top 20%) will be reimbursed at the rate of homes at the 80th percentile.¹ The maximum annual cost increase reimbursable in any cost center, will be the previous year's cost multiplied by the current Gross National Product (GNP) Deflator.

Uncontrolled costs. Unlike nursing or dietary services, some costs, such as utilities, employee benefits, self-employment taxes, and maintenance cannot be grouped across homes. These costs will simply be examined for their "reasonableness" and verified by field audit.

Certain managerial fees will also be reimbursed on a "reasonableness" basis. The former practice of some owners to specify themselves as "consultants" without performing any managerial service will not be allowed. Whenever possible, managerial time is to be allocated to each cost center.

Asset valuation. The State of Connecticut's Committee on State Payments bases the asset valuation in its proposed reimbursement system on New York State's Moreland Commission Report. Under this "Fair Rental Value System," all homes are depreciated on a straight line basis with an average life of forty years. This method seeks to end rapid turnover in homes at inflated prices and leaseback arrangements.

¹ The 80th percentile is admittedly somewhat arbitrary and may be shifted slightly up or down, based on experience.

While these abuses are expensive and must be controlled, the Fair Rental Value System may not allow the legitimate homeowner a fair return on his investment. This is due to a provision that disallows a re-valuation of the home during its forty-year life. If after 20 years, an owner wishes to sell, it might be difficult to obtain the fair market value, since the cost of the original mortgage, minus 20 years of depreciation, is all that will be allowed for reimbursement purposes. While it is recommended that the new reimbursement system be implemented, it is also recommended that the Committee on State Payments to Hospitals contract for an independent examination comparing the Fair Rental Value System with asset valuation systems in use in other states. Further, while a procedure exists for appealing reimbursement rates, a separate appeal process should be instituted for asset valuation.

Incentives. Under the new system, efficient management will be rewarded. A facility will be allowed to keep 10% of the difference between its actual costs and the ceiling for each cost center, when that difference is \$1,000 or more.

The concept of rewarding efficiency is a principle upon which entrepreneurs can agree. The proposed system may not offer enough incentive,¹ however, to make experimentation with cost-saving techniques attractive. It would, for example, produce a \$500 reward for a \$5,000 cost saving. Truly innovative approaches might not be instituted for fear of losses. It is therefore recommended that the Committee on State Payments review the proposed incentives for efficiency to determine whether an increase would save the state more money by making the effort more attractive. According to DSS, penalties will be imposed if quality of patient care deteriorates.

The Professional Policy Committee

The determination of a fee schedule for physician services and pharmaceuticals is the responsibility of the

¹ After three years of continued efficiency, the bonus would increase from 10% to 20% of the difference between actual costs and the allowable ceiling.

Professional Policy Committee. This Committee is composed of the Commissioner of Finance and Control and the Commissioner of Social Services. The specific mandate of the Committee is to establish a uniform fee schedule for practitioners of the healing arts and to develop a reimbursement method for pharmacists. To assist the Committee in determining appropriate rates, a Professional Advisory Committee consisting of representatives of the various medical specialities was established.

Pharmacy

Prescribed pharmaceuticals are covered under Title XIX of the Social Security Act. In 1975 an estimated 1.8 million prescriptions cost \$9 million, or 6% of Connecticut's Medicaid budget. As Table IV-4 shows, this was a significant increase over the prior year's payment and approximately 200% more than the allocation required in 1968.

Table IV-4. Pharmacy costs in Connecticut, 1968-1975.

<u>Year</u>	<u>Expenditures</u>
1968	\$3,041,065
1969	3,510,226
1970	4,819,780
1971	5,422,090
1972	5,927,538
1973	6,060,127
1974	7,021,600
1975	9,127,406

Source: Department of Social Services

For each prescription reimbursed under the program the following procedures must be followed:

- A patient profile record card for prescribed drugs must be maintained for audit and review purposes in Skilled Nursing and Intermediate Care Facilities.
- Prescriptions must not exceed the drug requirements for a period of thirty days, with the exception of patients residing in Skilled Nursing and Intermediate Care Facilities.

- The prescription must bear the practitioner's license number, degree and office address, and on a prescription for narcotics his Bureau of Narcotics and Dangerous Drugs Registry Number.
- The prescription must be retained by the pharmacy for a period of three years, according to state statute.
- A prescription or refill if telephoned by the practitioner to a pharmacist must be reduced to writing by the pharmacist for his records.
- A prescription in a situation of unusual medical nature requiring preparation or supplies over and above the usual quantity requires prior authorization.

In addition, prior authorization is required for prescribed drugs priced over \$16.00.

Pharmacy reimbursement. The Professional Policy Committee uses a cost plus professional fee method of reimbursing pharmacists. The professional dispensing fee is variable as shown below:

- \$ 2.00 - Skilled Nursing and Intermediate Care Facilities
- \$ 2.20 - Walk-ins/Homes for the Aged
- \$ 5.00 - If prescription is \$25.00 - \$49.99
- \$10.00 - If prescription is \$50.00 - \$75.00
- \$15.00 - If prescription is over \$75.00

The dispensing fee is designed to reflect the pharmacist's average costs of filling a prescription. This includes overhead, labor and profit. The current dispensing fees are based on a 1970 statewide survey of actual per prescription dispensing costs, updated for inflation in 1973.

The basic charge for each drug is based on average wholesale price indices. When a pharmacist bills the state, he specifies the average wholesale price and adds the dispensing fee to arrive at the total cost of that prescription.

The federal government has recently developed an Estimated Acquisition Cost (EAC) index for 825 commonly prescribed drugs. The EAC index was developed from extensive surveys throughout the United States and reflects commonly used buying practices. It is currently being contested in Federal District Court, however, by the Retail Druggists Association. If implemented, prices for items appearing on the EAC would supercede those specified in the wholesale price index.

The use of the variable fee methodology for both nursing homes and walk-ins is adequate but fails to take advantage of potential savings from use of other methods, such as a competitive bid system for nursing home services.

Prior use of the bid system for pharmacy services to nursing homes resulted in numerous problems. This was largely due to poor administration and a lack of specificity as to the pharmacies' obligation with respect to daily deliveries and emergency deliveries. This, in addition to the federally mandated "freedom of choice" requirement, which allows nursing home patients the right to designate a particular pharmacy to service them, provided the necessary rationale for elimination of the bid system.

Despite its prior problems, a properly instituted bid system could result in significant savings. The DSS Title XIX Task Force recently recommended a return to the bid system and estimated savings in excess of \$900,000 as a result. If each nursing home sought competitive bids from nearby pharmacies, the home could take advantage of specific managerial efficiencies present in some pharmacies and absent in others. Further, it would promote competition among pharmacies and induce cost saving techniques that might otherwise be bypassed.

It is therefore recommended that the Department of Social Services examine reinstatement of the bid system for providing pharmaceutical services to nursing homes. The Department in analyzing the strengths and weaknesses of the system, should address the following:

- waiver form for freedom of choice of pharmacy;
- use of biennial confidential review on the quality of service provided by the pharmacy to the respective home;

- limitation of the geographical area each pharmacy may service;
- limitation of the total number of beds each pharmacy may service;
- restricting the pharmacy providing service from acting as that home's pharmacy consultant;
- use of an explicit contract detailing routine and emergency service; and
- penalties for misconduct by the pharmacy in relation to its delivery obligations.

As noted at the beginning of this section, pharmacists dispensing fees are based on 1970 costs and have not been adjusted since 1973. It is therefore recommended that the Department of Social Services review the present professional fee for its relation to current costs of dispensing a prescription, and that this fee be examined on a regular basis to reflect necessary changes (increases or decreases), in the cost of providing this service.

Doctor and Dentist Fees

Physicians. As noted above the Professional Policy Committee sets doctor fees as authorized under Public Act 67-548. The Committee uses the "Relative Value Scale," which is an index of all medical procedures with corresponding units of value based on time and complexity. Determination of a dollar amount for each unit then gives rise to a fee for any particular procedure.

Presently, a basic medical service unit is reimbursed at \$4.50 and surgical and radiological units are reimbursed at \$5.00 per unit. For any standard medical procedure the Department of Social Services can easily determine the cost of reimbursement based on the R.V.S.

The Relative Value Scale, based on a 1964 study by the California Medical Association, was adopted in 1965 by the Connecticut State Medical Society and has remained the basis (with updates) of reimbursement for medical service since.

The actual rates for each unit of basic and surgical services were based on a 1968-69 survey by Connecticut General Insurance Company. This survey determined that Medicare level of reimbursement for various procedures and "usual and customary" charges for private patients. State policy has been to pay only 75% of usual or customary fees.

The use of a Relative Value Scale for medical fees is highly endorsed. It is recommended, however, that the Professional Policy Committee review the value of basic and surgical units and update these if necessary. Considerable discontent by the Connecticut State Medical Society over the lapse of time between revisions has been voiced. It is the Committee's responsibility to insure that the maximum number of physicians are participating in the program and that Medicaid recipients have access to all medical services. This will require adequate reimbursement to physicians for their time.

Dentists. The use of a dentist's services for Medicaid recipients requires prior authorization, except for the immediate relief of pain. None of the dental specialities are covered under Medicaid.

Prior authorization requires submission of pertinent X-rays to the DSS dental consultant. Dental reimbursement is negotiated with the Connecticut State Dental Association.

Table IV-5 shows that while medical expenditures have fluctuated considerably over the past five years, dental expenditures have been rising steadily.

Table IV-5. Medical and dental expenditures, 1968-1975.

<u>Year</u>	<u>Medical</u>	<u>Dental & Dental Clinics</u>
1968	\$ 3,308,483	\$ 847,737
1969	5,969,981	1,307,097
1970	6,864,323	1,559,362
1971	6,997,383	1,740,682
1972	10,047,015	2,089,100
1973	9,672,540	1,952,343
1974	9,317,626	2,046,527
1975	11,852,396	3,316,815

Source: Department of Social Services

Emergency Medical Services

Ambulance companies are reimbursed for services to Medicaid recipients. Until recently the Public Utilities Control Authority (PUCA) set ambulance rates. The responsibility was transferred to CHHC and then in 1975 to the Department of Health's Emergency Medical Services unit. In addition to rate-setting, the Office of Emergency Medical Services is responsible for the following:

- licensure or certification of ambulance operations, ambulance drivers, emergency medical, medical technicians, and communications personnel.
- licensure or certification of emergency room facilities, transportation equipment including land, sea and air facilities.
- periodic inspection of life saving equipment, emergency facilities and emergency transportation vehicles.

EMS is aided in its decision-making role by an Advisory Board of 25 various members each lending a different expertise to the Board.

Expenditures for ambulance services have quintupled over the past eight years, but remain less than 1% of Connecticut's Medicaid budget. Table IV-6 shows Medicaid expenditures for ambulance services for the period 1968-75.

Table IV-6. Medicaid expenditures for ambulances.

<u>Year</u>	<u>Expenditure</u>	<u>Bills Paid</u>
1968	183,328	N/A
1969	203,471	N/A
1970	341,184	N/A
1971	378,046	N/A
1972	471,293	N/A
1973	642,260	13,566
1974	705,670	14,698
1975	980,356	20,443

Source: Department of Social Services.

Presently there is no specific methodology used to establish state rates for ambulance service--the state pays the same rate as a private patient. The current rates are the result of an EMS hearing on October 17, 1975 requested by six ambulance companies. Though participants gave sworn testimony on increased operating costs and on the financial solvency of their companies, EMS had no capability to audit financial statements.

As a result of the hearing, basic ambulance rates were raised from \$38.50 to the present \$49.00 per call (see Appendix IV-1 for current ambulance fee schedule). It is recommended that for all future rate hearings for the 35 commercial ambulance companies, the Department of Health provide the Office of Emergency Medical Services the use of a financial analyst who can audit and verify the data upon which a rate determination is based.

Durable Medical Equipment

The Purchasing Division of the Department of Finance and Control is responsible for acquisition of durable medical equipment such as:

Beds and sides	Hearing aids
Bassinets	Ultraviolet lamps
Chairs-arthritic	Magnifiers
Chairs-wheel	Nebulizers
Commodos	Oxygen Equipment
Crutches	Walkers

Use of any of the above requires prior authorization by the DSS Medical Services Division, based on need, period of use, and cost. Medicaid expenditures for this type of equipment have increased from \$.5 million in 1968 to \$1.2 million in 1975.

In November, 1975 Finance and Control's Purchasing Division identified a number of problems with its system of handling durable medical equipment. Among these were:

- failure to keep up-to-date lists of equipment in use through DSS District Offices;
- lack of uniformity of the manner in which prior authorization was handled;

- lack of receipts for vendor deliveries;
- insufficient data for pick-up of equipment;
and
- rental of equipment when outright purchase
would be less expensive.

As a result of these inadequacies, new system of acquiring DME has been developed using a regional bid approach. A vendor will be selected for each of eight districts and a decision whether to rent or purchase the equipment can be made according to each patient's needs. The state will thereby cease to rent equipment when purchase would be less expensive. Administrative costs will be reduced by eliminating multiple billings for rentals in a large number of cases. Further, items under \$50 will be purchased.

Problems incurred from pick-up and delivery of equipment will be eliminated, since this will be performed by the vendor. The state will be able to sell back DME to the vendor who can re-use it at a depreciated price.

It is recommended that the Purchasing Division continue to implement the new plan concerning durable medical equipment.

V. UTILIZATION REVIEW

Utilization Review (UR) has two basic purposes: (1) to help insure that individuals receive quality medical care, and (2) to control program costs by preventing unnecessary use. The Social Security Act (Section 1902(a)30) requires states to have methods and procedures to review the utilization of care and services provided under Medicaid and to safeguard against unnecessary utilization. This program, according to HEW rulings, should provide for:

- Summarizing claims data to develop profiles of services provided or received and to screen and identify providers and recipients deviating by specified margins from prescribed parameters or norms of performance;
- Reviewing and investigating deviations to determine whether medical care or services have been appropriate or whether overuse has occurred; and
- Implementing appropriate corrective measures in cases involving overuse.

Connecticut, though not currently in compliance, is working to develop a comprehensive Medicaid Management Information System (MMIS) which will perform these functions and others as well (see Chapter VII).

Medical Review Team (MRT)

The Department of Social Services (Central Office) maintains a Medical Review Team (MRT) which is headed by a Medical Director (3/4 time). Two other medical doctors are on contract to assist the Director on a part-time basis (maximum of 15 hours/week). One social worker is employed (full-time) to assist in MRT functions. The Department also employs specialty consultants in podiatry, optometry, psychiatry, dental (one full-time, one on contract) and pharmacy (full-time).

MRT functions are twofold: medical eligibility determinations (Medically Needy Blind and Disabled, AFDC incapacitated father, and CAMAD) and utilization

control (prior authorization). Approximately 60% of the Medical Director's time is spent approving, amending or disapproving prior authorization requests for certain non-emergency medical procedures. Virtually all prior authorization requests (an estimated 1200-1500 weekly) are approved.

Because most medical consultants are employed on a part-time contractual basis, it is difficult to assess the adequacy of the utilization review staff. On a full-time equivalency basis, these consultants are making three to four hundred independent medical judgments weekly, or about one every six minutes. Because provider policy communication is so essential, and because prior authorization requests must be individually reviewed to deter overutilization, and because such positions are 75% federally reimbursed, the Committee recommends that the Department of Social Services restructure its Medical Review Team to include one or more additional full-time consultants, headed by a full-time Medical Director.

The Department's recent Title XIX Task Force Study recommended that the professional medical staff be decentralized. This would require the appointment of a part-time physician consultant for each district office. This procedure, which once existed, would allow consultants greater contact with district office social workers and would also provide community physicians with a direct medical policy liaison.

However, under this system, physician-consultants had little direction in implementing departmental policy, and were unable to provide meaningful prior authorization review. While the present system also shows a tendency to "rubber stamp" prior authorization requests, it does maintain accountability on the part of the contracted professionals through the Medical Director. Therefore, the LPR&IC recommends that no action be taken by DSS to decentralize its medical-professional staff.

Ambulances. Effective controls are particularly lacking in the transportation services area, which accounted for over \$1.1 million in FY 1975, 76% of which paid for ambulance services.

The Department has no formal regulations to effectively control the reimbursement of return trips from hospitals

(discharge and emergency) for Medicaid recipients. At the present time, ambulance companies are required to obtain prior authorization for non-emergency service only. DSS policy is undefined as to what constitutes an emergency return trip, yet it continues to pay for this service.

Since no review now exists of an ambulance trip if the vendor considers it an emergency, a procedure is recommended for the daily reporting of all emergency ambulance trips by each provider. A medical consultant should weekly review a 5% random sample of such claims (approximately 20 per week) to verify the medical condition which necessitated each service. Documented instances of provider or recipient overutilization could then be systematically reviewed by the DSS Post Payment Audit Group (see Chapter VI).

In addition, welfare recipients should be made aware of the types of alternative medical transportation available to them and the Department should actively instruct them under what circumstances each is to be used.¹ Such alternatives are taxicabs (prior authorization is not required), taxicabs with medical assistant, private cars or buses (recipient is reimbursed for both).

Non-emergency surgery. Connecticut spent approximately \$5.7 million in FY 1975 for surgery covered by Medicaid. According to the New Haven Legal Assistance Association, nearly \$2.5 million was spent on tonsillectomies, cholecystectomies, hysterectomies, D & C's, appendectomies and herniorrhaphies. DSS estimates that up to 35% of these surgical procedures were unnecessary (HEW estimates up to 50% nationally). If the Department's estimate is correct, Connecticut may be spending as much as a million dollars a year for unnecessary surgery under Medicaid. Commissioner Maher announced that a second medical opinion would be required for Medicaid reimbursement on each of these six surgical procedures beginning on January 1, 1976.

¹ Auditor of Public Accounts recommendation, July 25, 1974.

This Committee's Preliminary Report on Medicaid (March 25, 1976) urged that the Department implement its "overdue" second opinion plan for non-emergency surgical procedures. Only recently has the Department contracted for the hiring of a half-time surgical consultant for the purpose of controlling surgical overutilization. Providers were issued "regulations" covering the new procedure, which was rescheduled for implementation on August 1, 1976. Because the Department failed to hold public hearings as required by the Uniform Administrative Procedures Act, the plan is still not operational. This is only one of several instances during the course of this study in which DSS cost the state money by failing to follow prescribed procedures in attempting to implement Departmental regulations.

Pharmaceutical Consultants

During FY 1975, the average drug expenditure per Medicaid recipient rose from \$28.39 to \$35.64 (25%). The number of prescriptions paid increased from 1.5 to 1.8 million, while the average prescription price increased only 8% from \$4.59 to \$4.96 (see Table V-1). Thus, the dramatic rise in drug costs per recipient was due primarily to an 18% increase in drug utilization per recipient (from 6.1 to 7.2 prescriptions per recipient).

Table V-1. Utilization of drugs in Connecticut and selected comparisons.

	Conn. FY75	Conn. FY74	U.S. FY74	Mass FY74	R.I. FY74
Total Medicaid \$(millions)	\$158.0	\$129.8	\$10,148.0	\$453.3	\$62.1
Drug Program \$(millions)	\$9.1	\$7.0	\$706.7	\$25.8	\$5.3
Drugs as a percent of total	5.7%	5.4%	6.9%	5.7%	8.5%
Average drug \$/recipient	\$35.64	\$28.39	-	\$47.46	\$50.30
Total number Rx	1,839,859	1,529,810	-	-	-
Average Rx price	\$4.96	\$4.59	-	-	-
Rx/recipient	7.2	6.1	-	-	-

Source: Connecticut Pharmaceutical Association

The Connecticut utilization review system does not provide for a continuous, ongoing evaluation of the necessity and quality of non-institutional services provided under Medicaid. In the pharmaceutical area the DSS does not routinely generate recipient profiles of services received nor provider profiles of services furnished. "The DSS is presently aware of overutilization in their pharmacy program but are unable to cope with it effectively because of the lack of [a]utilization and review system." (Title XIX Task Force Study, page 35)

The Department of Social Services anticipates having a computerized utilization and review system (MMIS) for all medical services by September 1, 1978. As an interim measure, the Department has explored the alternative of having a private corporation (fiscal intermediary) administer its pharmacy program. This assignment would include both audit and utilization review functions. Chapter VI of this report details a cost-benefit analysis and recommendation which supports the implementation of this proposal.

One purpose of such an interim system would be to provide effective peer review to detect overutilization and other cost-related abuses. The contractor would be required to implement a utilization system based upon four profiles: patient, physician, pharmacy, and drug. Physicians and pharmacists would be selected by DSS to review these profiles. The Connecticut Pharmaceutical Association has offered its expertise to assist the Department in the implementation of this proposal.

According to the DSS Title XIX Task Force Study, the pharmacist employed by the Department would then "explore the abuses that were found by utilization and review reports." (page 35) Because such profiles do not now exist, the pharmaceutical reviewer is presently unable to perform an effective utilization review function.

Controls over services provided are totally or partially absent in the following situations:

- (1) when drug quantity exceeds a 30 day supply for an acute condition;
- (2) when a refill is made before the original supply should be consumed;

- (3) when a birth control prescription exceeds three months supply, or refill exceeds three months supply or there is more than one refill;
- (4) for a chronic condition, when original prescriptions and refill cover a period in excess of six months; and
- (5) when a claim exists for narcotics or alcoholic liquors for addicts.

Other than family planning services, these claims represent an undetermined potential for drug overutilization in the Connecticut Medicaid program.

The DSS pharmaceutical reviewer(s) should periodically sample and review Medicaid prescription billings to determine whether departmental policy is being followed with regard to drug quantity, refills, and narcotic and alcoholic drugs. Further, the Department of Social Services should amend its existing policy relative to the number of refills allowed on birth control prescriptions. By allowing three refills per prescription, recipients would be required to visit a doctor only once yearly (rather than twice) in order to obtain family planning prescriptions. This change would be consistent with standard gynecologic practice in the non-Medicaid population.

The LPR&IC also supports an important recommendation offered by the DSS Title XIX Task Force Study:

A working relationship should be established with the University of Connecticut School of Pharmacy so that student interns may assist in utilization studies conducted by the Central Office of the Department of Social Services. Such studies should include evaluations of utilization proposals concerning copayment of drugs; a restriction on the number of prescriptions issued per recipient; and the elimination of coverage for non-convalescent home patients of most non-prescription drugs except Insulin.¹

¹ The Connecticut Pharmaceutical Association estimates that the elimination of coverage for non-convalescent home patients of most non-prescription drugs (except Insulin) could save the state as much as \$900,000.

Nursing home pharmaceutical consultants. Federal regulations promulgated on January 17, 1974 require that the pharmaceutical services provided at a skilled nursing facility be under the supervision of a qualified pharmaceutical consultant. If the pharmaceutical consultant is not a full-time employee of the facility, he must devote a sufficient number of hours, based upon the needs of the facility during regularly scheduled visits, to carry out certain utilization review responsibilities.

The consultant reviews the drug regimen of each patient at least monthly, and reports any irregularities to the medical director and administrator. The pharmacist also submits a written report, at least quarterly, to the pharmaceutical services committee (see below) on the status of the facility's pharmaceutical services and staff performance.

A second responsibility of the pharmaceutical consultant is to determine that all drug records are in order and that an account of all controlled drugs is maintained and reconciled.

Finally, the pharmacist assures that the labeling of drugs and biologicals is based upon currently accepted professional principles and includes appropriate cautionary instructions, as well as the expiration date when applicable.

Each skilled nursing facility must also maintain a pharmaceutical services committee (composed of a pharmacist, the director of nursing, the home's administrator, and at least one physician) to develop written policies and procedures for safe and effective drug therapy.

Control over the actions taken by the pharmaceutical consultants is dispersed among four state agencies: the Departments of Health, Social Services, Consumer Protection, and the State Pharmacy Commission.

In Connecticut there are approximately 250 pharmaceutical consultants serving over 300 nursing facilities. There is no uniform method of reimbursement for these services by nursing homes. Some pharmaceutical consultants receive a stipulated monthly fee for providing independent professional services, while others provide drugs to particular nursing homes and also receive a flat fee for consultant services. A large number of consultants provide

their pharmaceutical services without fee, but also provide upwards of 70% of the drugs used in the homes. Uncontrolled, these financial arrangements have the potential of creating a direct conflict of interest. It is therefore recommended that the State Pharmacy Commission and the State Department of Health promulgate regulations designed to effectively control the professional services provided by nursing home pharmaceutical consultants. These regulations should include a conflict of interest provision which would prohibit pharmacists, who provide more than 50% of a nursing home's drug needs, from also serving as that home's professional pharmaceutical consultant.

Finally, all pharmaceutical consultants should be paid on a fee basis. Such fees would then be an allowable charge when nursing homes submit their annual costs to the Commission on Hospitals and Health Care and the Committee on State Payments to Hospitals (see Chapter IV).

Professional Standards Review Organizations (PSRO's)

As one means of safeguarding against unnecessary surgery and other excessive treatment, the federal government (P.L. 92-603) has mandated states to establish local "Professional Standards Review Organizations" (originally by January 1, 1976).

Connecticut has four designated PSRO areas which have begun limited operations. These are:

Connecticut Area II PSRO, New Haven,
Eastern Connecticut PSRO, Willimantic,
Hartford County PSRO, Hartford, and
PSRO of Fairfield County, Bridgeport.

In addition, the Connecticut Medical Institute of New Haven serves as the required statewide council.

PSRO's are mandated to "promote the effective, efficient, and economical delivery of health care services of proper quality..." for Social Security Act beneficiaries. PSRO's at a minimum, will perform:

- (a) hospital admission certification concurrent with a patient's admission;

(b) length of stay review; and

(c) medical care evaluation studies.

Medical personnel providing relevant information in good faith to PSRO's are protected from criminal and civil liability. Members or employees of PSRO's or persons furnishing professional counsel or services to such organizations shall be similarly protected from criminal and civil liability, provided they exercise due care. In Connecticut, P.A. 76-413 extends peer review immunity on a state level.

Each PSRO will be composed of formal committees of physicians who will be paid to review selected patient records to determine whether care provided was within the range of accepted standards. Under the law, responsibility for patient reviews can be met by: (a) the local PSRO performing the reviews; (b) the hospital performing the reviews under the monitoring and periodic evaluation of the local PSRO, or (c) some combination of local PSRO and hospital review actions. Connecticut PSRO's will be required to use and accept the findings of any hospital review committee which it deems capable of performing effective reviews.

Finally, physicians and other providers may be selected for review because they claim more than some specified amount from Medicaid, or they have aberrant provider profiles generated by a PSRO computer analysis, or a hospital "tissue committee" (which examines surgically removed tissue to determine whether the procedure was reasonably indicated), or because of client complaints. Physicians found to be performing unnecessary surgery or exceeding length of stay guidelines when not medically indicated, can be censured by the Connecticut State Medical Society, removed from the DSS approved vendor list, denied reimbursement, and potentially lose their license to practice medicine.

While the impact of PSRO operations is still undetermined, a "20 percent to 50 percent national decrease in inpatient admissions might occur."¹ This would therefore

¹ Hospital Financial Management, December 1974.

result in a shift of medical services to outpatient diagnostic testing, outpatient surgery, home visit nurses, and long-term care facilities. Because Connecticut's four PSRO's are not fully operational these estimates cannot be verified.

As each hospital becomes operational under the appropriate PSRO, the Department of Social Services is notified so that it may review Medicaid billings to examine length of stay documentation. By this procedure, the Department may refuse Medicaid billings which do not contain proper PSRO length of stay authorizations.

VI. EXPENDITURE CONTROLS

Previous chapters focused on the cost containment aspects of recipient eligibility controls, provider price controls (rate setting) and medical services utilization controls for both providers and recipients. These three facets of cost containment all impact on total Medicaid expenditures and are, in effect, "expenditure controls." However, this chapter directly addresses the claims review and payment operations of the Medicaid program; that is, controls over the actual payment of Medicaid bills. In addition, recovery of erroneous payments, vendor fraud and third-party liability are analyzed.

Description of the Medicaid Payment System

The Title XIX (Medicaid) program is primarily a "fee-for-service" vendor reimbursement program.¹ Providers who wish to participate in the Medicaid program apply to the Department of Social Services for a provider number, which is used to identify them by class and type (i.e., physician, surgeon) and for billing and record-keeping purposes. Medicaid recipients are issued a Medicaid Identification Card which they must present to the provider at the time of service. The provider uses the information on the card to complete a DSS invoice, which is signed by the recipient. For certain services, such as dental work or optometry, a prior authorization request (see p. 68) must be completed and attached to the invoice.

All invoices are counted and sorted in the DSS mail room for delivery to the following "provider type" work centers in the Medical Payments Section:

- (1) Physicians
- (2) Hospitals-Inpatient
- (3) Hospitals-Outpatient
- (4) Taxis-Misc.-Ambulances
- (5) Surgical Supplies and Appliances
- (6) Pharmacists
- (7) Nursing Homes
- (8) Dentists
- (9) Visiting Nurses Associations, Opticians, etc.

¹ [See Appendix VI-1 for discussion of prepaid health (HMO) care for Medicaid recipients.]

The invoices are "eye-scanned" by clerk reviewers in each work center for completeness, legibility, attachment of prior authorizations (if required), recipient signature, and certain other details such as, services rendered free by other state agencies. The invoices are then either accepted for further processing or rejected (e.g., for missing information) and returned to vendor (RTV). Accepted invoices are then prepared for data entry by the clerk reviewers. Data processing personnel key enter and verify the invoice data on a mini-computer.

At this point the main computer processes the invoices for payment by:

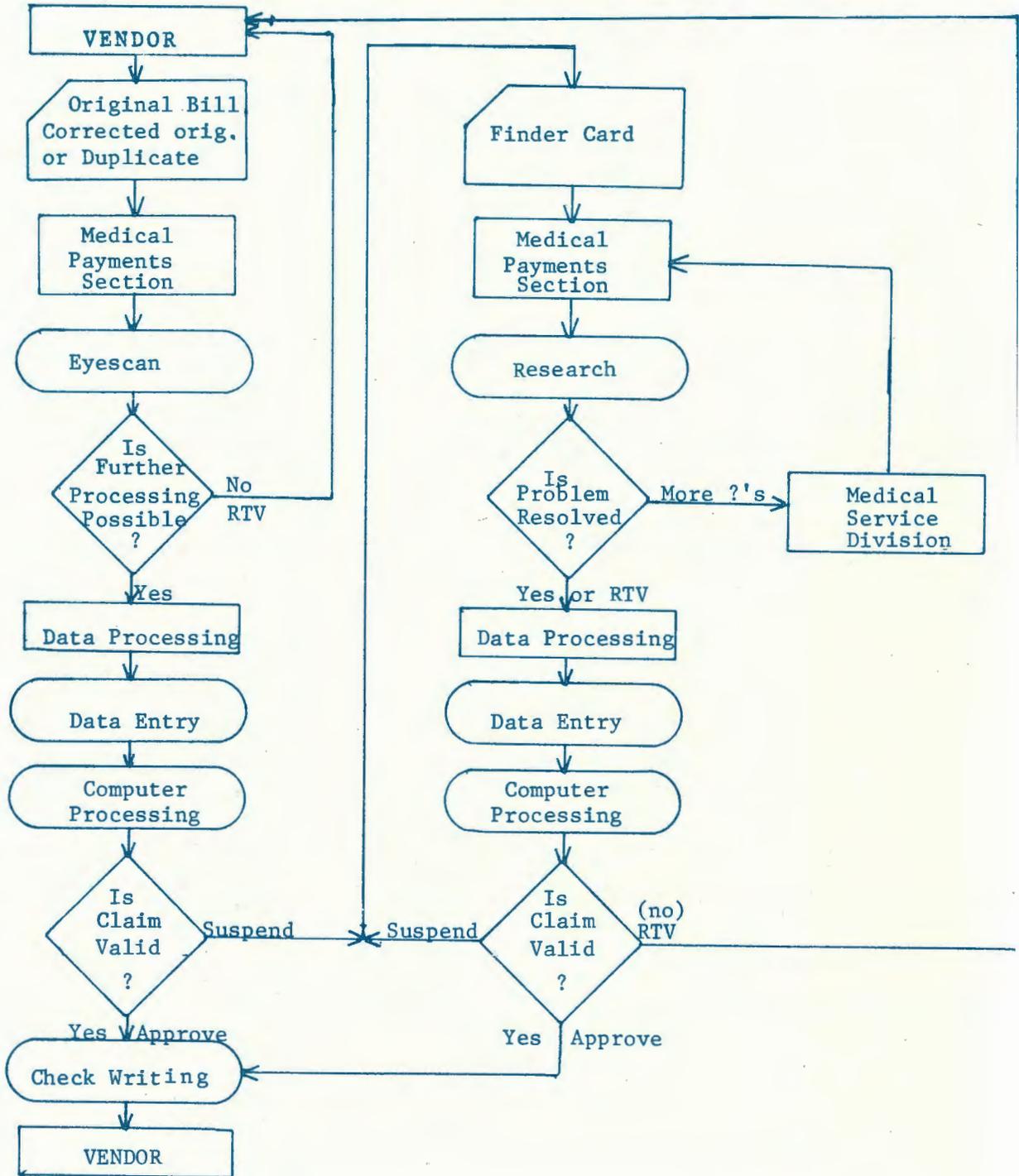
- (1) Verifying the eligibility of the recipient on the date of service.
- (2) Verifying that the vendor is an "approved" provider.
- (3) Comparing the current invoice to a two year recipient history file to ensure that this exact invoice (that is, same recipient, same provider, same date of service, and same procedure code) was not previously paid, and to determine whether the recipient has medical insurance.
- (4) Comparing procedure codes and amounts billed to the Relative Value Scale (RVS) files (in those cases where the RVS has been computerized) to insure the amount billed does not exceed the maximum amount allowable for the procedure.
- (5) Computing the amount payable using units of service and amount billed or RVS, whichever is less, net of any insurance or other credits.
- (6) Preparing "clean bills" (that is, all entries on the invoice have passed all tests (edits)) for checkwriting; or producing "finder cards" for those invoices which do not pass the tests and are therefore returned to the Medical Payment Section to be resolved.

- (7) Producing a list of exact and near duplicate (where the recipient, date of service and provider type match) payments (Duplicate Payment List). Checks are issued for near-duplicates but not for exact matches. This list goes to the Post-Payment Audit Group which attempts to recover overpayments from vendors (see p. 90).

All processed invoices are returned to the Medical Payments Section along with the finder cards associated with those invoices which were not paid. The clerk reviewers of the Medical Payments Section must then resolve the problems noted on the finder cards for rejected invoices. This is a time-consuming process which may involve comparison of the finder card to the original invoice, consulting the Central Office case file for recipient information, assistance from the Medical Services Division on prior authorizations, or other research to establish the validity of a claim. The finder cards are then re-processed with either corrected information, instructions to override certain edits, or instructions to return the invoice to the vendor (RTV). When all finder cards for a particular batch of invoices have been resolved, the invoices are sent to records storage, thus completing the medical payments cycle (see Figure VI-1).

Nursing homes. The payment system for nursing homes does not use the fee-for-service billing method described above. The homes receive a "pre-list" with their monthly checks which enumerates each recipient covered by the payment. This list is amended by the home to reflect admissions and discharges for the month and re-submitted to DSS as an invoice. The homes also complete daily admission and discharge forms and send copies to the Medical Payments Section and to the district office. The Medical Payments Section nursing home work center reviewers match the entries on the daily admission and discharge forms with the "pre-list" to verify dates of service. They will not process payments for new admission, however, until an authorization form has been received from the district office. After verification by the reviewer, changes are entered on the nursing home master recipient file. This file then becomes the basis for generating the nursing home "payroll" and payment checks. Each home's monthly payroll becomes the pre-list for the following month.

Figure VI-1. Medicaid Payment System



Source: LPR&IC analysis of Department of Social Services information.

Since the rates are set in advance for each home (see page 56) and entered on the master file, and no trans-actions can occur without an authorization form, the only apparent payment system weaknesses for long-term care facilities are in the eligibility determination and utilization review areas. The Medicaid eligibility determination process includes a review for potential Medicare eligibility. This complex and time-consuming process sometimes creates inordinate delays (up to six months according to the DSS Medical Payments Coordinator) in getting new admissions onto the master file. The accuracy of initial eligibility determination and redetermination (or lack thereof) also effect Medicaid nursing home expenditures.

Medical Payment Section Staffing

The Medical Payment Section is often behind in its work. During each of the last three months of FY 1976, the section averaged 1250 hours in overtime--the equivalent of 8.3 additional full-time employees. As shown in Appendix VI-2, the section operated for much of FY 1976 with only 34 of 47 positions filled. The Appendix also shows that this section is apparently processing two and one half times as many claim line items as the comparable section in a private insurance company.¹ The private insurer claims a payment error rate of less than one-half of one percent. While DSS cannot presently determine its payment system error rate, it is likely to be well above that of the private insurer. Even if the DSS payment system error rate were only 1%, that would mean some \$2 million in wasted funds. It is more than likely therefore, that DSS is wasting more through payment errors than it saves by having a small staff. Because of the importance of accuracy in the Medical Payments Section and the heavy backlog of work, it is recommended that DSS and the Department of Finance and Control assign a high priority to filling existing vacancies.

¹ One reason for the very large discrepancy in staffing is that the private insurer's computer operation is more sophisticated, thereby requiring more follow-up of computer noted exceptions. If the Department's new MMIS is to attain full effectiveness, DSS will also have to hire investigators to follow up the computer findings (see Chapter VII).

Salaries. Salaries for Medical Payments Section personnel (other than supervisors) average about \$6300 per year--a level which is reportedly too low to attract and retain qualified personnel.

The supervisor of the Medical Payments Section who, in addition to supervising the 40 clerical personnel in the unit, handling much of the provider relations work, writing medical payment policies and procedures, and updating fee schedules, earns a mere \$8400 to \$10,000 per year.

LPR&IC therefore recommends that DSS Medical Payments Section positions be reviewed for possible reclassification to attract and retain staff qualified to perform the important and complex manual review operations. This should be done in concert with the MMIS organizational analysis (see page 109).

Backlog. There has been much criticism of DSS by medical service providers for late (up to six months and sometimes a full year) payment of invoices submitted for Medicaid reimbursement. The Department claims to be paying "clean" bills (bills which pass all manual and computer tests on the first attempt) within the Governor's pledged payment deadline of 30 days for hospitals and 45 days for all other providers. According to Table VI-1, approximately 75% of all bills are being paid "on time." Included within this 75%, however, are an estimated 54,000 claim line items which have been returned to the vendor during the previous month and are only "on time" the second time around. The remaining 25% (121,700 claim line items) require further processing by Medical Payments Section personnel. The problems indicated on the "finder cards" for these bills must be resolved in-house or by returning the invoices to the vendor for correction.

The reviewers of the Medical Payments Section process finder cards as much as possible on a daily basis, but only when their work on incoming bills is caught up. Staffing is now at such a low level that most work centers can only work on the finder cards on an overtime basis when the backlog reaches overwhelming proportions or certain providers appeal to the Commissioner or the Governor for payment. As noted above, the section averaged 1250 hours in overtime per month in April, May and June, 1976.

Table VI-1. Average monthly activity, DSS Medical Payment Section (excludes long-term care facilities).

	<u>Claim Line Items</u>	
Approved during computer processing	368,300	75%
Suspended by computer for review:	121,700	25%
Returned to vendor	[53,900]	[11%]
Approved or corrected and reentered after review	[67,800]	[14%]
Average claims processed per month ¹	<u>490,000</u>	<u>100%</u>

¹ Based on period December 1975-June 1976. This total represents all claims: original invoices received for the first time, invoices returned to vendors and subsequently re-submitted for payment and duplicate invoices. It does not include invoices rejected during the initial eyescan operation.

Source: Legislative Program Review & Investigations Committee staff analysis of data provided by Department of Social Services.

When the problems indicated on the finder card(s) for a particular bill have been resolved, they are re-entered into the computer and the bill may be rejected again because an edit procedure, which could not be performed on the first pass (because of erroneous information), now picks up another error. If so, a new finder card is created and the process begins all over again, as shown in Figure VI-1 on page 81.

The Department has no statistics or information on the average length of time required to resolve the finder card problems, but, LPR&IC staff visits to the Medical Payments Section revealed a considerable backlog of unresolved finder cards. The hospital work center had a backlog of about three months, with some bills dating back six months. In the meantime, the provider has received no information regarding his unpaid invoice. When he calls the Department, he is often informed that the status of his unpaid invoice is not known and that he

should submit the carbon (duplicate) copy. This duplicate copy is then processed by the Medical Payments Section as if it were an original and if the same problem exists (and it probably does since this is a carbon copy) it too will end up in the unresolved finder card stack awaiting disposition. When the problems (finder cards) are finally resolved the vendor will receive either a check and an RTV notice or two RTV notices for the same bill. In the latter case, the vendor must then correct the problem indicated on the RTV notices and resubmit the bill for payment.

No doubt this causes much frustration among providers, and one could understand why a provider might feel justified in either slightly altering the duplicate invoice (creating a near duplicate payment situation) or adding items to the invoice to make up for the delay in payment which he has experienced. While we do not know the extent of such practices, the possibility does exist and the Department should take immediate steps to correct the situation.

Therefore, the LPR&IC recommends that a separate "suspended payments" unit be established to work only on the resolution of finder cards (see Appendix VI-3). This unit should be adequately staffed to insure that providers can be notified when payment problems exist within the 30 and 45 day time limits in effect for accurate or "clean" bills. This would have the dual advantages of greatly improving provider relations and reducing the burden of duplicate invoices on the system. The Committee further recommends that this unit be provided (if possible) with a computer-prepared "finder card status list" (by invoice number referencing the batch number on a weekly or monthly basis) indicating disposition and date which would allow unpaid invoices to be traced. All calls concerning unpaid invoices could be directed to this unit. If the invoice problems can be resolved by telephone, then payments could be further expedited by eliminating some of the paper-work delays and backlogs.

Lack of Instruction Manual and Training

The Medical Payments Section has no specific written instructions for personnel involved in eye-scanning and preparing invoices for computer processing. Manual procedures seem to have evolved (within personnel constraints)

as missing controls in the computer editing system were identified. As the computer editing capabilities change, so do the manual procedures. However, there has not been a good, methodical examination of the entire payment system to identify weaknesses and to develop alternative procedures. Several major areas of weakness are discussed below under "Third-Party Liability" and "Post Payment Review." However, other weaknesses are: (1) the lack of any (manual or computer) check to insure that the prescription number is listed for each item on a pharmacy invoice; and (2) the lack of (manual or computer) verification of drug prices. The prescription number is the only audit trail item which can be traced through the pharmacist's records to verify physician's written order for the medication and delivery of prescribed items. The Department's policy is that only prescribed items will be paid by Medicaid.

With respect to verification of drug prices, clerks could check drug prices against the published "Average Wholesale Price Index." Any unreasonably priced item could be further reviewed by DSS pharmaceutical reviewers (see page 93). The pharmaceutical price list will soon be computerized, eliminating the need for a manual review. Nevertheless, these two examples show the need to develop detailed written instructions for manual review (eye-scan) and suspended payments operations. The LPR&IC therefore recommends that a systematic study of the claims payment process be undertaken, and that appropriate detailed staff instructions be developed. It is further recommended that thorough pre-service and in-service training be provided on a regular basis; for, without effective training even the best written procedures are of little use.

The lack of written instructions and formal training of personnel was also identified in a report prepared for HEW by Control Analysis Corp. entitled "Assessment of Controls on Erroneous Medicaid Expenditures in the State of Connecticut," January 28, 1976. Appendix A of that report catalogued approximately 300 "potential erroneous claims situations" and rated the Department as having either control, partial control or no control over these situations. The Department has reportedly undertaken an examination of all "partial" or "no" control situations, with intent to either develop interim controls or to build them into the MMIS (see Chapter VII). While the Program Review and Investigations Committee shares the Department's

concern for controls, it should be emphasized that the Control Analysis report recommended that the Department "determine whether the magnitude of erroneous payments (in these areas) warrants the addition of appropriate system edits." Certainly it is possible to pay more for some controls than having them would save. The report also recommended that DSS "develop a formal method of carrying out quantitative cost-effectiveness analyses to determine the desirability of instituting particular claim edits."

The LPR&IC therefore recommends that the Department develop data on cost and estimated savings of present payment control systems (both manual and computerized). Claims processing procedures would lend themselves particularly well to cost/benefit analysis. Such a study would tell management how to allocate manpower and training resources to maximize the potential benefits of control procedures. This type of documentation would also be extremely useful in supporting additional staff requests by the Department.

Third Party Liability

A recent HEW study conducted in Maryland, Massachusetts, and North Carolina found that 50 percent of all categorical Title XIX recipients (see Chapter II) had some form of private health insurance as well. HEW noted that "there is ample data to indicate that Medicaid funds are paying for medical bills that should be paid for by (private) insurance companies." In Connecticut, the Department of Social Services has had significant problems in recouping accident-related insurance coverage, Medicare, and other private medical insurance.

There are no computerized claims processing edits designed to detect procedures and diagnoses which are accident-related and which might be subject to third-party liability. It is therefore possible for a Medicaid recipient to be injured in an automobile accident, be treated for these injuries under Medicaid, and still receive a no-fault insurance settlement. At the present time, the primary method for detecting accidents is through a manual post-payment review of ambulance claims. The irony is that while most vendor claim forms have a space to check if the patient was in an accident or is insured, the ambulance claim form (Bill for Medical Transportation)

contains no such space--an analysis of the "description of emergency" is needed to determine if the claim is accident-related. Even more surprising, when the "accident" space is checked on other vendor claims, the Department has no procedure for determining other third party liability.

A related problem occurs when a provider claim contains some indication of other insurance (a box is checked or a credit taken) and the Department makes no effort to enter the information in the recipient's file for future reference. Various estimates place the potential recovery from Medicare alone in the millions of dollars.

The Program Review and Investigations Committee is deeply concerned about the lack of effort in the Department to make Medicaid the payor of last resort. Additional staff in this area could save their salaries dozens of times over in a single year. Precise estimates are impossible since the extent of losses are unknown; it is known, however, that important control mechanisms are completely lacking. LPR&IC therefore recommends that the DSS establish a Claims Recovery Unit to gather and maintain insurance coverage and accident liability data on all Medicaid recipients (see Appendix VI-3). Computer files of all recipients who have declared, or have had indirectly reported by providers, insurance coverage or accident liability potential would be flagged. Computer flags are now in limited use--only for insurance reported at time of application. Further, the follow-up of flagged bills is done by the Medical Payments Section which, as already noted, is severely understaffed and lacks the opportunity to develop expertise in this area. The proposed Claims Recovery Unit should thoroughly investigate all third party payment potential before approving the bill for payment. If the unit is sufficiently staffed and trained, no significant delays in the payment processes should occur as a result of this added review. Based upon the HEW findings cited above, the potential for return on this investment in staff would appear to be highly significant.

Medicare. Finally, DSS has no Medicare eligibility information in its eligibility computer file. All medical bills for persons over 65 years of age are screened, however, against a list of Connecticut Medicare eligibles provided by the Social Security Administration. If the

recipient is eligible for Medicare, the Medicaid invoice is returned to the vendor with instructions to bill Medicare. Medicaid recipients who appear to be eligible but are not listed as Medicare recipients, have Medicare application made and premiums paid for them by the DSS Buy-in Coordinator.

Inpatient hospital bills (Medicare Part A) for persons under 65 years of age in the blind and disabled categorical programs are subjected to the same procedures; however, Medicare Part B (professional services other than inpatient hospital services) bills for these recipients are not reviewed for potential Medicare liability. This is due, in part, to low Medicare eligibility (approximately 15%) for this group, and to DSS staff limitations.

Weaknesses in this system exist, especially in the area of Medicare eligibility denials. It is estimated that over half of such denials when appealed, are overturned during the first step in the appeal procedure.¹

According to the New Haven Legal Assistance Association, Connecticut has a substantial number of Medicaid recipients who are eligible for Medicare. Some have simply not enrolled; others have not applied for benefits to which they are entitled; and still others are in institutions not approved for Medicare reimbursement.² Since the federal government pays essentially the full cost of services under Medicare, but generally only half of Medicaid costs, DSS should make a reasonable effort to insure that Medicare eligibles are receiving Title XVIII benefits to which they are entitled. Neglect of such an effort is costly to the state. The Connecticut Legislative Coalition on Aging has estimated combined recoverable past and present Medicare claims in this state to be between \$1.5 and \$4 million.

¹ The Legislative Coalition on Aging estimates the administrative hearing reversal rate at 70% for Part A and 50% for Part B.

² The Commissioner of Social Services estimates that approximately one-third of all Connecticut nursing homes are not Medicare approved.

Other state agencies have proven a capacity to implement a Medicare recovery plan. On February 20, 1975 the Departments of Health and Mental Health entered into a \$50,000 contract with a private health care corporation¹ for the purpose of identifying recoverable Medicare Part A (hospital) payments and developing a plan for recoupment. The contractor's final report estimates up to \$3.3 million has not been reimbursed to the state by HEW because of errors in handling Medicare accounts.

A similar contract was also executed for the purpose of recovering Medicare Part B (physician) reimbursement due these state agencies. The corporation is to receive 10% of all sums recovered. In less than seven months, the corporation has reviewed 1,459 claims and has recovered nearly \$62,000 leaving the state with a net gain of \$55,800.

The LPR&IC recommends the Department of Social Services investigate the feasibility of an outside contract to review DSS Medicare reimbursement procedures.

Post Payment Review

DSS has implemented a very limited manual post-payment control system. According to the Control Analysis report "any manual checks on the system are performed on an informal basis, and generally only when a problem has been brought to someone's attention on a happenstance or random basis."

The Department's Post Payment Audit Group was originally designed to perform systematic post-payment reviews of the entire Medicaid payment system. However, due to the "crisis" atmosphere that prevails in the Central Office, the unit's activities are limited to reviews in near-duplicate claims and third party liability areas. These controls are primarily accomplished through review of the Duplicate Payment List and ambulance claims.

The Duplicate Payment List, as described earlier, is generated by the computer at the time bills are processed. It enumerates all payments which have the same recipient, date of service and provider type as being near-duplicates

¹ National Health Care Resources, Inc.

(payment for original has already been made). In addition, bills with the above characteristics but also having the same procedure code and amount are shown as exact duplicates (payment has not been made). The Post-Payment Audit Group, consisting of three employees, is supposed to review each list (prepared daily) for possible duplicate payments by identifying "suspicious" or high risk entries on the list, then researching the invoices and ultimately attempting to collect the overpayment from the provider. The unit's efforts are hampered by several factors which should be corrected as soon as possible. There are no written instructions to guide the reviewers in the scrutiny of the Duplicate Payment List. They seem to perform this function more on "feel" and past experience than on any systematic exploration and documentation of high probability overpayment situations. During a visit to the Department, the LPR&IC staff noted a three- to six-month backlog in the Duplicate Payment List reviews and could find no evidence of systematic examination of all near duplicates on lists which had been reviewed. In addition, the Post-Payment Group's research efforts are significantly hampered by the fact that most of the paid invoices are filed either at the Huyshoppe Avenue or the Rocky Hill records storage areas, making the retrieval of actual invoices cumbersome.

Despite these recognized weaknesses, the Department recovered Medicaid refunds amounting to \$459,109 in FY 1975 and \$783,719 in FY 1976 in provider overpayments. In light of the potential for overpayment recovery which currently exists, the LPR&IC recommends that the Department hire sufficient staff to enable the full, current review of Duplicate Payment Lists; that written instructions be developed for the review; and that investigation techniques be employed.

Once it is determined that a provider has received an overpayment, a manual accounts receivable file is used for collections. Manual handling of collections can lead to considerable error and neglect. According to an HEW report,¹

...[t]here are many thousands of dollars of older accounts receivable (more than six months) out-

¹ Control Analysis Corp., "Assessment of Controls on Erroneous Medicaid Expenditures in the State of Connecticut," January 28, 1976.

standing, most of which have not received any follow-up attention due to a cut back in personnel in the post payment review group. Since the post payment review team is presently investigating possible duplicates that were paid 4 to 6 months earlier, the timeliness of accounts receivable collections is further relaxed.

The study estimated that Connecticut had over \$100,000 of known refunds outstanding for the last six months of 1975.

To maximize its collections of provider overpayments, the Department should implement an automated claims recovery system. Such a system should have the capability of blocking future provider payments until prior overpayments are recouped. In lieu of developing such a system, the Department might consider using the Central Collections Division of the Department of Finance and Control or a private collection agency to recover certain accounts receivable (assuming, of course, that confidentiality can be maintained). A vendor who refuses to cooperate in the refund of overpayments should be removed from the DSS approved vendor list.

A final function of the post payment audit group is to furnish Finance and Control's Division of Central Collections with vendor fraud referrals. In the current calendar year, the post payment audit group has been able to detect only three cases of suspected vendor fraud. One reason already cited for this inability is the fact that an effective control system for overpayments is non-existent. Secondly, the post payment group is making independent determinations as to which overpayments are attributable to willful provider misrepresentations and which are merely unintentional or negligent in nature. Such determinations by the post payment group are inappropriate from a policy standpoint.

The Department should maintain records of all provider overcharges and refer all overpayments in excess of \$500 to the Division of Central Collections for fraud investigation. Section 17-82m of the Connecticut General Statutes should be amended (see Appendix III-5) to provide for a systematic procedure for recovering such provider overpayments.

The Committee adopts the following recommendation proposed by the HEW Control Analysis Report:

The State of Connecticut should institute a quality control function to monitor the performance of the control system, including the computer processing as well as the manual claim review by professional and clerical personnel. The quality control function should include, as a minimum: regular random sampling of paid, suspended, and returned claims, with complete research of each claim to insure valid disposition; regular review of provider refunds, adjustments and voids, to determine the causes of erroneous expenditures brought to the state's attention by providers; and regular random sampling and reconciliation of files to insure accuracy of data. It could also include, if desired, submitting of fictitious test claims; tabulation of claims suspended resulting from processing errors (e.g., key-entry); and periodic review of manually-processed documents.

Pharmaceutical Reviewers

The Department currently operates a very limited manual audit system over pharmaceutical claims. Until January, 1976, the Department employed two pharmaceutical reviewers, who according to Department officials, disallowed several hundred thousand dollars of bills each year. In fact, as noted in Chapter V, the Department estimates that a good audit and utilization review system would save the state about 10% of drug costs, or currently about \$900,000.

In January, one of the pharmacists was laid off, allegedly due to the State's financial crisis. However, 75% of the claim reviewer's salary was federally reimbursed. Since pharmaceutical reviewers can save the state thousands of dollars by identifying overcharges and other abuses, the Committee recommends that the pharmaceutical reviewer position currently vacant be filled.

The remaining pharmaceutical reviewer examines less than 5% of all incoming drug claims. Less than 15% of his time is spent reviewing claims, while another 40% of his time is allocated to updating policy, procedures and drug fee schedules. Finally, the pharmaceutical reviewer does review all physician claims which contain charges other than services (i.e., drugs, medical supplies). This review is performed only "as time permits," even though a very high percentage of such billings reportedly contain overcharges by providers. It is not unusual for these billings to accumulate and remain unchallenged up to one month or more. Recently, the reviewer spent four

hours examining such bills and recovered \$2500 for the Department of Social Services. The DSS pharmaceutical reviewers should allocate sufficient time on a weekly basis for the purpose of auditing a sample of pharmaceutical and physician (non-service) claims under Medicaid.

The Department has had virtually no control over drug payments other than by manual review. Presently, computer edits reject only those claims which exceed \$16, irrespective of their reasonableness. This auditing capability will be improved with the introduction of two proposed drug file systems described below.

HEW has mandated each state to implement payment controls on 825 selected drugs not to be in excess of each drug's "estimated acquisition costs" (EAC) by August 26, 1976 (see Chapter IV). The National Association of Retail Druggists is in the process of challenging this mandate in Federal Court. The Connecticut Pharmaceutical Association has obtained an injunction against implementation of the plan by the Department of Social Services. However, the Department intends to adopt the EAC pricing system as soon as the procedural requirements prescribed by the Uniform Administrative Procedures Act have been met.¹

Secondly, the Department is in the process of instituting a comprehensive Master Drug Reference File covering 3900 drugs. Upon implementation, the computer will edit and reject all drug claims which exceed the costs established by the Department. Once this program becomes operational, the pharmaceutical reviewer will be required to systematically audit and approve all non-coded (non-computerized) drug bills and those claims which require

¹ DSS has repeatedly failed to implement policy changes according to the regulatory notice requirements of the Uniform Administrative Procedures Act. Because of this unwarranted legal delay in implementing EAC, the Department will be unable to recoup the total savings which were anticipated.

prior authorization. This computer auditing capacity is essential for the effective administration of the state's pharmacy program. Therefore, the Department is well-advised to assure itself that such proposals are implemented according to all state and federal requirements.

This Committee's "Preliminary Review of Medicaid Issues in Connecticut" (March 31, 1976) recommended passage of H.B. 5364, "An Act Concerning the Generic Substitution of Prescription Drugs." On October 1, 1976 the Act (P.A. 76-166) will take effect and will permit pharmacists to substitute equivalent generic drugs unless directed otherwise by a licensed medical practitioner or by the purchaser. The report estimated yearly savings of nearly \$750,000 for a fully implemented drug substitution law. LPR&IC recommends that the Department of Social Services implement a policy by which it reimburses pharmacists only for the lowest cost generic equivalent so that these savings can be fully realized.

One proposed alternative, designed to reduce the cost of Connecticut's pharmacy program, is to contract with a fiscal intermediary to perform all administrative functions. Such an arrangement should provide computerized bill payment review, utilization review (see Chapter V), on-site pharmacy audits, and provider relations activity. Several corporations have expressed an interest in developing such a program for Connecticut. However, the Department of Social Services has not acted upon any of the proposals submitted to date.

During the last fiscal year, Massachusetts estimated that it reduced its drug program costs by \$5.5 million through a private sector contract. Savings in Connecticut would chiefly result through cost auditing and utilization control. The potential savings for Connecticut's drug program is estimated to be \$1.3 million.

DSS administrative cost (\$.54 per line item for 1.8 million line items)	\$970,000
Estimated private sector administrative cost (\$.33 per line item; 1.8 million line items)	594,000
Savings on administrative costs	<hr/> \$376,000

10% projected savings through utilization and audit controls	900,000
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Total estimated savings	\$1,276,000
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In order to save an estimated \$1.3 million in pharmacy administration under Medicaid through improved efficiency and control, the Legislative Program Review and Investigations Committee recommends that the Department of Social Services solicit formal bids for the private administration of its pharmacy program. The contract should provide for: peer utilization controls, audit and cost controls, computerized profiles, 15-day payment cycles, qualification under MMIS, and a three-month implementation deadline.

Vendor Fraud

At the national level, HEW estimates that provider fraud and abuse are siphoning off up to \$750 million annually. Federal and state efforts to stop Medicaid fraud have been meager, with too few staff or funds to do the job. Until March of 1976, HEW had only one Medicaid fraud investigator for the whole country. State efforts are equally ineffective. Twenty states have never referred a suspected Medicaid vendor fraud case to state or federal agencies for prosecution. Connecticut presently has only six vendor fraud investigations pending (see page 98).

HEW Secretary David Mathews recently announced the staffing of a new Medicaid Fraud and Abuse Unit. Teams of federal auditors and investigators have been sent to Massachusetts and Ohio at the request of their respective governors. Three more states with high Medicaid expenditures will be included in the program within the next nine months.

Penalties. Various penalties exist for providers who fraudulently obtain Medicaid reimbursement. Penalties include state administrative sanctions, federal and state fines, and federal and state imprisonment. Additional non-criminal sanctions may be taken by professional and licensure groups. The Social Security

Amendments of 1972 specifically provided for fines up to \$10,000, or imprisonment for not more than one year, or both for providers convicted of fraudulently obtaining Medicaid payment. The vast majority of vendor fraud cases are prosecuted by local officials according to state law.

The 1975 Connecticut General Assembly expanded the fraud statutes with regard to Title XIX vendors (P.A. 75-558). The revised statute, as interpreted by the Attorney General's office, still did not permit administrative sanctions against providers unless a court conviction had been obtained. However, the Department of Social Services recognized that it had "many cases of overcharges, overutilization, and other devious practices which could not be prosecuted in court..." (Title XIX Task Force Study, page 26).

On June 1, 1976, Governor Grasso signed P.A. 76-242 which empowered the Commissioner of Social Services to suspend a fraudulent vendor under Title XIX. In addition to the criminal penalties of larceny, fraudulent vendors would be subject to suspension from the Medicaid program following an administrative due process hearing. Massachusetts instituted administrative sanctions in 1973 and has since suspended 28 providers, placed six on probation, issued 27 written warnings, and recovered nearly \$350,000. Thirty-three cases are presently under investigation.

Regulations. Public Act 76-242 requires the Commissioner of Social Services to distribute to all Medicaid providers a copy of the rules, regulations, standards, and laws governing the program. To date providers have only received a general policy statement on fraud and a statement of departmental policy relative to each type of vendor service. The Department was also required to adopt regulations regarding administrative sanctions by July 1, 1976. No hearings have yet been scheduled to promulgate such regulations.¹ Such regulations, at a minimum, should:

¹ As noted previously, the Department has repeatedly failed to implement regulations as required by the Uniform Administrative Procedures Act. Not only were regulations on vendor fraud not in effect by July 1, but such regulations were not even drafted as of August 20. The earliest possible implementation date, therefore, will be some six months after the legal effective date.

- (1) specify the manner in which fraud referrals will be made from its Post Payment Audit Group to the Central Collections Division of Finance and Control;
- (2) provide for civil recovery if a criminal conviction cannot be obtained;
- (3) provide for referral to Central Collections of all vendor billings which do not contain a required prior authorization; and
- (4) restrict medical vendors from obtaining a medical provider number individually as well as through a group practice, with limited exceptions.

Finally, the Department has not established a mechanism for notifying professional and licensing agencies of any such violations. It appears that the Department does not have a sufficient commitment to the elimination of provider fraud in the Medicaid program.

Referrals. Social Services averages only three suspected vendor fraud referrals per year to the Central Collections Division of Finance and Control. Central Collection's Special Investigations Unit is responsible for initiating criminal complaints against Title XIX vendors. Presently, six cases of alleged vendor fraud are under investigation. On average, one case of vendor fraud is successfully prosecuted each year. In many instances, DSS has not provided the support necessary to successfully investigate and prosecute a criminal case.

Since Connecticut's system for identifying and referring cases of suspected vendor fraud is so weak that reliable estimates of losses cannot even be made, the Commissioner of Social Services, through the Governor, should request the Secretary of HEW to assign a team of federal auditors and investigators to the Department to determine the extent of vendor fraud in Connecticut. If findings warrant, a vendor fraud and abuse unit should be established in Connecticut.

Nursing homes. Two investigations of alleged nursing home fraud were discontinued by Central Collections because it could not develop the necessary technical evidence

relative to nursing home cost accounting procedures. These nursing homes allegedly misused patient's personal money which is held in trust by the homes. In 1971, HEW found seven Connecticut homes which did not adequately account for funds held by them for their patients. Patient funds were used for "cookouts," and "parties," without authorization and were often kept by the home after a recipient died. Current allegations are that homes may be obtaining bank passbooks for recipients and naming themselves as joint beneficiaries. These problems, which are not addressed by the new nursing home reimbursement system, should be discovered in the Title XIX redetermination process, mandated by federal law (see Chapter III).

A 1976 HEW audit of Connecticut nursing homes identified further areas of possible abuse. HEW found eight homes in a sample of 20 (40%) that had included "improper" prescription drug bills in their rate setting cost reports. Based upon its review, HEW estimated that nursing homes received "\$142,000 for prescription drug costs that were not incurred by Medicaid recipients." DSS Commissioner Maher stated that HEW had "generously" called this procedure "error," yet the Department has taken no action to date to eliminate these practices.

Clinical labs. A potential area of concern for both the Departments of Social Services and Health is clinical laboratories. A recent federal report noted that 30% of all Medicaid payments received by clinical labs studies, were "kicked back" to doctors. If this figure accurately reflects the situation in Connecticut, fraud by clinical labs could reach as high as \$800,000. The kickbacks are often disguised as rental payments for a small room in a physician's office or salaries for a physician's employees. The Director of the Laboratory Division of the State Health Department stated that these practices "may be widespread" in Connecticut. In response, the Committee on Public Health and Safety introduced H.B. 5841 which would prevent unethical arrangements between clinical laboratories and health practitioners. The bill was not enacted during the 1976 legislative session. Given the recognition of widespread abuse on a national level by clinical laboratories, and in order to prevent such abuses from affecting Connecticut's Medicaid program, the Committee recommends the reintroduction and passage of H.B. 5841, An Act Concerning Inducements by Clinical Laboratories.

Time limit on vendor claims. Presently, the Department is reimbursing Medicaid vendors for services provided up to two years ago. This involves a complex procedure by which Departmental personnel must determine the reimbursement rate which was in effect at the time the service was provided. According to state law, legal action against the state for reimbursement of unpaid claims must be initiated within one year from date of service (C.G.S. 4-148). It is therefore recommended that all vendor claims, which, on the date of Departmental entry, cover billings for services provided one year or more from such entry date, shall be summarily rejected unless such provider has petitioned for relief under Chapter 53 of the Connecticut General Statutes.

VII. MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

In previous chapters, the need for controls over eligibility, prices, utilization, and expenditures was discussed. Throughout, the importance of a comprehensive, automated information management system was emphasized. The size, cost, and complexity of the Medicaid program requires such a system for efficient administration.

In response to this need, HEW developed a system to help states improve program administration and contain costs. The Medicaid Management Information System (MMIS) was designed to reduce costs by minimizing processing errors and by facilitating control of misuse and abuse of Medicaid services.

In this chapter, the inadequacies of the existing program management system will be described. In addition, the need for a comprehensive new system for claims processing and utilization review will be discussed, as will Connecticut's progress in designing and developing the new system. The Chapter will conclude with an evaluation of the state's MMIS project.

Existing System

The present system for monitoring utilization of services and processing vendor claims was described in detail in Chapters V and VI. In Chapter V, it was shown that the present system for utilization review involves some prior authorization for medical services, but no comprehensive review of utilization patterns after services are provided. In Chapter VI, it was shown that bill processing and post payment auditing are heavily dependent on manual review and manual resolution of problems. In addition, post payment auditing is limited in scope because of a lack of sufficient computer reports identifying payment errors.

The three major activities the Department of Social Services must perform to administer its Medicaid program are: (1) maintain a record of eligible recipients and providers, (2) validate claims submitted as legitimate and acceptable before being paid, and (3) monitor the program utilization of recipients as well as participation of providers.

Connecticut's present system is outdated in the way it accomplishes these three tasks. The system was developed six years ago when the volume of claims was much lower. The system was not designed with the flexibility required to accommodate the kind of program growth which Connecticut has experienced. It was designed at a time when computer applications were limited, and the computer in use at the time is now obsolete. In addition, it was developed when little emphasis was placed on utilization review. Thus, comprehensive monitoring reports were never developed as a part of the system.

Social Services administrators have known for some time that corrective measures (overtime work for employees and minor computer program modifications) are no longer an effective way to cope with the increased pressures on the existing system.

In 1975, a committee was formed in the Department of Social Services to evaluate the effectiveness of the Department's operating system. The committee identified substantial weaknesses in claims processing, eligibility data storage, and utilization review reporting.

In processing bills, too many manual steps are required from receipt of the vendor claim to final payment. Many manual computations are performed which should be machine processed. In addition, the procedure for handling problem claims is too cumbersome.

Too many manual steps are also required to store eligibility data in the computer. In some cases, the same information is stored in more than one computer file. The procedures for storing, updating, or checking eligibility information is time consuming and inefficient.

The Department's Evaluation Committee found that, in the area of utilization review, many needed reports are simply not available. Those reports which are available are inadequate or are not suited for their intended use. The capacity to generate reports is not sufficiently flexible to meet changing needs for information, nor to respond to increasing management demands.

Based on its findings, the committee recommended a major overhaul and modernization of the Department's computer capability and operating systems. With the

support of the Commissioner, the committee became a task force to plan for development of a new system--the MMIS.

The MMIS Project in Connecticut

The federal government has developed a Medicaid Management Information System capable of efficient claims processing and utilization review. The federal MMIS is a model system, originally developed in Ohio. Its logic and design is the standard HEW uses in approving all new systems.

The federal model consists of six major integrated subsystems which accomplish Medicaid claims processing and report generation. The six subsystems are:

- (1) Provider Subsystem-maintains a data file of certified health care providers;
- (2) Recipient Subsystem-maintains a file of eligible Medicaid recipients;
- (3) Reference File Subsystem-maintains a claims processing reference file, e.g., drug price list, physician fee schedule, and listing of covered services;
- (4) Claims Processing Subsystem-verifies the eligibility of the recipient to receive the services and the provider to perform the service, as well as validate the claim for price, procedure, and duplication;
- (5) Surveillance and Utilization Review Subsystem-generates statistical profiles of recipient utilization and provider participation in the program; and
- (6) Management and Administrative Reporting Subsystem-generates summary reports of overall program use for management planning and evaluation.

As an incentive for states to develop an MMIS, federal financial support is available for 90% of the cost of design, development, and installation of an approved system. Federal support is also available for

75% of operating costs. To qualify for the 90% federal reimbursement, states must meet several conditions. The state system must be compatible and integrated with Title XVIII (Medicare) and must provide for crossover claims for persons eligible for both Medicare and Medicaid. It must support the data requirements of the Professional Standards Review Organizations (PSROs). In addition, the system must be operated for sufficient time to justify federal investment, and the state must retain ownership rights to the system (programs and documentation) and permit unlimited access by HEW or its designees. The system must be likely to provide more efficient, economical, and effective Medicaid administration than the existing system and the state must have a method to identify those costs reimbursable under the federal match.

In addition to the 90% federal reimbursements for development and implementation costs for an MMIS, the federal government offers an incentive for its effective use. In Connecticut, for example, data processing, together with other administrative costs, are reimbursed at the rate of 50%. The federal government will increase the reimbursement for MMIS operating costs (including personnel) to 75% if the following conditions are met:

- (1) all requirements listed for the 90% reimbursement must be satisfied;
- (2) the complete system with all its components must be operating on a continuous basis for the period the increased (75%) match is claimed;
- (3) the system must generate patient and provider profiles for utilization review and program management purposes; and
- (4) the system must provide a written statement ("Explanation of Benefits") to the recipient within 45 days of payment for services. This statement must include the provider's name, services performed and dates of service. (The expectation here is that providers will be less likely to bill for services which were not performed if the patient receives a copy of the statement).

In September, 1975, DSS submitted its plan for an MMIS to HEW. Connecticut proposed to expand its present system to include new components, rather than to scrap the present system and transfer in a complete MMIS developed in another state. After assessing other state systems available for transfer, the Department decided the existing system was more suited to Connecticut's needs and could be upgraded into a comprehensive MMIS. In its plan, Connecticut also chose to develop its MMIS using in-house staff rather than contracting with a third party to develop the system.

To implement its plan and satisfy federal requirements, the Department must submit to HEW a detailed work plan. This plan must identify the major project tasks, responsibility for task accomplishment, manpower requirements for each task, and a schedule for project completion. The MMIS project staff is currently developing the detailed plan, scheduled for submittal to HEW in October.

After approval of the detailed plan, the Department must turn its MMIS plan into action. This will require coordinating of "users" (in-house staff, medical service providers, and other state and federal agencies), analyzing Department administrative structure for modification, and writing computer programs for the new system.

The Department estimates that the project will take two years to complete after acquisition of project development staff. Table VII-1 shows that 15 staff persons were scheduled to be hired by July, 1976 and ten more by July, 1977. Because the staff, scheduled for hire in July, 1976 are not expected to be working before September, three months after originally scheduled, the earliest completion date for the project is September, 1978.

Cost. The development cost of Connecticut's MMIS project primarily includes personnel and support expenditures (computer test time and supplies). Personnel costs are based on the estimated personnel requirements as submitted in the approved plan. As shown in Table VII-2, personnel costs are expected to reach \$1.2 million and support expenditures are expected to exceed \$250,000. Thus, the project is projected to cost a total of almost \$1.5 million. Because some portions of the state's MMIS are not reimbursable at the full 90% rate, an estimated 75-80%, or over \$1 million of this cost will be paid by HEW.

Table VII-1. Full-time MMIS development personnel and estimated date of assignment to the project.

	Presently Assigned	July 1976	Jan. 1977	July 1977	Total
<u>Project Administration</u>					
Project Coordinator	1				1
Clerktypist		1			1
<u>Program Personnel</u>					
Public Assistance					
Consultant		2			2
Medical Social Work Consultant		2			2
<u>Data Processing</u>					
EDP Project					
Leader	1				1
Systems Analysts	5	5			10
Computer Programmers		5	5	5	15
Cumulative Total	<u>7</u>	<u>22</u>	<u>27</u>	<u>32</u>	<u>32</u>

Source: Approved Advance Planning Document, May 1976.

Table VII-2. Projected development cost of Connecticut's MMIS, Fiscal Years 1977 and 1978.

<u>Personnel</u>		
Project Administration		\$ 89,548
Data Processing		\$ 936,350
Program		\$ 170,800
	Personnel Subtotal	<u>\$1,196,698</u>
<u>Support</u>		
Computer Testing		\$ 175,350
Miscellaneous		\$ 90,000
	Support Subtotal	<u>\$ 265,350</u>
Total Projected Cost of MMIS Development		\$1,462,048

Source: Approved Advance Planning Document, May 1976.

Savings. HEW officials estimate that as much as 4% of Medicaid expenditures (which would amount to \$8 million per year in Connecticut) can be saved in any state by MMIS. These savings can be captured by collecting from third party insurers, controlling utilization, and deterring fraud. However, DSS analysts estimated that Connecticut's savings will total only about \$9 million over the first three years of MMIS operation. This estimate was based on the experience of other states which have an MMIS and the capability of the Department's present staff to recover those savings. Unless post payment staffing is improved (see recommendation, page 91) Connecticut cannot expect to realize full MMIS savings potential.

Evaluation

Successful development and implementation of the MMIS project will require procurement of adequate and sufficient personnel to staff and manage the project, if project tasks are to be completed on schedule. The value of MMIS to the state, in terms of containing program costs, will depend on how the system is used after it becomes operational.

Progress. From the beginning, the progress of Connecticut's MMIS project has been slow and behind schedule. Progress has been impeded by delays in getting necessary federal approvals and project personnel. Although some problems were unanticipated and outside the control of the Department, other problems could have been avoided.

The Department lacked familiarity with the MMIS grant procedures, yet has failed to cooperate and work closely with federal officials. As a result, federal approval of Connecticut's advanced plan was held up and employment of personnel was unnecessarily delayed. Despite repeated prodding by LPR&IC staff, only recently has the Department improved its working relationship with federal officials. Due to continuing problems of cooperation, delays in obtaining approval of the detailed plan appear virtually certain.

Personnel and management. State personnel procedures for hiring staff have also contributed to project delays. While this problem is beyond the Department's control, other personnel problems are not.

HEW officials specified prior to submittal of Connecticut's plan in May, that four Social Services Program Specialists must be assigned full-time to the project, in addition to the data processing staff. The Program Specialists are needed to help coordinate the data processing unit with agency operating units, including eligibility services, income maintenance, and medical services. Although qualified specialists are available in the Department, no one had been assigned to any of the four required positions as of August 15, 1976.

Participation of the operating units in the MMIS project thus far has been inadequate and insufficient. The Medical Services director or his representative, for example, has only attended one of the five MMIS development committee meetings. Other agency operating units have expressed enthusiasm toward the project, but their involvement has been hampered by poor project leadership.

The LPR&IC identified a problem with project leadership and direction in its preliminary report on Medicaid issued in March. HEW officials also recognizing this weakness, demanded, prior to approval of Connecticut's plan, that the Commissioner of DSS appoint a director to oversee the MMIS project. The Commissioner selected the Department's Chief of the Bureau of Business Administration to serve in this capacity. Although the director may be capable of providing project oversight, he lacks the time, expertise, and specific background required to successfully direct the project. Because the project continues to lack adequate leadership and direction, it is recommended that DSS recruit a full-time director from outside the Department to assume responsibility for the MMIS project. With the assistance and support of HEW, a director with MMIS experience can be hired for the duration of the project. A competent, full-time director could improve overall management and control of the project. The likelihood of timely project success should increase as a result.

Development analysts have improved the progress of the project by diverting the "technical" aspects (computer hardware acquisition and technical support) to the Department of Finance and Control's central data center, but they don't appear to be making maximum use of other available resources.

Finance and Control's Division of Management and Budgeting has provided the Department of Social Services with management consulting assistance in the past. To help improve the administration of Connecticut's MMIS project, the LPR&IC recommends that the Department of Social Services seek the assistance of the Management Section of the Department of Finance and Control.

Because of the magnitude of the MMIS project (there are over 100 major tasks), project development staff have requested that the Department of Finance and Control's Central Data Processing Services provide a project management system to help schedule, control, and monitor MMIS progress. Because of the complexity of this important project and the need for continuous surveillance, the LPR&IC recommends that the Department of Finance and Control provide a project management system for MMIS.

This system will aid project managers in recognizing and avoiding unnecessary delays before they occur. In addition, the system will provide information required for HEW monitoring and legislative oversight.

Although the MMIS is intended to reduce personnel requirements, it is not clear how Connecticut's system will affect the Department of Social Services. It is therefore recommended that the Department of Social Services include, as part of the organizational analysis required for MMIS implementation, a Personnel Resource Impact Statement.

The statement should focus on those operating units which will be "users" of the new system as well as the EDP support personnel required to maintain it. The statement should identify those operating units which must be expanded to accommodate the operations of the new system, as well as those which can be reduced. In those which will have increased staff, job descriptions and classifications should be prepared to facilitate the transition from the old system to the new.

The entire MMIS development staff will not be required for the operation and maintenance of the system once it becomes fully operational. The Social Service's budget line item which provides the appropriations for this staff specifies they be used for MMIS implementation. If the Department of Social Services intends to retain this

staff, whose salaries exceed \$1/4 million yearly, it must justify that intent. If it intends to use "excess" personnel to further the development of its other data processing systems, the statement should specify what that effort will be. It should include a feasibility study of those improvements that the Department can initiate, based on the benefit which the Department would realize as well as the cost of implementation.

Connecticut is a late comer among states implementing an MMIS. It can turn this into an advantage if it capitalizes on the mistakes of its predecessors. One prominent example which seems universal among those states which have implemented Medicaid Management Information Systems is the ineffective use of the surveillance and utilization reports produced by the system.

In citing the inadequacy of its 25 member fiscal review staff, Ohio's welfare director said, "Using our central computers, we can identify potential abuse. But to prove it, we need competent field investigators to make on site inspection of books."¹ Michigan has taken a more aggressive approach which has paid off. They created a Fraud and Abuse Unit which reportedly saves \$6 in Medicaid program funds for every dollar spent.

It appears that Connecticut's post payment review staff as presently organized could not take full advantage of the "tools" that MMIS provides. Left unchanged, the savings to be realized from implementation of MMIS would probably be limited to the \$9 million for the first three years projected in the Advanced Planning Document.

The recommendation to seek consultation from the HEW Fraud and Abuse Unit (Chapter VI) would provide an opportunity for Connecticut to develop an effective Medicaid Fraud and Abuse Unit. This would improve the probability of maximizing the potential savings from the Medicaid Management Information System.

¹ State Government News, Vol. 19, No. 4, April, 1976.

VIII. INSTITUTIONAL LONG-TERM CARE

As noted throughout this report, long-term¹ care is the single most expensive item in Connecticut's Medicaid budget, accounting for 53% of expenditures or nearly \$100 million in FY 1976. While nursing home care is a major expense in every state's Medicaid budget and cost containment in this area is a national concern, it is of special importance in Connecticut. Connecticut spends a substantially higher percentage of its Medicaid budget for institutional long-term care (nursing homes) than other states, and over 90% of these funds are spent on expensive skilled nursing care (see Figure II-1, p. 11). This is not due to an unusually high long-term care or elderly population in the state. The Department of Social Services estimates the state's Medicaid long-term care population to be about 15% of total Title XIX eligibles, compared with about 20% for the nation as a whole.

Connecticut's nursing home problem is primarily due to a critical shortage of less intensive, less expensive intermediate care facilities, which results in inappropriate patient placement. The old reimbursement system for nursing homes (see Chapter IV) based rates on services provided, but did not take into account the need for or cost of such services. For an average of \$1 more per patient day in costs, an ICF could become a SNF and receive an average of \$10 more per patient day in Medicaid reimbursement. Consequently, by 1975, 95% of the nursing home beds in Connecticut were classified as A-1 SNF's receiving the highest reimbursement rate.

Since the physical plant standards are virtually the same in ICFs as in SNFs, no major construction or building modifications are necessary to convert to lower levels of care. The principal difference between ICFs and SNFs is in staffing, and if the widely publicized shortage of health care professionals exists, a redistribution of excess nursing home personnel should not involve any serious dislocations.

¹ "Long-term" refers to the chronic or convalescent patient who requires extended medical care or supervision. Generally, an institutional stay averaging over thirty days at a level less intensive than an (acute) hospital is involved.

The Program Review and Investigations Committee noted in its Preliminary Report in March that the federal government had announced its intent to cease reimbursing states for SNF care of patients requiring less intensive care, effective July 1, 1976. Estimates of inappropriate placement range from 20-50% of the current SNF population. Using a conservative 20%, the Committee estimated that \$6 million could be saved by reducing reimbursement to coincide with patients' needs. The \$6 million was subsequently deleted from the DSS appropriation for FY 1977. Faced with a known oversupply of SNF beds in Connecticut, home owners could either accept the ICF reimbursement rate for its reclassified patients or allow the patient to be transferred out, and gamble on vacancies.

It is recommended that the Department of Social Services establish a policy that skilled nursing facilities caring for reclassified (ICF) Medicaid patients either accept ICF reimbursement or if the ICF rate is rejected the patient will be transferred to a facility that will accept ICF reimbursement. With almost 70% of nursing home beds in Connecticut now occupied by Medicaid recipients and possible federal fiscal sanctions against inappropriately placed patients, the state has a major interest in seeing appropriate levels of institutional long-term care developed. The problems of facility classification and appropriate patient placement are analyzed in more detail below.

Institutional Providers of Long-Term Care

Several types of facilities are licensed to provide long-term care in Connecticut, but only those providing certain medical services are eligible to participate in the Medicaid program. Medicaid participation, which is voluntary, requires that a facility be licensed by the state and certified as a provider. The Department of Health is responsible for licensing (assuring minimum Public Health Code physical plant, staffing and other standards are met), inspecting (assuring that the standards continue to be met) and is under DSS contract to perform Medicaid certification surveys (assure that federal participation conditions are met). In Connecticut, Medicaid reimbursable long-term care is provided by two basic types of facilities: nursing homes (chronic and convalescent nursing homes and rest homes with nursing supervision) and chronic disease hospitals.

Nursing homes. Chronic and convalescent nursing homes are required by the Public Health Code to provide twenty-four hour skilled nursing care, dietary services, recreational activities and to meet strict physical plant standards. Arrangement for provision of medically-related

social services, rehabilitative (physical therapy, occupational therapy, etc.), laboratory and dental services, in addition to the above requirements, is mandated for Medicaid certification. The federal designation for homes meeting these requirements is "skilled nursing facility" (SNF). The level of care provided in a SNF is closest to inpatient hospital care.

Rest homes with nursing supervision must meet convalescent nursing home physical plant standards with a few minor exceptions. Twenty-four hour nursing supervision (as opposed to skilled nursing care) is necessary for licensure as are dietary services and recreational activities. Arrangement for rehabilitative and social services are additionally required for Medicaid certification. The federal designation for a home meeting these requirements is an "intermediate care facility" (ICF). Medicaid did not cover ICF's until 1971 although federal subsidization of intermediate care began in 1967 through direct payments to adult categorical recipients. In general, patients in ICF's are not well enough for "independent" living but do not need around-the-clock skilled nursing care.

The following table shows the distribution of beds and Medicaid patients in Connecticut nursing homes.

Table VIII-1. Number of beds and Medicaid patients by type of facility, 1976.

Type of Facility	Licensed Facilities	Medicaid Certified Facilities	Licensed Beds	Estimated Medicaid Patients
Chronic and Convalescent Nursing Homes (SNF)	215	204	20,123	11,000
Rest Homes with Nursing Supervision (ICF)	<u>63</u>	<u>56</u>	<u>3,141</u>	<u>2,000</u>
Total	278	260	23,264	13,000

Sources: Department of Health, Hospital and Medical Care Division and Department of Social Services, Medical Services Division.

As the table shows, the majority (almost 90%) of nursing home beds continue to be licensed at the SNF level of care although recently there has been some noticeable growth in the number of ICF beds. Without at least doubling the number of ICF beds in the state, transfer of the two to five thousand inappropriately-placed SNF patients will be impossible. More will be said about this in a later section.

Chronic disease hospitals. In addition to nursing homes, the Department of Social Services includes in its convalescent (long-term care) category, patients in chronic disease hospitals. These facilities provide 24-hour nursing care and complete medical services (including diagnosis and therapy) to a wide range of chronic disease (tuberculosis, cancer, arthritis, etc.) patients. In addition, the Public Health Code also requires that clinical laboratory and radiological services be available in the hospital and arrangements for surgical and pathological services be made. The chronic disease hospital falls in between an acute general hospital and a SNF. Placement of long-term patients is usually predicated on the availability of certain uncommon (and expensive) medical equipment or technology not provided in a SNF such as an iron lung or radiation therapy.

The "chronic" Medicaid population, although small (estimated to be 275 patients), involved payments of over \$3 million (state and federal contributions) in FY 1975. Three private chronic disease hospitals and three SNF's with chronic disease wings currently receive Medicaid payments.

Table VIII-2. Medicaid long-term care average cost per case per month by type of facility, FY 1975-77.

<u>Facility</u>	<u>Actual FY75</u>	<u>Estimated FY76</u>	<u>Estimated FY77</u>
Chronic and Convalescent Home (SNF)	\$ 572.60/mo	\$ 618.92/mo	\$ 656.43/mo
Rest Home With Nursing Supervision (ICF)	324.39	350.65	371.93
Chronic Disease Hospital	1,361.51	1,470.67	1,559.09

Source: Department of Social Services Budget Planning Document for FY 1976-77.

Costs. Table III-2 (above) presents average monthly costs per convalescent case for each level of care. ICF care costs average 40% less than SNF costs. The potential cost-savings of transferring inappropriately placed SNF patients to an ICF care are conservatively estimated at \$7 million for FY 1977.

While these estimates are based on current rates, it is likely that ICF rates will increase. The new, more stringent federal regulations for SNF care described on page 119 require patients to be reclassified to ICF care sooner. In some cases, therefore, patients may be at an earlier stage of illness than present ICF patients and may require more care, thus raising ICF costs and rates. Even now, some ICF rates are higher than some SNF rates. Present SNF rates range from approximately \$500 to \$900 per month. ICF rates range from about \$300 to almost \$700 per month. Even if the savings do not reach \$7 million, however, they will be substantial.

The Medicaid Convalescent Population

"Convalescent cases," caseload and expenditure figures for Medicaid patients in long-term care facilities, appear in the table below:

Table VIII-3. Medicaid long-term care (SNF, ICF, Chronic Disease Hospital) caseload and expenditures, FY 1975-77.

	<u>Actual 1975</u>	<u>Estimated 1976</u>	<u>Estimated 1977</u>
Total caseload	12,511	13,011	14,190
Total expenditures	\$81,790,975	\$93,406,000	\$107,599,804

Source: Department of Social Services Budget Planning Document, FY 1977.

The Department of Social Services collects a great deal of information about its convalescent cases as individuals, but has not analyzed this data to determine general characteristics and trends needed for planning purposes. National studies show that the average age of the Medicaid convalescent caseload is between 80 and 85 years and the average length of stay in a long-term care facility is between two and three years. The major reasons for institutionalization are fairly evenly divided between physical impairments (recovery from fractures, heart attacks, cataract surgery) and mental impairments (retardation, "confusion," senility). Most convalescent patients, because of their age, suffer from multiple chronic or crippling disabilities (e.g., a combination of arthritis, a bone fracture and a heart condition), and many are mentally impaired as well. This is a fact which complicates placement and recovery.

Medicaid vs. non-Medicaid patients. Little else is known about the Medicaid convalescent population, especially how they compare with non-Medicaid patients. A recent master's thesis prepared by Edith Baum, a Yale University graduate student, compared skilled nursing home patients in the greater Bridgeport area to determine differences between Medicaid and private or Medicare patients. Ms. Baum found that Medicaid patients entered skilled nursing facilities at an earlier stage of illness and had significantly longer lengths of stay than non-Medicaid patients. She claims that this occurs not for medical reasons, but primarily as a result of Medicaid reimbursement mechanisms and the lack of alternative types of care in this state. Ms. Baum also found that non-Medicaid patients are more likely to return home upon improvement. Few Medicaid patients ever return home because, according to Ms. Baum, they have no family (a much higher percentage of Medicaid patients were widowed or lived alone prior to admission) or had liquidated assets (home, savings) to become Medicaid eligible. With lower level care unavailable and return home impossible, Medicaid patients tend to stay at the SNF level despite improvement in condition.

Ms. Baum's findings, while useful and interesting, are based on a relatively small sample of patients (440) confined to one area of the state. Her report does identify and document problems that should be more thoroughly investigated. A federally-funded study to analyze and test Ms. Baum's findings statewide will be

conducted by Dr. John Thompson of Yale with the cooperation of the Departments of Health and Social Services.

The Legislative Program Review and Investigations Committee fully supports participation in this study by the Departments of Social Services and Health. Whatever the findings, this second study, should result in a better understanding of Medicaid nursing home patients in Connecticut, a necessary first step in planning and providing appropriate care. In addition, the Committee recommends that as staff time becomes available, individual convalescent patient information be analyzed to determine general population characteristics. It is conceivable that when MMIS is implemented, this task could be handled by computer. Generation of such information through MMIS would not only monitor utilization but also aid in DSS budgeting (expenditures could be better anticipated) and long-term care resource planning (need for different types of care could be better anticipated).

Currently, patient and provider information is not easily available from a central source. Ideally, patient information including personal descriptions, diagnosis and care needs, and provider information such as facility type, bed capacity, services offered, and occupancy rate should be collected in one place to facilitate appropriate placement. It will be some time before systematic patient assessment is feasible statewide. By building Medicaid convalescent patient and provider profile capabilities into MMIS, a long-term care information base for future development could be established.

Utilization Review of Convalescent Patients

Utilization review is the mechanism for reclassification and transfer of Medicaid nursing home patients as mandated by federal regulations. States that cannot demonstrate effective utilization review in the area of long-term care may soon be penalized with reduced federal Medicaid contributions. A Medicaid patient must now meet the more restrictive Medicare criteria for SNF placement although Medicare's three day prior-hospitalization requirement for eligibility does not apply to Medicaid patients. Medicaid skilled care eligibility is now dependent (like Medicare) on the rehabilitative potential of the patient. SNF Medicaid coverage continues only as

long as skilled care is required to produce improvement or prevent deterioration in the patient's condition.

Federal criteria for intermediate care (ICF) are more general. ICF's provide health care and services to individuals whose mental or physical condition necessitates institutional care beyond room and board, but less than skilled nursing. Most transfers from this level of care would occur when a patient's condition becomes serious enough to require hospitalization or skilled nursing care, or, less frequently, improves enough that medical services are not required on a regular basis.

Appropriateness of care for convalescent cases is periodically reviewed by two federally mandated groups-- Utilization Review Committees (URC's) and Patient Review Teams (PRT's).

Utilization Review Committees (URC's).¹ In Connecticut, any SNF participating in the Medicaid program must have in effect a method, approved by the Health Department, to review the need for services provided to Medicaid patients, including a facility-based peer review group known as a Utilization Review Committee (URC). DSS staff perform the URC function for ICF Medicaid patients. The URC is composed of physicians (at least two for a SNF and one for an ICF) and appropriate allied health professionals (nurse, therapist, dietician, pharmacist). The URC must review each SNF Medicaid patient at least four times a year, and each ICF patient twice a year. If a URC finds that a patient does not require the level of care or intensity of services being provided, the attending physician is consulted. After discussion, if the URC still believes current placement is inappropriate, a recommendation for transfer is made and the facility, attending physician and Department of Social Services are notified.

¹ Three types of URC's are permitted under federal requirements: (1) the single state agency (DSS) may assign staff to perform URC functions, (2) the URC may be facility-based, or (3) a local, independent group such as a medical association may be contracted to do utilization reviews.

All records and meeting minutes of the facility-based URC are kept at the SNF for review by the Health Department during its licensing and certification inspections. If health inspectors find the plan is not being met, deficiencies and follow up action are reported to the Department of Social Services Patient Review Team Coordinator. The Patient Review Teams also do an audit of sorts of the URC activities at the time of their inspections.

The effectiveness of the URC in controlling inappropriate utilization of nursing home services depends on the members and the facilities. To avoid conflict of interest, URC members must not do reviews of their own patients and cannot be employed by or have a financial interest in any nursing home. There is currently no effective way to prevent collusion between a Utilization Review Committee and a SNF despite monitoring by Health and the DSS Patient Review Teams. It is expected, however, that as PSRO's become more active in long-term care, URC's will be more strictly supervised and their usefulness as a control of overutilization will be strengthened.

DSS Patient Review Team (PRT). In addition to the Utilization Review Committees, the federal government mandates single state agencies to hire or contract for annual medical review of all Title XIX nursing home patients at least annually. These Patient Review Teams (PRT's) must be physician-supervised units, composed of appropriate health and social service professionals. Their charge is to evaluate the quality, adequacy and necessity of care and services provided to Medicaid patients in long-term care facilities. Connecticut has under contract, five SNF and two ICF Patient Review Teams, assigned to geographic areas, and based in the district offices. The teams are supervised by a coordinator in the DSS central office. The PRT's visit each home at least once a year to review the medical and social service records (physician and nurse's notes, care plans, medication records) of all Title XIX patients in the facility at that time, observe the patients, interview facility staff and review URC records. The facility is requested, about a month before the visit, to prepare certain patient information and have the staff available for interviews. Facilities cannot be given more than 48-hour notice of the actual time of visit.

At the end of the visit, the team meets with administrator and staff directors to discuss findings and recommendations. These are put into writing and sent to

the facility, the URC chairman and the State Health Department. The evaluations are kept on file in the PRT's district office and in the master file at the DSS central office.

If the PRT has identified patients needing transfer, the attending physician is contacted and given an opportunity to agree or disagree. If he disagrees, the attending physician must substantiate his opinion in writing to the PRT. If the PRT continues to support their original recommendation a second PRT opinion is sought to decide if transfer is appropriate. The patient is also allowed to appeal a PRT recommendation. If transfer is agreed upon by the second PRT or the physician initially agrees, the district office is notified to expedite transfer. When this review began (1972), many transfers resulted. The trend leveled off over time; however, recent changes in definitions of needed level of care have produced a new surge of recommended transfers. The PRT's have been very effective in their reviews of adequacy and appropriateness of care. While statistics are not available, few PRT transfer decisions are reversed either by attending physicians or second PRT review. Most problems the PRT's face come from the vague or changing definitions of levels of care and conflicts between the federal and state regulations. The Department's PRT coordinator felt that these problems would soon be eased as definitions are now in the process of being clarified and coordinated.

PRT recommendations other than transfer, have centered on improved documentation of patient care given at the facility. The PRT works to see that all its recommendations are implemented and estimated about 90% compliance.

Training for PRT's is a significant problem. New members are needed in the field as soon as they are hired, so most training occurs on the job under the supervision of more experienced team members. Although members are health professionals and most have prior experience in geriatrics, the complexities of the Medicaid program take time to understand. Staff meetings are now held on a quarterly basis, but this appears insufficient. While the part-time nature of the PRT job (most members work about 15 hours per week) makes more frequent meetings difficult, the Department should improve its efforts to keep all PRT members informed of policy changes.

Part of the training problem is due to the increased workload of the PRT's. Numbers of patients and reclassifications are increasing and demand more staff time. Review by the PRT is one of the few opportunities the Department has for field visit of the patient and the facility for cost and quality control purposes. It is important that this function be adequately staffed with well-trained personnel. The Committee recommends that the Department of Social Services determine what additional staff and training are necessary to properly carry out PRT responsibilities.

Transferring reclassified patients. When a URC or PRT determines a Medicaid patient should be transferred, and notifies the Department of Social Services, the appropriate district office social service worker is contacted. The worker, with the approval of the client's physician, will discuss transfer plans with the client and his family or interested party. If the family or interested party requests assistance in finding more appropriate placement, or no one else is available to do so, the worker will then make the necessary arrangements.

Federal regulations require that transfer from a SNF to a less-costly facility be made within 30 days following reclassification by a URC or PRT. A facility willing to keep a reclassified Medicaid patient at the new reimbursement rate (e.g., a SNF may decide to keep a patient at an ICF rate to insure bed occupancy) must receive DSS approval.

Transfer of skilled nursing patients to more appropriate (lower) levels of care has been hindered by the short supply of intermediate care beds. DSS has met with Health Department staff to find a solution to this problem. Reclassification of some skilled level facilities to ICF's is being considered, but will require changes in some state regulations (discussed later in this Chapter) and the cooperation of the industry. DSS reports that once a solution is found, transfers will be made as expeditiously as possible. The federal government, recognizing compliance efforts, will not reduce Medicaid contributions while progress is being made.

Planning Long-Term Care for Medicaid Patients

Reclassifying patients according to actual care needs and correcting Connecticut's imbalance of long-term care resources will bring the state into compliance with federal

regulations and produce cost-savings. Also important, is better planning for initial long-term care placement. The high costs of inappropriate placement and the adverse effect premature or improper institutionalization has on elderly patients have focused attention on this problem.

Hospital discharge planning for Medicaid patients is required by HEW, but has yet to be defined in regulations. Currently, the responsibility for most long-term care planning rests almost entirely on the Medicaid patient's attending physician. The Department of Social Services merely approves (or denies) the physician's recommended level of care (prior authorization of any long-term care placement is required) through a desk review at the central office.

The DSS Medical Review Team (see Chapter V) receives a medical information form completed by the attending physician with his recommendation for placement and a district office worker's patient (social) evaluation form. Based on these capsulized reports, the MRT decides if the recommended placement is appropriate. It is seldom that the MRT disagrees with the attending physician's decision, but if this happens, further substantiation of the doctor's recommendation is requested. If the MRT still disagrees, the district office social worker is contacted to consult with the attending physician, the patient's family (if any), and arrange for a more acceptable placement.

DSS involvement with a convalescent case is minimal. At one time workers were assigned to all general hospitals to help identify Medicaid patients, assist with forms and plan long-term care. District offices had specialized convalescent caseworkers available to serve elderly clients. DSS staff feels that convalescent clients received better service and cases were more accountable under the old system than under the present one.

Adult service workers. Now, the district offices have thirty-seven adult service workers available for all adult cases. Only thirteen work specifically with institutionalized clients. These workers, if aware of a hospitalized client, can assist in preparing a sound discharge plan. Often a family or hospital staff person will notify the adult service worker of the need to make long-term care arrangements for a client. Availability of needed services

however, especially discharge planning assistance, is restricted by the small number of adult service staff. There is also no way, because of staff shortages, for the district office to identify and plan appropriate care for potential Medicaid clients--those institutionalized elderly about to exhaust all assets. Increased adult service staff are necessary for more effective post-hospital care planning and follow-up on convalescent cases. It is especially important that social services be made more available to elderly clients since most have no family or friends to rely on.

Most general hospitals have "continuing care coordinators and social workers on their staffs. These professionals are helpful in planning post-hospital care for all hospitalized patients, but may not have an understanding of the complexities of the Medicaid program. The DSS adult service worker, with knowledge of the program and the client, could work with hospital staff and assist in planning appropriate care. Hospital continuing care staff could also be of use in identifying potential Medicaid clients and then notifying the district office. These discharge planning efforts and increased cooperation should be encouraged.

The Department has long recognized the need for appropriate and timely placement of Medicaid long-term care patients. Information is being requested from HEW concerning development of a centrally-located department "discharge and referral unit." The Committee supports this concept which would complement the MRT function and be a resource for adult service workers. Development of the unit as soon as HEW approval is received is urged.

In addition, the Committee recommends that the Department of Social Services increase the number of adult service workers to provide more services to long-term care clients and more effective long-term care planning. It is also recommended that social service workers handling elderly clients receive training to familiarize them with the special problems of the elderly and available long-term care resources. This training should involve contact with area health planning agencies, Visiting Nurse Associations, hospital continuing care coordinators, the State Department on Aging and other existing groups and individuals with expertise in health care planning for the elderly.

The State Public Health Code

Federal requirements for Medicaid provider certification are almost completely compatible with the state requirements for licensure of nursing homes as outlined in Connecticut's Public Health Code. One state regulation, however, has interfered with ICF placement and compliance with new federal regulations. The Code prohibits ICF admission of any person "physically or mentally incapable of making his own way without assistance to a place of safety outside the building." Federal standards allow non-ambulatory patients to be placed in ICF's which, to be certified, must be fire-safe and accessible to the handicapped. Since Connecticut's present physical plant standards for ICF's are for all practical purposes identical to SNF standards, the outdated ambulatory requirement, has become unnecessary and prohibits placement in accordance with federal criteria.

DSS and the Health Department, as part of the plan to facilitate transfer of ineligible SNF patients, are proposing a new state ICF classification that will care for non-ambulatory and "confused" convalescent patients, making a total of three levels of long-term care. The Committee supports this proposal and recommends that the Public Health Code be amended to allow two classifications of intermediate care facilities with one (new) caring for non-ambulatory intermediate care patients and one continuing to accept only ambulatory patients.

The Code revision recommended above should be implemented as soon as possible. In addition, the entire long-term care section of the Code should be reviewed. The Code has not been revised since the 1950's. While generally high standards for institutional care are assured, recent trends in long-term care and changes in the long-term care population are not reflected in the Code regulations. Facilities are currently classified for licensure according to structural and staffing standards rather than the level of care to be provided in the facility. The role of the chronic disease hospital in the continuum of long-term, for example care needs to be examined and clarified.

The Public Health Code classifications for long-term care facilities should be based on level of care provided, be related to patient needs, and allow for flexibility. The Code needs to be completely reviewed and updated to promote development of a continuum of long-term care and

compliance with federal regulations. The Committee recommends that the Public Health Council, the body responsible for revising the Public Health Code, determine (1) if existing facilities can meet the newly-defined patient needs, (2) if regulations that require a large dollar investment are unnecessary for provision of acceptable care, (3) what changes are necessary, and (4) if an alternative classification system is more desirable.

A great deal of information related to these areas has been collected by various state agencies, research groups and the nursing home industry. The Governor's Blue Ribbon Committee to Investigate the Nursing Home Industry in Connecticut is presently studying the Public Health Code to make recommendations for Code revisions that will result in coordinated state and federal standards for appropriate levels and quality of care. Their efforts and recommendations, expected to be released later this year, should be very useful to the Council in its Code revision task.

It is also recommended that an annual review of the state Public Health Code be statutorily mandated to assure its continued relevancy. Connecticut General Statutes, Section 19-13, states that "the Public Health Council shall establish a public health code and from time to time (emphasis added) amend the same." Amendment of the Code has been sporadic and piecemeal resulting in outdated and sometimes conflicting regulations for long-term care. Mandatory annual review should bring about more timely revisions.

Quality of care. The recommendation has been made to revise the Public Health Code and establish a new classification system for long-term care providers. The individuals responsible for revision must balance factors of quality and cost. Minimum standards for physical plant, staff, and services established during the revision will determine the costs of providing that level of care and ultimately the quality of care provided.

Admittedly, quality of care is a difficult issue. This Committee is not in a position to recommend quality of care standards for long-term care providers although it is felt recommendations to improve planning and placement procedures will result in better services to patients. The Governor's Blue Ribbon Committee to Investigate the Nursing Home Industry in Connecticut has assigned responsibility for examining the relation of facility standards to quality of care to one of its subcommittees. Experts in the area

of long-term care have been interviewed, hearings have been held and extensive research has been conducted over many months to determine what standards are important to insure quality of care. Findings of this subcommittee will appear in the full Committee's report expected to be released later this year.

It is recommended that the findings and suggestions concerning standards to insure quality of care contained in the Blue Ribbon Committee report be given full consideration by the Public Health Council during revision of the Public Health Code.

Another issue to consider during Code revision is enforcement of quality standards, which alone do not insure quality. The Health Departments Hospital Inspectors and Consultant's (HIC's) are responsible for enforcing, through field visits and follow-up action state and federal minimum standards. There are some doubts that because of added duties and HIC staff shortages, this function cannot be adequately fulfilled. Although the federal government finances about 80% of the HIC costs and additional federal funding may be sought, the state should examine the adequacy of its own financial commitment to enforcing quality of long-term care standards.

The Medicare Program

Medicaid covered services in the area of long-term care were expanded over the years to include intermediate care facilities and many types of home care. Medicare, 100% federally funded and intended to be a national health insurance program for the elderly has continued to include only skilled nursing care whether provided in an institution or at home and a prior three-day period of hospitalization is required. Restrictive eligibility and coverage of Medicare makes it unresponsive to the needs of the elderly. The average Medicare SNF stay in Connecticut is only 28 days, although Medicare can cover up to 100 days of SNF care per illness. Many patients continue to need nursing care or supervision and are unable to pay for it on their own.

The burden of paying the nursing home costs of the elderly has been shifted to the states through the Medicaid program. Staff in Connecticut's Department of Social Services have informed this Committee of the inadequacies of Medicare coverage and the impact that has on Connecticut's Medicaid expenditures as well as the administrative problems involved when elderly patients switch program coverage.

Congress is currently considering revision of Medicare to create a program more responsive to the needs of the elderly. This Committee recommends that the Commissioner of Social Services prepare a proposal addressing revisions of the Medicare program that will correct its current deficiencies as experienced by this state. The proposal should recommend additional services Medicare could cover to relieve the state's financial burden for long-term care and methods to simplify transfer between the Medicare and Medicaid programs. The Committee also recommends that this proposal be given the full support of the General Assembly and forwarded to Connecticut's Congressional Delegation with the request that it be submitted to Congress for its consideration.

IX. ALTERNATIVES TO INSTITUTIONALIZATION

The steadily rising costs of institutional long-term care (primarily nursing homes) and the growing elderly population needing long-term care have fostered an interest in developing less expensive alternative care. Further, such care (home care, day care and foster homes for the elderly) may be more appropriate to the medical and emotional needs of the aged. By prolonging the ability of the elderly to remain at home or in the community, a sense of quasi-independence is maintained and costs may be reduced.

This chapter describes some of the alternatives to institutional care now available in Connecticut, and the ways they can help to contain Medicaid costs.

Home Health Care

Home health care, Medicaid covered service, is perhaps the most well-developed alternative to institutionalization. Yet in FY 1975, less than one percent of the state's Medicaid budget was spent on home health service.

Home care includes an array of single or combined services designed to sustain the elderly in their own homes. Health-related or "home health aide" services are distinguished from other basic life-support or "homemaker" and chore services, which are not Medicaid reimbursable.

Home health care benefits under Medicaid. The Medicaid home health benefit program became effective in 1970, and varies considerably in its implementation from state to state. In contrast to Medicare home health benefits, Medicaid home care can be provided to a non-acute (long-term) patient. A Medicaid home care program must be ordered by a physician and supervised by a skilled professional. In Connecticut, many home health programs, which require DSS prior authorization, are carried out by trained home health aides under the direction of Visiting Nurse Association professionals.

To receive Medicaid reimbursement for home care, a provider must meet Medicare standards and be certified by the Department of Health. In addition, proprietary agencies

must be licensed by the state. Because Connecticut does not license home health agencies, all Medicaid reimbursable home health agencies in this state are non-profit. Changes in federal regulations have been proposed that would permit proprietary agencies to participate in the Medicaid program if they meet certain standards and are not forbidden by state law. The General Assembly's Public Health and Safety Committee and several other groups examining this issue are expected to recommend legislation for the 1977 Session.

The Health Department estimates that approximately 121 agencies offer home health services in Connecticut, 88 of which are Medicaid-certified. Non-Medicaid (proprietary) agencies usually offer both medical and non-medical "chore" services while the Medicaid certified providers generally offer only medical services. However, Medicaid agencies often work with non-profit homemaker agencies which provide "chore" services (light housekeeping, small repairs, shopping and cooking). While "chore" service costs are not presently covered by Medicaid, federal Title XX (Social Service) funds can be used to support such services.

The ability of the non-profit, voluntary agencies to provide adequate home care has been questioned, since most do not provide twenty-four hour or weekend service. Most proprietary agencies do offer round-the-clock services seven days a week. DSS occasionally utilizes proprietary agencies for night and weekend service using state funds only. Because home health care in these cases is significantly less expensive than institutionalization, cost-savings result despite full state funding.

Cost Effectiveness of Home Care

Cost data for home care services exist, but comparisons of home care and institutional care costs are not available except on a case by case basis. It is generally difficult to measure home care cost-effectiveness, although studies of several Connecticut home service programs demonstrate the potential for cost-savings through home care. Hartford's non-institutional Personal Care Program has provided data showing service costs well below nursing home costs, although firm conclusions cannot be generalized from this one program.

The General Assembly's Office of Fiscal Analysis conducted a study of the Department on Aging (DOA) "Meals-on-Wheels" program which home-delivers meals to the elderly. Thirty percent of responding clients reported that without "Meals-on-Wheels," they would have been forced to go into an institution. The costs of institutionalizing these clients for one year were estimated to be nine times higher than providing the meals at home. Further cost-effectiveness research is necessary before a large-scale financial commitment to the home care alternative would be justified, however.

DOA's home care demonstration project. The Department on Aging is now developing methods to measure cost-effectiveness of home care services in Connecticut as part of its new \$1 million home care demonstration project. DOA officials believe that an effective, properly-financed home care system can at least contain, and possibly reduce, long-term care expenditures. Efforts are now being made to prove this contention through carefully controlled experimental home care projects statewide.

The demonstration project is being jointly administered and funded by DSS and DOA. Federal Title XX funds (\$750,000) are being matched by a \$250,000 state appropriation. DOA's five Area Agencies on Aging will manage small, multi-town, home care systems, integrating existing resources (home-delivered meals, volunteer support services, and Visiting Nurses Associations) and funding development or expansion of other necessary services (transportation and chore services). DOA estimates that about 1,000 representative elderly will be served by the model project in FY 1977. Information concerning client needs, services provided, costs of services, and outcomes will be carefully collected and analyzed.

Triage. Triage, initiated in 1974, is a DOA long-range research and demonstration project designed to provide single-entry, full spectrum care to the elderly in seven central Connecticut towns. The project's emphasis has been on providing home-delivered medical and social services to support independent living.

Five teams of geriatric nurse-clinicians and social service workers (physicians, dentists and a pharmacist are available as consultants) assess referred clients and develop a complete care plan. Homemaker, home health

aide service, nurse or physician visits, psychological and family counseling, transportation, home-delivered meals "chore" help, companionship and other services are available through Triage. The current active caseload is estimated to be about 900. The vast majority of clients are able to avoid institutionalization because of Triage services. The University of Connecticut Health Center is under contract to DOA to evaluate Triage. Preliminary data suggest that Triage is a cost-effective alternative care system worthy of expansion.

Adult day care. Adult day care centers, usually based in long-term care institutions, provide non-residential medical and social services to elderly persons. Three Connecticut nursing homes (Avery, McLean and the Hebrew Home) currently operate day care programs, each serving a small number (10-20) of regular participants. Adult day care participants can benefit from the professional and other services available at an institution while maintaining independence and avoiding high-cost residential care. Families may be encouraged to keep elderly relatives at home if day care services are available during working hours.

According to an HEW report, the daily cost of day care nationally is less than half the daily cost of SNF care. Day care may also cost somewhat less than ICF care. Adult day care, although not reimbursable under Medicaid, could be utilized in the future as a low-cost alternative to institutional care.

Foster home program. The non-profit, Family Service Society (FSS), in Hartford operates one of the few foster home programs for the elderly in the state. The program which began as a privately-funded experiment has been in existence for about 20 years. The aim of the program is "to provide suitable arrangements for elderly who (either by preference or necessity) should not be living alone, but who neither need nor desire institutional living of any kind." The program is small, serving 25 to 30 ambulatory individuals capable of self-care in the Greater Hartford area. "Homegivers" (typically widowed older persons desiring companionship and extra income) receive payments based on whether board is provided (\$16-25/week for room with kitchen privileges, \$30-50/week for room and board). FSS estimates that almost half of the current clientele are Medicaid recipients.

The Foster Home Program costs less than institutional care and has been personally rewarding to both parties involved. Foster home programs have been very successful in other states. Yet, in Connecticut, public awareness, availability of suitable homes, and adequate financing has been lacking. Further development of foster homes for the elderly could prove to be an effective cost-saving program for Medicaid.

Outlook for Alternatives

The future success of many alternatives described above depends in part on the ability of DOA to produce conclusive data concerning the efficiency (cost-savings) and effectiveness (client satisfaction) of alternatives. The Department's strong commitment to promote independent living for the elderly is evidenced in its budget and its state plan for services. Almost all Department resources are directed toward the model home care system projects, better identification of clients, development of new services and continued funding of existing support services. DOA also intends to research additional alternatives such as sheltered housing projects, while exploring improvements in outreach projects like the Capitol region's "Breakthrough to the Aging" project.

The Department on Aging hopes to overcome the institutional bias in elderly health care. It remains much easier to institutionalize an individual than to arrange and coordinate an appropriate alternative care program. Many people, including physicians, are unaware of the scope of services available to the homebound elderly individual and feel that proper care can only be provided in an institutional setting. Development of full-range services essential to a successful home care plan is hampered by the lack of confidence in alternative care in addition to inadequate federal and state funding. DOA hopes its efforts will increase public awareness of the benefits of alternatives and prompt a greater state commitment to their development, financing and utilization.

APPENDIX I-1

GLOSSARY

AABD - Aid to the Aged, Blind, Disabled; federal categorical "adult" program

AFDC - Aid to Families with Dependent Children

AFDC-UP - Aid to Families with Dependent Children, Unemployed Parent

"bank" system - method of assigning work in which each eligibility worker is assigned cases at random

bid system (drugs) - contract for pharmaceutical services provided to nursing homes awarded to lowest bidder

CAMAD - Connecticut Aid and Medical Assistance to the Disabled

case - individual or family receiving program aid

caseload - number of cases in each program or number of cases handled by each eligibility worker

caseload system - method of assigning work in which each eligibility worker is responsible for the same cases on a continuing basis

Categorically Needy - persons who receive cash assistance in addition to medical assistance

certified - meets federal Medicaid/Medicare conditions of provider participation

CFR - Code of Federal Regulations

CGS - Connecticut General Statutes

CHHC - Commission on Hospitals and Health Care

chronic and convalescent nursing home - state-licensed facility providing 24-hour skilled nursing care (federal designation "SNF")

chronic disease hospital - state-licensed, provides 24-hour nursing care and many hospital services (more care than a SNF but less than a general hospital)

Appendix I-1 (continued)

DME - Durable Medical Equipment, e.g., wheelchair, crutches

DOA - Department on Aging

DSS - Department of Social Services

EAC - Estimated Acquisition Cost, of drugs

EDP - Electronic Data Processing

EMS - Emergency Medical Services, e.g., ambulances

Fair Rental Value System - property valuation system whereby asset is depreciated in a straight line basis for 40 years

finder card - IBM card which indicates the reason for a suspended payment

form W-262 - recipient fraud referral form

FSS - Family Service Society

GAO - General Accounting Office

GNP deflator - economic index to convert present year's dollars to previous year's dollars

HB - House Bill

HEW - U.S. Department of Health, Education, and Welfare

HIC - Hospital Inspector and Consultant

HRU - High Risk Unit

home for the aged - state licensed, provides custodial care not reimbursable under Medicaid

ICF - Intermediate Care Facility, federal designation of certified rest home with nursing supervision

licensed - meets State Public Health Code requirements for operation

LPR&IC - Legislative Program Review and Investigations Committee

Appendix I-1 (continued)

MARS - Management and Administrative Reporting Subsystem, MMIS
management report generator

Medically Needy - persons who receive public assistance for medical
services only

MMIS - Medicaid Management Information System

MRT - Medical Review Team

MSID - Medical Services Identification Card

PA - Public Act (state)

PL - Public Law (federal)

prelist - list of patients in each nursing home which is used for
billing DSS

profile - statistical report of health care delivery patterns of
medical providers or utilization patterns of recipients

PRT - Patient Review Team

PSRO - Professional Standards Review Organization mandated by federal
law to provide hospital length of stay review

QC - Quality Control, a federally mandated system for determining
error rates in the AFDC and Medically Needy caseloads

recipient fraud - a false statement by denial or misrepresentation...
with an awareness of the true facts on the part of the person
making it at the time

rest home with nursing supervision - state licensed, provides 24-hour
nursing supervision (federal designation "ICF")

RIV - Return To Vendor (inaccurate claim)

RVS - Relative Value Scale, basis of physician reimbursement

SNF - Skilled Nursing Facility, federal designation for certified
chronic and convalescent nursing home

SSI - Supplemental Security Income

Appendix I-1 (continued)

SURS - Surveillance and Utilization Review Subsystem, MMIS recipient
and provider profile report generator

Title IV-D - federal child support statute

Title XVIII - Medicare program

Title XIX - Medical assistance program, Medicaid

Title XX - Social Services program

Triage - federal/state funded research demonstration project to study
full spectrum care and alternatives to institutionalization
for the elderly

UR - Utilization Review

URC - Utilization Review Committee

VNA - Visiting Nurse Association

workload - number of cases or case actions per worker or work unit

APPENDIX I-2

AGENCY RESPONSE

It is the policy of the Legislative Program Review and Investigations Committee to submit the final draft of its reports (or sections thereof) to appropriate agencies for critical comment. Accordingly, relevant sections were reviewed by appropriate personnel in the Departments of Social Services, Aging, Health, and Finance and Control.

Written or verbal comments or technical corrections were received from each agency and have been incorporated when appropriate. In addition, the Commissioner of Social Services and the Commissioner of the Department on Aging submitted formal agency responses which are reprinted here.



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

110 BARTHOLOMEW AVENUE HARTFORD, CONNECTICUT 06115

September 23, 1976

OFFICE
OF THE
COMMISSIONER

TELEPHONE
(203) 566-2008

Ms. Linda Adams
Legislative Program Review Committee
Room 404, State Capitol
Hartford, Connecticut 06115

Dear Ms. Adams:

Thank you for making available for our review the draft of the Legislative Program Review Committee study of the Medicaid Program.

As I stated in the review session on the draft, we believe the study has been very well done. It is both comprehensive and perceptive, and provides the Department with a very solid base upon which to construct our future plans and efforts.

There is very substantial agreement on the part of the Departmental Executive Staff on the validity and logic of the recommendations made by the Task Force conducting the survey. I have made copies available to all affected units with instructions that each develop a plan for implementation of the major recommendations. I shall have a timetable for this shortly.

We continue to examine all the recommendations, and I hope will soon be able to respond to you specifically with regard to the Department's position on each.

Again, my thanks for the fine work that has been accomplished. I look forward to working with you and your staff as we continue to attempt mutually to improve administration of this extremely important State Government program.

Sincerely,

A handwritten signature in cursive script that reads "Edward W. Maher".

Edward W. Maher

EWM:ba



STATE OF CONNECTICUT

DEPARTMENT ON AGING

90 WASHINGTON ST. - HARTFORD, CONNECTICUT 06115
Tel. 566-2480

CHARLES E. ODELL
Commissioner

AN EQUAL
OPPORTUNITY
EMPLOYER

August 31, 1976

Ms. Linda A. Adams
Director
Program Review and Investigations Committee
State Capitol - Room 404
Hartford, Connecticut 06115

Dear Ms. Adams:

Thank you for permitting me to review the draft of selected sections of your preliminary review on Medicaid. Aside from typographical errors, which I'm sure you will pick up in final editing, the report seems to be a very constructive and useful piece of work.

While I think the report presents a reasonably accurate and fair treatment of alternatives to institutional care, I feel that it somewhat underplays the role and implications of the Department on Aging's home care demonstration programs. While it may be premature to claim too much for this effort, since it is in the start up phase and therefore faces the usual start up problems, it does, nevertheless constitute an attempt to move the State off dead center by raising the level of commitment to home care and by establishing a more comprehensive and systematic approach to the development of a cost effective alternative to institutional care.

In this sense, the Department's effort is more than just another demonstration program. It is really an attempt to concentrate the limited resources of the Department and its affiliated Area Agencies on Aging on the development of a comprehensive home care system for older persons and to create both a public as well as a bureaucratic awareness of the fact that there are viable alternatives to institutional care if there is a higher level of priority and commitment to pursue them.

While this may sound more like rhetoric than reality, I am personally convinced that ambivalence, if not indifference, is a major problem in the pursuit of the home care alternative. It is easier to complain about faulty law and regulation than to explain why we spend so little of our Medicare, Medicaid and other sources of health financing on the home care alternative.

Sincerely yours,

Charles E. Odell

CEO:me
CC: Max Doverman
Karen Trespacz

Charles E. Odell
Commissioner

APPENDIX II-1

GENERAL ASSISTANCE

In addition to paying 50% of the federal/state Medicaid program, Connecticut also reimburses 90% of local welfare (General Assistance) benefits—budgeted at \$18 million for FY 1977.

General Assistance is administered locally by the state's 169 cities and towns, which pay the remaining 10% of benefits and all administrative costs.

Most states subsidize local welfare programs, though the level of subsidy and coverage of services varies substantially. Considerable debate has been waged in Connecticut as to whether the state should increase or decrease its reimbursement, or merely improve its expenditure controls. Steps have already been taken to improve administrative accountability through uniform application and record keeping forms and increased auditing, but the level of subsidy remains an issue in need of careful examination. Such an examination is not within the scope of this study, however. The Committee merely sought a brief analysis of medical assistance provided by towns to identify major problem areas.

Medical. Prior to this year, the Department of Social Services did not distinguish (for all 169 towns combined) medical service costs from cash assistance payments to local welfare departments. In response to a legislative request during the 1976 Session, medical expenses were identified for three cities during the period from April 1, 1974 to September 30, 1975. These three cities—Hartford, Bridgeport, and New Haven—comprising 15% of the state's population, spent 78% of total General Assistance funds during that period. As shown in Table 1, medical expenditures for the City of Hartford were nearly four times higher than for the other two similar-sized cities combined.

Department officials recognize that the City of Hartford is spending considerably more per recipient for medical services than Bridgeport and New Haven. For the 18-month period ending September 30, 1975, Hartford spent and estimated \$957 per recipient compared with New Haven's \$401 and Bridgeport's \$174. Hartford officials, when pressed to explain, claim that several factors account for their higher medical expenditures: (1) the availability of more hospital beds and medical services in the area, (2) higher rates for services, (3) greater recipient awareness of medical services, and (4) the Combined Hospitals Alcoholism Program (CHAP), a special project not funded in other towns. In response to increases in medical payments, Hartford recently implemented a computerized claims processing system comparable to the state system.

Appendix II-1 (continued)

Table 1. General Assistance: Cash Assistance and Medical Expenditures in Hartford, Bridgeport, and New Haven: April 1, 1974 - September 30, 1975.

	<u>Hartford</u>	<u>Bridgeport</u>	<u>New Haven</u>	<u>Total</u>
Population (1970)	156,500	152,900	132,500	441,900
Recipients (9/75)	4,696	2,763	1,838	9,297
<u>TOTAL EXPENDITURES</u> ¹	\$16,285,889	\$6,053,537	\$5,182,744	\$27,522,170
<u>CASH ASSISTANCE</u>	\$11,764,661	\$5,522,360	\$4,401,407	\$21,688,428
% of Total	72.2%	91.2%	84.9%	78.8%
Amount per Recipient	\$ 2,505	\$ 1,999	\$ 2,395	\$ 2,333
<u>MEDICAL SERVICES</u>	\$ 4,495,828	\$ 481,349	\$ 736,381	\$ 5,713,558
% of Total	27.6%	8.0%	14.2%	20.8%
Amount per Recipient	\$ 957	\$ 174	\$ 401	\$ 615

¹ Total includes burial expenses (0.4% of total).

Source: Department of Social Services

Towns are responsible for day-to-day monitoring of recipient eligibility, utilization rates, and vendor claims. Under General Assistance, medical claims are submitted to and paid directly by the towns. The Department of Social Services, according to Department auditors, has limited information on medical disbursements, and will investigate town medical payments only if "wide swings" or "anything out of the ordinary" is found on a town's quarterly report compared with previous reports.

General Assistance records are field audited annually in all 169 towns by the Department of Social Services. DSS maintains a staff of six auditors for the General Assistance program who review medical expenditures in every town every year. The auditors, however, are unable to perform indepth evaluation other than bookkeeping.

Because the state pays 90% of local medical costs, and these costs can only be expected to climb, the Program Review and Investigations Committee recommends that the Department of Social Services substantially improve its capability to monitor and audit local medical

Appendix II-1 (continued)

expenses on an ongoing basis. In addition, the Legislative Auditors should conduct thorough field audits of the towns with the highest medical costs per recipient to determine whether such expenditures are justified.

Computerization of basic cost and caseload data will be facilitated by the newly mandated uniform accounting system. Such system improvements should enable existing staff to be substantially more effective in their review. The new uniform accounting system should generate comparable utilization data in all cities and towns, which could eventually be analyzed on the state's Medicaid Management Information System (MMIS).

APPENDIX II-2

CONNECTICUT AID AND MEDICAL ASSISTANCE TO THE DISABLED (CAMAD)

On January 1, 1974 the federal government assumed responsibility for state programs providing Aid to the Disabled. Persons applying for such assistance after that date had to meet the federal definition of disability which is more restrictive than Connecticut's definition. The Department of Social Services was confronted with two alternatives relative to new applicants who met the state (but not the federal) definition of disability. One alternative was to require local welfare offices to assume financial responsibility under the existing General Assistance Program. Towns and cities would then be required to assume all administrative costs plus 10% of cash and medical payments. The adopted alternative was to create a new state program which would provide medical and/or financial assistance to such persons. Approximately 64% of the initial CAMAD caseload was receiving General Assistance payments prior to the implementation of the program (see Table 1).

On October 1, 1974 the Commissioner of Social Services created the Connecticut Aid and Medical Assistance to the Disabled program (CAMAD). The program was designed for "permanently and totally" disabled persons between the ages of 18 and 65 who are not eligible for (a) Supplemental Security Income or (b) Title XIX Medical Assistance (Medicaid). The program operated for nearly two years without statutory authorization, regulation or review.

The Department proposed legislation (P.A. 76-252) and drafted regulations by which the program would operate. In addition, a caseload review was undertaken which has already eliminated a substantial number of recipients who were no longer eligible for assistance. The new CAMAD legislation defines "permanently and totally disabled" as any impairment of body or mind, other than alcoholism or drug addiction, which is catastrophic, short term¹ and which prevents a recipient from gainful employment or homemaking.

Applicants for CAMAD must meet the following minimum eligibility requirements:

- (1) must have been determined to be permanently and totally disabled;

¹ Rehabilitable blind, amputee, but mostly functional disorders such as schizophrenia, and manic/depressive.

Table 1. CAMAD caseload profile.

<u>Active Cases</u>	<u>Number</u>	<u>Percent</u>
Medical Assistance Only	324	26.5
Medical and Cash Grants	897	73.5
	<u>1,221</u>	<u>100.0</u>
<u>Prior General Assistance Status</u>	<u>Number</u>	<u>Percent</u>
Received General Assistance	773	63.3
No General Assistance	448	36.7
<u>Ages of CAMAD Recipient</u>		
18-30	365	29.8
31-50	401	32.8
51-65	455	37.2
<u>Sex of Recipients</u>		
Male	533	43.6
Female	688	56.3
<u>Types of CAMAD Disability</u>		
Endocrine System	112	12.7
Emotional/Mental Disorders	485	55.1
Musculoskeletal System	260	29.6
Visual Impairments	22	2.5
<u>Length of Time Cases Have Been Active</u>		
Less than 3 Months	36	2.9
3 to 6 Months	174	14.2
6 to 12 Months	509	41.7
12 to 18 Months	488	40.0
Over 18 Months*	14	1.1

*CAMAD Program Began October 1, 1974

Location of Active CAMAD Cases (December 31, 1975)

<u>District Office</u>	<u>Cash and Medical</u>	<u>Medical Only</u>	<u>Total</u>	<u>Percent</u>
Hartford	191	22	213	17.4
New Haven	129	83	212	17.4
Norwich	76	31	107	8.8
Waterbury	57	34	91	7.4
Middletown	96	27	123	10.1
Stamford	45	13	58	4.7
Bridgeport (estimated)	303	114	417	34.2
	<u>897</u>	<u>324</u>	<u>1,221</u>	<u>100.0</u>

Source: Department of Social Services

Appendix II-2 (continued)

- (2) be a resident of the state and a citizen or lawful alien;
- (3) not a resident of a mental or penal institution;
- (4) not eligible for Aid to Families with Dependent Children (AFDC);
- (5) not be eligible under Title XIX, Medicaid; and
- (6) not have made within seven years, a transfer or disposition of property without adequate compensation.

In addition, individuals meeting the six criteria listed above must:

- (1) have income below the Department's standard of need;
- (2) not have more than \$250 in cash or a burial reserve;
- (3) agree to assign to the Commissioner all life insurance policies;
- (4) agree to have a lien placed on any real property;
- (5) agree to liquidate any real property other than a home; and
- (6) be liable to reimburse the state for all assistance provided under the program.

Regulations designed to implement the CAMAD program were required to be issued by the Commissioner of Social Services by July 1, 1976. Emergency regulations became effective on June 22, 1976.

CAMAD Budget

The Department of Social Services requested \$2.5 million for cash assistance for FY 1976-77 based upon an average of 939 cases at an average cost of \$223.38 per case, per month. The Governor's budget recommendation reduced this request to \$2.2 million. In addition \$2.0 million was appropriated in a separate budget request for medical expenses covered by CAMAD; bringing total program costs to \$4.2 million. However, DSS projects that FY 1976-77 expenditures may be twice as high as the appropriation. This projection was made prior to the CAMAD redetermination project which has preliminarily found about 18% of current caseload ineligible. Table 2 indicates that

Table 2. CAMAD monthly caseload and expenditures, FY 1976.

<u>Month</u>	<u>Recipients</u>	<u>Percent Increase</u>	<u>Cash Assistance</u>	<u>Medical Assistance</u>	<u>Total Monthly Expenditures</u>	<u>Percent Increase (Decrease)</u>
July 1975	361	-	\$ 95,685	\$ 175,426	\$ 271,111	-
August	427	18.3%	73,011	140,410	213,421	(21.3)
September	488	14.3	108,789	130,186	238,975	10.6
October	570	14.4	119,770	124,608	244,378	2.3
November	643	12.8	138,942	89,805	228,747	(6.4)
December	703	9.3	122,850	126,330	249,180	8.9
January 1976	776	9.4	159,422	210,678	370,100	52.9
February	826	6.4	159,097	200,744	359,841	(2.8)
March	891	7.9	169,066	164,115	331,181	(7.4)
April	916	2.8	163,735	180,413	344,148	3.3
May	950	3.7	161,015	181,737	342,752	0.4
June	962	1.3	169,700	172,222 ¹	341,922	0.0
	Totals		\$1,641,082	\$1,896,674	\$3,537,756	-
	(Percent)		(46.4%)	(53.6%)	(100.0%)	

¹ Estimate, actual figure is not available

Source: Budget and Management Division, Department of Finance and Control

Appendix II-2 (continued)

growth of the CAMAD budget will not reach these projected levels. Rather the program, in terms of caseloads and expenditures is stabilizing. More careful monitoring of eligibility, duration and redetermination is clearly needed and will substantially reduce that previously unreviewed caseload.

In order for the legislature to properly assess the fiscal impact of the CAMAD program, the Department of Social Services should provide detailed monthly cost analysis for all CAMAD maintenance and medical payments to the Budget and Management Division of the Department of Finance and Control. The Department of Social Services should also consolidate all CAMAD costs into a single program budget request. Future budget requests should include: projected medical expenditures; projected maintenance expenditures; average costs per case by type of expenditure; average caseload by type of expenditure; and total administrative costs (see Table 2).

Caseload Review

Given the fact that over 40% of all CAMAD recipients have been on the program 12 months or more, the Department of Social Services should promulgate permanent regulations which define the "short term" nature of CAMAD disability. Such regulations should require a verified medical condition in which the capacity to rehabilitate can reasonably be accomplished within the one year maximum CAMAD eligibility period.

As already noted, the Department of Social Services has attempted to establish certain cost control systems relative to the CAMAD program. An entire caseload review, beginning with the oldest cases, began on June 1, 1976 and is expected to be completed by October 1, 1976. The estimated costs for such a review are:

(1) Medical re-examinations (\$20 per examination)	\$23,500
(2) Staff costs to verify non- medical eligibility data (1600 hours overtime)	\$ 9,500
(3) Medical eligibility determina- tion by Medical Review Team (\$6 per case)	\$ 7,050
(1175 cases) TOTAL COST	<u>\$40,050</u>
COST PER CASE REVIEW:	\$34.08

Appendix II-2 (continued)

Based upon an earlier review, such a redetermination process is cost-effective. In February, 1976 a survey of 197 CAMAD cases (25% sample) revealed that nearly 18% were on CAMAD in error, of those,

- (1) 7.1% were determined eligible for federal disability benefits;
- (2) 6.6% were eligible for Title XIX Medicaid benefits; and
- (3) 4.1% were ineligible for any federal or state assistance.

If this projection holds for the entire CAMAD caseload (with allowance for federal reimbursement and SSI appeals where applicable) CAMAD expenditures will be reduced more than \$315,000 in FY 1976-77. Furthermore, the cost of finding this saving (\$40,050) is less than one-seventh the expected return.

LPR&IC recommends that the Department of Social Services formally implement permanent regulations by which systematic CAMAD caseload reviews will be made. Initial eligibility, as determined by the Medical Review Team, should be limited to a maximum period of six (6) months. Upon issuance of a Medical Services Identification Card (MSID), each CAMAD recipient will receive notice detailing his or her eligibility period (total eligibility, including redetermination periods, not to exceed one year). Two months prior to the end of the covered period another notice will be mailed to the recipient announcing the Department's intention to discontinue cash or medical assistance. This notice should advise the recipient that continued eligibility will be based upon an application renewal and a medical re-examination indicating continued disability. Finally, all recipients should be advised of their due process right to a Fair Hearing (C.G.S. 17-2a) in the event that their disability claim is rejected. No person should be denied CAMAD benefits while he or she is processing a valid and reasonable CAMAD or SSI appeal.

All medical reports submitted by recipients to the Medical Review Team must contain a substantiated medical diagnosis completed by a doctor who specializes in the disability noted on the examination report. The Department of Social Services should promulgate regulations defining those specialists available within the following disability categories:

- (1) conditions affecting the musculoskeletal system;
- (2) diseases or injuries of the special sense organs;
- (3) respiratory diseases;

Appendix II-2 (continued)

- (4) cardiovascular disease;
- (5) disorders of the digestive system;
- (6) disorders of the genito-urinary system;
- (7) diseases of the hemic and lymphatic system;
- (8) skin diseases;
- (9) disorders of the endocrine system;
- (10) neurological disorders;
- (11) mental disorders;¹and
- (12) neoplastic diseases

SSI Appeals

Nearly three-quarters of all CAMAD recipients receive both maintenance and medical assistance payments. The application for CAMAD maintenance and medical assistance is processed by an Eligibility Intake Unit only after the Department of Social Services has received a notice of SSI (Supplemental Security Income) rejection from the applicant's local social security office.

The SSI disability determination is conducted by the Connecticut Bureau of Vocational Rehabilitation which is under contract with the federal Social Security Administration. SSI disability claims are reviewed by a professional staff and a part-time medical team. The medical team has no face to face interview, examination or contact with the applicant. The burden of proof for establishing federal medical disability rests with the applicant. If an applicant is denied benefits, a series of administrative and judicial appeal may be taken within 60 days at the local district office (Hartford and New Haven).

¹ These regulations are particularly significant in the area of emotional and mental disorders which account for 55% of all CAMAD disabilities (see Table 1).

Appendix II-2 (continued)

CAMAD assistance payments could be reduced by as much as one-third if recipients utilized their federal appeals process. According to the Social Security Administration, the reversal rate on SSI administrative appeals in Connecticut is 49%. In March, 1976 this Committee received a letter from the New Haven Legal Assistance Association which indicated a willingness to process "SSI rejections if these cases were referred to (them) by the Department of Social Services." Had the Department of Social Services instituted an effective appeal process (assuming a 50% reversal rate) for the present CAMAD caseload nearly \$1.4 million in maintenance and medical costs could have been saved.

In order to take advantage of these federally-funded legal services at a substantial program savings, the LPR&IC recommends that the Department of Social Services implement an effective appeal referral system with the various Connecticut legal service programs. Such a system should consolidate all appeals of CAMAD eligible applicants who have been denied SSI disability benefits, but who have not filed for an appeal within the required 60 days.

Legally Liable Relatives

Because CAMAD is a state funded program, the Department of Social Services has considerable latitude in establishing program policy and is not restrained by federal regulations regarding legally liable relatives. Connecticut General Statutes, section 17-82e, authorizes the Commissioner of Social Services to investigate the financial condition of each applicant and recipient's husband or wife, and in the case of an applicant who is less than eighteen years of age, his father and mother, and in the case of an applicant who is less than 65 years, his child or children. This statute extends liability to children of CAMAD, state supported, recipients.

In addition to this provision for claims against legally liable relatives; the new CAMAD legislation (P.A.76-252) requires that recipients be liable to reimburse the state, on an ability-to-pay basis, for all assistance rendered under the program.

The Department of Social Services should promulgate regulations that effectively implement the legal responsibility of children for CAMAD recipients (C.G.S. 17-82e). The Department of Social Services should also promulgate regulations which specifically describe the recoupment process available to the Department under the CAMAD enabling statute. Such regulations should include the identification and investigation process of liable recipients and the collection procedure to be utilized by the Central Collections Division of Finance and Control.

APPENDIX II-3

MEDICAL SERVICES FEDERALLY REIMBURSABLE UNDER MEDICAID

Required Services

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

(4) (A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere.

Optional Services

(1) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(2) home health care services;

(3) private duty nursing services;

(4) clinic services;

(5) dental services

Appendix II-3 (continued)

(6) physical therapy and related services;

(7) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(8) other diagnostic, screening, preventive, and rehabilitative services;

(9) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(10) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a) (31) (A) of this title, to be in need of such care;

(11) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section; and

(12) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary; except as otherwise provided in paragraph (16), such term does not include-

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Source: Social Security Act, Title 42, Section 1396(d).

APPENDIX II-4

MEDICAL ASSISTANCE (MEDICAID) PROGRAMS IN FISCAL YEAR 1975
CONNECTICUT VS. ECONOMICALLY-SIMILAR STATES

	(1) Resident Civilian Population (July 1975) (thousands)	(2) Medicaid Recipients Average Number (thousands)	(3) Recipients Per 1,000 Population (2)÷(1)	(4) Medical Vendor Payments Total Fiscal 1975 (thousands)	(5) Per Capita (4)÷(1)	(6) Per Recipient (4)÷(2)	(7) Recipients Age 65 Or Over Average Number (thousands)	(8) Annual Payments (thousands)	(9) Monthly Pmts. Per Person (8)÷(7) +12 months	(10) Family Membership (Children & Adults) Average Number (thousands)	(11) Annual Payments (thousands)	(12) Monthly Pmts. Per Person (11)÷(10) +12 months
United States	211,445	8,371	40	\$12,187,860	\$ 58	\$1,456	1,970	\$4,580,254	\$194	4,644	\$3,929,374	\$ 71
California	20,896	1,064	51	1,366,496	65	1,284	272	375,067	115	563	518,344	77
Connecticut	3,081	90	29	161,075	52	1,790	22	78,739	298	51	39,038	64
Illinois	11,107	771	69	713,654	64	926	65	162,306	208	617	328,229	44
Indiana	5,302	98	18	172,433	33	1,760	21	73,603	292	63	51,046	68
Maryland	4,051	168	41	204,141	50	1,215	27	53,149	164	95	78,414	69
Massachusetts	5,810	327	56	524,706	90	1,605	66	266,348	336	206	136,073	55
Michigan	9,143	334	37	639,388	70	1,914	64	200,474	261	217	289,025	111
New Jersey	7,289	269	37	368,130	51	1,369	37	146,209	329	196	153,973	66
New York	18,094	1,150	64	2,953,608	163	2,568	196	1,131,070	481	668	867,503	108
Ohio	10,744	301	28	366,325	34	1,217	56	119,340	178	209	161,168	64
Pennsylvania	11,816	360	30	727,875	62	2,022	82	286,572	291	150	193,081	107
Rhode Island	923	47	51	72,079	78	1,534	17	35,267	173	23	16,499	60
Washington	3,491	125	36	171,593	49	1,373	28	58,736	175	61	45,266	62
Wisconsin	4,605	159	35	360,571	78	2,268	45	147,864	274	89	87,670	82

Sources: Resident Civilian Population: Current Population Reports, Series P-25, No. 615, issued November 1975, U.S. Bureau of the Census
Medicaid Recipients
Medical Vendor Payments
Recipients Age 65 Or Over
Family Membership } Medicaid Statistics, Fiscal Year 1975, DHEW Publication No. (SRS) 76-03154, NCSS Report B-5 (FY 75), issued March 1976, Social and Rehabilitation Service, U.S. Department of Health, Education And Welfare

APPENDIX III-1

AFDC NATIONAL CASE ERROR RATES: JULY-DECEMBER 1975 ERROR RATES COMPARED WITH ERROR RATES IN JANUARY-JUNE 1975 AND APRIL-SEPTEMBER 1973^a

State	Cases with Errors as a Percent of Total Cases								
	Ineligible			Eligible but Overpaid			Eligible but Underpaid		
	Jul- Dec. 1975 ^{b/}	Jan- June 1975	Apr- Sept 1973	Jul- Dec. 1975 ^{b/}	Jan- June 1975	Apr- Sept 1973	Jul- Dec. 1975 ^{b/}	Jan- June 1975	Apr- Sept 1973
U.S. Average ^{g/}	6.4	7.5	10.2	14.7	17.5	22.8	5.6	7.3	8.1
Alabama.....	4.0	6.1	10.5	9.5	12.0	15.1	5.5	7.5	8.4
Alaska.....	3.8	7.5	12.3	15.2	14.5	14.2	12.1	5.0	5.8
Arizona.....	9.6	12.0	9.3	23.4	26.2	23.6	10.7	10.3	7.3
Arkansas.....	5.3	4.3	2.2	12.7	9.8	7.1	6.9	6.8	7.3
California.....	2.9	5.4	8.4	12.4	12.0	17.8	4.4	4.9	7.9
Colorado.....	6.4	7.5	4.4	12.4	10.7	15.9	3.0	2.6	6.5
Connecticut.....	6.4	7.5	6.5	13.4	14.8	16.2	4.2	6.1	5.4
Delaware.....	7.6	12.9	14.1	19.5	21.9	29.6	7.1	9.5	9.7
Dist. of Col.....	13.4	12.8	10.9	24.5	25.6	24.5	6.6	5.7	3.8
Florida.....	4.2	9.0	11.0	9.0	14.2	27.1	3.0	5.6	9.3
Georgia.....	11.5	10.7	7.0	20.9	26.7	24.9	6.8	8.9	10.5
Hawaii.....	5.7	11.3	4.6	20.5	18.8	19.9	8.8	7.5	5.6
Idaho.....	5.9	3.4	5.8	13.3	13.0	13.0	6.9	3.9	1.9
Illinois.....	8.3	11.7	11.7	21.4	28.1	37.6	3.6	4.3	10.6
Indiana.....	1.4	2.6	8.0	6.2	9.0	19.5	2.3	4.9	4.4
Iowa.....	4.7	7.8	9.7	15.3	22.0	20.0	10.6	10.9	7.3
Kansas.....	5.4	9.2	10.3	11.8	16.5	26.0	5.6	8.8	9.2
Kentucky.....	6.2	6.5	10.1	11.5	13.3	29.4	2.2	4.0	7.7
Louisiana.....	4.1	3.9	14.8	7.8	10.8	21.1	3.6	3.2	5.4
Maine.....	10.5	8.9	3.7	20.3	18.2	7.2	6.9	3.2	1.8
Maryland.....	8.0	10.8	14.7	19.7	24.9	28.5	5.6	10.2	10.3
Massachusetts.....	8.6	12.1	9.6	20.1	25.7	29.7	5.4	9.3	13.5
Michigan.....	6.7	8.0	5.7	21.0	25.4	20.3	7.3	7.2	4.9
Minnesota.....	3.3	5.0	6.0	11.6	13.1	28.1	5.4	4.8	12.9
Mississippi.....	4.3	3.6	2.3	11.8	7.1	8.6	4.0	3.9	5.2
Missouri.....	7.4	7.8	7.1	9.3	13.0	14.2	3.6	3.0	4.4
Montana.....	10.3	15.5	10.3	13.4	15.9	18.6	3.1	5.5	4.2
Nebraska.....	6.8	7.3	6.5	14.6	11.5	10.3	8.4	15.9	2.7
Nevada.....	1.1	—	2.6	1.1	2.8	7.8	0.6	2.3	4.6
New Hampshire.....	8.4	9.3	11.9	20.7	25.0	40.9	5.9	7.4	7.5
New Jersey.....	3.8	3.0	4.3	13.0	16.2	18.3	4.7	7.4	4.4
New Mexico.....	2.4	4.8	5.0	5.9	7.4	13.2	6.1	4.8	4.2
New York.....	10.6	8.6	17.5	20.2	25.8	31.9	13.2	18.2	11.1
North Carolina.....	3.9	4.6	7.7	13.0	16.2	21.3	8.5	12.4	19.2
North Dakota.....	1.3	—	1.9	3.2	4.6	8.4	4.5	6.0	1.9
Ohio.....	10.0	13.4	13.7	12.0	14.0	27.0	2.2	4.8	8.3
Oklahoma.....	2.0	2.2	4.1	5.6	5.5	13.5	2.1	2.0	2.9
Oregon.....	2.8	4.8	6.3	10.1	15.3	16.2	5.2	4.2	3.5
Pennsylvania.....	8.6	8.0	16.7	18.5	19.1	24.8	4.3	5.3	8.1
Puerto Rico.....	6.2	10.8	16.4	12.9	19.0	19.9	7.5	11.6	7.7
Rhode Island.....	3.6	3.9	4.5	8.2	21.0	21.3	6.3	5.5	3.5
South Carolina.....	4.9	5.3	10.1	16.7	15.0	27.3	7.2	10.5	10.0
South Dakota.....	3.1	1.8	2.5	5.6	9.1	14.5	3.1	4.1	4.4
Tennessee.....	7.1	8.1	9.1	11.4	12.9	12.8	3.7	4.8	6.3
Texas.....	4.0	2.6	10.4	6.3	6.5	16.3	1.5	2.6	3.5
Utah.....	4.8	4.6	5.9	7.7	14.9	14.7	3.2	6.5	3.9
Vermont.....	7.2	6.0	10.3	13.6	16.0	27.2	8.1	4.5	6.0
Virginia Islands.....	6.8	18.0	5.8	12.2	16.0	15.2	4.7	9.3	14.5
Virginia.....	5.2	4.3	5.3	11.6	14.3	27.4	5.4	6.1	13.3
Washington.....	3.2	4.1	4.5	7.4	7.3	10.2	3.6	3.2	2.8
West Virginia.....	4.0	2.4	5.6	7.4	6.5	10.7	3.6	3.5	4.3
Wisconsin.....	1.7	2.9	4.7	9.7	15.0	14.5	8.3	13.5	16.5
Wyoming.....	9.4	3.8	8.0	8.8	14.6	14.2	4.4	6.4	8.6

^{a/} Based on reviews of statistically reliable samples of approximately 44,000 cases in each six-month reporting period from an average national AFDC caseload of over 3 million families.

^{b/} For comparability with previous periods, these rates were not computed by the statistical regression method. (See Table 6 for error rates based on the regression method.)

^{g/} Weighted average.

Source: HEW

APPENDIX III-2

AFDC QUALITY CONTROL ERROR RATES (BY PERCENT OF CASE REVIEWS COMPLETED)

<u>Reporting Period Ending</u>	<u>June 30, 1971</u>	<u>Dec. 31, 1971</u>	<u>June 30, 1972</u>	<u>Dec. 31, 1972</u>	<u>March 31, 1973</u>	<u>Sept. 30, 1973</u>	<u>June 30, 1974</u>	<u>Dec. 31, 1974</u>	<u>June 30, 1975</u>	<u>Dec. 31, 1975</u>
Ineligible Cases	6.3%	5.2%	6.8%	6.4%	8.4%	6.5%	5.7%	5.8%	7.5%	6.4%
Eligible Overpaid Cases	20.0	19.1	22.3	16.6	15.1	16.2	17.3	16.3	14.8	13.4
Eligible Underpaid Cases	10.9	11.0	11.3	5.7	4.7	5.4	4.1	10.1	6.3	4.2
Amount of Payment to Ineligible Cases	4.4	4.4	5.8	5.2	7.3	5.5	4.2	4.8	5.9	6.2
Amount of Overpayments	3.9	3.0	4.2	4.0	3.2	4.5	4.1	3.9	3.2	3.3
Amount of Underpayments	0.9	1.1	0.9	0.8	0.9	1.1	0.6	0.8	0.7	0.6

Source: Department of Social Services Quality Control Reports

APPENDIX III-3

AFDC QUALITY CONTROL 1974-1975: PERCENT OF ERROR CASES BY TYPE OF AGENCY AND CLIENT ERRORS - INELIGIBLE CASES ONLY

REPORTING PERIOD	1/1/74 to 6/30/74	7/1/74 to 12/31/74	1/1/75 to 6/30/75	7/1/75 to 12/31/75
(Number) % of Total	(22) 45.8	(16) 34.8	(20) 30.8	(20) 25.6
AGENCY ERRORS -- Total				
A. Correct policy but incorrectly applied (10)	13.6	0.0	5.0	10.0
B. Wrong policy applied (20)	4.5	0.0	5.0	5.0
C. Failure to take indicated action;				
1. Reported information disregarded or not applied (30)	13.6	68.8	15.0	40.0
2. Failure to follow-up on impending changes (40)	9.1	6.3	20.0	5.0
3. Failure to follow-up on inconsistent or incomplete information (50)	22.7	0.0	15.0	5.0
4. Failure to verify where required by agency policy (60)	36.4	25.0	40.0	35.0
D. Arithmetic computation (70)	0.0	0.0	0.0	0.0
I. CLIENT ERRORS -- Total	(26) 54.2	(30) 65.2	(45) 69.2	(58) 74.4
A. Information not reported (01)	73.1	83.3	91.1	84.5
B. Information is incorrect (02)	26.9	13.3	8.9	15.5
C. Information is incomplete (03)	0.0	3.3	0.0	0.0
II. INDICATION OF WILLFUL MISREPRESENTATION OF FACTS BY CLIENT -- Total	(48) (48)	(46) (46)	(65) (65)	(78) (78)
A. Cases with willful misrepresentation . . . T code .	45.8	54.3	61.5	69.2
B. Cases with no willful misrepresentation . . . T code .	54.2	45.7	38.5	30.8

Source: Department of Social Services Quality Control Reports

APPENDIX III-4

THE SURVEY OF DSS ELIGIBILITY WORKERS

A systematic survey of DSS workers was undertaken to obtain information on how Department employees feel about their training, supervision, and working conditions. The survey instrument was as brief and clear as possible so that workers would be likely to take the time to read and respond to the survey. While responses to most items involved a "forced choice" among alternatives provided, space was available for "open ended" comments.

Methodology. Names of eligibility and case management workers for each district office were obtained from the Department's April 30, 1976 roster of positions. Envelopes individually addressed to each worker were prepared containing a cover letter explaining the purpose of the survey, a copy of the survey, and a business reply envelope.

During the week of June 7, 1976, 450 surveys were bulk mailed in six large manila envelopes, one to each district office. A separate cover letter addressed to the district directors requested that the envelopes (containing the surveys) addressed to employees be distributed through the office mail room. Prior to receiving the surveys, district directors had been informed about the survey in a memo from the Deputy Commissioner of DSS who asked for their cooperation.

After the surveys were mailed out, no further follow-up effort was made to encourage workers to respond.

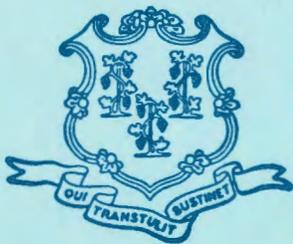
By July 12 (six weeks after the surveys were mailed out), 228 completed surveys had been returned. This represents a 53% response rate. Seven surveys were returned after July 12, too late to be included in the analysis. Another 23 surveys were returned undelivered. Most of these were addressed to employees who were no longer working for the Department at the time surveys were mailed out.

With the help of keypunchers and a programming consultant, survey data was analyzed July 12-14 at the Department of Finance and Control's Data Center. A computer package, "Data Text," was selected for use and programs were prepared. Data analysis included development of frequency distributions and crosstabulations for each item. In addition, several significance tests were run on the data including t-tests, analyses of variance (F-tests), correlations, and multiple regression analyses. Major results of the survey are reported in Chapter III.

Cost. Although exact figures are not available, the survey cost an estimated \$88.

Mailing expenses	\$10.00
Reply envelopes	40.00
Data processing services	37.75
TOTAL	<u>\$87.75</u>

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Appendix III-4 (continued)

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Room 404, State Capitol, Hartford, Conn. 06115
(203) 566-4843

June 7, 1976

Dear Eligibility Worker:

Our Committee, set up by the General Assembly to evaluate State programs, is studying ways to improve the Medicaid program (Title XIX) in Connecticut. As part of this study, the Committee is examining the system and procedures for determining recipient eligibility under the AFDC program.

Enclosed is a questionnaire which we are sending to all eligibility investigators and technicians in the Department of Social Services. We are interested in learning how you feel about working conditions, training, and supervision in your work unit.

We would very much appreciate your taking the time to fill out this questionnaire and return it to us. Your response is important since it will help us identify areas which need improvement. It is not necessary to sign your name to the questionnaire. All responses will be anonymous and confidential.

The Committee thanks you for your cooperation and willingness to participate in our Medicaid study.

Sincerely,

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE

Linda A. Adams
Director

Please respond to the following questions by printing in the appropriate information or checking the appropriate line. Be sure to answer each item. Your response will be combined with those of others in your office and other district offices. Individual confidentiality will be maintained.

District Office: Hartford- N=47 Bridgeport- N=43 Waterbury- N=29
New Haven- N=31 Norwich- N=26 Middletown- N=30

Job Title (Check one): Investigator I N=53 Welfare Eligibility Technician I N=76
Career Trainee N=12 Welfare Eligibility Technician II N=2
Investigator II N=13 Welfare Eligibility Supervisor N=17
Investigator III N=13
Welfare Aide N=42

Male N=63 Female N=156

Age: 18-24 N=20 25-29 N=60 30-39 N=49 40-49 N=50 50-65 N=43

How many years of education have you completed (check one)?

10 N=8 11 N=5 12 N=73 13 N=15 14 N=23 15 N=10 16 N=65 17 or more N=25

How many months have you been in your present position? X=26.9

How many months have you worked for the Social Services Department? X=66.1

Do you speak Spanish? yes N=22 no N=203

1. What kind of training did you receive when you first started working in this unit? (check items which apply)

None 7.0% (16/228)

"On the job" training by supervisor 62.7% (143/228)

"On the job" training by fellow workers 50.4% (115/228)

A formal training session 32.5% (74/228)

Other (Please specify) 10.1% (23/228)

2. What kind of in-service training (during employment) have you received? How often?

a. Kind	b. How often		
	Less than once a year	About once a year	More than once a year
None	<u>17.5%</u> (39/223)		
"On the job" training by supervisor	<u>58.7%</u> (131/223)	<u>16.5%</u> (18/109)	<u>5.3%</u> (6/109)
"On the job" training by fellow workers	<u>35.0%</u> (78/223)	<u>18.8%</u> (12/64)	<u>4.7%</u> (3/64)
Formal training session(s)	<u>33.2%</u> (74/223)	<u>30.4%</u> (21/69)	<u>15.9%</u> (11/69)
Other (Please specify)	<u>13.9%</u> (31/223)		

3. In general, how happy are you with your job?
VERY HAPPY 1 2 3 4 5 VERY UNHAPPY X=3.0

4. How satisfied are you with your present salary?
VERY SATISFIED 1 2 3 4 5 VERY UNSATISFIED X=4.4

5. How satisfied are you with your work "space" or the environment and atmosphere in your office?
VERY SATISFIED 1 2 3 4 5 VERY UNSATISFIED X=3.9

6. How adequate do you think your training was in preparing you to do your job?
VERY ADEQUATE 1 2 3 4 5 NOT AT ALL ADEQUATE X=3.2

7. How adequate do you think your in-service training is in helping to improve or update your skills?
VERY ADEQUATE 1 2 3 4 5 NOT AT ALL ADEQUATE X=3.4

8. At the present time, do you feel capable of handling your responsibilities and doing a good job?
YES, DEFINITELY 1 2 3 4 5 NO, DEFINITELY NOT X=1.9

9. If you do not feel capable of handling your job, is this because of (check items which apply):

 Lack of ability on my part 0.0% (1/225)

 Work load is too heavy 29.6% (67/226)

 My training was poor 13.7% (31/226)

 Management and supervision is poor 13.3% (30/226)

 Other (Please specify) 8.4% (19/226)

 I feel capable of handling my job.

10. How well do you feel you are supervised?
VERY WELL 1 2 3 4 5 NOT AT ALL WELL X=2.2

11. Do you feel you get (check the appropriate line):

 Too much supervision 2.3% (5/220)

 Too little supervision 21.4% (47/220)

 Just about the right amount of supervision 76.4% (168/220)

12. In your present position, how much opportunity do you feel there is for career development?
VERY MUCH OPPORTUNITY 1 2 3 4 5 NO OPPORTUNITY AT ALL X=4.2

In this space, please feel free to comment on any of the questions and issues raised in this survey. If you would like to be interviewed personally or want to talk to us, please sign your name or call our office at 566-4843.

Appendix III-4 (continued)

Table 1. Type of training: "What kind of training did you receive when you first started working in this unit?"

<u>Response</u>	<u>Percent of Workers Giving Each Response¹</u>			
	<u>Investigators²</u> <u>N=79</u>	<u>Technicians³</u> <u>N=95</u>	<u>Aides⁴</u> <u>N=42</u>	<u>Total⁵</u> <u>N=216</u>
None	10%	5%	7%	7%
Trained by Supervisor	66	56	71	63
Trained by Fellow Workers	61	35	55	48
Formal Training Session	15	52	21	32
Other	11	11	5	10

¹Figures total more than 100% because some respondents reported training in more than one category.

²Investigator I, Investigator II, Investigator III - Eligibility Services Unit.

³Eligibility Technician I, Eligibility Technician II, Welfare Eligibility Supervisor - Income Maintenance Unit

⁴Welfare Aides - Income Maintenance Unit

⁵Total does not include Career Trainees (12) who responded to the survey

Source: LPR&IC Survey of Department of Social Service Eligibility Workers.

Appendix III-4 (continued)

Table 2. Type of in-service training: "What kind of in-service training (during employment) have you received?"

	Percent of Workers Giving Each Response ¹			
	Investigators N=79	Technicians N=95	Aides N=38	Total N=212
None	25%	15%	11%	18%
In-Service Training by Supervisor	51	60	74	59
In-Service Training by Fellow Workers	39	27	42	34
Formal In-Service Training Session	32	36	32	34
Other	17	12	11	13

¹ Figures total more than 100% because some respondents reported training in more than one category.

Source: LPR&IC Survey of Department of Social Service Eligibility Workers

Table 3. Adequacy of supervision: "How well do you feel you are supervised?"

	Investigators N=77	Technicians N=94	Aides N=37	Total N=208
Very Well	48%	42%	49%	45%
Well	13	25	5	17
Unsure	17	18	16	17
Poorly	8	5	22	9
Very Poorly	14	11	8	12

Source: LPR&IC Survey of Department of Social Service Eligibility Workers

Appendix III-4 (continued)

Table 4. Job capability: "At the present time, do you feel capable of handling your responsibilities and doing a good job?"

	Investigators N=76	Technicians N=94	Aides N=40	Total N=210
Yes, Definitely	51%	50%	58%	52%
Yes	21	23	18	21
Unsure	20	15	8	15
No	3	4	10	5
No, Definitely Not	5	7	8	7

Source: LPR&IC Survey of Department of Social Service Workers

APPENDIX III-5

"AN ACT CONCERNING OVERPAYMENTS MADE BY THE DEPARTMENT OF SOCIAL SERVICES" (PROPOSED)

Section 17-82m of the general statutes is repealed and the following is substituted in lieu thereof:

Section 1: In any case in which a beneficiary of public assistance under this chapter receives any award or grant in excess of that to which he is entitled under the laws governing eligibility; and in any case in which a provider of Title XIX medical services receives any payment in excess to that authorized by law or in violation of Public Act 76-242; the Department of Social Services shall immediately refer such overpayment, except as provided by section 2 of this Act, to the Central Collections Division of Finance and Control, with full supporting information, for investigation and determination as to whether it should be submitted to a prosecuting authority for prosecution, or to the Attorney General for civil recovery, or referred back to the Department of Social Services for such other action as conforms to federal regulations, and said division shall take such of said actions as the facts of the case warrant.

Section 2: When any overpayment, referred to by section 1 of this Act, amounts to or accumulates to \$500 or less; the Department of Social Services may recoup such overpayments at a rate and in a manner which is consistent with any applicable federal regulations.

APPENDIX III-6

WELFARE FRAUD INVESTIGATIONS (FY 1975) AND COMPARATIVE SUMMARY OF FRAUD
ACTIVITIES, 1973-1975

Table 1. Summary of welfare fraud investigations, FY 1975.

<u>Number of Fraud Referrals Returned Without Investigation</u>	<u>412</u>
<u>Number of Fraud Charges Disposed Of:</u>	
Guilty - Fraud	268
Larceny - Food Stamps	12
Nolle - Fraud	141
Larceny - Food Stamps	29
Not Guilty	1
Dismissed - Fraud	18
Larceny - Food Stamps	1
<u>Total</u>	<u>470</u>

Recoveries and Collections:

	<u>No. of Cases</u>	<u>Amount</u>
Actual Collections - Convictions	280	\$ 25,746.17
Nolles	170	46,808.32
Non-prosecutions	18	26,434.78
Dismissed	19	4,266.07
<u>Total Recoveries and Collections</u>	<u>487</u>	<u>\$103,255.34</u>
<u>Estimated Savings by Discontinuances</u>		
Due to Conviction of Fraud	42	\$ 41,407.20
<u>Estimated Savings by Recoupment</u>	11	6,424.16
<u>Expected Recoveries - Payment Plans</u>	112	140,021.09
<u>Expected Recoveries - No Payment Plans</u>	122	120,851.46
<u>Totals</u>	<u>774</u>	<u>\$411,959.25</u>

NOTE: In addition to the above, accounts are established in the Centaur System, as shown below, for Welfare Fraud which the Division of Central Collections is attempting to collect. Some of these accounts are subject to the control and supervision of the Department of Adult Probation, some are subject to recovery through the "off-set" method employed by the Department of Social Services, and, in some instances, the payer (recipient) has no income or assets from which we can recover.

<u>Bill Code</u>	<u>Program</u>	<u>Balance June 30, 1975</u>
391	Fraud-Billings	\$288,696.36
392	Fraud-Delinquent Accounts	5,761.29
398	Fraud-No Billings	383,650.02
	<u>Total</u>	<u>\$678,107.67</u>

Source: Division of Central Collections, Finance and Control

Appendix III-6 (continued)

Table 2. Comparative summary of welfare fraud activities, FY 1973-75.

	<u>1972-73</u>	<u>1973-74</u>	<u>1974-75</u>
Outstanding Cases Beginning of Year	2,119	783	953
New Cases	<u>1,261</u>	<u>1,283</u>	<u>1,507</u>
Closed Cases	<u>3,380</u>	<u>2,066</u>	<u>2,460</u>
	<u>2,597</u>	<u>1,113</u>	<u>1,713</u>
Outstanding Cases, End of Year	<u>783</u>	<u>953</u>	<u>747</u>
Referrals Returned Without Investigation	<u>270*</u>	<u>737</u>	<u>412</u>
<u>Source of Referrals</u>			
District Offices-Dept. of Social Services	944	1,149	1,336
Family Relations Division	109	71	19
Police Departments	38	10	14
Other	170	53	138
<u>Total Referrals</u>	<u>1,261</u>	<u>1,283</u>	<u>1,507</u>
Number of Completed Investigations	1,560	1,121	1,282
Number of Arrests	562	541	471
<u>Summary of Charges</u>			
Fraud	562	480	425
Non-support	83	34	13
Obtaining Monies Under False Pretenses	41	0	0
Forgery	9	10	62
Larceny-Food Stamps	0	0	45
Larceny-Other	2	192	39
Other	37	15	45
<u>Total Charges</u>	<u>734</u>	<u>731</u>	<u>629</u>
<u>Disposition of Court Cases</u>			
Guilty	382	323	332
Nolle	318	302	193
Not Guilty	6	0	1
Dismissed	0	6	19
Recoveries - Not Prosecuted	0	0	20
<u>Total Dispositions</u>	<u>706</u>	<u>631</u>	<u>565</u>
<u>Summary of Recoveries and Orders</u>			
Actual Recoveries-Number of Cases	102	102	156
Amount	\$90,999	\$91,015	\$110,642
Orders of Support	34	13	0
Payment Plans	86	49	112

*1-1-73 to 6-30-73

Source: Division of Central Collections, Finance and Control

APPENDIX IV-1

FEE SCHEDULE FOR AMBULANCE SERVICES

Effective 7-1-76

Base Rate	\$48.00	Note a
Mileage	\$ 1.75	Note b
Procedure	Not Specified	Note f
17001 Oxygen & Mask	\$10.00	
17003 Resuscitator	\$10.00	
17004 Suction Machine	\$10.00	
17005 Female Attendant	\$18.50	
17006 Waiting Time	\$25.00 per hour	Note c
17007 Waiting Time (Additional)	\$ 6.25 per one quarter hour	
17008 Cancelled Call	\$25.00	Note d
17009 Multiple Patients	Note e	By Report

Note a. Base rate shall be applicable where both the origin and destination are within one town.

Note b. Mileage to be applied from point of origin of movement to any final destination outside town in which pick-up is made. Mileage to be determined from the P.U.C.A.'s Official Mileage Docket No. 6770.

Note c. Waiting time charges apply per hour. Additional waiting time beyond the first hour will be assessed in multiples of 15 minutes at the rate of \$6.25 per quarter hour.

Note d. A charge for cancelled ambulance call will be assessed whenever such ambulance call is cancelled after an ambulance has been called for and dispatched to a home, hospital, or scene of accident.

Note e. Whenever multiple patients are carried in any one given ambulance, the base rate will be charged for each patient requiring medical attention. The other charges to be equally assessed against all patients transported are mileage, waiting time, and where applicable, female attendant.

Note f. Charges for loss of equipment used in transporting patients shall be assessed at actual cost, subject to proof of connection between loss of equipment and the transportation of patient.

Note g. There shall be no charges assessed for the transportation of non-patients as riders accompanying patients requiring ambulance service.

(attachment to Index No. 462, Vol. 3)

Revised 4-26-76
Effective 7-1-76

APPENDIX VI-1

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Health Maintenance Organizations and other "prepaid health plans" offer an alternative to the traditional "fee-for-service" medical delivery system. Enrollees prepay a fixed fee based on actuarial data. This fee covers virtually all medical care, including preventive care. Generally, the plan operates from a central clinic, and subcontracts for special services and hospitalization.

Connecticut has only one HMO in operation at the present time-- Community Health Care Plan (CHCP) in New Haven. Another is scheduled to open early in 1977 in Bridgeport, and a third is in the planning stages in Windsor.

CHCP has been in operation since October 1, 1971 and serves some 20,400 persons on a prepaid "group" basis. One such group is state employees living in the Greater New Haven area, who chose to enroll in CHCP as an alternative to Blue Cross and CMS.

The Department of Social Services has been negotiating with the New Haven HMO for the enrollment of approximately 1600 AFDC recipients. Most of the details of the agreement have been worked out, except the capitation (per person) fee. Resolution seems imminent, however, with the help of the HEW Regional Office.

In the short run, this approach is not expected to reduce Medicaid expenditures. The preventive care aspects of the program, however, are expected to generate savings over the long term through decreased use of acute treatment services. The Legislative Program Review and Investigations Committee endorses the use of HMO's for Medicaid recipients because the emphasis is on maintaining health rather than curing sickness. Such an approach can be expected to be both more efficient and more effective than the present system. Because payment is made in advance and regardless of actual services performed, however, careful monitoring will be required to assure that recipients receive the care they need.

The Medi-Cal (Medicaid) program in California, after several years of experimentation and many mistakes, seems to have developed a workable prepaid health plan satisfactory to recipients, providers, HEW, and the state. DSS might look to the experience of the Medi-Cal program in developing its contracts with HMO's.

APPENDIX VI-2

PERSONNEL¹ AND WORKLOAD COMPARISON

<u>Department of Social Services</u>		<u>Private Insurer</u>	
<u>Unit</u>	<u>Number of Positions</u>	<u>Unit</u>	<u>Number of Positions</u>
Medical Payments Section ² (excluding Convalescent Work Center)	47	Claims Service Unit	10
Medical Services Reviewers	5	Claims Examining Unit	40
Post Audit Reviewers	3	Claims Recovery Unit	9
	—		—
		Total	59
Total	55		
Estimated Claim Line items processed per month	490,000		200,000
Average claim line items per month per employee	8,909		3,390

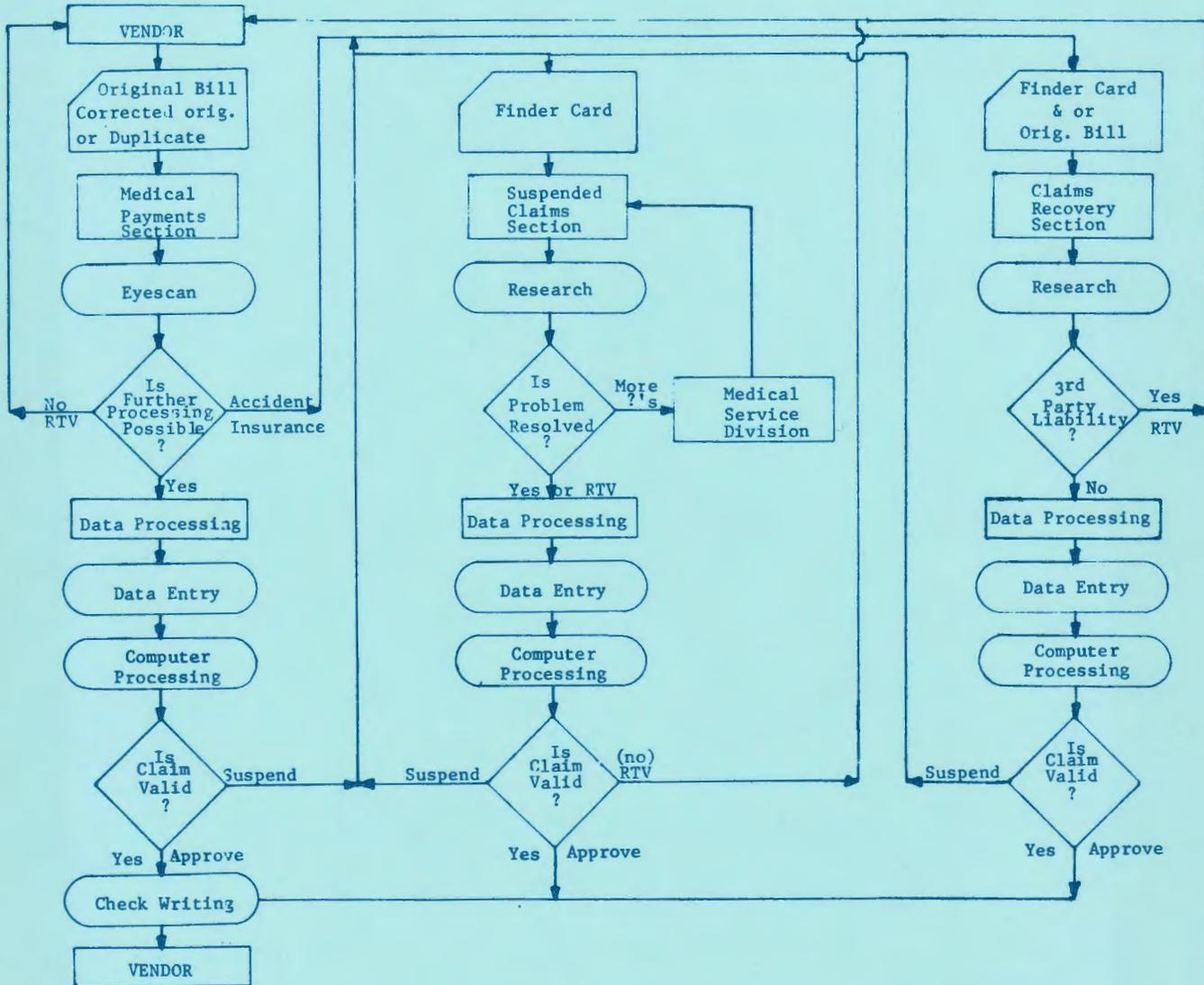
¹ The organizational units shown do not perform parallel functions; however, the combined units do have basically the same responsibilities. They are shown primarily to display the private insurer's organizational structure since recommendation is made in this chapter to establish a Claims Recovery Unit in DSS which would have a parallel function.

² Currently operating with only 34 staff members due to unfilled vacancies and leaves of absence.

Source: LPR&IC staff analysis of data provided by Connecticut Medical Service, Inc. (CMS) and the Department of Social Services

APPENDIX VI-3

LPR&IC PROPOSED MEDICAID PAYMENT SYSTEM



Source: LPR&IC analysis of Department of Social Services information with proposed modifications.



CONNECTICUT LEGISLATIVE PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

PUBLICATIONS LIST

Grants-in-Aid to Municipalities, Vol. II, in press.

Bonding in Connecticut, in press.

Containing Medicaid Costs in Connecticut, September, 1976.

Preliminary Review of Selected Medicaid Issues in Connecticut, March 24, 1976.

Report on Connecticut State Unemployment Compensation Program, September, 1975.

Preliminary Report on the Financing of Connecticut's Unemployment Compensation Program, April 7, 1975.

Report on the University of Connecticut Health Center, January, 1975.

Report on State Grants-in-Aid to Municipalities, Vol. I, December, 1974.

Community Colleges in the State of Connecticut, July, 1974.

Secondary Vocational Education in Connecticut, March, 1974.

Land Acquisition by the State of Connecticut, September, 1973.

Special Education in Connecticut, April, 1972.

Copies of reports published by the Legislative Program Review and Investigations Committee may be obtained by contacting Ms. Linda Adams, Director, Room 404, State Capitol, Hartford, Connecticut 06115.

