Report of the

State Auditor

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

TWO YEARS ENDED JUNE 30, 1975

STATE of COLORADO
Denver

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June 14, 1976

Legislative Audit Committee
2410 Lincoln Center Building
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Gentlemen:

The enclosed report on Medical Assistance covering the period July 1, 1973 through June 30, 1975 is one of a series of reports on the Department of Social Services.

Respectfully submitted,

John P. Proctor

JOHN P. PROCTOR, CPA
State Auditor

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

TWO YEARS ENDED JUNE 30, 1975

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STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

TWO YEARS ENDED JUNE 30, 1975

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STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

TWO YEARS ENDED JUNE 30, 1975

REPORT DIGEST

The purpose and scope of this audit was to:

- evaluate the Department of Social Services, Division of Medical Assistance for compliance with State statutes, Federal regulations and the State plan with its corresponding manual regulations and guidelines.

- evaluate the implementation of recommendations in prior audit report.

Our review of the Division of Medical Assistance covered four areas. They were Physician and Hospital Services, Nursing Home Program, Supplemental Medical Insurance Benefits and Drug and Pharmaceutical Services. The audit period was for the two years ended June 30, 1975.

The Department of Health, Education and Welfare Audit Agency will review the Early Periodic Screening Diagnostic Testing Program and Utilization Review. Their report on these areas will be issued at a later date. Therefore, we did not include these areas in our review.

Physician and Hospital Services covers the medical and hospital services provided for eligible welfare recipients. Blue Cross and Blue Shield acts as fiscal agent in making program payments to providers of these services. We tested the processing of claims and accumulation of the related administrative costs by Blue Cross and Blue Shield.

The review of the Nursing Home Program was conducted on a test basis. Our sample included 110 nursing home recipients from within eleven counties. We also reviewed 68 nursing home facilities in which the 110 recipients resided for compliance with applicable regulations. For the same recipients, our test included examination of documentation supporting payments for drugs and physicians services and the personal needs funds maintained by the facilities for the recipients.

To qualify for Supplemental Medical Insurance Benefits, a recipient must be eligible and receiving a money payment. We reviewed the eligibility and money payment status of recipients for December 1974.

For Drugs and Pharmaceutical Services, we reviewed the in-house system for verifying the eligibility of recipients and authorizing payment for drugs and pharmaceuticals.

SUMMARY OF CURRENT AUDIT COMMENTS

The following is a summary of findings disclosed in our review of the Division of Medical Assistance. The problems are summarized and presented in detail under the sections of this

report entitled Auditor's Comments.

Physician and Hospital Services

A physician may be compensated various amounts for similar procedures. Claims are paid based on codes defining the diagnosis of the illness and the procedures of the physician to treat that illness. A physician with a good knowledge of diagnostic and procedure codes could increase his compensation for various services through the use of these codes.

Procedure codes are obtained from the 1968 Colorado Relative Value Study which describes the myriad services available in terms of "medical units of service". Many definitions of procedures are not comparable with current medical practice as a result of technical advances within the medical profession. An updated version of the Colorado Relative Value Study is used by Blue Cross and Blue Shield in processing claims for their private subscribers. Administrative difficulties are created by using the outdated Colorado Relative Value Study.

Colorado Department of Social Services needs to improve accounting control over the administrative costs being charged against the Medicaid program by Blue Cross and Blue Shield.

Nursing Home Program

Many of the nursing home facilities did not provide separate facilities and staff for the skilled and intermediate care

patients as required by the regulations.

53% of the 74 files which we reviewed relating to skilled nursing care did not indicate a re-evaluation of the individuals' needs for skilled care had been made every thirty days.

We were unable to trace 10% of payments for drugs to the recipients' medical records. We were also unable to trace 24% of physicians' visits for which payment had been made to the patients' medical records.

We reviewed the methods and procedures used by the nursing homes to manage the funds in patients' personal needs accounts. These methods and procedures are generally inadequate and do not ensure these funds are being properly used and accounted for.

Supplemental Medical Insurance Benefits

The agreement between the Secretary of the Department of Health, Education and Welfare and the Colorado Department of Social Services requires individuals in the "coverage group" to be eligible for and receiving money payments under one of the approved titles of the Social Security Act, if reimbursement is to be received.

A computer program was designed in 1973 by the Department to identify the individuals whose premiums were not eligible for Federal reimbursement. However, the introduction of the Supplemental Security Income Program (SSI) in January 1974 made this computer program obsolete.

The Department has claimed Federal Financial Participation on total premiums paid since January 1974, without regard to the money payment requirement.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

PHYSICIAN AND HOSPITAL SERVICES

TWO YEARS ENDED JUNE 30, 1975

INTRODUCTION

BACKGROUND

Physician and Hospital Services, provided under Title XIX of the Social Security Act, as amended, and Article 4 of Title 26, C.R.S. 1973, as amended, are part of the overall audit of the Colorado Department of Social Services.(CDSS).

The audit of Physician and Hospital Services covered the period July 1, 1973 through June 30, 1975. CDSS is responsible for administering the Title XIX "Medicaid" assistance program. This program provides medical and hospital services to eligible welfare recipients. CDSS has entered into an agreement with Colorado Medical Service, Inc. and Colorado Hospital Service, Inc. (Blue Shield and Blue Cross) to act as its fiscal agent (FA) in making program payments to providers of these services.

To fulfill its responsibilities with CDSS, the FA receives medical claims, reviews them for completeness, confirms existence of the provider, and verifies eligibility of the patients. Payment is made from State funds in accordance with directives issued by the Medical Assistance Division. The agreement requires payment be made within a reasonable time, usually thirty days. CDSS also reimburses the FA for the administrative costs

of performing these services.

The FA processed claims for physician/suppliers services, inpatient care, outpatient care, home health care, extended care, medically indigent program, and the early periodic screening diagnostic testing program. The gross amounts of medicaid claims paid by the FA were $43,744,470 and $30,826,802 for fiscal years ended June 30, 1975 and 1974, respectively.

Our review of the activities of the FA was divided into two parts: the procedures used to process medicaid claims and the procedures used to accumulate the associated administrative costs. Reimbursement to the FA for administrative costs incurred were $2,769,392 and $2,295,541 for the fiscal years ended June 30, 1975 and 1974, respectively.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

PHYSICIAN AND HOSPITAL SERVICES

TWO YEARS ENDED JUNE 30, 1975

AUDITOR'S COMMENTS

CLAIMS PROCESSING

The objectives of our testing were to determine that proper payments were made to eligible providers in behalf of eligible recipients within a reasonable time. For testing eligibility, we accepted the status as indicated on the computer eligibility lists prepared by CDSS.

Our sample, selected with the assistance of the U. S. Department of Health, Education, and Welfare Audit Agency, included claims processed for payments to physicians/suppliers and payments to hospitals for inpatient and outpatient care. In addition, we tested claims processed with a specific procedure code service description. An interval method was used to select the samples from computer listings generated by the FA.

Based on the testing performed, we were able to determine that most medicaid claims were being properly paid and processed within a reasonable time.

However, certain problems were noted which we feel should be discussed.

Diagnosis Codes

A physician may be compensated various amounts for similar procedures. The physician is able to accomplish this by varying the diagnosis and/or procedure code on the claims filed.

Certain medical procedures can be performed in one visit or in several visits.

One example noted was an immunization procedure wherein one injection can produce immunization for several diseases such as Diptheria, Pertussis, and Tetanus (DPT). Some physicians perform this immunization in one injection; however, it is possible to administer these same immunizations in three injections.

When the latter procedure is followed and three separate claims are filed indicating three separate dates of service, payment could be increased as much as ten times over the cost of the single injection.

Another physician performed the identical procedure on three recipients and received different compensation for each. This was accomplished by reporting different levels of severity of the illness through the diagnosis code.

The FA indicated they must rely upon the professional judgment of the physician in making the diagnosis and made no attempt to determine if the diagnosis was proper.

Peer review procedures were in operation during our audit period. A peer review is an effort to verify the proper utilization of treatment by other qualified physicians, but was terminated at June 30, 1975. Division personnel stated insufficient benefits were being derived.

In our opinion, an effective peer review would be of benefit as it appears a physician with a good knowledge of diagnostic codes and procedure codes could increase his compensation for various services through the manipulation of these codes.

Recommendation

1. The Medical Assistance Division should establish an effective peer review procedure.

DEPARTMENT'S RESPONSE: To be implemented July 1977. (pages 45 and 51)

Non-Physicians Services

The FA reimbursed non-physicians for services rendered at the same rate as physicians. An example noted was psychotherapy being given by a trained social worker billed and paid at the rate applicable to physician services.

We were told new procedures were initiated after the close of our audit period to rectify this situation.

Recommendation

2. The Medical Assistance Division should ensure the new procedures are implemented by the FA to establish equitable payments for professional skills.

DEPARTMENT'S RESPONSE: Implemented July 1975. (pages 45 and 51)

Procedure Code

If the physician does not enter a procedure code on the claim, the FA prices it by inserting a code after reviewing the description of the service performed. This code is obtained from the 1968 Colorado Relative Value Study (1968 CRVS), which describes the myriad services available in terms of "medical units of service". Many definitions of procedures included in the 1968 CRVS are not comparable with current medical practice as a result of technical advances within the medical profession.

In our prior audit report, we recommended the Medical Assistance Division use a more current CRVS for processing Title XIX claims. No action was taken on implementing this

recommendation. However, the problem of applying more specific procedure codes to claims increases as the 1968 CRVS becomes more outdated. An updated version of the CRVS was published in mid-1972 and has been used by the FA in processing claims for its private subscribers since 1974. The 1971 CRVS incorporated newer, more technical procedures used in the profession.

The required use of two CRVS's creates administrative difficulties for the providers of medical services and increases the potential of error in processing both medicaid and private claims.

Our testing of procedure code 9071 (defined as "Prolonged detention with patient in critical condition, requiring constant attention beyond usual service") disclosed several claims where this code was used although the description of the services on the claim did not agree with this definition. The various types of services for which procedure code 9071 was used included initial office visit, comprehensive diagnostic history, physical examination, speech therapy, consultations, and office visit to change a dressing.

Further discussion with the FA disclosed procedure code 9071 is used on any claim where prolonged care is a factor in pricing. The definition in the 1968 CRVS is not in agreement with the fiscal agent's current policy of using this procedure code.

It appears that use of procedure code 9071 provides an arbitrary number of additional medical service unit values whenever a physician deems services in excess of normal were rendered. This code does not accurately correlate to true

services provided and invites abuse by the provider filing the claim. We were informed this problem exists with both the 1968 and 1971 CRVS's.

Recommendations

3. The Medical Assistance Division should require the FA to use a more current CRVS for pricing medical claims.

DEPARTMENT'S RESPONSE: Deferred. (See additional Agency comment pages 45 and 51)

4. Refine procedure code 9071 to properly correlate with the nature and intensity of services actually rendered.

DEPARTMENT'S RESPONSE: Rejected. (See additional Agency comment pages 45 and 51)

Review of FA Activities

In our prior report we recommended the Medical Assistance Division should implement procedures to review the activities of the FA and monitor its performance. The Medical Assistance Division has not implemented this procedure and has no basis to evaluate the performance of the FA.

Recommendation

5. The Medical Assistance Division should, at least on a sample basis, systematically review supporting documentation for claims paid by the FA to determine that services are paid for in accordance with Division directives.

DEPARTMENT'S RESPONSE: To be implemented January 1977. (pages 45 and 51)

ADMINISTRATIVE COSTS

Our objective in testing the administrative procedures in use by the FA was to determine if they had a reasonable method of accumulating the costs of administering the Medicaid Program and agree this accumulation to the amount billed Medical Assistance Division for our audit period. In addition, we tested the FA's records of the Medicaid bank accounts to verify if these accounts had been properly handled.

The FA has developed the Standard National Accounting Program (SNAP) which is a computerized cost system to allocate administrative expenses to the various lines of business within the company.

We selected a sample of administrative expenses charged to various Medicaid lines of business from the line of Business Verification Report (NAP 40-50 Report) on a judgment basis for review. The items in this sample were then traced through the SNAP system to the final line of business. All allocations for the items in our sample were recomputed to verify the accuracy of the distribution of costs. In addition, we traced costs allocated to the program back to the original invoice or other source document to confirm their accuracy.

Based upon the work performed, the FA has a reasonable method of accumulating and distributing the administrative costs to the Medicaid Program. However, certain problems were noted which we feel should be discussed.

ALLOCATED COSTS

The costs allocated by the SNAP system to the Medicaid Program are materially correct. However, we were not able

to reconcile the total costs as developed by the SNAP system to the total amount billed to the Medical Assistance Division because of the following problems:

1. The monthly invoices prepared by the FA for administrative costs were usually based on estimates because the SNAP system was not on a current basis. The difference between the estimated costs and the actual costs were adjusted on a subsequent month's invoice. However, neither the FA nor the Medical Assistance Division attempted to reconcile the total amount invoiced for the fiscal years to the final costs as developed by the SNAP system.

2. The Cathode Ray Tubes (CRT) were put into the cost allocation system both as a direct (dedicated peripheral) and as an indirect (shared peripheral) charge in February 1975. This error which went undetected until June 1975 resulted in the various Medicaid lines of business being overcharged approximately $5,981 for the months of February, March, April, and May 1975. Although the FA reran the SNAP system for these months, no adjustment has been made in the amount invoiced the Medical Assistance Division for these months.

CDSS needs to improve accounting control over the administrative costs being charged against the Medicaid Program by the FA.

Recommendations

6. CDSS should test documentation supporting administrative charges to the Medicaid programs on a periodic basis.

DEPARTMENT'S RESPONSE: To be implemented January 1977. (pages 46 and 51)

7. CDSS should reconcile the estimated administrative costs billed to the State with the actual costs generated by the FA's cost system at least annually.

DEPARTMENT'S RESPONSE: To be implemented January 1977. (pages 46 and 52)

8. CDSS should verify the amount of the overcharges during the four-month period and require an adjustment to be made. This should be done any time there is a correction of the SNAP system.

DEPARTMENT'S RESPONSE: Implemented March 1976. (pages 46 and 52)

COST REPORTED ON FINANCIAL STATEMENTS

We were not able to agree the total administrative costs incurred for the years ended June 30, 1975 and 1974 to the financial statements of CDSS. CDSS is reporting the total amount of their appropriation as expenditures for fiscal agent reimbursement instead of their actual expenses, the difference being credited to accounts payable or charged to a subsequent year's appropriation. See also the comment in the overall administration report.

Recommendation

9. CDSS should report only those accrued expenses for administrative costs on their financial statements for which there is supporting documentation.

DEPARTMENT'S RESPONSE: To be implemented January 1977. (pages 46 and 52)

Missing Documentation

When we requested certain bank account reconciliations from the FA for fiscal years ended June 30, 1975 and 1974, they were unable to produce all of the bank statements for

the fiscal year ended June 30, 1974 for our review. We were therefore unable to complete our testing of the cash accounts through which Medicaid expenditures were paid.

Recommendation

10. The FA should establish a more effective system of record retention and retrieval for the cash records.

DEPARTMENT'S RESPONSE: To be implemented. (pages 46 and 52)

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

PHYSICIAN AND HOSPITAL SERVICES

TWO YEARS ENDED JUNE 30, 1975

PRIOR AUDIT RECOMMENDATIONS AND THEIR DISPOSITION

	Recommendation	Disposition
1.	A review of the data processing programs should be made to determine why eligibility data on the micro-fiche is different from the State eligibility tape.	Implemented.
2.	Based on the review, programs should be rewritten to insure the eligibility data on the micro-fiche is the same as the tape.	Implemented.
3.	The county welfare offices should be instructed to properly identify transfer recipients.	Implemented.
4.	An effort should be made to obtain and destroy the medical identification eligibility cards when the recipients terminate their eligibility. The possibility of a provider acting in good faith based on an incorrect card would be reduced.	Implemented.
5.	A procedure should be developed to confirm medical services on a current basis.	Implemented. See current year comment in the Nursing Home section of this report, page
6.	Data received from the verification of medical services should be accumulated and evaluated.	Is being implemented. See current year comment in the Nursing Home Section of this report, page 25.
7.	Exceptions should be investigated with appropriate steps taken to reduce their recurrence.	Is being implemented. See current year comment in the Nursing Home Section of this report, page 25.

Recommendation	Disposition
8. Procedures should be initiated to establish the new per diem rates early in the fiscal year.	No longer applicable. Regulations now state that retroactive adjustments will no longer be allowed.
9. The CRVS procedure codes should be defined more precisely to establish their limits.	Not implemented. See current year comments, page 12.
10. A review should be made to determine the feasibility of obtaining a more precise definition of services from the provider to facilitate pricing claims.	Not implemented. See current year comments, page 12.
11. A more current Colorado Relative Value Study should be used in processing Title XIX claims.	Not implemented. See current year comments, page 10.
12. The eligibility of the recipients receiving services at the Colorado Springs Medical Center, when the eligibility check has been bypassed, should be compared to the State eligibility tape to determine the propriety of payments.	Implemented.
13. The DSS should reestablish the procedure of authorizing the payment for medical services performed at the Colorado Springs Medical Center based on information within the State eligibility tape.	Implemented.
14. The FA's analysts should review the software system used by McDonnell Douglas to obtain a good understanding of how the system functions.	Implemented.
15. A macro flowchart of the system should be prepared for easy reference.	Not implemented.
16. The license of out-of-state physicians should be verified prior to paying claims.	Implemented.
17. The DSS should implement procedures to: a) review the activities of the fiscal agent, and b) effectively monitor its performance.	Not implemented. See current year comments, page 15.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

NURSING HOME PROGRAM

TWO YEARS ENDED JUNE 30, 1975

INTRODUCTION

BACKGROUND

Nursing home services are provided under Title XIX of the Social Security Act, as amended, and Article 4 of Title 26, C R.S. 1973, as amended. CDSS prepares rules and regulations governing the operations of the facilities based upon regulations and directives received from Social and Rehabilitation Services (SRS), a Federal agency.

The audit of the Nursing Home Program covered the period July 1, 1973 through June 30, 1975. Expenditures for nursing home care during this period were $44,227,598 and $36,574,961 for fiscal 1975 and 1974, respectively. Federal funds claimed were $25,180,569 and $20,803,975 for fiscal 1975 and 1974, respectively.

Our review was limited to eleven counties and was conducted on a test basis. The sample, drawn from computer listings provided by CDSS, resulted in the testing of 110 recipients and 68 nursing home facilities.

Our random selection of nursing home patients included 51 in skilled care, 40 in intermediate care and 19 receiving both levels of care at varying times during our audit period. 68 nursing facilities were tested. 27 delivered skilled care,

20 delivered intermediate care and 21 offered both skilled and intermediate care. In those facilities where both levels of service were offered and our sample contained patients receiving both levels of care, we tested the facility for compliance with regulations governing both types of facility.

Medical files of patients and records of the nursing facilities were reviewed and tested for compliance with State and Federal rules and regulations. We tested payments to facilities for nursing care of Title XIX recipients totaling $529,921 for the two fiscal years ended June 30, 1975.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

NURSING HOME PROGRAM

TWO YEARS ENDED JUNE 30, 1975

AUDITOR'S COMMENTS

Nursing Home Facilities

The nursing home facilities reviewed were determined by randomly selecting a sample of medicaid recipients and visiting the homes in which they resided. Non-compliance with specific CDSS regulations (referenced as ( ) below) were noted as follows:

Skilled Care Facilities

4.1% (2 homes out of 48) did not have either a registered nurse or a licensed practical nurse on duty 24 hours a day, (CDSS A-4331.242). The Colorado Department of Health requires a licensed, skilled nursing care facility to have a registered nurse on duty 24 hours a day. This is in conflict with CDSS regulations which allow a registered nurse or a licensed practical nurse to be on duty. 33.3% (16 homes out of 48) of the skilled nursing care facilities which we tested did not meet the Department of Health requirement.

27.1% (13 homes out of 48) did not have adequate staff to provide at least 2 hours of professional nursing care for each recipient each 24-hour period, (CDSS A-4331.243).

2.1% (1 home out of 48) were licensed for only one level of care but had patients at both levels of care.

64.6% (31 homes out of 48) did not provide separate facilities and staff for the skilled care patients, (CDSS A-4331.301)

Intermediate Care Facilities

2.4% (1 home out of 41) did not have either a registered nurse or a licensed practical nurse on duty during the day shift, (CDSS A-4331.311).

46.3% (19 homes out of 41) did not provide separate facilities and staff for the intermediate care patients, (CDSS A-4331.301).

CDSS is not adequately enforcing regulations concerning the level of staffing or the requirement to have separate staff and facilities for skilled and intermediate care recipients.

Recommendations

11. CDSS should more vigorously enforce their regulations pertaining to staffing requirements of skilled and intermediate nursing care facilities.

DEPARTMENT'S RESPONSE: To be implemented August 1977. (pages 47 and 52)

12. CDSS should resolve the conflict between its regulations concerning required nursing home staff for skilled care recipients and the regulations of the Department of Health.

DEPARTMENT'S RESPONSE: Requires legislation. (pages 47 and 52)

13. CDSS should enforce its regulation requiring separate facilities and staff for skilled and intermediate care recipients.

DEPARTMENT'S RESPONSE: To be implemented February 1977. (pages 47 and 52)

14. CDSS should verify on a periodic basis that the nursing care facilities receiving payments under this program are meeting their staffing and separate facilities requirements.

DEPARTMENT'S RESPONSE: To be implemented February 1977. (pages 47 and 52)

Levels of Care

A selection of nursing home patients was made on a random basis from the eleven largest counties in the state. Our sample included 54% skilled care and 46% of intermediate care recipients. Non-compliance with specific CDSS regulations (referenced as ( ) below) were noted as follows:

Skilled Nursing Care Recipients

34.8% (250 monthly visits of 718) of the required monthly visits by the physician were not documented in the files, (CDSS A-4331.262).

52.7% (39 files of 74) of the files did not indicate a re-evaluation of the individual's need for skilled care had been made every thirty days, (CDSS A-4331.263).

4.1% (3 files of 74) of the files did not contain a summary of treatment or a physician's treatment plan, (CDSS A-4331.263).

2.7% (2 files of 74) of the files did not contain physicians' notes, (CDSS A-4331.262).

Intermediate Nursing Care Recipients

18.9% (55 quarterly visits of 290) of the required quarterly visits by the physician were not documented in the files, CDSS A-4331.342).

3.2% (2 files of 62) of the files did not contain a physician's treatment plan, (CDSS A-4331.342).

The number of instances of non-compliance with specific CDSS regulations, whose purposes are to ensure recipients receive proper levels of care provided by the Title XIX program, indicates recipients are not receiving services to which they are entitled under the program.

Recommendation

15. CDSS should expand its audit review of nursing homes to include testing of compliance with program requirements.

DEPARTMENT'S RESPONSE: To be implemented August 1977. (pages 47 and 52)

16. CDSS should ensure corrective action is taken when non-compliance with program requirements are noted in audit reviews.

DEPARTMENT'S RESPONSE: To be implemented August 1977. (pages 47 and 52)

Payments for Drugs and Physicians

Payments for Drugs

We obtained lists of drugs purchased during our audit period for recipients in our test and attempted to agree them (on a test basis) to the recipients' medical records at the nursing home. Of the drugs selected for this test, we could not agree 10.03% (34 claims of 339) to the recipients' medical records.

Payments to Physicians

We obtained Statistical Information Sheets (SIS) for each recipient in our test which showed the payments made by Medicaid for physician visits and other medical services. We attempted to verify the physician visits paid for by examining the recipients' medical records at the nursing home. We were unable to trace 24.2% (64 claims of 265) of these visits to the medical records.

The Division of Medical Assistance has designed and is presently implementing a method of verifying the receipt of medical services directly with the recipients. We have reviewed the procedures to be followed in the verification of services received by medicaid recipients and feel the system will meet the objectives and be a productive operation.

The system has not been in operation over a long enough time-span to make a thorough evaluation of results at this time. The effectiveness of the verification process will be directly dependent upon the Division's ability to keep the system on a current basis.

Recommendations

17. CDSS should institute procedures which will verify that payments for drugs and physician services are actually received by the recipients.

DEPARTMENT'S RESPONSE: Implemented. (pages 48 and 53)

18. Continue to operate the system of verifying the receipt of medical services by medicaid recipients, evaluate the results and take appropriate action.

DEPARTMENT'S RESPONSE: Implemented. (pages 48 and 52)

Personal Needs Funds

We reviewed the methods and procedures used by the nursing homes in handling the funds in patient personal needs accounts. Our testing disclosed the following problems.

25.4% (17 homes of 67) of the homes did not maintain proper accounting records as required by the regulations, (CDSS A-4331.172).

14.9% (10 homes of 67) did not record the proper credits to the recipients' accounts.

7.5% (5 homes of 67) did not maintain a separate checking account, savings account, or certificate of deposit designated as "patient trust funds account" separate and apart from operating funds, (CDSS A-4331.172).

35.1% (13 homes accumulating interest of 37) did not allocate interest income generated by the personal needs funds to the individuals having funds in the account or use it to the benefit of all the patients in the facility as required by the regulations, (CDSS A-4331.172).

5.9% (4 homes of 67) expended personal needs funds for unauthorized items.

23.9% (16 homes of 67) did not obtain the required approval from the recipient for disbursements from personal needs funds, (CDSS A-4331.172).

The following additional problems were noted:

- Several nursing homes failed to maintain the required balances in their separate trust accounts for personal needs funds.
- In many instances, it was not possible to agree our separate bank confirmations to the book balances of the trust accounts because of inadequate or missing accounting records.

- In one case a large corporation which controlled several nursing homes also directly controlled a substantial portion of the homes' personal needs funds. No effort was made to allocate the interest or use it for the benefit of those in the homes.
- The regulations (CDSS A-4331.172) state there must be legal authority for a conservator, guardian, relative or other person to manage the personal needs funds of a recipient who is not able to manage his own funds. Many of the nursing homes failed to obtain the required authority.
- In one case, the corporation owning the nursing home borrowed a substantial portion of the patients' personal needs funds under the terms of a promissory note ($21,865).
- Some mentally retarded patients had income in excess of the personal need fund allowance of $25.00 per month. The excess was not being applied towards the cost of patient care.

The methods and procedures used by the nursing homes in accounting for personal needs funds are inadequate and do not ensure that these funds are being properly used and accounted for.

Recommendations

19. CDSS should enforce the present regulations concerning maintenance and use of personal needs funds.

DEPARTMENT'S RESPONSE: Implemented July 1976. (pages 48 and 53)

20. CDSS should use all means at the Department's disposal to force compliance with the regulations concerning personal needs funds.

DEPARTMENT'S RESPONSE: Implemented July 1976. (pages 48 and 53)

21. CDSS should determine why the mentally retarded recipients who have incomes in excess of the personal needs allowance are not applying the excess income to the cost of their care.

DEPARTMENT'S RESPONSE: To be implemented November 1976. (pages 48 and 53)

Records Retention at Division of Medical Assistance Office

The Division of Medical Assistance had difficulty in locating required information for the recipients in our sample because of the following problems:

- In some instances, CDSS had two State identification numbers for the same individual.
- Certain information was difficult to locate because of the general lack of organization in which they were filed. These records were the audit reports of per diem costs for each nursing home, the patient evaluation forms, (form NH-11) and the nursing home admission authorization (NH-7) for each recipient. Although personnel at the Division of Medical Assistance spent considerable

time attempting to locate these records, the following information was not found:

- 22.1% (25 documents of 113) of the NH-7s could not be located.
- 48.3% (43 documents of 89) of the medical evaluations either were not completed or were not located.

The general condition of the files in the Division of Medical Assistance required the expenditure of a large amount of agency staff time searching for records and did not permit the application of auditing procedures to proceed on a timely basis. This also hampers CDSS' ability to monitor the nursing home operations.

Recommendations

22. CDSS should establish procedures to ensure that all recipients are assigned only one State identification number and eliminate the second number.

DEPARTMENT'S RESPONSE: Implemented. (pages 48 and 53)

23. CDSS should organize the filing system in the Medical Assistance Division to ensure that all information is readily retrievable.

DEPARTMENT'S RESPONSE: To be implemented March 1977. (pages 49 and 53)

Medical Evaluations

In our prior audit of the Nursing Home Program, we noted the annual Utilization Reviews (UR), to determine if recipients were receiving the proper levels of care, were not being conducted on a timely basis by CDSS.

During our current audit we conducted a limited review of this area to determine if the agency was conducting these reviews in accordance with their response to our prior audit recommendation. The Department of Health, Education and Welfare Audit Agency will conduct an in-depth review of this area at a later date. Therefore, we did not extend the scope of our testing.

Our testing to determine if the required annual medical review had been completed indicated:

48.3% (43 evaluations of 89) of the medical reviews were either not completed or could not be located.

The patient evaluation form does not show the State I.D. number, but only the household number which is subject to change.

39.4% (28 evaluations of 71) of the patient evaluation forms examined were not completed in the section relating to the frequency of physicians' visits.

The Division of Medical Assistance did not maintain a log or record of the last completed medical evaluation.

We were not able to determine if the required annual medical reviews were being made because of the above problems.

Recommendations

24. CDSS should establish procedures to ensure that all annual medical reviews are completed on a timely basis.

DEPARTMENT'S RESPONSE: To be implemented February 1977. (pages 49 and 53)

25. CDSS should review the patient evaluation forms to ensure they are properly completed before accepting them.

DEPARTMENT'S RESPONSE: Implemented. (pages 49 and 53)

Timely Filing

CDSS requires a completed NH-7 (nursing home admission authorization) be sent to the Medical Assistance Division 72 hours after the admission of a recipient to the nursing home. If this is not done, payment will not be made for more than

72 hours of care prior to the receipt of the NH-7. Our tests to determine compliance with the 72-hour requirement disclosed the following:

22.1% (25 documents of 113) of the NH-7s could not be located at the Division offices.

15.2% (18 documents of 113) of the NH-7s were date-stamped by the Medical Assistance Division more than 72 hours after admission of the recipient. However, payment was approved for more than 72 hours of care. We were informed payment was made based on the postmark on the envelope. However, in these cases, the envelopes were not retained. We were, therefore, unable to verify if the NH-7s were always timely mailed.

We were unable to conclude if CDSS was enforcing the 72-hour rule.

Recommendations

26. CDSS should establish procedures to ensure that all the NH-7s are properly filed and available for inspection.

DEPARTMENT'S RESPONSE: To be implemented March 1977. (pages 49 and 53)

27. For those NH-7s which are date-stamped after the end of the 72-hour period and payment is made for more than 72 hours, the envelope should be retained to verify that the NH-7 was mailed within the allowable time period.

DEPARTMENT'S RESPONSE: Implemented. (pages 49 and 53)

Frequency of CDSS Field Audit Reviews

In our prior audit report, we recommended CDSS increase the frequency of their field audit reviews to ensure compliance with program regulations governing levels of care and patients'

personal needs funds.

Additionally, we recommended audits be made when there was a change in ownership in accordance with CDSS regulations.

During our current audit, the records of five facilities selected for review were unavailable for our examination because they had discontinued operations. We were unable to locate audit reports on these facilities.

Recommendations

28. The CDSS should increase the frequency of reviews performed by their field audit staff.

DEPARTMENT'S RESPONSE: Implemented. (pages 49 and 53)

29. The CDSS should require a field audit review when there is a change in ownership or a nursing home discontinues operations.

DEPARTMENT'S RESPONSE: Implemented. (pages 49 and 53)

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

NURSING HOME PROGRAM

YEARS ENDED JUNE 30, 1975 AND 1974

DISPOSITION OF PRIOR RECOMMENDATIONS

	Recommendations	Disposition
1.	Social Rehabilitative Services should determine what adjustment, if any, should be made to the Federal reports. The recommendations discussed in the County Assistance Programs report would apply to this program also.	Implemented.
2.	CDSS should more vigorously enforce their regulations pertaining to staffing and record-keeping for skilled and intermediate levels of care in nursing homes to ensure recipients are receiving services to which they are entitled.	Not implemented. See current year comments, page 24.
3.	CDSS should ensure all residential nursing home administrators are aware of the Department of Health's regulation requiring maintenance of medical records for mentally retarded recipients.	No longer applicable. Residential care no longer qualifies under this program.
4.	A follow-up review should be made to ensure compliance.	Not implemented. See current year comments, page 24.
5.	CDSS should initiate a procedure to monitor compliance with the nursing home regulations published by the Department. CDSS auditors should incorporate a limited program review into their present financial audit program for nursing homes.	Not implemented. See current year comments, page 24.

Recommendations	Disposition
6. Utilization reviews should be made in accordance with Federal regulations to ensure program objectives are being met.	To be reviewed by H.E.W.
7. CDSS should clarify the regulation in regard to documentation required to support expenditures from patients' personal-needs fund.	Implemented, but not adequately enforced. See current year comments, page .
8. CDSS should obtain a legal opinion as to the ownership of the interest income generated by investing patients' funds.	Implemented. Change in agency rules made to satisfy this recommendation.
9. CDSS should increase the frequency of the reviews performed by their audit staff.	Not implemented. See current year comments, page 32.
10. Audit review of nursing homes should be on a more frequent basis and be mandatory prior to a change of ownership.	Not implemented. See current year comments, page 32.
11. Audit programs should include a limited program review to assist CDSS in locating areas of non-compliance with regulations.	Not implemented. See current year comments, page 31.
12. Additional field audit staff should be employed to enable this section to comply with audit requirements.	Implemented.
13. CDSS should provide for a systematic, on-going procedure to review the program on a timely basis as required by the Federal code and regulations.	To be reviewed by H.E.W.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

TWO YEARS ENDED JUNE 30, 1975

INTRODUCTION

BACKGROUND:

Supplemental Medical Insurance Benefits (SMIB) is a program whereby premiums paid by CDSS are remitted to the Social Security Administration (SSA) which enables an eligible recipient to receive benefits under Title XVIII, Part B, of the Social Security Act. Under this buy-in provision, charges for physicians' services are first paid through the Medicare Program which is totally federal funded. Only those charges which are in excess of Title XVIII limitations are subject to payment by Medicaid, Title XIX. Premium payments made to the SSA are considered vendor payments and, therefore, subject to partial reimbursement by the Department of Health, Education and Welfare (DHEW).

Our audit covered a 24-month period ending June 30, 1975. The SMIB premium payments made during this period were $2,739,549 for the year ended June 30, 1974, and $2,738,377 for the year ended June 30, 1975. Federal funds were respectively claimed of $1,390,729 and $1,566,899. The net cost to the State for the 24-month period totaled $2,520,298. SMIB premium payments are authorized under Title XIX of the Social Security Act, as amended, and Article 4 of Title 26, Colorado Revised Statutes 1973, as amended.

The State Plan for Medical Assistance was initially implemented and expenditures incurred effective January 1, 1969. In February 1971, a report by HEW Audit Agency noted certain errors made by the Colorado Department of Social Services (CDSS) in claiming Federal reimbursement of expenditures. These deficiencies continued through June 1972. Subsequently, Social and Rehabilitation Services (SRS) and CDSS agreed to use a sampling plan to develop a financial settlement. In June 1974, a settlement was reached and adjustments were made to the Federal report totaling $643,718 in the favor of HEW for the period January 1969 through June 1972.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

TWO YEARS ENDED JUNE 30, 1975

AUDITOR'S COMMENTS

Premium Payments

An individual must be eligible under certain titles of the Social Security Act to qualify for participation in the SMIB Program. We tested the list of SMIB recipients enrolled for December 1974, to determine if they were properly eligible. Our test resulted in an error rate of 2.6%. Exceptions noted were predominately caused by failure to terminate recipients when his eligibility lapsed. Comparing enrolled recipients to the master eligibility tape would reduce this problem. Projecting the 2.6% to the December 1974 premium payment we estimate an overpayment to SSA of $6,224.

CDSS does not reconcile the number of individuals enrolled in the program to the number reported by SSA on their monthly invoice. Additionally, the premium per recipient is not multiplied by the number of enrolled recipients to reconcile the total invoice. The invoices are sent to the accounting office for payment without verifying their accuracy.

Recommendations

30. SMIB participants should be compared with the master eligibility tape to determine their continuing eligibility.

DEPARTMENT'S RESPONSE: To be implemented October 1976. (pages 50 and 54)

31. A computer processing method should be designed to identify the additions and deletions of SMIB participants from the monthly eligibility processing documents.

DEPARTMENT'S RESPONSE: To be implemented October 1976. (pages 50 and 54)

32. An independent computation of the premiums due SSA should be reconciled with the monthly invoices to support the payments.

DEPARTMENT'S RESPONSE: To be implemented October 1976. (pages 50 and 54)

Federal Reimbursement

The SMIB agreement between the Secretary of HEW and CDSS requires individuals in the "coverage group" to be eligible for and receiving money payments under one of the approved titles of the Social Security Act, if reimbursement is to be received. A money payment is defined as payments in cash, checks, or warrants immediately redeemable at par, made to the grantee or his legal guardian with no restrictions imposed by the agency on the use of funds by the individual. Under P.L. 92-603, an individual is deemed to be receiving a money payment even though he had been disqualified for participation due to the September 1972 increase in social security benefits.

We sampled the recipients enrolled for December 1974 and found 17.6% were not receiving money payments nor deemed to be receiving money payments. The premium paid for these recipients plus the ineligible recipients (2.6%) noted in the previous comment were improperly claimed for Federal reimbursement. Based on the total exception rate of 20.2% we estimate CDSS has overclaimed Federal reimbursement for December 1974 of $27,332.

A computer program was designed in 1973 to identify the recipients whose premiums were not eligible for Federal reimbursement due to non-money payments. However, the computer program was made obsolete by the introduction of the new Supplemental Security Income Program (SSI) January 1, 1974. CDSS has not updated the program to identify the ineligible participants. Federal financial participation has been claimed on the total of SMIB premiums since January 1974 without regard to the non-money payment requirement.

Subsequent to our audit period, the Office of Planning and Evaluation of CDSS conducted an extensive evaluation of the SMIB system. It would appear, their recommendations would effectively reduce the problems within the SMIB program.

Recommendations

33. A computer program should be designed and utilized to identify those SMIB participants who are not receiving money payments.

DEPARTMENT'S RESPONSE: To be implemented October 1976. (pages 50 and 54)

34. Premiums paid for those individuals not receiving money payments should not be claimed for Federal financial participation.

DEPARTMENT'S RESPONSE: To be implemented October 1976. (pages 50 and 54)

35. The total amount of Federal funds claimed erroneously during the period of January 1, 1974 through June 30, 1975, should be determined and refunded to the Federal Government.

DEPARTMENT'S RESPONSE: Deferred. (See additional Agency comment page 54)

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

SUPPLEMENTAL MEDICAL INSURANCE BENEFITS

TWO YEARS ENDED JUNE 30, 1975

DISPOSITION OF PRIOR RECOMMENDATIONS

Recommendations	Disposition
1. The computer program should be applied as proposed.	Implemented.
2. The results of applying the computer program should be used to make the appropriate adjustment to Federal funds claimed.	Implemented.
3. S.R.S. should be requested to determine if a disallowable amount exists.	Implemented.
4. Based upon the ruling by SRS, appropriate adjustment should be made.	Implemented.
5. The master award list should be compared to the county payrolls and to the list of SMIB participants to insure changes are properly recorded on all pertinent records.	Partially implemented. See current year comments, page 37.
6. The computer programs used to process the SMIB participants and additions, deletions and credits (EMAMR 1-2-3) should be revised to provide pertinent totals by type of payment and these totals should be agreed to the monthly billings from SSA.	Implemented.

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

DRUGS AND PHARMACEUTICAL SERVICES

TWO YEARS ENDED JUNE 30, 1975

INTRODUCTION

BACKGROUND

The Colorado Department of Social Services (CDSS) provides pharmaceutical services to eligible recipients under Title XIX (Medicaid) of the Social Security Act, as amended, and Article 4 of Title 26, Colorado Revised Statutes 1973, as amended.

In our prior report, it was noted CDSS reduced total reported expenditures for the program, (a practice which has been discontinued), to off-set erroneous payments and possible refunds to the Federal Government. During our current audit period, a plan was developed to recover the Federal share of the unreported expenditures. After a review of the plan by the Department of Health, Education and Welfare Audit Agency (HEWAA), the amount of Federal funds determined to be recoverable was off-set against disallowances generated by audit exceptions.

A final disposition was made on this basis December 31, 1975 with CDSS returning $340,171 to the Federal government.

Gross recorded expenditures for drug and pharmaceutical services during the two years ended June 30, 1975 were $14,777,418. Federal financial participation (FFP) claimed was $8,455,638.

Period	Gross Recorded Expenditures	Federal Financial Participation
1973-1974	$ 6,823,690	$3,904,515
1974-1975	7,953,728	4,551,123
	$14,777,418	$8,455,638

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

DRUGS AND PHARMACEUTICAL SERVICES

TWO YEARS ENDED JUNE 30, 1975

AUDITOR'S COMMENTS

Processing of Drug Payments

Our test of drug claims paid for the two-year period included a test of recipient eligibility. Recipient eligibility is verified by matching the vendor and recipient against the Department's eligibility master files. No exceptions were noted in our test. Our conclusion is the in-house system is functioning as intended to verify eligibility, eliminate duplicate payments and over-or-under payments.

However, the Department's master medical eligibility file is produced by information submitted by the various counties. Therefore, an overpayment may have occurred due to the counties submitting inaccurate eligibility information. A review of county eligibility determination is discussed in detail within our report of County Operations.

Approval of Vendor Invoices

Vendor invoices in excess of $25 are extracted from normal processing and forwarded to the Medical Assistance Division. These invoices are reviewed for drug abuse and upon approval, returned to the processing section for payment. However, we found no indication on the invoices they had been reviewed or approved. Failure to identify the approved invoices could result in improper payment, or duplicative review.

Recommendation

The Medical Assistance Division should mark the reviewed vendor invoices to document their approval.

DEPARTMENT'S RESPONSE: Implemented July 1976. (pages 50 and 54)

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

DRUGS AND PHARMACEUTICAL SERVICES

TWO YEARS ENDED JUNE 30, 1975

PRIOR AUDIT RECOMMENDATIONS AND THEIR DISPOSITION

	Recommendations	Disposition
1.	DSS should implement procedures to insure drug payments are made only for eligible persons.	Implemented.
2.	SRS and DSS should determine the final disposition of the amount projected as payments to ineligible recipients.	Implemented.
3.	Procedures should be implemented to insure duplicate postings do not occur.	Implemented.
4.	Reconciliations should be made on a timely basis.	Implemented.

RICHARD D. LAMM
GOVERNOR

State of Colorado

DEPARTMENT OF SOCIAL SERVICES

1575 SHERMAN STREET
DENVER, COLORADO 80203

HENRY A. FOLEY, Ph.D.
Executive Director

July 16, 1976

Mr. John P. Proctor, C.P.A.
State Auditor
1660 Lincoln Street, Suite 2410
Denver, Colorado 80203

Dear Mr. Proctor:

Attached is this Department's response to the pre-release audit report for the Division of Medical Assistance, Colorado Department of Social Services, for the two years ended June 30, 1975.

Sincerely,

HENRY A. FOLEY, Ph.D.
Executive Director

HAF:ahk

Attachment

cc: Mr. Ken MacNeill

Report Page Ref.	No.	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE	See Comments	Requires Legislative Action **	Implemented*	To be Implemented*	Deferred **	Rejected **
		CLAIMS PROCESSING Diagnosis Codes						
10	1	The Medical Assistance Division should establish an effective peer review procedure.	X			July 1977		
		Non-Physicians Services						
10	2	The Medical Assistance Division should ensure the new procedures are implemented by the FA to establish equitable payments for professional skills.	X		July 1975			
		Procedure Code						
12	3	The Medical Assistance Division should require the FA to use a more current CRVS for pricing medical claims.	X				(Indefinite)	
12	4	Refine procedure code 9071 to properly correlate with the nature and intensity of services actually rendered.	X					X
		Review of FA Activities						
12	5	The Medical Assistance Division should, at least on a sample basis, systematically review supporting documentation for claims paid by the FA to determine that services are paid for in accordance with Division directives.	X			January 1977		

Report Page Ref.	No.	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE	See Comments	Requires Legislative Action **	Implemented*	To Be Implemented*	Deferred **	Rejected **
		ADMINISTRATIVE COSTS ALLOCATED COSTS						
15	6	CDSS should test documentation supporting administrative charges to the Medicaid programs on a periodic basis.	X			January 1977		
15	7	CDSS should reconcile the estimated administrative costs billed to the State with the actual costs generated by the FA's cost system at least annually.	X			January 1977		
15	8	CDSS should verify the amount of the overcharges during the four-month period and require an adjustment to be made. This should be done any time there is a correction of the SNAP system.	X		March 1976			
		COST REPORTED ON FINANCIAL STATEMENTS						
15	9	CDSS should report only those accrued expenses for administrative costs on their financial statements for which there is supporting documentation.	X			January 1977		
		Missing Documentation						
16	10	The FA should establish a more effective system of recording retention and retrieval for the cash records.	X			Continuous		

Report Page Ref.	No.	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE	See Comments	Requires Legislative Action **	Implemented*	To Be Implemented*	Deferred **	Rejected **
		NURSING HOME PROGRAM						
		Nursing Home Facilities and Skilled Care Facilities						
22	11	CDSS should more vigorously enforce their regulations pertaining to staffing requirements of skilled and intermediate nursing care facilities.	X			August 1977		
22	12	CDSS should resolve the conflict between its regulations concerning required nursing home staff for skilled care recipients and the regulations of the Department of Health.	X	X			Indefinite	
22	13	CDSS should enforce its regulation requiring separate facilities and staff for skilled and intermediate care recipients.	X			February 1977		
23	14	CDSS should verify on a periodic basis that the nursing care facilities receiving payments under this program are meeting their staffing and separate facilities requirements.	X			February 1977		
		Levels of Care, Skilled Nursing Care Recipients and Intermediate Nursing Care Recipients						
24	15	CDSS should expand its audit review of nursing homes to include testing of compliance with program requirements.	X			August 1977		
24	16	CDSS should ensure corrective action is taken when non-compliance with program requirements are noted in audit reviews.	X			August 1977		

Page of.	No.	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE	See Comments	Requires Legislative Action **	Implemented*	To Be Implemented*	Deferred **	Rejected **
		Payments for Drugs and Physicians						
25	17	CDSS should institute procedures which will verify that payments for drugs and physician services are actually received by the recipients.	X		March 1975			
25	18	Continue to operate the system of verifying the receipt of medical services by medicaid recipients, evaluate the results and take appropriate action.	X		March 1975			
		Personal Needs Funds						
28	19	CDSS should enforce the present regulations concerning maintenance and use of personal needs funds.	X		July 1976			
28	20	CDSS should use all means at the Department's disposal to force compliance with the regulations concerning personal needs funds.	X		July 1976			
28	21	CDSS should determine why the mentally retarded recipients who have incomes in excess of the personal needs allowance are not applying the excess income to the cost of their care.	X			November 1976		
		Records Retention at Division of Medical Assistance Office						
29	22	CDSS should establish procedures to ensure that all recipients are assigned only one State identification number and eliminate the second number.	X		October 1975			

Page Ref.	No.	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE	See Comments	Requires Legislative Action **	Implemented*	To Be Implemented*	Deferred **	Rejected **
29	23	CDSS should organize the filing system in the Medical Assistance Division to ensure that all information is readily retrievable.	X			March 1977		
		Medical Evaluations						
30	24	CDSS should establish procedures to ensure that all annual medical reviews are completed on a timely basis.	X			February 1977		
30	25	CDSS should review the patient evaluation forms to ensure they are properly completed before accepting them.	X		October 1975			
		Timely Filing						
31	26	CDSS should establish procedures to ensure that all the NH-7s are properly filed and available for inspection.	X			March 1977		
31	27	For those NH-7s which are date-stamped after the end of the 72-hour period and payment is made for more than 72 hours, the envelope should be retained to verify that the NH-7 was mailed within the allowable time period.	X		October 1975			
		Frequency of CDSS Field Audit Reviews						
32	28	The CDSS should increase the frequency of reviews performed by their field audit staff.	X		January 1976			
32	29	The CDSS should require a field audit review when there is a change in ownership or a nursing home discontinues operations.	X		September 1975			

Report Page Ref.	No.	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE	See Comments	Requires Legislative Action **	Implemented*	To Be Implemented*	Deferred **	Rejected **
		SUPPLEMENTARY MEDICAL INSURANCE BENEFITS						
		Premium Payments						
37	30	SMIB participants should be compared with the master eligibility tape to determine their continuing eligibility.	X			October 1976		
38	31	A computer processing method should be designed to identify the additions and deletions of SMIB participants from the monthly eligibility processing documents.	X			October 1976		
38	32	An independent computation of the premiums due SSA should be reconciled with the monthly invoices to support the payments.	X			October 1976		
		Federal Reimbursement						
39	33	A computer program should be designed and utilized to identify those SMIB participants who are not receiving money payments.	X			October 1976		
39	34	Premiums paid for those individuals not receiving money payments should not be claimed for Federal financial participation.	X			October 1976		
39	35	The total amount of Federal funds claimed erroneously during the period of January 1, 1974 through June 30, 1975 should be determined and refunded to the Federal Government.	X				Indefinite	
43	36	The Medical Assistance Division should mark the reviewed vendor invoices to document their approval	X		July 15, 1976			

Comments on Recommendations in State Auditor's Report for Division of Medical Assistance
For the Two Fiscal Years Ended June 30, 1975

	Recommendations		Comments
#1	The Medical Assistance Division should establish an effective peer review procedure.	#1	Concur. Recommendation will be implemented. Actions included in Division Management Improvement Plan.
#2	The Medical Assistance Division should ensure the new procedures are implemented by the FA to establish equitable payments for professional skills.	#2	Concur. Implemented July 1, 1975.
#3	The Medical Assistance Divsion should require the FA to use a more current CRVS for pricing medical claims.	#3	Concur in principle. Fiscal impact of converting to more current CRVS to coincide with Medicare changeover is being investigated. Cost may be has high as $1,000,0(
#4	Refine procedure code 9071 to properly correlate with the nature and intensity of services actually rendered.	#4	Do not concur. The FA guidelines for use of procedure code 9071 are consistent with the Medical Review Committee and the Medical Society's Relative Value Committee's interpretations for the use of this code in many situations to make payment for unusual services not otherwise described by codes available in the medical care area. The use of this code (used in .01% of all line items coded), to the extent practicable, doe: relate to the nature and intensity of services actually rendered.
#5	The Medical Assistance Division should, at least on a sample basis, systematically review supporting documentation for claims paid by the FA to determine that services are paid for in accordance with Division directives.	#5	Concur. Although a number of current activities informally achieve this objective, the Division will establish a more formal system.
#6	CDSS should test documentation supporting administrative charges to the Medicaid Program on a periodic basis.	#6	Concur. Formal testing procedures will be prepared, coordinated, and implemented.

#7	CDSS should reconcile the estimated administrative costs billed to the state with the actual costs generated by the FA's cost system at least annually.	#7 Concur. The FA will submit to CDSS annually a reconciliation between invoiced administrative costs and SNAP generated costs beginning with calendar year 19
#8	CDSS should verify the amount of the overcharges during the four-month period and require an adjustment to be made. This should be done any time there is a correction of the SNAP system.	#8 Concur. The overcharge resulting from the CRT misallocation for all Title XIX programs was $5,228.80. This amount was credited to CDSS on the March 1976 invoi
#9	CDSS should report only those accrued expenses for administrative costs on their financial statements for which there is supporting documentation.	#9 Concur. Recommendation will be implemented.
#10	The FA should establish a more effective system of recording retention and retrieval for the cash records.	#10 Concur. This concurrence is tempered by the FA contenti that the missing bank statements were subsequently located and the auditors notified as to their availabili
#11	CDSS should more vigorously enforce their regulations pertaining to staffing requirements of skilled and intermediate nursing care facilities.	#11 Concur. Recommendation will be implemented. Actions included in Division Management Improvement Plan.
#12	CDSS should resolve the conflict between its regulations concerning required nursing home staff for skilled care recipients and the regulations of the Department of Health	#12 Concur in principle. Conflict will be reviewed in discussions with Department of Health.
#13	CDSS should enforce its regulation requiring separate facilities and staff for skilled and intermediate care recipients.	#13 Concur. Regulation should have been changed at time of Federal change, but will be amended to delete requiremen
#14	CDSS should verify on a periodic basis that the nursing care facilities receiving payments under this program are meeting their staffing and separate facilities requirements.	#14 Concur. Recommendation will be implemented regarding staffing requirements. Separate facilities requirement to be deleted.
#15	CDSS should expand its audit review of nursing homes to include testing of compliance with program requirements.	#15 Concur. Recommendation will be implemented. Actions contained in Division Management Improvement Plan.
#16	CDSS should ensure corrective action is taken when non-compliance with program requirements are noted in audit reviews.	#16 Concur. Recommendation will be implemented. Actions contained in Division Management Improvement Plan and coordinated with Office of Investigations.

#17	CDSS should institute procedures which will verify that payments for drugs and physician services are actually received by the recipients.	#17	Concur. Recommendation implemented.
#18	Continue to operate the system of verifying the receipt of medical services by Medicaid recipients, evaluate the results and take appropriate action.	#18	Concur. Recommendation implemented.
#19	CDSS should enforce the present regulations concerning maintenance and use of personal needs funds.	#19	Concur. The Office of Investigations working with the Attorney General and an expanded personal needs audit staff have implemented this recommendation.
#20	CDSS should use all means at the Departments' disposal to force compliance with the regulations concerning personal needs funds.	#20	Concur. See Comment #19.
#21	CDSS should determine why the mentally retarded recipients who have income in excess of the personal needs allowance are not applying the excess income to the cost of their care.	#21	Concur. Recommendation will be implemented.
#22	CDSS should establish procedures to ensure that all recipients are assigned only one State identification number and eliminate the second number.	#22	Concur. It is believed that the AP-700 system initiated in October 1975 will alleviate and ultimately resolve this problem.
#23	CDSS should organize the filing system in the Medical Assistance Division to ensure that all information is readily retrievable.	#23	Concur. Recommendation being implemented.
#24	CDSS should establish procedures to ensure that all annual medical reviews are completed on a timely basis	#24	Concur. Recommendations will be implemented. Actions contained in Division Management Improvement Plan.
#25	CDSS should review the patient evaluation forms to ensure they are properly completed before accepting them.	#25	Concur. Recommendations implemented.
#26	CDSS should establish procedures to ensure that all the NH-7s are properly filed and available for inspection.	#26	Concur. Recommendation is being implemented.
#27	For those NH-7s which are date-stamped after the end of the 72 hour period and payment is made for more than 72 hours, the envelope should be retained to verify that the NH-7 was mailed within the allowable time period.	#27	Concur. Recommendation implemented.

#28	The CDSS should increase the frequency of reviews performed by their field audit staff.	#28 Concur. Recommendation implemented with augmented field staff.
#29	The CDSS should require a field audit review when there is a change in ownership or a nursing home discontinues operations.	#29 Concur. Recommendation implemented.
#30	SMIB participants should be compared with the master eligibility tape to determine their continuing eligibility.	#30 Concur. Recommendation will be implemented. Actions contained in OIS Management Improvement Plan.
#31	A computer processing method should be designed to identify the additions and deletions of SMIB participants from the monthly eligibility processing documents.	#31 Concur. Recommendation will be implemented. Actions contained in OIS Management Improvement Plan.
#32	An independent computation of the premiums due SSA should be reconciled with the monthly invoices to support the payments.	#32 Concur. Recommendation will be implemented. Actions contained in OIS Management Improvement Plan.
#33	A computer program should be designed and utilized to identify those SMIB participants who are not receiving money payments.	#33 Concur. Recommendation will be implemented. Actions contained in OIS Management Improvement Plan.
#34	Premiums paid for those individuals not receiving money payments should not be claimed for Federal Financial Participation.	#34 Partially concur. Some individuals not receiving money payment are eligible.
#35	The total amount of Federal funds claimed erroneously during the period January 1, 1974 through June 30, 1975 should be determined and refunded to the Federal government.	#35 Concur. HEW currently reviewing. Recommendation will be implemented but completion date uncertain.
#36	The Medical Assistance Division should mark the reviewed vendor invoices to document their approval.	#36 Concur. Recommendation has been implemented.

SUMMARY AND REMARKS

The audit of the Division of Medical Assistance for the two year period ending June 30, 1975, represents an audit of only a portion of the programs which are operated by this Division. The audit utilizes the technique of generalizing particular findings to an entire program or to a subset of that program. In some instances, if the auditors found additional examples of procedural or program deficiencies, the auditors should have reported all deficiencies so that we could more effectively and efficiently correct the problems which were identified. On the other hand if the auditors found only the deficiencies noted, then the generalizations are not supported by the audit findings. For example, the audit suggested that providers (particularly physicians) are manipulating our reimbursement system by utilizing a procedure code (9071) for the purpose of acquiring additional medical service benefits beyond those considered "normal" for the medical condition of the patient. In fact, the use of the 9071 procedure code is consistent with the medical Review Committee's and the Medical Society's Relative Value Committee's interpretation of the use of this procedure code. The code is utilized for less than .01% of all the line items coded.

A second general comment concerning the audit relates to the fact that many of the recommendations as contained in the audit were already corrected at the time of the completion of the written report. Further, in other instances, the problem had already been identified and procedures were under way to correct the deficiencies which existed. During communications with the auditors, particularly at the time of the exit interview, this issue was brought to the attention of the auditors; yet no recognition of this fact was noted in the Pre-Release Audit Report. A review of the responses to the recommendations will note the high percentage of recommendations which have already been corrected or are in the process of being corrected.

A third general comment applicable to the report relates to the frequent use of exceedingly general recommendations. In numerous cases, the recommendations are so general as to provide little if any direction to the Division in correcting the deficiencies noted. For example, recommendation (1) suggests that the "Medical Assistance Division should establish an effective peer review procedure." This suggestion provides no direction since effective peer review does not exist (due to the current state of the art), as our staff suggested during the audit. In the absence of direction, Division of Medical Assistance will be working with the Colorado Foundation for Medical Care to improve institutional utilization review. However, with the overall recommendation, neither this Division nor any other responsible organization or individual could disagree. Implementation, on the other hand, is an entirely different matter.

A final comment which applies to the entire report relates to the lack of recognition of standards (frequently accepted professional standards) against which to judge the severity of the deficiencies noted. For example, the percentage of the number of skilled and/or intermediate nursing facilities which did not meet certain requirements contained in our Staff Manual are presented. The audit noted that 2.7% of the patient

files in skilled nursing homes inspected did not contain physician progress notes, while 3.2% of patient files in intermediate care facilities did not contain a physician treatment plan. In evaluation of quality of care rendered in nursing homes, these figures represent extremely low values. The more appropriate way of determining compliance with our regulations would be to evaluate the entire program of care in a nursing home, rather than identifying a particular problem with one file for one patient in a particular home. In other words, if a nursing home was found to have only 2.7% of its files lacking a physician progress report, while all other files were in compliance with regulations, including evidence of required monthly visits by physicians, evidence of continuing evaluation of an individual(s) needs for skilled care, that nursing home by any professional evaluation would be in substantial compliance with the intent of the regulations. However, presenting percentages by deficiency area does not allow for reflection of this fact. Nonetheless, with the overall recommendation of requiring compliance with our program requirements, the Division of Medical Assistance and the Department of Social Services does not take exception.

In summary, the audit report findings did not elicit substantial deficiencies in the operation of the Medicaid Program in Colorado. Nonetheless, improvements are required, and we have already initiated many programs by which to correct problems noted. The precise responses to the recommendations are contained in the summary table which is attached to the Pre-Release Audit Report.