

Table of Contents

Key Points

Executive Summary	1
--------------------------------	----------

Overall Conclusion	3
---------------------------------	----------

Section 1:

Monitor HCS Costs More Closely	3
---	----------

Analyze and Audit HCS Costs.....	4
----------------------------------	---

Modify HCS Billing System	5
---------------------------------	---

Section 2:

Analyze and Audit ICF/MR Costs.....	7
--	----------

Section 3:

Continue to Regulate Providers and Administer Contracts Effectively	8
--	----------

Section 4:

Improve Medicaid Administrative Activities.....	8
--	----------

Analyze Business Processes	8
----------------------------------	---

Regularly Review and Revise Policies and Procedures	10
---	----

Capture and Use All Relevant Information to Monitor Providers.....	12
---	----

Issue for Further Study:

New Long-Term Care Billing System in 1999	15
--	-----------

Appendices:

1 - Objective, Scope, and Methodology	17
---	----

2 - Resources for Business Process Analysis	21
---	----

3 - Management Comments on HCS Costs.....	23
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Key Points of Report

An Audit Report on Medicaid Services at the Department of Mental Health and Mental Retardation

December 1999

Overall Conclusion

The Department of Mental Health and Mental Retardation (Department) does not routinely analyze the cost of providing Medicaid services through Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Services (HCS). In fiscal year 1999, the Department spent approximately \$928 million on ICF/MR and HCS services. Without routine analysis, the Department cannot evaluate the reasonableness of expenses or look for potential fraud, waste, and abuse.

Key Facts and Findings

- The average monthly cost per client for HCS services increased from \$2,013 in fiscal year 1995 to \$4,070 in fiscal year 1999. The Department will have to take steps to decrease the average cost per person during fiscal years 2000 and 2001. The 76th Legislature enacted an appropriations rider stating, "it is the intent of the Legislature that... the overall average monthly expenditure per client shall not exceed \$3,706 per month in fiscal year 2000 and \$3,511 per month in fiscal year 2001."
- The Department should routinely analyze HCS cost reports to evaluate the reasonableness of costs and to look for potential fraud, waste, and abuse. Additionally, the Department should conduct desk audits of all HCS cost reports and a sufficient number of on-site financial audits in accordance with generally accepted auditing standards.
- The Department should review each ICF/MR provider's cost data to ensure that the financial and statistical information submitted conforms to all applicable rules and instructions. The Department should conduct a sufficient number of on-site financial audits in accordance with generally accepted auditing standards.
- With a shift of services from ICF/MR to HCS settings, the Department must move from the role of provider to regulator. Many controls are in place to administer provider contracts and to regulate providers. However, the Department can improve central office Medicaid operations and administration, particularly its business processes, policies and procedures, and information systems.

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This audit was conducted in accordance with Government Code, Section 321.0133.

Executive Summary

The Department of Mental Health and Mental Retardation (Department) does not routinely analyze the cost of providing Medicaid services through Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Services (HCS). In fiscal year 1999, the Department spent approximately \$928 million on ICF/MR and HCS services. Without routine analysis, the Department cannot evaluate the reasonableness of expenses or look for potential fraud, waste, and abuse.

As mental retardation services have shifted from ICF/MR to HCS settings, costs for ICF/MR have remained relatively stable, while the average monthly HCS cost has doubled from fiscal year 1995 to fiscal year 1999. Routine analysis of costs will help the Department manage rising costs proactively rather than react to external forces.

With the shift of services, the Department must move from the role of provider to regulator. Many controls are in place to administer provider contracts and to regulate providers. However, the Department can improve central office Medicaid operations and administration, particularly its business processes, policies and procedures, and information systems.

Monitor HCS and ICF/MR Costs More Closely

The Department does not analyze HCS and ICF/MR costs on an ongoing basis to evaluate their reasonableness and to look for potential fraud, waste, or abuse. Furthermore, the Department has not conducted audits of HCS and ICF/MR cost reports as required in the Texas Administrative Code.

The average monthly cost per client for HCS services increased from \$2,013 in

fiscal year 1995 to \$4,070 in fiscal year 1999. The Department will have to take steps to decrease the average cost per person during fiscal years 2000 and 2001. The 76th Legislature enacted an appropriations rider stating, "it is the intent of the Legislature that... the overall average monthly expenditure per client shall not exceed \$3,706 per month in fiscal year 2000 and \$3,511 per month in fiscal year 2001."

Costs for ICF/MR services have been relatively stable, but they could rise without being managed or explained, in the same way that HCS costs increased. The average monthly cost per client for ICF/MR services has risen only 16 percent from fiscal year 1995 to fiscal year 1999 (from \$3,423 to \$3,959).

Continue to Regulate Providers and Administer Contracts Effectively

The Department has implemented effective controls to regulate ICF/MR and HCS providers. The divisions of Medicaid Administration and Community Services:

- Administer contracts with all ICF/MR and HCS providers.
- Monitor provider services through utilization reviews and focus reviews.
- Survey and certify HCS providers.
- Conduct compliance audits and trust fund reviews of ICF/MR providers.

Executive Summary

Improve Medicaid Administrative Activities

The Department can improve central office Medicaid operations and administration, particularly its business processes, policies and procedures, and information systems.

- Management has not analyzed or assessed job tasks since workforce reductions in January 1998. High levels of overtime since March 1998 may be the result of inadequate staffing and/or inadequate management of existing resources.
- Management does not monitor operations consistently to determine which areas need new policies or procedures. Policies and procedures are integral to the planning process and are essential tools for managerial direction and control of the operating environment.
- The Department does not efficiently and effectively capture and use all relevant provider information to assess risk, and to monitor and evaluate ICF/MR and HCS providers' performance. Without a comprehensive understanding of a provider's history, the Department risks making inappropriate decisions that leave the State vulnerable to fraud and abuse by providers.

Summary of Objective and Scope

The objective of the audit was to evaluate the Department's management controls over ICF/MR and HCS programs. The scope of the audit included the duties and responsibilities of the Department's divisions of Medicaid Administration, Community Services, and Long Term Services and Support. We reviewed contract administration, utilization review and utilization control, billing and fiscal monitoring, rate setting, Medicaid reimbursement and analysis, HCS survey and certification, and ICF/MR compliance audits.

Summary of Management's Response

The Texas Department of Mental Health and Mental Retardation takes seriously our responsibility to prevent fraud, waste and abuse. To this end, the Department routinely reviews various elements of the cost of care in both HCS and ICF/MR programs. In addition, the Department will institute further measures to improve administration of the programs pursuant to the recommendations in this report. We appreciate the opportunity to respond to the findings of this audit. See Appendix 3 for management comments on the overall conclusion.

Overall Conclusion

The Department does not routinely analyze the cost of providing Medicaid services through Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Services (HCS). For the year ending August 31, 1999, ICF/MR expenditures were approximately \$684 million and HCS expenditures were approximately \$244 million. Without routine analysis, the Department cannot evaluate the reasonableness of expenses or look for potential fraud, waste, and abuse.

As mental retardation services have shifted from ICF/MR to HCS settings, costs for ICF/MR have remained relatively stable, while the average monthly HCS cost has doubled from fiscal year 1995 to fiscal year 1999. Routine analysis of costs will help the Department manage rising costs proactively rather than react to external forces.

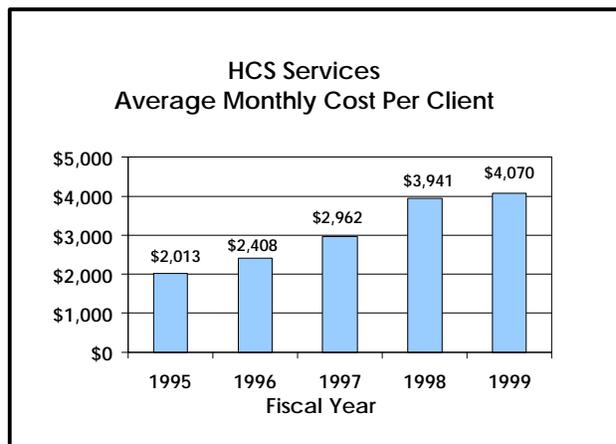
With the shift of services, the Department must move from the role of provider to regulator. Many controls are in place to administer provider contracts and to regulate providers. However, the Department can improve central office Medicaid operations and administration, particularly its business processes, policies and procedures, and information systems.

Section 1:

Monitor HCS Costs More Closely

The average monthly cost per client for HCS services increased from \$2,013 in fiscal year 1995 to \$4,070 in fiscal year 1999 (see Figure 1). The Department will have to take steps to decrease the average cost per person during fiscal years 2000 and 2001.

Figure 1



Source: Department of Mental Health and Mental Retardation

The 76th Legislature enacted an appropriations rider stating, "it is the intent of the Legislature that... the overall average monthly expenditure per client shall not exceed \$3,706 per month in fiscal year 2000 and \$3,511 per month in fiscal year 2001."

The average monthly cost per client for HCS services increased over 100 percent because the total costs of HCS have increased more rapidly than the total enrollment. Total costs of HCS increased 270 percent from fiscal year 1995 to fiscal year 1999.

In 1996, the Deloitte & Touche Consulting Group reviewed and analyzed 1994 costs and reimbursement rates to provide recommendations

for restructuring the reimbursement methodology for the HCS program. That review led to a change from per diem to fee-for-service in 1996, which appears to have pushed up total HCS costs. Since then, rates have only been adjusted for inflation. (See Appendix 3 for management comments on HCS costs.)

Additionally, HCS expenditures exceeded the appropriated amount in fiscal year 1998 by about \$15 million and in fiscal year 1999 by about \$35 million. Thus, HCS expenditures were funded from other sources over and above the appropriated amount. This is not in compliance with Health & Safety Code, Section 533.062 (f), which states that the capacity of the HCS waiver program should not exceed appropriated funding amounts.

In order for the Department to appropriately manage HCS costs, it should routinely analyze and audit HCS costs and billings.

Section 1-A:

Analyze and Audit HCS Costs

The Department does not analyze HCS costs to evaluate their reasonableness and to look for potential fraud, waste, or abuse. Furthermore, the Department has not conducted audits of HCS cost reports as required in the Texas Administrative Code. The Department is required to conduct desk audits of all full cost reports and/or direct service cost reports and to conduct on-site reviews of a sample of HCS providers submitting cost reports. On-site reviews are to be performed in a manner consistent with generally accepted auditing standards.

The Department has not conducted audits of cost reports from state operated providers since the review of 1994 costs by the Deloitte & Touche Consulting Group. The Department conducted desk reviews of direct service cost reports submitted by non-state operated providers for fiscal year 1997. Desk reviews for fiscal year 1998 are in progress. However, the Department has not conducted on-site reviews. The Department's utilization review and provider survey and certification processes do not meet the audit objectives.

As of July 1999, the Department had conducted only one on-site billing and payment review of an HCS provider. This review identified \$32,252 worth of claims made in error, which was an error rate of approximately 50 percent. Specific errors included lack of documentation, improper documentation, and inaccurate claims for service. The error rate may not be indicative of all HCS providers, as the provider's past business practices were questionable. However, the error rate indicates that the review process will produce meaningful results.

The Department documented and distributed a new "protocol" as of June 1, 1999, based on that one review. The protocol is designed to ensure that providers maintain sufficient financial and service delivery documentation to support claims. The Department notified providers of its plan to review each provider every four years. Yet, the Department has not documented an action plan or risk assessment for billing and payment reviews.

Recommendation:

The Department should analyze cost reports routinely to evaluate the reasonableness of costs and to look for potential fraud, waste, and abuse. Additionally, the Department should conduct desk audits of all HCS cost reports and a sufficient

number of on-site financial audits in accordance with generally accepted auditing standards. The analysis of cost reports should be used to assess risk and select providers for on-site audits.

The Department should implement billing and payment reviews with the new protocol promptly. It should document an action plan and risk assessment for billing and payment reviews. Additionally, the Department should consider implementing a process of analyzing electronic claims billing data to look for potential fraud, abuse, and waste. The Department should discuss this recommendation with the Texas Health and Human Services Commission to assess the use of the Medicaid Fraud and Abuse Detection System.

Management's Response:

We agree the Department should routinely analyze cost reports to evaluate the reasonableness of costs and to look for potential fraud, waste, and abuse. We agree the Department should conduct desk audits of HCS cost reports and a sufficient number of audits selected based on an analysis of the cost reports. Currently, Medicaid Administration conducts desk audits of HCS cost reports using a desk audit program. At this point, cost reports are returned to the provider for correction of material items and/or support material is requested from the provider to substantiate items. Once the cost reports pass through this process, an in-depth analysis of cost items is prepared and assessed with input from the Management Audit section to determine which providers require on-site financial audits. The rate rebasing will require full cost reports for FY 99. The Department plans to field audit a sufficient number to ensure the reasonableness of the cost data. We are also initiating an effort to utilize more statistical analysis to determine the appropriate number of audits and the degree of testing that should be used to further identify and correct potential fraud, waste and/or abuse.

The Department has implemented billing and payment reviews for HCS. We are evaluating the availability of staff resources for this procedure in order to increase the effort in this area. The Department will use a risk analysis to determine which providers should be reviewed.

Section 1-B:

Modify HCS Billing System

The automated HCS billing system has edit checks to ensure that actual service units and dollars do not exceed authorized amounts and to comply with program caps defined in Texas Administrative Code, Title 25, Chapter 409. However, we identified exceptions related to the cap for Supported Employment and time limits for claims payment and claims rejection.

- At least six consumers exceeded the Supported Employment cap of \$3,000 per year because the automated edit is based on units (hours), not dollars.

- The HCS billing system does not have an edit to ensure that rejected claims are resubmitted by the provider within 180 days from the end of the month of service, per Texas Administrative Code, Title 25, Section 409.105.
- Billing and Fiscal Monitoring overrides the automated edit that limits the processing of claims within 95 calendar days from the end of the month of service. We identified 23,747 claims processed 120 days after the end of the month of service, between September 1997 and May 1999, for a total of \$1,678,717.
- Management has allowed providers to process claims 45 days from notification of approval of enrollment instead of 30 days, as required by Texas Administrative Code, Title 25, Section 409.103 (g)(4).

Recommendation:

The HCS billing system should be modified to:

- Ensure that the \$3,000 per year cap for Supported Employment is not exceeded. The Department should modify the automated edit to track dollars, not units. Otherwise, the Department should amend its rule from a cap based on dollars to a cap based on units.
- Ensure that rejected claims are not submitted 180 days after the end of the month of service or within 30 days of notification of a rejected claim by the Department.

Additionally, the Department should enforce or change the rule found in Texas Administrative Code, Title 25, Section 409.103 (g)(4). The rule states that the provider is not entitled to payment if the initial claim for service is not received by the Department within 95 calendar days from the end of the month of service or within 30 days of notification of approval of enrollment by the Department, whichever is later. The Department should develop written procedures to address exceptions to the rule.

Management's Response:

The Department agrees that the edit for the cap for Supported Employment in the HCS billing system should be based on units and will amend its rule from a cap based on dollars to a cap based on units.

The HCS billing system has been modified such that rejected claims cannot be submitted 180 days after the end of the month of service. This was implemented September 1, 1999.

On September 27, 1999, the Department proposed a change to the HCS provider reimbursement rule. This change appears in 25 TAC §419.170(f) and states: The program provider must submit a claim for a service component with the department by the latest of the following dates:

- (1) *within 95 calendar days after the end of the month in which the service component was provided;*
- (2) *within 45 calendar days after the date of the enrollment approval letter issued by the department; or*
- (3) *within 95 calendar days after the end of the month in which the program provider receives a dated response from a source other than the HCS Program to a correctly submitted request to that source for payment for the service component.*

The Department agrees to establish written procedures for making exceptions to this rule for circumstances that are beyond the provider 's control. These procedures will be reviewed by the Department's internal auditor to ensure that appropriate internal controls are in place.

Section 2:

Analyze and Audit ICF/MR Costs

Costs for ICF/MR services have been relatively stable, but they could rise without being managed or explained, in the same way that HCS costs increased. The average monthly cost per client for ICF/MR services has risen only 16 percent from fiscal year 1995 to fiscal year 1999 (from \$3,423 to \$3,959).

In 1996, the Deloitte & Touche Consulting Group reviewed and analyzed 1994 costs and reimbursement rates to provide recommendations for restructuring the ICF/MR reimbursement methodology. Benchmarks were effectively developed through the rate-setting process for non-state operated facilities. However, there is no ongoing analysis of cost data to evaluate the reasonableness of costs among the different types of facilities.

Since the ICF/MR cost report audit function was transferred from the Department of Human Services to the Department of Mental Health and Mental Retardation in 1996, the Department has not conducted audits of ICF/MR cost reports as required in the Texas Administrative Code. Federal regulations require the Department to review each ICF/MR provider's cost data to ensure that the financial and statistical information submitted conforms to all applicable rules and instructions. The Department is to perform a sufficient number of on-site financial audits in a manner consistent with generally accepted auditing standards. The Department's compliance audits and trust fund reviews do not meet these objectives.

Recommendation:

The Department should review each ICF/MR provider's cost data to ensure that the financial and statistical information submitted conforms to all applicable rules and instructions. The Department should conduct a sufficient number of on-site financial audits in accordance with generally accepted auditing standards. Additionally, the Department should analyze cost reports to evaluate the reasonableness of costs and to look for potential fraud, waste, and abuse. The analysis should be used to assess risk and select providers for on-site audits.

Management's Response:

We agree the Department should review ICF/MR providers' cost data to ensure that the financial and statistical information submitted conforms to applicable rules and instructions. We also agree the Department should conduct a sufficient number of on-site financial audits. We agree the Department should analyze cost reports to evaluate the reasonableness of costs and to look for potential fraud, waste, and abuse. Currently, the Medicaid Administration division conducts desk audits of ICF/MR cost reports using a desk audit program. At this time, cost reports are returned to the provider for correction of material items and/or support material is requested from the provider to substantiate items. Once cost reports pass through this process, an in-depth analysis of cost items is prepared and assessed with input from the Management Audit section to determine which providers require on site financial audits. The rate rebasing will require full cost reports for FY 99. The Department plans to field audit a sufficient number to ensure the reasonableness of the data. We are also initiating an effort to utilize more statistical analysis to determine the appropriate number of audits and the degree of testing that should be used in each audit to further identify and correct potential fraud, waste and/or abuse.

Section 3:

Continue to Regulate Providers and Administer Contracts Effectively

The Department has implemented effective control systems to regulate ICF/MR and HCS providers. The divisions of Medicaid Administration and Community Services:

- Administer contracts with all ICF/MR and HCS providers.
- Monitor provider services through utilization reviews and focus reviews.
- Survey and certify HCS providers.
- Conduct compliance audits and trust fund reviews of ICF/MR providers.

The Department's ICF/MR and HCS contracts are generally designed and monitored to address financial, performance, and compliance requirements. A test of 15 ICF/MR contracts showed that the contracts adequately address financial, performance, and compliance requirements applicable to the programs. A test of 15 HCS contracts showed that the contracts adequately address financial, performance, and compliance requirements applicable to the programs.

Section 4:

Improve Medicaid Administrative Activities

The Department can improve central office Medicaid operations and administration, particularly its business processes, policies and procedures, and information systems.

Section 4-A:

Analyze Business Processes

Management has not analyzed or assessed job tasks and staffing activities since workforce reductions in January 1998. High levels of overtime since March 1998

may be the result of inadequate staffing and/or inadequate management of existing resources.

- Some of the overtime in Medicaid Administration may have been caused by the implementation during 1999 of the new Claims Management System that handles ICF/MR billings. (See Issue For Further Study.)
- In Community Services, it appears that significant amounts of overtime were an issue before the workforce reductions in January 1998, especially in Quality Management and HCS Survey. Compensatory balances were extremely high in March 1998, approximately 2,000 hours. (However, it appears that HCS surveyors' available time from September 1998 to June 1999 is appropriately accounted for and is reasonable.)

A business process analysis will help make decisions about resource allocation, staffing, and workload. It will help determine the cost-effectiveness of activities. For example, we analyzed a billing and payment review conducted by the Department. The review had significant results and was cost-effective. We estimated a cost of approximately \$1,000 to conduct the review, and the review identified over \$32,000 worth of claims made in error. Similar analysis should be done for Utilization Review/Utilization Control focus reviews, HCS survey and certification, compliance and trust fund audits, and quality management reviews.

Certain information is missing or is not used to analyze business processes and costs:

- Because employee timekeeping is on an exception basis and only captures leave time, management is not able to easily evaluate administrative costs.
- Some managers and supervisors are not aware of budget information or are not using the information properly.
- There is a lack of formal performance measures to evaluate internal administrative operations.

While management has not evaluated its administrative operations, it has evaluated whether the programs achieve their service delivery objectives. An agency work group recently evaluated service cost and utilization data regarding the ICF/MR and HCS programs. The work group recommended strategies that will ensure that individuals receive the services they need in appropriate settings and that provide the best value, that the service delivery system is flexible and affords options to consumers, and that programs comply with Health Care Financing Administration requirements and legislative mandates.

Recommendation:

Management should consider a fact-based analysis of its business processes to determine which of its processes are in greatest need of improvement in terms of cost, quality, and timeliness. Process analysis is concerned with "why" a step, task, or activity is taken rather than "how" it is done. Since there is a cost to review business

processes, the Department should determine if the expected long-term benefits would outweigh the cost.

To assist the Department, there are guides and reports on business process analysis, reengineering, and activity based costing. (See Appendix 2.) The Department could also glean information from the Department of Human Services about its recent reengineering project for the Long-Term Care Regulatory program.

Management's Response:

The Department has moved the HCS survey and certification staff into the Medicaid Administration Division to create an opportunity for streamlining review activities in Medicaid waiver programs. The recommendations for streamlining should be completed by the end of calendar year 2000.

Section 4-B:

Regularly Review and Revise Policies and Procedures

Management of Medicaid Administration and Community Services does not monitor operations consistently to determine which areas need new policies or procedures. Policies and procedures are integral to the planning process and are essential tools for managerial direction and control of the operating environment. They help to standardize operations and facilitate attainment of goals and objectives. The following policies and procedures were missing or inadequate:

- The Department does not have a formal, written policy or procedure for employees who interact directly with providers to disclose potential conflict of interest, such as prior employment at a regulated provider or a relative who is employed by or served by a provider.
- The Department does not have a formal process to document referrals between sections. For example, when a concern about over-billing is detected during a focus review, it may be referred to the Billing and Fiscal Monitoring Section, but there is no process to document that referral. Without a record of referrals, there is no assurance that the issues are addressed.
- There is no supervisory review of the decisions reached by the Utilization Review staff for approvals or denials of requests for increases in the level of need or requests for the highest level of need. If a provider appeals the decision, the original analyst could be assigned to reconsider the decision.
- As part of the annual survey to determine compliance with HCS principles, the survey staff does not maintain written documentation that all of the 102 principles have been tested. Additionally, in a review of 16 HCS provider survey files, three contained a total of seven complaints, all of which lacked complete information. Lacking were either the complaint, the resolution, and/or the actions taken to respond to the complaint. Without complete information, it is difficult to assess the magnitude of the complaint and determine whether it has been resolved.

- Billing and Fiscal Monitoring does not have written procedures for data entry of HCS claims for minor home modifications, adaptive aids, and dental services. (Data entry is done at the Central Office.) This poses a risk of duplicate entries.
- Medicaid Administration does not have written procedures for the computation of Medicaid rates.

Recommendation:

Management of Medicaid Administration and Community Services should monitor operations consistently to determine which areas need new policies or procedures.

- Medicaid Administration and Community Services should adopt a policy to require employees who regulate providers to disclose potential conflict of interest. Procedures should require employees to document the potential conflict of interest in writing at the time of employment with the Department and when a change occurs. Management should document scheduling and assignment decisions related to potential conflicts of interest.
- The Department should establish a central log to track referrals between sections. This log should identify the provider, the date of the referral, the receiving party within the Department, the reason for the referral, and the date/action taken of resolution.
- Utilization Review should institute a process whereby each of the level of need review decisions is subject to a quality control review by the section manager. This process could include three steps: (1) select a sample of level of need packets from each employee, perhaps two every six months; (2) independently review the packets for adequate support of the decision to approve/deny; and (3) document the quality control review. When a provider appeals a decision, a new analyst should be assigned to reconsider it.
- To document HCS survey coverage, a sign-off document could be developed to note that each of the 102 principles, or a category of principles, have been tested for compliance. This document would list the principle numbers or category of principles, beside which the assigned surveyor would initial that the evidentiary review had been completed.
- A complaint tracking document should be established for each written complaint. This document would identify the date and source of the complaint, the general topic of the complaint, a history of actions taken to address the complaint, and the final resolution. This document should require review and approval by the appropriate supervisor.
- Billing and Fiscal Monitoring should document procedures for entering HCS claims for minor home modifications, adaptive aids, and dental services into the automated HCS billing system.

- Medicaid Administration should prepare written procedures for the computation of Medicaid rates.

Management's Response:

1. *The Department will revise the job descriptions of employees who regulate the activities of providers to require the applicant/employee to disclose any potential conflict of interest and to inform the applicant/employee that decisions concerning their work assignments will be made to prevent any possible conflict.*
2. *The Department will develop a form to track referrals from HCS Survey and Certification or Utilization Review to Billing/Fiscal Monitoring. The form will document the reason for the referral, the date of the referral, the action taken for resolution and the date of resolution.*
3. *The Utilization Review Section (UR) will ensure that a reconsideration of a desk review will be performed by a different analyst than the one who made the initial decision. Internally, UR has established quality control measures where senior staff review a sample of decisions by each analyst to ensure the consistent application of policy.*
4. *The Department agrees to develop a sign-off document to note that each of the 102 HCS principles or category of principles has been tested for compliance during survey and certification. The Department presently uses a complaint tracking system that is administered and maintained by the Department's Consumer Services section. The software package utilized to track complaints identifies the date and source of the complaint, the topic of the complaint, actions taken to address the complaint and the final resolution of the complaint. Consumer Services monitors complaints in HCS to ensure that adequate resolution of complaints is achieved.*
5. *Billing/Fiscal Monitoring will document its procedures for entering HCS claims for minor home modifications, adaptive aids, and dental services into the HCS billing system.*
6. *The Department has begun the process to develop written procedures for the computation of Medicaid rates.*

Section 4-C:

Capture and Use All Relevant Information to Monitor Providers

The Department does not efficiently and effectively capture and use all relevant provider information to assess risk, and to monitor and evaluate ICF/MR and HCS providers' performance. Without a comprehensive understanding of a provider's history, the Department risks making inappropriate decisions that leave the State vulnerable to fraud and abuse by providers. A comprehensive history about a provider's status should include information on licensure, survey results, complaints, fiscal monitoring results, claims processing results, quality of services, and sanctions.

Within the Department, there are multiple databases and tracking systems, but the data is not electronically shared among users. Some of the systems do not have complete information. For example, there is no database to track HCS survey results or focus review results. Duplication occurs in the compilation of sanctions, as the Department of Human Services and the Department of Health are also involved.

The Department does not have efficient access to relevant provider information maintained by other agencies. For example, the Department does not have access to the Department of Health's electronic licensure data.¹ A fully executed Memorandum of Understanding has not been in effect between the Department and the Department of Health since 1995. The Department of Health shared information on a manual basis with the Department of Mental Health and Mental Retardation, but the Department enters HCS provider and contract data directly into its own database.

Additionally, the Department of Human Services Long-Term Care Regulatory division has a database that contains ICF/MR provider data, but the Department of Mental Health and Mental Retardation does not have access to it. The database is called the Integrated System, and it contains survey and complaint investigation results and proposed sanctions.

Recommendation:

The Department should identify and evaluate alternative means for establishing a comprehensive database of relevant provider information. The database should include information such as a history of licensure, survey results, utilization review/utilization control results, level of need reviews, results of compliance audits and trust fund reviews, billing and payment reviews, complaints, referrals, and sanctions. Individual databases and tracking logs should eventually be deleted.

The Department should initiate discussions with the Department of Human Services to evaluate methods for accessing provider data maintained by that agency. The Department should complete and implement a Memorandum of Understanding with the Department of Human Services as expediently as possible. The Memorandum of Understanding is the document that guides the relationship between the two agencies. Without this document in place, misunderstandings and errors could result that compromise the efficiency and effectiveness of the program.

Management's Response:

The Department will evaluate the feasibility and utility of developing a more comprehensive database for sharing relevant provider information among survey and certification, utilization review, and billing/fiscal monitoring sections.

The Department is in agreement that it should complete and implement a Memorandum of Understanding with the Texas Department of Human Services (TDHS) regarding the Home and Community Support Services Agency license as soon as possible and is meeting with TDHS on this MOU.

¹ On September 1, 1999, this function was transferred to the Department of Human Services.

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Issue For Further Study:

New Long-Term Care Billing System in 1999

A new automated claims management system (CMS) was implemented during 1999 for long-term care billings, including ICF/MR. The Department has an interagency contract with the Department of Human Services for this system. The Department of Human Services contracts to pay claims of the providers. The Department of Human Services contracts with National Heritage Insurance Company for operation of a portion of CMS.

Delays in the implementation of CMS occurred, and as a result the Department used administrative claims to pay private providers and General Revenue to pay public providers. During January through March 1999, the Department used General Revenue to pay its state schools. The Department was not drawing down federal monies. Thus, interest earned on state monies was lost during this time.

As CMS is fully implemented, a review should be conducted of the system to ensure that it is meeting the needs of its users.

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Objective, Scope, and Methodology

Objective

The objective of the audit was to evaluate management controls at the Department of Mental Health and Mental Retardation over Intermediate Care Facilities for Mentally Retarded Persons (ICF/MR) and Home and Community Service (HCS) programs. Specifically, the following questions were addressed:

- Are contracts designed and monitored to address financial, performance, and compliance requirements?
- Are payment rates determined and controlled in accordance with federal, state, agency, and/or best practice requirements?
- Are services and activities coordinated among all health and human service agencies including the Health and Human Services Commission, the Department of Human Services, and the Department of Health?

Scope

The scope of this audit included the duties and responsibilities of the Department's divisions of Medicaid Administration, Community Services, and Long Term Services and Support. We reviewed contract administration, utilization review and utilization control, billing and fiscal monitoring, rate setting, Medicaid reimbursement and analysis, HCS survey and certification, and ICF/MR compliance audits.

Methodology

We applied conventional audit procedures to collecting information, including interviews with management and staff of the Department of Mental Health and Mental Retardation, the Department of Health, the Department of Human Services, and the Health and Human Services Commission. We analyzed operational data and relevant reports and documentation.

Information collected included the following:

Documentary evidence such as:

- Texas Administrative Code
- Texas Health and Safety Code
- Chapter 15, House Bill 7, Articles 4413 (502) 72nd Legislature – First Called Session, 1991
- Code of Federal Regulations and required federal reports

- Various management reports from the Department
- Agency documents, memoranda, and publications
- Policy and procedure manuals and provider handbooks
- Memoranda of Understanding between the Department and the Health and Human Services Commission, the Department of Health, and the Department of Human Services
- Prior State Auditor's Office reports
- Deloitte & Touche Consulting Group's report entitled *Texas Department of Mental Health and Mental Retardation, ICF/MR Reimbursement Methodology Alternatives Final Report*, dated March 1996
- Deloitte & Touche Consulting Group's report entitled *Texas Department of Mental Health and Mental Retardation, HCS Reimbursement Methodology Alternatives Final Report*, dated July 1996

Interviews with management and staff of the Department of Mental Health and Mental Retardation, Department of Health, Department of Human Services, and the Health and Human Services Commission.

Procedures and tests conducted:

- Review of documentation relating to agency operations
- Review of focus review files, survey and certification files, contract files, and personnel files
- Review of the Department's electronic billing data and program documentation
- Observation of a focus review and a HCS survey

Analysis techniques used:

- Control review
- Process documentation of agency operations, including analysis of employee overtime
- Trend and ratio analysis of relevant operational statistics
- Trend and ratio analysis of provider sanctions
- Trend and ratio analysis of Medicaid rates and costs

- Comparison of records between the Department and the Department of Health and the Department of Human Services

Criteria used:

- Texas Administrative Code
- Texas Health and Safety code
- Code of Federal Regulations
- Agency policy and procedure manuals and provider handbooks
- Relevant contracts and memoranda of understanding
- Best business practices related to contract administration

We conducted fieldwork from April 1999 to August 1999. The audit was conducted according to applicable professional standards, including:

- Generally accepted government auditing standards
- Generally accepted auditing standards

There were no instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's Office:

- Jon Nelson, CISA (Project Manager)
- Margene Beckham, CPA
- Tony Chavez
- Bill Hurley
- Ed Osner, CPA
- Susan Phillips
- Bruce Truitt, MPA (Quality Control Reviewer)
- Joanna B. Peavy, CPA (Audit Manager)
- Deborah L. Kerr, Ph.D. (Audit Director)

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Resources for Business Process Analysis

Brimson, James A., *Activity Accounting: An Activity-Based Approach*. New York: John Wiley & Sons, 1991.

Brimson, James A., and John Antos, *Activity-Based Management for Service Industries, Government Entities, and Nonprofit Organizations*. New York: John Wiley & Sons, 1994.

Galloway, Dianne. *Mapping Work Processes*. ASQC Quality Press, Milwaukee, Wisconsin.

Hicks, Douglas T., *Activity-Based Costing for Small and Mid-Sized Businesses: An Implementation Guide*. New York: John Wiley & Sons, 1992.

O'Guin, Michael, *The Complete Guide to Activity-Based Costing*. New York: Prentice Hall, 1991.

Turney, Peter B.B., *Common Cents: The ABC Performance Breakthrough*. Hillsboro, OR: Cost Technology, 1991.

United States General Accounting Office. *Business Process Reengineering Assessment Guide*. April, 1997.

Wiersema, William H., *Activity-Based Management*. New York: AMACOM, 1995.

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Management Comments on HCS Costs

The Department takes seriously our responsibility to prevent fraud, waste, and abuse. To this end, the Department routinely reviews various elements of the cost of care for both HCS and ICF/MR consumers. In HCS, the amount of service a person can receive is determined by the consumers' Individual Plan of Care (IPC). The Department reviews IPCs with particular attention given to IPCs that exceed the average cost of ICF/MR services. In addition, providers whose consumers' IPCs have a pattern of exceeding service guidelines are targeted for review by department staff in order to identify unnecessary expenditures.

In 1998, the Department implemented a Fiscal Accountability process that assures providers spend a significant portion of the reimbursement rate on direct care staff wages and benefits. Providers that do not meet the standards set by the Department Board are required to pay back a portion of the reimbursement they have received.

The department also conducts compliance audits of ICF/MR facilities to verify billing and trust fund management. Billing reviews of HCS providers have begun and the department has plans to double the staff dedicated to this effort.

With respect to the increased total costs for HCS, two factors are of critical importance. First, 82 percent more people were being served in fiscal year 1999 than in fiscal year 1995. Secondly, the rates and costs for fiscal year 1999 include costs for services such as day habilitation that were counted separately and funded totally by general revenue until 1997. The inclusion of such costs in the HCS cost and program structure was consistent with recommendations by Deloitte and Touche in 1997 that suggested approaches to maximize federal funds.

In 1996 the Deloitte & Touche Consulting Group (D&T) made recommendations to the Department's Board concerning revisions to the previous rate methodologies for ICF/MR and HCS. In the recommendations concerning HCS, D&T pointed out that general revenue was being used to cover costs not captured in the old HCS per diem methodology and that by using other funding streams such as the prospective payment program (PPP) and day habilitation, the Department was missing an opportunity to maximize the federal funds available to cover these costs. In order to maximize the federal funding, D&T recommended, and the Department's Board and the Healthcare Financing Administration (HCFA) approved a move to a fee for service methodology that captured the full cost of HCS services and included services such as day habilitation. The Board also approved a D&T recommendation that the Department establish modeled rates for both ICF/MR and HCS and that these rates be "rebased" or re-calculated every four years. On an annual basis, between "rebased" years, the modeled rates would be adjusted by inflation. These methodology changes became effective on January 1, 1997, with the approval of the HHSC and HCFA.

The Department continues to implement cost containment measures for the HCS program and to keep state leadership informed of our progress in meeting the intent of Appropriations Rider 7.

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