A Report
to the
Montana
Legislature

Performance Audit

Reimbursement Office Business Practices

Department of Public Health and Human Services

September 2009

Legislative Audit
Division

08P-12

Performance Audits

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Members of the performance audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business and public administration, journalism, accounting, economics, sociology, finance, political science, english, anthropology, computer science, education, international relations/security, and chemistry.

Performance audits are performed at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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LEGISLATIVE AUDIT DIVISION

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September 2009

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Reimbursement Office managed by the Business and Financial Services Division of the Department of Public Health and Human Services.

This report provides the legislature information about the reimbursement of expenses for housing and treating residents at the five department-operated facilities. This report includes recommendations for improving overall program management, security of private health information, the process for collecting data to conduct billing, the process for billing insurers and private-pay residents, resolution of unpaid resident accounts, and accounting practices.

We wish to express our appreciation to department personnel for their cooperation and assistance during the audit.

Respectfully submitted,

/s/ Tori Hunthausen

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REPORT SUMMARY

Reimbursement Office

The Department of Public Health and Human Services spent $68.9 million for services received at its facilities in fiscal year 2008, of which $26.6 million (39 percent) was recovered by the Reimbursement Office; by strengthening business practices and internal controls the Reimbursement Office could increase the amount of money recovered.

Audit Findings

The Reimbursement Office (RO) is managed by the Department of Public Health and Human Services (department). The office is responsible for securing reimbursement of expenses incurred by the state by billing for services provided to residents residing at the department's facilities. There are four sources of reimbursement including Medicaid, insurance proceeds, payments by residents or persons legally responsible for them, and Medicare. As seen in the table, total charges submitted to the RO for fiscal year 2008 were $68.9 million. The RO secured reimbursement of $26.6 million (39 percent) of the expenses incurred by the facilities. The remaining 61 percent, or $42.4 million, is absorbed primarily through the general fund.

Total Cost of Services Submitted for Billing and Dollars Reimbursed
Fiscal Year 2008

Facility	Cost of Services	Reimbursements	
		Amount	Percent
Montana State Hospital	$34,308,892	$9,003,703	26%
Montana Veterans' Home	$7,022,589	$4,672,191	67%
Montana Developmental Center	$15,443,113	$9,224,076	60%
Montana Chemical Dependency Center	$3,891,867	$93,880	2%
Montana Mental Health Nursing Care Center	$8,282,525	$3,600,234	43%
Total	**$68,948,986**	**$26,594,084**	**39%**

Source: Compiled by the Legislative Audit Division from Management Information and Cost Recovery System (MICRS) data.

Audit objectives addressed whether controls exist to ensure:

- Residents' financial information and service documents are collected and transferred to the RO.
- Medical claims and resident bills are processed efficiently and accurately.
- Resident accounts receivable balances are addressed and resolved in a timely manner.
- Management controls are effective to guide operations.
- Personal health data is secure and protected.

To answer the above objectives, we conducted interviews with department staff and performed file review of 180 financial investigator resident files and over 300 medical service documents. Through file review, we identified the department has controls in place over bed day service documents; however, the department does not have controls to ensure all medical service documents are received by the RO. Additionally, we identified 53 percent of all services provided in calendar years 2007 and 2008 were unbilled. Of these services, we identified 12,146 of these unbilled services could be denied for untimely filing. During our interviews and observations, we identified improvements could be made in the overall management of the RO.

Audit Recommendations

Audit recommendations address improvements in business practices and internal controls to increase the RO's efficiency and effectiveness of collecting reimbursements. Twelve recommendations are made to the department. Recommendations include the following:

- Establish policy and procedures for financial investigator's activities
- Comply with state accounting procedures
- Ensure all medical service claims are sent to the RO within set timeframes
- Ensure unbilled and denied claims are processed
- Develop an overall management plan
- Establish controls to ensure confidential information is secure and protected.

Chapter I – Introduction

Introduction

The Department of Public Health and Human Services (department) is responsible for managing resident care at the following five state-operated facilities:

- Montana Chemical Dependency Center (MCDC), Butte
- Montana Developmental Center (MDC), Boulder
- Montana Mental Health Nursing Care Center (MMHNCC), Lewistown
- Montana State Hospital (MSH), Warm Springs
- Montana Veterans' Home (MVH), Columbia Falls

All expenses for housing and treating residents at these facilities are paid for through appropriations to the department. The department is then responsible for securing reimbursement for cost of services provided. The department's Reimbursement Office (RO), located in the Business and Financial Services Division (division), is responsible for securing reimbursement by billing Medicaid, Medicare, private health insurance, and residents or persons legally responsible.

The Legislative Audit Committee requested a performance audit of the department's Reimbursement Office operations.

Audit Scope

Performance audit work was conducted in conjunction with Information Systems and Financial-Compliance audit work. Performance auditors reviewed controls over the business practices of the RO, while Information Systems auditors reviewed the use and capability of the Management Information and Cost Recovery System (MICRS). MICRS is used by the department to aid in the billing and reimbursement process. Information Systems audit work is in a separate report titled *Management Information and Cost Recovery System: Claims Processing (09DP-06)*.

Audit scope focused on the business practices and overall operations of the RO. Areas of operations examined included overall program management, security of private health information, collection of essential data necessary to conduct billing, the process for billing insurers and private-pay residents, and resolving unpaid resident accounts. Private-pay refers to the claim amount a resident or financially responsible party is obligated to pay. We examined service records for residents admitted to state-operated facilities between December 1, 2007, and November 30, 2008.

Audit Objectives

The overall objective of the performance audit was to examine business practices of RO to ensure efficient and effective billing is occurring and reimbursements to the state's general and special revenue funds are maximized. In order to determine this, we developed the following specific audit objectives:

1. Determine whether controls are in place to ensure resident financial information and service documents are collected and transferred to the department's RO and subsequently entered into MICRS.
2. Determine whether controls exist to ensure medical claims and resident bills are processed efficiently and accurately.
3. Determine whether controls exist to ensure resident accounts receivable balances are addressed and resolved in a timely manner.
4. Determine whether the department has effective management controls to guide RO operations.
5. Determine whether controls exist to ensure personal health data is secure and protected.

Audit Methodologies

To address the five audit objectives, we conducted the following audit work:

- Reviewed applicable state laws, administrative rules, and department policies and procedures.
- Reviewed related federal regulations.
- Interviewed department management and RO staff.
- Interviewed facility staff and department contractors.
- Observed operations and billing processes at the RO.
- Examined a random sample of service and billing documents for facility residents.
- Examined a random sample of billing records contained on MICRS.
- Reviewed results of the department's internal audit of RO billing procedures and the division's business process review.
- Compared and contrasted RO's billing operations to the private sector and other states' reimbursement office operations.

File Review

We conducted file reviews of service and billing documents processed and generated by the department's RO. We selected a random sample of medical service documents for services provided to residents admitted between December 1, 2007, and November 30, 2008. Auditors traveled to all five of the department's state-operated

facilities to complete file reviews. Auditors also examined records maintained at the department's Helena office. We reviewed a random sample of original medical service documents kept at facilities and compared this information to data on MICRS to determine whether services were billed. In addition, we selected a random sample of records contained on MICRS and traced the sampled items to original supporting documentation to ensure services were provided and supporting documents existed.

Management Memorandum

A management memorandum is a written notification to an agency for issues that should be considered by management, but do not require a formal agency response. We issued a management memorandum to the department addressing language included in §53-1-411, MCA, and ARM 37.2.712 that should be clarified.

Report Contents

The remainder of this report includes chapters addressing each of our audit objectives, which are summarized as follows:

- Chapter II provides background information about RO operations.
- Chapter III examines activities of RO financial investigators, the process used to collect and forward financial information and service records to Helena for processing, and controls over input into MICRS.
- Chapter IV provides an analysis of internal controls to ensure efficient and accurate billing.
- Chapter V includes an assessment of actions taken to address resident accounts receivable including writing-off portions of balances and collecting on delinquent accounts.
- Chapter VI addresses overall program management controls including controls related to maintaining security of residents' personal health information.

In recent years, the department recognized there was a need to examine the RO's billing process. In August 2008, department staff issued the results of an internal audit of the billing process and division staff supplemented the internal audit by conducting a business process review.

Our performance audit was a broader scope and designed to complement the results of the department's internal review. The performance audit identified areas for improvement in business practices and overall operations of the RO. In fiscal year 2008, the state paid for $42.4 million in care that was not reimbursed by third-party providers and responsible parties. By strengthening business practices and internal controls, the department should be able to improve its success in securing reimbursement and

collecting additional funds. The findings and recommendations issued in this audit will further assist the department in improving controls over operations, processing claims more efficiently, and increasing reimbursements to the state.

Chapter II – Background

Introduction

This chapter provides background information about Reimbursement Office's (RO) operations. The office is responsible for securing reimbursement of expenses incurred by the state by billing Medicaid, Medicare, private health insurance, and residents or persons legally responsible, for services provided to residents residing at Department of Public Health and Human Service (department) facilities. It includes an overview of services provided to residents, cost of services provided, dollar amounts reimbursed, and procedures used for processing claims and obtaining reimbursement.

Services Provided at Facilities

When a person is admitted to a facility, the department is responsible for housing and treating that individual. The cost of residency is referred to as "bed charges" and is a daily rate that generally covers room, board, and basic services. Treatment involves ancillary medical services. Depending on a resident's diagnosis and the facility, medical services typically include physician services; laboratory testing; prescriptions; X-rays; immunizations; physical, occupational, or speech therapy; psychological or psychiatric services; and dentistry. Medical services are either provided at the facility by onsite medical staff or outside the facility by providers such as physicians, hospitals, or contracted providers.

Cost of Providing Services

The department bills for and receives reimbursement revenue for the cost of housing and treating residents at the five department-operated facilities. In fiscal year 2008, the average daily population for these facilities was 513 residents. There are four funding sources of reimbursement revenue: 1) Medicaid; 2) insurance proceeds; 3) payments by residents or persons legally responsible for them; and, 4) Medicare. Most of the reimbursements come from Medicaid. Table 1 presents total costs of services (bed charges and ancillary medical services) submitted to the RO for billing and dollars reimbursed for fiscal year 2008.

Table 1
Total Cost of Services Submitted for Billing and Dollars Reimbursed
Fiscal Year 2008

Facility	Cost of Services	Reimbursements	
		Amount	Percent
Montana State Hospital	$34,308,892	$9,003,703	26%
Montana Veterans' Home	$7,022,589	$4,672,191	67%
Montana Developmental Center	$15,443,113	$9,224,076	60%
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Montana Mental Health Nursing Care Center	$8,282,525	$3,600,234	43%
Total	**$68,948,986**	**$26,594,084**	**39%**

Source: Compiled by the Legislative Audit Division from Management Information and Cost Recovery System (MICRS) data.

Total charges submitted to RO for fiscal year 2008 were $68.9 million. The RO was able to secure reimbursement of $26.6 million which is 39 percent of expenses incurred by the facilities. The remaining 61 percent, or $42.4 million, is absorbed primarily through the general fund. Reimbursement varies between facilities ranging from 2 to 67 percent. The department is unable to obtain 100 percent reimbursement of cost of care because of several factors including serving a population of indigent individuals. However, by implementing recommendations discussed throughout this report, the RO could increase its reimbursements.

Revenue collected through the department's reimbursement process is deposited into the general fund with the following exceptions:

- Reimbursements from Montana Developmental Center and Montana State Hospital are first used to pay debt service on bonds issued to fund construction at these facilities. The remainder is deposited into the general fund.
- Reimbursements received for the Montana Veterans Home and Montana Chemical Dependency Center are deposited into state special revenue accounts and appropriated to fund operations of these facilities.

In fiscal year 2008, $19.1 million was deposited in the general fund and $7.5 million in special revenue accounts.

Reimbursement Process

The reimbursement process starts with the work conducted by RO's financial investigators. When a person is admitted to a facility, a financial investigator determines

the resident's ability to pay for the cost of care. Financial Investigator responsibilities include determining who is legally responsible for resident's debts; identifying insurance coverage(s), including Medicare, Medicaid, and private insurance; and determining a resident's ability to pay beyond what insurance will cover by examining a resident's financial information. Financial investigators work with residents and their legal guardians to obtain this information. Once eligibility information is obtained for a resident, financial investigators enter the information into the Management Information and Cost Recovery System (MICRS).

Processing Service Documents and Generating Claims

RO staff located in Helena is responsible for preparing medical claims for Medicare, Medicaid, and private insurers. Staff also prepare bills for private-pay residents. To begin billing for reimbursement, the RO's billing clerks must obtain residents' bed charges and medical service documents from the facilities. This information is input to MICRS. There are four billing clerks at the RO. Each billing clerk is responsible for an individual billing resource (Medicaid, Medicare, private insurance, and resident or financially responsible parties' payment). The billing clerks have specific methods in which they perform their billing because of the unique way claims must be submitted for payment. There is a billing hierarchy, depending on what resources the resident has. Billing is generally completed in the following order:

1. Medicare
2. Private health insurance
3. Medicaid
4. Other resources, including private-pay

Billing clerks must apply the rules and regulations associated with each resource to claims processing. Once billing clerks complete claims processing, claims are submitted either electronically or manually to Medicare, Medicaid, private insurance, and other resources.

Management Information and Cost Recovery System (MICRS)

The RO uses an in-house information system called MICRS to support their billing process. MICRS has the ability to track detailed information regarding residents, to produce claims, and to record payments for medical services at the five department facilities. This system was implemented July 2003 and completed three development phases before becoming fully operational in June 2006. The facilities do not currently have the ability to directly download medical service claims into MICRS. Therefore, a data entry clerk manually inputs medical service information for residents into MICRS.

Chapter III – Resident Information And Services

Introduction

This chapter presents audit work conducted to answer the objective of whether controls are in place to ensure resident financial information and service documents are collected and transferred to the Reimbursement Office (RO) and subsequently entered into the Management Information and Cost Recovery System (MICRS). Audit findings and recommendations for improvement are presented in the following order:

- Obtaining residents' third-party payer and financial information
- Transferring service documents from facilities to RO
- Timeliness of transferring service documents from facilities to RO and entering information into MICRS

Obtaining Resident Third-Party Payer and Financial Information

The RO currently has five financial investigators (FIs) who are responsible for obtaining, verifying, and entering residents' third-party payer and financial information into MICRS. Since some facilities serve a transient population, it is more difficult to obtain information once a resident is discharged; therefore, FIs typically collect information upon admission.

To obtain resident information, FIs, with the help of the resident or their financially responsible party, fill out the Confidential Financial Statement form. The form includes the following sections related to resident information:

Part I – Demographic Information (e.g., insurance, Medicaid, spouse, etc.)

Part II – Income (e.g., wages/salary, escrow, royalties, dividends, etc.)

Part III – Assets (e.g., checking, savings, stocks, life insurance, vehicles, etc.)

Part IV – Fixed Expenses (e.g., housing, transportation, medical, daycare, etc.)

FIs use information from the Confidential Financial Statement to identify residents' third-party payers and the resident or their financially responsible party's ability to pay for the cost of care once third-party payers have been billed and submitted reimbursement. Collection of this information is important since the billing clerks in Helena use it for billing purposes. Table 2 shows the FTE and physical location of FIs for each facility.

Table 2
Reimbursement Office Financial Investigators Staffing
Calendar Year 2008

Facility	FTE	Location
Montana Developmental Center (MDC), Boulder*	0.5	Helena
Montana Mental Health and Nursing Care Center (MMHNCC), Lewistown*	0.5	Helena
Montana Veterans' Home (MVH), Columbia Falls	1	Butte
Montana Chemical Dependency Center (MCDC), Butte	1	Butte
Montana State Hospital (MSH), Warm Springs	2	Warm Springs

*One financial investigator is assigned to MDC and MMHNCC.

Source: Compiled by the Legislative Audit Division.

As seen in the table, the FI for Montana Veterans' Home (MVH) in Columbia Falls is located at the Montana Chemical Dependency Center (MCDC) in Butte, and the FI at the RO in Helena is assigned to the Montana Developmental Center (MDC) in Boulder and the Montana Mental Health Nursing Care Center (MMHNCC) in Lewistown. The two FIs for Montana State Hospital (MSH) are located onsite in Warm Springs. We selected a random sample of FIs' resident files at each facility to determine whether controls are in place to ensure consistency and objectivity among FIs. In total, we reviewed 180 FI resident files for residents admitted between December 1, 2007 and November 30, 2008. We examined resources used by FIs to verify resident information, reviewed Confidential Financial Statement forms to ensure they were complete and signed, and assessed the consistency of documentation in the files.

Inconsistencies Among Financial Investigator Files Exist

FIs sometimes use outside organizations and sources to obtain and verify resident information. Resources we identified include Social Security Administration, Veterans' Administration, the Office of Public Assistance (OPA), and financial institutions. During audit work, we noted resources used and documentation collected by FIs to investigate and verify resident information was not consistent. For example, some FIs used vehicle registration and supplemental nutrition assistance (food stamp) information to verify resident's information, while other FIs were not aware of or did not use these resources.

Other areas in which we noted inconsistencies during file reviews were:

- All files did not have a complete Confidential Financial Statement or documentation describing attempts to obtain information on the statement.

- All files did not have copies of documentation used to verify information (e.g., bank statements, mortgage/rent payments, vehicle payments, etc.).
- All files did not have documentation related to undeliverable mail if they could not contact the resident or their financially responsible party.
- All Confidential Financial Statements forms were not signed by the resident or their financially responsible party, or by the FI.

During review of other states' reimbursement offices, we identified controls were in place to ensure consistency and objectivity of determining residents' ability to pay. One state's reimbursement office required a supervisory signature on every Confidential Financial Statement. Additionally, the office had policies and procedures for financial investigators to follow. Controls for maintaining consistency and objectivity ensures equal treatment of individuals.

Controls Could Be Strengthened to Ensure Consistency

Since FI resident files were not consistent and documentation was not always located in the files, we could not verify FIs' determination of the resident's or their financial responsible party's ability to pay. As a result, the ability to pay may not be correctly calculated and residents treated equitably. If the ability to pay is calculated inaccurately, residents may be required to pay more than they should. Additionally, the state may not be maximizing its reimbursements from residents or their financially responsible party. As a result, general fund is primarily used to pay for residents' services.

Through file reviews and interviews with FIs, we determined the department does not have controls in place to ensure consistency among its FIs. The department should establish policies and procedures to ensure FIs are aware of and use all available outside resources to verify information. Additionally, the department should establish documentation standards to ensure FIs obtain support to verify information on the Confidential Financial Statement form. By establishing policies and procedures, the department will have assurance FIs obtain and report reliable information when determining the ability to pay.

RECOMMENDATION #1

We recommend the Department of Public Health and Human Services establish policies and procedures for financial investigators, including documentation standards, to ensure consistency when investigating and verifying resident information.

Transferring Service Data From Facilities to RO

Facilities manually send service data required for billing to the RO in Helena. Data includes the number of bed days for each resident and any ancillary medical services provided to the resident. Once RO receives this information, the data entry clerk manually enters the data into MICRS. This information must be input into MICRS before claims can be processed. Since completeness and accuracy of data is critical in the billing process, we reviewed whether controls are in place to ensure required data is transferred to the RO for processing and subsequently entered into MICRS.

Transfer of Resident Bed Charge Data

RO obtains bed day information to calculate bed charges for the resident. Bed charges are calculated by taking the bed days for a resident and multiplying them by the facility's daily rate. Audit work identified controls are place to ensure accurate bed day information is provided to the RO for claims processing and input into MICRS. For example, facility staff and RO's data entry clerk communicate, at least once a month, to balance the resident bed days for each facility. This ensures the RO receives accurate resident bed day information.

Conclusion

Controls are in place to ensure accurate bed day information is transferred to the RO for claims processing and entered into MICRS.

Transfer of Medical Service Data

Ancillary medical services are either provided at the facility at an additional charge or by outside providers not employed or contracted by the facility (e.g., community hospitals, dentists, etc.). For medical services provided at a facility, a service document is typically created by facility staff and sent to the RO through mail. Information located on service documents generally includes the resident's facility number, name, type of service, date the service was provided, and the charge for the service.

For services provided by outside providers, facility staff either send RO a service document or, in some cases, the outside providers' bill. These service documents are manually input into MICRS by the RO's data entry clerk. Service documents from the pharmacy contractor for MCDC, Montana State Hospital (MSH), and MDC are submitted electronically, as well as, documents from the laboratory and pathology contractor for MSH and MCDC. The data entry clerk is able to electronically upload these documents into MICRS.

Review of Medical Service Documents

During audit work, we tested whether controls are in place to ensure all medical service documents are transferred from facilities to RO, and subsequently entered into MICRS. We traveled to five facilities to review medical service documents for a random sample of residents. Service documents reviewed were for services provided from December 1, 2007, to November 30, 2008.

To conduct thorough audit work, we traced a sample of medical service documents from the facility to the service charge on MICRS and service charges on MICRS to facilities' service documents. This ensured service documents received by RO were subsequently entered into MICRS and that the facility had supporting service documents for the service charges on MICRS. In total, we reviewed over 300 medical service documents. Findings from this review are discussed in the following section.

RO Lacks Controls to Ensure All Medical Service Documents Are Received

The following table illustrates which medical service documents are sent from facility staff to the RO.

Table 3
Medical Service Documents Sent to the Reimbursement Office By Facility
Services Provided in Calendar Year 2008

Subject	MSH	MDC	MCDC	MVH	MMHNCC
Pharmacy	X	-	X	X	X
Dental	X	X	X	-	-
Immunizations	X	X	-	X	X
PT/OT/Speech	X	-	-	X	-
X-Ray	X	-	-	-	-
EKG	X	-	-	-	-
Physician Services	X	-	X	X	X
Psychiatric Services	X	X	-	-	X
Psychology Services	X	-	-	-	X
Laboratory	X	-	-	X	-
Outpatient Services	X	-	-	X	-
X = Indicates a medical service document sent to RO.					

Source: Compiled by the Legislative Audit Division.

As the table illustrates, medical service documents sent to RO varies by facility. During our review of medical service documents, we identified the following examples that demonstrate areas in which RO should establish controls to ensure RO is receiving all medical service documentation.

We identified approximately four percent of sampled services provided at facilities were not input into MICRS. Either these service documents have not been sent to RO, the documentation was lost in the mail, or RO received the documentation; however, it is not located in the data entry clerk's batches and was not entered into MICRS. During audit work, we could not verify why documentation was not input into MICRS; however, we were able to determine the resident was not billed for the service, meaning the state has not been reimbursed for the service.

As stated above, the resident can receive medical services from outside providers not employed or contracted by the facility. When this occurred, it was difficult to determine whether RO or the provider was responsible for submitting the claims. During interviews, it was unclear to facility staff which entity should submit the claim (RO or the outside provider). The following example highlights process inefficiencies that currently exist. At one of the facilities, facility staff sent all outside provider service documents to RO. The RO section supervisor then wrote on the document whether RO was responsible for billing, made a copy of the documentation, and sent it back to the facility. The facility then notified the outside provider whether they should submit the claim.

If RO does not receive medical service documents, it cannot bill for the service, meaning the state will not be reimbursed for the service. During audit work, we identified an example where an outside provider provided services to a resident in November 2007, submitted the claim, and was reimbursed by Medicaid. RO later discovered it was responsible for submitting the claim after receiving the outside provider's statement a year after the service had been provided. Since the outside provider submitted the claim to Medicaid, RO is unable to submit a claim to Medicaid until the outside provider reimburses Medicaid. As of June 2009, RO has not submitted a claim to Medicaid for these services. This issue occurred because clear direction was not provided upfront on which entity was responsible for billing.

The fundamental part of billing for medical services is ensuring the provider of services transfers medical service documents to the party responsible for billing. Other state's reimbursement offices and the private industry billing office we reviewed had controls in place to ensure all services were transferred to the reimbursement office. One of the other state's reimbursement offices enters medical service documents directly into the reimbursement office's computer system at the facility and no transfer of data takes place.

During audit work, we identified the department has not established controls to ensure RO receives all medical service documents from facilities, its contractors, or outside providers. If RO does not receive medical service documentation, it is unable to submit claims to third-party payers or bills to the resident or their financially responsible party. To ensure RO is maximizing its reimbursements, the department should establish controls to ensure RO receives all medical service documents from the facilities, facilities' contractors, and outside providers.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services establish controls to:

A. *Clarify the Reimbursement Office's responsibility in billing medical services provided by outside providers.*

B. *Ensure the Reimbursement Office receives all medical service documentation from facilities, facilities' contractors, and outside providers.*

Timeliness of Data Input Into MICRS

We also conducted audit work to determine whether service documents are entered into MICRS in a timely manner. Before RO can process claims, the data entry clerk must receive and enter medical service documents and bed days into MICRS. Since billing clerks cannot process claims until information is input into MICRS, timeliness of service documents entered into MICRS is vital. Additionally, if information is not entered timely, it can ultimately affect RO's success of obtaining reimbursement. To test this area, we examined the time between when the service or bed day was provided to the resident and when the service document was entered into MICRS.

We tested the timeliness of all claims provided between calendar years 2007 and 2008 by extracting data from MICRS. MICRS has four different tables in which data is input, they include bed days, pharmacy claims, services, and other services. The "services" table represents services provided by the facility and the "other services" table represents services provided by outside providers. Table 4 shows the timeliness of service information input into MICRS.

Table 4
Timeliness of Service Information Input Into MICRS
All Claims in Calendar Years 2007 and 2008

	MICRS Service Table			
Range of Days*	**Bed Day**	**Pharmacy**	**Services**	**Other Services****
0-60 Days	99.9%	98.5%	96.3%	58.0%
61-120 Days	0.1%	1.1%	3.0%	24.6%
121-180 Days		0.4%	0.5%	8.8%
181-240 Days			0.1%	3.4%
241-300 Days			0.1%	2.1%
301-360				0.2%
Over 360 Days				2.9%

*Range of days represents the number of days between when the service was provided and the date the service was entered into MICRS by the Reimbursement Office's data entry clerk.

** "Other Services" are services provided outside the facility (e.g. hospitals).

Source: Compiled by Legislative Audit Division using MICRS data.

The table shows 99.9 percent of "bed days" are entered into MICRS within 60 days. As stated earlier in this chapter RO has controls in place to ensure bed day documentation is transferred and accurate. This may contribute to almost 100 percent of the bed days being entered into MICRS within 60 days.

Controls Over Submitting Medical Service Documents Could be Improved

As can be seen in the Table 4, in some cases, the medical service documents were not entered into MICRS until a year after the service was provided. When looking at "other services," only 58 percent of other services are entered into MICRS within 60 days. The following sections discuss two examples of the gap that can occur between these two dates and how it affects RO's billing timeliness and success of reimbursement.

During file review at RO, we identified instances where RO received a batch of medical service documents from the facility two months after the service had been provided:

- RO did not receive a batch of medical service documents, for services provided in June 2008, until August 2008. Claims for these services were not submitted until October 2008.
- RO did not receive the service documentation for services provided by an outside provider in 2007 until a year later, and as of June 2009 has not billed for these services.

Throughout interviews with RO staff and our file review, we determined the department does not have controls in place to ensure RO receives all service documents in a timely manner. Since RO's billing clerks must submit claims within specific timeframes to obtain reimbursements, it is important RO receives and enters all services into MICRS in a timely manner. To ensure the state is receiving its reimbursements in a timely manner to meet billing timeframes, the department should establish controls to ensure all medical service documents are sent to RO and entered into MICRS within a reasonable timeframe established by the department.

RECOMMENDATION #3

We recommend the Department of Public Health and Human Services establish timeframes for submitting medical service documents to the Reimbursement Office to ensure compliance with billing timeframes.

Chapter IV – Process For Filing Claims And Submitting Bills

Introduction

Once a resident's ability to pay, third-party payer information, medical services, and bed days are entered into the Management Information Cost Recovery System (MICRS), the Reimbursement Office's (RO) billing clerks use this information to process claims. This chapter presents audit work conducted to answer the objective of whether controls exist to ensure medical claims and resident bills are processed efficiently and accurately. Audit findings and recommendations for processing unbilled and denied claims are presented in this chapter. Findings addressing the role of MICRS in the billing process are reported in *Management Information and Cost Recovery System: Claims Processing (09DP-06).*

Manual Review of Claims

Through interviews and review of RO billing procedures, we noted billing clerks are manually reviewing claims before they are issued. The clerks review claims to verify codes are correct and data is complete and accurate. When asked how often the review returned exceptions, the billing clerks indicated it was rare.

As discussed in the Information Systems audit report 09DP-06, MICRS has controls in place, including verifications, and can be relied upon to process claims accurately. As a result, manual verification of MICRS processed claims is unnecessary. Additionally, the department's internal audit report made multiple recommendations related to discontinuing the use of manual checks against MICRS data. During audit work, it was determined manual checks are still occurring, which affects the amount of time billing clerks have to process and follow-up on claims. Because these manual checks are unnecessary, this procedure should be discontinued.

RECOMMENDATION #4

We recommend the Department of Public Health and Human Services discontinue manual claim reviews and rely on the Management Information and Cost Recovery System to process claims.

Review of Unbilled Claims

To determine whether RO is processing claims efficiently, we extracted all service data from MICRS for calendar years 2007 and 2008. To assess RO's timeliness of processing claims, we compared the date the service was entered into MICRS to the date the claim was sent. Table 5 illustrates our findings related to RO's timeliness. The table shows the range of days between the date the service was entered into MICRS and the date the claim was sent to third-party payers. The table also shows total billed charges, number of claims, and percentage of claims for each range.

Table 5
Reimbursement Office's Timeliness of Processing Claims
All Services Provided in Calendar Years 2007 and 2008

Range of Days	Billed Charges	Number of Claims	Percentage of Total Claims
Unbilled	$55,665,242*	70,054	52.6%
0-90 Days	$68,029,207	57,545	43.2%
91-180	$5,575,309	3,937	3.0%
181-365 Days	$2,658,308	1,494	1.1%
Over 365 Days	$808,817	195	0.1%
Total	**$132,736,883**	**133,225**	**100%**

*Based on estimated bed day charges and actual medical service charges.

Source: Compiled by Legislative Audit Division using MICRS data.

As the table shows, the majority of services billed are done so within 90 days from when the service is entered into MICRS. However, "unbilled" services total 53 percent of all services provided in calendar years 2007 and 2008. If a service is unbilled, this means the service was entered into MICRS; however, the billing clerks have not generated a claim. Therefore, 53 percent of services provided in 2007 and 2008 appear to be unbilled.

During our review of unbilled services, we identified instances in which billing clerks could not bill a third-party payer or the resident for services. These are referred to as "nonbillable" services and include:

- Resident does not have third party payers nor do they have an ability to pay.
- The resident does not have insurance coverage for the service (e.g., dental insurance) and no ability to pay.
- The resident is admitted under a specific commitment code that is not billable to third-party payers (e.g., if a resident is admitted as a "forensic commitment") and does not have an ability to pay.

Addressing Unbilled and Denied Claims Not Timely

As seen in Table 5, we identified 70,054 claims in calendar years 2007 and 2008 are unbilled. Since reasons do exist why RO would not bill for a service we extracted services we identified as nonbillable. After the extraction, we were left with 17,913 unbilled services, which we estimate total $25 million in charges.

As of June 2009, we also identified RO billing clerks have approximately 300 denied claims requiring follow-up. We randomly selected 18 denied claims to identify if controls were in place to ensure denied claims were followed-up in a timely manner. During our review, we noted six of the denied claims were for services obtained prior to 2008 and have not been resolved. For example, a $45,000 claim for services obtained in July 2005 was resubmitted in July 2006 and denied due to untimely billing. Another denied claim was $9,000 for services provided in October 2007 and has not been resolved; the last follow-up work conducted on this claim was in May 2008.

The following timeframes outline how long RO has to file a claim:

- Medicare: According to 42 CFR §424.44, Medicare has an established timeframe for filing a claim that ranges between 15 and 27 months depending on when the service was provided. For services provided between October 1, 2006 and September 30, 2007, claims must be submitted by December 31, 2008. According to 42 USC 1395 (g)(4)B)(i), if a claim is submitted more than one year after the service has been provided, it is subject to a ten percent reduction.
- Medicaid: ARM 37.85.406 states that a claim must be submitted to Medicaid within 12 months from the date of service, with some exceptions.
- Private Insurance: For most private insurance companies, claims are to be received no more than one year from the date of service.

When RO bills for the current backlog of unbilled services and denied claims, it is probable the majority of the claims will be denied for untimely filing since 12,146 of these services were provided before June 1, 2008. Since claims can be denied for untimely filing, this affects the amount of dollars reimbursed to the state.

RECOMMENDATION #5

We recommend the Department of Public Health and Human Services establish controls to ensure action is taken to address and process unbilled and denied claims.

Chapter V – Resolving Resident Accounts

Introduction

Once the Reimbursement Office (RO) bills the resident's third-party payers, the resident or their financially responsible party is billed the balance. This chapter presents audit work conducted to answer the objective of whether controls exist to ensure resident account balances are addressed and resolved in a timely manner. Audit findings and recommendations for improvement are presented in the following order:

- Compliance with ARM
- Inconsistency in reductions to residents' unpaid balances
- Transferring delinquent accounts
- Current accounting practices

Resolving Unpaid Account Balances

RO's financial investigators (FI) are responsible for determining each resident's ability to pay. Residents are not billed the account balance if they do not have an ability to pay and this amount is not reimbursed to the state. However, if the resident has an ability to pay, the resident or their financially responsible party is billed the unpaid balance, up to their ability to pay. During our review of 180 FI records, we noted 63 percent of residents did not have an ability to pay based upon determinations made by the FI.

Reductions to Unpaid Account Balances

During audit work, we determined reductions are made to the resident's unpaid balance for various reasons. These reductions are called write-offs. Since reimbursement amounts are decreased by write-offs, we reviewed documentation for 13 individual write-off instances to determine whether controls were in place to ensure consistency among financial investigators. Through file review and audit work, we identified three different types of write-offs exist. These include care and maintenance, charge-offs, and charity write-offs. The next section specifically discusses care and maintenance write-offs.

Care and Maintenance Write-offs Not Allowed By ARM

"Care and maintenance" write-offs occur when RO's FIs increase a resident's fixed expenses for a specific month. By increasing fixed expenses, the resident's ability to pay decreases. According to ARM 37.2.703, when determining ability to pay, fixed expenses, "shall be limited to reasonable and necessary living and mandatory expenses over which the resident or responsible person has little or no control, **and which have been incurred or committed to prior to admission**" (emphasis added).

During our review of write-offs, we identified four instances in which a resident received a care and maintenance write-off for an expense that was incurred and committed to **after** the resident's admission. For example, one resident was admitted to a facility in February 2008 and received a noncovered outside dental service in May 2008. The FI included these noncovered services into the fixed expenses when determining the ability to pay.

Since these types of write-offs decrease the resident's ability to pay, they also decrease the amount of dollars reimbursed to the state for services it provides to the residents. While we recognize the RO must respond to residents' unique circumstances, ARM 37.2.703 clearly states only expenses "incurred or committed to prior to admission" shall be included in fixed expenses.

RECOMMENDATION #6

We recommend the Department of Public Health and Human Services comply with ARM 37.2.703 and only use expenses incurred and committed to prior to a resident's admission when determining ability to pay.

Inconsistent Write-Off Methods and Amounts for Unpaid Accounts

As stated in the previous report section, RO uses three different forms of write-offs to adjust resident's accounts. The other two forms of write-offs are "charity" and "charge-off." In both of these cases, the write-off is deducted straight from the resident's account, instead of added to their fixed expenses when determining ability to pay.

During our review, we noted variations related to how write-offs were applied to the resident's account. For example, the write-off either reduces the resident's ability to pay (care and maintenance) or is deducted straight from the resident's account (charge-offs and charity). Our audit work also showed inconsistencies related to controls over write-offs. Not all reviewed write-offs had:

- Explanation of the write-off included on an Authorization for Account Adjustment form
- Documented review and authorization completed by the section supervisor
- Documentation related to the expense incurred by the resident (e.g., invoices)

Additionally, for charity write-offs, RO writes off the difference between Medicaid's nursing home obligation and RO's ability to pay determination. Since portions, and in some cases the full nursing home obligation amount is written-off each month, the state is not reimbursed the full amount determined by Medicaid as the resident's responsibility. This amount totalled approximately $100,000 in fiscal year 2008.

Since RO has limited controls in place over write-offs, variations in RO's staff procedures occur and staff is unclear about what is required when making a reduction to a resident's unpaid balance. Additionally, three of the four care and maintenance write-offs we reviewed resulted in the resident's ability to pay to be miscalculated. Two write-offs resulted in a loss to the state of over $200 and another overbilled a resident by approximately $20.

While we understand unique resident circumstances arise, RO should have controls in place to ensure staff is consistent when making reductions to resident's unpaid account balances. Other state agencies have a clearly defined process and specific timeframes to ensure consistent resolution of unpaid account balances.

RECOMMENDATION #7

We recommend the Department of Public Health and Human Services establish controls to:

A. *Ensure a consistent approach is used when writing-off portions of residents' unpaid account balances.*

B. *Develop documented definitions of write-offs, general guidelines for situations that warrant a write-off, and establish a formal review and authorization process.*

C. *Address charity write-offs to ensure consistency.*

RO Turns Over Delinquent Resident Accounts to the Department of Revenue

As discussed in the above section, when an unpaid balance is remaining on a resident's account, the resident or their financially responsible party will be billed their ability to pay. If RO sends a bill and does not receive payment after 30 days, the resident's account is delinquent. According to MOM 2-1190.00, when an agency has made all reasonable attempts and cannot collect a valid account's receivable, it must transfer the account to Department of Revenue (DOR) or an outside collection agency.

We reviewed RO's process for delinquent accounts and determined RO is sending delinquency letters and, after 120 days of delinquency, is transferring the account to the DOR for collections. If DOR is able to collect on a delinquent account, it will transfer a portion of the payment to RO.

CONCLUSION

The RO has a process in place to transfer delinquent resident accounts to the DOR.

Current Accounting Practices Could Provide More Complete Records

Audit work revealed the department has appropriate cash collections controls in place; however, current accounts receivable practices could be improved. When recording the RO's accounts receivable on the state's financial reporting system (SABHRS), the department currently records net accounts receivable (gross accounts receivable minus any uncollectible accounts). For example, if the total cost of services for a fiscal year was $70 million and RO expects to collect reimbursements of $30 million, only the expected amount of $30 million is recorded. Gross accounts receivable and allowance for uncollectible accounts are not currently recorded on SABHRS.

State accounting policy, MOM 2-1180.00, states an allowance for uncollectible accounts should be established so the balance sheet and operating statement are fairly stated at the amount expected to be collected. While the department believes it has the option of choosing its accounting method and has elected the practice of recording net accounts receivable, discussions with the State Accounting Division management indicated the department should be recording gross accounts receivable for the RO and establish an "allowance for uncollectible accounts."

The department is not currently complying with state accounting policy. By following state accounting policy, the department would be providing a more complete record of the cost of providing care to residents at department facilities including a detailed accounting of uncollectible accounts.

RECOMMENDATION #8

We recommend the Department of Public Health and Human Services record gross accounts receivable in accordance with state accounting policy.

Chapter VI- Overall Program Management

Introduction

Issues discussed in the previous chapters relating to processing claims more efficiently highlight the need for improvements in the Reimbursement Office's (RO) management controls. Management controls are an essential part of business operations. Good management controls provide for long-term vision and guide staff in carrying out management initiatives and conducting effective daily operations. During the audit of the Department of Public Health and Human Services (department) RO business practices, we examined overall program management controls including controls related to maintaining security of residents' personal health information. This chapter addresses two audit objectives. First, determine whether the department has effective management controls to guide RO operations. Secondly, determine whether controls exist to ensure personal health data is secure and protected. Audit findings and recommendations are presented in the following order:

- Long-term planning
- Performance measures and management information
- Human resource management
- Security of confidential health information

Long-Term Planning Needed

Management controls include a documented long-term plan of an organization's methods and procedures adopted by management to ensure its goals are met. An organization's long-term plan can be defined as a "road map" to lead an organization from where it is now to where it would like to be in the future. Characteristics of a useful plan include:

- Short and simple. Keep it focused on the most important things to accomplish, everything in the plan needs to be addressed.
- Identify the organization's purpose and create a "mission statement" or a statement that describes why the organization exists (its basic purpose).
- Detailed, measurable, and time sensitive goals. Goals should also be prioritized.
- Identify specific approaches or "strategies" that must be implemented to reach each goal.
- Identify specific action plans to implement each strategy. These are specific activities the organization must do to ensure its effectively implementing each strategy (sometimes referred to as "objectives"). These action plans should be clearly worded to the extent that management can assess if they have been met.

- Monitor and update the plan. Assess whether goals have been met and action plans implemented.

Creating a basic long-term plan ensures resources (time, employees, and funds) are properly allocated to activities that are key priorities. The plan also provides a base from which progress can be measured and establishes a mechanism for informed change when needed. The plan should be reviewed at least once a year. By reviewing the plan annually, the organization can identify goals to be achieved over the coming year, resources needed to achieve those goals, and funding needed to obtain those resources.

Currently, the RO does not have a comprehensive long-term management plan in place to guide the program and management decisions. The only goal we were able to identify during audit work was in the Business and Financial Services Division's (division) goals and objectives document. The goal is to continually work to improve the business processes used within the division. While the division had an objective related to conducting timely financial assessments for 100 percent of residents and collecting funds in order to minimize dependency on tax revenues, there was no strategy or detailed action plan to reach this goal other than introducing legislation. The department does not have a long-term plan for RO operations and does not have specific goals or goals targeting RO. Additionally, current objectives are limited to only one.

As discussed in previous sections of this report, RO is not ensuring all services are billed and billed in a timely manner; improvements should be made to improve process efficiency and effectiveness. Also discussed are issues related to resolving a resident's ability to pay and addressing account balances; process improvements are needed to ensure residents are treated consistently and fairly. During the audit we noted billing process inconsistencies that could be addressed such as:

- Financial investigators use different means to investigate resident resources.
- File documentation varies between financial investigators.
- Some service documents are submitted manually while others are electronic.
- The medical services RO bills and how often service documents are sent from facilities to RO.
- Writing off portions of resident account balances.

The department's internal audit and business process review (discussed in Chapter I) identified similar concerns with process efficiency. While the department conducted a business process review and internal audit, these reviews focused on how to solve pressures currently faced by the office and how to resolve current information technology issues and did not address long-term plans.

By implementing a long-term plan, RO would have a mechanism in place to better assess improvements needed in the future. There are a number of evolving issues that will impact medical claims processing in the future including use of electronic payment systems and electronic medical records. The federal government requires electronic processing of all Medicare claims. Another impending change that will impact future operations of the RO is retirements of key section staff. Development of a long-term plan, which is driven by specific goals and quantifiable objectives, would help ensure the vision and expectations of department management and incoming RO supervisory staff are aligned.

RECOMMENDATION #9

We recommend the Department of Public Health and Human Services develop a management plan for the Reimbursement Office that guides the long-term vision of program operations.

Program Performance Measures and Management Information Needed

An integral part of a long-term plan is performance measurement. Performance measurement is the ongoing monitoring and reporting of an agency's progress towards meeting its established goals and objectives. Used over time, performance measurement provides quantifiable information on the agency's impact, efficiency, and effectiveness and can identify where program operations are strong and where improvements are necessary. Management information is the quantifiable information that facilitates performance measurement.

When conducting interviews with management from other states' reimbursement and private-sector medical billing offices, we identified various forms of management information used to monitor office performance. Private industry management creates performance measures for claims processing and tracks these daily. For example, management sets a measure and monitors the number of patients entered each day by billing clerks. Private industry management also monitors aging reports related to unpaid claims and ensures they are followed-up in a timely manner. The other states' reimbursement office also collects information related to the number of open accounts and is able to generate the specific number of open accounts broken down by whether the resident was at the facility or discharged. RO could use department resources to identify a similar process to the department's Mental Health Services Plan (MHSP), which is another reimbursement function. MHSP gathers extensive information on

claims processing to allow them to track program activities. For example, queries on numbers of claims processed, paid, and denied and the reasons for claim denial allow staff to track how funding is spent and identify evolving trends.

During audit work, we determined the department collects limited management information and does not have performance measures in place to gauge progress. Currently, the only management information the department collects relates to the total dollars reimbursed each fiscal year. Management does not collect any data specific to timeliness of claims processing, pending denied claims, or aging of unpaid claims. Additionally, while the Management Information and Cost Recovery System (MICRS) was created to not only process claims but provide management information, RO is using it to generate limited management reports. For example, although MICRS currently contains data that would allow the department to compare cost of services provided to dollars reimbursed for each facility, staff does not query or use this type of data.

Since the RO collects only limited management information, this impacts their ability to effectively manage the operation. For example, since they do not currently compile data regarding claims processed per billing clerk, there is no way to ensure workload is equitably distributed. Also, collecting data on the aging of unpaid claims would assist management in prioritizing which unpaid claims should be addressed.

The primary reason the RO does not collect additional management information is their focus is dollars reimbursed. The department was reimbursed $26.6 million in fiscal year 2008, which is an average of 39 percent of cost of services provided at facilities. However, by focusing on the total amount of reimbursements only, RO lacks other key information which could be used to better benchmark performance. The department should develop other performance information to allow them to monitor their business practices such as timeliness of billing, completeness of billing, pending claims, and portion of expenses not reimbursed. Performance measures should also provide long-term benchmarks providing a gauge of progress over time. By collecting additional management information, RO would be better able to identify where resources should be allocated and where performance could be improved. This could potentially increase the amounts reimbursed to the general and state special revenue funds.

RECOMMENDATION #10

We recommend the Department of Public Health and Human Services establish results-oriented performance measures and collect additional management information to better assess performance of the Reimbursement Office.

Human Resource Management Is Critical to Efficiency and Effectiveness

The performance of employees in an organization is the primary reason behind an organization's success or failure toward reaching its long-term goals. Strong human resource management is one of the most important support functions of management, as it provides the principles by which employees are allocated and assigned duties, and whether they are used efficiently and effectively. Effective management of human resources includes:

- Active workforce planning, which includes identification of the most efficient and effective tasks and processes, as well as, anticipating and addressing issues such as the aging and shrinking size of the workforce that will affect the organization's success in the future.
- Training and development of an organization's employees.
- Management of employee performance that links individual performance to organizational outcomes.

MOM 3-0115 states monitoring performance is a basic management practice and involves such activities as performance evaluations. The department also has policies in place that address the need to promote and provide appropriate training opportunities for department employees.

During our audit we identified several areas where human resource management is lacking within RO operations:

- ***Does not have an active workforce plan in place***. For example, the section supervisor planned to retire in June 2009 and worked with the RO for over 30 years. During interviews with management and observations of operations, it was evident the supervisor had a large amount of organizational knowledge and retirement would significantly impact the RO. However, there was no succession plan in place to seamlessly continue operations when the supervisor retired. Additionally, RO does not have an active plan in place if a financial investigator or billing clerk either temporarily or permanently ceases employment with the department. Yet these individuals each possess

highly individualized and specialized knowledge of the operation and cross-training has been limited.

- ***Limited oversight of offsite staff is provided***. The RO employs specialized staff that is located centrally in Helena, and across the state. Supervisors work at the Helena office and rarely visit employees located at offsite facilities. Additionally, staff meetings are rarely held and the last office meeting that included all RO staff was in 2005.
- ***Limited training and development opportunities provided to staff***. The department does not have a training coordinator. According to department policy, the program supervisor is responsible for coordinating with the Bureau Chief on training requests for the office. Other than training related to collection methods provided to financial investigators at the end of 2008, we did not identify any other training recently provided to RO staff. The department's recent internal audit and business process review recommended staff receive training in both Microsoft Excel and SABHRS.
- ***Individual performance measurement is not completed***. RO supervisors conducted a performance evaluation for only one employee in the last five years.

The lack of human resource management controls impacts business practices and office operations in the following ways:

- Without succession planning, RO is unable to ensure a seamless level of operations if a staff member retires or leaves the office.
- Since the RO does not schedule staff meetings, office communication related to RO's overall operation is limited.
- Individual performance is not measured or tracked. As a result, staff does not have clear guidelines of performance expectations nor receive feedback whether they are meeting management's expectations.
- Training is not used as a tool for developing employee's skills in order to address future office needs. Training needs are not identified as employee performance appraisals are not conducted.

While the section supervisor indicated these controls are important, they have not been prioritized due to the amount of time spent completing other tasks. The department has recognized the amount of the section supervisor's time spent on other tasks and stated it will be reevaluating the tasks completed by incoming management. However, to ensure RO is operating efficiently and effectively, the department should prioritize the importance of human resource management.

RECOMMENDATION #11

We recommend the Department of Public Health and Human Services prioritize and implement human resource management controls that include:

A. *An active workforce plan.*

B. *Supervision and oversight of all staff including offsite staff.*

C. *Training and development opportunities for staff.*

D. *Individual performance measurement of staff.*

Security of Confidential Health Information

Maintaining security over the use and disclosure of individuals' health and personal information is an area safeguarded by both federal regulations and state law. One of our audit objectives was to determine whether controls exist to ensure personal health data is secure and protected. To address this objective, we reviewed applicable federal regulations, department policy, and private industry standards. We interviewed department management, staff from the RO and department-operated facilities, and representatives of the private medical billing industry. We observed employee actions to protect security of confidential health and personal information.

Protected Health Information and Safeguard Requirements

Documents maintained by the department's RO contain both protected health information (PHI) and personal information. PHI is defined as anything that includes individually identifiable health information. Examples of information maintained and transmitted by department staff include:

- Medical service (billing) documents
- Medical diagnoses
- Resident names, social security numbers, addresses, and birthdates
- Financial information including bank records, assets, and property liens

These types of documents are used by the RO to prepare medical claims and bills for submission to Medicare, Medicaid, private insurance and private-pay residents. Documents are transmitted from facility staff to the RO either electronically through e-mail, or hard-copy through the mail. These documents are transferred to the RO on a weekly, monthly, or yearly basis depending on the type of document and the facility sending them.

Federal regulations outline privacy and security measures for handling PHI. The Health Insurance Portability and Accountability Act (HIPPA) requires development of standards for privacy and security of health documents. The privacy provisions pertain to all PHI records including paper and electronic.

The department has adopted policies to create an environment that ensures the security of protected health information. The department's policy, *Physical Security for Protected Health Information (Policy Number 014)*, requires department employees to make reasonable efforts to provide for the security of both hard-copy and electronic PHI. Some specific requirements include requiring only PHI documentation in current use should be on an employee's desk and all other PHI should be in a covered folder. Policy also states when an employee is gone for an extended period of time (lunch break, gone for the day) all PHI should be contained in a locked filing cabinet. Additionally, e-mail messages containing PHI must be transferred over an encrypted network line. The State of Montana currently offers a secure network line through the use of Montana e-Pass that is designed for the purpose of securing the transfer of sensitive data.

Protected Health Information Not Always Safeguarded

Audit work revealed PHI is not being protected according to HIPPA, department policy, and private industry standards. We identified concerns with security of the transmission of electronic correspondence and storage of hard-copy files. The following examples illustrate these findings:

- RO staff corresponds with other department staff regarding resident information through e-mail. During our audit, we found e-mail correspondence between RO, facility, and other division staff that contained residents' full names, addresses, and social security numbers. Some e-mails also contained information that pertained to a resident's medical condition. E-mails containing this type of sensitive information were not sent via an encrypted network nor were resident identifiers (resident number, initials, etc.) used instead of PHI to identify a resident during correspondence.
- Files are to be stored on designated storage shelves with only documentation in current use on an employee's desk and all other PHI should be in a covered folder. Audit work revealed this practice is not followed and RO employees typically have multiple files on their desks. RO staff indicated it is often difficult to locate medical service files since they are not always located on the designated storage shelves and there is no way to track where files are other than looking on each employee's desk. These practices increase the risk of exposing PHI to individuals who should not have access to the information. In addition, there is increased potential for misplacing information and RO staff loses time searching for missing medical service files needed for processing and billing medical claims.

Controls Should Ensure PHI Is Protected

While RO management is aware of HIPPA and department privacy policies, they were not aware that current staff practices do not adhere to policy. By strengthening controls to ensure staff is complying with federal regulations and department policy related to the protection of PHI, the department could better protect itself against the threat of exposing or losing sensitive documentation.

RECOMMENDATION #12

We recommend the Department of Public Health and Human Services establish controls to ensure both hard-copy and electronic health and other confidential information is secure and protected.

Department of Public Health and Human Services

Department Response

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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September 15, 2009

Angie Grove
Deputy Legislative Auditor
Performance Audits
Legislative Audit Division
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PO Box 201705
Helena, Montana 59620-1705

Dear Ms. Grove:

The Department of Public Health and Human Services has reviewed the Reimbursement Office Business Practices Performance Audit (08P-12) completed by the Legislative Audit Division. Enclosed you will find our responses to each recommendation, the expected corrective action and a planned completion date.

We appreciate the effort that your staff put into this audit and look forward to using these recommendations to continue improving business processes in the Reimbursement Office.

Sincerely,

Anna Whiting Sorrell
Director

Cc. Staci Roope
Dan Forbes
Laurie Lamson
Marie Matthews

Recommendation #1

We recommend the department establish policy and procedures for financial investigators, including documentation standards, to ensure consistency when investigating and verifying resident information.

Response: Concur

Corrective Action: The department will develop desk procedure manuals for financial investigators including documentation standards, develop a formalized supervisory review process and incorporate a quality assurance cycle into the financial investigation business process.

Planned Completion Date: 03/31/10

Recommendation #2

We recommend the department establish controls to:

A. Clarify the Reimbursement Office's responsibility in billing medical services provided by outside providers.

B. Ensure the Reimbursement Office receives all medical service documentation from facilities, facilities' contractors, and outside providers.

Response: Concur

Corrective Action: The department will develop internal protocols for timely submission of outside medical service provider information, expand the Reimbursement Office's ability to identify potential outside medical services and communicate the importance of timely billing to our most significant outside medical partners.

Planned Completion Date: 03/31/10

Recommendation #3

We recommend the department establish timeframes for submitting medical service documents to the Reimbursement Office to ensure compliance with billing timeframes.

Response: Concur

Corrective Action: The department will develop standards for timely submission of medical service documents from our applicable facilities to the Reimbursement Office.

Planned Completion Date: 12/31/09

Recommendation #4

We recommend the department discontinue manual claim reviews and rely on the Management Information and Cost Recovery System to process claims.

Response: Concur

Corrective Action: The department will complete a review the of existing billing tables within the Management Information and Cost Recovery System (MICRS). Upon completion of the review process, the Reimbursement Office staff will discontinue re-validating MICRS claim data.

Planned Completion Date: 12/31/09

Recommendation #5

We recommend the department establish controls to ensure action is taken to address and process unbilled and denied claims.

Response: Concur

Corrective Action: The department will implement a series of escalating control processes to ensure claims billing and appeals processes generate the maximum level of net revenue possible for the state general fund.

Planned Completion Date: 12/31/09

Recommendation #6

We recommend the department comply with ARM 37.2.703 and only use expenses incurred and committed to prior to a resident's admission when determining ability to pay.

Response: Concur

Corrective Action: The department will review all applicable policies and practices surrounding ARM 37.2.703 (Fixed Expenses) and ARM 37.2.701 (7) (Personal Needs) to ensure operating procedures result in the fair treatment of all residents while complying with existing rules. If after review, we find that the two rules are in conflict or incomplete we will pursue rule modifications.

Planned Completion Date: 03/31/10

Recommendation #7

We recommend the department establish controls to:

A. **Ensure a consistent approach is used when writing-off portions of residents' unpaid account balances**
B. **Develop documented definitions of write-offs, general guidelines for situations that warrant a write-off, and establish a formal review and authorization process.**
C. **Address charity write-offs to ensure consistency.**

Response: Concur

Corrective Action: The department will develop desk procedure manuals including write-off policies, documentation standards, escalating authorization requirements and a quality assurance cycle related to the write-off process.

Planned Completion Date: 03/31/10

Recommendation #8

We recommend the department record gross accounts receivable in accordance with state policy.

Response: Concur

Corrective Action: The department will begin reporting the year end gross accounts receivable in conjunction with an estimated allowance for uncollectible accounts.

Planned Completion Date: 07/10/10

Recommendation #9

We recommend the department develop a management plan for the Reimbursement Office that guides the long term vision of program operations.

Response: Concur

Corrective Action: The Business and Financial Services Division will continue to formalize its vision for the Reimbursement Office, along with all other components of the division, in a division wide management plan.

Expected completion date: 01/31/2010

Recommendation #10

We recommend the department establish results-oriented performance measures and collect additional management information to better assess performance of the Reimbursement Office.

Response: Concur

Corrective Action: The Business and Financial Services Division will identify the quantitative and qualitative factors that measure success within the Reimbursement Office. Once success measures are identified a periodic reporting cycle will be implemented to manage performance against the expectations.

Expected completion date: 01/31/2010

Recommendation #11

We recommend the department prioritize and implement human resource management controls that include:

A. An active workforce plan.
B. Supervision and oversight of all staff including offsite staff.
C. Training and development opportunities for staff.
D. Individual performance measurement of staff.

Response: Concur

Corrective Action: The department will continue to pursue opportunities to maintain and improve the workforce within the Reimbursement Office. Recent actions include the inclusion of a lead working in the billing unit and the purchase of computer training courses for staff. The Business and Financial Services Division received authorization to hire a management level position in the Reimbursement Office beginning in SFY 2011. This position will greatly assist the ability to provide continued staff development and performance evaluation.

Expected completion date: 09/30/2010

Recommendation #12

We recommend the department establish controls to ensure both hard copy and electronic health and other confidential information is secure and protected.

Response: Concur

Corrective Action: The department will develop and implement a review of protected information as it flows into, within and out of the Reimbursement Office. All identified risks will be mitigated as appropriate.

Expected completion date: 12/31/2010