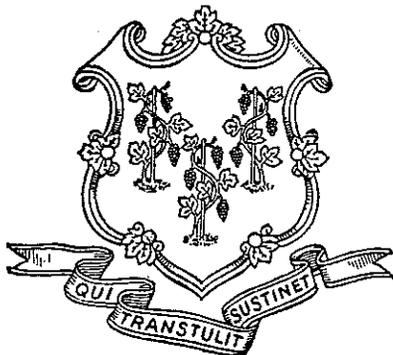


Department of Income Maintenance

Error Detection and Prevention

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1984

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 as the Legislative Program Review Committee to evaluate the efficiency and effectiveness of selected state programs and to recommend improvements where indicated. In 1975 the General Assembly expanded the Committee's function to include investigations and changed its name to the Legislative Program Review and Investigations Committee. During the 1977 session, the Committee's mandate was again expanded by the Executive Reorganization Act to include "Sunset" performance reviews of nearly 100 agencies, boards, and commissions, commencing on January 1, 1979.

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

1983-84 Committee Members

Senate

Kevin P. Johnston, Cochairperson
John C. Daniels
M. Adela Eads
Fred H. Lovegrove, Jr.
Richard F. Schneller
Carl A. Zinsser

House

Dorothy K. Osler, Cochairperson
Maureen Murphy Baronian
Abraham L. Giles
Vincent A. Roberti
William J. Scully, Jr.
David W. Smith

Committee Staff

Michael L. Nauer, Ph.D., Director
Anne E. McAloon, Program Review Coordinator
George W. McKee, Chief Analyst
Carrie E. Vibert, Staff Attorney
L. Spencer Cain, Senior Analyst
Catherine McNeill Conlin, Program Analyst
Debra S. Eyges, Program Analyst
Jill E. Jensen, Program Analyst
Michael O'Malley, Program Analyst
Susan Scher, Program Analyst
Nancy J. Treer, Program Analyst
Lillian B. Crovo, Administrative Assistant
Mary Lou Derr, Administrative Assistant

Staff on this Project

Debra S. Eyges, Jill E. Jensen

PERFORMANCE AUDIT

THE DEPARTMENT OF INCOME MAINTENANCE:
ERROR DETECTION AND PREVENTION

LEGISLATIVE PROGRAM REVIEW AND
INVESTIGATIONS COMMITTEE

DECEMBER 1984



TABLE OF CONTENTS

RECOMMENDATIONS..... iii

I. INTRODUCTION..... 1

 Scope..... 1

 Methodology..... 2

II. DESCRIPTION..... 5

 Office of Program Integrity..... 5

 Quality Control Unit..... 5

 Medical Audit Unit..... 10

 Town Audit Unit..... 18

 Computer Audit Unit..... 19

 Internal Audit Unit..... 21

 District Offices..... 27

 Structure..... 27

 Staff Resources..... 32

 Case Processing System..... 33

III. ANALYSIS OF ELIGIBILITY AND PAYMENT ERROR..... 57

 Trends..... 57

 Comparisons to Other States..... 64

 District Office Error Rates..... 66

 Causes of Error..... 71

 Error Elements--Problem Areas..... 75

IV. FINDINGS AND RECOMMENDATIONS..... 81

 Mandatory Verification Policy..... 81

 Home Visit Guidelines..... 82

 Notice of Reporting Responsibilities..... 83

 Expedited Redeterminations..... 83

 District Office Monitoring and Evaluation..... 84

 Resources Units..... 85

 Administrative Disqualification Hearings..... 85

 Fair Hearings..... 90

 Medical Audit Unit..... 91

 Computer Capability..... 92

APPENDICES..... 95

- A. Survey of Quality Control Reviewers..... 97
- B. Survey of Medical Audit Provider Examiners..... 100
- C. AFDC Program: National Comparisons..... 104
- D. Food Stamp Program: National Comparisons..... 105
- E. Medicaid Program: National Comparisons..... 106
- F. Department of Income Maintenance Response to
Staff Recommendations..... 107

ERROR PREVENTION AND DETECTION

RECOMMENDATIONS

1. The Department of Income Maintenance should establish a mandatory, consistent verification policy regarding eligibility determination for all public assistance programs it administers. This policy should be in effect in all district offices by June 30, 1985.
2. The department should monitor district office compliance with agency guidelines on home visits.
3. The department should analyze the outcomes of the home visit process after six months of statewide operation to identify costs and benefits, and to determine if the current criteria for selection of cases for home visits should be modified.
5. The department should periodically notify clients of their responsibility to report eligibility changes and the consequences of not reporting as required. Notices should be mailed with AFDC checks and food stamp authorizations-to-participate cards at least every two months; notices to other assistance recipients should be mailed at least quarterly.
6. The department should evaluate the effectiveness of the expedited redetermination processes in the Hartford and Bridgeport offices. The impact of the process on error rates and staffing levels should be determined. If it is found that expedited redeterminations do not increase the likelihood of error, the program should be expanded to other offices.
7. The department should develop and implement a management evaluation system for all district office operations. At a minimum, the system should focus on the development of district office profiles and identification of management or administrative factors causing error.
8. The department should insure that quality control eligibility and payment error findings are analyzed and reported within four months of the end of a quality control period.
9. Resources unit investigatory functions should be separated from the overpayment recovery and reimbursement functions to promote the error prevention and detection role of district office resources staff.

10. The department should explore the use of private collection agencies for recovery of overpayments from public assistance recipients. Since collection agency fees are 75 percent reimbursable under the Food Stamp program, the department should initiate this procedure with food stamp cases.
11. An administrative disqualification hearing process should be incorporated into the Department of Income Maintenance's existing fair hearing process and the department should be required to use both fair hearings and administrative disqualification hearings where appropriate. In addition, the department should:
 - hire at least 5 new hearing officers plus additional clerical staff to manage the additional workload;
 - require that the existing 13 fair hearing officers plus the additional 5 officers have responsibility for hearing all administrative cases; however, when an administrative disqualification hearing is held regarding food stamp fraud, the Department of Income Maintenance will be eligible to receive a 75 percent reimbursement on that case or portion of the case;
 - increase the monetary limit for case referral to the state police so that food stamp fraud cases involving less than \$1,000 or combination cases of AFDC and food stamp fraud totalling less than \$1,000 are handled by administrative disqualification hearing;
 - establish special training programs regarding the administrative fraud hearing process for all staff involved in claim preparation, including policy and methods of collecting and presenting evidence; and
 - require training for all hearing officers regarding the administrative disqualification hearings; in addition, the 5 new hearing officers should also be trained in the general administrative hearing process.
12. The Department of Income Maintenance should require that program supervisors or unit supervisors sign off on fair hearing summaries compiled by all eligibility technicians and senior eligibility technicians to verify accuracy and appropriateness of such summaries.

13. Both senior eligibility technicians and eligibility technicians involved in preparing fair hearing summaries should receive intensive training in the fair hearing process and administrative law.
14. The department's Medical Audit Unit should establish formal requirements for a reasonable number of audits per medical services provider category to be completed each year, and that such a schedule be used as a management tool to assure efficient and effective use of resources.
15. To audit general pharmacies, the department should use a random computer selection by prescription number sequence. To accomplish this task, the department should either instruct Electronic Data Services (EDS), the company under contract to provide computer services to the state, to implement programming changes, or the department should use its own personal computer to perform this function.



CHAPTER I

INTRODUCTION

Public Act 83-446 passed during the 1983 legislative session mandated the Legislative Program Review and Investigations Committee (LPR&IC) to conduct a performance audit of selected programs within the Department of Income Maintenance (DIM). An ad hoc legislative committee was established to consult with the program review committee and give final approval concerning the specific programs to be included in the audit scope. Members of the ad hoc committee included the co-chairpersons and ranking members of the Human Services and Government Administration and Elections Committees as well as the members of the appropriations subcommittee with cognizance over the Department of Income Maintenance.

One of the three programs selected for the audit was the department's efforts to prevent and detect error and abuse in the public assistance programs it administers. One reason these activities were chosen is the impact errors have on program costs. In state fiscal year 1984, almost \$900 million of state and federally funded assistance (not including local welfare benefits) was issued under the various programs administered by the Department of Income Maintenance. Therefore, a reduction in overpayments to eligible clients, payments to ineligible recipients, and incorrect or improper payments to service providers by even one percent saves or avoids expenditures of millions of dollars.

In addition, reducing overpayment and eligibility error rates is important since the federal government has threatened, and in some instances actually imposed, financial penalties on states that exceed allowable error rates for the Medicaid, Food Stamp, and Aid to Families with Dependent Children (AFDC) programs. At the time the Legislative Program Review and Investigations Committee initiated its performance audit, Connecticut's error rates for the AFDC and Food Stamp programs were greater than the federal target rates, thus exposing the state to potential fiscal sanctions. Furthermore, the state was already facing a \$1.3 million federal penalty for an excessive Food Stamp program error rate from the April to September 1981 period.

Scope

The scope of the program review committee's performance audit was limited to error control efforts concerning the three major assistance programs: AFDC, Food Stamp, and Medicaid. These programs account for the bulk of the agency's budget and more than 90 percent of all benefits issued by the Department of Income Maintenance. The smaller assistance programs not included in the committee's performance audit were the State Supplement to the Sup-

plemental Security Income (SSI) program, the Energy Assistance Program, and the Refugee Assistance Program.

The committee's performance audit focused on agency efforts to prevent and detect eligibility and payment errors. Activities to control errors concerning department claims for federal reimbursement of the administrative costs of public assistance programs were not examined. Errors that result when the federal government disallows Medicaid reimbursement for certain services provided to institutionalized Department of Income Maintenance clients were also outside the scope of the audit. Similarly, the audit did not address Medicaid disallowances due to untimely medical recertification of the need for continued care for nursing home patients.

For the purposes of the audit, error prevention was defined as department activities aimed at making correct decisions on applicant eligibility for assistance, the amount of assistance granted, and the amount of payments to service providers. Error detection included department activities directed at identifying improperly paid public assistance recipients or service providers.

Applying the audit definitions, error prevention and detection are a department-wide responsibility. However, the audit concentrated on those functional areas of the Department of Income Maintenance with a major role in preventing and detecting error: the district offices, where eligibility for public assistance is initially determined and monitored; and the five units of the Office of Program Integrity that have responsibility for examining and auditing department operations to identify errors, improprieties, or inadequate procedures. The five specific program integrity units reviewed were quality control, medical audits, internal audits, computer audits, and town audits.

Methodology

The Legislative Program Review and Investigations Committee performance audit process began with a review of the department's written policies, procedures, and statutory mandates concerning error prevention and detection. This review provided background information on the purpose, structure, and process of the various error prevention and detection activities carried out by the Department of Income Maintenance.

More detailed information on error prevention and detection activities, including qualitative and quantitative data on staffing levels, staff time, workload, and accomplishments, was gathered and analyzed through a variety of research methods. Data collection and analysis were divided into two segments, with one focused on the Office of Program Integrity and the other concentrated on district office operations.

In regard to the program integrity office, the committee staff interviewed key personnel to develop a step-by-step understanding of each major office function designed to prevent and detect errors. In addition, surveys were developed and sent to medical audit and quality control workers to gather information on staff resources and time allocated to specific error control functions. Audit reports, monthly status reports, and other materials issued by the various program integrity units under review were also examined.

To obtain information on district office operations for preventing and detecting error, the program review committee staff conducted field visits of three offices--Hartford, New Haven, and Norwich. In the Hartford district office, personnel at all levels, from the district director to the line staff responsible for making eligibility and payment decisions, were interviewed concerning the eligibility process as well as the staff resources involved in making eligibility decisions. The program review staff, with client permission, also observed actual application and eligibility redetermination processes. Using the Hartford office as a model, the committee staff visited the other two offices to interview the district directors concerning similarities and differences in organization, staffing, and procedures.

These interviews and observations permitted the development of detailed flow diagrams of each phase of the district office system for processing AFDC, Medicaid, and Food Stamp program cases. Examination of the various forms used by the district offices also aided in developing an understanding of the district office processes for determining initial eligibility and monitoring continued eligibility of income maintenance clients.

District office staffing and workload data available through the Department of Income Maintenance's central office were also used in the committee's performance audit. A sample of monthly status reports on filled district office positions as well as on applications and active cases from December 1980 through June 1984 were analyzed. In addition, the program review committee staff examined various workload management reports that provide monthly information on the number of activities accomplished (e.g., applications disposed of, eligibility redeterminations completed, etc.) and the time spent per activity.

Central office field operations staff were interviewed to determine their role in district office efforts to prevent and detect errors. The director of field operations and the chief of eligibility services and corrective action were among the central office personnel questioned about major program areas as well as statewide activities implemented or planned to address eligibility and payment errors at the district office level.

The department's director of staff development was also interviewed regarding training aimed at reducing the occurrence of errors within the district offices. Statistics on the types and amount of training provided to district office personnel over the past several years were collected and analyzed. Program review committee staff also met with the income maintenance policy director to discuss the relationship of policy and procedures to district office eligibility and payment errors. The agency's efforts to revise its policy manual were also discussed.

In addition to thoroughly examining program integrity and district office operations, the committee staff collected and analyzed department data and reports on errors and error rates for the AFDC, Medicaid, and Food Stamp programs to determine trends. Among the materials reviewed were quality control findings and department corrective action plans issued for each of the three major assistance programs since October 1980.

In order to evaluate the performance of the Department of Income Maintenance in preventing and detecting error, statewide and district error rates over time were charted. Connecticut's actual program error rates were also compared with federal targets. Error rates among programs and among district offices were compared to identify similarities and differences. In addition, error rate data from other states were gathered for comparative purposes.

The department's quality control findings concerning the primary causes and specific reasons for the occurrence of error in the AFDC and Food Stamp programs were thoroughly reviewed. This permitted the committee staff to develop a better understanding of why errors occur and what program aspects are the most error-prone. Information on the causes and reasons for eligibility and payment error over several recent time periods was analyzed to determine if corrective actions implemented by the department were addressing major problem areas.

Two public hearings were also held by the Legislative Program Review and Investigations Committee to gather information on all three Department of Income Maintenance programs being audited. At the hearings, legislators, Department of Income Maintenance officials, and interested members of the general public presented testimony and answered questions concerning error prevention and detection as well as the other audited programs.

CHAPTER II

DESCRIPTION

The Legislative Program Review and Investigations Committee audit of error prevention and detection efforts concentrated on those functional areas of the Department of Income Maintenance with a central role in controlling public assistance program errors. Two department areas were examined in detail: the Office of Program Integrity, which has primary responsibility for examining and auditing agency operations to identify errors or inadequate procedures; and the district offices, where eligibility for public assistance is initially determined and continually monitored.

The Office Of Program Integrity

The Office of Program Integrity assists the department's efforts at preventing and detecting fraud and abuse by assuring the soundness of program and agency operations through routine as well as specific audits of both recipients and providers of services. The office, staffed by 80 persons, is composed of 5 separate units: quality control, medical audits, computer audits, internal audits, and town audits. A description of each unit and the manner in which each is involved in agency efforts at detecting and preventing error is presented below.

Quality Control Unit

Purpose. As a condition to receiving federal support for providing public assistance, Connecticut is required to operate a quality control program. The purpose of the program is to provide an accurate estimate of the eligibility and payment error rates in each of three federally supported assistance programs administered by the Department of Income Maintenance (i.e., AFDC, Food Stamp, and Medicaid), and to have the state develop corrective action plans aimed at reducing or eliminating errors.

Structure. The quality control program makes extensive use of personnel from the quality control unit and the research and statistics unit of the office of management planning and evaluation. Table II-1 shows the allocation of staff and the personnel costs for this program.

Table II-1. Staff Allocation to Quality Control Program.

<u>Staff</u>	<u>Percent of Time</u>	<u>Estimated FY 85 Salary Costs</u>
Program Integrity Office		
Director (Office)	15	\$ 7,469.28
Director (Fraud)	20	9,575.80
Consultant	30	8,521.50
Unit Chief	100	37,116.30
Supervisor (6)	100	160,581.72
Reviewer (30)	100	739,611.60
Support (8)	54	60,683.74
Management Planning		
Director	30	14,363.70
Unit Chief	30	10,706.54
Ass't. Chief	30	8,917.48
Research Analyst (4)	60	113,065.68
Support Staff (4)	35	21,062.86
		<u>\$1,191,675.90</u>

Source: Department of Income Maintenance.

Process. On a monthly basis the Office of Management Planning and Evaluation forwards a list of cases to be reviewed to the quality control unit of the Office of Program Integrity. The cases are randomly selected by the department's data processing unit following specifications supplied by the management planning office and approved by federal authorities. Typically, the cases are distributed among six categories as shown in Table II-2.

Federal procedures allow states to use an integrated case review method. Under this approach a single case can be reviewed for more than one type of assistance. The research and statistics unit, following a federally approved procedure, determines whether a case is reviewed for one or more than one type of assistance. As a result of the integrated case review method, the actual number of case reports completed by the quality control auditors differs considerably from the numbers shown in Table II-2.

Table II-2. Number of Quality Control Reviews Per Month, by Type of Assistance.

<u>Type of Assistance</u>	<u>Positive Cases</u> ¹	<u>Negative Cases</u> ²
AFDC	149	20
Food Stamp	109	71
Medicaid	<u>145</u>	<u>20</u>
Total	403	111

¹ Positive cases = cases active during the period under review.

² Negative cases = cases in which assistance was denied or discontinued during the period under review.

Source: Department of Income Maintenance.

Cases are assigned to individual auditors by a supervisor in the quality control unit. In making assignments, the supervisor attempts to minimize travel and equalize workloads. At the time the auditors are given their case assignments, the department's district and subdistrict offices are notified by a clerk in the quality control unit as to which cases are going to be reviewed. It is the responsibility of each office to pull together information on the selected cases and have it ready for the auditor when he or she arrives at the office.

Each positive case review requires the quality control auditor to analyze the case record, conduct a face to face interview with the client, and verify through collateral sources the accuracy of the information used to determine the client's eligibility and the amount of payment. The case record is analyzed to determine the facts related to the recipient's eligibility, the acceptability of the supporting documentation, and the specific elements that must be verified through a field visit and collateral sources. The entire case record review takes about three staff hours. The field visit, which requires about two hours, focuses on ascertaining the accuracy of the facts outlined in the case record.

The quality control auditor uses collateral sources, such as relatives, bank records, town records, and motor vehicle and labor department records, to verify factors establishing eligibility and the payment level. The collateral source verification process requires about eight staff hours to complete.

Including preparation of the report, positive case reviews average between 13 and 18 hours to complete. The variation is due to the type(s) of assistance being reviewed. Negative case reviews take considerably less time, about two hours, because the auditor is not generally required to make field visits or contact collateral sources. Table II-3 shows the average number of hours and calendar days that it takes to complete each type of positive and negative case review.

Table II-3. Average Time Required to Complete Quality Control Reviews.

<u>Type of Review</u>	<u>Positive Case</u>		<u>Negative Case</u>	
	<u>Hours</u>	<u>Days</u>	<u>Hours</u>	<u>Days</u>
AFDC Only	17	55	2	33
AFDC & Food Stamps	17	55	NA	NA
AFDC & Food Stamps & Medicaid	18	57	NA	NA
AFDC & Medicaid	17	55	NA	NA
Food Stamps Only	16	54	2	39
Medicaid Only	13	65	2	35

N/A= Not Available

Source: LPR&IC Survey of Quality Control Auditors.

All completed case reports are reviewed and approved by a supervisor. Cases in which errors are found as well as cases with unusual problems are also reviewed by the chief of the quality control unit. The close attention given to cases in which errors have been detected is related to the fact that the error rate derived from these cases becomes the basis upon which federal authorities calculate what, if any, financial sanctions are to be imposed on the state.

On a weekly basis, copies of a list of completed case reviews are sent to the directors of the department's program integrity and management planning offices, and to the appropriate federal agencies (i.e., AFDC--Social Security Administration; Food Stamps--United States Department of Agriculture; and Medicaid--Health Care Financing Administration). In addition, case reports are filed with the appropriate district office of the Department of Income Maintenance.

The initial error rates determined by the state are adjusted after federal auditors complete a re-examination of a sample of

the reviewed cases. The federal review is an ongoing process using techniques similar to those employed by the state quality control auditors, and is one of the reasons the quality control unit is required to submit a weekly list of its completed case reports.

The state-computed error rates are adjusted by the federal government and compared to targets set for the state. Where the rate is higher than the target, a financial penalty can be imposed. The state does have the right to challenge federal findings in individual case reviews, and the final error rates for each program are not established until the state has had an opportunity to contest federal findings in individual cases.

All errors detected by the quality control auditors are brought to the attention of the appropriate district office for corrective action. The auditors transmit the information on a 1201 form. If, in the judgement of the quality control unit staff, systematic errors are occurring as a result of a procedural deficiency, this information is reported to the director of program integrity for possible review by the office's internal audit unit. Copies of the form are also sent to the central office for informational purposes.

The final component of the department's quality control effort is the development of a corrective action plan. The process starts with an analysis of the quality control data by the management planning and evaluation office's research and statistics unit. The analysis is aimed at identifying problems that need to be brought to the attention of the department's corrective action panel.

The panel meets regularly and is responsible for developing plans aimed at reducing errors identified through the quality control review process. The panel consists of 10 members: 7 persons from the central office and 3 representing the district offices. In addition to the panel's scheduled meetings, three subcommittees meet during the interim to discuss and plan corrective actions for full committee decisions.

Not only is the corrective action panel necessary for internal operations and improvements but it serves another function. For example in 1982, the state was notified of its potential liability for \$688,000 as a result of exceeding the federal target in the Medicaid program by 0.7 percent. The mechanism for avoiding the penalty was the development, approval, and implementation of a corrective action plan.

The panel produces separate plans covering the AFDC, Food Stamp, and Medicaid programs. The plans are subject to approval by the federal government. Each plan includes findings of the

previous review period, recommendations for reducing or preventing errors, and a progress report on the implementation of prior recommendations.

Medical Audit Unit

Purpose. The purpose of the medical audit unit is to assure the appropriateness of payments made to medical services providers participating in the Medicaid program and to prevent and detect fraud and abuse.

Structure. The medical audit unit is located within the department's Office of Program Integrity. Table II-4 illustrates the staff resources devoted to medical audits and the amount of time spent on such reviews. One supervisor is responsible for 11 examiners involved primarily with the review of the billing for medical services by providers; the other supervisor along with four examiners audit hospitals.

Table II-4. Medical Audit Unit Resources--State FY 84.

<u>Staff</u>	<u>Percent of Time Allocated to Medical Audits</u>	<u>Estimated FY 85 Salary Costs</u>
Unit Head (1)	100%	\$ 40,923.74
Supervisor (2)	100%	58,572.80
Examiner (16)	100%	37,883.78
Director, Program Integrity (1)	15%	7,469.28
Director, Fraud Prevention and Detection (1)	20%	9,575.80
Legal Consultant (1)	30%	8,521.24
Ct. Career Trainee (G.A.Audits) (2)	20%	6,528.08
Administrative Secretary (1)	15%	2,400.32
Senior Secretary (1)	20%	3,015.22
Clerk (3)	67%	28,578.94
Director, Mgt. Planning & Eval. (1)	1%	478.92
Chief, Mgt. Planning and Eval. (1)	5%	1,784.38
Research Analyst (1)	10%	2,383.68
Research Analyst (1)	15%	2,536.04
Research Analyst (1)	1%	169.00
		<u>\$551,315.44</u>

Source: Department of Income Maintenance.

Process. The medical audit unit has primary responsibility for the audits of hospitals and all other medical providers. The unit head selects the hospitals for review and assigns staff based on worker case load, geographic location of the hospital, examiner experience, and the size of the hospital.

The selection process for medical provider reviews is different. Medical audit staff use the medicaid management information system (MMIS) to generate information about the medical services providers participating in the Medicaid program. The system identifies aberrant patterns of care and services by such medical providers. For example, the system can provide the following information: the average bill per provider, the amount paid by Medicaid, the average number of recipients seen, and the types and number of services provided. Using such measures, providers in the high and low ranges are identified for possible review.

Medical audit examiners are assigned these cases based on past experience and their geographic location. Table II-5 shows the number of medical audits completed in state FY 84 as well as the amount of money identified as overpayments.

Table II-5. Medical Audit Unit--State FY 84.

Total Number of Reviews Initiated	479
Total Number of Reviews Completed	397
Total Number of Reviews Outstanding	82
Total Dollars Reviewed	\$173,354,061
Total Dollars Identified as Overpayments	\$2,866,367
Total Dollars Recovered	\$2,857,237

Source: Department of Income Maintenance.

Hospital Reviews. Previously, all hospital reviews were completed by a desk audit. Now the hospital examiners also conduct an on-site visit. All 36 acute care hospitals in Connecticut will be reviewed over a three-year cycle. For purposes of review, inpatient and outpatient programs are generally treated separately. The three-year review involves outpatient programs only.

Departmental time limits have not been imposed on examiners regarding the completion of hospital reviews. The only requisite is that the department must complete five audits (either inpatient or outpatient) per year as mandated by the federal government. In state FY 84, the unit completed 40 hospital reviews, 36 inpatient audits, and 4 outpatient audits.

The period of review for each hospital is 15 months. An MMIS summary computer printout is ordered for one to three hospitals from the research and statistics unit. That unit generates a sample of 350 patient cases per hospital. One hundred of those cases are randomly selected for immediate review. Using all available information, the examiners conduct a desk audit to determine whether the service billed for was actually rendered, prior authorization for the service was required, the bill was paid, and the proper amount was billed and paid.

The examiner schedules an entry visit with a hospital staff person and provides the hospital with a list of the 100 names selected randomly via the computer for review. This requires the hospital to gather all the medical charts regarding all 100 patients.

Each reviewer examines medical records, billing records, and other documents to determine what services were performed and that the billing is correct. Specifically, the review includes: a check for double billing, a review of the admission form, a comparison of medical chart information to the billing, and verification that the recipient named on the billing form received the care. Only 100 cases are reviewed unless serious procedural or billing problems exist or the hospital requests that a larger sample be completed. If problems exist or a request to expand the audit results, the audit may be expanded to include all of the 350 cases originally generated.

The examiner, supervisor, and director analyze the results of the sample audit including exceptions, findings, and recommendations. In addition, a list of all cases audited is sent to the research and statistics unit with the dollar error amounts. The research unit then computes a percentage error for the sample audit and extrapolates that percentage to the universe of payments. The extrapolated amount represents the overpayment amount.

An exit conference is scheduled with the hospital representative to discuss the results of the audit. The hospital is billed the extrapolated amount. The Department of Income Maintenance reports that it recovers overpayments by one of two methods: direct billing or offsetting against current payments.

Provider reviews. The federal government requires the state to audit 3 percent of the total service providers serving the department's clients per year. The medical audit unit completed 357 provider reviews in state FY 84, 5 percent of the approximately 7,000 participating providers.

As mentioned earlier, the selection process for medical services provider audits is accomplished by using information gener-

ated by the MMIS. The system compares individual providers to their peers, based on parameters determined by the department and highlighting exceptions from the norm. By analyzing this information, the Department of Income Maintenance is able to detect certain types of abuse within the medicaid system. The providers are selected for audit on the basis of the high or low ranking by MMIS, the volume of business done with the state, whether the provider was reviewed in an earlier quarter, and whether complaints regarding a particular provider were received in the past.

Selection for examination is generally made quarterly by the supervisor. All examiners are assigned cases based on experience and geographic location.

The medicaid management information system can provide information regarding the patients seen during a 15-month period by a certain provider, the services that he or she rendered, the cost of the services, and other pertinent facts. After completion of this portion of the desk audit, a determination is made as to whether a full scale investigation should be undertaken.

If the decision is to audit further, the examiner takes a 10 percent sample of the provider's case load from the 15-month computer printout. Approximately 50 names are selected for the sample randomly by the examiner. At this point, all billings on those 50 recipients are retrieved.

At a desk audit the examiner compares the bills with information on the computer printout to check the accuracy of the billing and the printout. Verification that the description of the diagnosis matches the billing code is made.

If there is a billing discrepancy involving the procedure code, then the provider is contacted by phone or letter to inquire about the problem. To verify a pharmacy bill, the examiner might also call a prescribing doctor to check what was ordered and whether the provider filling the prescription did so properly.

Based on all research completed by the examiner, a report and recommendation are prepared and submitted to the supervisor. If there is a discrepancy for example between the ordering physician and the billing provider, the examiner recommends an on-site visit. If, after the supervisor evaluates the examiner's report, a determination is made to conduct an on-site visit, the supervisor will decide whether to use the same 50 names or start with a new sample.

The examiner goes to the provider facility to review records to support the billing. If the provider refuses to permit the on-site visit, the examiner turns the case over to the department's legal advisor who informs the provider that he or she must

submit to such a review in order to remain in the Medicaid program. The Department of Income Maintenance may stop payments and remove the individual from the program for noncompliance.

Pharmacy reviews. The reviews of pharmacies are performed by a staff specialist who is a pharmacist. Two types of reviews are conducted by the examiner: pharmacies serving nursing homes and general pharmacies.

The examiner begins with a desk audit, which involves reviewing copies of billings stored on microfilm in the office. The bills are reviewed for the strengths of the drugs prescribed, the quantities, and the variety of drugs.

The department has an in-house computer that generates a six-month history of all drugs purchased by a patient. To determine the appropriateness of a billing, the examiner may write to a recipient to verify that the patient actually received the drug. This is done via a questionnaire. If the recipient responds saying that no drug was ever received, the examiner continues to investigate by sending questionnaires to as many recipients as possible who are getting the same medication from the same physician. In addition, the examiner may also call the pharmacist to discuss the problem.

Pharmacies serving nursing homes are routinely checked by both a desk audit and an unannounced on-site visit. To conduct an on-site review, the examiner goes directly to the convalescent home medicine room and checks all the medications. In addition, the examiner reviews the prescriptions, directions, physicians' orders, and the facility's cardex (a charting of when the nurses dispense the medications to the patients). The examiner makes a determination as to whether the medications were ordered, whether there were any substitutions, and whether generic or brand name drugs were billed when generic were dispensed.

Table II-6 indicates the approximate amount of time required for the examiner to complete an audit for a pharmacy serving a nursing home. The table illustrates the actual staff time needed to complete the review as well as the number of calendar days involved.

To audit a general pharmacy, the examiner calls the pharmacy to schedule an on-site visit. The pharmacies are chosen by randomly selecting 10 percent of the pharmacies on the MMIS list of participating providers. Certain pharmacies may also be selected for review if the department has received complaints regarding their business activities.

Table II-6. Pharmacies Serving Nursing Homes--Average Audit Time.

Total staff time - 3 days

1 day preparation
1 day on-site visit
1 day completion of review

Calendar time - 3-4 months (waiting for verification, bills, surveys, etc.)

Source: LPR&IC.

In this type of review, the examiner uses 3 months of the pharmacy's medicaid billings and selects 10 percent of the total claims or at least 100 claims. The claims and prescription numbers are brought to the pharmacy.

In the pharmacy the examiner looks for any recurring billing errors. The medication, patient number, supply of medication, and dosage refills authorized are checked. The examiner is looking for the reducing or increasing of quantities.

Third-party liability. In 1982, four medical audit examiners were assigned to a study being conducted by the computer unit to identify unreported or incorrect third-party coverage and to recoup medicaid overpayments. Staff reviewed samples of processed medicaid claims in order to check opportunities for third-party coverage, for example, under Medicare or medical insurance provided through employment. In cases where coverage existed but had not been identified by the claims processing system, recoupment of medicaid overpayments was pursued.

Based upon the unit's findings and recommendations, better computer controls are being developed by the medicaid processing agent, Electronic Data Services. In the meantime, the computer audit unit is continuing its research and recovery of third-party liability. Approximately \$173,354,000 in payments were reviewed by the medical audit staff during state FY 84; third-party liability audits accounted for \$155,000,000 of the total. In addition, of the \$2,857,237 recovered by the medical audit unit, approximately \$2 million was due to incorrect or unreported third-party coverage. Information from the third-party liability project has also been used to update department files regarding third-party coverage.

Nursing homes. Nursing homes are audited every two years by an outside private firm. In a 1984 competition, Ernst and Whinney won the state's contract award for \$4.8 million to be paid over four years. The contract requires the firm to determine rates of nursing home costs and to verify costs for per diem rates. The state supplements these audits with an additional review of the appropriateness of these billings.

Medicaid Fraud Control Unit. The Medicaid Fraud Control Unit (MFCU) is part of the Office of the Chief State's Attorney. The 10-person unit is composed of 3 auditors, 4 state inspectors, 2 attorneys, and 1 clerical person. Currently, 75 percent of the unit's costs are paid for by the federal government.

Federal regulations require the Department of Income Maintenance to refer all cases of suspected fraud to the MFCU. If such a situation exists, the director of fraud prevention and detection of the Department of Income Maintenance reviews the recommendations of the medical audit examiners. If a determination is made that the case involves fraud, the department stops all investigation involving the suspected provider and turns the case file over to fraud unit.

Table II-7. Medicaid Fraud Control Unit: Disposition of Arrests 1978-1983.

25 Arrests resulted in:

- 15 convictions
- 1 nolle
- 5 accelerated rehabilitations
- 4 cases pending

Source: LPR&IC.

Table II-7 indicates the total number of arrests and the outcomes resulting from the fraud control unit's investigations. The breakdown of the arrests by provider type is shown in Table II-8 as well as the number of arrests by type of crime.

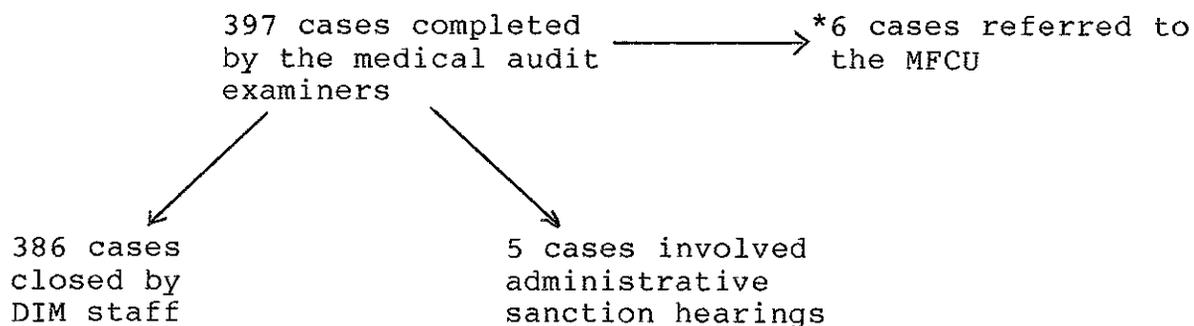
Table II-8. Medical Fraud Control Unit Arrests By Type 1978-1983.

<u>Breakdown of Arrests by Provider Type</u>	<u>Breakdown of Arrests by Type of Crime</u>
- 12 Doctors	- 10 False billing
- 6 Nurses	- 7 Cost report fraud
- 3 Pharmacies	- 4 Patient abuse
- 4 Others	- 3 Bribery
	- 1 Patient fund theft

Source: LPR&IC.

Figure II-1 shows the total number of cases reviewed by medical audit staff in state FY 84. The figure illustrates that the majority of the cases were closed by either the supervisor, the medical audit unit head, the director of program integrity, or the director of fraud prevention and were relatively simple audits. In addition, six cases were referred to the Medicaid Fraud Control Unit and five cases required administrative hearings. An administrative hearing is held by the department if a determination is made that there was no intent to defraud by the provider.

Figure II-1. Medical Audit Unit Reviews--State FY 84.



* Note that four of those cases were sent back to the Department of Income Maintenance for additional information.

Source: LPR&IC.

Town Audit Unit

Purpose. The purpose of the town audit unit is to determine whether expenditures and procedures associated with each town's administration of the General Assistance program complys with state statutes and policies.

Description. The unit that is chiefly responsible for conducting town audits is located within the department's Office of Program Integrity. The Department of Income Maintenance's management planning, data processing, and general assistance offices provide technical support to the unit. Table II-9 shows the staff resources devoted to the town audit function.

Table II-9. Staff Resources Devoted to Town Audits.

	<u>Percent of Time</u>	<u>Estimated FY 85 Salary Costs</u>
Program Integrity		
Director	20	\$ 9,959.04
Unit Chief	75	26,606.06
Examiner (7)	90	147,690.40
Trainee (2)	20	6,528.34
Clerical (1)	20	3,200.60
Management Planning		
Director	1	478.92
Unit Chief	5	1,486.16
Analyst	40	8,937.76
Admin. Secy.	20	3,200.60
		<u>\$ 208,087.88</u>

Source: Department of Income Maintenance.

Towns with \$50,000 or more in general assistance expenditures are audited annually, while towns with expenditures under \$50,000 are audited biennially. It takes approximately 3-4 days to audit a small town, 8-10 days to audit a medium-size town, and 2-4 months to audit each of the 6 large cities.

Each town audit can be divided into three components: 1) financial; 2) workfare; and 3) eligibility/compliance. The financial aspect of the audit involves verification that expenditures claimed by a town are supported by records.

The workfare portion of the audit is designed to provide verification that the town's monthly categorization lists showing

case load and employability status are accurate, the required number of employables participated in the program, charges for administrative costs are accurate, and incentive grants have been properly calculated.

The eligibility/compliance part of the audit involves verification that persons receiving general assistance meet the program's statutory and regulatory requirements. In towns expending less than \$50,000 on the program, each recipient case is reviewed. In towns exceeding \$50,000 in expenditures, auditors review cases from a random sample selected through a formula developed and administered by the management planning office. Results from the review of the sample are projected to the town's entire case load. Elements included in the auditor's eligibility review fall into one of three categories: 1) technical (e.g., was the application signed); 2) procedural (e.g., did the town conduct a redetermination within the prescribed time limit); and 3) programmatic (e.g., are the client's assets within eligibility limits).

If a case fails to meet the program requirements examined in the eligibility/compliance audit, a financial penalty is imposed on the town. The penalty is equal to a percentage of the money expended in noncompliance with the requirements. The financial penalty started at 10 percent in state FY 82 and will increase until it reaches 80 percent in FY 86.

Table II.10 shows adjustments claimed for each of the audited areas for state FY 82.

Table II-10. Audit Adjustments Claimed by Program Component for State Fiscal Year 82.

<u>Element</u>	<u>Adjustment</u>
Financial	\$(618,702)
Workfare	(147,739)
Eligibility/Compliance	(1,200,008)
TOTAL	\$(1,966,449)

Source: Department of Income Maintenance.

Computer Audit Unit

Purpose. The computer audit unit is responsible for determining if the Department of Income Maintenance's data processing systems are operating as intended, and controls for assuring the

validity, privacy, and security of data are adequate. Computer audit reports are intended to provide the department with information on the effectiveness of data-processing operations and actions needed to correct deficiencies.

Structure. Computer audits are carried out by a four-person unit within the Office of Program Integrity. Staff includes a unit head (chief computer auditor), who reports to the director of program integrity, and three auditors (two accounts examiner I and one accounts examiner II). Support services are provided to the unit as needed by the program integrity clerical staff. Personnel resources allocated to the computer audit function are shown in Table II-11.

Table II-11. Personnel Resources Allocated to Computer Audits.

<u>Staff</u>	<u>Percent of Time</u>	<u>Est. FY 85 Salary Costs</u>
Director Program Integrity	15%	\$ 7,469
Chief Computer Auditor	100%	46,037
Accts. Examiner II (1)	100% each	24,569
Accts. Examiner I (2)	100%	46,886
Admin. Secretary (1)	15%	2,400
	TOTAL	\$127,361
<u>Other</u>		
Consultant Services	3 mo. contract	\$45,500

Source: Department of Income Maintenance.

As Table II-11 indicates, computer audit resources in state FY 85 include outside consulting services provided to the department under a three-month contract worth \$45,500. The consultant firm, Arthur Andersen & Co., was selected by a committee of Department of Income Maintenance personnel through a competitive bid process coordinated by the chief computer auditor. Under the contract, the consultant audited Electronic Data Services (EDS), the firm that operates the department's medicaid management information system. In addition to processing Medicaid claims, the computerized MMIS produces reports on recipient utilization, provider participation, expenditure trends, and other data that help the Department of Income Maintenance control its medical assistance program.

The EDS audit began in April, and the final audit report was issued in August 1984. The consultant reviewed EDS operations to

determine if required services were being adequately performed, to validate EDS billings for services, and to identify actions needed to correct any deficiencies in EDS systems or services.

Process. Since the computer audit unit has only been in existence since 1984, the process for conducting computer audits is still in the development phase. Until August 1984, the unit's primary assignment was administration of the contract with Arthur Andersen & Co. for auditing Electronic Data Services. Under the terms of the contract, unit staff were participating in the consultant's audit as training for future computer audit activities. The working papers, audit tests, and software from the EDS audit were provided for the unit's use in subsequent reviews.

With the experience and materials from the EDS audit, the computer audit unit is now beginning its own auditing activities. Future computer audits will focus on the controls within the agency computer systems that prevent loss or alteration of agency data. Other primary concerns are safeguards against unauthorized access to the computer systems and provisions for manual controls in cases of mechanical or electronic breakdown.

Another aspect of the computer audit function is verification of the department's computerized data. Recommendations to improve the quality of information that is processed as well as to correct any insufficient system controls would be included in computer audit reports. This aspect of computer audits is expected to contribute to the reduction of agency errors resulting from inaccurate or incomplete eligibility or payment information contained in computerized data files.

Internal Audit Unit

Purpose. The internal audit unit is responsible for examining the efficiency and effectiveness of department operations and compliance with department policies. A primary objective is to reduce error rates and enhance federal funding participation by determining if agency procedures and policies for controlling eligibility and payments are adequate and are being implemented as intended. Internal audit reports are intended to provide management and operational units with information on how well functions are being performed and how to correct deficiencies in agency policies and procedures.

Structure. Internal audits is a four-person unit within the Office of Program Integrity. Staff includes a unit head (chief internal auditor), who reports to the director of program integrity, and three internal auditors (one accounts examiner I and two accounts examiner II). Clerical services are provided as needed by the support staff of the program integrity office. Personnel costs associated with internal audits are shown in Table II-12.

Table II-12. Staff Allocated to Internal Audits.

<u>Staff</u>	<u>Percent of Time</u>	<u>Est. FY 85 Salary Costs</u>
Director Prog. Integ.	20%	\$ 9,959
Director Fraud Prev.	20%	9,576
Chief Internal Auditor	100%	32,006
Accts. Examiner II (2)	100% each	49,137
Accts. Examiner I (1)	100%	23,443
Admin. Secretary (1)	20%	3,201
Sr. Secretary (1)	20%	<u>3,015</u>
		Total \$130,337

Source: Department of Income Maintenance.

Process. The three internal auditors work as a team on all projects, with one, designated by the unit head, serving as audit manager. The audit manager is responsible for overseeing all aspects of the project and drafting the audit report. The unit head coordinates audit activities, reviews all work plans and working papers, and sometimes participates in audit field work. The unit head also attends all entrance and exit conferences with the audit team.

The time to complete an internal audit varies from about two weeks to several months depending on the scope of the project. From March 1982 to June 1984, 13 audits were completed. On average, a final report was issued every two months. Audit report topics and a summary of findings and recommendations are included in Table II-13.

All but one of the audits completed as of June 1984 (the nursing home duplicate payment audit) focused on district office operations or activities carried out at the district office level. The majority of recommendations (61 percent) have been made in response to findings of inadequate procedures and concern the development or institution of improved eligibility determination activities within the district offices.

Topics for internal audits are selected on the basis of sensitivity and significance in terms of dollar impact, the possibility of federal sanctions, and legislative interest. Internal auditors continuously review quality control reports, which contain eligibility and payment error rate data for the department's three major assistance programs, in order to identify topics. In

Table II-13. Internal Audit Reports Summary.

Audit Topic	No. Recommendations ¹	Types of Findings		
		Non-compliance	Untimely Action	Inadequate policy Inadequate procedure
WIN: Systems and procedures re registration requirements	3	1	1	1
Transfer of property: compliance with policy on eligibility	0	(no serious problems found)		
Change of address: follow up procedures re PA Food Stamp cases	1	<div style="text-align: center;"> } 1 (combination) </div>		
Food Stamps: duplicate cashings; ineligibility /over issuance problem	4		1	3
Nursing homes: preventing duplicate payment	1		<div style="text-align: center;"> } 1 (combination) </div>	
AFDC application process: reducing time; presumptive eligibility feasibility	8		2	6
DMV microfiche: use within district offices	3			3
District office operations (6 separate reports): administrative and programmatic aspects re				
payroll distribution	0	(no irregularities)		
property accountability	1			1
pursuit of VA benefits	1			1
use of labor dept. info	1			1
verification of children	1			1
timely discontinuances	1		1	
actions on QC findings	1	1 (minor)		
control of revenue and Food Stamp ATPs		(recs. from Food Stamp audit reiterated)		

¹ Recommendations include only those with statewide impact; recommendations specific to a district office not included.

Source: LPR&IC.

addition, the quality control unit through the director of program integrity alerts the internal auditors whenever large numbers or significant patterns of errors are uncovered by its reviews. Other sources of internal audit topics include meetings of top agency managers, information from the research and statistics unit, and other program integrity staff.

Internal audit staff meet periodically, sometimes in conjunction with other program integrity staff, to discuss new topics and develop a proposed audit schedule. Topic selection is a group decision of all program integrity staff, although final selection of an internal audit topic, like other audit topics, is subject to the approval of the director of program integrity. The audit schedule for all program integrity units is established at periodic meetings of the office's director and unit heads.

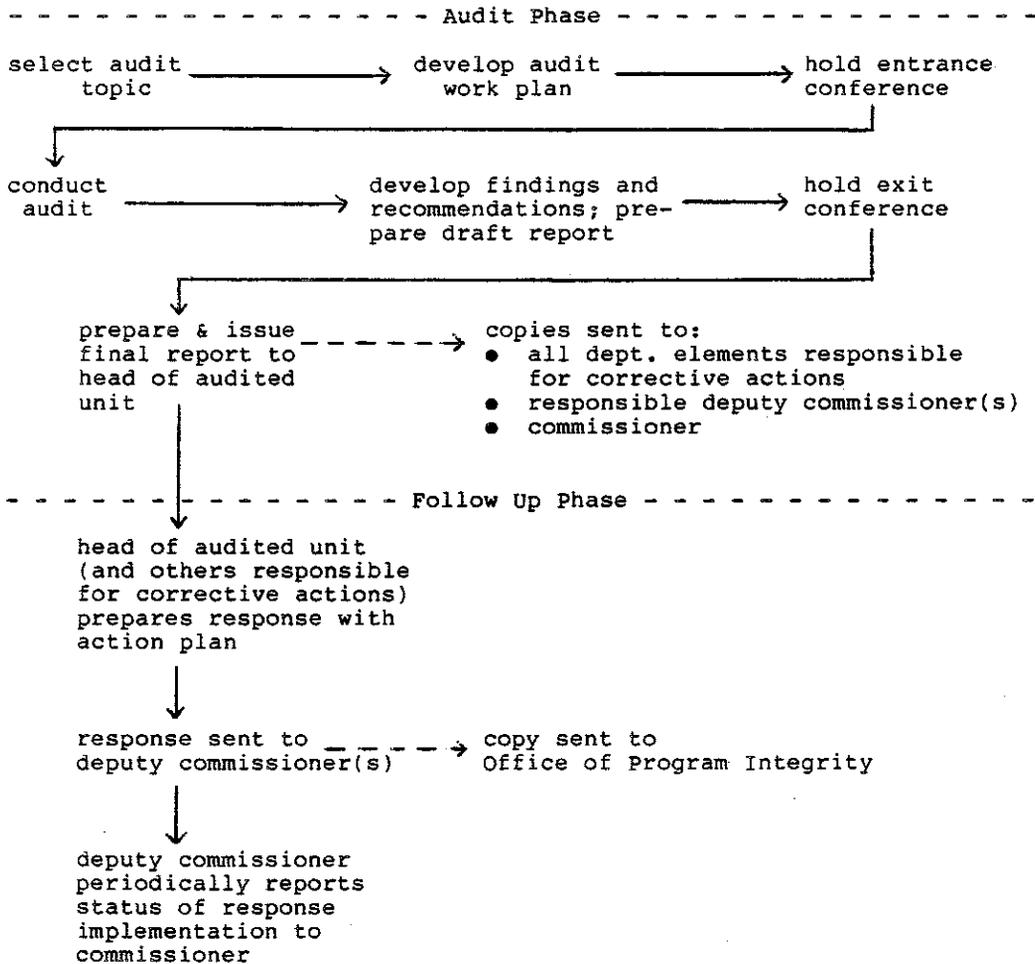
Guidelines for conducting internal audits are contained in the Office of Program Integrity's audit manual, which is based upon the auditing and reporting standards established by the U.S. comptroller general. Written work plans that define the scope and objectives of the audit as well as outline the auditing procedures that will be used are prepared by the audit manager for each internal audit. Major steps in the internal audit process are shown in Figure II-2.

The head of an agency unit or district office subject to internal audit is notified by a letter from the head of the internal audit unit, who also schedules an entrance conference. At the entrance conference, the internal auditors discuss the scope and process with unit or office supervisors, request records and all related documents (forms, guidelines, etc.), and make arrangements for work space and staff interviews.

In conducting audits, the internal auditors use a number of techniques including interviews, observations, and record examinations. The internal auditors' primary concerns are determining if there are procedural inadequacies, untimely actions, or lack of adherence to department policies. To identify problem areas, a variety of audit tests--methods for checking accuracy of data or procedural compliance--are performed. For example, to verify a district office payroll the internal auditors have used a standard audit test of comparing canceled payroll checks with the payroll ledger. Another auditing procedure common to most internal audits is an examination of samples of files to insure that actions are documented as required and completed within the prescribed time-frame.

Findings concerning each area audited, whether or not a problem is disclosed, are developed for the final audit report. If findings are inconclusive as to the seriousness or the extent of errors or inefficiencies, the auditors may suggest in the final

Figure II-2. Internal Audit Process.



Source: LPR&IC.

report that program managers study the area further. Whenever possible, the internal auditors quantify the financial impact of findings that disclose improper billings and claims.

Internal auditors are required to maintain working papers that document the auditing process and contain all materials that support their audit findings and recommendations. Working papers are reviewed by the head of the internal audit unit prior to finalizing the audit and are retained for three years.

Findings and recommendations to correct weaknesses and deficiencies (unless they involve highly sensitive or criminal issues) are discussed with audited personnel throughout the process. The internal auditors will attempt to obtain concurrence regarding their proposals with the audited department and see that corrective action is taken before they leave the audit site. A formal exit interview with the head of the audited unit or office is held at the end of the process in order to report the audit results and provide them with an opportunity for comment, particularly concerning any factual inaccuracy.

Staff working days devoted to the major components of a typical audit are presented in Table II-14. However, time spent on each step of the auditing phase process varies depending on the complexity and scope of topic.

Table II-14. Typical Internal Audit: Working Days to Complete Major Functions.

Develop Work Plan	5 days
Entrance Conference	1 day
Conduct Audit (interviews, field work, etc.)	20 days
Draft Audit Report	5 days
Unit Head Reviews Draft	5 days
Program Integrity Director Review	2 days
Exit Conference	1 day
Final Audit Report	2 days
Total	<u>41</u> days

Source: Estimate of DIM chief internal auditor.

In addition to internal audit steps, Figure II-2 outlines the department's audit response and follow-up mechanism. This mechanism was established in November 1983 by the commissioner for all Office of Program Integrity audits to promote the use of audits as a management tool. The head of the audited entity, as well as

other department staff responsible for implementing audit recommendations, must prepare a written response indicating corrective actions taken or planned within 30 days of receiving a final internal audit report. For example, if an audit of a district office recommends changes in office procedures and the development of new policy, the district director, the director of field operations, and the director of program policy would all receive the final report, and each would be required to issue a response.

Responsibility for monitoring implementation of the response action plans rests with the appropriate Department of Income Maintenance deputy commissioner. However, the director of program integrity receives a copy of all responses for informational purposes.

District Offices

The Department of Income Maintenance district offices have a primary role in preventing and detecting errors that result in payments to ineligible clients or overpayments to eligible clients. Major functions of the district offices are determining the eligibility of applicants for department administered programs and monitoring the eligibility of active clients.

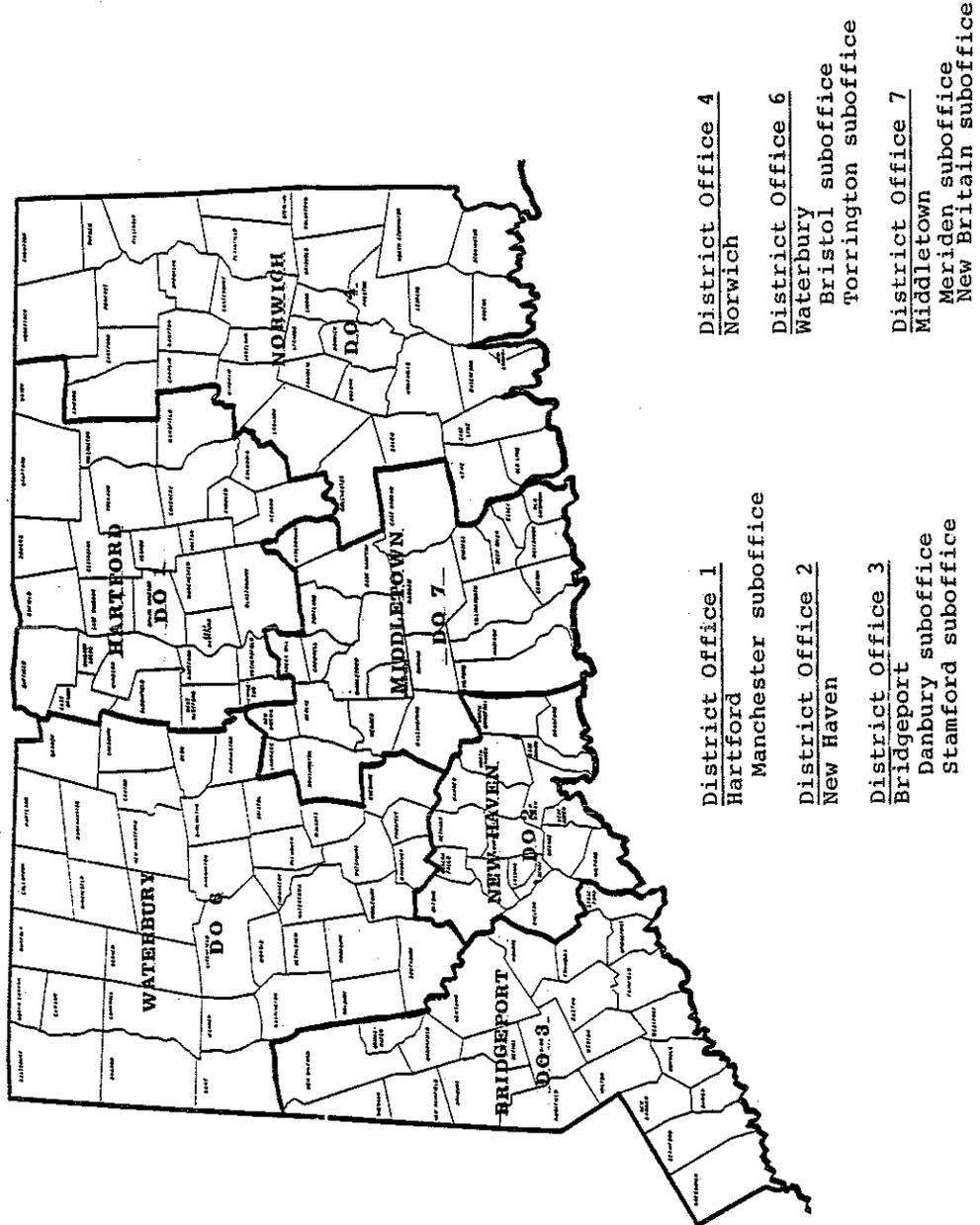
To minimize eligibility and payment errors, district office workers perform a variety of activities to obtain and verify all necessary information concerning client income, assets, living arrangements, and other eligibility factors. A description of the district office case processing system, highlighting activities to prevent eligibility and payment errors, is presented below. Information on the structure of the district offices, staff resources, and inputs and outputs associated with each component of the case processing system is also presented.

Structure

There are six district offices and seven suboffices located throughout the state. A map of the districts, and a list of the offices and suboffices are shown in Figure II-3. Each district office is headed by a district director who reports to the central office director of field operations.

District offices are functionally organized into units of eligibility workers with specific responsibilities such as intake (determining initial eligibility for assistance) or case management (monitoring eligibility of active cases). In the three large offices, Hartford, New Haven and Bridgeport, the case management function is further split into two aspects: interim activity, the processing of eligibility changes that occur between the time a client is initially approved for assistance and the time client

Figure II-3 . Department of Income Maintenance Districts and District Offices.



Source: Department of Income Maintenance.

eligibility is formally re-evaluated; and redetermination, the periodic, formal re-evaluation of eligibility. In the Norwich, Waterbury, and Middletown District Offices, interim activity and redetermination activities are combined and handled by case management units.

District office workers, and sometimes whole units, generally specialize in intake or case management for either AFDC or adult cases. In addition, all district offices have separate units that only administer the nonpublic assistance Food Stamp program. These units have responsibility for intake and case management functions concerning food stamp clients who are not receiving AFDC benefits.

Within each district office there are also special monthly reporting units that handle all aspects of case management for AFDC and other clients who have earned income. Another specialized unit within all district offices is the resources unit. Resources units provide investigatory support services to other district office units regarding complicated eligibility issues or allegations of recipient fraud. Since 1982, separate investigators responsible for following-up on food stamp fraud allegations have been attached to the district office resources units.

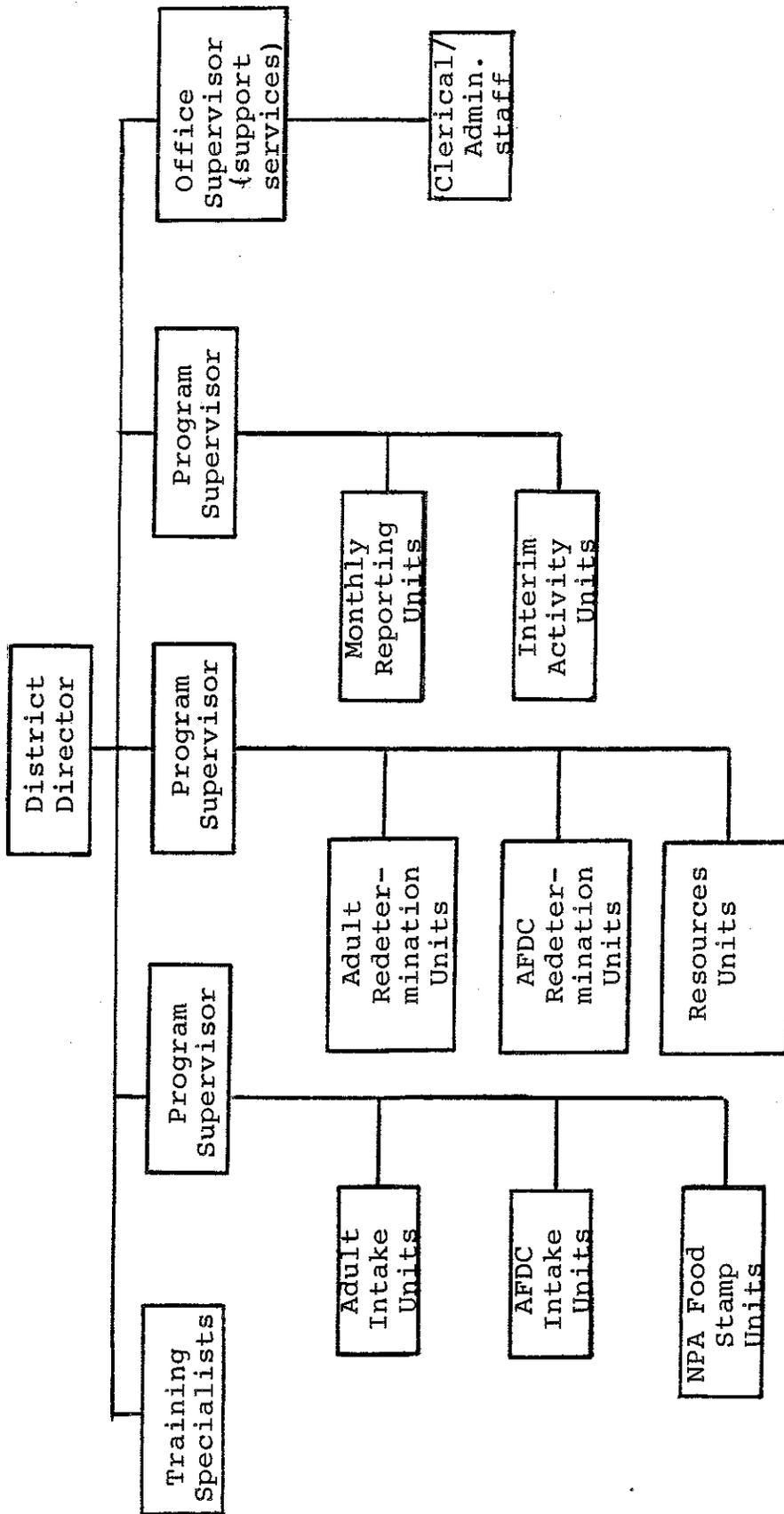
On average, each district office unit consists of five to six eligibility technicians, a senior eligibility technician, and an eligibility supervisor. Resources units are similarly structured with investigatory staff. Unit supervisors are overseen by program supervisors, who are responsible for the overall administration of major office functions and report to the district director.

A typical district office structure is outlined in Figure II-4. In reality, the actual organization of each district office varies in terms of the number of units, the program supervisor assignments, the type of case management approach (combined or divided), and whether the office includes suboffices. As shown in Figure II-4, support services for intake, case management, and food stamp units are, for the most part, provided by centralized administrative and clerical staff within each district office. Among the support services provided are processing paperwork, filing case records, and mailing notices to clients.

In some cases, clerical and administrative staff are also directly assigned to district office units. For example, monthly reporting units usually include data entry operators who input information into the department's computerized system for managing cases with earned income. Most resources units also have their own clerical staff.

There are two additional types of district office units that are not included in the scope of the program review committee's

Figure II-4. Typical Department of Income Maintenance District Office Organization.



performance audit--Early and Periodic Screening, Detection, and Treatment program units, and energy assistance units. Under the early screening program, a component of the medicaid program, services to ensure access to preventative health care are provided to AFDC children and other Medicaid clients under the age of 21. Since the staff assigned to district office early and periodic screening units are not involved in error prevention and detection activities, they were excluded from analysis. As the committee's performance audit did not address error prevention and detection within the federally funded energy assistance program, the part-time staff hired by district offices to administer this program were similarly excluded.

Figure II-5. District Office Professional Staff Positions and Salary Ranges (numbers in parentheses are number of filled positions, September 1984).

<u>District Director</u>	
(3) Large Office \$37,650 - \$46,214	
(3) Small/Medium Office \$34,808 - \$42,725	
(15) <u>Program Supervisor</u>	
\$29,186 - \$35,825	
(100) <u>Eligibility Supervisor</u>	(7) <u>Investigations Supervisor</u>
\$22,163 - \$26,382	
(106) <u>Sr. Eligibility Technician</u>	(22) <u>Sr. Investigator</u>
\$19,155 - \$23,048	
(479) <u>Eligibility Technician</u>	(34) <u>Investigator</u>
\$16,566 - \$20,156	
(61) <u>Connecticut Careers Trainee</u>	
(one-year, entry level position)	
\$15,656 beginning	
(29) <u>Social Services Trainee</u>	
(two-year, entry level position)	
\$13,843 first year; \$14,266 second year	

Source: Department of Income Maintenance, Personnel and Payroll Office.

Staff Resources

District office professional staff positions and salary ranges are shown in Figure II-5. As Figure II-5 indicates, the majority (68 percent) of the 844 district office professional staff are eligibility and senior eligibility technicians, the workers with direct responsibility for determining client eligibility and benefit amounts. Less than 10 percent of the staff are in investigatory positions. Top managers and unit supervisors account for 15 percent of all district office professionals.

Data on monthly district office staffing levels over the past three years are presented in Table II-15. The number of filled positions (professional and clerical) for each major district office function are shown for each June and December since the end of 1980. (The table does not include early and periodic screening or energy assistance program staff.) The administration/office management category in Table II-15 includes the district director, the program supervisor, and centralized support staff positions.

Table II-15. District Office Staffing Levels by Function. (No. filled positions).

	<u>Total</u>	<u>In- take</u>	<u>Case Mgt.</u>	<u>NPA Food Stamp</u>	<u>Re- sources</u>	<u>Food Stamp Fraud</u>	<u>Admin/ Office Mgt.</u>
June 84	1,112	183	477	219	65	17	154
Dec. 83	1,027	180	432	199	56	20	140
June 83	1,059	176	460	202	57	21	143
Dec. 82	1,021	170	432	194	59	21	145
June 82	989	154	427	189	59	17	143
Dec. 81	979	153	456	176	54	-	140
June 81	955	141	487	153	51	-	123
Dec. 80	992	146	506	158	55	-	127

Source: Department of Income Maintenance.

Overall, the number of filled positions for all functions except case management increased or remained the same between December 1980 and June 1984. Total district office staff resources grew 12 percent during this period with the largest increase (85 filled positions) occurring between December 1983 and June 1984. Staffing levels for the nonpublic assistance food stamp function showed the greatest increase, growing from a low of

153 filled positions in June 1981 to a high of 219 positions in June 1984 (43 percent).

The upward trend in district office staff resources is partially due to additions of new positions for new functions, such as the food stamp fraud personnel added during state fiscal year 1983. Over the past several years, nearly all of the new staff authorized for district offices have been dedicated to specific projects or procedures, many of which are aimed at error prevention and detection. Authorized staffing levels for the basic intake and case management functions have not changed significantly. The most recent department budget (FY 85), for example, provided for the following new district office staff: 32 new positions to establish a monthly reporting system for the Food Stamp program; 34 new positions to expand the AFDC home visits program; 17 new staff to pursue recoupment of AFDC and food stamp recipient overpayments; and 10 new resources investigator positions.

Information on staff resources and workloads in each district office is contained in Table II-16. In general, district office staffing levels for intake, case management, and nonpublic assistance food stamp functions are proportional to their application and active case workloads. For example, District Office 1 (Hartford) received one-quarter of all new cash and medical assistance program applications during June 1984 and had one-quarter of all the filled intake staff positions. The patterns that appear in Table II-16 have been fairly consistent over the past three years.

Case Processing System

Although district offices vary in size, structure, and staff resources, the system used to process cases from intake through redetermination is basically the same. The district office case processing system is outlined in Figure II-6.

The process begins with an application for assistance, which is handled through the intake function unless the applicant is seeking nonpublic assistance food stamps. As the figure shows, a separate but parallel process exists to handle nonpublic assistance food stamp cases.

Cases approved for assistance are monitored for changes in eligibility and/or payment levels through the interim activity and redetermination (or recertification, in the case of the Food Stamp program) aspects of the system. AFDC cases involving earned income are subject to special monitoring through the monthly reporting function. The resources function supports the other case processing functions but is not directly part of the system.

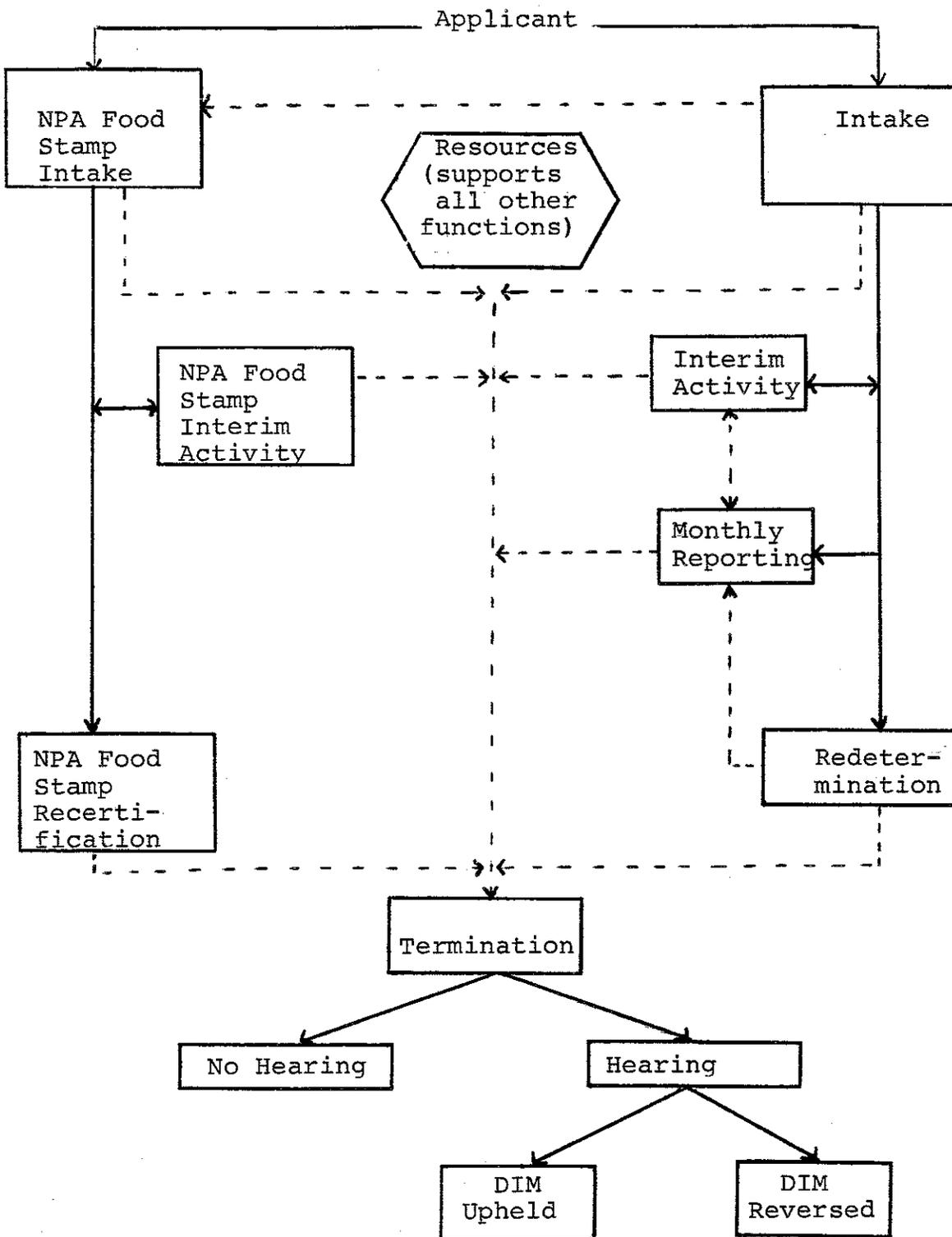
Table II-16. District Office Application, Active Case, and Staffing Data, June 1984.

	No. Statewide	Percent		Percent		Percent		Percent	
		D.O. 1	D.O. 2	D.O. 3	D.O. 4	D.O. 6	D.O. 7		
Money/Med. Asst. Appl.	6,388	24	21	23	10	11	12	12	
Intake Staff	183	24	16	24	11	12	14	14	
Money/Med. Asst. Cases	95,011	26	18	22	10	12	12	12	
Case Mgt. Staff	474	23	19	25	10	12	12	12	
NPA Food Stamp Appl.	3,902	25	24	19	11	12	10	10	
Cases	30,902	24	23	21	11	12	10	10	
Staff	219	24	20	18	12	16	11	11	
Admin./Mgt. Staff	154	31	21	14	10	14	11	11	
Total Staff	1,112	25	19	22	11	12	12	12	

Note: Percentages may not add up to 100 percent due to rounding.

Source: LPR&IC.

Figure II-6. District Office Case Processing System.



Source: LPR&IC.

At any point in the system, a case can be terminated--either an application is denied or an active case is discontinued due to ineligibility. Clients have the right to request a hearing whenever a district office decision results in denial of an application, discontinuance of assistance, or reduction of assistance payments. Each component of the case processing system outlined in Figure II-6 is discussed in detail below.

Intake. Workers within the intake component of the case processing system are responsible for obtaining and verifying information necessary to determine a client's initial eligibility for Department of Income Maintenance money and medical assistance programs. The steps taken by intake workers to insure that accurate decisions are made on applications prevent eligibility and payment errors. The average number of new applications received per month as well as average monthly intake staffing levels at each district office are presented in Table II-17.

Table II-17. District Office Intake Workload and Staffing Data (monthly average).

No. New Applications Received ¹	<u>D.O.1</u>	<u>D.O.2</u>	<u>D.O.3</u>	<u>D.O.4</u>	<u>D.O.6</u>	<u>D.O.7</u>
All Money Asst. ² (AFDC)	861 (642)	537 (438)	795 (620)	355 (285)	332 (275)	388 (262)
Medicaid only	642	653	637	346	353	371
No. Intake Staff ³	40	26	38	19	19	23

¹ Average of new applications received in December and in June, from December 1980 through June 1984.

² Includes AFDC, State Supplement to SSI, and Refugee Assistance programs.

³ Rounded average of positions filled in December and in June, from December 1980 through June 1984.

Source: LPR&IC.

Face-to-face interviews must be held with AFDC applicants while applications for the Medicaid and other money assistance programs may be made in person or by mail. Intake interviews usually take 45 to 60 minutes to complete. During an intake

interview, the worker completes the application and any accompanying forms. Since AFDC recipients are automatically eligible for medical assistance, AFDC and medicaid applications are combined and completed at the same time.

Applicants who need to provide additional information and/or documentation are usually given a deadline for submission, generally 10 days. If a client fails to meet the deadline and has not contacted the intake worker regarding problems obtaining required information, the application will be denied.

Individuals seeking assistance other than AFDC may call or write the district office for an application. Intake workers send the appropriate application materials to the clients and generally request that they be returned by a specific date, usually within two weeks. When the completed application is received, it is assigned to an intake worker for processing.

The intake worker who conducts the interview or receives a mail-in application is responsible for verifying the client's eligibility. To insure information provided is complete and accurate, workers are expected to follow-up on all possible sources of income and assets. Information provided by the client is also checked against a variety of collateral sources such as motor vehicle ownership records, Department of Labor employment files, lists of public assistance recipients in other states, former employers, and banks.

Although most assets and income sources can be investigated by the intake worker, complicated or time-consuming cases are referred to a resources unit. The intake worker fills out a resources investigation request form, which is cosigned by the intake unit supervisor. Resources staff do the field work and other investigating necessary to clarify the applicant's eligibility in terms of income and/or assets, and submit a written report back to the intake worker.

Many referrals to resources units, especially those involving medicaid only cases, concern real estate appraisals or transfer of asset questions. Occasionally, intake referrals to resources staff concern the value of an automobile. Cases involving a pending lawsuit from which a client may receive a settlement are automatically referred.

Beginning in October 1984, a home visit became another verification step in the intake process for all AFDC applications. Home visits have been conducted on a pilot project basis since October 1982 in the Hartford and Waterbury District Offices.

At the conclusion of an AFDC intake interview, if all information indicates the applicant will be eligible for AFDC, the

worker makes a referral to a home visit worker. Home visits are preannounced and, on average, take about one-half hour. During the home visit, the worker re-interviews the client concerning income, assets, living arrangements, and other circumstances that affect eligibility. Generally, the home visit process is completed and the information obtained is reported back to the intake unit within one week.

Once the intake worker has completed the investigation of the client's eligibility, the decision to grant or deny the application is made. The worker's decision is reviewed and must be approved by the unit supervisor. The most recent available information on monthly outputs of district office intake units is presented in Table II-18. In May 1983, almost 6,500 applications for money and medical assistance programs were disposed of statewide. Table II-18 shows that the time needed to dispose of an application varied among the district offices from a low of 2.4 hours in Waterbury to a high of 2.9 hours in Hartford and New Haven.

Table II-18. District Office Intake Data, May 1983.

	<u>No. Workers</u>	<u>No. Appl. Disposed of</u>	<u>Hours Per Accomplishment</u>
Hartford	33	1,509	2.9
New Haven	27	1,194	2.9
Bridgeport	35	1,506	2.8
Norwich	16	737	2.9
Waterbury	15	775	2.4
Middletown	18	774	2.7
Statewide	<u>144</u>	<u>6,495</u>	2.8

Source: Department of Income Maintenance.

District office clerical workers process all necessary paperwork to finalize applications and mail out notices of approval or denial to the clients. The Department of Income Maintenance central office is notified to start payments if the case has been approved. If a client is currently receiving support under the General Assistance program, the municipality providing it will be notified that the application for assistance administered by the Department of Income Maintenance has been approved.

If a client's application has been denied, the notice sent to the client will include information and a form concerning the department's fair hearing process. Applicants who are denied assistance can request a fair hearing by completing the form and returning it to the district office. If a hearing is requested, the intake worker responsible for the case prepares a summary of the factors leading to the decision to deny the application and represents the department during the hearing.

Information on the numbers of applications granted and denied by intake workers in June 1984 is provided in Table II-19. About 40 percent of the AFDC applications acted upon during June were denied while nearly 60 percent of the applications for medical assistance only were disapproved. Overall, slightly more than half (51 percent) of all money and medical assistance applications disposed of during the month were denied.

Table II-19. Disposition of Money and Medical Assistance Program Applications, June 1984.

<u>Applications</u>	<u>All Money/ Med. Asst. Programs</u>	<u>AFDC Program</u>	<u>Medicaid only Program</u>
No. pending (beg. mo.)	6,917	1,703	4,452
No. received (new)	<u>6,338</u>	<u>2,456</u>	<u>3,280</u>
Total	13,255	4,159	7,732
No. Acted Upon			
No. granted	2,513	1,097	1,131
No. denied	3,054	877	1,919
No. other (e.g., withdrawn, etc.)	402	150	210
No. pending (end mo.)	7,286	2,035	4,472

Source: Department of Income Maintenance.

The disposition of assistance applications is subject to specific time frames. Under federal requirements and court directives, an applicant for AFDC must receive his/her first check or a denial notice within 45 days of the date assistance was requested. The department has set a limit of 30 days on the processing of AFDC applications to ensure that initial awards are delivered to eligible clients within 45 days.

Applications for medicaid as well as for the State Supplement to Supplemental Security Income must be processed within 45 days, except when a case involves eligibility due to disability. The decision to grant or deny assistance under both programs when the applicant is disabled must be made within 60 days.

Case management. District office workers responsible for case management monitor the eligibility status of active money and medical assistance program clients. The average number of case management workers as well as the average number of active cases monitored at each district office are presented in Table II-20. The three aspects of case management, interim activity, redetermination, and monthly reporting are described below. Each is aimed at both preventing and detecting errors due to changes in client eligibility factors that occur after assistance has been granted.

Table II-20. District Office Case Management Workload and Staffing Data (monthly average).

	<u>D.O. 1</u>	<u>D.O. 2</u>	<u>D.O. 3</u>	<u>D.O. 4</u>	<u>D.O. 6</u>	<u>D.O. 7</u>
<u>No. Active Cases</u> ¹						
AFDC	11,522	8,658	10,816	4,237	4,750	4,252
All Money Asst. ²	15,147	10,734	13,948	5,298	5,885	5,808
Medicaid only	8,935	6,334	6,939	4,132	5,173	5,247
Total (money/ medical asst.)	24,082	17,068	20,888	9,430	11,058	11,055
<u>No. Case Mgt. Staff</u> ³	113	93	104	43	52	55

¹ Average of active cases in December and June, from December 1980 through June 1984.

² Includes AFDC cases.

³ Rounded average of positions filled in December and in June, from December 1980 through June 1984.

Source: LPR&IC.

Case management workers responsible for interim activity handle changes in client eligibility factors that occur after assistance is granted and before a regularly scheduled review of eligibility (redetermination). Among the sources of information on interim activity are Department of Income Maintenance clients, who are required by statute to report any changes that affect their eligibility in writing within 15 days. Interim client eligibility changes may also be reported to district offices by the central office based on their client records. For example, if central office files indicate an AFDC child will no longer be eligible for assistance due to reaching age 18, a notice will be sent to the appropriate district office.

The central office also sends notices of client changes to be implemented because of new or revised policy. Third party "tips" are another source of information regarding changes in client eligibility. Employers, landlords, or other clients may contact district offices to report changes in a recipient's status.

Clients who come to the district office to report changes see an interim activity or case management worker. In some district offices "walk-in units" have been established to handle all interim activity matters concerning clients who appear at the district office.

In addition to taking information on changes in eligibility, interim activity responsibilities include handling client questions and problems, processing requests for replacement checks, and making referrals to other sources of assistance and services. Interim activity actions range from processing a change of address to adding a newborn child to an AFDC grant to discontinuing a client who becomes ineligible due to employment. The most recent available information on all interim activity outputs is presented in Table II-21.

For interim eligibility changes reported in person, by mail, or by telephone, workers obtain all information necessary to complete the appropriate forms. If a client has not initially provided sufficient verification, the worker will give the client a check list of documents needed and set a time limit for submission. Interim activity information is verified in the same manner as during the intake process. Workers handling interim activity may request a resources unit investigation if they believe additional follow-up is needed to determine the impact of a change on the client's eligibility.

Table II-21. District Office Interim Activity Data, May 1983.

<u>District Office</u>	<u>No. Workers</u>	<u>Accomplishments*</u>	<u>Hours Per Accomplishment</u>
Hartford	42	6,104	.8
New Haven	33	3,966	1.0
Bridgeport	28	4,033	.8
Norwich	18	1,827	.7
Waterbury	23	2,392	1.0
Middletown	21	3,586	.6
Statewide	<u>165</u>	<u>21,908</u>	.8

* Interim activity accomplishments include: change of address, nonreceipt of check, regularly scheduled reviews, beginning of employment, end of employment, change in income/assets, add/remove assistance unit member, change in budgetary requirements, quarterly incentive earnings review, change in categorical eligibility requirements, energy assistance, and nongrant action.

Source: Department of Income Maintenance.

In regard to interim changes in a client's eligibility factors, workers determine what action will be taken. These actions include: continue the case with no change; continue the case but with a program change (e.g., a client determined to be ineligible for AFDC may still be eligible for medicaid); continue the case with a payment change (increase or decrease in assistance); or discontinue the case. The worker's decision on a case is reviewed and signed by the unit supervisor.

Adverse actions (discontinuances or reductions in assistance) resulting from interim activity decisions, like those occurring in the intake process, can be appealed by the client. Workers must send a notice of any adverse action to a client 10 days in advance of the change. The client is also sent information and a form concerning the fair hearing process.

District office monthly reporting units handle all employed AFDC clients that have earned income. These special case management units were established to closely monitor employed clients since they tend to be more error-prone than other clients due to fluctuations in income. Once an initial award has been made to an employed AFDC client, the case is assigned to the monthly reporting unit. Active clients who become employed are immediately

referred to a monthly reporting unit. As of June 1984, about 3,000 clients were included in the monthly reporting system.

During the intake process, AFDC applicants with earned income must provide documentation of their earnings (e.g., pay stubs) as well as all normally required verifications. The intake worker then develops a budget in which earnings are offset against the regular AFDC payment, although provisions are made for special expenses due to employment (e.g., child care, transportation). As an incentive to continue working, a certain portion of earned income is additionally disregarded in calculating the AFDC grant amount.

The intake worker also explains the monthly reporting requirements the client will be subject to and gives the client a monthly earnings reporting form and a booklet explaining the process. As soon as the client's initial award is granted, the case is transferred to a monthly reporting unit.

Most new monthly reporting cases, however, are active AFDC clients who become employed after they have been receiving assistance. For active AFDC clients entering the monthly reporting system, workers establish budgets and calculate work expense and incentive allowances.

Workers handle monthly reporting clients on a case load management basis. Each worker is responsible for monitoring interim changes and redetermining eligibility regarding their assigned group of clients. In accordance with federal requirements, the eligibility for AFDC clients with earned income must be redetermined annually in a face-to-face interview. Redetermination interviews with monthly reporting clients take an average of one-half hour.

Under the monthly reporting system, clients must submit a monthly earnings reporting form by a specific date each month. The client's case worker reviews the form for completeness as well as for any changes in household composition or reported earnings. The worker computes the impact of any changes in earned income on the client's grant amount. Based on this review, the worker makes the decision to increase, decrease, discontinue, or continue without change the assistance provided. Supervisors are required to co-sign worker decisions only in certain cases, such as additions to the client's family or actions to transfer a client out of the monthly reporting unit.

If the worker determines that a client is making sufficient income to meet needs, the case will be discontinued from the AFDC program. However, the client's eligibility for medicaid is automatically continued for four months, and the case is transferred to the regular case management system.

If a monthly reporting client becomes unemployed, monthly earnings reporting forms must continue to be filed for three months, although the award is changed to the appropriate AFDC grant amount. After three months, if the client remains unemployed, the case is transferred to the regular AFDC case management system.

Clients who submit incomplete monthly reporting forms or submit them after the deadline are penalized with the loss of their working expenses and incentive allowance. Clients who fail to submit a report by the end of a month are discontinued automatically by the monthly reporting computer system. If the client promptly contacts the monthly reporting worker, the client can be reinstated; otherwise the client must reapply through the regular intake process. Monthly reporting clients who are discontinued or whose payments are reduced are notified of their right to a fair hearing.

Periodic re-evaluation of client eligibility is a primary district office activity for both preventing and detecting errors. The eligibility of clients receiving AFDC is redetermined by case management workers three months after the initial award in accordance with Department of Income Maintenance policy and every six months thereafter to meet federal requirements. In contrast, most adult cases including medical assistance only clients are redetermined once per year, although some may be done more frequently if it appears their circumstances are likely to change.

AFDC redetermination schedules are generated via computer at the Department of Income Maintenance central office. AFDC clients receive notification of their redetermination interview from the central office, which also forwards a list of the cases to be redetermined during a particular month to the district offices. In addition, the central office cross matches the monthly list of AFDC clients scheduled for redetermination with Department of Labor employment files and forwards the results to the district offices for follow-up.

Clients who fail to appear for their AFDC redetermination appointments are sent notices by the district office unit that state unless they come to the office within 10 days, their next assistance check will be held. If the client still fails to appear, the check will be held for a total of 30 days (from the date of the first notice); after this period, if the client has not come to the office, a discontinuance notice will be mailed.

During AFDC redetermination interviews, case management workers question clients about all eligibility factors. Frequently, reference is made to actual case record files. If clients have not brought the necessary documentation to verify their eligi-

bility, they will be requested to provide it within a specified deadline. Clients who fail to meet the deadline are sent a discontinuance notice.

The length of an AFDC redetermination interview varies from about 10 minutes to 1 hour. In most cases, the same collateral checks of the client's eligibility factors performed during intake are completed by the redetermination worker after the interview. Workers may request a home visit or an investigation by a resources unit if they believe more in-depth information is required to determine eligibility.

Special attention is devoted to cases that, based on the check of labor records, indicate client employment. If the client is currently employed at the time of the redetermination, the case will be referred to a monthly reporting unit for review. If the client did not report being employed prior to or during the redetermination interview, the worker will request written verification from the employer and refer the case to a resources unit for investigation.

In general, redetermination unit supervisors review all decisions made by the workers unless a case involves no changes and has been handled by an experienced worker. The most recent available data on AFDC redetermination accomplishments are shown in Table II-22.

Table II-22. AFDC Redetermination Data, May 1983.

<u>District Office</u>	<u>No. Workers</u>	<u>AFDC Redeterminations Completed</u>	<u>Hours Per Accomplishment</u>
Hartford	18	1,821	1.3
New Haven	16	1,326	1.4
Bridgeport	19	1,010	2.3
Norwich	9	559	1.8
Waterbury	16	592	1.7
Middletown	17	606	1.7
Statewide	<u>95</u>	<u>5,914</u>	2.3

Source: Department of Income Maintenance.

Unlike the AFDC process, the redetermination process for medicaid as well as other adult assistance cases is completely manual and seldom involves a face-to-face interview. Redetermination dates for adult program cases are established during the

intake process. Cards that contain the name and address of the client and all actions taken on a case are maintained by unit clerks according to redetermination date (month and year). At the beginning of a month, the unit supervisor makes a log of all adult redeterminations scheduled for the month and assigns cases to case management workers.

In addition to a redetermination form, a list of any verifications that must be provided as well as a form and information regarding the fair hearing process are mailed to clients scheduled for redetermination. The client has a specified time from the date of receipt in which to complete and return the forms and verifications. Clients who fail to return the redetermination form by the deadline are sent a discontinuance notice.

On rare occasions, an adult assistance client may come into the district office instead of returning the form by mail. In such cases, a worker will then interview the client and complete the form in person. Adult program clients who are unable to complete the form without assistance and cannot find assistance or come to the office will be visited by an adult redetermination worker. In nearly all cases, however, adult redeterminations are done by mail with a desk review by the worker.

Adult redetermination workers complete the same verification procedures and collateral checks as other eligibility workers, although most cases only require verification of income and assets. Unit supervisors review and sign off on all cases. Table II-23 contains the most recent available data on redeterminations completed for medicaid only and other adult assistance cases.

Table II-23. Adult Redetermination Data, May 1983.

<u>District Office</u>	<u>No. Workers</u>	<u>Adult Redeterminations Completed*</u>	<u>Hours Per Accomplishment</u>
Hartford	13	979	1.7
New Haven	8	826	1.2
Bridgeport	14	966	1.8
Norwich	8	610	1.4
Waterbury	14	721	1.6
Middletown	10	637	1.8
Statewide	<u>67</u>	<u>4,739</u>	1.6

* Medicaid only, State Supplement to SSI, and refugee assistance cases.

Source: Department of Income Maintenance.

Nonpublic assistance food stamps. As discussed earlier, each district office administers the nonpublic assistance Food Stamp program separately from the department's money and medical assistance programs. Nonpublic assistance food stamp cases include any individual or family that does not receive federally matched AFDC assistance, although the clients may be receiving state-funded AFDC, state supplement, medicaid, or other types of public assistance. The average monthly number of applications received, active cases, and filled nonpublic assistance food stamp staff positions for each district office are shown in Table II-24.

Table II-24. District Office Nonpublic Assistance Food Stamp Workload and Staffing Data (monthly average).

	<u>D.O.1</u>	<u>D.O.2</u>	<u>D.O.3</u>	<u>D.O.4</u>	<u>D.O.6</u>	<u>D.O.7</u>
<u>No. New Appl.</u> <u>Received</u> ^[1]	1,188	1,052	1,141	618	770	481
<u>No. Active</u> <u>Cases</u> ^[2]	8,108	7,490	7,362	4,035	4,411	3,464
<u>No. NPA Food</u> <u>Stamp Staff</u> ^[3]	44	38	36	25	26	17

¹ Average of new applications received in December and in June, from December 1980 through June 1984.

² Rounded average of active cases in December and in June, from December 1980 through June 1984.

³ Average of positions filled in December and in June, from December 1980 through June 1984.

Source: LPR&IC.

Applications from clients who are not yet receiving AFDC are taken by nonpublic assistance food stamp intake workers; however, once the client is awarded an AFDC grant, the case is transferred out of the food stamp unit. All food stamp matters concerning active AFDC clients including the application process are the responsibility of case management staff assigned to AFDC cases.

Individuals who come to the district offices to apply for food stamps are interviewed by nonpublic assistance food stamp

intake workers. Like AFDC applicants, individuals seeking food stamps must be interviewed face-to-face. Applicants are asked to provide information and verification of their income, assets, living arrangements, and other eligibility factors. Food stamp intake interviews generally last between 15 minutes and one-half hour.

Under the Food Stamp program, approval for benefits is referred to as certification. Based on the intake interview, the worker first determines if a client's certification for food stamps should be expedited. Expedited certification is designed to assist persons without resources to meet immediate food needs.

The primary criteria are that the applicant's monthly income be less than \$150 and liquid resources (cash on hand, savings account, etc.) not exceed \$100. Clients who meet these requirements are certified for a one-month food stamp award, which according to federal regulations must be received within five days. Due to the five-day deadline, verification is usually limited to checking the client's identity and residency. At the application interview, expedited clients are advised about the process and documentation required for regular food stamp certification.

In accordance with federal requirements, the regular food stamp certification process must be completed within 30 days. During the intake interview, the client is told what additional information and/or documentation is needed to process the application. Workers usually set a 10-day deadline for submission, and a reminder letter will be sent if nothing has been received by the deadline. If the client does not provide the information or contact the intake worker, a discontinuance notice is sent.

Nonpublic assistance food stamp workers follow the same verification procedures as eligibility workers for other assistance programs and may refer complex cases to a resources unit for further investigation. Once all necessary information has been obtained and verified, the worker makes the decision whether to certify the client for food stamps for a period from one month to one year. The unit supervisor must review and approve all worker decisions. Like other program applicants, persons who are denied nonpublic assistance food stamps are sent information concerning their rights to a fair hearing.

Clients who cannot come to the district office to make a food stamp application may authorize another individual to apply for them. On rare occasions, this cannot be arranged and food stamp intake workers will make home visits to take applications. Nonpublic assistance food stamp intake workers also take applications at outreach sites at prescheduled times. Outreach sites are set up, usually at the request of an outside service organization such

as the Salvation Army or a community youth organization, to interview and take applications from large groups.

Nonpublic assistance food stamp recipients are required by federal regulations to report any changes in their eligibility factors within 10 days. Changes can be reported in person at the district office, over the phone, or by mail. Information regarding changes in a client's status that could affect food stamp benefits is also reported in writing to the nonpublic assistance food stamp units by other district office workers who handle the money or medical assistance aspects of a food stamp case.

Clients, who appear at the district office to report interim changes are seen by food stamp case management workers. Information is taken from the client, and if additional documentation is required, a deadline is established for submission. Clients who fail to provide required material by the deadline without contacting the worker are sent a discontinuance notice.

If insufficient information on changes in eligibility is provided by letter or phone, the nonpublic assistance food stamp worker will contact the client and, if necessary, set deadlines for submitting required documentation. Similar follow-up is conducted regarding client changes reported from other program workers. As in the intake process, workers verify reported interim changes in nonpublic assistance food stamp cases by checking computerized data sources such as labor department employment files and motor vehicle records as well as by contacting employers, banks, landlords, or others as necessary.

Interim activity workers are responsible for determining what impact the reported change has on the client's food stamp status, although unit supervisors review and sign off on all decisions. A client may be continued with no change, discontinued, or the amount of the grant may be increased or decreased. Like other Department of Income Maintenance clients, nonpublic assistance food stamp recipients whose benefits are decreased or discontinued are given 10 days notice and informed of their right to a fair hearing. If the worker determines the client has been overpaid and suspects that it is the result of fraud, the case is referred to the food stamps fraud investigators for follow-up.

The formal, periodic re-evaluation of client eligibility for food stamp benefits is referred to as recertification. The recertification cycle for nonpublic assistance food stamp clients is established by the intake worker, subject to the review and approval of the unit supervisor. Generally, "fluid" food stamp cases, those involving employed clients or young families, are scheduled for recertification every three months, although some clients are recertified every month. Elderly clients, those with fixed incomes, and other stable cases, after an initial six-month

recertification, are subject to annual review. Eligibility for food stamps must be recertified at least once every year to meet federal requirements.

Each month a computer print-out listing of all cases scheduled for recertification, along with the necessary recertification forms, are sent from the Department of Income Maintenance central office to the district offices. The food stamp recertification workers mail the forms, which indicate the client's recertification interview date, to the clients, enclosing a new application and a check list of the information the client needs to supply as verification of eligibility.

Recertification is handled the same way as an initial certification. Clients are interviewed by the recertification workers either in the office or at an outreach site. Recertification interviews generally last 15 to 30 minutes. Clients who are home-bound may be visited by recertification staff if no other arrangements can be made. Clients who fail to appear for an interview or who do not provide all required documentation by an established deadline are subject to discontinuance.

Routine verification procedures are performed by the recertification workers, although internal policy in some district offices permits cases involving changes amounting to \$25 or less to be processed without written documentation. The typical recertification requires about one hour of "desk time" that includes scheduling the recertification, completing the paperwork, and conducting the interview. Information on nonpublic assistance food stamp recertifications during fiscal year 1984 is provided in Table II-25.

Since the nonpublic assistance Food Stamp program is computerized, clients are automatically discontinued by the computer if recertification instructions are not entered into the system by the close-out date established for the month. Clients who do not provide required verification, or who fail to show up for their recertification interview and do not contact the district office by the 15th of the month of their final eligibility, must go through the initial application process to be reinstated. A recertification worker will take the application if the client appears and/or provides required verification before the end of the month; otherwise, the client must see an intake worker.

Table II-25. Nonpublic Assistance Food Stamp Recertification Activities, State Fiscal Year 1984.

		<u>Scheduled Recertifi- cations</u>	<u>No. Cases Continued</u>	<u>No. Cases Discontinued</u>
July	1983	8,476	5,869	2,607
August	1983	7,922	5,361	2,561
September	1983	7,240	5,177	2,063
October	1983	7,476	5,117	2,359
November	1983	7,642	5,265	2,377
December	1983	7,095	4,798	2,297
January	1984	7,342	4,972	2,370
February	1984	7,356	4,979	2,377
March	1984	7,260	5,018	2,242
April	1984	7,185	4,897	2,288
May	1984	7,139	4,790	2,349
June	1984	<u>6,929</u>	<u>4,596</u>	<u>2,333</u>
TOTAL		89,062	60,839	28,223

Source: Department of Income Maintenance.

Resources units. Among the duties of district office resources units are the investigation of complicated or time consuming asset and income questions as well as follow-up on fraud complaints and recipient overpayments. Both types of activities aid in the prevention and detection of eligibility and payment errors.

District office resources unit staffing levels are shown in Table II-26. Resources personnel include special food stamp fraud investigators. Food stamp fraud staff were attached to resources units in all district offices in FY 83 to handle fraud allegations and overpayments concerning food stamp recipients. Not unexpectedly, the three larger district offices, Hartford, New Haven, and Bridgeport, have the greatest numbers of resources and food stamp fraud staff.

Table II-26. District Office Resources Unit Staffing Levels.

<u>District Office</u>	<u>No. Resources Staff</u>		<u>No. Food Stamp Fraud Staff</u>	
	<u>June 84¹</u>	<u>Average²</u>	<u>June 1984¹</u>	<u>Average²</u>
Hartford	19	15	5	5
New Haven	10	9	3	3
Bridgeport	16	14	4	5
Norwich	7	6	2	3
Waterbury	6	6	1	2
Middletown	7	7	2	3

¹ Number filled positions (professional and clerical).

² Rounded average number filled positions (professional and clerical) in June and in December, from December 1980 through June 1984.

Source: LPR&IC.

District office resources operations are coordinated by the resources unit of the Office of Field Operations. The central office resources staff handle the final processing of actions investigated and prepared by the field investigators. For example, district office workers forward overpayment reports to the central office resources unit, which institutes recovery procedures. The central office resources staff also operates the Department of Income Maintenance fraud telephone hotline. The resources division includes 6 food stamp fraud personnel as well as 15 resources employees.

As noted above, district office resources units investigate complicated asset and income issues regarding cases that are referred from intake, case management, and nonpublic assistance food stamp workers. Resources staff perform the field work and other research necessary to clarify client eligibility in terms of income and/or assets, thereby preventing eligibility and payment errors. For example, resources staff investigates the disposition of real property to insure that applicants meet eligibility requirements concerning the transfer of assets.

In general, individuals are ineligible for Department of Income Maintenance administered assistance programs if they dispose of property for less than fair market value within two years of applying for assistance. Title searches and real estate appraisals are among the activities performed by resources investigators for cases involving transfer of assets. During state FY 84, resources investigations of transferred assets resulted in the denial of benefits in 173 cases and the delay of assistance payments in 157 cases. Total cost avoidance from these actions amounted to about \$3.5 million.

Follow-up on complaints of recipient fraud received through the central office fraud hotline is another responsibility of district office investigators. Details are taken from fraud hotline callers by the central office staff, and the information is checked to verify that the case involves a Department of Income Maintenance client. Valid complaints are then forwarded to the appropriate district office resources units. Resources units also handle fraud complaints received directly at the district offices.

The resources staff investigates the fraud complaints by checking case records and collateral sources. If the resources staff determines that fraud has occurred, the case will be referred for prosecution. In addition, when a resources investigation reveals client ineligibility and/or overpayment, the appropriate case action (discontinuance or award reduction) will be initiated.

In state fiscal year 1984, complaints concerning 3,433 cases were received via the fraud hotline. About one-third were not relevant (e.g., the individual reported was not a client, the matter was not within the jurisdiction of the income maintenance department, etc.). Of the remaining cases, 370 fraud cases were revealed, 94 of which were referred for prosecution. Fraud hotline information also resulted in discontinuance or benefit reduction in 147 cases.

Resources units play another role in detecting error through their review and investigation of overpayment cases referred from other district office units. Overpayments may be administrative or fraudulent. Administrative overpayments are the result of agency error or administrative procedures such as the fair hearing process in which a client can opt to continue receiving assistance until a decision is reached. If the hearing finds the client ineligible, the overpayment that occurs is considered administrative. Fraudulent overpayments involve willful withholding of information on the part of the client; either the client makes an intentional misstatement concerning eligibility or fails to report eligibility information.

Resources staff determines whether money or medical assistance program overpayments detected by other district office workers are administrative or fraudulent. The separate food stamp fraud personnel attached to the resources units makes this determination regarding Food Stamp program overpayments. In accordance with state statute, cases involving alleged public assistance fraudulent overpayments of \$500 or more are referred to the state police Welfare Investigation Unit for prosecution. Alleged food stamp fraud cases involving \$200 or more in overpayments must be forwarded to the state police. For cases under these limits, resources or food stamp fraud personnel determines if the overpayment is due to willful withholding of information and calculate the amount of overpayment.

Another duty of resources staff, or in the case of food stamp overpayments, food stamp fraud personnel, is establishing the mechanism for recovery of recipient overpayments. The investigators review the overpaid client's ability to reimburse the state

Table II-27. Resources Overpayment Recoveries and Recoupments, State Fiscal Year 1984.

	<u>FY 84</u>
<u>Money/Medical Asst. Overpayments</u>	
<u>recoveries</u>	
administrative	\$ 61,155
fraud	461,086
<u>recoupments (award reductions)</u>	
administrative	370,086
fraud	253,877
<u>Food Stamp Overpayments</u>	
<u>recoveries</u> ¹	
agency error	11,599
nonfraud	15,566
fraud	<u>98,241</u>
<u>Total Recoveries</u>	\$1,272,362

¹ A policy permitting recoupment of Food Stamp program overpayments through benefit reduction did not go into effect until August 1984.

Source: Department of Income Maintenance.

and determine if funds will be recovered through lump sum or periodic repayments, or, for active clients, through the reduction of assistance. The recovery mechanism established by district office investigators is instituted by resources staff at the Department of Income Maintenance central office.

If a recipient has assets or is employed, recovery is first obtained from these resources. In most situations, however, overpaid clients do not have assets or income. Overpayments are then recouped by reducing the assistance award. Generally, overpayments on cases that have subsequently been discontinued are recovered through a billing process. As Table II-27 shows, almost \$1.3 million in overpayments were recovered through resources units efforts during state fiscal year 1984.

In addition to clarifying eligibility and investigatory overpayments and alleged fraud resources, investigators secure claims against client income and assets on behalf of the state. Resources unit efforts in this area include placing liens and mortgages on real property, assigning interest from pending claims (e.g., insurance settlements), and making recoveries from the estates of deceased clients. The units are also responsible for investigating and establishing support contributions from legally liable relatives of assistance recipients. Although not related to error prevention and detection, several million dollars are recovered for the state each year through these various efforts. (See Table II-28.)

Table II-28. Resources Units' Recoveries from Recipient Income and Assets.

	<u>FY 83</u>	<u>FY 84</u>
Liens and Mortgages	\$ 643,812	\$ 992,269
Title XIX	1,776,339	2,695,731
Assigned Life Insurance and Burial Reserves	283,650	258,291
Decedent Estates	1,303,990	1,502,710
Assignment of Interest in Claims	1,898,475	2,220,024
Legally Liable Relative Contributions	145,809	103,279
Other	<u>309,146</u>	<u>290,390</u>
Total	\$6,361,221	\$8,062,694

Source: Department of Income Maintenance.

Information on resources units' accomplishments during the first six months of calendar year 1984 is presented in Table II-29. As the table shows, there is a large backlog of pending resources investigations referrals. Most of the pending referrals are requests for investigations of legally liable relatives, the lowest priority function of the resources units. Resources units give highest priority to referrals from intake units concerning applicant eligibility since applications must be processed within specific time frames. Referrals requiring the securing of claims against client assets or income also are given priority, again because of time limits established for taking these types of actions.

Table II-29. District Office Resources Units Workload and Staffing Data.

	<u>Jan.84</u>	<u>Feb.84</u>	<u>Mar.84</u>	<u>Apr.84</u>	<u>May 84</u>	<u>June 84</u>
<u>No. Referrals</u>						
Received	3,507	3,613	3,824	3,679	3,778	3,204
Completed	3,481	3,635	3,946	3,310	3,879	3,644
Pending	5,894	5,663	5,649	6,012	6,061	5,621
<u>No. Investigators</u>	45	46	44.5	42	42.5	43.5
<u>Completed Referrals</u>						
<u>Per Investigator</u>	77.4	79.0	88.7	78.9	91.3	83.8

Source: Department of Income Maintenance.

CHAPTER III

ANALYSIS OF ELIGIBILITY AND PAYMENT ERROR

One measure used by the program review committee to evaluate the effectiveness of the error prevention and detection efforts of the Department of Income Maintenance was its excess payment error rates. These rates are made up of payments to ineligible clients and overpayments to eligible clients. Error rates for the AFDC, Food Stamp, and Medicaid programs, the department's three major assistance programs, are developed by the agency's quality control unit in accordance with federal requirements.

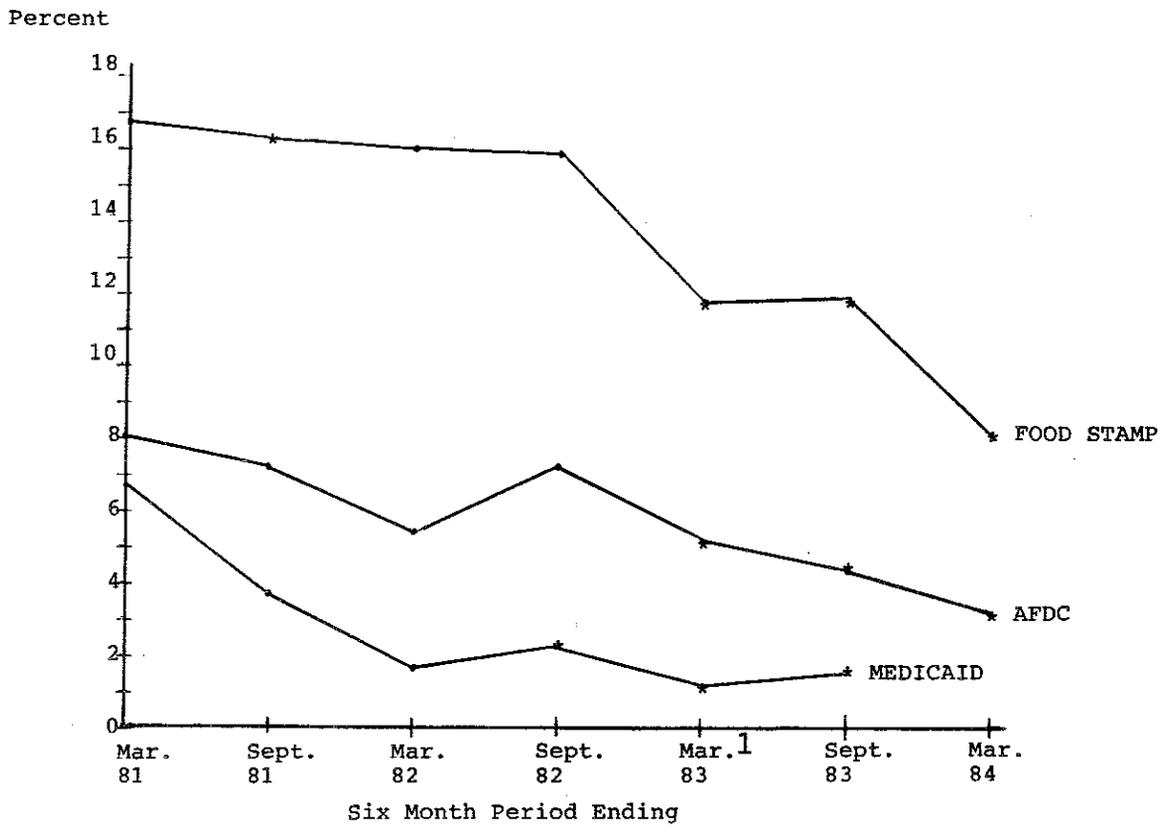
Error rates for the AFDC, Food Stamp, and Medicaid programs over the past three and one-half years were analyzed by the program review committee to determine trends and make comparisons among programs. Connecticut's error rates were also compared with federal target rates and rates of other states. Similarities and differences among the individual district office error rates for the AFDC and Food Stamp programs were examined as well. AFDC and food stamp error rates, which have been consistently higher than federal targets, were additionally analyzed in terms of the major causes and reasons for such errors.

Trends

Figure III-1 plots the Department of Income Maintenance's error rates for the Food Stamp, AFDC and Medicaid programs over the past three and one-half years. The Food Stamp program has experienced the highest error rate overall, at 16.7 percent in a six month period ending in March 1981. Medicaid has attained the lowest error rate of all three programs, with a 1.1 percent error rate during the October-March 1983 period. All three programs have experienced a downward trend in error rate levels since March 1981.

The Medicaid error rate is clearly far below the rates in the AFDC and Food Stamp programs. The department maintains a low Medicaid error rate for a variety of reasons. Generally, the department workers determining eligibility for medical assistance have more time to make a decision than in either the Food Stamp or AFDC programs. A food stamp eligibility determination must be made within 30 days under federal regulations while a worker has up to 60 days in the Medicaid program. This allows the eligibility technician more time to verify the applicant's information and make a correct decision. Also, the Medicaid population tends to be older and more stable than those in the other public assistance programs.

Figure III-1. Food Stamp, AFDC, and Medicaid Program Error Rates, October 1980 - March 1984.



* = state computed error rate subject to federal review and adjustment

¹ Food stamp error rates no longer include underissuance error after September 1982.

Source: LPR&IC.

Federal regulations have remained fairly constant in the Medicaid Program while the AFDC and Food Stamp programs have undergone many policy changes over the past three years. This contributes to problems of disseminating and implementing policy changes in those two programs.

Table III-1. Dollar Value of AFDC, Medicaid, and Food Stamp Program Error Rates (dollars in thousands).

Six Month Period Ending	Gross Expenditures ¹ and Dollar Value of Error Rate		Coupon Value ² and Dollar Value of Error Rate
	AFDC	Medicaid	Food Stamp
Mar. 81	\$104,416 8.0% = \$8,353	\$186,498 6.6% = \$12,309	\$ 29,288 16.7% = \$4,891
Sept. 81	\$108,230 7.1% = \$7,684	\$199,760 3.6% = \$7,191	\$32,317 16.2%* = \$5,235
Mar. 82	\$108,750 5.3%* = \$5,764	\$212,020 1.6% = \$3,392	\$32,753 16.0% = \$5,240
Sept. 82	\$108,159 7.2% = \$7,787	\$237,345 2.7%* = \$6,408	\$31,934 15.8% = \$5,046
Mar. 83	\$111,764 5.2%* = \$5,812	\$249,898 1.1%* = \$2,749	\$36,145 11.7%* = \$4,229
Sept. 83	\$114,140 4.3%* = \$4,908	\$262,919 1.5%* = \$3,944	\$34,917 11.8%* = \$4,120
Mar. 84	\$115,718 3.1%* = \$3,587	\$277,351 N/A	\$33,761 8.0%* = \$2,701

¹ Total state and federal funds expended.

² Total dollar value of food stamp coupons issued (100% federally funded).

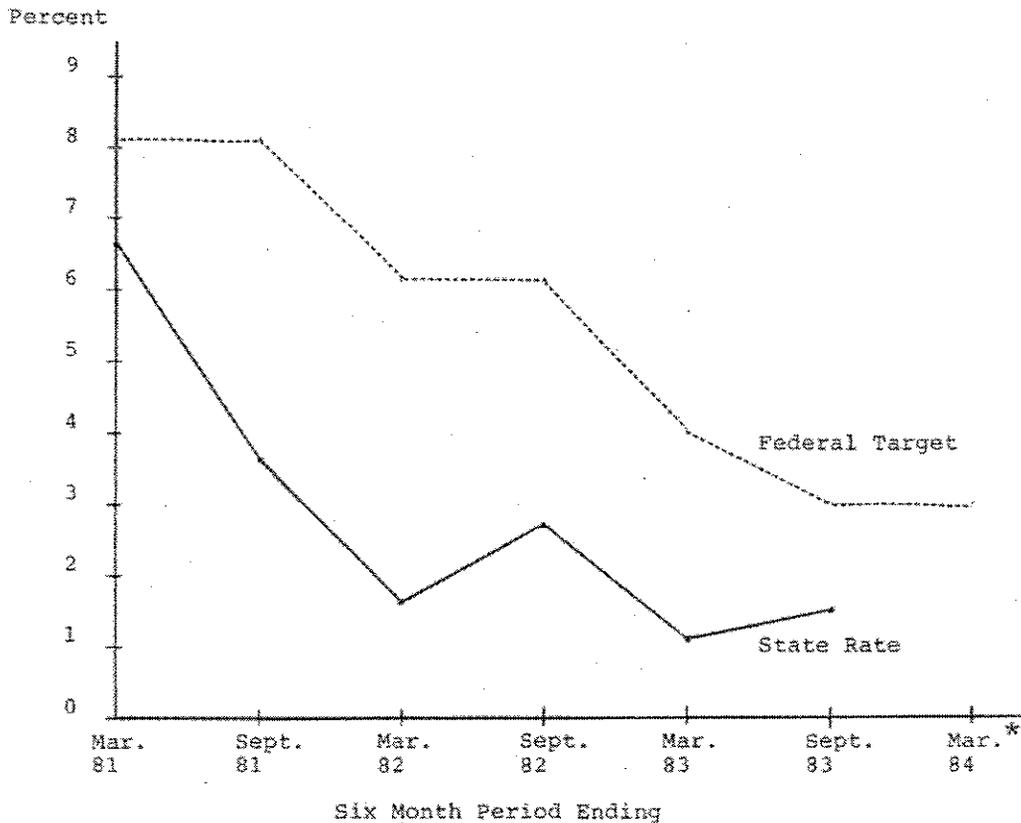
* State computed error rate subject to federal review and adjustment.

N/A = Not available.

Source: LPR&IC.

Additionally, the department has emphasized the urgency for making correct eligibility determinations to keep Medicaid error rates low because of a high dollar cost of error. Table III-1 shows what the dollar value of an error means in each program. For example, in March 1981, a 6.6 percent error rate in Medicaid actually equaled \$12,309,000, while an 8 percent error in that same period for AFDC resulted in a dollar error of \$8,353,000. Clearly, because the Medicaid program involves substantial sums of money, the same percent of error will be more costly in that program than in either the AFDC or Food Stamp programs.

Figure III-2. Medicaid Program Error Rate.



*State computed error rate for March 1984 not available.

Source: LPR&IC.

Medicaid error rates, as shown in Figure III-2 have been consistently below federal target rates. However, both the AFDC and Food Stamp program error rates are of concern because they continue to exceed the federal target. Although the AFDC error rate has been above the federal target since September 1982, the most recently state computed rate is close to the federal target. Figure III-3 shows that the federal target rate for the October - March 1984 period is 3 percent, and the state computed error rate is approaching that figure with 3.1 percent.

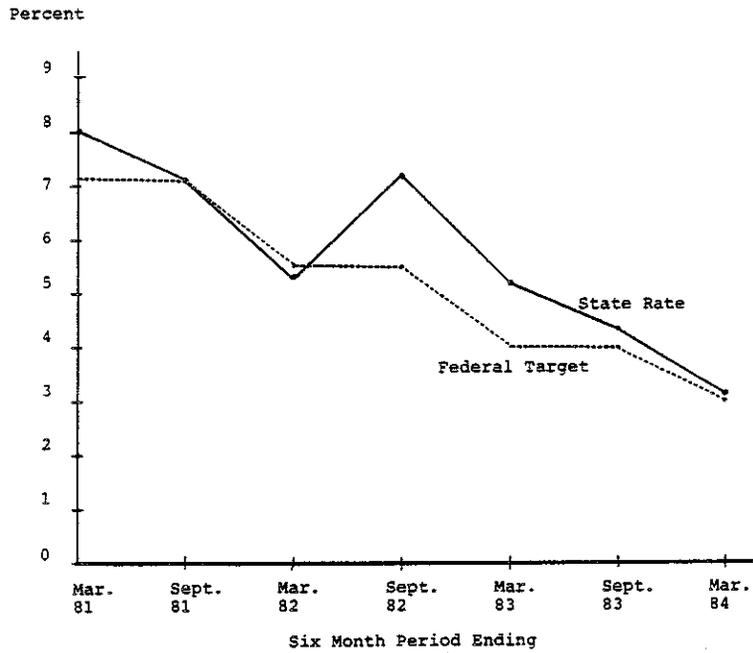
As can be seen in Figure III-4, food stamp error rates remain high. Fewer staff resources assigned to this area and higher average case loads seem to contribute to an excessive error rate. The "fluid" nature of the clientele, that is the fact the clients' eligibility status fluctuates, making their participation in the food stamp program vary month to month, is also a factor. Because of the large number of applicants, department workers spend less time in the initial food stamp client interviews than other public assistance program interviews.

Additionally, the food stamp error rate includes both non-public assistance and public assistance food stamps. Figure III-5 illustrates the trends for both program categories. Clearly, the nonpublic assistance food stamp error rate is much higher than the public assistance food stamp error rate. The six-month period ending in September 1983 indicates that the nonpublic assistance error rate is at 20.3 percent; the public assistance error rate was at 5.8 percent for the same period. In fact, in the April-September 1983 review period, 71 percent of the food stamp dollars paid in error can be attributed to the nonpublic assistance program.

Public assistance food stamps are awarded in conjunction with AFDC benefits. Since AFDC is 50 percent state funded, Connecticut has made efforts to reduce the AFDC error rate and consequently, the public assistance food stamp rate has also come down.

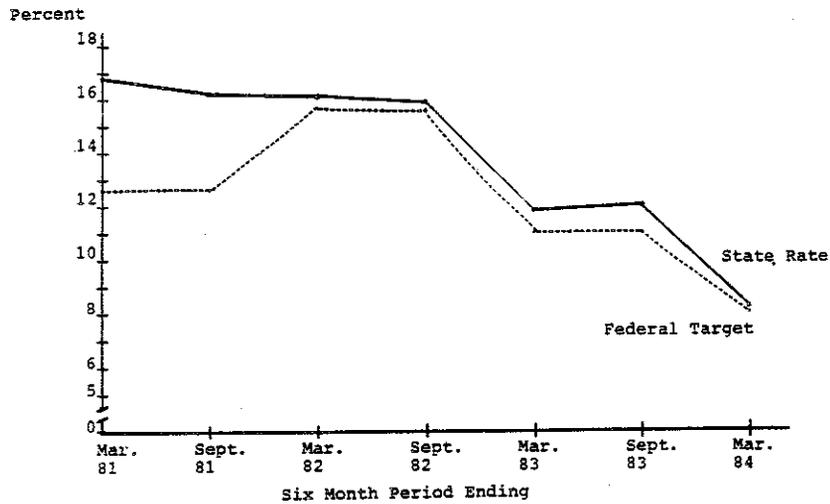
However, nonpublic assistance food stamps are generally for the working poor. This category is more error prone because the client's earnings and wages vary. If these monetary changes are not detected within a federally specified number of days, the case is found to be in error.

Figure III-3. AFDC Program Error Rate.



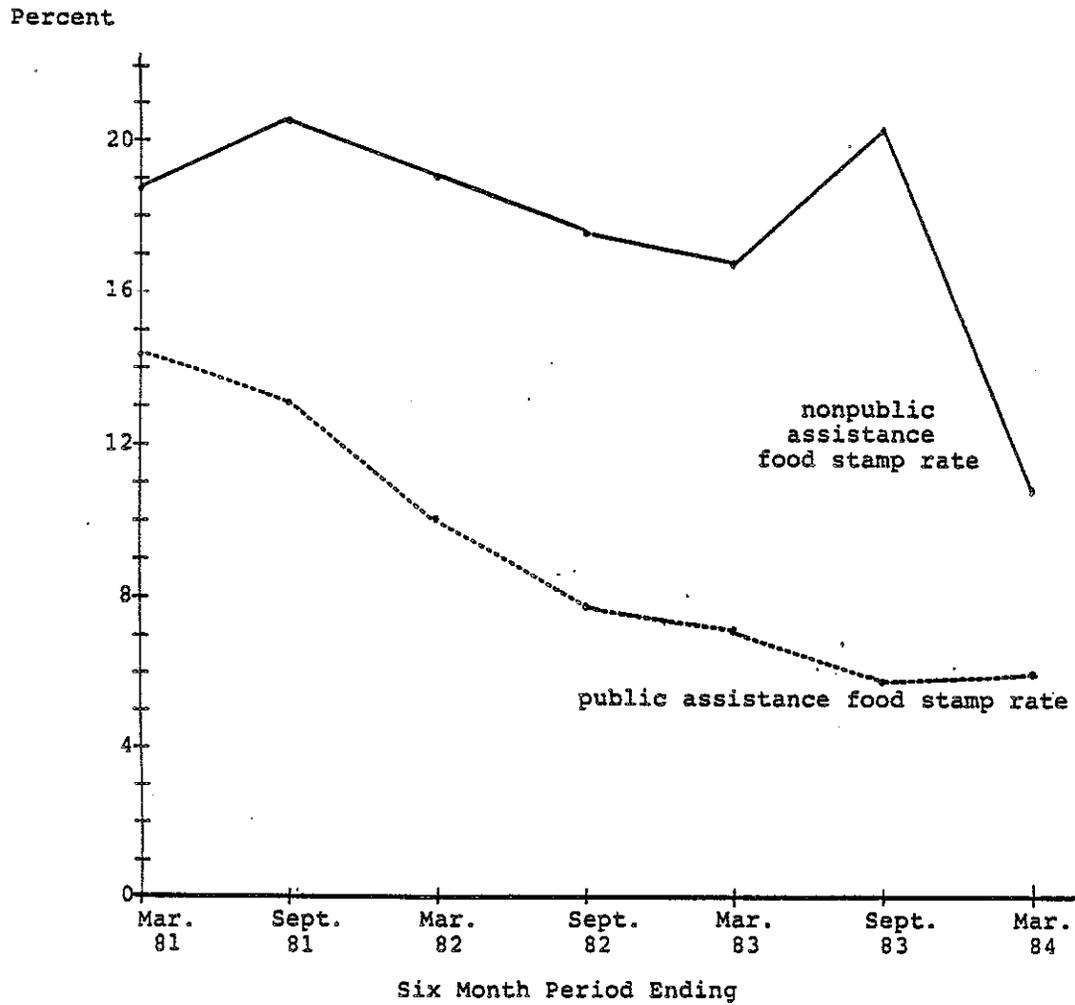
Source: LPR&IC.

Figure III-4. Food Stamp Program Error Rate.



Source: LPR&IC.

Figure III-5. Public Assistance and Nonpublic Assistance
Food Stamp Program Error Rates.*



*State computed error rates.

Source: LPR&IC.

New federal policies and other changes contribute to increased food stamp error rates. Delay in disseminating and implementing federal policy changes may result in increased errors.

The program review committee audit revealed that the varied district office structures that administer the nonpublic assistance food stamp program provides for little coordination among offices. This apparent lack of uniformity was also identified in a recent department study of the nonpublic assistance Food Stamp program. The possibility exists that state and federal policies are not implemented uniformly when procedures and organizations differ significantly among offices.

During the course of the program review committee study, it appeared that error control within the Food Stamp program had been a low priority for the department. Benefits in the program are 100 percent federally funded. Until recently there has been little incentive for the state to reduce error rates. However, the federal government has begun to financially penalize states that exceed the federal target error rates.

Although the error rate sanction system for AFDC was established in 1974, Congress did not create such a system for the Food Stamp program until 1980. Connecticut's first notification of a potential major sanction in the Food Stamp program involved a \$1.2 million liability for the October 1980 to March 1981 period. The state was granted a waiver of liability for this sanction. However, the state was sanctioned again for \$1.3 million in the Food Stamp program for the April to September 1981 period and was not granted a waiver. Although the state has paid the penalty, it is currently involved in appealing the sanction.

Comparisons to Other States

The most recent available comparison data on AFDC, Food Stamp, and Medicaid error rates for all states is for the October-March 1982 period. Table III-2 shows that Connecticut's AFDC error rate is below the national average. Compared to others, Connecticut's performance was better than more than half of all states. Specifically, among the New England states, Connecticut had the lowest error rate at 5.7 percent while New Hampshire had the highest at 6.4 percent. (See Appendices C, D, and E for national comparisons of all states' error rates for the AFDC, Food Stamp, and Medicaid programs.)

Table III-2. AFDC Error Rates--New England State Comparisons for October - March 1982.

State	Percent of Total Benefits Issued in Error	National Ranking (of 51 states)
United States	7.9%	
Connecticut	5.7	34
Maine	5.9	31
Massachussetts	6.2	28
New Hampshire	6.4	25
Rhode Island	6.2	28
Vermont	6.3	26

Source: U.S. General Accounting Office, Federal and State Liability for Inaccurate Payments of Food Stamp, AFDC, and SSI Benefits (April 1984) p.36.

For food stamps, however, Connecticut's error rate has been among the highest in the country; it was fifth highest as of March 1982. Even compared to other New England states, Connecticut still has a high error rate, exceeded only by New Hampshire. The

Table III-3. Food Stamp Error Rates--New England State Comparisons for October - March 1982.

State	Percent of Total Benefits Issued in Error	National Ranking (of 51 states)
United States	12.2%	
Connecticut	16.5	5
Maine	9.7	39
Massachusetts	15.9	7
New Hampshire	17.7	3
Rhode Island	12.0	26
Vermont	12.1	23

Source: U.S. General Accounting Office, Federal and State Liability For Inaccurate Payments of Food Stamp, AFDC, and SSI Benefits (April 1984) p.31.

New England states are evenly split, with Connecticut, Massachusetts and New Hampshire having error rates among the highest in the nation while Maine, Rhode Island, and Vermont have error rates lower than the 12.2 percent national average.

In the Medicaid program, Connecticut performs favorably compared with other error rates in the country. The state is well below the federal target of 6.1 percent for the October to March 1982 period. Connecticut has a lower Medicaid error rate than about three-quarters of all the other states. Table III-4 illustrates that compared to other New England states, Connecticut has the second lowest error rate while Maine has the highest error rate at about 6.6 percent.

Table III-4. Medicaid Error Rates--New England State Comparisons for October - March 1982.

State	Percent of Total Benefits Issued in Error	National Ranking (of 51 states)
Federal Target	6.1	
Connecticut	2.14	37
Maine	6.59	3
Massachusetts	4.33	12
New Hampshire	2.65	28
Rhode Island	1.74	42
Vermont	2.54	30

Source: U.S. Health Care Financing Administration.

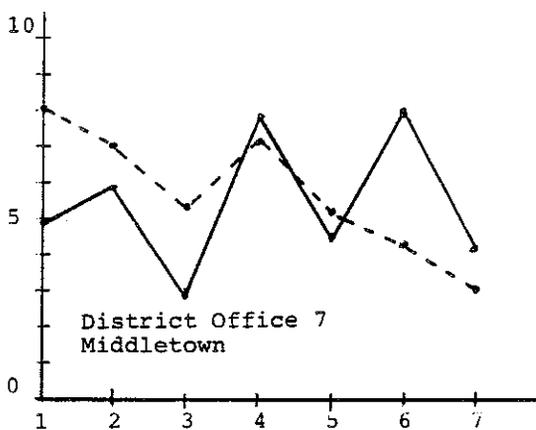
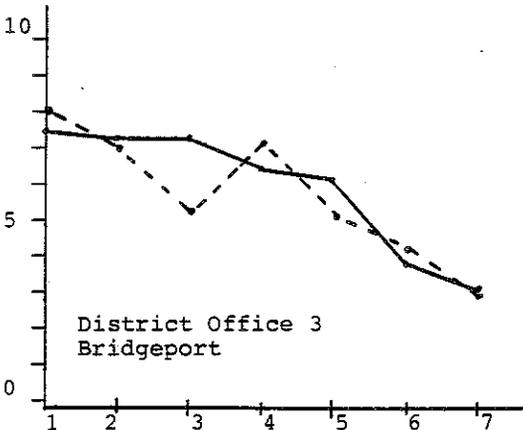
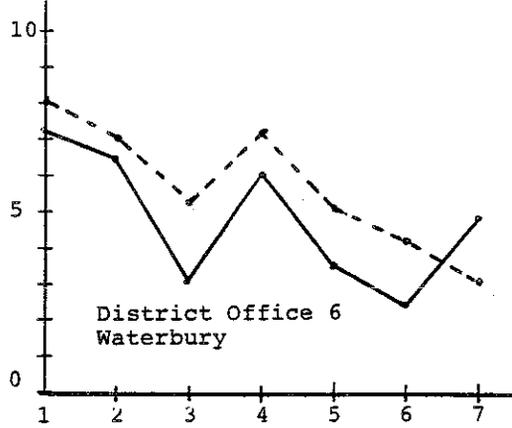
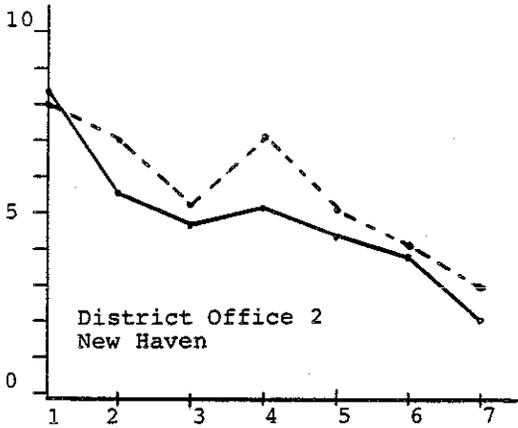
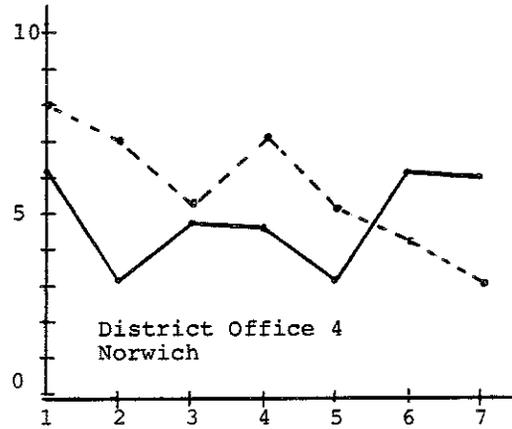
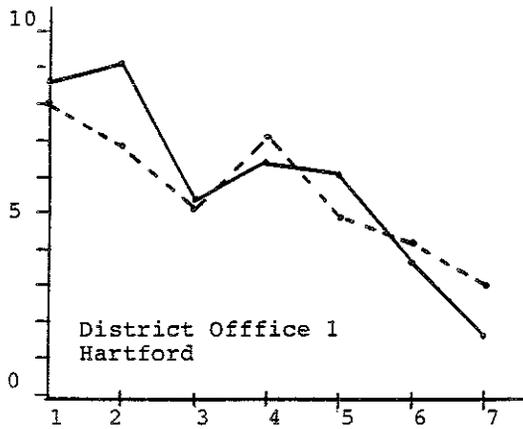
District Office Error Rates

In addition to statewide error rates, error rates are developed for each district office. Individual office rates for the AFDC and Food Stamp programs over the past three and one-half years are presented in Figures III-6 and III-7, respectively. Comparable district office error rates for the Medicaid program were not available.

Both figures show that district office error rates vary substantially among offices and even within offices over time. With regard to the AFDC error rates shown in Figure III-6, the three larger district offices, Hartford, New Haven, and Bridgeport, have

Figure III-6. District Office AFDC Program Error Rates.

Percent



Key:

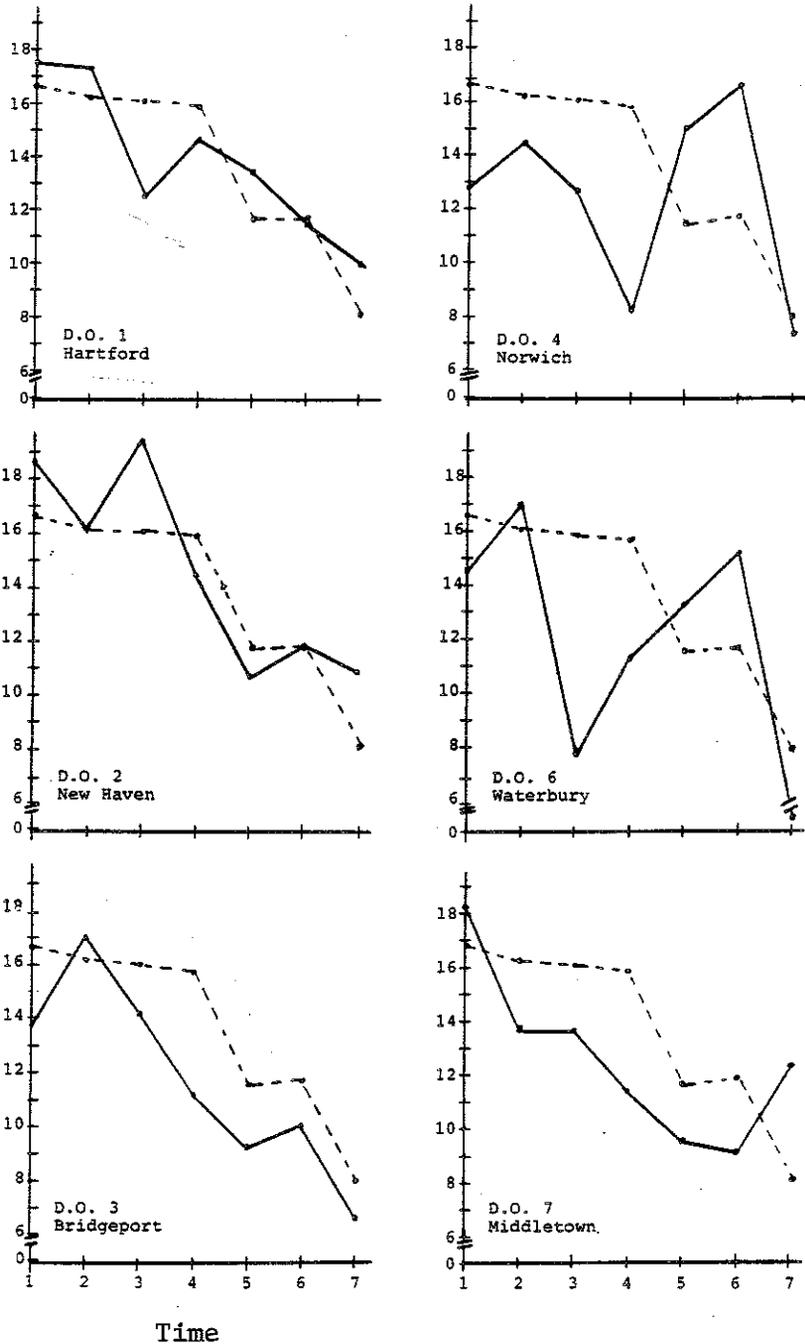
- District Office Rate
- - - Statewide Rate

Time = six month periods ending
 Mar.81(1), Sept.81(2), Mar.82(3),
 Sept.82(4), Mar.83(5), Sept.83(6),
 Mar.84(7).

Source: LPR&IC.

Figure III-7. District Office Food Stamp Program Error Rates.

Percent



Key:

— District Office Rate

- - - Statewide Rate

Time = six month periods ending
 Mar.81(1), Sept.81(2), Mar.82(3),
 Sept.82(4), Mar.83(5), Sept.83(6),
 Mar.84(7).

Source: LPR&IC.

experienced fairly steady declines in error rates, although only New Haven has generally been below the statewide AFDC error rate. The three smaller offices, Norwich, Waterbury, and Middletown, have exhibited more erratic patterns, with Middletown showing the most dramatic increases and decreases in error rates.

According to Figure III-7, Food Stamp program error rates at the district office level demonstrate even more variation than AFDC rates. The only consistent pattern appears in the Middletown office, which has had relatively low and, until recently, steadily declining food stamp error rates. In contrast, error rates in the other offices rise and fall, sometimes sharply as can be seen in the Norwich and Waterbury offices.

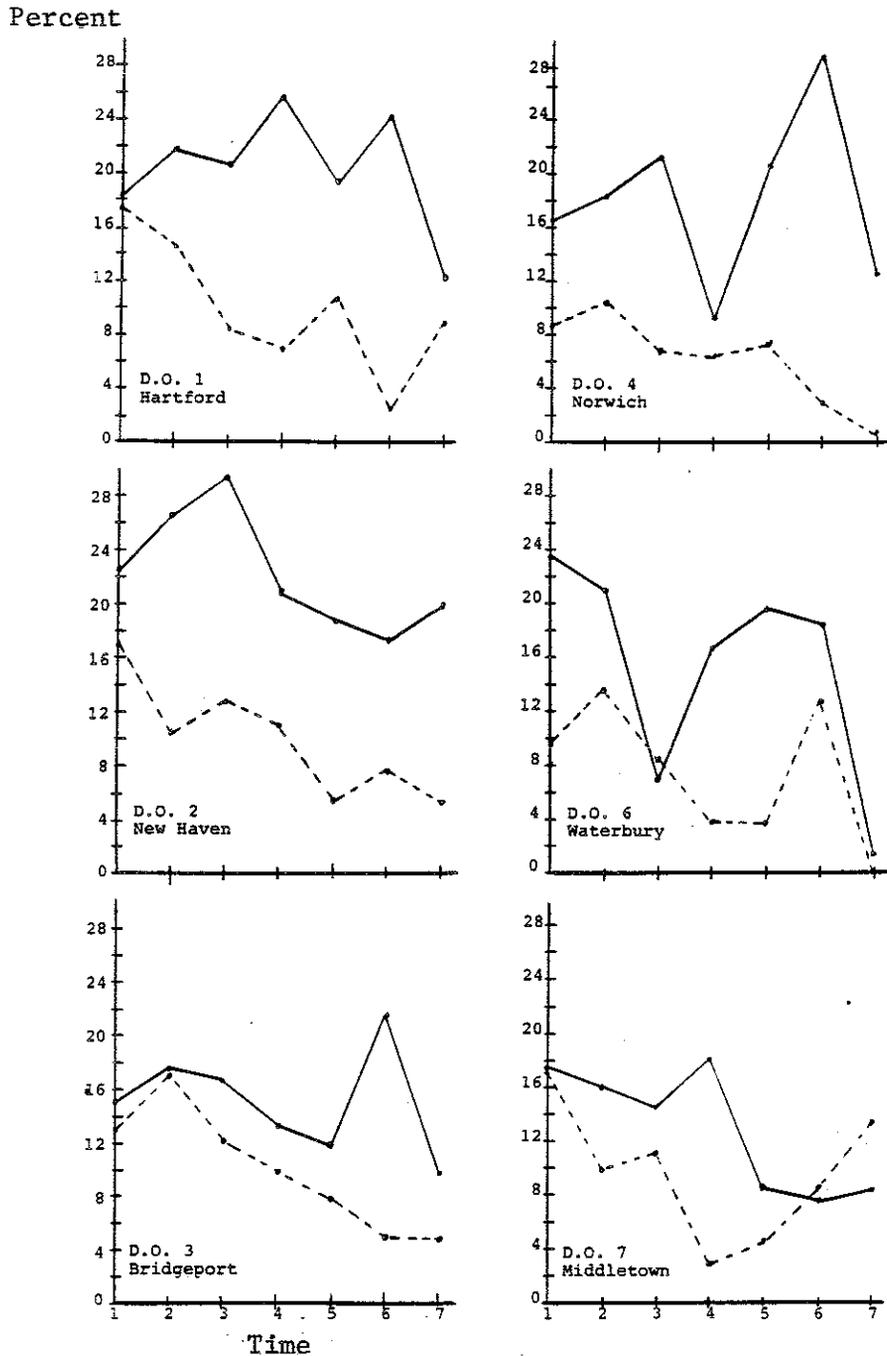
District office error rates for the two components of the Food Stamp program, public assistance and nonpublic assistance food stamps, were also reviewed. Like the overall district office food stamp error rates, the component error rates shown in Figure III-8 vary widely among offices and over time. Furthermore, the district office component rates generally mirror the statewide pattern in which nonpublic assistance food stamp error rates are far above error rates for public assistance food stamp cases.

To further examine the variations in AFDC and food stamp error rates, the program review committee staff performed a statistical test of the differences. The purpose of conducting the procedure was to determine if there were any statistically significant differences in the district office error rates.

Based on the results of the analysis, the variations in both AFDC and overall food stamp error rates at the district office level are not statistically significant. In other words, there are no real differences in district office rates for these programs. Variation in the district office nonpublic assistance food stamp error rates, however, was found to be statistically significant.

It is recognized that these results must be interpreted cautiously since the analysis is based on a limited amount of error rate data; AFDC and food stamp rates for each district office for only seven six-month periods (October to March 1981 through October to March 1984) were included. Due to the data limitations, the program review committee did not attempt further analysis to determine how the district offices varied in terms of nonpublic assistance food stamp error rates. In addition, nonpublic assistance food stamp procedures and structures in all offices are undergoing a major reorganization. The reorganization, which becomes effective in February 1985, is based on the results of a Department of Income Maintenance study of district office nonpublic assistance food stamp operations.

Figure III-8. District Office Public Assistance and Nonpublic Assistance Food Stamp Program Error Rates.



Key:

—— NPA Food Stamp Rate
 - - - PA Food Stamp Rate

Time = six month periods ending
 Mar.81(1), Sept.81(2), Mar.82(3),
 Sept.82(4), Mar.83(5), Sept.83(6),
 Mar.84(7).

Source: LPR&IC.

The department's study, which was prompted by the excessive nonpublic assistance food stamp error rates, was completed in March 1984. A major finding was that each of the 13 district offices and suboffices had developed a distinctly different way of operating the nonpublic assistance food stamp program. In addition, the study revealed substantial variations in the nonpublic assistance food stamp staff workloads as well as some significant differences in work environments.

To standardize both structure and procedure, a reorganization plan was developed by central office staff with input from district office personnel. Along with greater uniformity, the agency expects the reorganized district office nonpublic assistance food stamp operations will promote more accountability for case decisions, provide better management controls, and improve worker productivity in all offices.

Causes of Error

For cases found to contain eligibility and payment errors, quality control reviewers identify whether the errors are client-caused or agency-caused. Under the definitions used by the Department of Income Maintenance, client-caused error is the result of clients either not reporting information necessary to determine eligibility or reporting incomplete or incorrect eligibility information to the department. Agency error occurs when department workers take incorrect actions or fail to perform required activities concerning eligibility or payment decisions.

Data on the causes of error in the AFDC and Food Stamp programs, where error rates continue to exceed federal targets, are presented in Tables III-5 and III-6, respectively. For both programs, the majority of errors are client-caused. Table III-5 shows that 68 percent of the AFDC error rate during the period ending September 1983 was due to client-caused error while 32 percent was due to agency-caused error. Client-caused error accounted for 72 percent of the food stamp error rate for October 1983 through March 1984 according to Table III-6. Client-caused error was slightly higher (77 percent) for the public assistance (PA) food stamp component and slightly lower (69 percent) for nonpublic assistance (NPA) food stamps during the same period.

Information about whether misrepresentation was involved in client-caused error has been collected for the AFDC program since the March 1983 period and since the September 1982 period for the Food Stamp program. In both programs, as Tables III-5 and III-6 show, most client-caused error involves misrepresentation and almost half of all program error is the result of clients misrepresenting eligibility information.

Table III-5. AFDC Program: Client versus Agency Caused Error (percent of error dollars according to reason), October 1981 - September 1983.

	Six Month Period Ending			
	Sept. 83	Mar. 83	Sept. 82	Mar. 82
<u>Client-Caused Error</u>				
<u>Error Rate*</u> (client-caused)	2.9	4.6	5.4	4.4
% Info. not reported				
% no misrepresentation	19.5	20.2	N/A	N/A
% misrepresentation	43.9	43.2	N/A	N/A
Total	<u>63.4</u>	<u>63.4</u>	82.2	74.1
% Info. incorrect/complete				
% no misrepresentation	1.3	2.8	N/A	N/A
% misrepresentation	3.3	22.8	N/A	N/A
Total	4.4	<u>25.6</u>	6.1	9.0
<u>Total % client-caused</u>	<u>67.8</u>	<u>89.0</u>	<u>88.3</u>	<u>83.1</u>
<u>Total % misrepresentation</u>	47.2	66.0	N/A	N/A
<u>Agency-Caused Error</u>				
<u>Error Rate*</u> (agency-caused)	1.4	0.6	0.7	0.9
% Policy incorrectly applied				
% Reported info. disregarded	5.9	0.8	1.1	3.7
% Failure to follow-up inconsistent incomplete information	15.5	5.1	1.5	7.2
% Failure to follow-up impending change	3.8	0.6	4.8	1.6
% Failure to verify required information	1.6	0.8	0.7	0.6
% Other	5.1	3.2	3.7	3.4
Total	-	0.4	0.1	0.5
<u>Total % agency-caused</u>	<u>31.9</u>	<u>10.9</u>	<u>11.9</u>	<u>17.5</u>

* State computed error rates, subject to federal review and adjustment.
N/A = Not available

Source: Department of Income Maintenance.

Table III-6. Food Stamp Program: Client versus Agency Caused Error, October 1981 - March 1984.

	Six Month Period Ending				
	Mar. <u>84</u>	Sept. <u>83</u>	Mar. <u>83</u>	Sept. <u>82**</u>	Mar. <u>82**</u>
<u>FOOD STAMP</u>					
<u>Error Rate*</u>	8.0	11.8	11.6	12.2	3.8
% Client-caused	72	69	76	72	69
% No misrep.	25	23	34	23	N/A
% Misrep.	47	46	42	49	N/A
% Agency-caused	28	31	24	28	31
<u>PA FOOD STAMP</u>					
<u>Error Rate*</u>	6.0	5.8	7.1	7.8	10.0
% Client-caused	77	63	75	67	67
% No. misrep.	16	17	28	19	N/A
% Misrep.	61	46	47	48	N/A
% Agency-caused	23	37	25	33	34
<u>NPA FOOD STAMP</u>					
<u>Error Rate*</u>	11.0	20.3	16.7	17.5	19.0
% Client-caused	69	71	77	74	71
% No. misrep.	33	25	37	25	N/A
% Misrep.	36	46	40	49	N/A
% Agency-caused	31	29	23	26	29

* State computed error rates.

** Underinsurance error included in rates for these periods.

N/A = Not Available

Source: Department of Income Maintenance, Office of Management Planning and Evaluation.

Approaches to preventing and detecting error differ depending on the cause of error. To address client-caused error, efforts are aimed at verifying information provided by applicants or active clients and checking collateral sources to determine if relevant eligibility information has not been reported. Since the majority of AFDC and food stamp error is client-caused, the Department of Income Maintenance has focused many of its recent corrective actions on expanding existing collateral checks and developing new computer crossmatching capabilities. For example, during the committee's review the department was developing a new landlord letter procedure to verify the information AFDC and food stamp applicants provide on rent payment, utility responsibility, and other related eligibility factors.

Since 1982, AFDC cases have been crossmatched against labor department wage and unemployment files to determine if information on earned income has been fully and accurately reported by clients. Labor department crossmatching was later extended to food stamp cases to prevent and detect client-caused wage and salary errors within that program. Crossmatching of income maintenance cases with motor vehicle department records, which was initiated in 1983, is similarly intended to verify reported information and detect unreported vehicle ownership. A pilot project to crossmatch Department of Income Maintenance cases with bank records was conducted in the spring of 1984 as a corrective action for reducing errors related to inaccurately reported or unreported bank accounts.

The department's home visit project, which was expanded statewide in October 1984, was another corrective action aimed at client-caused error. Through the home visit process, AFDC applicants are re-interviewed about their eligibility in their homes by district office eligibility workers. According to Department of Income Maintenance officials, the home visit, in addition to allowing workers to personally verify eligibility factors such as the client's living arrangement and household composition, permits follow-up on incomplete information and sometimes results in the reporting of new information prior to the final decision on whether to grant assistance.

Department of Income Maintenance efforts to address agency-caused error include activities directed at improving the skills of the workers responsible for making eligibility and payment decisions, clarifying agency policies and procedures, and revising ineffective or inefficient policies or procedures. These activities range from special projects like the proposed revision of the department's massive policy manual to routine functions such as the agency's staff training program.

From a review of training program statistics, it appears that reducing agency-caused error has been a primary objective of department training activities. Nearly 80 percent of the 29,000 hours of training provided in state fiscal year 1984 were in support of improving administration of the AFDC and Food Stamp programs. Much of this training was focused on increasing worker knowledge of specific program policies and procedures, for example, eligibility criteria or verification requirements. In addition, many training hours were devoted to general skill improvement sessions like interviewing techniques and use of computerized data (e.g., labor department employment files, etc.) that emphasize ways district office workers can prevent and detect error.

Significant training resources have been devoted to improving interviewing skills since district office workers can avoid client error as well as agency error through thorough questioning of applicants and active clients. Over the past three fiscal years, approximately 90 percent of the agency's eligibility technicians have received training on client interviewing.

Error Elements--Problem Areas

Through the quality control process, errors can be traced to any one or several of the various elements that impact client eligibility and payment levels. Quality control findings on error elements are used to develop corrective actions that address the major problem areas within an assistance program.

Major elements of the AFDC error rate over four recent quality control review periods are shown in Table III-7. Actual error rates (percent of program dollars paid in error) for each element are contained in the top half of the table while the rankings and percentages of the total error rate appear in the bottom half. For example, in March 1984, the 0.7 percent error rate of the wages and salaries element made it the number one AFDC element, accounting for 22.6 percent of the total program error rate of 3.1 percent.

As Table III-7 indicates, the three largest error elements for the AFDC program at present are bank accounts, work/WIN program registration, and wages and salaries. Bank accounts/cash on hand, and wages and salaries are continually among the top three error elements in AFDC cases. The primary corrective actions undertaken by the Department of Income Maintenance to reduce these error elements in the AFDC and the Food Stamp programs are the labor and bank computer crossmatches.

It is still too early to know the results of the bank match project, and the department does not collect information on the number of applicant or active cases that are denied assistance or discontinued because of labor match findings. However, overpayment

Table III-7. AFDC Program: Major Error Elements, April 1982 - March 1984.

Six Month Period Ending	Excess Payment Error Rate										Total*
	Bank Acct. or Cash on Hand	Work/ Win Reg.	Wages and Salaries	Deemed Income	Living Arran./ Household Composition	Real Property	Vehicles	Cont. Absence	Other		
Sept. 82	1.0	0.4	0.8	-	0.6	0.5	1.3	0.7	1.0		6.2%
Mar. 83	0.7	0.2	0.8	**	0.5	0.2	1.3	0.4	1.1		5.2%
Sept. 83	1.0	0.6	0.5	0.5	0.3	0.2	0.2	0.2	0.8		4.3%
Mar. 84	0.5	0.4	0.7	0.1	0.2	-	0.1	0.3	0.8		3.1%
Rank and Percent of Error											
Sept. 82	$\frac{2}{16.8}$	$\frac{7}{6.9}$	$\frac{3}{12.6}$	-	$\frac{5}{9.1}$	$\frac{6}{7.5}$	$\frac{1}{20.4}$	$\frac{4}{11.2}$	$\frac{15.4}{15.4}$		100.0%
Mar. 83	$\frac{3}{14.0}$	$\frac{8}{4.0}$	$\frac{2}{14.8}$	$\frac{14}{0.7}$	$\frac{4}{9.6}$	$\frac{8}{3.6}$	$\frac{1}{24.0}$	$\frac{5}{8.5}$	$\frac{21.0}{21.0}$		100.0%
Sept. 83	$\frac{1}{23.1}$	$\frac{2}{14.4}$	$\frac{3}{11.0}$	$\frac{4}{10.3}$	$\frac{5}{7.6}$	$\frac{6}{5.2}$	$\frac{7}{4.9}$	$\frac{8}{4.7}$	$\frac{18.7}{18.7}$		100.0%
Mar. 84	$\frac{2}{16.1}$	$\frac{3}{12.9}$	$\frac{1}{22.6}$	$\frac{6}{3.2}$	$\frac{5}{6.5}$	-	$\frac{6}{3.2}$	$\frac{4}{9.7}$	$\frac{25.8}{25.8}$		100.0%

* May not add due to rounding.
** Less than 0.05%.

Source: Department of Income Maintenance.

information from the resources unit of the Office of Field Operations seems to indicate that the labor match is effective in detecting unreported earned income. In FY 84, 1,690 cases with unreported income involving total recipient overpayments of \$1.78 million were discovered by crossmatching AFDC and food stamp cases with labor department records.

Errors concerning the eligibility requirement that clients register with the work incentive (WIN) program, seem to be a growing problem for the AFDC program. While currently the third largest error element, the work/WIN registration element had been ranked seventh and eighth in earlier periods included in Table III-7. During the committee's performance audit, corrective actions to address this element were still in the planning phase.

Conversely, motor vehicle ownership, which had been the number one AFDC error element, is declining as a problem area as indicated by the table. As of March 1983, vehicle-related error accounted for 24 percent of all AFDC dollars paid in error, but one year later less than 5 percent of the program error rate was attributable to the motor vehicle element. Based on this data, it appears that the department's motor vehicle computer crossmatching activities have been effective in addressing this error element.

Major problem areas for the Food Stamp program in terms of error elements are highlighted in Table III-8. Like the AFDC program, wages and salaries, and bank accounts/cash on hand are among the largest elements of the food stamp error rate. However, errors concerning wages and salaries appear to be a more serious problem within the Food Stamp program. In the two most recent periods shown in Table III-8, the wages and salaries error element accounts for just over half of all Food Stamp program error. This may be due to the fact that many food stamp clients, particularly nonpublic assistance food stamp clients, are employed ("the working poor") while only a small portion of the AFDC case load has earned income.

In addition, AFDC clients with earned income are subject to special monitoring through the monthly reporting process that aids in preventing errors due to wage or salary fluctuations. A monthly reporting system for food stamp clients with earned income is being instituted by the department as a corrective action during FY 85.

The three remaining major food stamp error elements for the most recent period contained in Table III-8, bank account/cash on hand, public assistance/general assistance benefits, and shelter deduction, together account for 25 percent of all program error. As noted above, the department's bank match project is aimed at reducing the bank account error element in both the Food Stamp and the AFDC program. Similarly, the landlord verification letter discussed above is expected to aid in preventing and detecting

Table III-8. Food Stamp Program: Major Error Elements,
April 1981 - March 1984.

<u>Error Element</u>	Six Month Period Ending					
	<u>Sept.81</u>	<u>Mar.82</u>	<u>Sept.82</u>	<u>Mar.83¹</u>	<u>Sept.83¹</u>	<u>Mar.84¹</u>
Wages and Salaries	6.6%	5.9%	4.1%	5.1%	6.0%	4.2%
Bank Acct/ Cash on Hand	1.2%	0.3%	0.8%	1.3%	1.3%	0.5%
PA or GA Benefits	1.3%	0.8%	1.2%	1.0%	1.1%	0.7%
Shelter Deduction	1.1%	1.1%	0.9%	0.7%	0.5%	0.8%
Other Earned Income	*	*	*	0.02%	0.4%	*
All Other	<u>6.0%</u>	<u>5.7%</u>	<u>5.2%</u>	<u>3.3%</u>	<u>2.5%</u>	<u>1.9%</u>
Error Rate[2]	16.2%	13.8%	12.2%	11.7%	11.8%	8.0%

* Other Earned Income included in All Other.

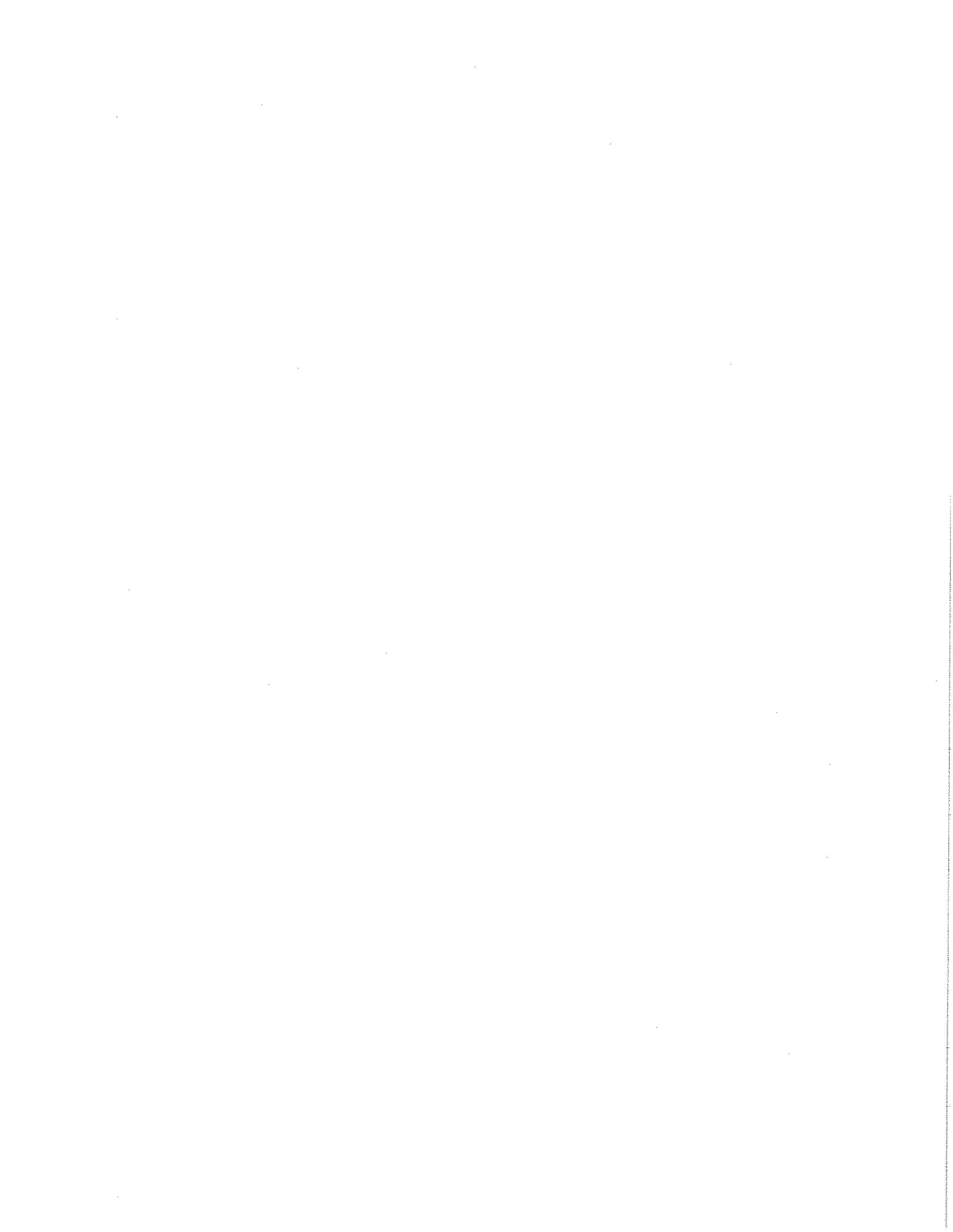
¹ Rates no longer include underissuance errors.

² Rates shown are state computed error rates, subject to federal review and adjustment.

Source: Department of Income Maintenance, Office of Management Planning and Evaluation.

shelter deduction errors in food stamp cases as well as reduce residence/living arrangement errors in AFDC cases.

Several corrective actions have been developed to address errors that result when information on the public assistance (PA) or general assistance (GA) payments a client is receiving is incorrect or misapplied in determining food stamp eligibility. The department is working to improve the exchange of information between the district office personnel or local general assistance administrators that have responsibility for a client's cash assistance and the eligibility staff that handle the food stamp aspects of a case. In addition, handbooks and desk references that outline policy differences between the AFDC and Food Stamp programs were recently revised and issued to all district office eligiblity workers. The reference materials are intended to reduce errors by clarifying eligibility and payment issues in combined public assistance/food stamp cases.



CHAPTER IV

FINDINGS AND RECOMMENDATIONS

The Legislative Program Review and Investigations Committee's analysis of error rate data indicates that the Department of Income Maintenance is making progress towards reducing error in its three major public assistance programs: AFDC, Food Stamp, and Medicaid. Throughout the committee's performance audit, the committee sought to identify the specific activities carried out by the department that have contributed to the reduction of eligibility and payment errors. In addition to evaluating current activities, the program review committee considered additional and alternative methods aimed at improving error prevention and detection.

Mandatory Verification Policy

At present, approximately 70 percent of the excess payment error in the AFDC and Food Stamp programs is caused by clients not reporting or reporting incomplete or incorrect information regarding eligibility. To address client-caused error, it is essential that district office workers verify all information provided by clients and explore through collateral sources possible unreported assets or income when determining eligibility.

The most recent department policy on what factors of eligibility must be verified was issued in 1968 and pertains to the application process. A 1981 policy revision only addresses the primary and alternative documents acceptable for verifying age, relationship, deprivation of support, and real property ownership. Policy bulletins have been issued concerning the required use of recently developed computerized motor vehicle and labor department information to check eligibility.

The Department of Income Maintenance has not, however, issued a single, comprehensive policy outlining what information provided by the client must be verified, what efforts must be made to explore possible unreported eligibility information, and what verification procedures, including collateral checks, must be utilized to determine and redetermine eligibility. As a result, the extent of the eligibility verification process frequently is a matter of individual worker judgment and can vary from office to office.

In the New Haven office, for example, a landlord letter has been routinely used to verify aspects of AFDC eligibility during the intake process. The Bridgeport and Waterbury District Offices have arranged to receive local public assistance printouts to verify income information provided by nonpublic assistance food stamp recipients. The department's own study of nonpublic assis-

tance food stamps found wide variation in the use of labor department information by district office workers to investigate and verify client eligibility.

To promote thorough investigation of eligibility as well as uniformity among district offices, the Legislative Program Review and Investigations Committee recommends that **the department establish a mandatory, consistent verification policy regarding eligibility determination for all programs it administers. This policy should be in effect in all district offices by June 30, 1985.**

Home Visit Guidelines

Home visit units for field investigation of client eligibility began operating in all district offices in October 1984. Home visit guidelines based on two years of pilot program experience in the Hartford and Waterbury offices have been developed by the eligibility services staff of the Office of Field Operations.

The guidelines call for scheduling home visits for a specific time rather than between 10:00 a.m. and 2:00 p.m. as in the Hartford pilot program. Hartford home visit workers estimated that from 25 to 50 percent of home visits could not be completed on the originally scheduled day because clients were not at home. Specific appointment times should address this problem.

Unnecessary duplication of collateral checks is also addressed by the home visit guidelines. Hartford home visit workers generally repeated all verification procedures performed by the referring unit worker, although errors or new information were seldom detected. Under the guidelines, worker responsibility is delineated for four mandatory sources to be checked as well as a number of optional sources of corroboration of eligibility information provided by the client.

Recommended times for scheduling visits (within three days of referral) and for completing home visits (within seven days of referral) are also included in the guidelines. Although Hartford home visit workers reported no significant problems in reporting results to referring unit workers within one week, it is important to emphasize timeliness. When home visits reveal ineligibility or lesser assistance needs, overpayment error can be prevented if the information is available prior to making the decision to grant assistance.

Adherence to these and other recommended procedures will enhance the efficiency and effectiveness of the home visit project. Therefore, the Legislative Program Review and Investigations Committee believes **the department should monitor district office compliance with home visit guidelines.**

A Department of Income Maintenance evaluation of the home visit pilot project found that in its first year of operation, home visits were essential to the detection of 63 percent of the cases that contained errors. However, the remaining 37 percent of the error cases were discovered through collateral checks; home visits were not necessary. The program review committee, therefore, recommends that **the department analyze the outcomes of the home visit process after six months of statewide operation to identify costs and benefits, and to determine if the current criteria for selection of cases for home visit should be modified.** Analysis of outcome information will identify the types of errors and cases best handled by home visit staff and by existing or new collateral checks.

Notice of Reporting Responsibilities

Public assistance recipients are required by state statute to report in writing any changes in their eligibility to the department within 15 days of the change. Federal regulations similarly require food stamp recipients to report eligibility changes within 10 days. Despite these requirements, client failure to notify the Department of Income Maintenance about changes in eligibility status remains a primary cause of error.

Client failure to report changes in eligibility as required results in payment errors. To improve client compliance with change reporting requirements, the program review committee recommends that **the department periodically notify clients of their responsibility to report eligibility changes and the consequences of not reporting as required.** Notices should be mailed with AFDC checks and food stamp authorization-to-participate cards at least every two months; notices to other assistance recipients should be mailed at least quarterly.

Expedited Redeterminations

The eligibility of AFDC clients must be redetermined three months after the initial award and every six months thereafter. To meet this requirement despite staff shortages, an expedited redetermination process was established in the Hartford and Bridgeport District Offices.

In Hartford, workers estimate that 80 percent of all AFDC redeterminations each month, which average about 1,500, are expedited. Despite concerns that errors may increase because of the shorter and less intensive redetermination interview, expedited cases have not been specifically examined to determine the occurrence of error.

The Legislative Program Review and Investigations Committee recommends that **the department evaluate the effectiveness of the expedited redetermination processes in the Hartford and Bridgeport offices. The impact of the process on error rates and staffing levels should be determined. If it is found that expedited redeterminations do not increase the likelihood of error, the program should be expanded to other offices.**

District Office Monitoring and Evaluation

To improve coordination and control over its 13 district offices and suboffices, the Department of Income Maintenance established the position of director of field operations in May 1983. The field operations director is responsible for directing, monitoring, and evaluating district operations. One of the director's major duties is to establish and maintain an effective field monitoring and evaluation system.

In accordance with federal requirements, a management evaluation system is already in place for food stamp operations. However, there is no mechanism for routine review and appraisal of overall district office management and administration.

The program review committee recommends that **the department develop and implement a management evaluation system for all district office operations. At a minimum, the system should focus on the development of district office profiles and identification of management or administrative factors causing error.** Findings on management and administrative practices that contribute to error will facilitate development and implementation of effective corrective actions.

Among the information available for evaluating district office performance are quality control findings on eligibility and payment error. Analysis of quality control findings can identify problem areas and indicate trends in numbers and types of errors.

One responsibility of the Office of Management Planning and Evaluation is preparation of narrative analysis reports on quality control findings for the AFDC, Food Stamp, and Medicaid programs. At the time of the committee's audit, a narrative analysis report had not been issued for either the AFDC or Food Stamp programs since the April - September 1982 quality control period. The most recent Medicaid quality control narrative analysis report was prepared for the October 1982 - March 1983 period.

To meet management needs for problem area and error trend information, selective analyses of subsequent quality control findings have been prepared by management planning staff at various times over the past two years. However, the absence of complete error analysis reports on a timely basis has necessitated

research efforts by field operations and district office staff that in effect duplicate management planning staff responsibilities. To maximize the usefulness of quality control findings, the program review committee recommends that **the department insure quality control findings are analyzed and reported within four months of the end of a quality control period.**

Resources Units

District office resources units perform a variety of investigatory activities that aid in the prevention and detection of eligibility and payment errors. Upon referral from other workers, resources staff investigate client assets and income, property sales and transfers, and determine the value of real and personal property in order to clarify eligibility. Responsibility for reviewing, investigating, and referring cases of suspected recipient fraud also rests within the resources units, although food stamp fraud is handled by the unit's food stamp fraud workers.

In addition to eligibility and fraud investigation functions, resources units carry out a variety of recovery and reimbursement activities. These include securing claims for the state against client assets and income, reviewing discontinued cases for possible claims, and establishing billing or recoupment (reduction of awards) regarding cases of recipient overpayment.

While both types of resources unit functions are important, the workers' role in the investigation of eligibility and fraud should be emphasized. As the department improves existing methods and institutes new methods for discovering unreported client eligibility information, there will be an increased need for the field investigation capability and expertise of resources workers. Therefore, the program review committee recommends that **resources unit investigatory functions be separated from recovery and reimbursement functions.**

In regard to recoveries and reimbursements, the Legislative Program Review and Investigations Committee further recommends that **the department explore the use of private collection agencies. Since collection agency fees are 75 percent reimbursable under the Food Stamp program, the department should initiate this procedure with food stamp cases.** If the results with food stamp cases prove cost beneficial, the use of private collection agencies should be expanded to recoveries in other assistance cases.

Administrative Disqualification Hearings

The Department of Income Maintenance refers any case of suspected fraud to the state police Welfare Investigation Unit for investigation. By law, cases involving fraud of \$500 or more in the AFDC program must be referred to the state police. According

to department policy, cases of suspected fraud of \$200 or more in food stamp cases, or a combination of AFDC and food stamp fraud totalling \$500, must be referred to the state police. However, due to the large number of cases sent to the unit by the department, the state police only assign for investigation those cases involving fraud of \$3,000 or more. As a result, the unit currently has approximately 4,000 unassigned cases of unknown monetary value. As of September 1984, the state police had 5,485 active cases in addition to the 4,000 unassigned cases.

The state police department's Welfare Investigation Unit has a staff of 22 persons: 16 investigators, 2 state troopers, and 4 clerks. The unit is responsible for investigating alleged AFDC fraud, food stamp fraud, child nonsupport, and some child abuse cases. Generally, most cases referred to the Welfare Investigation Unit by the Department of Income Maintenance involve a combination of suspected AFDC and food stamp fraud. Table IV-1 illustrates the number of cases referred to the state police by the department and shows the increase in cases referred to the Welfare Investigation Unit.

Table IV-1. State Police Welfare Investigation Unit (WIU)- State Fiscal Year Statistics.

	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>FY 84</u>
No. of cases referred from DIM to WIU					
Assigned	1,561	1,657	4,179	5,232	2,795
Unassigned	*	*	*	*	*
Cases resulting in arrests	642 (41%)	799 (48%)	1,021 (24%)	1,113 (21%)	647 (23%)
Cases sent back to DIM	600	654	606	1,019	354
Monies due by court order in AFDC & Food Stamp cases	\$766,431	\$814,111	\$776,584	\$1,072,000	\$1,096,268

* This indicates zero or a very small inventory of unassigned cases.

Source: LPR&IC.

In state FY 82, the Department of Income Maintenance increased the number of food stamp fraud personnel in the district offices and, as a result, began to refer more cases to the state police. In order to keep up with the growing case load in FY 83, the state police unit began using overtime to stay current. Each investigator began working an additional five hours per week. However, in FY 84, the unit reverted to its regular 35 hour week, reducing its ability to stay up-to-date with its cases. In addition, the unit lost one of its two clerical personnel, a position that remained vacant for eight months.

From FY 80 through FY 83, the Welfare Investigation Unit assigned to an investigator nearly every case referred by the Department of Income Maintenance. But, by FY 84, due to the high volume of cases and limited resources, the unit could not investigate every case and had about 4,000 unassigned cases.

Table IV-1 shows the number of cases that resulted in arrest during the past five years. Until FY 82, the unit had nearly a 50 percent success rate in arrests, but in the past three years it has had difficulty maintaining this level.

Although many cases result in arrest and prosecution, the state police must return some cases to the Department of Income Maintenance. The table shows that anywhere from 354 to 1,019 cases per year have been returned to the department. This may occur for a variety of reasons: the statute of limitations has run out, the prosecutors refuse the case, or the unit cannot prove client fraud.

The monetary recoveries in AFDC and food stamp fraud cases can be substantial. Table IV-1 indicates the sums that can be recovered by court order. The importance of this is twofold: first, fraudulent clients are required to repay what they owe the system; and second, the state of Connecticut is permitted to keep 50 percent of all monies recovered within the food stamp fraud program. Because the federal government pays 100 percent of the food stamp benefits, it offers the state an incentive to investigate food stamp fraud by permitting it to retain 50 percent of whatever it can recover.

As noted earlier, suspected fraud cases under the \$500 AFDC and \$200 food stamp limits are not sent to the Welfare Investigating Unit, and, therefore, do not even enter the prosecutorial process. Prior to August 1984, there was no provision in the Food Stamp program to collect any money from suspected fraudulent clients without a court conviction. The only alternative the department had to recover money from the recipient was to send a "demand letter" to the client requesting repayment.

As of August 1984, the department may treat those cases of suspected fraud involving less than \$200 as unintentional program

violations, which permits the department to recoup funds from the award of active cases. The state can reduce a recipient's award by up to 10 percent. However, inactive cases remain virtually free from the department's recoupment efforts.

The state has no other mechanism to pursue cases of alleged fraud that are below the monetary limits for referral to the state police. The department cannot independently initiate an action against a client whom it believes to be acting fraudulently. This can only be done through the prosecutorial process. However, under new federal regulations, a state may institute an administrative disqualification hearing process. If the Department of Income Maintenance had such a process, it could determine "fraud" in cases rejected for prosecution or pending in the state police inventory of unassigned cases.

The best estimate available on the projected number of cases that might be handled by an administrative disqualification hearing was developed by the Hartford District Office resources unit. It estimates approximately 1,800 statewide cases per year might be adjudicated by the administrative disqualification hearing process. The program review committee believes that to reduce the backlog of unassigned cases in the Welfare Investigation Unit and to insure timely action on alleged client fraud, an alternative to the current system is needed.

It appears that the federal regulations regarding the administrative disqualification hearings are a viable alternative. A disqualification process could be merged into the existing fair hearing process. Currently, there are 400-500 requests for fair hearings per month. Approximately 200-300 fair hearings are actually held per month, while the other cases are closed without a hearing as a result of either client or department agreement. Table IV-2 shows a sample of the unit's workload.

Table IV-2. Fair Hearing Unit - Workload Statistics.

	<u>Jan 84</u>	<u>Dec. 83</u>	<u>Nov. 83</u>	<u>Oct. 83</u>	<u>Sept. 83</u>
Total no. of cases closed without a decision	203	176	193	200	209
Total no. of decisions issued	286	179	188	218	349

Source: Department of Income Maintenance, Fair Hearing Unit.

If an administrative disqualification hearing process were incorporated into the present fair hearing structure, some modifications would be necessary. There are 13 fair hearing officers in the fair hearing unit. Based on an average of 250 hearings per month, each hearing officer presides over approximately 19 per month. A minimum of 2,000 administrative disqualification hearings per year (based on cases involving less than \$200 of suspected food stamp fraud) would result in about 166 cases per month. The department indicates that it would need about 5 new hearing officers in order to handle the additional workload created by the administrative disqualification hearings.

Therefore, the Legislative Program Review and Investigations Committee recommends that an administrative disqualification hearing process be incorporated into the Department of Income Maintenance's existing fair hearing process and that the department be required to use both fair hearings and administrative disqualification hearings where appropriate. In addition, the department should:

- hire at least 5 new hearing officers plus additional clerical staff to manage the additional case load;
- require that the existing 13 fair hearing officers plus the additional 5 officers have responsibility for hearing all administrative cases; however, when an administrative disqualification hearing is held regarding food stamp fraud, the Department of Income Maintenance will be eligible to receive a 75 percent reimbursement on that case or portion of the case;
- increase the monetary limit for case referral to the state police so that food stamp fraud cases involving less than \$1,000 or combination cases of AFDC and food stamp fraud totalling less than \$1,000 are handled by administrative disqualification hearing;
- establish special training programs regarding the administrative fraud hearing process for all staff involved in claim preparation, including policy and methods of collecting and presenting evidence; and
- require training for all hearing officers regarding the administrative disqualification hearings; in addition, the 5 new hearing officers should also be trained in the general administrative hearing process.

Fair Hearings

Applicants or recipients of public assistance programs administered by the Department of Income Maintenance can appeal any department decision by requesting an administrative fair hearing. The department's fair hearing officers preside over all hearings. Generally, it is the staff worker who took the action on a case resulting in a client's request for a hearing who prepares the fair hearing summary and represents the department at the fair hearing.

It came to the program review committee's attention that some fair hearings are requested as a result of inaccurate staff work. This was confirmed by the director of the fair hearing unit, who reported that about 20-25 percent of all cases heard by fair hearing officers per month are a result of worker misapplication of policy to the cases.

In the past, department supervisors signed off on fair hearing summaries, indicating that each summary had been reviewed for accuracy. However, the increased volume of hearing requests virtually eliminated this practice.

The program review committee was recently informed that the department plans to implement a policy that requires supervisors to review all fair hearing summaries. The committee believes that a mandatory review and sign off by supervisors on fair hearing summaries is critical to the department's efforts at reducing its own agency error.

The department reports that hearing officers, district directors, and program supervisors received training last year regarding administrative hearings. The department also reports that it plans to train eligibility technicians in January 1985 in the administrative hearing process. The program review committee believes it is important to prepare the worker who actually writes the fair hearing summary and represents the department at the fair hearing.

Therefore, the Legislative Program Review and Investigations Committee recommends that:

- **Department of Income Maintenance program supervisors or unit supervisors sign off on fair hearing summaries compiled by all eligibility technicians and senior eligibility technicians to verify accuracy and appropriateness of such summaries; and**

- both senior eligibility technicians and eligibility technicians involved in preparing fair hearing summaries receive intensive training in the fair hearing process and administrative law.

Medical Audit Unit

The purpose of the medical audit unit is to prevent and detect fraud and abuse through a review of the medical services providers serving the clients of the Department of Income Maintenance. The unit has primary responsibility for the audits of hospitals and all other medical providers.

Currently, departmental time limits have not been imposed on examiners regarding the completion of their reviews. The only requisite is that the department must complete five hospital audits (either inpatient or outpatient) per year, and it must audit 3 percent of the total service providers serving the department's clients per year.

Table IV-3 indicates that the medical audit unit completed 397 provider reviews in state FY 84; 40 audits involved hospitals.

Table IV-3. Medical Audit Unit Statistics--State FY 84.

Total Number of Reviews Initiated	479
Total Number of Reviews Completed	397
Total Number of Reviews Outstanding	82
Total Dollars Reviewed	\$173,354,061
Total Dollars Identified as Overpayments	\$2,866,367
Total Dollars Recovered	\$2,857,237

Source: Department of Income Maintenance.

Of the 7,000 active providers, the medical audit unit completed 357 provider reviews, 5 percent of the total participating providers.

Table IV-3 also shows the total dollars reviewed, which includes the total dollar amount identified by the audits as money already paid to the provider. The total dollar amount identified as overpayments, \$2,866,367, is a substantial sum. Most importantly, in state FY 84, as a result of the medical audit unit's work, the state recovered \$2,857,237 in improperly paid claims.

The Legislative Program Review and Investigations Committee believes the unit should establish a formal schedule of audits to

be completed each year to assure maximum usage of the unit's time and resources. Since the unit generally completes more reviews than the federal government currently requires, the unit should be able to continue, if not surpass, this level in the future. Creation of the formal schedule could also be used as a management tool.

Accordingly, the Legislative Program Review and Investigations Committee recommends that **the medical audit unit of the Department of Income Maintenance establish formal requirements for a reasonable number of audits per medical services provider category to be completed each year, and also that such a schedule be used as a management tool to assure efficient and effective use of resources.**

Computer Capability

Electronic Data Services (EDS), the company responsible for the medicaid management information system (MMIS), can generate a random sample of any medical services provider's clients, by client identification number or type of claim. This provides the department with an automated random list in order to audit selected providers for verification of the appropriateness of billings.

Unfortunately, EDS does not currently generate a random selection of prescription numbers by sequence, a list needed for the audit of general pharmacies. Whenever a pharmacy is selected for an onsite visit, the sample needed to audit the pharmacist's files should be in prescription number sequence. Since EDS does not generate this information, the pharmacist on the medical audit staff must do the selection manually.

Currently, to generate a manual random sample, the medical audit examiner must review all the prescription numbers on microfilm and print the microfilm. Each microfilm sheet only prints a list of approximately 13 paid bills. The examiner needs enough copies of bills to make a random selection of at least 10 percent. Therefore, about 1,000 copies of bills are needed to count every tenth prescription manually. The medical audit unit estimates it takes nearly one week of staff time to compile the list.

In state FY 84, the unit completed 43 audits of pharmacies. The majority of these audits involved reviews of pharmacies serving nursing homes where no random prescription sequence is needed. Only two general pharmacies were audited with a review of random prescription numbers to verify the accuracy of the provider's billing because of the time needed to compile the random sample.

The medical audit unit reports that with a computerized random selection at least 70-80 general pharmacy reviews could be completed each year while still maintaining the number of reviews of pharmacies serving nursing homes. The program review committee believes the department should use a computer-generated list in order to pursue provider fraud and abuse.

Therefore, the Legislative Program Review and Investigations Committee recommends that **to audit general pharmacies, the department should use a random computer selection by prescription number sequence. To accomplish this task, the department should either instruct Electronic Data Services (EDS), the company under contract to provide computer services to the state, to implement programming changes, or the department should use its own personal computer to perform this function.**



APPENDICES

APPENDIX A

Legislative Program Review and Investigations Committee
*
Survey of Quality Control Reviewer

1. How many years have you been working with the department's quality control unit? (Please round to the nearest whole number.)

7 Years

2. How many years have you been working with the Department of Income Maintenance? (Please round to the nearest whole number.)

12 Years

3. Please indicate the highest degree earned.

High School Diploma
 Bachelor's Degree
 Master's Degree
 Doctorate Degree

4. For all positive case reviews, please indicate the average number of days it takes to complete each phase of the audit process. Start counting days from the day you receive the case, not when you start the task.

For example, if you receive the case on March 1 and complete the Case Record Analysis on March 15, put 15 days. If you complete the Field Visit on March 30 put 30 days.

Type of Review	Complete Case Record Analysis	Complete Field Visit	Obtain Info. from Collateral Sources	Complete Review Report
AFDC Only	<u>8</u>	<u>16</u>	<u>44</u>	<u>55</u>
AFDC + F.S.	<u>9</u>	<u>16</u>	<u>46</u>	<u>55</u>
AFDC + F.S. + Med.	<u>9</u>	<u>17</u>	<u>48</u>	<u>57</u>
AFDC + Med.	<u>8</u>	<u>16</u>	<u>44</u>	<u>55</u>
F.S. Only	<u>8</u>	<u>17</u>	<u>43</u>	<u>54</u>
Medicaid Only	<u>11</u>	<u>21</u>	<u>50</u>	<u>65</u>

* n=22

5. Please indicate the average number of days it takes to complete a negative case review. Start counting days from the day you receive the case, not when you start the review.

<u>Type of Review</u>	<u>Average Number of Days Needed to Complete Review</u>
AFDC Only	<u>33</u>
AFDC + F.S.	<u>NA</u>
AFDC + F.S. + Med.	<u>NA</u>
AFDC + Med.	<u>NA</u>
F.S. Only	<u>39</u>
Medicaid Only	<u>35</u>

6. For all positive case reviews, please indicate the average number of staff hours (reviewer only) it takes to complete each of the following tasks. (For example, if over the course of a case review it takes an average of 3 reviewer hours to identify, contact and obtain information from collateral sources then enter 3 under the "Obtain Information from Collateral Sources category.")

<u>Type of Review</u>	<u>Case Record Analysis</u>	<u>Field Visit</u>	<u>Obtain Info. From Collateral Sources</u>	<u>Prepare Review Report</u>
AFDC Only	<u>3</u>	<u>2</u>	<u>8</u>	<u>4</u>
AFDC + F.S.	<u>3</u>	<u>2</u>	<u>8</u>	<u>4</u>
AFDC + F.S. + Med.	<u>3</u>	<u>2</u>	<u>9</u>	<u>4</u>
AFDC + Med.	<u>3</u>	<u>2</u>	<u>8</u>	<u>4</u>
F.S. Only	<u>2</u>	<u>2</u>	<u>8</u>	<u>4</u>
Medicaid Only	<u>2</u>	<u>2</u>	<u>5</u>	<u>4</u>

7. For all negative case reviews, please indicate the average number of staff hours (reviewer only) it takes to complete each type of review.

<u>Type of Review</u>	<u>Average Number of Hours Needed to Complete</u>
AFDC Only	<u>2</u>
AFDC + F.S.	<u>NA</u>
AFDC + F.S. + Med.	<u>NA</u>
AFDC + Med.	<u>NA</u>
F.S. Only	<u>2</u>
Medicaid Only	<u>2</u>

8. Please indicate the average number of reviews you complete per month in each of the following categories.

<u>Average Completed Per Month</u>		<u>Type of Review</u>
Positive	Negative	
<u>2</u>	<u>1</u>	AFDC Only
<u>1</u>	<u>NA</u>	AFDC + F.S.
<u>1</u>	<u>NA</u>	AFDC + F.S. + Medicaid
<u>2</u>	<u>NA</u>	AFDC + Medicaid
<u>2</u>	<u>2</u>	F.S. Only
<u>2</u>	<u>1</u>	Medicaid Only
<u>10</u>	<u>4</u>	Total

APPENDIX B

Distributed - 11
Respondents - 8
Response Rate - 73%

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Survey of Medical Audit Provider Examiners

1. How many years have you been working with the Department of Income Maintenance's medical audit unit? (Please round to nearest whole number.)

5 Years

2. How many years have you been working with the Department of Income Maintenance? (Please round to nearest whole number.)

6 Years

3. Please indicate the highest degree earned.

1 High School Diploma

4 Bachelor's Degree

1 Master's Degree

0 Doctorate Degree

2 Associates Degree

*4. Please indicate the average number of audits you complete per month by provider group.

Type of Provider Audit	Audits with desk audit only	Audits with full scale review (i.e., on-site visit)
Physician	2	2
Podiatrist	3	1
Optometrist	1	1
Optician	1	-
Dentist	-	-
Clinic	1	1
Pharmacy	20	6
Laboratory	-	3
Med. Transp.	-	1
Psychologist	.15	-
Other	14	-

* Most answers rounded to the nearest whole number.

NOTE: Six respondents to this question.

- *5. Please indicate the average number of days taken to complete each phase of the provider audit process. Start counting days from the day you receive the case, not when you start the task.

For example, if you receive an assignment on March 1 and complete the desk audit on March 15, put down 15 days. If you complete the on-site visit on March 30, put down 30 days. (If most of the audits for certain providers require only a desk audit and final report, then just fill in those two columns.)

Type of Provider Audit	Complete Desk Audit	Complete On-site Visit	Obtain Info. From Collateral Sources	Complete Final Report
Physician	10	3	26	49
Podiatrist	27	34	35	86
Optometrist	27	2	22	58
Optician	11	2	30	83
Dentist	15	2	30	105
Clinic	8	11	28	47
Pharmacy	13	2	45	98
Laboratory	15	2	30	105
Med. Transp.	15	2	30	105
Psychologist	10	2	30	56
Other	10	8	33	55

* Answers rounded to the nearest whole number.

NOTE: Six respondents to this question.

6. Please indicate the average number of staff hours (examiner only) taken to complete each of the following tasks. For example, if during the audit process an average of 7 examiner hours is taken to prepare for an on-site visit, enter 7 under that category of the chart below.

Type of Provider Audit	Complete Desk Audit	Complete Preparation for On-site Visit	Complete On-site Visit	Obtain Info. From Collateral Sources	Complete Final Report
Physician	62	21	17	14	22
Podiatrist	64	14	14	2	11
Optometrist	59	12	15	5	23
Optician	68	21	25	7	18
Dentist	109	21	25	-	21
Clinic	43	21	43	14	28
Pharmacy	109	21	25	-	21
Laboratory	109	21	25	-	21
Med. Transp.	109	21	25	-	21
Psychologist	72	21	25	-	32
Other	56	35	35	21	39

* Answers rounded to the nearest whole number.

APPENDIX C

AFDC PROGRAM

Percent of Total Benefits and Amount
of Federal Funds Issued in Error
(Oct. 1980 through Mar. 1982)

State	Percent of total benefits issued in error			Amount of federal funds issued in error		
	Oct-Mar 1981	Apr-Sept 1981	Oct-Mar 1982	Oct-Mar 1981	Apr-Sept 1981	Oct-Mar 1982
	(thousands)					
U.S. Total	9.0 ^a	7.6 ^a	7.9 ^a	\$307,014	\$266,804	\$273,990
Alabama	8.7	7.4	5.6	2,486	1,976	1,451
Alaska	14.3	22.6	13.4	1,173	2,058	1,092
Arizona	9.1	8.5	12.2	791	765	1,071
Arkansas	7.7	7.6	9.4	1,444	1,399	1,161
California	9.2	5.6	7.9	56,925	36,442	54,029
Colorado	10.4	7.0	5.5	2,433	1,658	1,240
Connecticut	8.5	7.5	5.7	4,261	3,924	3,007
Delaware	13.0	11.1	10.6	1,049	891	774
Dist. of Col.	15.4	12.7	18.1	3,452	2,786	3,883
Florida	8.2	9.1	7.0	4,977	5,531	4,086
Georgia	8.3	6.3	5.1	4,235	3,423	2,777
Hawaii	11.5	10.8	9.1	2,652	2,543	2,035
Idaho	13.1	5.7	5.8	997	388	384
Illinois	9.0	8.4	7.9	17,047	16,984	15,812
Indiana	5.5	3.9	3.9	2,261	1,658	1,500
Iowa	4.7	4.5	4.1	2,038	1,833	1,399
Kansas	8.2	9.3	6.2	1,908	2,234	1,307
Kentucky	6.1	4.8	3.7	3,072	2,385	1,533
Louisiana	6.0	8.2	6.7	2,664	3,716	2,891
Maine	8.8	7.4	5.9	1,773	1,495	1,223
Maryland	12.1	11.6	9.3	6,824	6,587	4,936
Massachusetts	11.3	7.5	6.2	15,267	9,826	8,055
Michigan	7.7	8.1	9.5	21,405	21,939	26,295
Minnesota	4.2	5.5	3.3	2,735	3,851	2,118
Mississippi	8.5	7.2	5.4	2,043	1,743	1,202
Missouri	7.3	8.3	7.0	4,305	4,793	3,721
Montana	7.8	3.4	1.8	457	206	108
Nebraska	5.1	7.0	6.3	669	967	877
Nevada	2.5	2.0	1.7	76	64	50
New Hampshire	6.2	8.7	6.4	529	726	471
New Jersey	8.8	8.2	9.6	11,495	11,425	12,569
New Mexico	13.1	12.7	12.1	2,015	2,060	1,813
New York	10.7	8.5	8.7	39,507	32,996	36,730
North Carolina	7.0	5.4	4.4	3,723	2,851	2,184
North Dakota	3.9	4.2	1.4	196	202	62
Ohio	8.6	9.5	8.3	14,003	16,271	14,032
Oklahoma	4.9	8.8	4.9	1,448	2,537	1,140
Oregon	7.3	7.1	7.6	2,260	2,200	2,051
Pennsylvania	10.0	8.7	9.5	21,002	18,392	20,276
Puerto Rico	10.8	9.9	11.0	3,908	3,638	2,670
Rhode Island	6.8	6.0	6.2	1,605	1,188	1,411
South Carolina	8.6	9.0	10.0	2,391	2,544	2,731
South Dakota	7.9	2.2	4.3	479	130	244
Tennessee	10.7	8.1	5.8	3,159	2,394	1,456
Texas	7.5	8.2	8.8	3,324	3,556	3,415
Utah	6.4	4.1	5.5	1,111	682	879
Vermont	4.5	6.7	6.3	599	900	845
Virgin Islands	(b)	(b)	(b)	(b)	(b)	(b)
Virginia	4.5	3.7	3.4	2,232	1,820	1,594
Washington	10.1	9.6	7.7	6,701	5,041	4,512
West Virginia	7.6	7.9	8.6	1,510	1,685	1,644
Wisconsin	11.1	8.2	9.3	11,978	9,321	11,164
Wyoming	19.4	8.7	3.8	420	180	80

^aWeighted average.

^bData not available.

Source: U.S. General Accounting Office, April 1984.

APPENDIX D

FOOD STAMP PROGRAM

Percent and Amount of Benefits
Issued in Error
(Oct. 1980 through Mar. 1982)

State	Percent of total benefits issued in error			Amount of benefits issued in error		
	Oct-Mar 1981	Apr-Sept 1981	Oct-Mar 1982	Oct-Mar 1981	Apr-Sept 1981	Oct-Mar 1982
(thousands)						
U.S. Total	13.1a	11.8a	12.2a	\$669,776	\$652,268	\$635,335
Alabama	10.7	8.0	7.5	15,531	11,833	10,564
Alaska	22.5	28.0	23.4	3,588	4,107	3,252
Arizona	18.8	13.4	15.5	11,421	8,555	9,462
Arkansas	11.2	12.1	12.6	7,571	8,598	8,411
California	11.7	9.1	12.1	33,345	28,999	34,950
Colorado	14.3	16.8	17.3	6,117	7,543	7,003
Connecticut	16.8	16.2 ^b	16.5	5,772	5,972	5,361
Delaware	11.7	8.7	8.5	1,580	1,194	1,150
Dist. of Col.	19.1	16.9	18.7	4,415	4,069	4,218
Florida	15.0	15.3	12.9	37,494	38,548	29,470
Georgia	12.6	12.5	8.8	18,789	19,471	12,540
Guam	6.5	13.2	7.2	553	1,234	597
Hawaii	9.4	9.2	9.1	3,096	3,350	3,026
Idaho	10.8	12.4	8.9	1,870	2,154	1,711
Illinois	11.5	11.5	9.8	27,660	30,419	27,320
Indiana	10.0	8.0	9.3	9,977	8,365	9,685
Iowa	12.3	9.3	11.4	4,227	3,774	4,630
Kansas	14.6	12.8	11.8	3,593	3,518	3,141
Kentucky	10.9	8.8	9.0	13,780	12,348	11,951
Louisiana	12.2	13.5	12.5	16,254	18,587	15,143
Maine	12.7	8.8 ^b	9.7	4,370	3,091	3,220
Maryland	16.7	16.7	12.3	13,715	14,812	10,283
Massachusetts	16.1	11.8 ^b	15.9	14,831	11,573	15,644
Michigan	12.5	11.9	11.4	22,661	25,361	25,331
Minnesota	8.9	10.1	11.8	3,478	4,416	4,760
Mississippi	12.4	11.6	12.8	14,125	14,043	14,345
Missouri	10.9	10.4	9.1	9,523	9,876	8,399
Montana	17.4	14.3	8.9	1,880	1,710	1,017
Nebraska	13.2	12.9	14.4	1,970	2,098	2,196
Nevada	5.1	3.7	3.0	532	375	288
New Hampshire	16.0	14.7 ^b	17.7	2,135	2,004	2,220
New Jersey	11.9	11.2	10.9	15,992	16,289	15,399
New Mexico	15.3	15.7	15.8	6,879	7,006	6,442
New York	19.2	15.7	16.8	80,357	71,573	69,689
North Carolina	15.8	16.2	13.4	21,057	22,516	17,631
North Dakota	6.9	7.3	9.1	388	473	567
Ohio	10.1	8.9	10.5	23,912	23,800	27,548
Oklahoma	12.2	11.9	11.5	5,033	4,919	4,241
Oregon	8.6	13.1	15.5	5,335	8,916	10,983
Pennsylvania	13.6	10.6	13.7	31,165	27,646	34,132
Puerto Rico	13.9	9.8	10.3	59,675	44,306	45,732
Rhode Island	14.2	11.2 ^b	12.0	3,002	2,181	2,295
South Carolina	10.5	12.2	12.9	10,806	13,063	12,945
South Dakota	12.3	7.8	12.5	1,260	838	1,390
Tennessee	14.4	13.2	13.3	23,855	22,973	21,446
Texas	10.9	11.9	13.1	32,395	36,128	36,207
Utah	11.5	11.5	10.1	1,555	1,750	1,491
Vermont	11.3	10.6 ^b	12.1	1,069	1,050	1,140
Virgin Islands	19.7	13.2	16.5	1,999	1,406	1,671
Virginia	10.1	9.0	9.8	9,637	9,508	9,638
Washington	10.6	9.6	12.1	6,264	7,287	9,022
West Virginia	9.9	13.1	11.3	5,201	9,097	6,383
Wisconsin	14.3	13.2	14.8	6,653	6,989	7,746
Wyoming	12.6	14.6	9.1	434	557	309

^aWeighted average.

^bState's reported error rate not adjusted by the Service.

Source: U.S. General Accounting Office, April 1984.

APPENDIX E

State Medicaid Program Error rates, Oct. 81 - Sept. 82
Annual Rate

Federal Target Rate: 6.1

<u>State</u>	<u>Rate</u>	<u>State</u>	<u>Rate</u>
AK	1.43	MT	5.94
AL	2.30	NC	1.77
AR	2.68	ND	1.40
CA	4.95	NE	3.24
CO	5.12	NH	2.65
CT	2.14	NJ	1.87
DC	10.80	NM	7.67
DE	N/A	NV	1.34
FL	4.06	NY	1.44
GA	4.85	OH	2.85
HI	4.55	OK	2.67
IA	3.45	OR	3.46
IO	2.44	PA	4.32
IL	1.35	RI	1.74
IN	2.82	SC	4.19
KS	2.97	SD	2.36
KY	2.25	TN	2.38
LA	2.79	TX	4.90
MA	4.33	UT	3.40
MD	1.88	VA	1.87
ME	6.59	VT	2.54
MI	2.19	WA	2.90
MN	0.54	WI	2.76
MO	4.86	WV	4.45
MS	5.41	WY	2.59

Source: U.S. Health Care Financing Administration.

APPENDIX F

Department of Income Maintenance's Response to the Program Review and Investigations Committee's Staff Recommendations

[Note: Included in this appendix are the Department of Income Maintenance's comments on the program review committee's initial staff report. Several changes were made by the committee prior to the report being finalized, and hence there are some discrepancies between the department's comments and the information contained in this report.]

LPR and I Committee: Error Prevention and
Detection Findings and Recommendations

The Department has focused more attention on Error Prevention, Detection and Reduction than perhaps any other issue which faces us. The report very accurately notes that "error prevention and detection is a department-wide responsibility". While the committee indicates its audit concentrated on district offices and Program Integrity, we would like to add that the committee also spent a lot of time reviewing our corrective action process, which is an integral part of our operation.

A. Recommendation: The department should establish a mandatory, consistent verification policy regarding eligibility determination for all programs it administers. This policy should be in effect in all district offices by June 30, 1985.

Comment:

We agree that we should establish and issue a verification policy for all our programs, although we disagree about the target date. This is a major undertaking in that federal regulations for verification are complex and differ among programs. What is required for one program may not be required for another. We are addressing this issue as part of our policy manual rewrite project which is due for completion by January, 1986. We believe it would not be helpful to extract this element and try to push it through earlier than that time.

B. Recommendation: The department should monitor district office compliance with home visit guidelines.

The department should also analyze the outcomes of the home visit process after six months of statewide operation to identify costs and benefits, and to determine if the current criteria for selection of cases for home visit should be modified.

Comment:

We agree with both recommendations, and a monitoring/evaluative component is already built into the home visit project.

C. Recommendation: The department should periodically notify clients of their responsibility to report eligibility changes and the consequences of not reporting as required. Notices should be mailed with AFDC checks and food stamps authorizations-to-purchase at least every two months; notices to other assistance recipients should be mailed at least quarterly.

Comments:

We have some problems with this finding. We sent a stuffer to recipients for a three month period last year. This action was taken as part of a corrective action panel suggestion. Each month, the notice changed color so that it would not appear repetitive. The results in terms of client calling to report changes were not encouraging. If we are to use this method as a corrective action, we need approach it differently.

Finally, we believe the frequency suggested by the committee is not appropriate. Several times during the year, we send notices to clients, to inform them of a benefit (such as the energy program) or of a federally mandated change (such as a mass Food Stamp adjustment). It would be confusing to add warning notice stuffers to this load, unless there were clear indications of good results. We believe, however, that client education about their responsibilities is important. We would rather approach this via home visits, interviews, signed statements of understanding, and other measures.

D. Recommendation: The department should evaluate the effectiveness of the expedited redetermination processes in the Hartford and Bridgeport offices. The impact of the process on error rates and staffing levels should be determined. If it is found that expedited redeterminations do not increase the likelihood of error, the program should be expanded to other offices.

Comments:

We believe it not best to change the Redetermination process at this time. We would like to consider this recommendation as we move to implement EMS. We are, as part of EMS, radically changing District operations so that the role and function of Redeterminations will be substantially different. If each worker has a clear caseload, as is the plan, the process by which Redetermination interviews are assigned and conducted will change.

E. Recommendation: The department should develop and implement a management evaluation system for all district office operations. At a minimum, the system should focus on the development of district office profiles and identification of management or administrative factors causing error.

Comments:

We have taken several steps to expand our ability to evaluate district operations. Since April, 1983 we have hired a Director of Field Operations, hired a new chief and assistant chief of Eligibility Services, expanded the Resources Unit to include Food Stamp Recipient Fraud, and moved the Food Stamp Management Evaluation (ME) function into the Field Operations Unit.

We would like to develop a formal ME process for all programs. As we implement new projects, we are creating an evaluative component for each. To establish the capacity suggested, however, would require substantial additional resources and a major expansion of the Field Operations Unit.

F. Recommendation: The department should insure that quality control findings are analyzed and reported within four months of the end of a quality control period.

Comment:

The delay in issuing QC reports does not directly impact the district offices, since they receive immediate notice on a form W-1201, as soon as each case review is complete. District staff use this information to make case specific changes and to track for patterns or trends which require more basic change (this mechanism allows for timely action to correct problems even before the end of a QC period)

It is physically impossible to issue analyses and reports within four months of a QC period. Findings are based on completed samples so they reflect the

entire caseload. For AFDC, the last reviews are due 120 days, or four months, after the end of the period. Medicaid statistics lag several months longer while bills can be processed so that errors can be "dollarized." There appears to be some confusion about the dissemination of Q.C. information to agency managers. A narrative analysis report is not required by any of the three federal agencies. What is required is a corrective action plan which must include an analysis of error by a variety of factors. Food Stamp and AFDC plans are required twice a year with Medicaid plans required annually. Through extensive manual work the agency has met every plan deadline. These plans are widely distributed throughout Central and District offices.

G. Recommendation: Resources investigatory functions should be separated from recovery and reimbursement functions within the resources units.

Comments:

We believe the problem here is essentially lack of sufficient numbers of staff rather than ineffective assignment of work. Specializing the investigatory functions apart from the recovery functions would create duplicate handling of cases. This duplication is probably not cost effective in the long term and also leaves more room for error or oversight.

H. Recommendation: The department should explore the use of private collection agencies. Since collection agency fees are 75 percent reimbursable under the food stamps program, the department should initiate this procedure with food stamp cases.

Comment:

We agree with this finding. We are exploring the possibility for food stamp cases. We have contacted other states to determine how they use private agencies to maximize food stamp recoveries. We are also working with the Bureau of Collection Services to enhance their capacity to pursue collection in Food Stamps.

I. Recommendation: The program review committee staff recommends that an administrative disqualification hearing process be incorporated into the Department of Income Maintenance's existing fair hearing process and require the department to use both fair hearings and administrative disqualification hearings where appropriate. In addition, the department should:

1. hire at least five new hearing officers plus additional clerical staff to manage the additional caseload;
2. require that the existing 13 fair hearing officers plus the additional five officers have responsibility for hearing all administrative cases; however, when an administrative disqualification hearing is held regarding food stamp fraud, the Department of Income Maintenance will be eligible to receive a 75 percent reimbursement on that case or portion of the case.
3. increase the monetary limit for case referral to the state police so that food stamp fraud cases involving less than \$1,000 or combination cases of AFDC and food stamp fraud totalling less than \$1,000 are handled by administrative disqualification hearing.

4. establish special training programs regarding the administrative fraud hearing process for all staff involved in claim preparation, including policy and methods of collecting and presenting evidence; and
5. require training for all hearing officers regarding the administrative disqualification hearings; in addition, the five new hearing officers should also be trained in the general administrative hearing process.

Comment:

We agree and endorse this recommendation. We have been reviewing other states' experiences with hearings and have had extensive discussions with federal officials about such hearings. We have, in fact, proposed administrative hearings as a budget option for the next fiscal year.

It must be recognized, however, that this is a major new undertaking for us and represents a totally new function for the department. Without additional staff the fair hearings unit will not be able to absorb this major new initiative.

J. Recommendation:

1. Department of Income Maintenance program supervisors or unit supervisors sign off on fair hearing summaries compiled by all eligibility technicians and senior eligibility technicians to verify accuracy and appropriateness of such summaries; and

2. Both senior eligibility technicians and eligibility technicians involved in preparing fair hearing summaries receive intensive training in the fair hearing process and administrative law.

Comment:

We agree with both findings, and implementation of both is underway. Last spring we formed an internal work group; chaired by our Chief of Fair Hearings, to examine all concerns raised about the fair hearing process. The work group includes a District Director, our Director of Policy, and a member of our Program Integrity staff. One of the recommendations from this group was the requiring of supervisory sign-off on Fair Hearing summaries. This requirement was communicated to all staff in a memo dated July 12, 1984.

We have started a training program in Fair Hearings for all supervisors, senior technicians and eligibility technicians. This involves several hundred people and should be complete next spring. The program is unique in that we are using our Fair Hearing Unit, an administrative law professor and our internal training unit.

K. Recommendation: The Medical Audit Unit should establish formal requirements for a reasonable number of audits per medical services provider category to be completed each year and also use such a schedule as a management tool to assure efficient and effective use of resources.

Comment

We agree with the concept of the recommendation and we believe that the actions we plan to take will accommodate its intent.

Our selection of medical providers to be audited is predicated on the requirements set forth by the federal government as to the number to be reviewed in the various categories of providers (e.g. hospitals, etc.), and computer analyses provided on a continuing basis throughout the year which identify aberrant billings and activities of specific providers when compared to their peers in the same category. The latter cannot feasibly be identified in advance of reviewing and analyzing the computer printouts.

Nevertheless, we believe that we can and should do more to enhance the audit planning process in this area and we are already taking steps to accomplish this. For example, an annual schedule indicating the specific hospitals, clinics and laboratories to be audited, and the time-phasing of such audits is deemed to be practicable and is in the planning stage. The audit scheduling of individual practitioners such as doctors, dentists, podiatrists, etc. will take some thinking.

L. Recommendation: The Department of Income Maintenance should instruct EDS, the company under contract to provide computer services to the state, to implement programming changes to generate a random computer selection by prescription number sequence or require the department to use its own personal computer to perform this function.

Comment:

We agree with this finding and believe it will facilitate the audit process.

We will work with our Data Processing Unit to build this capacity.