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Digest of
Medicaid Recipient Controls

The Division of Health Care Financing's (HCF) restriction program, designed to control recipient overuse of Medicaid benefits, is effective in reducing excessive use of services, but can improve its effectiveness and efficiency. Expanding this program can increase effectiveness by controlling more recipient overuse. Higher efficiency can be achieved by using computer resources better. Enrolling overusing recipients more efficiently can control overuse sooner, thereby increasing associated cost savings. Further, in response to a request to review specific procedures related to Medicaid, we found that HCF has appropriate procedures in place to respond to a recipient who questions a charge on an Explanation of Medicaid Benefits summary. Also, we found that reasonable efforts are made to ensure that applicants meet eligibility requirements, specifically asset limitations, when applying for benefits through the Office of Family Support in the Department of Human Services.

The following paragraphs summarize the most significant findings in our report.

The Restriction Program Is Effective and Should Be Expanded. According to a limited sample of restricted recipients whose services we reviewed, the restriction program is effective in reducing service use and costs to Medicaid. Based on the results of our sample, we believe that the restriction program's enrollment should be expanded. We found there were recipients with high levels of use who were not reviewed or restricted. Staff should consider additional recipients for restriction program placement to lower costs to Medicaid and increase the likelihood of coordinated medical care being provided. Also, staff should develop a way to measure program effectiveness. Finally, educational letters can be put to better use and contacts with providers can improve.

The Restriction Program Can Be More Efficient. The current restriction program can be improved if processes are streamlined. Reviews of high use recipients take too long because review processes are inefficient and involve too many manual steps. Needed changes include improving the Surveillance and Utilization Review Subsystem (SURS) reports used in reviews and automating manual processes so that staff can decrease the time taken to complete each step of an unnecessarily long review process. Reduced processing time will save Medicaid money by controlling use sooner and will aid staff in staying current in their work load. Efficiency improvements will increase cost savings to Medicaid since each month an overusing recipient is enrolled saves about $384, based on the results of the sample described above.

Procedures Exist for Questioned Charges and Consideration of Assets. Concerns expressed by a legislator over the adequacy of procedures in two distinct areas of Medicaid service use and eligibility led us to review specific procedures at HCF and the Department of Human Services (DHS). First, we found that HCF has adequate procedures in place to check questioned service use listed on a recipient's Explanation of Benefits (EOB) form, and that pharmacies have fairly standard procedures to follow when they suspect someone of improper use of a Medicaid card. In the second, unrelated area, the application process for assistance at DHS that determines eligibility takes assets in the home into consideration, with verifications obtained on liquid assets and income. Applicants' information on the value of assets in the home is accepted without formal verification unless there is reason to question the provided information.

Chapter I
Introduction

The Division of Health Care Financing's (HCF) restriction program, designed to control recipient overuse of Medicaid benefits, is effective in reducing excessive use of services, but can improve its effectiveness and efficiency. Expanding this program can increase effectiveness by controlling more recipient overuse. Higher efficiency can be achieved by using computer resources better. Enrolling overusing recipients more efficiently can control overuse sooner, thereby increasing associated cost savings. Further, in response to a request to review specific procedures related to Medicaid, we found that HCF has appropriate procedures in place to respond to a recipient who questions a charge on an Explanation of Medicaid Benefits summary. Also, we found that reasonable efforts are made to ensure that applicants meet eligibility requirements, specifically asset limitations, when applying for benefits through the Office of Family Support in the Department of Human Services.

Audit Scope and Objectives

Our audit was initiated in response to the request of a legislator who was concerned that recipients' Medicaid identification cards could be misused by others to obtain prescription drugs and that adequate controls might not be in place to respond to a recipient questioning the resultant entry on the summary of benefits form. Another concern was that there might not be sufficient controls over asset consideration in the application process to guard against ineligible people receiving assistance.

Specifically, we were asked to review the following areas:

Determine if adequate controls exist to ensure that appropriate action is taken with regard to information provided on questionable charges through the Explanation of Benefits.

Determine if adequate controls exist to ensure that clients who receive Medicaid benefits meet the assets test.

We expanded the audit to include a review of the restriction program because it is designed to address overuse and abuse issues, which are related to the issues raised in the legislator's request.

Background Information

The Division of Health Care Financing is the single state agency responsible for administering the Medicaid program; while eligibility for Medicaid is determined by the Office of Family Support in the Department of Human Services, the Medicaid program is administered by HCF. Fiscal year 1993 total expenditures in Utah for Medicaid services were $462,262,000, with $113,915,315 or 25 percent of that amount coming from state and local funds. There were 165,000 active Medicaid recipients in fiscal year 1993.

Approximately 75-80 percent of Medicaid recipients are enrolled in case management; that is, recipients choose one physician, group practice, clinic, or Health Maintenance Organization (HMO) to be their primary provider of medical care. All needed medical care is supposed to be coordinated through the primary care provider (PCP). Additional needed care is available via referral from the PCP. The remaining Medicaid recipients live in rural areas of the state and are not required to enroll in case management because of fewer available providers, although many rural recipients do enroll in case management.

Within the division's Managed Health Care Bureau is the restriction program, designed to curb recipient overuse and abuse of Medicaid benefits. Every quarter, the federal government requires HCF to conduct post-payment reviews of 0.01 percent of active Medicaid recipients, focusing on those who use services at unusually high levels. This is the main function of the restriction program. Staff review categories of service use, including the number of different physicians seen, number of pharmacies used, number of emergency room visits, total number of prescriptions and number of abuse potential prescriptions obtained, and number of dentists and dental visits; cost to Medicaid is also considered. Specific levels of use have been set as acceptable, and higher use is considered excessive. The categories of service of most concern to restriction program staff when conducting the reviews are the number of different physicians seen, emergency room use, use of drugs with abuse potential, and number of different pharmacies used in a year. Diagnoses are considered to determine whether the high use is justified.

In order to conduct the reviews, staff obtain a report that lists the Medicaid recipients with excessive use based on the number of exception points generated over the last year of services. Points are accumulated based on the use of services beyond levels established as acceptable; recipients are listed in descending point order so that the highest users can be identified for review. These reports are generated from a computer subsystem called the Surveillance and Utilization Review Subsystem or SURS. SURS is a component of the Medicaid Management Information System which contains and analyzes claims and payment information for all Medicaid recipients.

If staff determine that use is overly high or abusive, recipients are notified that they are

being enrolled in the restriction program. This program restricts them to obtaining care from one primary care physician who is responsible for coordinating all medical care, including providing written referrals to other providers. Although most Medicaid recipients are supposed to use just one primary care physician, those who become enrolled in the restriction program often have visited multiple primary care physicians. Recipients are also restricted to obtaining prescriptions from one pharmacy so that better care coordination occurs with prescribed drugs. Restriction is initially for the period of one year, with a review of use scheduled for the end of the year to determine whether or not to continue the recipient in the program. Recipients are given the opportunity to choose their primary care provider and pharmacy, and are also informed in the notification letter of their right to appeal the restriction decision.

The restriction program's goals are to achieve better coordinated care for the recipients and to reduce unnecessary use of services and cost to Medicaid. Most restricted recipients have gone to multiple primary care and other providers, used multiple pharmacies, and obtained high levels of prescription drugs, especially abuse potential drugs, from various providers prior to becoming enrolled in the program. Unnecessary use of emergency rooms for non-emergency care is another abusive pattern that results in higher cost to Medicaid than if recipients went to their primary care providers for care.

The program is staffed by one full-time employee. In addition to reviewing recipients for consideration in the program, the staff person is responsible for annual reviews of restricted recipients. Reviews evaluating recipients for restriction are also done at the request of providers who call with concerns about specific recipients who may or may not have shown up on a SURS report. Other activities of the program staff include sending educational letters to some recipients instead of restricting them, and reviewing borderline cases at given intervals during the year to determine whether use has dropped or restriction should be implemented. Telephone contact with recipients, providers, health program representatives, and case workers is an ongoing activity.

This audit of a component program of Medicaid was conducted during a time when health care reform was being discussed nationally. It is impossible to predict the outcome of the current debate on health care reform or the resultant form of Medicaid or its programs. Further, the planned addition of more Health Maintenance Organizations or HMOs as Medicaid providers in Utah may affect the restriction program, since HMOs have their own procedures to control overusing or abusing members. These changes and perhaps others may affect the level of need for a restriction program. However, given the local and national changes occurring or planned, we believe that the recommendations made in this report for the Medicaid restriction program will result in cost-beneficial improvements both now and in future should this program continue to exist beyond health care reform.

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Chapter II
The Restriction Program Is Effective and Should Be Expanded

According to a limited sample of restricted recipients whose services we reviewed, the restriction program is effective in reducing service use and costs to Medicaid. Based on the results of our sample, we believe that the restriction program's enrollment should be expanded. We found there were recipients with high levels of use who were not reviewed or restricted. Staff should consider additional recipients for restriction program placement to lower costs to Medicaid and increase the likelihood of coordinated medical care being provided. Also, staff should develop a way to measure program effectiveness. Finally, educational letters can be put to better use and contacts with providers can improve.

Restriction Program Is Effective

Recipients' use of services and costs paid by Medicaid during the first year on the restriction program decreased significantly when compared to use and costs before restriction. Overall costs went down by 53 percent and use of specific services decreased by as much as 77 percent for the sample population's first year on the program. We were unable to randomly select a sample of recipients, so savings projections to the entire restricted population may be unrepresentative.

We analyzed the use of medical services for a sample of 22 Medicaid recipients who became enrolled in the restriction program during the first quarter of 1993. We compared services used for the year prior to placement on restriction with services used for the first year on the program. The following figure shows the changes in medical costs between these two years for the recipients in the sample group.

Figure I

Comparison of Medicaid Cost for 22 Restriction Recipients (Enrolled First Quarter 1993)

Recipient	Year Before Restriction	Year After Restriction	Percent Difference
1	$10,810	$4,914	54.5%
2	1,118	883	21.0
3	4,978	1,583	68.2
4	4,360	4,155	4.7
5	10,877	969	91.1
6	1,175	268	77.2
7	7,475	4,393	41.2
8	1,889	529	72.0
9	7,363	10,358	-40.7
10	16,764	2,240	86.6
11	9,564	1,533	84.0
12	19,178	9,423	50.9
13	5,604	2,770	50.6
14	6,283	2,733	56.5
15	2,943	1,332	54.7
16	7,915	5,822	26.4
17	18,654	11,065	40.7
18	11,490	3,443	70.0
19	13,740	8,516	38.0
20	2,503	2,958	-18.2
21	4,911	1,397	71.6
22	7,732	3,193	58.7
Totals	$177,326	$84,473	52.4%
Monthly Average [1]	$730	$346	52.6%

[1] ***Based on total months eligible for all 22 recipients during both "Before" and "After" time periods.***

As Figure I illustrates, costs came down substantially during the first year recipients were on the restriction program. In fact, services during the first year of restriction cost $92,850 less than services for the year prior to restriction for the 22 recipients, which converts to an average savings of $12.60 per day. We compared only the levels and costs of *routine and ongoing* services during these separate times. Therefore, we did not include costs for infrequently occurring services such as inpatient hospital stays or life-threatening emergency room use.

Not only did costs to Medicaid come down for the sample, but use of services decreased in every category we evaluated. Most notably, use decreased in emergency room visits by 77 percent, different pharmacies used by 73 percent, and claims for abuse-potential drugs by 64 percent. These are three areas of possible abuse that concern Medicaid staff; the decreases not only reduce costs to Medicaid but also suggest that recipients are receiving more coordinated care. This is because too frequent use of emergency rooms for non-emergency care prevents the primary care physician from coordinating all care, and the use of multiple pharmacies makes obtaining many drugs, especially abuse potential drugs or drugs with adverse interactions, hard to identify.

Data Problems Limited Our Analysis and Caused Time Delays

During the audit, we encountered some problems with requested data. Some reports came back showing no claims history for recipients during a period when use was high enough to merit restriction program enrollment. Further, reports that covered claims more than two years old had numerous duplications, rendering them useless. Repeated requests yielded reports that still contained incomplete data. Finding the reasons for the problems added about six weeks to our audit fieldwork. By then, HCF staff had identified and corrected most of the problems and were able to provide us with new data.

Because we were still unable to obtain accurate data older than two years, we revised our sampling to avoid the need for data older than 24 months. This allowed us to proceed with a cost effectiveness analysis for the recipients in our sample. As previously described, the sample involved the 22 recipients who became enrolled in the restriction program during the first quarter of 1993; as such, the sample was time specific and not random within the universe of those who were restricted during 1993. Our analysis was restricted because we could not select a random sample, and the time spent on the audit was extended because of the data problems.

Because the sample was not random, we are unsure whether our sample of 22 recipients is

representative of the population of the 77 recipients restricted during 1993. Therefore, we cannot project with statistical certainty the reduction in costs for all recipients on the restriction program. However, *if* the sample is representative of the restricted population at large, placing recipients on the restriction program will result in a significant decrease in the costs of Medicaid services for restricted individuals. If the behavior of the recipients in our sample is fairly representative of all recipients restricted during 1993, there will be a first-year savings of roughly $354,000 for the 77 recipients who became enrolled in the program during that year. With staff costs of approximately $44,000 for salary and benefits, the program is cost effective, saving both the state and federal government money.

Program Enrollment Should Be Expanded

Because the restriction program is effective in reducing costs and coordinating care, enrollment in the program should be increased to include more recipients showing patterns of abuse. A number of recipients were not reviewed for restriction yet showed similar levels of excessive use of services to those who were reviewed and restricted during 1993, while the recipients who used services at levels just below those restricted could also be considered for restriction. Restricting more recipients who show signs of excessive use or abuse would create additional cost savings and provide controlled care for more recipients.

The Division of Health Care Financing is mandated by federal law to review for restriction a minimum of 0.01 percent of the active Medicaid recipient population from each quarterly Surveillance and Utilization Review subsystem (SURS) printout as an ongoing effort to control abuse. On a quarterly basis, the federal review requirement typically equals approximately eight to ten recipient reviews, though program staff consistently review more than that to ensure the minimum is met.

In looking at three quarterly SURS exception logs from March 1993 to September 1993, we found that 21 recipients were not reviewed for placement on restriction although they had used medical services at the same exception point level (80 points) as other recipients who were restricted. After eliminating those already on restriction, under review, or whose high use was justified, we found that seven of these recipients appeared to be good candidates for placement on restriction. If these recipients had been reviewed and found suitable for restriction, an additional savings of some $32,000 would have been realized over their first year on the program, using the rate of savings identified for the sample discussed previously.

In addition, in 1993 there were 60 recipients with 75 points and 108 with 70 points. Since each use of services over acceptable use levels generates at least five points, these additional recipients are using services at levels very close to the level of those being restricted. Although some of these may not be good candidates for restriction, these recipients represent a

logical group that should be considered for restriction if the program is expanded.

Although the program is effective in reducing use and costs in the first year of restriction, it should be noted that the majority of recipients remain on the program for more than one year. We reviewed 32 recipients who were restricted in 1992 to see whether they were kept on the program after staff conducted a review of first year use. Twenty-one of 32 had received an annual review, and 20 were kept on the program because medical use was still unacceptably high. The remaining recipient was dropped because of ineligibility for Medicaid, not because use had reduced significantly. Although use decreases once a recipient is enrolled in the restriction program, it does not decrease to acceptable levels in most cases after only one year on the program. (Acceptable use is defined as use below the thresholds established for placing recipients on restriction, such as fewer than three emergency room visits for non-emergency purposes, fewer than four different physicians used, and fewer than three different pharmacies used.)

The fact that some annual reviews had not been done for the sample just discussed points out the need for improvements in the efficiency of the restriction program's processes, which will be discussed in the next chapter.

Program Effectiveness Should Be Measured and Educational Efforts Increased

To determine program effectiveness, division staff should develop a means to measure the cost reductions generated by the restriction program over time. In addition, HCF should send out more education letters to borderline recipients and monitor the effect this has on use. Staff can also improve communication to providers about the restriction program and about recipient abuse.

Program Effectiveness Should Be Measured

HCF staff does not currently perform an analysis of Medicaid cost reductions generated by the restriction program. Assessment of effectiveness would show whether the program reduces use of medical services and the associated cost to Medicaid. It should also monitor changes in use over time so that trends could be identified. From there, decisions on needed program changes could be made. For example, once effectiveness assessment is in process, division management would have data to determine whether staffing increases are justified based on the cost reductions generated by the program.

The previous manager of the restriction program had computed a gross level savings figure

that reflected the difference between total costs for the year prior to restriction and total costs for the first year on the program. However, we were unable to ascertain that this computation took into consideration the fact that recipients might not have been eligible for services for the full year. Ineligibility to use medical services during the first year on restriction would lower costs and cause the savings to be inflated compared to a full year of use prior to restriction. Further, we could not determine that one-time expenses which could skew the results (such as an expense for major surgery) had not been included in the

analysis, because the previous manager was unavailable. The current program manager has indicated to us that no cost savings analysis is presently being performed.

Program staff should develop a methodology to compute the effectiveness of the restriction program and should also track use reduction into the second and third years when possible to identify trends in use. Because of the data limitations we encountered, we were unable to analyze service use beyond the first restriction year, but we believe that this information would be useful to program staff. For example, if use goes back up in the second year on the program, perhaps more education of recipients is needed. If use trends downward, staff might be able to calculate and project a typical reasonable enrollment period for the majority of recipients on the program.

HCF Should Bolster Its Program to Educate Recipients

Program effectiveness can be improved if the restriction program makes better use of warning or educational letters to recipients showing potential for abuse. Of a sample of recipients who were reviewed but not placed on restriction, only 16.7% were sent educational letters. HCF staff should send education letters to more recipients whose use may be excessive, and they should also assess the letters' effectiveness in curtailing abuse.

Education letters are supposed to be sent to recipients whose use is borderline in terms of the thresholds for being restricted, or to recipients having some reason (such as a particular diagnosis) that may partially justify high use. However, even recipients with valid high use of medical services may show some unacceptable patterns of use, such as filling prescriptions at multiple pharmacies. This could be a problem since incompatible drugs could be obtained from the various stores without a pharmacist being able to identify the conflict. An educational letter might be sent to inform the recipient of acceptable use patterns in the area of concern.

We expected to see that educational letters would have been sent to all those reviewed but not restricted, but this was not the case. We reviewed 18 recipients who had been considered for restriction but not restricted. Only 3 or 16.7 percent had been sent education letters. Some of the remaining recipients could have been sent educational letters as well, such as the four who were restricted at a later date or the six whose use was within restriction point ranges even though they had not been eligible for the entire review period. We believe that expansion of the use of education letters is needed, both to reduce overuse and to educate recipients on proper use of medical services. According to a joint state project report on SURS programs in 11 states, sending out education letters to those who were not restricted reduces use. We also found that two of the states we contacted send out warning or educational letters to recipients in an effort to reduce use without putting the recipient on restriction. One of these states monitors subsequent use to determine whether other action is needed.

Once letters are sent, maintaining the reduction requires that staff follow up on the initial

contact by conducting a review to see whether use has decreased, as the other states do. In a sample of the recipients filed for review in six months, we found that 39 percent of scheduled reviews had not been done on time, and another 39 percent had not been done at all. While not all of the recipients to be reviewed in six months have received education letters, it is important to follow up on those who have been contacted. Follow-up review of use subsequent to sending an educational letter is necessary to ensure that use does not return to higher levels, according to an audit report on Georgia's restriction program. Staff here are currently working on conducting these reviews to bring them up to date.

Finally, in order to assess the effectiveness of the educational letters, staff should compare the use levels found at the time of the follow-up review compared to use prior to a letter being sent to determine whether use has dropped or other action is needed.

Restriction Staff Should Contact Providers More

Staff can improve formal communication with Medicaid providers. As noted in the introductory chapter, telephone contact is ongoing with providers already involved with providing care to restricted recipients or to those who call in with concerns about a patient. Also, letters are sent to thank physicians who have agreed to act as primary care providers to restricted recipients. However, Utah's Medicaid program could do more to educate providers generally about the restriction program's existence and purpose.

Providers need to be aware of the purpose and goals of the restriction program and how they play a pivotal role in its success. Disseminating information to providers about the program could have some impact on the effectiveness of restriction. The program manager indicated she would like to include some restriction program information in a Medicaid bulletin regularly mailed out to providers, but she has not done so to date. Further, during our discussions with providers, we talked with a head nurse for a group of internists who are Medicaid providers who had not heard of the restriction program.

Provider communication takes a number of forms elsewhere. We found that staff in two of the states we contacted send service use profiles to the doctors of high use patients in an effort to better coordinate patient care. Staff in another state send all involved providers a letter to inform them when a patient is restricted to one physician so that they do not see the patient without a referral. Staff here indicated that this type of provider contact takes place only on occasion. Consideration should be given to methods used elsewhere that assist primary care physicians in providing care to restricted recipients.

Recommendations:

1. We recommend that the Division of Health Care Financing expand the restriction program enrollment to include at least those recipients who currently generate exception points at levels comparable to or close to recipients who are being enrolled. (This recommendation is made with the assumption that other recommendations affecting program efficiency will also be implemented, so that an increase in enrollment is feasible.)

2. We recommend that the restriction program staff develop a method to measure program cost effectiveness to include multi-year tracking of recipients.

3. We recommend that more education letters should be sent, and the effect of the letters on recipients' use of services should be tracked.

4. We recommend that information on the restriction program should be included in regular bulletins or newsletters to Medicaid providers.

Chapter III
Restriction Program Can Be More Efficient

The current restriction program can be improved if processes are streamlined. Reviews of high use recipients take too long because review processes are inefficient and involve too many manual steps. Needed changes include improving the Surveillance and Utilization Review Subsystem (SURS) reports used in reviews and automating manual processes so that staff can decrease the time taken to complete each step of an unnecessarily long review process. Reduced processing time will save Medicaid money by controlling use sooner and will aid staff in staying current in their work load. Efficiency improvements will increase cost savings to Medicaid since each month an overusing recipient is enrolled saves about $384, based on the results of the sample described in the previous chapter.

Time Taken to Restrict Recipients Is Excessive

An unnecessary amount of time is now taken to get recipients on restriction because of the manual nature of the restriction review process. At present, the process takes longer than five months on average to get recipients enrolled in the restriction program. This time is excessive because a new set of SURS reviews must be performed every three months. At present, staff are behind in quarterly reviews as well as in other required work.

We looked at a sample of seven recipients who were reviewed from the SURS exception log dated March 26, 1993 and found that it took from four to eight months for the recipients to become enrolled in the restriction program. The basic review and enrollment process starts with selecting a sample of recipients to review from the exception log. The log prints about 4,000 overusing recipients in descending order of use, so staff start on the first page and work down through about four pages to select 20-25 recipients to review. A secondary report called an exception profile is reviewed and then a Claims History Detail Report (CHDR) is requested. This is also reviewed and totals are derived in categories of use so staff can decide whether restriction is needed. Letters are sent, and time is given for recipients to request a hearing or notify program staff of their choice of providers if they accept restriction status.

The following figure shows the time taken to get each individual on restriction, using April 1, 1993 as a starting date for the process for the March 26 report.

Figure II Time Span to Get Recipients Restricted			
	Reasonable Date	**Effective Date of**	**Total**
1	4/1/93	9/1/93	5
2	4/1/93	12/1/93*	8
3	4/1/93	10/1/93*	6
4	4/1/93	9/1/93	5
5	4/1/93	8/1/93	4
6	4/1/93	9/1/93	5
7	4/1/93	10/1/93*	6
Average			5.56
* ***Hearing to appeal restriction was requested.***			

As shown in Figure II, it took an average of about five and one-half months before these recipients were enrolled in the program. In three cases, part of the time span is explained by the fact that recipients requested a hearing to appeal the restriction decision and this added time to the process which could not be directly controlled by staff. However, a significant portion of the time to restrict occurs over a period when staff have the ability to control the process: this period is from the time a quarterly report is generated until the restriction decisions are made and letters sent out.

After the notification letter has been sent, staff have little ability to expedite the process. Recipients are asked to call Medicaid with their provider choices within two weeks; if they do so, restriction becomes effective at the beginning of the next month. However, if they do not call, staff still wait 30 days because recipients are given that much time from the date of the letter to request a hearing on the restriction decision. A request for a hearing can add another one to three months to the process by the time the hearing is scheduled and held, a decision is made, and the restriction is activated if upheld. Figure III shows the length of time taken from the start of the review process (when the quarterly report printed) to the point when restriction letters were sent out for the sample from Figure II.

Figure III
Time Span to Send Restriction Letters

Recipient	Start Date	CHDR [1] Received	CHDR Reviewed	Restriction Letter Sent	Months Lapsed
1	4/1/93	5/1/93	6/2/93	7/7/93	3.22
2	4/1/93	5/1/93	6/30/93	7/8/93	3.25
3	4/1/93	5/1/93	6/30/93	8/3/93	4.11
4	4/1/93	5/1/93	6/30/93	7/8/93	3.25
5	4/1/93	5/19/93	6/30/93	7/8/93	3.25
6	4/1/93	5/1/93	5/18/93	7/9/93	3.29
7	4/1/93	5/1/93	7/12/93	7/13/93	4.42
Average					3.40

1 Claims History Detail Report

As Figure III illustrates, it took an average of almost three and one-half months to get recipients reviewed and restriction letters sent. It took as long as a month and a half from the first of April for staff to select the recipients for review and request the relevant CHDR. The CHDR is typically ready in one working day so this does not add much time to the process. Once received, as many as 73 days lapsed before staff reviewed the CHDRs. Once restriction decisions were made, it took from one to 52 days to send out the letters notifying recipients that they were being enrolled in the restriction program.

In the interests of increasing efficiency, we developed a review scenario that reduced the time to get notification letters sent to about 12 days. We calculated a potential cost savings of $8,400 for this sample of seven recipients if they had been placed on the restriction program sooner. This calculation was based on the daily savings identified for the sample discussed in Chapter II. Our calculations assume that restriction staff would place top priority on conducting the reviews and sending out the notification letters as efficiently as possible in order to maximize the daily cost savings that accrue. We also assumed that staff would use a simplified review process with modified claims reports, which will be discussed in a later section of this chapter. Therefore, we assumed staff would be able to select the sample and request the CHDRs within a matter of a few days, and would begin reviewing the CHDRs within a couple of days of receiving them. Under this scenario, staff can greatly condense the time from the date a SURS exception log prints to the date restriction decisions are made and notifications sent out to recipients. Once notification letters are sent, we

assume staff are not able to expedite the process given the time allowed for a recipient to respond to the notification with provider choices or to request a hearing.

Some Restriction Program Processes Are Inefficient

The restriction program's primary function, that of identifying and restricting overusing recipients, is highly manual and therefore time consuming, which explains why it takes so long to get an overusing recipient enrolled. Specifically, the current SURS exception log and exception profile reports are inefficient to use and require too much staff time to summarize the data and make restriction decisions.

Reports Used Require Manual Interpretation

The quarterly SURS exception log, used to generate samples of recipients for review, is cumbersome to use. The report lists names of all non-institutionalized recipients between the ages of 16 and 44 who generate any exception points, or indicators of higher than usual use, and lists them in descending point total order. The difficulty is that the report includes recipients already on the restriction program, without specifically designating their status. Thus, staff must read through the first few pages of the report, determine which listed recipients are already enrolled, and then manually eliminate those recipients from consideration when selecting a sample to review.

For example, staff selected 21 recipients to review from the December 22, 1993 SURS exception log. In order to get their sample, staff had to go through four pages and 68 names, 65 percent of whom were already enrolled in the restriction program, to identify the sample eligible for review. Since the report does not indicate whether listed recipients are restricted or not, staff had to enter each identification number into the computer, bringing up the file that indicates the status of each recipient, in order to determine whether the listed individual was already restricted or else eligible for that quarter's review.

Once the sample is chosen, staff then pull the exception profile report for each recipient and conduct a preliminary review of the report. This report has not been used to make restriction decisions, however, although most of the relevant and necessary information is contained in summary fashion in this report. Instead, staff request another report, the Claims History Detail Report (CHDR), to review for each recipient under consideration for restriction. The CHDR lists each individual claim that occurred within the specific time of the report, and contains the most detailed level of information about services used. However, it requires manual totalling of the various categories of use (except total cost) and recaps much of the information already found in the exception profile report. Since these

CHDRs can be hundreds of pages long for some of the recipients under review, the time involved in manual counting and adjusting of claims categories can be significant.

Reports Are Excessively Long and Waste Paper

Each quarter's exception log report contains the names of approximately 4,000 recipients who have generated any exception points. Over the last year, however, staff have only reviewed an average of 20-25 recipients each quarter for placement on restriction in order to meet the 0.01 percent federal review requirement. While the report is over 200 pages long, staff select their sample from the first four to six pages. Thus, the bulk of the report is not needed or used.

In addition, an exception profile report prints for each of the nearly 4,000 recipients listed on the exception log, although only the 20 to 25 reports corresponding to the recipients selected for review are pulled by staff for a preliminary review of the summarized data. This report is about five pages long for each of the 4,000 recipients and fills three large boxes each quarter, with only about 125 pages or less than one percent of them needed out of approximately 20,000 sheets of paper.

Changes Would Improve Efficiency and Save Money

Greater cost savings will accrue to Medicaid and recipient care will be coordinated sooner if computer reporting capabilities are more fully utilized and other changes are made in the current review and restriction process. With recent changes in division and program level management, there is an opportunity to make improvements in efficiency that will enhance the program's effectiveness.

SURS Reports Should Be Changed to Streamline Review Process

As suggested by the sample and review scenario discussed in the previous section, timeliness can be improved in the restriction process. A major reduction in staff time needed to conduct the quarterly SURS reviews can be achieved if improvements are made to the SURS reports used in those reviews.

Specific improvements to enhance efficiency begin with removing recipients already restricted from the SURS exception logs and profile reports so that staff do not have to sift through these recipients to identify those eligible for review. As previously discussed, staff

must identify already restricted recipients and eliminate them from consideration in order to choose a group of recipients to review. Since about 65 percent of the people listed on the first four pages of the report we analyzed were already restricted, removing those from the report would make a difference in the time it takes to choose a sample; staff could conceivably just choose the top 20 or so names on the log and begin their reviews. The quarterly reports should include a separate printout, in alphabetical order, of all restricted recipients with their current exception point totals; this would provide a quick indication of whether or not reduction in use is occurring and would allow for trend studies of program effectiveness.

Further, since only the first few pages of recipients on the exception log are reviewed, both the exception log and exception profile reports should be adjusted so that only those recipients scoring at or above a certain number of exception points, such as 70 or 75, actually print on the log and profiles. This change would help streamline the review process and eliminate a certain amount of waste of printing time and paper, since the log would include only about 70 names instead of approximately 4,000, with a corresponding reduction in the volume of exception profile reports printing.

Once a more efficient SURS exception log allows a sample to be chosen quickly, changes to the exception profile report are needed. Currently, the exception profile report summarizes most of the relevant information needed to make decisions about restricting recipients such as number of emergency room visits, number of abuse potential prescriptions, and number of different physicians seen. However, the report lists diagnoses, surgical procedures, and drug prescriptions that recipients received in numeric code, making it difficult for staff to quickly review these items. If the information was printed on the exception profile report in text rather than code, restriction staff would in most cases have all the information necessary to make decisions without having to request, review, and manually summarize a Claims History Detail Report for each recipient as is currently done. We found that Medicaid offices in both Oregon and Colorado routinely use reports containing summary data for making restriction decisions as opposed to requesting detail level reports and reviewing them manually.

The restriction program manager has expressed a concern that the data included in the exception profile report is no more recent than three months prior to the print date. Originally, this time lag was intended to allow time for claims to be submitted and included in the data to be reviewed. However, since most providers now have shorter turnaround times and electronic billing to Medicaid, HCF should look at reducing the time lag of the data included in the exception profile report to as short a period as possible so that staff can review up-to-date claims information.

Toward the end of our audit and in response to our discussions with staff about needed improvements, the restriction program manager met with division management to discuss the changes recommended above and other ways to improve the usefulness and efficiency of the SURS reports. Several of the recommended adjustments to the exception log and profile report have been put in place as of the writing of this report. We commend division staff for their

responsiveness and efforts to improve the restriction program's efficiency.

Other Computer Changes Can Also Increase Efficiency

Once improvements to the SURS processes are made, other changes would help improve efficiency. Staff should use computer capabilities to generate restriction and education letters automatically. Staff should also develop an automatic reminder system that tells them when reviews are due on recipients scheduled for interim or annual reviews.

At present, the restriction notification and educational letters exist as form letters in the computer, but require staff time to edit for each individual to be contacted. Thus, letters are generated and printed one at a time and require manual editing. Staff call up the form letter, then type in specific information to identify the individual being contacted and the reasons for restriction. While this allows maximum individual content, it takes a lot of staff time to type in the appropriate content. If, as we have been told, there are a few common reasons for recipients to be restricted, staff should either develop a short series of letters that would address each of the usual restriction reasons, or set up a file that would merge an explanatory paragraph into the main restriction letter, depending on the reason for restriction. Letters could then be automatically generated and printed without requiring individual editing. The joint state project report cited on page 10 also suggested that "in many cases, letters that notify recipients that their service use exceeds certain limits can be generated through use of a computer."

To further enhance efficiency, the computer could be used for scheduling purposes to generate reminders for staff listing the recipients due for three- and six-month or annual reviews. From our phone calls we learned that the Colorado Medicaid office has a computerized system designed to schedule reviews and other activities. Using a computerized reminder system would eliminate the need for staff to file folders in a separate drawer for interim reviews, and would increase the likelihood of the reviews occurring on schedule. As noted in Chapter II, we found examples of six-month and annual reviews that had not been conducted on schedule and believe that the filing system is an inadequate reminder to staff of reviews that are due.

Manual Processes Should Be Made More Efficient

Other staff duties related to maintaining recipients on the restriction program should be reassessed and made more efficient. Currently, a number of overlapping manual filing systems exist that are difficult to access and could be reorganized if the computer can be programmed to provide reminders to staff of reviews needing to be done.

When a recipient is identified for review, a paper file folder is prepared that includes handwritten notes tracking the various steps followed. The folders are kept in filing cabinets

and arranged by the month restriction went into effect, regardless of year. Thus, anyone who was restricted in January of any year will be filed in the "January" section. Folders are accessible neither alphabetically nor by year, but staff must first ascertain the month an individual went onto the program before they are able to find a file. In order to determine the month, staff look up the recipient in an alphabetized card file, since an index card for each restricted recipient was also prepared when the recipient became enrolled. The index card file shows the month recipients were restricted. This system is cumbersome and is further complicated by the use of separate three- and six-month review file drawers that are also arranged by month, as well as boxes of folders for those reviewed but not acted upon, and boxes containing folders of those no longer on restriction.

The filing system could be arranged in traditional alphabetical order if staff use the computer to remind them when reviews are due instead of using a complicated monthly filing system to determine when interim or annual reviews are needed. This would eliminate the necessity for a card file system, especially with the recent addition of a DataEase file that records restricted recipient information. As of the writing of this report, staff were in the process of alphabetizing the main restriction files; we believe this will simplify file location, and believe that all program files should be similarly alphabetized.

Other manual steps include maintaining handwritten lists of the results of SURS reviews, which list whether or not reviewed candidates were restricted. These lists may or may not show whether an education letter was sent to those not restricted. Also, a separate handwritten list of education letters sent is kept, but we found it to be incomplete. Again, these lists should be unnecessary if the computer records are set up in such a way to allow recording and tracking of actions taken in regard to restriction program participants.

Recommendations:

1. We recommend that the SURS exception log be modified by removing the names of already restricted recipients and listing them separately in alphabetical order with point totals.

2. We recommend that the exception log be modified so that only recipients with exception points above a designated cutoff point print out.

3. We recommend that the exception profile report be modified to exclude those already on restriction and those below the designated cutoff point from printing.

4. We recommend that the exception profile report be modified to print out the text of diagnoses, surgical procedures, and drugs instead of the codes for these items.

5. We recommend that the reports be modified to minimize the time lag on included data

so that staff review up-to-date claims information.

6. We recommend that restriction letters and education letters be automatically generated.

7. We recommend that the program use computer-generated reminder lists for the regular reviews of recipients.

8. We recommend that the filing system be reorganized alphabetically.

9. We recommend that maintenance of handwritten lists of restricted recipients and education letters cease in favor of computerized record keeping.

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Chapter IV
Procedures Exist for Questioned Charges and Consideration of Assets

Concerns expressed by a legislator over the adequacy of procedures in two distinct areas of Medicaid service use and eligibility led us to review specific procedures at HCF and the Department of Human Services (DHS). First, we found that HCF has adequate procedures in place to check questioned service use listed on a recipient's Explanation of Benefits (EOB) form, and that pharmacies have fairly standard procedures to follow when they suspect someone of improper use of a Medicaid card. In the second, unrelated area, the application process for assistance at DHS that determines eligibility takes assets in the home into consideration, with verifications obtained on liquid assets and income. Applicants' information on the value of assets in the home is accepted without formal verification unless there is reason to question the provided information.

We were asked to determine if adequate controls exist to ensure that appropriate action is taken when a Medicaid recipient questions charges on the Explanation of Benefits (EOB) form or believes someone else has used his or her Medicaid identification (ID) to obtain drugs. An EOB is a form periodically mailed to recipients that lists all paid services for a specific period. We were provided with an example of a recipient whose ID was used by someone else to obtain prescription drugs. Discussion with the recipient revealed that she found out about the fraudulent use of her ID when an investigator came to see her about questionable patterns of use of her ID at several pharmacies. The recipient told us that she had also noted unfamiliar charges on her EOB. The incident happened over two years ago and the defrauding individual has been arrested.

In the second area, we were asked to review asset consideration in eligibility determination because of concern that some Medicaid recipients might not have met the assets test. We were provided with an example of a Medicaid recipient who was receiving home health care and questions were raised about the number and value of personal assets seen in his home; a second concern was raised about the expensive vehicle he owned.

Procedures Exist to Respond to Questioned Use

A procedure is in place within the Claims Processing Bureau to check EOBs returned to

HCF so that recipient questions about listed services or charges are addressed. However, fraudulent use of a Medicaid card appears to be most often identified by pharmacists, who are regarded as the "front line control" by HCF staff. Pharmacists say they call the police, HCF, and/or the prescribing physician when they suspect a problem. Most of the pharmacists we talked with said that fraudulent use of a Medicaid card is an unusual occurrence.

A control procedure exists in HCF to address concerns, although it did not exist at the time of the incident that generated the legislator's request to us. According to the procedure, recipients are instructed to return the EOB to HCF if they have any questions or concerns. Designated claims processing bureau staff then review not only the questioned claim or claims, but every item on the form. Documents related to the claims in question are reviewed, providers are called if necessary, and the recipient is consulted.

According to our review of the returned EOBs on file, the majority of returned EOBs were found to be an accurate listing of services rendered. In other words, 46 percent of the EOBs had been returned to HCF even though the recipient had no question about any items, and another 37 percent involved a misunderstanding on the part of the recipient. For example, a claim was submitted from a physician who had interpreted test results, and the recipient did not recognize the physician's name, since no direct contact had occurred; however, the service had been provided. Provider error was involved in 16 percent of the questioned items, and these were reprocessed to correct the claims. Most of these items involved billing to the wrong ID number. One claim in the sample, or one percent, involved billing for a piece of medical equipment not provided, and the overpayment was recovered from the provider.

There was no record that the individual in the information provided to us had returned her EOB to HCF. However, the procedure to check on questioned charges or services had been put in place in early 1992, and the questioned charge had appeared on the recipient's September 1991 EOB. According to the information we obtained from the recipient and the pharmacist, it appears that someone had obtained the recipient's Medicaid ID and had used it to call prescriptions in to the pharmacy. The person then showed up to pick up the drugs, claiming to be a volunteer delivering prescriptions to homebound recipients. Once the pharmacist became aware that someone was misusing a Medicaid ID, he called the police, who arrested the individual the next time she came in to pick up prescriptions.

Pharmacists Follow Set Procedures When Concerned

We talked with pharmacists and pharmacy administrators at three large store chains, the Utah Pharmacy Association, one medical center, and one small chain. With one exception, they do not feel that Medicaid fraud, such as altering prescriptions or using someone else's Medicaid card, is a big problem. If they do have a concern, they have procedures to follow, including verifying with the prescribing physician, refusing to fill a prescription, keeping the scrip, and calling the police and/or HCF.

In general, the pharmacists with whom we spoke indicated that although problems do occur, they do not see a fraud problem with their Medicaid customers in particular. Several commented that they know their customers well, and would therefore recognize problems like the use of someone else's card. Standard policies and procedures are in place in most pharmacies to deal with problems that do arise. Pharmacists are encouraged to visually check the Medicaid card and even make a photocopy of it for their records. When dispensing narcotics or other controlled substance prescriptions, the pharmacists indicated they match the name on the Medicaid card to the name on the prescription, or may ask for other identification. If they have any concerns, they contact the prescribing physician to verify the prescription, or may call Medicaid regarding eligibility concerns. Suspicions about the completed prescription itself would lead them to keep it for evidence, and most indicated they would call police if they suspected forging or altering the prescription.

Five of the six pharmacists mentioned the need for or benefits of a fully implemented point-of-sale program, which is a computerized system that will instantly tell pharmacists what Medicaid will pay for prescriptions. HCF was in the process of testing and implementing a point-of-sale computer system during the course of this audit. The system also has the ability to alert pharmacists if a recipient has recently filled the same prescription elsewhere, and will have features including drug interaction warnings once the second phase is implemented. (The first phase of the point-of-sale program has been implemented in most pharmacies in the state since our discussions with the pharmacists took place.) The pharmacists felt that the point-of-sale program would aid in identifying drug abusive behavior and provider prescribing problems in addition to providing eligibility and payment information to them.

Finally, one pharmacist suggested that perhaps a copayment on all prescriptions is needed to increase the effectiveness of drug dispensing for recipients. He felt that even a small copayment would cause recipients to think about whether they really need a prescription. Another pharmacist commented that Medicaid recipients don't pay anything for their prescriptions, so they don't care about the cost.

Assets Are Considered When Determining Eligibility

It appears that reasonable procedures are in place to determine eligibility for assistance, especially regarding consideration of assets. Eligibility for Medicaid and other assistance programs is determined by the Office of Family Support in the Department of Human Services. Generally, procedures involve asking applicants for full disclosure of assets, obtaining documentation for verification of income and liquid assets, and following up in more detail if necessary. Certain assets are exempt from consideration, depending on the category of assistance. Our work in this area found that procedures were followed in the example we were asked to review, and that OFS workers follow established guidelines when determining which

assets will be considered in eligibility determination.

We were asked to review asset consideration because of concern over the possibility that some Medicaid recipients might not have met the assets test. As noted previously, the case of a Medicaid recipient of home health care had been brought to a legislator's attention because home health agency staff had questions about the personal assets seen in his home; a second concern was raised about the expensive vehicle he owned.

Specific Case Which Caused Concern Met Established Guidelines

We found that the individual had caused concern among the home health agency workers serving him for various reasons, but that OFS was satisfied that established eligibility guidelines were met in his application and review process. Our information indicated that the individual was eligible for Medicaid due to a disability.

In the example we reviewed, home health aides had noticed a variety of different types of electronic equipment in the home, including VCRs, tape editing equipment, a computer and printer, stereo equipment, and a fax machine and answering machines. Further, the individual owned or had use of a vehicle referred to in one report as a BMW. For these reasons, the agency staff felt that the individual might not meet eligibility requirements for assistance.

Discussion with staff in OFS found that the individual had not declared any single asset in the home with a *resale* value over $500. According to OFS, any asset in the home with resale value less than that amount is exempt from consideration for disabled candidates such as the individual in the case we reviewed. Also, in general, assets in the home such as furniture and household goods are exempt from consideration. This would most likely include electronic (stereo and VCR) equipment, according to OFS staff. Thus, assets that the home health aides questioned may have been exempt because of the resale, not retail, value requirement. Finally, again according to the OFS policy coordinator, DHS does not have the ability to check the accuracy of each application for assistance, and they have no choice but to accept the information provided by the applicant, unless something on the application leads them to seek further verification.

Regarding a vehicle, policy states that any vehicle used to obtain medical care at least four times a year or needed for work is also exempt from consideration, regardless of its value. Thus, even if the vehicle was a BMW, if used to obtain medical care, it would not cause an individual to be ineligible.

Application for Assistance Asks for Asset Disclosure

The application process for assistance involves a lengthy application and requires the applicant to provide various documents verifying income, assets such as bank accounts and insurance policies, and ownership of other assets. Generally, one vehicle is exempt from consideration as is a home. Workers verify information by requesting documents such as pay stubs or W-2s, bank statements, and bills; they take applicants' word regarding asset valuation. Numerous exemptions are allowed, including assets with resale value under $500 and any vehicle if used to obtain medical care four times a year. Applicants are warned that withholding or falsifying information is a crime, and are asked to sign a full disclosure statement. Verification processes that occur on a regular basis include checking federal IRS records for interest earnings to determine whether a recipient is earning interest on an unreported asset. Visual checks are done during visits to the home for reviews by case workers, but searches are not done without cause; also, investigations will be done if something occurs that leads OFS to question eligibility.

In the case of the individual recipient we reviewed, the concerns of the home health agency staff were reported to state officials, and an investigation was conducted to follow up on those concerns. OFS staff told us an investigation was conducted by the Office of Recovery Services in DHS. The focus of the work was to determine whether the equipment in the home was used for a home business. Had this been the case, any income from the business would need to be counted when determining eligibility. The investigation was inconclusive, and the case was closed.

Home Health Care Providers Feel Abuse by Recipients Is Rare

Finally, interviews with five home health care providers indicate that very little recipient abuse or overuse of home health benefits occurs. Three providers, including the nurse at the home health agency for the individual in our request documents, indicated they had only known of one case they considered abusive. Two other providers had not had any occasion to question either eligibility or use of services for any Medicaid clients. The three who each had one case of concern indicated that the majority of cases needed the assistance, and that the case causing concern was "very much the exception."

As a result of the work done in these two areas, we believe that the agencies provided us with sufficient and satisfactory information explaining the circumstances for the specific cases in our audit request. Further, we do not feel it necessary to recommend any changes in current procedures for the areas reviewed.

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Agency Response