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Medicaid: Prepayment and Post-Payment Review Follow-Up Study

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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Medicaid: Prepayment and Post-Payment Review Follow-Up Study

August 1988

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

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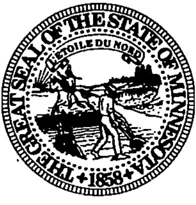

STATE OF MINNESOTA
OFFICE OF THE LEGISLATIVE AUDITOR
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JAMES R. NOBLES, LEGISLATIVE AUDITOR

August 31, 1988

Representative Phil Riveness, Chairman
Legislative Audit Commission

Dear Representative Riveness:

In March 1984, the Office of the Legislative Auditor issued an evaluation report on the administration of Minnesota's Medicaid program. The report concluded that the Department of Human Services was generally doing a good job in administering the program, but noted deficiencies in prepayment and post-payment controls over Medicaid expenditures.

In March 1988, the office initiated a follow-up study to determine whether the deficiencies found eariler had been addressed by the department. This report finds progress in many areas. But it finds that the department still lacks adequate controls over recipient utilization of Medicaid and recommends an expansion of the state's "restriction" program. Such an expanded program could save the state a significant amount of money.

We received the full cooperation of the Department of Human Services in conducting this follow up.

The report was researched and written by Tom Walstrom (project manager) and Kathleen Vanderwall.

Sincerely yours,

James R. Nobles
Legislative Auditor

Roger Brooks
Deputy Legislative Auditor

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Medicaid: Prepayment and Postpayment Review Follow-up

Executive Summary

Medicaid (or Medical Assistance) is a joint state/federal program that pays health care providers for services furnished to clients of public assistance programs. Medicaid is a large program, with expenditures totally over $1.1 billion for fiscal year 1987. The program is administered in Minnesota by county welfare agencies and the state Department of Human Services (DHS). DHS acts as the fiscal agent for the Medicaid program, receiving invoices from medical providers and paying them according to a detailed schedule of allowable reimbursement rates. In fiscal year 1987, DHS paid almost nine million provider reimbursement claims.

This report follows up on recommendations we made in a 1984 evaluation study entitled *The Administration of Minnesota's Medicaid Program.* We reviewed the department's progress in improving prepayment and postpayment control systems. We found that DHS has made progress in improving prepayment expenditure controls. Although some deficiencies remain, the department hopes that a new Medicaid claims processing and information system will help resolve many of them.

DHS has also made good progress in improving its postpayment provider surveillance activities. In contrast to our 1984 report, we found that the tangible results from provider surveillance are now more in line with the effort extended. For example, investigations, monetary recoveries, and prosecution referrals are all up markedly from 1984.

In one area, however, the department has not implemented our 1984 recommendation. We recommended that DHS expand its recipient restriction program. This program restricts recipients who misuse Medicaid services to one medical provider. The idea behind the program is that one provider coordinating a patient's care will cut down on unnecessary and abusive service use. In recent years, physician case management programs similar to the restriction program have been widely adopted by other health care payors.

In 1984 we found that less than .1 percent of Minnesota's Medicaid recipients were participating in the program. In 1988, despite a doubling of the restriction period, only about .04 percent of those eligible for Medicaid are in the restriction program. We found that other states had much larger proportions of their Medicaid population in similar programs.

We also examined the cost-effectiveness of Minnesota's restriction program. As Figure 1 shows, we found average monthly costs for recipients before they were restricted was $1,097 compared with average costs of $672 per month after restriction. Thus, for those recipients we examined, the costs avoided by

restriction were about $5,100 per year. After considering administrative costs, the benefit-cost ratio of Minnesota's current program is about 4 to 1. Other states' programs are also cost-effective according to a number of research studies. We conclude that the potential exists to save millions of dollars by expanding the recipient restriction program. In addition, more appropriate health care can be provided through the program.

The potential exists to save millions by expanding the recipient restriction program.

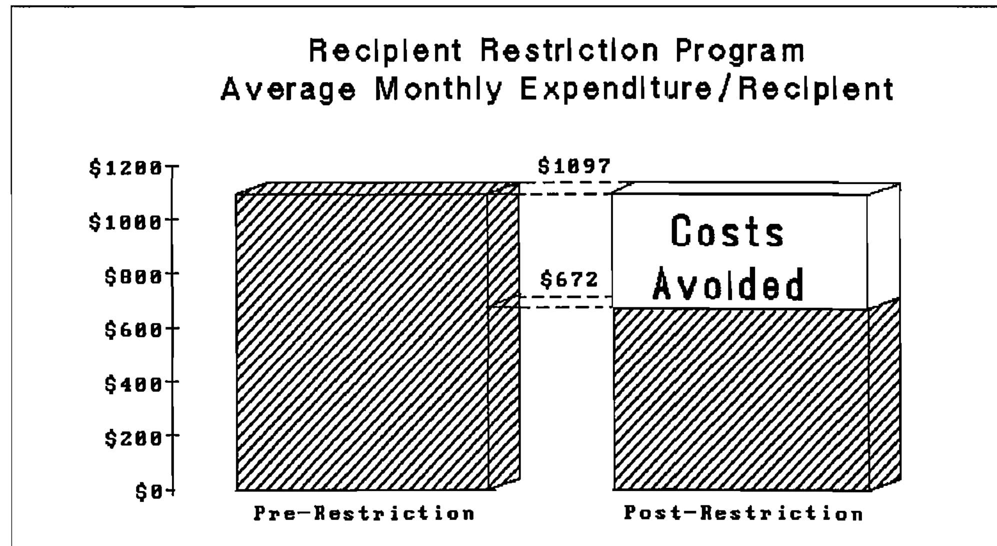

Figure 1

We recommend:

- **DHS should substantially increase the restricted recipient caseload. If necessary, DHS should consider adding staff to accomplish this goal. DHS should carefully monitor the cost-effectiveness of placing various types of recipients in the restriction program.**

- **DHS should consider establishing a program to send notices to recipients who appear to be misusing Medicaid services. The department should also provide information on how to most appropriately use Medicaid services.**

In order to expand the restriction program effectively and efficiently, DHS should take three administrative steps. We recommend:

- **DHS should automate payment of restricted recipients' claims.**

- **DHS should improve its use of computerized screening reports by determining which groups of recipients most frequently misuse services. DHS reviews then should focus on those groups most likely to misuse or abuse services.**

- **DHS should modify its written standards to allow restriction of recipients who are misutilizing services, but not breaking the law.**

Each of our recommendations could be implemented separately, but all are important to improve the operation of the program, to save Medicaid dollars, and to ensure that recipients receive appropriate health care.

Follow-up Report Medicaid: Prepayment and Postpayment Review

In March 1984 the Office of the Legislative Auditor issued a report examining the Department of Human Services (DHS) administration of the Medicaid program. Although we found the program generally well administered, we noted a number of deficiencies and made recommendations for improvement. This brief report follows up on the department's progress in improving the program's administration since March 1984. We focus on prepayment and postpayment controls over Medicaid expenditures, and do not deal with eligibility issues discussed in our previous report. Specifically, we examine how DHS has responded to the recommendations made in our 1984 report.

PREPAYMENT REVIEW

Invoice Processing

Prepayment review of Medicaid expenditures consists of two major functions: invoice processing and medical review. Our 1984 evaluation found that Minnesota met all of the federal requirements for timely and correct payment of claims, but also noted a number of deficiencies. The most serious problems were related to the age and design of the Medicaid Management Information System (MMIS).

The MMIS is a computerized information and claims processing system required by the federal government to ensure federal financial participation in the Medicaid program. Minnesota's MMIS was one of the first certified by the Health Care Financing Administration (HCFA) in 1975. Once the MMIS is certified by HCFA, a state is eligible for reimbursement of 75 percent of the costs of running and maintaining the system. A state is also eligible for 90 percent reimbursement of MMIS systems development and enhancement costs.

Since Minnesota's system was designed and approved in 1975, there have been numerous developments in state and federal Medicaid policy that have required extensive changes to the system. For example, new types of services such as Developmental Achievement Centers, Prepaid Health Plans, and

several waiver programs have necessitated changes. In addition, hundreds of computerized edits have been deleted or added over the years to help prevent payment of ineligible or inaccurate claims and to reflect policy changes.

The MMIS computer programs are lengthy, complex, and difficult to change and maintain. However, it is important that the MMIS be kept up to date because the Medicaid program is largely an automated system. A computerized system is the only way the state can reasonably handle the volume of claims and payments made for Medicaid and General Assistance Medical Care (GAMC). As Table 1 shows, Minnesota paid over 8.7 million claims, totalling almost $1.1 billion, for Medicaid in fiscal year 1987. Because the system is automated, no matter how many policy or operational decisions are made about Medicaid, the decisions cannot take effect until the MMIS is changed.

In 1984 there was approximately a two-year backlog in MMIS systems analysis and programming projects, and there were a number of deficiencies in the edits that insure proper payments for Medicaid-covered services. User documentation of the numerous changes made to the MMIS was lacking, and coordination and control over changes to the MMIS was weak. In addition, the department's ability to generate useful management information from the MMIS was limited.

These findings led us in 1984 to recommend that DHS should:

- **Undertake a systematic review of the MMIS edit structure.**
- **Improve the documentation of MMIS system changes.**
- **Devote more emphasis and personnel to computer systems functions.**
- **Significantly enhance or replace the long-term care payment subsystem of the MMIS.**
- **Increase its ability to respond to ad hoc requests for management information from department officials and legislators.**
- **Ensure that adequate production and audit controls over the processing of Medicaid claims exist.**

In 1984, we noted a number of problems with DHS's information system.

When our 1984 evaluation was released we advocated replacing the old and patched together MMIS with a more "state of the art" computer processing system. In 1987, the Legislature appropriated $875,000 for Minnesota's share of the costs for a new information system. HCFA requires states to undertake both conceptual and implementation planning before it will approve a system eligible for 90 percent reimbursement. The department has contracted with a consulting firm to prepare the Advanced Planning Documents (APD). The first phase (Planning APD) was completed on June 15, 1988 and the Implementation APD is due on September 30, 1988.

Provider Type	FY 1983 Claims Paid	FY 1987 Claims Paid	FY 1983 Expenditures	FY 1987 Expenditures
Nursing Home - General	61,972	73,184	$ 13,625,425	$ 19,407,535
Inpatient Hospital	145,382	69,004	133,012,784	125,684,879
Outpatient Hospital	398,732	370,802	21,902,724	27,611,690
Mental Health Center	31,027	60,946	2,089,575	5,374,595
Rehabilitation Center	11,863	33,204	1,436,313	4,936,575
Crippled Children's Service	582	448	13,965	17,671
Physician - Drug	422	469	2,873	3,303
Dept. of Health - EPSDT	5,754	5,377	171,106	190,981
State Hospital	31,232	24,843	95,202,177	107,915,160
Waiver		51,789		23,337,001
DAC		51,477		20,036,242
Physician - Individual	287,496	249,958	11,269,315	10,943,208
Physician - Group	999,498	1,191,405	32,988,188	57,138,901
Dentist - Individual	178,914	192,227	9,624,999	12,080,242
Dentist - Group	68,673	77,537	3,061,291	4,264,772
Optometrist	44,232	53,914	1,576,016	2,031,739
Podiatrist	16,967	12,478	361,627	384,005
Chiropractor	25,632	44,765	787,199	1,867,934
Nurse	11,375	22,716	3,672,981	7,743,383
Physical Therapist	2,748	2,555	263,333	329,623
Speech Therapist	5,312	1,923	393,250	157,503
Occupational Therapist	228	5	169,870	9,550
Licensed Psychologist	41,495	68,051	2,896,867	6,465,536
Audiologist	577	3,040	21,725	93,395
Public Health & OEO	41,606	38,887	1,335,175	1,307,663
Family Planning	1,772	2,215	78,866	108,483
Prof. School Clinic Dentistry	2,134	1,489	49,499	83,495
Home Health Agency	41,200	58,227	4,281,010	7,959,509
Pharmacy	3,328,407	3,967,309	31,812,116	50,672,578
Optician & Optical Supplier	44,678	80,020	1,186,993	1,818,931
Medical Equipment Supplier	63,098	119,970	2,465,533	6,265,657
Hearing Aid Supplier	16,252	20,410	601,417	861,710
Independent Lab	47,281	40,427	315,366	708,263
Medical Transportation	109,340	173,149	4,177,986	8,519,127
Subtotal	6,073,709	7,164,220	$380,847,564	$ 516,330,839
Nursing Home - General	947,055	925,054	$466,910,475	$ 564,572,236
Medicare Part B Buy-in	183,401	192,498	2,283,763	3,356,750
HMOs	51,651	453,952	2,371,779	27,213,129
Recipient Adjustments	7,828	11,616	(7,090,343)	(15,518,162)
TOTAL	7,255,816	8,747,340	$845,323,238	$1,095,954,791

Source: Department of Human Services.

Table 1: Medicaid Expenditures and Claims, Fiscal Years 1983 and 1987, By Provider Type

Most of the problems identified in our earlier report still exist. For example, documentation of systems changes has remained a weak point of the MMIS. Most MMIS changes are only documented in computer code, consequently no one person has a good handle on the whole system.

Management information about existing and potential Medicaid problems is still a weak point for DHS. DHS's ability to generate information for departmental managers and legislators is limited both by the design of the MMIS and by a lack of staff. The department's capability to generate management information has increased somewhat since 1984, with the addition of two positions (one currently vacant) devoted to research and evaluation on Medicaid policy questions. Unfortunately, the number of policy and management questions that need to be addressed far outweigh the capacity of the department's research and other professional staff to deal with them.

The new MMIS offers the potential of addressing some of these problems. DHS staff estimates of the time necessary to develop a new MMIS range from 2 to 5 years. In the interim, changes still have to be made to the system and it still has to operate to pay Medicaid claims. Because some changes to the system will be deferred in favor of the new MMIS, and because of the remaining deficiencies in the current system, we believe that DHS should choose an approach that will minimize the time necessary to bring the new system on-line.

DHS has made progress in several areas and hopes the new MMIS will solve other problems.

The department has made progress in several areas. First, the computer systems support devoted to Medicaid has increased, through the use of contract employees, from approximately 10 staff in 1984 to approximately 14 in 1988. However, the backlog of systems analysis and programming projects is at about the same level as in 1984.

Second, progress has been made on a new system for processing and controlling reimbursements for long-term care. Our previous study found that there was a lack of computerized checks to control inappropriate and duplicate payments for long-term care services. The department began to develop a new long-term care subsystem of the MMIS in 1986. The project has been delayed by a number of problems, but is now scheduled to begin operation on October 1, 1988. When fully operational, the system promises to improve control over long-term care expenditures and to provide better management information about nursing home reimbursements.

Third, coordination of systems changes has improved. DHS has continued a systems/invoice processing coordination group and formed a policy coordination group in 1987. DHS formalized control over changes in the MMIS computerized edits and service prices in Spring 1988. Previously, any number of DHS staff could make changes in the MMIS reference file that prices Medicaid services. This lack of control over the reference file resulted in cases of inconsistent service pricing. DHS now requires approvals from operating and policy managers before changes are made in the MMIS programs.

Medical Review

The second component of Medicaid prepayment review is the examination of services to ensure that they are medically necessary and appropriately

provided. This includes prior authorization requirements for certain services, second surgical opinions for some surgeries, drug utilization reviews, and an inpatient hospital admission certification program.

Prior Authorization

Prior authorization is one method allowed by Medicaid regulations to safeguard against unnecessary use of services. Minnesota has operated a prior authorization program since 1974. The prior authorization process requires medical providers to submit a request form before providing certain services.[1] The requests are reviewed by DHS medical staff in conjunction with a panel of approximately 25 medical consultants. The medical consultants make recommendations to DHS about whether the service should be approved at the level requested.

Our 1984 study noted several improvements that could be made in evaluating and processing prior authorization requests. One problem was DHS's inability to develop information about the nature, frequency, and cost of services requested, the number of requests denied or approved, and the costs associated with them. Because requests were processed manually, it was difficult to process them quickly and efficiently, and it was difficult to generate management information. Also, DHS could not ensure requests were consistently reviewed, because DHS policies regarding what was medically necessary and appropriate had not been formally developed. We recommended that:

- **DHS should formally adopt policies and criteria for prior authorization.**

- **DHS should institute a system for tracking and evaluating the cost-effectiveness of prior authorization reviews. Both the cost-effectiveness of maintaining current prior authorizations and the potential for adding additional services should be examined.**

In 1984, DHS began to revamp the prior authorization system. The department estimated the changes would take about six months to a year to complete. Although the project has taken longer than expected, DHS is currently testing changes to the prior authorization system that will allow on-line resolution of requests and will include a new reporting component. Reports available from the new system will allow better prior authorization cost-effectiveness assessments.

The department received authority from the 1987 Legislature to make changes in the list of services requiring prior authorization through notices in the State Register rather than through rulemaking. The department used this authority to publish a new list in December 1987. The department dropped requirements for over 100 procedures. Although the department did not base the decision to drop prior authorization on any formal analysis, it generally dropped low cost procedures and those it felt were rarely denied. A number of new procedures were also added to the list requiring authorization.

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1 Except in cases of medical emergency.

The department has made progress in formalizing criteria for prior authorization.

The Department of Human Services also has made progress in formalizing the criteria and policies regarding prior authorization. The department published a new rule covering prior authorizations and second surgical opinions in 1986. Additionally, DHS has been in the process of developing more detailed criteria for approval of certain services, such as diabetic education programs, uterine monitoring devices, nutritional counseling, and psychological services. More detailed criteria are also being developed for pain treatment programs, and sleep and eating disorder treatment programs.

The department has recently compiled a new Medicaid *Provider Manual*. The manual pulls together the current policies regarding covered services and procedures into one easily-updated document that takes the place of numerous provider bulletins. The *Provider Manual* includes a number of clarifications and standards for approval of services requiring prior authorization.

In summary, DHS has made good progress towards rationalizing its prior authorization process, however:

- **The department should continue to formalize its prior authorization and medical services policies.**

Second Surgical Opinion Program

The second surgical opinion program was authorized by the 1983 Legislature and became operational on April 1, 1985. The program covers inpatient hospital elective surgeries for:

- tonsillectomies and adnoidectomies,
- hysterectomies,
- hernia repairs, and
- cholecystectomies.

The goals of the second surgical opinion program are to eliminate unnecessary surgeries and to help contain costs. A preliminary analysis of the program by DHS in 1986 indicated that the number of covered elective inpatient surgeries had decreased. The data also indicated that the program was cost-effective. Beginning in 1988, the department plans to transfer the function to the review agent (currently Blue Cross/ Blue Shield) that handles the inpatient hospital admission certification program. The bids for the contract showed it was more cost-effective to have the review agent administer second surgical opinions along with the inpatient hospital admission certification program.

In-Patient Hospital Admission Certification

At the time of our 1984 report, review of inpatient hospital admissions, along with review of long-term care facilities, was carried out in the Utilization Control Unit of the Surveillance and Utilization Review Section (SURS). That unit was responsible for monitoring and preventing unnecessary or inap-

propriate delivery of institutional care and services to Medicaid recipients. The responsibilities were carried out by contracting with Professional Standards Review Organizations (PSROs) to review inpatient hospital services, and with the Minnesota Department of Health to certify long-term care facilities and services.

Review of inpatient hospital services is now separate from review of long-term care facilities. We limited our follow-up to inpatient hospital review, which is currently carried out by the Audit Division.

In 1984 the PSROs' utilization review responsibilities included:

- Determining the medical necessity and appropriateness of services, including pre-admission screening of inpatient admissions;

- Identifying problem areas in utilization and quality of care for inpatient facilities; and

- Developing and monitoring implementation of utilization and quality of care goals for inpatient facilities.

In 1984 the PSRO contract totalled nearly $500,000. In spite of the dollar amount of the PSRO contract, we found that DHS had not evaluated contract performance. The Utilization Control Unit received quarterly and yearly reports from the PSROs, but did not use the information to monitor PSRO performance.

While the organizational locus of utilization review has changed since 1984, its purpose remains the same. Responsibilities are now contracted to a review agent, currently Blue Cross/Blue Shield of Minnesota (BCBSM), and the contract amount has increased to $650,000. Under the new contract, effective July 1, 1988, the review agent will also be responsible for implementing the Second Surgical Opinion program.

The review agent contract includes criteria for evaluating performance, and BCBSM submits detailed information in monthly, quarterly, and yearly reports. The department reviews the reports to see that the required number and types of reviews are performed. DHS also conducts occasional on-site visits to hospitals, and performs special studies, such as an analysis of the accuracy of BCBSM's DRG validations. In addition, DHS and BCBSM meet regularly to discuss issues or concerns about the program.

While DHS has been active in monitoring certain aspects of the review agent's performance, we found that one area had not been evaluated. During our follow-up study we found that:

- **A formal evaluation of the criteria used by BCBSM to certify or deny admissions, and the way the criteria are applied, has never been performed.**

DHS should evaluate the review agent's contract performance just because of the amount of money involved. Although the program is saving enough

DHS needs to review the in-patient hospital admission certifications.

money, through denials of certification, to pay the costs of the contract, DHS has no way of knowing whether more could be saved. Also, DHS does not know if the review agent is making appropriate certification decisions. If admissions are approved or denied inappropriately recipients may not be getting the best care they could, and DHS may be spending more money than necessary.

DHS staff agree that a formal evaluation of the contract is important. Although they have lacked time and other resources to perform the evaluation in the past, they are working to complete one in a few months. Considering the size of the contract and the potential harm to recipients if admission decisions are made inappropriately, and the potential savings involved, we feel that a formal evaluation of contract performance is long overdue. We recommend that:

- **DHS should conduct a thorough evaluation of the review agent's certification criteria, and**
- **DHS should institute an ongoing process to monitor the review agent's application of the criteria.**

The evaluation and ongoing monitoring should include review of a sample of certification requests, so that DHS can be certain that the review agent is applying appropriate decision criteria in a consistent manner.

POSTPAYMENT REVIEW OF MEDICAID CLAIMS

The Department of Human Services (DHS) conducts a federally-required postpayment review of Medicaid claims. The program is carried out by the Surveillance and Utilization Review Section (SURS). The purposes of postpayment review are:

- to detect and deter abuse and fraud by Medicaid vendors and recipients,
- to recover overpayments that have slipped by prepayment controls,
- to monitor and control overutilization of services both to save money and to protect and enhance the health of Medicaid recipients, and
- to enforce appropriate administrative sanctions against providers and recipients and to refer cases to other agencies for appropriate action.

SURS includes three units: the Provider Surveillance Unit, with 8 staff; the Recipient Surveillance Unit, with 7 staff; and the General Support Services Unit, with 6 staff. The 1987 SURS budget was $896,500.

Provider Surveillance

Both the Provider Surveillance unit and the General Support Services unit review providers' practices. In addition, the Medicaid Fraud Control Unit (MFCU), located in the Attorney General's office, investigates and prosecutes cases in which fraud is suspected. The Fraud Control unit has 9 staff, including 2 attorneys and 5 investigators.

Allegations of fraud and abuse are received from a number of sources. The primary source of allegations is the SURS computerized reporting system. Providers whose practices are markedly different from their peers are flagged by the system, and SURS staff conduct further investigation to determine whether the difference indicates possible fraud or abuse of Medicaid. Other sources of allegations include private insurers, other providers, and recipients.

In our 1984 report, we concluded;

- **The results of provider surveillance were disappointing given the resources devoted to the function.**

We found that very few cases had been referred to the Attorney General for further investigation or prosecution, and that only a small amount of money had been recovered from providers.

Our 1984 examination of provider surveillance was impeded by the unit's deficient record keeping and statistical practices. We found that:

- **Statistical reports were inconsistent and inaccurate. As a result, management was unable to evaluate the unit's productivity or to respond to legislative information requests.**

In 1988 we found much-improved provider surveillance activities.

The SURS unit has substantially increased the number of investigations initiated each quarter. Referrals to the Attorney General increased from 13 in the 11-quarter period we examined in 1984, to 102 in the most recent 13-quarter period. Monetary recoveries have also increased, from an average of $38,000 per quarter to an average of almost $238,000 in each of the last 13 quarters. In contrast to our earlier review, SURS recoveries from providers (over $1 million this year) are enough to cover its operating costs.

We found provider surveillance greatly improved from 1984.

We found SURS record-keeping practices are also greatly improved. Since our last report, SURS has instituted an automated record-keeping system, which is used by both the Provider and the Support Services Units. We tested the new record-keeping system and found it adequate to produce the case management information necessary for efficient operations.

The Attorney General's Medicaid Fraud Control Unit (MFCU) had just been established at the time of our previous report, so we were not able to comment on its activities. However, we did review its activities during our 1988 follow-up. MFCU currently has a caseload of 30-35 investigations and prosecutions, most of which are criminal cases. The unit has so far recovered almost $1 million from providers, and appears to have the potential to do

much more. Major investigations generate an enormous amount of evidence, however, and the unit is hampered somewhat in its efforts to pursue large cases against nursing homes and other institutional providers by a lack of investigative staff. In addition to monetary recoveries, MFCU undoubtedly presents a deterrent to provider fraud. To enhance that effect, MFCU has printed brochures which describe their activities, and will distribute them to law enforcement officials, providers, recipients, and others.

Recipient Surveillance and Utilization Review

Background

The recipient surveillance function is carried out by a unit of the same name in the Surveillance and Utilization Review Section (SURS). This unit has responsibility for recipient reviews, as well as two unrelated functions: provider enrollment, and employment-related activities for personal care attendants. About three full-time equivalent positions are devoted to recipient utilization reviews.

The primary recipient surveillance emphasis is on a restriction or "lock-in" program. Although Medicaid regulations generally require that states allow recipients freedom to choose any enrolled Medicaid provider, there are a number of exceptions. One such exception is the state's ability to restrict recipients' freedom of choice if the agency "finds that a recipient has utilized Medicaid services or items at a frequency or amount that is not medically necessary."[2]

Medicaid recipients suspected of fraud, abuse, or misutilization of services are identified from several sources. Many referrals come from county human service departments and providers, and the recipient SURS unit also generates some preliminary cases from its computerized utilization screening of Medicaid claims.

The recipient restriction program's provisions are much like those of many Minnesotans' health plans.

The recipient SURS unit examines a claims history of the recipient suspected of abuse, and goes through a process to determine if misutilization has occurred. The medical review committee then examines the cases and, if warranted, refers the recipient to the restriction program. County caseworkers explain the program to recipients and notify them of their right to appeal. The program requires that recipients choose one primary doctor and one pharmacy to provide all but emergency services.[3] The recipients receive a different Medicaid identification card that shows they are restricted to the identified providers.

Despite the somewhat punitive connotation of the recipient restriction or "lock-in" program's name, its provisions are no different than those of many Minnesotans' health care plans. Health care case management has been used increasingly by third-party health care payors to hold down costs. In those plans, the physician case manager provides, supervises, or approves all client

2 42 CFR 431.54 (e).

3 Recipients are almost always restricted for physician services and pharmacy. Some recipients are also restricted for other provider types such as hospitals and medical transportation.

medical care. Thus, the case management model ensures access to one provider, but reduces generalized access to health care by client self-referral. The idea is that better health care results if it is coordinated by one primary provider. At the same time the health care payor saves money previously spent on inappropriately used services.

Findings of Previous Study

In our 1984 study, we found that only an extremely small percentage of the Medicaid population (less than one-tenth of one percent) were participating in the restriction program. We also found evidence that, despite the program's slight use, it was cost-effective.

In reviewing why the program was so little used we found that the department ran the restriction program mostly to meet federal requirements and it had probably identified only a fraction of recipients misusing Medicaid services. We also found that the department had not used the SURS computer system effectively to identify recipient abuse and misuse of services. The department focused its efforts almost exclusively on drug abusers, and did not pursue many other types of misuse such as "doctor shopping" and unnecessary emergency room use.

In our 1984 study we recommended that:

- **DHS should undertake a significant expansion of the recipient restriction program.**

We felt that the restriction program could save the state expenditures wasted on inappropriately used services as well as improve recipients health care.

We also recommended that the department address the impediments to using the program better: an inefficient manual claims processing system, an underused computerized system to identify misuse, and a lack of staffing devoted to recipient surveillance.

Findings of This Review

In our 1988 follow-up, we found that:

- **The Department of Human Services has made no progress in addressing the deficiencies identified in our previous report. The restriction caseload has not increased, the restricted recipients' claims are still processed manually, and the computerized exception system used to generate potential cases is not used effectively.**

No progress has been made in addressing the restriction program's deficiencies.

The recipient restriction program has continued to serve less than one-tenth of one percent of Medicaid recipients. In fact, fewer recipients have actually entered the program recently than during our earlier study. Since our 1984 report, the length of restriction was doubled from one to two years. As a result, one would have expected approximately twice as many recipients to be participating in the program. This expected increase did not occur.

Fewer recipients are in the restriction program than in 1984.

The invoices submitted by providers serving restricted recipients continue to be processed manually, in spite of the fact that more than 90 percent of them could be paid automatically. The manual processing of claims requires approximately .75 full-time-equivalent positions. According to department personnel in charge of maintaining the MMIS, the system changes necessary to automate payment would be a relatively small and simple project. We estimate that the payback period from such a change would be less than one year. Automating the payment of claims would have an even higher payback if the program were expanded.

We also found no change in the use of exception reports as a means to generate potential restriction cases. DHS still focuses on drug-related problems, with about 75 percent of the restricted caseload made up of recipients suspected of overutilizing prescription drugs. DHS gives other potential problem areas much less attention.

The department wastes effort reviewing recipients unlikely to be abusing services.

Since 1984, DHS has done no formal studies of which services are most likely to be abused or which groups are most likely to abuse them.[4] DHS reviews groups of whom little abuse would be expected, such as those in long-term care facilities, as much or more than groups where more abuse logically would be expected, such as 18-45 year old AFDC recipients. In fact, we found most of the recipients currently participating in the restriction program were in this 18-45 age group.

When we questioned department personnel about why the program had not been changed, they responded with two reasons. First, the department manager in charge of this function told us he was philosophically opposed to restricting recipients' freedom of choice in any but the most extreme cases. The second reason, following from this attitude, is that it was not a departmental priority to devote sufficient personnel and computer resources to make this program more effective. Some department managers appear to view the program as a sanction against the worst service abusers, rather than as a way to control Medicaid costs and ensure better health care for participants. This attitude is further expressed in the written standards outlining "grounds for sanctions against recipients".[5] A strict interpretation of these standards would appear to allow restriction only for fraudulent or other illegal behavior. However, behavior that is not illegal may still be deleterious to the health of the recipient and costly for the state.

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4 DHS is currently conducting such a study. At the direction of the Legislature, the department has set up a Managed Care Task Force to "examine the applicability and usefulness of focused utilization review, case management services, and other managed care approaches...". As part of the Task Force's work plan, the department is examining utilization patterns of MA and GAMC recipients.

5 *MA/GAMC Provider Manual.* Minnesota Department of Human Services (St. Paul, 1988), p. 7-08.

Other States Recipient Programs

To further examine this issue, we contacted a number of other states that operate restriction programs to gain information about their operation and cost-effectiveness.

Types of Recipient Programs

Some states send educational letters to high service users.

States have adopted a number of means to control recipient fraud and misuse of Medicaid services. A 1983 report by the National Governors' Association found that 37 states were using a lock-in program, 13 had education and monitoring programs, and 4 used prior authorization to control overuse of services.[6] In Minnesota, recipients whose use of Medicaid services has been found to be fraudulent or especially inappropriate may be placed on the restriction program, but there is no intermediate program for those who may need some assistance in using services appropriately.

Texas uses a program of educational letters and follow-up for such recipients. Texas sends about 6,000 letters per month to recipients who are high users of services. The letters inform the recipient that his or her use appears excessive, and will continue to be monitored. The recipient also receives informational pamphlets on the appropriate use of Medicaid services, and a toll-free number which may be called for additional information. Texas finds that 60 percent of recipients who receive a letter improve their use of services without further intervention. Estimated savings from the program are $120 per month per recipient.

California uses a similar though less extensive program. California officials estimate their savings at $50 per recipient per month from their educational letter program. California also uses a prior-authorization program to control use of services. Recipients who overutilize services may be required to have all physician or pharmacy services authorized prior to their provision. California officials estimate savings are $150 per month for pharmacy prior-authorization, $200 for physician services, and $250 for a combination of both.

Use of Exception Reports

Many states limit utilization reviews to likely abusers.

Other states' recipient control units reported that certain groups' utilization is not reviewed. Several states do not review children, on the theory that children are not controlling their own use of medical services. The elderly and those with critical diagnoses are also not reviewed, because high use of services by those groups would likely be justified by their medical conditions. For example, out of about 450,000 recipients per month, Texas screens only about 60,000 with exception reports. However, these are the most likely abusers, and the review results in a restricted caseload of about 7,000. California, Washington and Wisconsin also limit their exception reports in this way.

In contrast, Minnesota does not limit its screening to the groups most likely to misutilize services. Each quarter Minnesota selects one or more recipient groups to screen. During the four quarters ending in March 1988, DHS screened 12 groups. Of the twelve groups, four included only elderly persons,

6 National Governors' Association, Center for Policy Research, *Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs* (Washington D.C.: June 1983).

four included non-elderly who were either medically needy or in long-term care institutions, and one included only children. Only three groups included those most likely to abuse Medicaid services, namely non-elderly adults receiving AFDC or GA. According to Minnesota's recipient program personnel, they have tried to meet minimum federal review standards. However, federal personnel told us that "focused" recipient utilization reviews were allowable under federal regulations.

Cost Effectiveness of Restriction Programs

Other states' experiences with recipient restriction programs strongly suggest the potential for large cost savings. The 1983 National Governor's Association study found the 20 programs it studied were cost effective, with an average benefit-to-cost ratio of $12.79 to $1.00.[7]

The gross savings from the program is $5,100 annually per recipient.

In order to get some idea of the cost-benefit of Minnesota's restriction program, we examined the Medicaid costs of 42 recipients before and after they were put on the program. The Department of Human Services was able to provide us with the last two years of Medicaid claims data for recipients currently on restriction. We examined all recipients who, during the two year period, had at least five months claim experience before and after being put on restriction. We calculated the Medicaid expenditures for each recipient before they were put on restriction and after they were assigned to the program. Figure 1 shows the average monthly costs before and after recipients were placed on restriction. We found that the average difference in Medicaid costs between the pre-restriction and post-restriction periods was $425 per month or $5,100 annually. Since about 140 of the 161 restricted

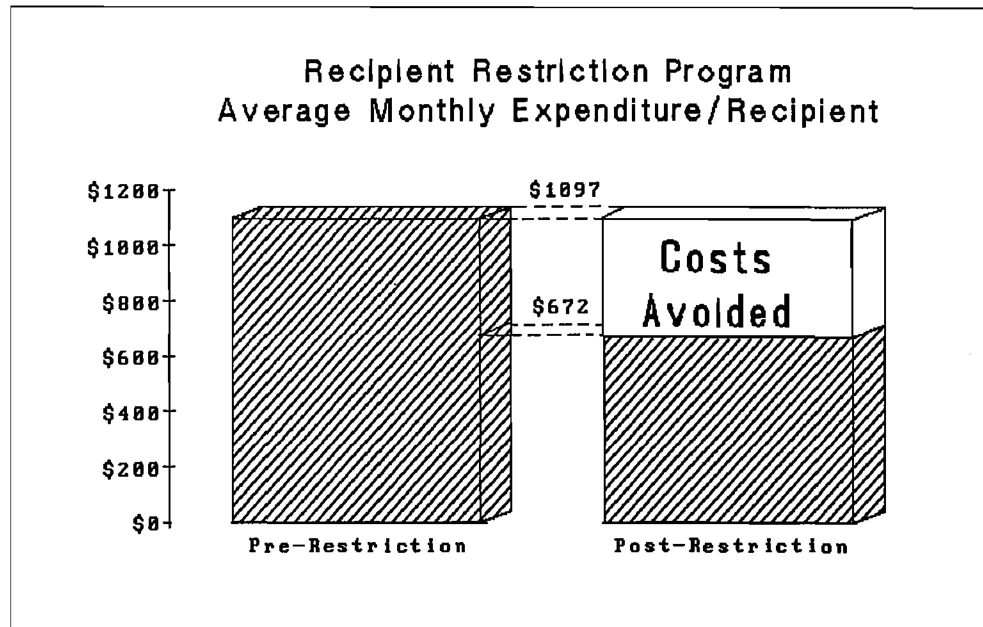

Figure 1

7 Illinois runs the largest (1.7 percent of eligible MA recipients) and the most cost-effective (estimated benefit-cost ratio of 21) restriction program. If Illinois is excluded from the analysis, the average state benefit-cost ratio was 6.85.

recipients are eligible for Medicaid in any one month, the expenditure avoided each year by the restriction program is approximately $714,000.

The Department of Human Services estimates that its administrative costs for the recipient program are about $166,000 per year. Thus, a rough estimate of the current program's benefit-cost ratio is 4 to 1. Although this is a rough estimate because of the limits of the data provided by DHS, it is consistent with the findings of the National Governors' Association and other studies.[8]

We estimate the program's benefit-cost ratio is 4 to 1.

Two other factors should be considered when examining the cost-effectiveness of restriction programs. First, the restriction program's administrative costs are "fixed" costs up to a point, since the federal government requires states to conduct recipient utilization reviews. Second, Minnesota currently restricts mostly drug abusers. Other states have found that the savings from restricting drug abusers tend to be less then the savings from restricting those misusing other services. Thus, if Minnesota were to expand the restriction program, the average savings per recipient could rise.

Table 2 presents estimates of costs that might be avoided if Minnesota's restriction caseload was increased. The amount that the state would actually save is the difference between the costs avoided and the administrative costs of running the recipient program. The table includes a range of costs avoided from $1,000 to $5,000 per recipient per year. Other states have experienced cost reductions within this range. For example, a GAO study found costs avoided by the restriction program in 1985 were $1,272 annually in Texas, $2,592 in Ohio, and $2,772 annually in California.[9] The state of Washington told us that its restriction program avoided $3,300 in costs annually per recipient, excluding hospital costs.

Annual Costs Avoided Per Recipient	Number of Recipients					
	150[a]	300	450	600	750	900
$1,000	$150,000	$ 300,000	$ 450,000	$ 600,000	$ 750,000	$ 900,000
2,000	300,000	600,000	900,000	1,200,000	1,500,000	1,800,000
3,000	450,000	900,000	1,350,000	1,800,000	2,250,000	2,700,000
4,000	600,000	1,200,000	1,800,000	2,400,000	3,000,000	3,600,000
5,000[b]	750,000	1,500,000	2,250,000	3,000,000	3,750,000	4,500,000

NOTE: The actual savings from expanding the program would be the difference between the costs avoided and the administrative cost of the program.

[a]There are now about 150 recipients in the restriction program.
[b]The costs avoided by the current program are about $5,000 annually.

Table 2: Medicaid Costs Avoided by Expanding the Recipient Restriction Program, Various Assumptions

8 A 1980 study by Pracon, Inc. found Minnesota's program had a benefit-cost ratio between 1.38 and 2.59 depending on the assumptions used to allocate administrative costs to the program. See Pracon, Inc. *Case Study and Analysis of the Minnesota Medical Assistance Recipient Restriction Program.* (Fairfax, Va.: September 1980).

9 General Accounting Office. *Medicaid: Improvements Needed in Programs to Prevent Abuse.* GAO/HRD-87-75. (Washington, D.C.: September 1987).

Large savings can result when the number restricted increases.

As Table 2 shows, even very low levels of per-recipient savings can result in large total savings when the number of restricted recipients increases. The proportion of Medicaid recipients in restriction programs varies dramatically among states, from .003 percent of the Medicaid population in Arkansas to 1.73 percent in Illinois. According to a study by the Inspector General of the U.S. Department of Health and Human Services, the differences could not be explained solely by geographic variations in the extent of abuse or the length of time that the programs had been operating.[10] Minnesota currently restricts approximately .04 percent of those eligible for Medicaid. We believe that there are many more recipients misutilizing services than those currently restricted. Department officials agree that there are more recipients that could be put on the restriction program if staff were available. There is some limit to the increase in the restriction program. For example, it would not be cost-effective to extend the restriction program's case managment to the whole Medicaid population. However, we believe the department could profitably expand the program's size a minimum of 5 - 10 times through a combined strategy of educational letters and restriction.

More recipients are misutilizing services than those currently restricted.

While the potential cost savings from increasing the restricted caseload are important, an equally compelling reason is the fact that medical care can be improved when it is managed properly. When one provider supplies the majority of an individual's health care, greater continuity of care results. Greater continuity of care reduces the risk of different providers prescribing contraindicated drugs or treatments, and makes monitoring changes in a patient's condition easier. These benefits may be especially important if the Medicaid population is more medically or emotionally fragile than the general population.

Recommendations

Based on our findings, we conclude that DHS has not operated the recipient surveillance function in the most effective manner. We recommend that:

- **DHS should take the necessary steps to automate payment of restricted claims, rather than waiting to include it in the MMIS update.**

- **DHS should improve its use of exception reports by determining which groups of recipients most frequently misuse services, and which services are most frequently abused. Reviews should focus on those groups most likely to misuse or abuse services.**

- **DHS should modify its written standards to allow the restriction of recipients who are not breaking the law, but who are misutilizing Medicaid services.**

- **DHS should consider establishing a program to send informational letters to recipients who appear to be misusing Medicaid services.**

10 U.S. Department of Health and Human Services, Office of Inspector General. *Prescription Drug Abuse and Diversion in the Medicaid Program.* (Washington D.C., October 1983).

The restriction program should be significantly expanded

- **DHS should substantially increase the restricted recipient caseload. If necessary, DHS should consider adding staff to accomplish this goal. DHS should carefully monitor the cost-effectiveness of placing various types of recipients in the restriction program.**

Each of our recommendations could be implemented separately, but all are important to improve the operation of the program, to save Medicaid dollars, and to ensure that recipients receive appropriate health care.

SELECTED PROGRAM EVALUATIONS

Board of Electricity, January 1980	80-01
Twin Cities Metropolitan Transit Commission, February 1980	80-02
Information Services Bureau, February 1980	80-03
Department of Economic Security, February 1980	80-04
Statewide Bicycle Registration Program, November 1980	80-05
State Arts Board: Individual Artists Grants Program, November 1980	80-06
Department of Human Rights, January 1981	81-01
Hospital Regulation, February 1981	81-02
Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill, February 1981	81-03
State Designer Selection Board, February 1981	81-04
Corporate Income Tax Processing, March 1981	81-05
Computer Support for Tax Processing, April 1981	81-06
State-sponsored Chemical Dependency Programs: Follow-up Study, April 1981	81-07
Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights, April 1981	81-08
Individual Income Tax Processing and Auditing, July 1981	81-09
State Office Space Management and Leasing, November 1981	81-10
Procurement Set-Asides, February 1982	82-01
State Timber Sales, February 1982	82-02
Department of Education Information System,* March 1982	82-03
State Purchasing, April 1982	82-04
Fire Safety in Residential Facilities for Disabled Persons, June 1982	82-05
State Mineral Leasing, June 1982	82-06
Direct Property Tax Relief Programs, February 1983	83-01
Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes,* February 1983	83-02
Community Residential Programs for Mentally Retarded Persons,* February 1983	83-03
State Land Acquisition and Disposal, March 1983	83-04
The State Land Exchange Program, July 1983	83-05
Department of Human Rights: Follow-up Study, August 1983	83-06
Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf,* January 1984	84-01
The Administration of Minnesota's Medical Assistance Program, March 1984	84-02
Special Education,* February 1984	84-03
Sheltered Employment Programs,* February 1984	84-04
State Human Service Block Grants, June 1984	84-05
Energy Assistance and Weatherization, January 1985	85-01
Highway Maintenance, January 1985	85-02
Metropolitan Council, January 1985	85-03
Economic Development, March 1985	85-04
Post Secondary Vocational Education: Follow-Up Study, March 1985	85-05
County State Aid Highway System, April 1985	85-06
Procurement Set-Asides: Follow-Up Study, April 1985	85-07

Insurance Regulation, January 1986 86-01
Tax Increment Financing, January 1986 86-02
Fish Management, February 1986 86-03
Deinstitutionalization of Mentally Ill People, February 1986 86-04
Deinstitutionalization of Mentally Retarded People, February 1986 86-05
Management of Public Employee Pension Funds, May 1986 86-06
Aid to Families with Dependent Children, January 1987 87-01
Water Quality Monitoring, February 1987 87-02
Financing County Human Services, February 1987 87-03
Employment and Training Programs, March 1987 87-04
County State Aid Highway System: Follow-Up, July 1987 87-05
Minnesota State High School League, December 1987 87-06
Metropolitan Transit Planning, January 1988 88-01
Farm Interest Buydown Program, January 1988 88-02
Workers' Compensation, February 1988 88-03
Health Plan Regulation, February 1988 88-04
Trends in Education Expenditures, March 1988 88-05
Remodeling of University of Minnesota President's House and Office, March 1988 88-06
University of Minnesota Physical Plant, August 1988 88-07
Medicaid: Prepayment and Postpayment Review - Follow-Up, August 1988 88-08
Variation in Educational Curricula, Forthcoming
Welfare Aid Coordination, Forthcoming
Housing Programs, Forthcoming
State Cost of Living Variations, Forthcoming
Access to Medical Assistance Services, Forthcoming

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.