THE ADMINISTRATION OF MINNESOTA'S MEDICAL ASSISTANCE PROGRAM

March 5, 1984

PROGRAM EVALUATION DIVISION
Office of the Legislative Auditor
State of Minnesota

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OFFICE OF THE LEGISLATIVE AUDITOR
PROGRAM EVALUATION DIVISION
STATE OF MINNESOTA
Veterans Service Building
St. Paul, Minnesota 55155
612/296-4721

PREFACE

In May 1983 the Legislative Audit Commission directed the Program Evaluation Division to conduct an evaluation of the administration of Medicaid. The high cost and rapid growth of the Medicaid program is a source of legislative concern, and there is general public interest in seeing that the program is administered as efficiently and effectively as possible.

This report finds that the Medicaid Program is generally well-administered in Minnesota, but improvements are needed in a number of areas. Post-payment review of Medicaid claims needs to be strengthened and data processing support needs to be improved in several areas.

Our study has benefited from the cooperation of many people in the Department of Public Welfare. We hope that the complexity of their task will be better understood as a result of this report and that they, as well as legislators and others, will find this report useful.

This study was directed by Elliot Long. Major components of the study were carried out by Rob Nevitt, Marie Scheer and Tom Walstrom.

James R. Nobles
Legislative Auditor

PROGRAM EVALUATION DIVISION

The Program Evaluation Division is part of the Office of the Legislative Auditor. The division's general responsibility, as set forth in statute, is to determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives and utilizing resources efficiently. A list of the division's studies appears at the end of this report.

Topics for study are approved by the Legislative Audit Commission (LAC), but the findings, conclusions, and recommendations in Program Evaluation Division reports are solely the responsibility of the Legislative Auditor and division staff and are not necessarily the position of the LAC or any of its members. Upon completion, reports are sent to the LAC for review and are distributed to other interested legislators and legislative staff.

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INTRODUCTION

This report examines the administration of the Medical Assistance (Medicaid) program in Minnesota. In many respects, Medicaid is well administered by the Department of Public Welfare. However, we found a number of problems, some urgent, that require attention. Post-payment review of Medicaid fraud and abuse, in particular, needs to be strengthened. And improvements need to be made in prepayment edits and controls.

Medicaid pays for the health care, including nursing home care, of the aged, blind, disabled, AFDC recipients, and certain others who are unable to pay for it themselves. The cost of Medicaid in Minnesota is shared between the federal, state, and local government with about 50 percent of the cost now borne by the federal government, 45 percent by the state, and 5 percent by the counties.

Medicaid expenditures have grown rapidly since the program's inception in 1966. In 1983, combined federal, state, and local spending reached $839 million, up from $750 million in 1982. The state share of 1983 Medicaid expenditures was $359 million and an additional $40 million was paid by counties.

- Total Medicaid spending in Minnesota increased 106 percent between 1978 and 1983, the state and local share increased 121 percent.

- Total expenditures increased 128 percent between 1968 and 1973 and 116 percent between 1973 and 1978. The state share has grown even faster.

THE ADMINISTRATION OF MEDICAID

The administration of Medicaid consists of three major parts: determination of eligibility for benefits, processing of claims submitted by health service providers, and control and review of payments in order to assure that payments are accurate and appropriate. This study asks:

- Is eligibility for Medicaid benefits determined in an accurate and fair way? Is the Minnesota system of shared state and local responsibility for eligibility determinations effective?

- Are Medicaid claims properly reviewed prior to payment for accuracy, completeness, consistency, and eligibility? Is the timeliness and accuracy of claims processing up to reasonable standards?

- Is Minnesota's program of post-payment review of claims appropriate and effective? Is the investigation of fraud and abuse in the Medicaid program appropriately organized and managed, and is it effective?

ELIGIBILITY DETERMINATION

The efficiency and accuracy of Minnesota's eligibility determination system play an important role in the state's ability to contain Medicaid costs and provide prompt medical care to needy persons. We examined the following questions relating to eligibility determination:

- Are eligibility determinations accurate? Are proper quality control and corrective action initiatives undertaken by DPW?

- Does DPW effectively supervise the eligibility determination process carried out by counties and is DPW's technical assistance to counties appropriate and adequate?

- Is the present administrative structure for eligibility determination effective?

Minnesota is one of only six states to delegate the actual work of eligibility determination to county government. This decentralized administrative structure creates at least a potential for problems in controlling the eligibility determination process and in achieving uniformity across the state in the implementation of Medicaid guidelines. It also creates the need for a strong quality control function at the state level and the maintenance of good channels of communication between DPW and county welfare offices.

We found:

- Overall, the eligibility determination system is working well. Minnesota's eligibility payment error rate (determined according to a federally mandated methodology) is one of the lowest in the nation and Minnesota has consistently avoided federal fiscal sanctions.

- Variation across the state in eligibility determination does not appear to be a problem.

While too much importance should not be attached to a comparison of error rates across states since the criteria for determining eligibility errors are not the same across the country, we take the low Minnesota error rate to mean that the state is successful in implementing its own eligibility criteria.

Because the State Medicaid Plan specifies the criteria for determining eligibility errors, the error rate will be sensitive to changes in the plan, particularly the implementation of more complex eligibility restrictions which increase the chances for mistakes.

Minnesota's eligibility error rate is probably low enough to permit more complex eligibility restrictions without causing the error rate to surpass federal tolerance levels and cause fiscal sanctions to be imposed.

Despite the low eligibility error rate, we found a number of problems with DPW's supervision of county practices and provision of technical assistance:

- There is very little administrative review of county management of the Medicaid program either through required reports, on-site audits, or by persons who serve a liaison function between DPW and local welfare offices.

- DPW does not have standardized training guidelines for county Medicaid personnel.

- The Medicaid Eligibility Manual is not updated to incorporate new state policy in a timely fashion.

- The Quality Control sample, while adequate to generate accurate data on a statewide level, is not large enough to provide accurate data for each county administrative unit.

While DPW management is aware of these problem areas, we found little evidence that improvements were being made. We recommend that DPW:

- Establish a program for ongoing administrative review of county Medicaid management practices. These reviews should include a look at county caseload levels, treatment of individual applicants, and consistency of intake practices.

- Develop a system of standardized training guidelines for county Medicaid personnel.

- Incorporate instructional and informational bulletin material into the State Medicaid Eligibility Manual more quickly.

- Perform special county Quality Control reviews in counties suspected of having high eligibility error rates.

- Coordinate Quality Control and Corrective Action findings with an administrative review process. Corrective Action initiatives should directly address administrative issues.

PREPAYMENT REVIEW

Prepayment review of claims consists of the intake, examination, and payment of invoices or claims for payment from medical practitioners enrolled as participants in the Medicaid program. Prepayment review should ensure that claims are paid promptly, to eligible providers, for covered services performed for the benefit of eligible recipients.

Prepayment review includes two major functions: invoice processing and medical review. Invoice processing is a largely automated task, heavily dependent on an integrated set of programs known as the Medicaid Management Information System (MMIS). The MMIS computer programs are designed to ensure that claims are paid properly and to provide data processing support for all Medicaid activities.

Medical review is the process by which the state ensures that only medically necessary services are provided to recipients. Medical review consists of the authorization of specified types of services before they are provided, and the review of other services prior to payment to ensure they are medically necessary.

Our findings regarding prepayment review of claims can be summarized quite briefly:

- DPW is performing acceptably well in processing Medicaid claims. Minnesota compares favorably to other states in claims processing error rates, and has consistently paid claims to medical vendors with a minimum of delay.

- Minnesota's Medicaid Management Information System (MMIS) has performed acceptably well, meeting federal standards consistently through the years.

- Minnesota's process for prior authorization and review of medical necessity is also working well, and providing a positive return to the state.

Despite our generally favorable review of DPW's prepayment controls, we also found a number of areas that need improvement. In particular, we found that the use and support of the automated claims payment and control system part of the Medicaid Management Information System (MMIS) needs improvement. We found that:

- The MMIS was designed and the software implemented over 10 years ago.

- The MMIS software is complex and has been extensively modified over the years. Despite the extensive modifications, the majority of the documentation of the system has not been updated since 1975.

- Adequate controls over production and computer processing of claims are lacking. As a result, duplicate checks have been produced several times.

- There is still a significant backlog of requests for changes to the MMIS. Enhancements to the MMIS are put off because of the maintenance programming workload. For example, the long-term care payment system has not been upgraded, despite recognition of many deficiencies. Lack of a duplicate payments edit in this system has cost the state hundreds of thousands of dollars over the years.

- There is no formal mechanism to ensure that all state and federal policy changes are reflected in the MMIS. Despite the numerous changes in federal and state policies and requirements over the years, there has never been a formal review of the edit structure of the MMIS. Until recently no process for coordination and priority setting existed among policy-makers, invoice processing, and systems personnel.

- DPW does not have an adequate capability to generate timely management information about the Medicaid program.

As a result of these findings, we recommend that DPW take a number of actions designed to upgrade the capabilities of its automated systems:

- DPW should update the audit control and security provisions of the claims processing system.

- DPW should undertake a systematic review of the edit structure of the MMIS to ensure that it is updated and coordinated with current federal and state requirements.

- DPW should take steps to improve the documentation of the MMIS set of programs.

- DPW should undertake a significant enhancement or replacement of the current long-term care payments system.

- DPW should evaluate its management information needs, design and implement needed reports, and discontinue unneeded and unused reports.

- DPW should develop the capability to more readily respond to requests for information from department and legislative policy-makers.

In order to implement these recommendations it will be necessary to allocate more DPW staff to systems functions or to obtain needed support from the Information Services Bureau (ISB).

We also found that the medical review activities of DPW are adequate. However, we found that medical policies regarding services and payment are too informal. In addition, we found that the basic requirements of an effective management reporting and control system are lacking in the Professional Services Section. As a result, we recommend:

- DPW formalize its policies regarding medical services and price setting.

- DPW should initiate a management tracking system for prior authorizations, and develop control systems necessary to evaluate its performance in this area.

POST-PAYMENT REVIEW OF CLAIMS

The Surveillance and Utilization Review Section (SURS) of DPW conducts a substantial program of post-payment review of Medicaid claims. The purposes of post-payment review are:

- To detect and deter Medicaid abuse and fraud by providers and recipients, and in cases of abuse to impose administrative sanctions or refer cases to other agencies for appropriate action.

- To monitor and control overutilization of services both to save money and to protect and enhance the health of Medicaid recipients.

We examined how well post-payment review of Medicaid service providers and recipients is being carried out, whether these functions are effectively managed, and whether post-payment review is cost-effective.

Provider Surveillance

Concerning post-payment investigation and review of non-institutional providers, we found:

- The tangible results of provider surveillance are disappointing. Between January 1981 and September 1983, only a few providers have been suspended from the Medicaid program. Only 13 cases have been referred to the Attorney General's Office for further investigation and possible prosecution.

- About $418,000 has been recovered from providers during this period. This sum is far less than the cost of conducting DPW's program of post-payment review of providers.

In general, we have concluded that the results of investigations of fraud and abuse by providers are less than what might reasonably be expected given the scope of the state's effort.

This conclusion is based on a comparison of the total results of provider investigations to the resources committed to this function. Over the 11 quarters reviewed, about seven full-time positions have been allocated to provider surveillance.

It must be clearly acknowledged that the deterrent effect of provider surveillance is not reflected in statistics on prosecutions, administrative sanctions, or dollars recovered. DPW argues that the preventative impact of its provider surveillance program is substantial, although unmeasurable.

We believe that the deterrent effect of provider investigations will be enhanced if the tangible and direct results are increased. An effective deterrent should include:

- At least a few highly publicized criminal investigations each year;

- Notification that an audit program is in place that subjects every provider to a definite chance of being reviewed; and

- Better use of the computer to identify providers who are high potential candidates for investigation.

Our examination of provider surveillance was impeded by the fact that record keeping and statistical reporting practices are deficient.

- Statistical reports relating to provider investigations are inconsistent and inaccurate. Inconsistent definitions are used, numbers reported in required quarterly reports do not correspond to cases identified in unit logs and cases are filed in a way that impedes management's ability to determine or report investigation results.

We believe that once an acceptable record-keeping and case management system is set up, it will be possible for DPW management or an outside auditor to more accurately assess the results of provider surveillance and make changes to improve its performance of this function.

Although it is too soon to tell, we believe the recent establishment of a unit dedicated to Medicaid investigation and prosecution in the Attorney General's Office will strengthen fraud and abuse control in general and improve DPW's ability to deal with questionable practices by providers, even where criminal intent is absent.

Recipient Surveillance

DPW also operates a recipient surveillance program consisting of a supervisor, two analysts and clerical support. Medicaid recipients suspected of fraud or abuse are identified from several sources including computerized exception reports, providers, and county welfare departments.

The principal emphasis of the recipient surveillance program is a recipient "lock-in" program where recipients suspected of Medicaid abuse are required to use a single pharmacy or primary physician for a period of time. Criminal prosecution and monetary recovery are rarely sought in cases of recipient abuse.

We believe that DPW's emphasis on provider rather than recipient fraud and abuse is appropriate, and that emphasis on a recipient restriction program also makes sense. But we believe the recipient restriction program can and should be expanded.

- Data we reviewed suggest that the recipient restriction program (in contrast to the provider surveillance activities) is clearly cost-effective in that recipients placed on restriction use fewer services during and following their period of restriction, and that savings thus realized more than pay

for the cost of the recipient restriction program. Depending on how the costs of running the restriction program are figured, this amounts to a savings of $1.38 to $2.59 per dollar invested.

We conclude:

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

The restricted recipient caseload was 113 in September 1983. This is less than one-tenth of one percent of Medicaid recipients. We think it is reasonable to assume that drug abuse and other types of misutilization of health services is more prevalent than this among Medicaid recipients. Since the recipient restriction program pays for itself, we recommend that:

- The recipient restriction program be expanded until additions to the program cease to save money.

- DPW should automate its review of claims submitted for restricted recipients.

Utilization Control

The Utilization Control section within SURS is responsible for monitoring and preventing unnecessary or inappropriate delivery of care and services to Medicaid recipients in in-patient hospital and long-term care facilities. A large percentage of these activities are conducted outside of DPW, under contract with Professional Standards Review Organizations (PSROs) and the Minnesota Department of Health (MDH). Contracts for PSRO services in fiscal year 1982 totaled over $480,000. We found:

- Monitoring of PSRO contracts has been inadequate.

DPW has not undertaken a comprehensive evaluation of PSRO contract performance and the Utilization Control section does not systematically utilize PSRO supplied data to evaluate PSRO effectiveness in reducing unnecessary or inappropriate Medicaid services in in-patient hospitals.

We recommend that:

- DPW initiate an ongoing and systematic evaluation of PSRO contract performance and effectiveness.

Both Utilization Control staff and Minnesota Department of Health (MDH) staff (under contract to DPW) conduct annual on-site reviews of long-term care facilities in the state. MDH staff reviews include an examination of the appropriateness and quality of care provided by each facility as a whole and to individual recipients. The Utilization Control section conducts additional compliance reviews as well as relatively minor data collection activities for the other units within SURS.

In our opinion, this dual data collection and monitoring effort is poorly coordinated. Economies of effort could be achieved by MDH staff assuming responsibility for all or most on-site reviews. Monitoring of MDH performance could be integrated into the present contractual arrangement between DPW and MDH.

We recommend:

- The on-site review activities now carried out by the Utilization Control section should be carried out by MDH as part of its broader quality assurance activities.

The Utilization Control system in Minnesota is a product of detailed federal regulations. The present system, while meeting minimum federal requirements, appears to have many deficiencies, particularly in the area of long-term care. We found:

- Within the Utilization Control section itself, much staff time is spent performing perfunctory paper compliance reviews. Data collected by the Utilization Control section is scarcely ever used for analytical or planning purposes.

- The Quality Assurance and Review system (operated by MDH under contract to DPW) has little authority to make binding recommendations concerning the proper level of care for long-term care residents.

- The long-term care facility data base is not coordinated, preventing adequate system-wide analysis.

We conclude that:

- The effectiveness and appropriateness of Minnesota's Utilization Control system for long-term care need to be closely examined.

We recommend that:

- DPW and MDH should examine and consider alternative systems to accomplish the utilization control function.

- DPW should work closely with MDH to develop an integrated and cross-referenced long-term care facility data base, including facility certification, quality assurance review, and nursing home cost data sources.

This system will allow the state to develop and examine comprehensive facility profiles of utilization, quality of care, and cost indicators.

I. INTRODUCTION

A. RESEARCH OBJECTIVES

This report examines the administration of the Medical Assistance (Medicaid) program in Minnesota. Legislative interest in Medicaid is understandably high, since Medicaid payments topped $839 million in fiscal year 1983 and the cost of the program is growing rapidly.

The primary focus of this study is the administration of Medicaid rather than policy issues relating to reimbursement, delivery systems, or cost containment. The 1983 Legislature and earlier sessions made a number of important reforms that have not yet been fully implemented, and therefore cannot be evaluated at this time. The evaluation agenda for the Medicaid program is a long one. In coming years we will certainly need to consider examining the effectiveness of recent legislative decisions to:

- limit the supply of nursing home beds;
- establish prospective reimbursement formulas for nursing homes and hospitals;
- encourage the enrollment of Medicaid recipients in HMOs; and
- encourage the use of home health services as a substitute for residential care.

Since these reforms are so recent, they cannot be usefully evaluated at this point. Instead, we have focussed on the administration of Medicaid, a less glamorous but equally important topic.

The administration of Medicaid consists of three major parts: determination of eligibility for benefits, processing of claims submitted by health service providers, and control and review of payments in order to assure that payments are accurate and appropriate. This study asks:

- Is eligibility for Medicaid benefits determined in an accurate and fair way? Is the system of shared responsibility for eligibility determinations between the state and counties in Minnesota effective?
- Are Medicaid claims properly reviewed prior to payment for accuracy, completeness, consistency, and eligibility? Is the timeliness and accuracy of claims processing up to reasonable standards?

- Is Minnesota's program of post-payment review of claims appropriate and effective? Is the investigation of fraud and abuse in the Medicaid program appropriately organized and managed, and is it effective?

These issues are taken up in Chapters II, III and IV of the report. The remainder of this chapter presents a description of the Medicaid program and how it is organized and financed. Appendix I presents status reports on five recent policy initiatives. These, as we said, cannot be evaluated at this point but are important topics for future study.

B. THE STRUCTURE OF MEDICAID

The Medical Assistance program was authorized by Congress in 1965 by Title XIX of the Social Security Act and became operational in January 1966. Medicaid pays for the health care of many but not all Americans who are unable to pay for it themselves.

The cost of Medicaid is shared between the federal, state, and (in nine states, including Minnesota) local government. Across the U.S., the federal government pays between 50 and 78 percent of the cost of Medicaid. The federal share varies inversely with state per capita income. In Minnesota in 1983[1], 50.3 percent of the cost of Medicaid was borne by the federal government, 44.73 percent by the state, and 4.97 percent by counties.

The federal share of Medicaid costs has been declining steadily since the program's inception. In 1966 the federal share was 60.31 percent, in 1975 it was 56.84 percent, and in 1982 it was 52.21 percent. The federal government shows continuing interest in capping Medicaid expenditures either by reducing its financial participation even further, or by assuming total responsibility for the program.

Eligibility for Medicaid is determined by a complex set of federal and state regulations. These are presented in some detail in the next chapter. Basically, Medicaid covers the "categorically needy" who qualify for Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) programs. In addition, Minnesota (along with 29 other states) has chosen to cover the "medically needy." The medically needy are aged, blind or disabled individuals, or families and children under 21 who have income or resources in excess of Medicaid income limits but who have medical expenses high enough to meet program requirements through a "spend-down" provision. Individuals who are not blind, aged, disabled, or with dependent children but qualify for General Assistance are not covered by Medicaid but by a state program, General Assistance Medical Care.

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[1]After the 1981 Federal Reconciliation Act. The basic federal share for 1983 is 52.67 percent.

With the recent addition of Arizona, all states now participate in Medicaid. States are required to provide certain services through Medicaid and may elect to cover others. Mandated services include:

- inpatient and outpatient hospital services,
- laboratory and X-ray services,
- skilled nursing home services for those over 21,
- physician's services,
- early and periodic screening of individuals under 21,
- family planning services, and
- home health care services.

Virtually all services made optional by the federal government are available to the categorically and medically needy in Minnesota. These include:

- mental health services,
- rehabilitation services,
- intermediate care facility (ICF) services, including ICF services for the mentally retarded,
- prescription drugs,
- medical supplies and transportation,
- dental and optometric services, and
- psychological services.

1. THE COST OF MEDICAID

Medicaid service expenditures in Minnesota reached $839.4 million in 1983 and the total cost of the program including administrative costs was $870.8 million. Table 1.1 shows annual Medicaid expenditures since 1976 and Figure 1.1 presents a graph of Medicaid expenditures since 1967. As Figure 1.1 and Table 1.1 clearly show, the growth of Medicaid expenditures has been dramatic in recent years.

Nationally, Medicaid spending grew at an annual rate of 15.5 percent from 1973 to 1979 and in Minnesota, spending grew at an annual average rate of 17.3 percent during the same period.

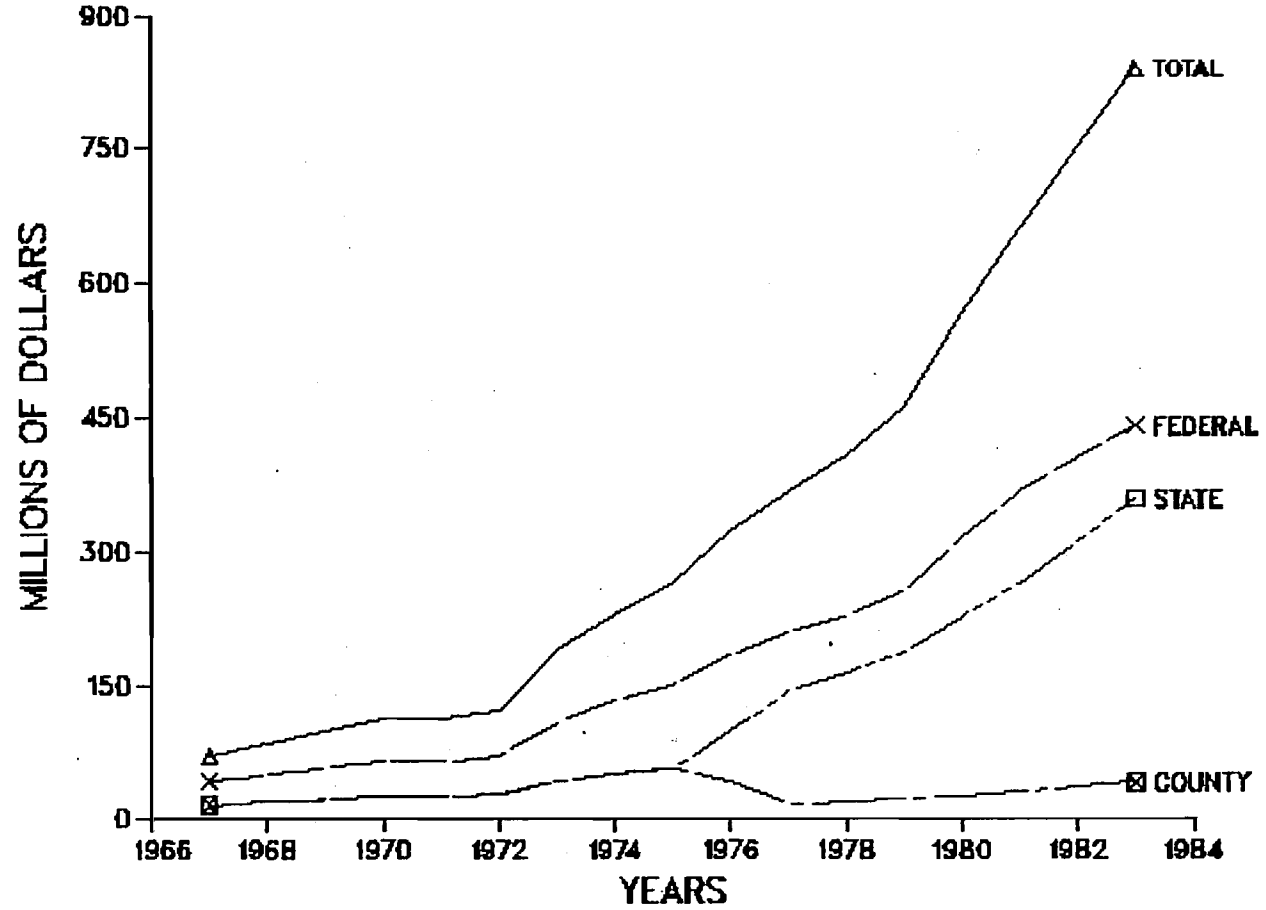
TABLE 1.1

MEDICAID EXPENDITURES BY FUNDING SOURCE
Fiscal Years 1966-1983

Fiscal Year	Total	Federal	State	County
1966 (½ yr)	$ 34,054,848	$ 20,538,479	$ 6,758,185	$ 6,758,184
1967	69,048,737	41,643,293	13,702,722	13,702,722
1968	82,816,625	48,364,909	17,225,858	17,225,858
1969	96,531,757	56,374,546	20,078,605	20,078,606
1970	110,668,482	63,025,700	23,821,391	23,821,391
1971	111,276,289	63,371,847	23,952,221	23,952,221
1972	121,106,134	68,812,505	26,146,814	26,146,815
1973	188,912,024	107,339,812	40,786,106	40,786,106
1974	227,389,859	130,453,562	48,468,148	48,468,149
1975	261,226,844	149,865,840	55,680,502	55,680,502
1976	321,575,493	182,783,510	97,147,956	41,644,017
1977	367,624,575	208,957,808	142,785,385	15,881,382
1978	407,486,537	226,807,006	162,627,877	18,051,654
1979	461,615,020	255,088,460	185,892,369	20,634,191
1980	566,368,921	314,617,936	226,604,205	25,146,780
1981	657,814,974	366,008,152	262,599,738	29,206,984
1982	749,590,946	403,954,561	311,080,243	34,556,142
1983	839,378,312	440,530,919	358,960,135	39,887,258
Percent Increase				
1968-1973	128%	122%	137%	137%
1973-1978	116	111	299	-56
1978-1983	106	94	121	121
1967-1983	1,116%	958%	2,520%	191%

Source: Department of Public Welfare, Reports and Statistics Section.

FIGURE 1.1
MEDICAID EXPENDITURES BY FUNDING SOURCE
FISCAL YEARS 1967–1983



SOURCE: DEPARTMENT OF PUBLIC WELFARE

The growth of Medicaid spending has become a national crisis because it has proved difficult to control. In recent years the primary reason for spending increases is higher prices for health care rather than expanded coverage or eligibility criteria. It is safe to say that these increases in the cost of Medicaid are viewed as less acceptable than the increases of earlier years that were due to expanded benefits and coverage.

The growth in the cost of Medicaid parallels the growth of health care spending as a whole. In fact, as rapidly as Medicaid payments have grown, the rise in Medicaid spending is not out of line with increases in other health expenditures. Between 1973 and 1979 Medicaid spending rose 138 percent, but Medicare spending rose 205 percent, all private health care spending rose 95 percent, and the average cost per community hospital inpatient day rose by 112 percent.[2]

2. EXPENDITURES BY CATEGORY OF SERVICE

Medicaid expenditures and growth in expenditures are concentrated in Long-Term Care (LTC). Information on where Medicaid payments are going and how this has changed between 1976 and 1983 is presented in Table 1.2 and Figure 1.2.

As Table 1.2 shows, long-term care (nursing homes) received 66.0 percent of Medicaid payments in 1983, up from 57.6 percent in 1976. Almost one-half of long-term care expenditures go to Intermediate Care Facilities (ICF) including Intermediate Care Facilities for the Mentally Retarded (ICFMR). Total LTC expenditures rose 199 percent, a rate that is faster than any category of service listed on Table 1.2 with the exception of ancillary services in nursing homes. These rose 591 percent. It is scarcely an exaggeration to say that in Minnesota the problem of Medicaid cost containment is a problem of regulating the capacity, efficiency, and profitability of LTC providers who are reimbursed by Medicaid. Minnesota ranks fifth among the states in nursing home beds per person 65 years of age or older.[3] As noted earlier, the 1983 Legislature enacted new laws designed to limit the supply of nursing home beds, provide an incentive for efficient operation, and encourage the use of home health services as an alternative to nursing homes. It remains to be seen if or to what extent these new laws are effective.

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[2]Medicaid grew from $8.6 to $20.5 billion, Medicare from $9.6 to $29.3 billion, all private medical spending from $63.9 to $124.5 billion, and hospital costs from $102.30 per day to $217.10. Data are from Muse and Sawyer Medicare and Medicaid Data Book; Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review, vol. 3, no. 1, (September 1981), pp. 1-54; and Health Insurance Association of America, Source Book of Health Insurance Data, 1981-1982.

[3]Based on a count of Medicare and Medicaid certified beds only. Data are from the Health Care Financing Administration, Division of Information Analysis.

TABLE 1.2

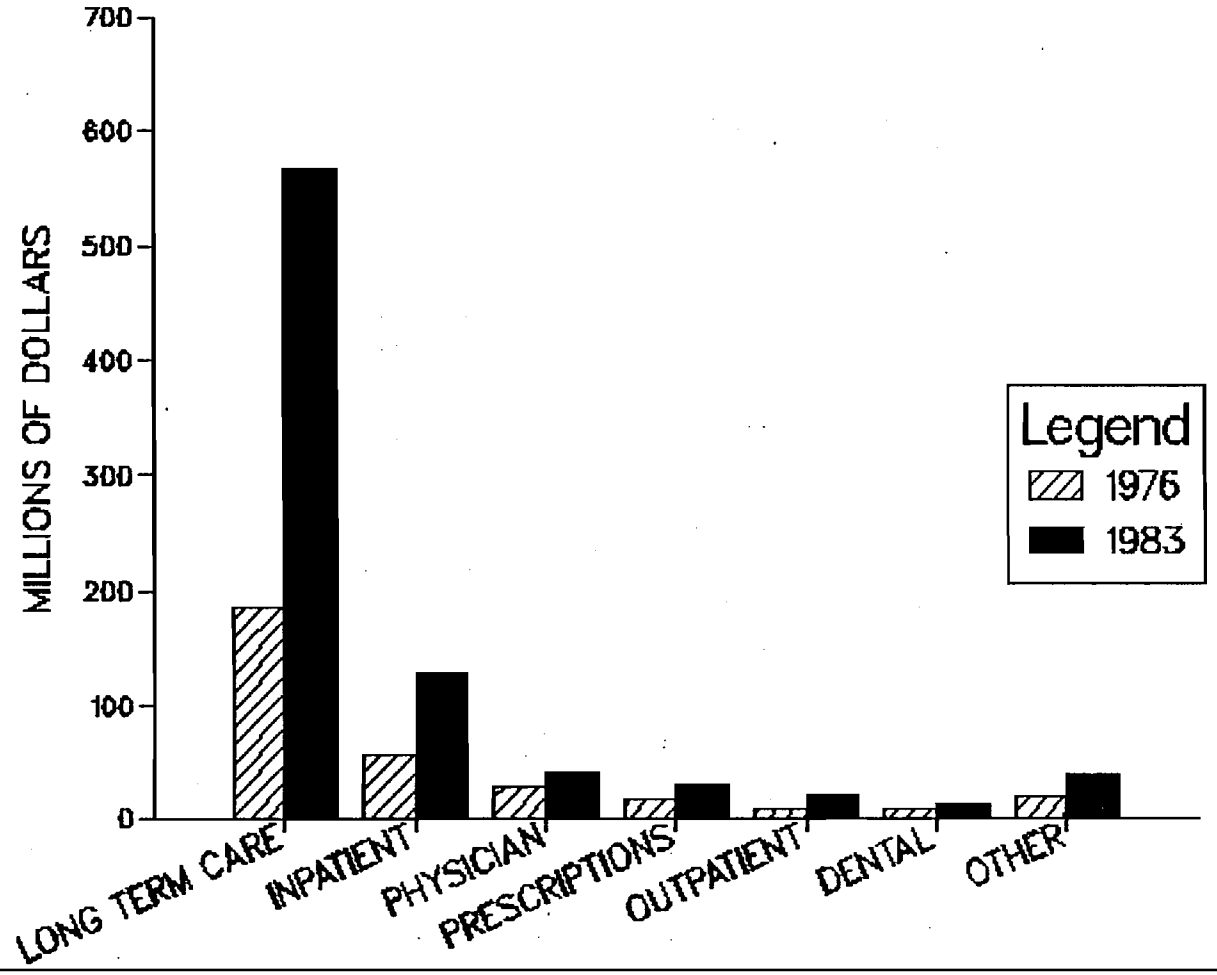
MEDICAL ASSISTANCE EXPENDITURES BY CATEGORY OF SERVICE
Fiscal Year 1976 and Fiscal year 1983
(in thousands of dollars)

	Fiscal Year 1976		Fiscal Year 1983		Percent Increase 1976-1983
	Cost	Total MA Expenditures	Cost	Total MA Expenditures	
Long-Term Care:					
Skilled N.H.	$ 66,963	20.8%	$256,868	30.6%	284%
ICF-I	55,146	17.1	115,798	13.8	110
ICF-II	6,653	2.1	10,946	1.3	65
ICF-MR	12,612	3.9	83,776	10.0	564
Inst. MR	43,861	13.6	86,341	10.3	97
Total Long-Term Care	$185,235	57.6[a]	$553,729	66.0[a]	199
Inpatient Hospital Care	55,409	17.2	129,936	15.5	135
Physician/Osteopathic	27,583	8.6	41,617	5.0	51
Prescribed Drugs	16,409	5.1	29,684	3.5	81
Outpatient Hospital	8,048	2.5	20,793	2.5	158
Dental	8,463	2.6	11,978	1.4	42
Services in Nursing Homes	1,964	0.6	13,581	1.6	591
Other	18,464	5.7	38,060	4.5	106
TOTAL MA EXPENDITURES	$321,575	100%[a]	$839,378	100%[a]	161%

Source: Department of Public Welfare, Reports and Statistics Division.

[a]May not add due to rounding.

FIGURE 1.2
MEDICAID EXPENDITURES BY SERVICE CATEGORY
FISCAL YEARS 1976 AND 1983



3. NUMBER AND TYPE OF RECIPIENTS

Table 1.3 presents a count of average monthly recipients by eligibility category. As Table 1.3 shows, about 135,000 people receive Medicaid services each month. Over one-half are AFDC families and one-fourth are blind or disabled. The monthly average number of Medicaid recipients has risen only 37 percent since 1976, while total Medicaid costs have risen 161 percent.

TABLE 1.3

AVERAGE MONTHLY RECIPIENTS BY ELIGIBILITY CATEGORY
1975-1983

Fiscal Year	AFDC	65 or Older	Disabled/ Blind	Needy Children	Non AFDC Families	Total
1983	69,621	33,536	22,093	6,549	3,723	135,522
1982	72,627	33,891	21,274	5,442	1,673	134,907
1981	73,962	33,056	20,365	6,640	1,449	135,472
1980	63,231	32,071	19,567	6,585	1,062	122,516
1979	60,245	31,193	19,111	6,327	886	117,762
1978	60,376	31,515	19,247	6,589	1,011	118,738
1977	58,765	30,070	16,925	6,883	1,115	113,758
1976	58,696	31,062	14,548	7,594	1,173	113,073
1975	47,418	31,456	13,442	5,332	1,269	98,917
Percent Increase						
1975-1983	47%	7%	64%	23%	193%	37%

Source: OLA calculations from Department of Public Welfare data.

Table 1.4 presents data on the average monthly cost per recipient across eligibility categories. While AFDC recipients are the largest category of Medicaid recipients, they are younger and healthier than other groups and account for far less Medicaid payments per person than recipients 65 or older, the blind or disabled, and the other eligibility categories presented in Table 1.4. Again, this is because many recipients who are over 65 are in nursing homes.

TABLE 1.4

AVERAGE MONTHLY COST PER RECIPIENT BY ELIGIBILITY CATEGORY
1975-1983

Fiscal Year	AFDC	65 or Older	Disabled/ Blind	Needy Children	Non-AFDC Families	Total
1983	$132.74	$914.88	$1,179.72	$440.77	$288.90	$516.14
1982	123.83	851.33	1,033.98	389.68	300.24	463.03
1981	110.90	781.39	902.51	308.43	247.08	404.64
1980	103.13	675.98	850.58	316.99	251.07	385.23
1979	98.61	566.82	666.07	301.03	240.07	326.66
1978	93.45	469.80	593.22	285.42	199.79	285.91
1977	93.60	431.70	590.50	289.44	149.78	269.30
1976	84.15	402.48	587.90	91.37	93.85	237.00
1975	80.76	310.33	537.92	152.92	105.43	220.10
Percent Increase						
1975-1983	64%	195%	119%	188%	174%	135%

Source: OLA calculations from Department of Public Welfare basic data.

C. ORGANIZATION OF THE MEDICAID PROGRAM

Several state departments share responsibility for aspects of Medicaid administration. The Attorney General's Office recently established a unit responsible for investigation and prosecution of Medicaid fraud, the Health Department conducts the greater part of the state's oversight of long-term care facilities, but the primary locus of responsibility for Medicaid administration is the Department of Public Welfare (DPW).

Figure 1.3 presents a high-level organization chart of DPW and Figure 1.4 provides additional detail on the Health Care Programs Division in which responsibility for Medicaid is primarily located. In the next three chapters the organization of Medicaid is discussed as it pertains to our evaluation of the effectiveness of the administration of Medicaid.

Medicaid is substantially organized along a single line of authority in DPW. Most of Medicaid is located in DPW's Income Maintenance Bureau (see Figure 1.3). Two exceptions are the location of DPW's data processing support unit (the System and Data Flow Division) in the Bureau of Support Services along with the nursing home rate setting function. The vast part of what DPW's Systems and Data Flow Division does pertains to Medicaid data processing, and, as we have just seen in Table 1.2, long-term care expenditures constitute two-thirds of Medicaid expenditures. Thus, locating these functions outside the Income Maintenance Bureau creates a potential problem of coordination within the department. Indeed, Income Maintenance Bureau management does feel that the location of nursing home rate setting and the systems office in another bureau creates difficult problems.

As noted, Medicaid is primarily administered in the Health Care Programs Division. In addition, the Operations Review Division performs some quality control functions for Medicaid and income maintenance programs such as AFDC and General Assistance.

Figure 1.4 shows the Health Care Programs Division in greater detail. Referring to Figure 1.4, the Professional Services Section provides professional medical consultation and develops policy for the Medicaid program on issues relating to prior authorization of claims, disability determinations, the appropriateness of medical service utilization, and hospital reimbursement. We discuss these functions in Chapter III.

The Program Administration and Policy Section is responsible for developing and interpreting eligibility policy for Medical Assistance. This unit maintains and administers the Medicaid state plan and provides and coordinates technical assistance to county welfare offices on eligibility policy. In addition, the policy section is responsible for administering several other Medicaid-related projects. We discuss eligibility determination in Chapter II, and several other policy initiatives administered by this section in Appendix I.

FIGURE 1.3

DEPARTMENT OF PUBLIC WELFARE

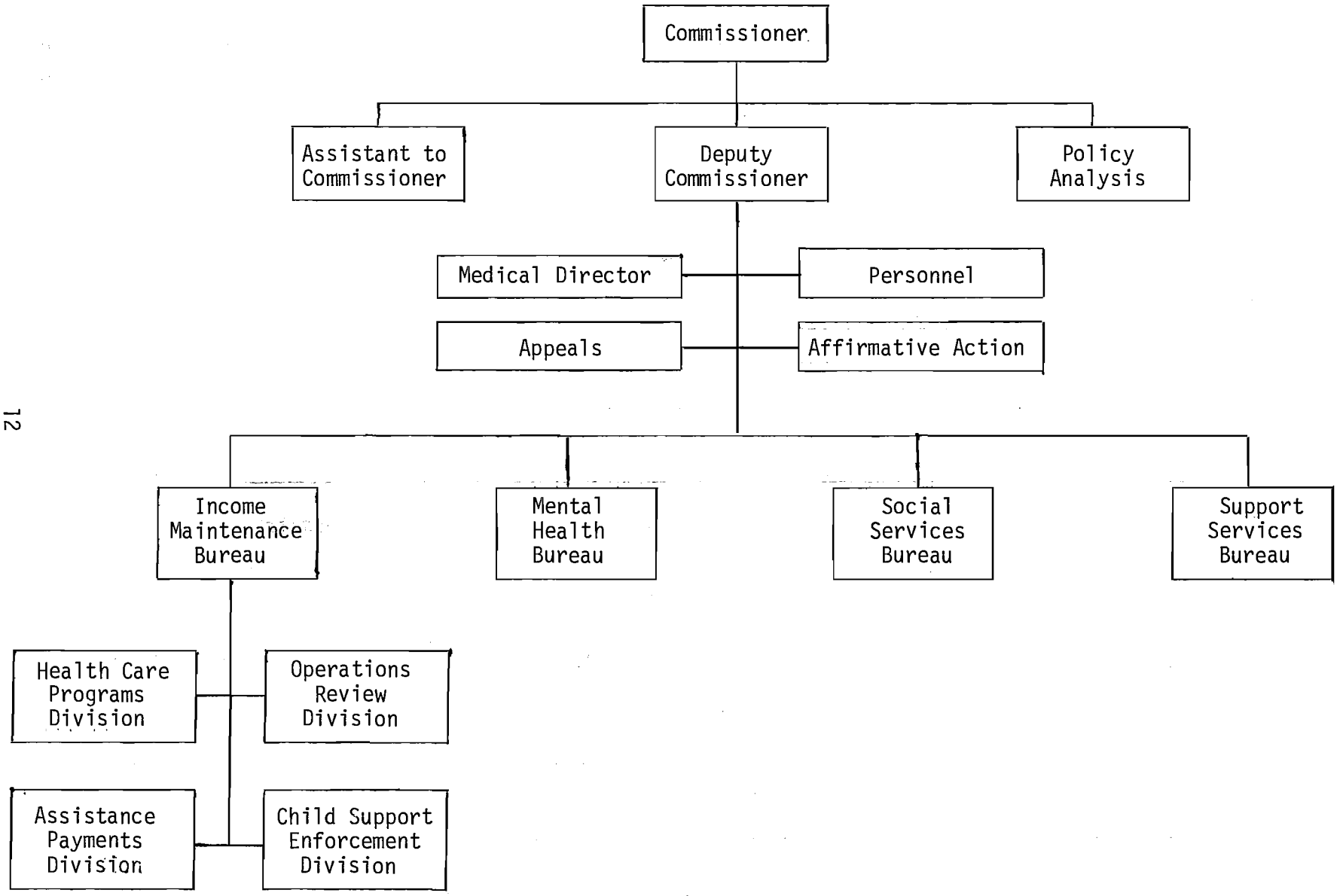
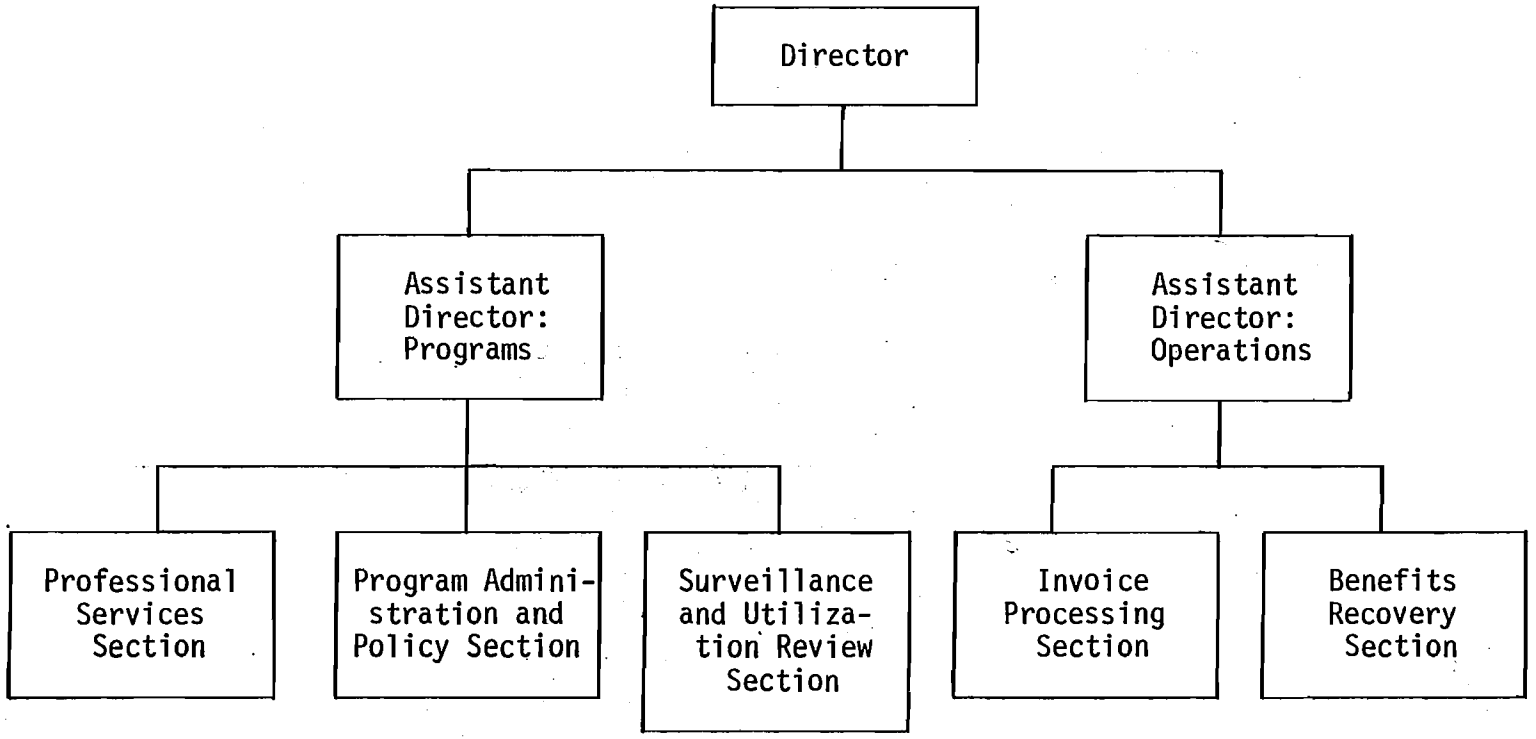


FIGURE 1.4

HEALTH CARE PROGRAMS DIVISION



The Surveillance and Utilization Review Section is responsible for post-payment review of Medicaid claims including fraud and abuse investigation and utilization review. Chapter IV presents a detailed review of these functions.

Medicaid payment operations are located in the Invoice Processing Section and our review of this function appears in Chapter III..

II. ELIGIBILITY DETERMINATION

A major component of Medicaid program administration is the determination of eligibility for Medicaid services. County welfare offices, under the supervision of the Department of Public Welfare (DPW) and the Health Care Financing Administration (HCFA), are responsible for conducting Medicaid eligibility determinations and redeterminations across the state. In fiscal year 1982, approximately 168,000 Medicaid eligibility cases were approved, denied, or closed by county welfare staff. The efficiency and accuracy of this eligibility determination system plays an important role in Minnesota's ability to contain Medicaid costs and to provide prompt medical care to all needy persons.

This chapter examines the administration of the Medicaid eligibility determination system in Minnesota. The first section describes the administrative structure of the eligibility system and the current composition of Medicaid eligible caseloads. The next section examines the effectiveness of Minnesota's eligibility determiniation system. This section focuses on the following questions:

- Are eligibility determinations accurate? Are proper quality control and corrective action initiatives being undertaken by DPW?

- Does DPW effectively supervise the eligibility determination process carried out by counties and is DPW's provision of technical assistance to counties appropriate and adequate?

- Is the present administrative structure for eligibility determinations effective?

Our study found:

- Overall, the eligibility determination system in Minnesota is accurate and working effectively.

However, we also found a number of problems with DPW's supervision of county practices and provision of technical assistance including:

- A lack of proper administrative reviews of county management practices.

- A lack of standardized training guidelines and assistance for county Medicaid personnel.

- Inadequate updating of the Medicaid Eligibility Manual.

- Inadequate targetting of Quality Control reviews to counties suspected of having high eligibility error rates.

A. ADMINISTRATIVE STRUCTURE

Federal Medicaid guidelines direct the state to develop and implement an administrative system which provides for the proper and efficient operation of the Medicaid program.[1] Federal administrative guidelines require:

- Development of a State Medicaid Plan which directs the operation of the Medicaid program under equitable standards for administration that are mandatory throughout the state.
- The designation of a single state agency to administer, or supervise the administration of the Medicaid program in accordance with the State Plan.
- Development of a system of information dissemination and planned examination and evaluation sufficient to assure the continuous operation of the Medicaid program.

Within these broad administrative requirements, the state has a large degree of discretion and autonomy in designing an eligibility determination system. Minnesota has chosen to delegate Medicaid eligibility determination responsibilities directly to the 87 county welfare offices across the state. DPW, as the designated single state agency, is responsible for overseeing and evaluating the county administered eligibility system. Minnesota is one of only six states in the nation to adopt a county administered, state supervised system.

Table 2.1 shows the breakdown of responsibilities within the Minnesota eligibility determination system between county, state and federal administrative units.

1. COUNTY ADMINISTRATION

The counties have primary responsibility for approving or disapproving Medicaid applications based on state and federally established policies, procedures, and rules.[2] In addition, counties provide in-house training for financial workers, supervise financial worker performance, and implement corrective actions called for by the state agency.

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[1] 42 CFR, Part 431.

[2] Minn. Stat. Chapter 373 provides authority for counties to administer public welfare programs, under the supervision of the Commissioner of Public Welfare.

TABLE 2.1

MEDICAID ELIGIBILITY PROCESS
County, State and Federal Responsibilities

County (local welfare agency)	Administration of the MA eligibility process, including: • Screening and interviewing of MA applicants. • Verification of eligibility factors (e.g., applicant income, household status, etc.). • Determination of eligibility. • Update of MMIS Eligibility Subsystem. • Redetermination of eligibility statue (at least once a year for each case, except every 6 months with 6 month spend down cases). Provide in-house training for financial workers. Supervise financial worker performance. Implement appropriate corrective actions.
State (DPW)	Promulgate rules and regulations in accordance with state and federal requirements. Supervise local agency performance, including: • Accuracy of eligibility determinations conducted through Quality Control (QC) reviews. • Administrative and case-management performance. Provide technical assistance to local agencies, including: • Development and dissemination of eligibility policies and manuals. • Development of corrective action initiatives. • Provision of general skill and program related training. • Operation of the Policy Center. • Systems support. Comply with federal reporting and administrative requirements.
Federal (HCFA)	Monitor state compliance with federal requirements for: • Eligibility determinations. • QC reviews. • Corrective Action Plans. • MMIS systems requirements. Provide technical assistance to state staff.

Of county Medicaid responsibilities, eligibility determination is the most time consuming administrative activity. Caseload responsibility includes initial intake and financial determination procedures, ongoing monitoring of eligibility factors, and annual redetermination for each case. Table 2.2 shows how eligibility determination levels have increased over time, from 126,211 in fiscal year 1977 to 168,004 in fiscal year 1982. This increase in the administrative burden has put additional pressure on the already strained county welfare administrative budget.

Eligibility determinations made at the county effect Medicaid costs for all levels of government because caseload has a direct relationship to cost of the Medicaid benefits. The county share of the Medicaid reimbursement formula is only 4.6 percent, and yet, for most counties, this is the largest item in their budget. Also, county procedures are critical because poor administration can result in federal financial sanctions, directly affecting the state budget.

In addition to affecting Medicaid costs, county administration also plays a large role in determining whether the program has statewide uniformity in its treatment of Medicaid applicants.

TABLE 2.2

MEDICAID APPLICATIONS
1977 - 1982

Fiscal Year	Approvals	Denials	Closings	Total[a]
1983	76,729	16,033	68,776	161,540
1982	75,988	12,784	79,232	168,004
1981	68,715	11,503	67,731	147,949
1979-80[b]	58,260	9,783	55,769	123,812
1977-78[b]	58,399	10,119	57,694	126,212

Source: Minnesota Medical Assistance Annual Report Fiscal Year 1982 and Biennium Report Fiscal Year 1979-1980. Department of Public Welfare, Reports and Statistics Section.

[a]Excludes transfers.

[b]Average for each year over the biennium.

2. STATE SUPERVISION

DPW has the dual role of supervising the county eligibility determination system and administering the state program so that it meets federal guidelines.[3] DPW is responsible for ensuring that county intake, financial determination, and approval or disapproval decisions are in accordance with the state plan. In addition, DPW is accountable to HCFA for all agreements in the State Medicaid Plan, and must provide reports to support state program performance.

The Income Maintenance Bureau within DPW is organized around federal mandated activities. Activities related to eligibility determination are located in the following sections:

1.	Health Care Programs	
	Benefit Recovery	Determines whether applicants are eligible for other benefits.
	Professional Services	Determines whether applicants are eligible for specific services.
	Surveillance and Utilization Review	Determines whether recipients are misusing Medicaid benefits.
	Policy Section	Provides technical assistance such as policy development, dissemination of information, and program monitoring.
2.	Invoice Processing	Reimburses providers for recipient services.
3.	Operations Review	Identifies erroneous payment benefits and reduces eligibility errors.
4.	Systems and Data Flow (in Support Bureau)	
	Eligibility System	Maintains the Client Information (CI) file as part of the MMIS system.

Elgibility determination is a critical aspect of the Medicaid program. To conduct this effectively, counties need technical assistance, standardized guidelines, and assistance in interpreting policy, statute, or rule changes. The state agency must monitor county activities and provide assurance to the federal government that counties are meeting minimum federal administrative and performance requirements.

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[3] DPW administers the Medicaid program under MCAR 2.047, 2.049, and 2.052. In addition, DPW recently published Temporary Rules 50 and 53.

3. FEDERAL REIMBURSEMENT AND MONITORING

Federal monitoring is conducted to ensure that Medicaid reimbursement is allowed only for approved services provided to eligible persons, and that the state is in compliance with all guidelines. Guidelines include eligibility determinations, quality control reviews, corrective action plans, and MMIS requirements. Federal auditors annually monitor the state Medicaid program to determine whether these requirements are being met. States found to be out of compliance can be penalized through financial sanctions.

B. MINNESOTA'S MEDICAID ELIGIBILITY POLICY

The federal Social Security Amendments of 1972 redefined eligibility standards for Medicaid coverage of categorically needy and medically needy groups. Prior to establishment of the Supplemental Security Income (SSI) program through these amendments, Old Age Assistance, Aid to the Blind and Aid to the Disabled cash assistance programs mandated that recipients receive Medicaid benefits. The new umbrella program created through the amendments allowed states to choose automatic Medicaid coverage for all SSI recipients or to apply "more restrictive standards" as long as those "more restrictive" standards are not more restrictive than those in effect in 1972. Minnesota chose the latter type of Medicaid program (known as 209B status). Most states provide MA automatically to SSI recipients. Within federal guidelines the state determines which benefits and which groups will be covered. The following section describes groups eligible for benefits through federal and state provisions, which together make up the state's Medicaid policy.

1. ELIGIBLE GROUPS

The 1972 SSA amendments and clarification of conditions for participation in the Aid to Families with Dependent Children (AFDC) program resulted in the following groups being declared categorically needy and automatically eligible for Medicaid benefits.

- SSI recipients who received assistance from the former Old Age Assistance, Aid to the Blind, and Aid to the Disabled programs are "grandfathered" in with automatic coverage.
- All Minnesota Supplemental Aid recipients are eligible for Medicaid benefits without separate applications (unless they are residents of an institution for the treatment of mental disease).
- All Aid to Families with Dependent Children (AFDC) recipients are eligible for Medicaid benefits without a separate application.
- Also, recipients of Title IV-E funding for Subsidized Adoptions are automatically eligible for Medicaid benefits.

Individuals/families who do not receive public assistance grants can also qualify for Medicaid benefits through a provision for categorically related and medically needy eligibility. To qualify, applicants must have income and resources at or below the Medicaid income standards. SSI recipients with no MSA grant must apply for Medicaid and meet an income/assets test before they are approved for benefits.

Persons whose income is in excess of the standard can qualify for Medicaid benefits through a spend down provision by incurring medical bills. Medically needy recipients are aged, blind, or disabled individuals and children under 21, and adult caretakers (absent, incapacitated, or unemployed) within limits set under the Medicaid State Plan. Minnesota has chosen to provide optional medically needy coverage through two types of spend down.

1) Six month spend down. Incurred medical expenses are equal to one-half the individual's annual excess income. Eligibility is restricted to six month periods with provision for reapplication.

2) Continued spend down. Continued medical expenses exceed the amount of the individual's excess income each month. Continued spend down is limited to institutionalized individuals and special situations approved by DPW.

2. ENROLLMENT WITHIN EACH CATEGORY

Table 2.3 shows the number of persons in each group who are eligible for Medicaid benefits, or the pool of people who could potentially use services. The total increase in eligibles over the period 1975 through 1983 is only 5.3 percent.

Table 2.4 shows the number of persons within each group who use Medicaid services, compared to the number of persons eligible for services in fiscal year 1983. This table shows the rate of utilization for each group. The utilization rate is highest for the 65 or older and disabled and blind groups at 86.2 and 83.8 percent respectively. The average rate of Medicaid utilization for 1983 is 66.8 percent for all programs, compared with a rate of 48.8 percent in 1975.

Table 2.5 shows average monthly recipients within each eligible group. The highest percent increase in number of recipients is in the non-AFDC category, and most of that increase has been since 1982. The primary cause of the increase is the shift away from the AFDC program caused by 1981 federal changes in treatment of earned income of AFDC recipients. While this action reduced the number of persons in the AFDC program, it had less effect on the Medicaid program because Minnesota has a provision which approved many of these applicants for Medicaid benefits through the spend down provision. Even with this increase, the total of AFDC and non-AFDC recipients has been reduced somewhat from 1981.

TABLE 2.3

AVERAGE MONTHLY ELIGIBLES BY ELIGIBILITY CATEGORY

Fiscal Year	AFDC	65 or Older	Disabled/ Blind	Needy Children	Non-AFDC Families	Total Eligible
1983a	140,437	38,907	26,364	11,086	7,213	224,007
1982	143,531	39,144	25,217	8,570	2,789	219,251
1981	149,397	38,892	24,440	9,501	2,228	224,457
1980	134,281	37,376	23,670	8,379	1,728	205,434
1979	130,885	36,245	23,212	8,958	1,513	200,813
1978	134,770	36,509	23,023	10,788	1,719	206,808
1977	132,099	36,565	22,877	12,905	1,786	206,231
1976	134,339	37,966	20,927	18,481	3,164	214,877
1975	129,416	39,881	21,819	18,283	3,351	212,750
Percent Change 1975-1983	+8.5%	-2.4%	+20.8%	-39.4%	+115.2%	+5.3%

Source: OLA calculations from Department of Public Welfare data.

TABLE 2.4

UTILIZATION OF MEDICAID SERVICES BY ELIGIBLE GROUPS FOR FISCAL YEAR 1983

Eligible Group	Average Monthly Eligibles	Average Monthly Recipients	Percent Utilization
AFDC	140,437	69,621	49.6%
65 or Older	38,907	33,536	86.2
Disabled/Blind	26,364	22,093	83.8
Needy Children	11,086	6,549	59.1
Non-AFDC	7,213	3,723	51.6

Source: OLA calculations from Department of Public Welfare basic data.

C. STATE SUPERVISION AND PROVISION OF TECHNICAL ASSISTANCE

Federal regulations are written primarily for state administered Medicaid programs. Minnesota's program is county administered so there is shared responsibility between the state and county agencies for compliance with federal regulations. Supervision and technical assistance provided by DPW is critical to achieving statewide program uniformity and assuring applicants of equal treatment regardless of the county in which they apply.

We visited 11 counties[4] with a standard set of questions about state agency supervision and provision of technical assistance. We also interviewed DPW staff to determine how these obligations are carried out. This section presents these findings with recommendations for internal change.

1. POLICY DEVELOPMENT AND INFORMATION DISSEMINATION

Federal guidelines for distribution of information require the department to provide methods for informing staff in local agencies of state Medicaid policies, standards, procedures and instructions. The

[4]Benton, Dakota, Hennepin, Kandiyohi, Meeker, Ramsey, Rice, Sherburne, Stearns, Steele, and St. Louis Counties. Interviews were conducted September 12 through October 27, 1983.

TABLE 2.5

AVERAGE MONTHLY RECIPIENTS BY ELIGIBILITY CATEGORY

Fiscal Year	AFDC	65 or Older	Disabled/ Blind	Needy Children	Non-AFDC Families	Total	Total Expenditures
1983	69,621	33,536	22,093	6,549	3,723	135,520	$839,378,000
1982	72,627	33,891	21,274	5,442	1,673	134,907	749,591,000
1981	73,962	33,056	20,365	6,640	1,449	135,472	657,815,000
1980	63,231	32,071	19,567	6,585	1,062	122,516	566,369,000
1979	60,245	31,193	19,111	6,327	886	117,762	461,615,000
1978	60,376	31,515	19,247	6,589	1,011	118,738	407,379,000
1977	58,765	30,070	16,925	6,883	1,115	113,758	367,625,000
1976	58,696	31,062	14,548	7,594	1,173	113,073	321,575,000
1975	47,418	31,456	13,442	5,332	1,269	98,917	261,254,000
Percent Increase 1975-1983	47%	7%	64%	23%	193%	37%	221%

Source: OLA calculations from Department of Public Welfare data.

department meets this requirement by issuing information and instructional bulletins to county staff in response to legislative or policy changes. This information is later incorporated into the State Medicaid Manual.

Information distribution is a critical aspect of DPW's responsibility. Bulletins and manuals are used to communicate state and federal guidelines and criteria for eligibility approval and disapproval decisions. The documents also provide the legal basis for implementing and monitoring the Medicaid program. Since counties rely heavily on these documents as a principle source of program information, bulletins and manuals must be timely and clear.

We found no problems with clarity of the bulletins or the manual; counties agreed that they are usually clear and easily understood. Similarly, bulletins are issued within an acceptable time following federal regulation or state statutory changes. We did find that the lag time between bulletin publication and the time when these changes are incorporated into the Medicaid Manual causes some confusion for county workers. For example, when bulletins advise a policy or procedure that is different than the Manual, county staff must interpret the difference, notify all staff, and monitor workers so that the change is carried out correctly. This is made more difficult by the fact that often changes in the bulletin are not cross-referenced with Manual sections. Counties agree that this practice could result in extra work for county staff, inconsistent treatment of individual applications, and different policy interpretations by different levels of government. Therefore, we recommend that:

- DPW more quickly incorporate bulletin material into the Medicaid Eligibility Manual, and that the department change the bulletin format so that there is a system of cross reference with each manual section affected by each bulletin change.

2. ADMINISTRATIVE REVIEWS OF COUNTY MANAGEMENT PRACTICES

Federal regulations pertaining to administrative review state that the department must conduct systematic planned examination and evaluation of operations in local offices by regularly assigned state field staff who make regular visits. Until 1981, this function was conducted by field staff who were assigned to various regions of the state. These positions were eliminated by the Legislature at that time and until recent efforts through organizational changes, there has been little to take their place. In July 1983, the Health Care Policy Unit obtained two staff persons to visit counties and provide technical support and observe county operations.

During the interviews, counties emphatically expressed a need for increased communications with the department. Some counties believe they are left out of decisions, some want to discuss general issues with department staff, and others need clarification of policies or procedures. All agreed that the quality of assistance provided by DPW is satisfactory, but would like it expanded.

We found there is very little administrative review of county management of the Medicaid program either through reporting requirements, on-site audits, or by persons who serve an intermediary role between the state agency and local welfare agencies. We conclude that in order to be assured that county policies and procedures are in compliance with federal regulations, statute and rules, and agency policies, the administrative review function should be better defined and conducted routinely by DPW staff. Preferably, administrative review by the agency should be designed to meet the federal regulation. We recommend that:

- DPW establish a program for ongoing administrative reviews. The reviews should provide essential county management information to the department and make counties accountable for acceptable program practices that go beyond those factors assessed through quality control reviews. The reviews should include more broadly based program criteria than the technical review conducted by Quality Control reviewers for purposes of determining error rates. Examples are county caseload levels, treatment of individual applicants, and consistency of intake reviews.

3. TRAINING AND OTHER SUPPORT SERVICES

Federal training regulations for local welfare staff state that the single state agency must have an organized training program, supervision, and supportive services for staff that have direct contact with Medicaid applicants. As Minnesota utilizes a state-supervised county-administered program, the requirements for provision of training appear to apply equally to DPW and the counties. There are two types of training to consider; 1) staff training which includes initial orientation to Medicaid policies, procedures, and report forms, and development of interview and other intake skills, and 2) ongoing informational meetings to discuss program changes and how to implement them.

Our review found:

- DPW does not have standardized training guidelines for county Medicaid personnel.

Counties vary in their perspective of training needs. Large counties with staff development units provide their own training program and expressed few complaints about the absence of training opportunities from the department. Smaller counties without special training units rely on on-the-job experience, and were quick to point out the need for additional staff training programs. Smaller counties also mentioned that it was difficult to get county boards to approve training costs, forcing them to improvise with whatever methods are available. The on-the-job approach to training can have hidden costs for counties because supervisors attention may be diverted from their work, and also may reinforce bad habits or local biases.

DPW acknowleges that provision of training has decreased recently because of staff and budget reductions, and minimal federal emphasis on training requirements. At one time the department provided counties with a series of programmed instructional tapes to use in their training procedures. The most recent effort is to develop a computerized instruction program which would be available to counties with a 3270 terminal, or for use through the state hospital micro computer system. This system is not ready for application at this time.

State training opportunities are not as available as they were previously but the need still exists. Specific informational seminars are presented to counties by the department when there have been significant program changes, but often, these presentations are scheduled only once a year. Also, county boards are limiting participation by local staff, resulting in most training being conducted by the county.

We conclude that staff training and other support services are important factors in maintaining continuity and consistency in the statewide Medicaid program. The department delegates most training responsibilities to counties and a large portion of the training is provided on-the-job. This approach may contribute to unequal eligibility determination practices and treatment among the counties. We recommend that:

- DPW should increase efforts to develop a system of standardized county training guidelines and materials for county use.

D. QUALITY CONTROL AND CORRECTIVE ACTION

The Department of Public Welfare, in accordance with federal requirements, operates Quality Control (QC) and Corrective Action (CA) programs to monitor and assess the accuracy of Medicaid eligibility determinations across the state. The Quality Control and Corrective Action programs are important components of Minnesota's Medicaid cost-containment efforts. The primary objective of the Quality Control and Corrective Action programs is to ensure that Medicaid funds are paid only to those persons who are eligible under state and federal law. This section examines the effectiveness of DPW's Quality Control and Corrective Action programs in meeting this objective.

1. QUALITY CONTROL

a. Background

Federal regulations require states participating in the Medicaid program to operate a Quality Control review program to identify and measure Medicaid benefits erroneously being paid to

ineligible persons.[5] Quality Control reviews are conducted every six months through an examination of a statistically significant sample of active Medicaid cases across the states. In Minnesota, a random sample of 1,500 active cases is reviewed during each six month review period. The review identifies cases for which Medicaid payment was made to persons who:

- Were ineligible at the time of the review or at the time services were received.
- Had not properly met spend down liability requirements prior to receiving Medicaid services.

From these reviews, DPW calculates an eligibility payment error rate for the review period. The eligibility payment error rate is a measure of the accuracy of eligibility determinations, and is defined as the percentage of Medicaid benefits in the six-month sample that are erroneously paid out. The Quality Control sample is designed to yield a statistically significant estimate of the total percentage of Minnesota Medicaid benefit dollars that are inappropriately awarded as a result of incorrect eligibility determinations.

Once the DPW review is complete, the Health Care Financing Administration (HCFA) re-reviews a subset of the state Quality Control sample to establish a federal eligibility payment error rate for Minnesota. The DPW and HCFA error rates are combined, using a mathematical formula, to form the "official" payment error rate. States having "official" error rates greater than federally established tolerance levels are subject to federal fiscal sanctions.[6]

In addition to reviewing active eligibility cases, the DPW Quality Control section reviews approximtely 300 negative action cases every six months to determine whether cases were appropriately denied eligibility status, or whether the termination of Medicaid benefits was correctly undertaken. Federal fiscal sanctions are <u>not</u> based on these negative action reviews.

b. <u>Payment Error Rates in Minnesota</u>

Table 2.6 presents data on Medicaid eligibility payment error rates in Minnesota for the five most recently completed review periods.[7] As Table 2.6 shows, Minnesota's "official" error rate has been less than one percent for all review periods, which is well below federal tolerance levels. Thus, Minnesota has consistently avoided federal Medicaid sanctions.

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[5] 42 CFR, Section 431.800.

[6] 42 CFR, Section 431.802.

[7] (1) April-September 1980, (2) October 1980-March 1981, (3) April-September 1981, (4) October 1981-March 1982, and (5) April-September 1982.

TABLE 2.6

MINNESOTA MEDICAID ELIGIBILITY PAYMENT ERROR RATE
(Percent of Benefit Dollars in Error)

	4-9/1980	10/1980-3/1981	4-9/1981	10/1981-3/1982	4-9/1982
DPW Calculated Error Rate	0.19%	0.18%	0.24%	0.21%	0.47%
Official Error Rate	0.50	0.30	0.60	0.50	0.60
Federal Tolerance Rate[a]	6.20	9.00	9.00	6.50	6.50
National Average	5.00	4.10	N/A	N/A	N/A

Source: Department of Public Welfare, Corrective Action Section.

[a]The federal tolerance rate will drop to 4.0 percent for the 10/1982-3/1983 review period and to 3 percent for the 4-9/1983 review period and thereafter.

DPW's Quality Control sample for the April through September 1982 review period estimated that only 0.47 percent of total Minnesota Medicaid benefit dollars distributed during that time were awarded to ineligible persons. Within the Quality Control sample of approximately 1,500 active cases, 15 error cases were reported. Table 2.7 presents a breakdown of error cases, by type of error, for the April through September review.

One liquid asset error case in this review caused 78 percent of the total eligibility payment error rate. The difference between DPW's calculated error rate of 0.47 percent and the "official" payment error rate of 0.60 percent represents additional differences in policy interpretations between DPW and HCFA which resulted in the identification of additional federal quality control errors.

Minnesota's eligibility payment error rate is one of the lowest in the nation. Table 2.8 presents an interstate comparison of payment error rates for two review periods in 1980 and 1981. Minnesota had the lowest error rate in the nation for the April through September 1980 review period, and the second lowest for the following six month period. Although more current data on interstate comparisons are not available, the HCFA regional office has indicated that Minnesota continues to have a comparatively low payment error rate.

TABLE 2.7

REVIEW OF ERROR CASES BY TYPE OF ERROR
April 1982 - September 1982

Type of Error	Number of Cases	Error As a Percent of All Medicaid Payments
Unreported, or improper consideration of liquid assets	3	0.373%
Unreported, or improper consideration of government benefits	3	0.037
Unreported, or improper consideration of other income	3	0.025
Unreported, or improper consideration of RSDI	3	0.018
Unreported, or improper consideration of earned income	2	0.016
Unreported, or improper consideration of pension income	1	0.006
TOTAL	15	0.475%

Source: Medical Assistance Corrective Action Plan, April 1982 - September 1982. Department of Public Welfare, Corrective Action Section.

Interstate comparisons of eligibility payment error rates may not provide a totally accurate ranking of states. Quality Control reviews conducted in each state use the state's approved Medicaid Plan as the criteria for determining eligibility errors. Because approved state plans vary significantly across the country, the basis for determining payment error rates is not consistent from state to state. However, the payment error rate does measure the degree to which each state correctly implements its own eligibility criteria. Therefore, it is fair to conclude that in Minnesota:

- A comparatively small percentage of total Medicaid benefits are erroneously awarded to ineligible persons.

TABLE 2.8

NATIONAL ELIGIBILITY PAYMENT ERROR RATES

	October - March 1981	April - September 1980
National Average[a/b/c]	4.1	5.0
Region I		
Connecticut	6.6	5.8
Maine	8.7	10.0
Massachusetts	6.6	13.2
New Hampshire	1.5	1.3
Rhode Island	4.1	5.5
Vermont	2.5	11.7
Region II		
New Jersey[d]	4.4	4.3
New York[a]	2.7	4.6
Puerto Rico[a]	4.1	5.0
Virgin Islands[a]	4.1	5.0
Region III		
Delaware	15.4	8.3
D.C.	3.3	4.7
Maryland[b/c]	2.9	2.4
Pennsylvania[b/c]	3.7	8.1
Virginia	1.9	2.4
West Virginia	12.7	3.7
Region IV		
Alabama	1.6	8.8
Florida	6.3	8.0
Georgia	6.9	12.7
Kentucky	5.1	2.0
Mississippi	3.7	1.1
North Carolina	5.4	5.9
South Carolina	2.2	6.2
Tennessee	3.1	3.7
Region V		
Illinois[d]	5.6	2.8
Indiana[d]	.9	1.5
Michigan[d]	4.0	4.3
Minnesota	.3	.5
Ohio	2.1	3.8
Wisconsin[d]	3.5	6.2
Region VI		
Arkansas	3.2	6.5
Louisiana	1.8	3.4
New Mexico	1.6	5.9
Oklahoma	3.4	2.4
Texas	2.4	5.2

TABLE 2.8
(con't)

	October - March 1981	April - September 1980
Region VII		
Iowa	3.3	6.8
Kansas	2.9	3.2
Missouri	.6	2.3
Nebraska	2.8	1.0
Region VIII		
Colorado	5.1	9.7
Montana	18.3	16.6
North Dakota	5.3	1.4
South Dakota	6.8	1.5
Utah	4.8	3.4
Wyoming	2.8	6.2
Region IX		
Guam[a]	4.1	5.0
California[c]	8.1	7.0
Hawaii	7.2	1.5
Nevada	0.0*	1.2
Region X		
Alaska	11.7	5.1
Idaho	11.8	4.4
Oregon	2.9	2.0
Washington	4.0	2.0

Source: Department of Health and Human Services, Health Care Financing Administration, Bureau of Quality Control, Medical Assistance Quality Control Report - Eligibility (Interim Report), March 8, 1982.

*Rate is greater than "0" but less than .05 percent.

[a]Puerto Rico, Virgin Islands, and Guam were assigned the weighted National Mean error rates due to incomplete data.

[b]Pennsylvania's error rates were determined using contract staff to perform reviews analogous to normal MQC review procedures. The resulting rates were included in the weighted national mean error rates.

[c]California's October 1980-March 1981 error rate is preliminary and subject to change. The rate is included in the weighted national mean error rate.

[d]Error rates for October 1980-March 1981 are tentative pending final resolution of AFDC group error determinations.

Because the state plan specifies the criteria for determining eligibility errors, the payment error rate for a state will necessarily be sensitive to changes in that plan, particularly the implementation of more complex eligibility restrictions which increase the chances for error. Minnesota's payment error rate is probably low enough to provide a cushion to implement new, more complex eligibility requirements, without the error rate surpassing the federal tolerance level (4 percent for the October 1982-March 1983 review period, and 3 percent thereafter). However, as there is no way to accurately predict how much the error rate will rise in response to new eligibility restrictions, the Legislature should fully consider the possibility of federal fiscal sanctions as a result of exercising this option. In the absence of such changes, Minnesota should continue to meet the federal tolerance level.

c. Negative Action Cases

Table 2.9 shows a summary of DPW's negative action case reviews for the past two years. From Table 2.9, we can see that the vast majority of negative action errors have occured with eligibility terminations rather than eligibility denials.

DPW data show that the recent jump in incorrect termination actions can be attributed entirely to county agency noncompliance with a recent policy change which requires that a notice of termination be sent in cases closed as a result of the client's death. This change accounted for 33 of the 40 incorrect termination actions in the most recent review period. In the absence of these errors, the error rate would have been 2.3 percent, consistent with the previous trend of declining error rates. Interstate comparison data for negative action errors is not available.

2. CORRECTIVE ACTION

In conjunction with Quality Control reviews, DPW operates a Corrective Action Program to prevent and reduce the incidence of errors found in Quality Control sample cases. Federal rules require the Corrective Action section to:

- Utilize Quality Control sample data to identify error prone eligibility requirements and case management practices.
- Develop and implement appropriate Corrective Action initiatives to alleviate the potential for future errors in these problem areas (including negative action).

The Corrective Action Program is DPW's primary administrative mechanism for keeping eligibility payment error rates low. Corrective Action is, in essence, a Medicaid eligibility cost-containment program. It is designed to prevent increased Medicaid costs due to incorrect eligibility determinations. Our examination of DPW's Corrective Action Program found:

- The Corrective Action Program consistently exceeds minimum federal Medicaid requirements.

TABLE 2.9

NEGATIVE ACTION CASE REVIEWS
April 1981 through March 1983

Period	Denials		Terminations		Total	
	Actions Reviewed	Incorrect Actions	Actions Reviewed	Incorrect Actions	Actions Reviewed	Incorrect Actions
4/81-9/81	34	1	292	16	326	17 (5.2%)
10/81-3/82	43	0	231	12	274	12 (4.4%)
4/82-9/82	47	0	257	10	304	10 (3.3%)
10/82-3/83	53	1	258	40	311	41 (13.2%)

Source: Medical Assistance Negative Action Corrective Action Plan, October 1982 - March 1983. Department of Public Welfare, Corrective Action Section.

- Corrective Action initiatives are appropriate and effective.

The Corrective Action Section has implemented a number of important Corrective Action initiatives over the past few years. These include:

- Development of a Corrective Action panel to assess county agency Quality Control problems and needs.

- Development of semi-annual Corrective Action reports (distributed to counties) which detail Quality Control review errors and suggest actions counties should take to reduce the incidence of these errors.

- The development of a supplemental Quality Control data sheet to allow the Corrective Action section to gather more information about error causation.

- Development of a Supervisory Case Review system to allow counties to perform their own Quality Control reviews to check individual case worker performance.

- Development of a Policy Center to provide counties with prompt answers to case specific eligibility questions.

These initiatives go beyond minimum federal requirements for Corrective Action. The initiatives address important eligibility issues and provide counties with much needed Corrective Action support and technical assistance. County welfare staff interviewed for this report were very supportive of these efforts, particularly the Policy Center and Supervisory Case Reviews. The innovative and comprehensive approach to Corrective Action taken in Minnesota is undoubtedly a major contributor to the state's low eligibility payment error rate.

3. LIMITATIONS OF MINNESOTA'S QUALITY CONTROL AND CORRECTIVE ACTION PROGRAM

Minnesota's Quality Control and Corrective Action programs have consistently met and surpassed minimum federal requirements, as well as provided the state with one of the lowest eligibility payment error rates in the nation. Despite this excellent record, there are a number of important limitations with the present Quality Control and Corrective Action programs. In particular:

- The Quality Control sample, while adequate to generate accurate data on a statewide basis (1,500 cases every six months), is not large enough to provide accurate data for each of the 87 county administrative units.

Because the Quality Control sample size is determined on a statewide basis (in accordance with federal regulations), there are a number of small counties in the state that have very few (five or less) Quality Control reviews performed during a six-month review

period. Without a significant number of Quality Control reviews, it is difficult if not impossible, to properly assess the accuracy of eligibility determinations within these counties.

- Quality Control reviews and Corrective Action initiatives do not adequately address important county administrative issues.

Federal regulations for Quality Control reviews do not include specific requirements for assessing the appropriateness or effectiveness of county administrative and case management practices. As a result, Quality Control reviewers do not attempt to collect or analyze county data on administrative practices. Administrative reviews have historically been the responsibility of other units within DPW, with little contact or coordination with the Quality Control and Corrective Action sections. In our estimation, the administrative review function must be tightly coordinated with the Quality Control and Corrective Action findings in order to be effective.

RECOMMENDATIONS

- The Quality Control section should perform separate, targetted county reviews.

Federal regulations do not limit DPW's ability to add additional state review components, separate from the federal requirements. The Quality Control section should review eligibility determinations more fully in those counties having consistenly small Quality Control samples, or counties suspected of having high eligibility error levels. Targetted reviews will allow DPW the flexibility to concentrate additional Quality Control resources where they are needed most. These reviews should include active as well as negative action cases.

- Quality Control findings should be coordinated with an administrative review process. Corrective Action initiatives should directly address administrative issues.

Coordinating administrative reviews with the existing Quality Control data collection system and Corrective Action information dissemination system will effectively utilize staff resources and expertise for this important state supervisory responsibility.

III. PREPAYMENT REVIEW OF MEDICAID CLAIMS

A. INTRODUCTION

In this chapter we address the following questions:

- How is DPW organized to conduct prepayment reviews of Medicaid claims?
- How well is DPW conducting prepayment claims review?
- What improvements are possible in prepayment review?

Prepayment review of claims includes the intake, examination, and payment of invoices or claims for payment from medical practitioners enrolled as participants in the Medicaid program. Prepayment review consists of two major functions: invoice processing and medical review.

In order to evaluate prepayment review, we conducted over 40 interviews with DPW management and staff, medical consultants, legislators, federal Medicaid officials, and other fiscal intermediaries. In addition, we did sample testing and examination of the claims processing system.

Our findings regarding prepayment review of claims can be summarized quite briefly:

- DPW is performing acceptably well in processing Medicaid claims. Minnesota compares favorably to other states in claims processing error rates, and has consistently paid claims to medical vendors with a minimum of delay.
- Minnesota's Medicaid Management Information System (MMIS) has performed acceptably well, meeting federal standards consistently through the years.
- Minnesota's process for prior authorization and review of medical necessity is also working well, and providing a positive return to the state.

Despite our generally favorable view of DPW's prepayment reviews, we find that there are a number of areas where improvements could be made:

- Computer production controls and audits need improvement.
- DPW needs to undertake a systematic review of the prepayment edits to ensure they are working in a manner consistent with each other and consistent with current legislative and departmental policy.

- DPW needs to devote more resources to updating and maintaining the automated invoice processing and prepayment review system.

The following sections describe the organization and function of prepayment review and discuss recommended improvements in more detail. First, we discuss the organization of prepayment review, next, the claims processing system, and finally, the prior authorization and medical review process.

B. ORGANIZATION OF PREPAYMENT REVIEW

The prepayment review of Medicaid claims is carried out within several organizational units in DPW. The primary locus of prepayment review is the Health Care Programs, Invoice Processing Section.[1] Other aspects of prepayment review are carried out by the Professional Services Section, and the Systems and Data Flow Division of the Support Services Bureau. We examined the prepayment review function across organizational lines in order to get a complete picture of how DPW accomplishes review of Medicaid payments.

The prepayment review function relies heavily on data processing support. As a result, we interviewed a number of management and staff of the Support Services Bureau's Systems and Data Flow Division. The Systems division, although located organizationally in the Support Services Bureau, spends the majority of its time and resources on meeting the data processing needs of Medicaid and related programs.

C. INVOICE PROCESSING

The sheer size of Medicaid invoice processing is impressive. In fiscal year 1983, over 7.2 million claims were processed, distributing over $845 million of federal, state, and county funds to over 14,000 active Medicaid providers. The records of approximately 240,000 Medicaid eligibles must be kept track of, and the prices of over 30,000 medical procedures and diagnoses and 25,000 drugs must be kept up to date. Table 3.1 breaks down the number of claims processed and dollars paid to different types of providers in fiscal year 1983.

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[1]See the organization chart presented in Figure 3.1 and Figure 3.2 on pages 42 and 43.

TABLE 3.1

NUMBER OF CLAIMS PROCESSED AND PAID
Fiscal Year 1983

Provider Type	Total Claims	Payments
Nursing Home	61,972	$ 13,625,425
Inpatient Hospital	145,382	133,012,784
Outpatient Hospital	398,732	21,902,724
Mental Health	31,027	2,089,575
Rehabilitation Center	11,863	1,436,313
Crippled Childrens	582	13,965
Physician-Drug	422	2,873
Department of Health	5,754	171,106
State Hospital	31,232	95,202,177
Physician-Individual	287,496	11,269,315
Physician-Group	999,498	32,988,188
Dentist-Individual	178,914	9,624,999
Dentist-Group	68,673	3,061,291
Optometrist	44,232	1,576,016
Podiatrist	16,967	361,627
Chiropracter	25,632	787,199
Nurse	11,375	3,672,981
Physical Therapist	2,748	263,333
Speech Therapist	5,312	393,250
Occupational Therapist	228	169,870
Psychologist	41,495	2,896,867
Audiologist	577	21,725
Public Health	41,606	1,335,175
Family Planning	1,772	78,866
Professional School Clinic	2,134	49,499
Home Health Agency	41,200	4,281,010
Pharmacy	3,328,407	31,812,116
Optician/Optical Supplier	44,678	1,186,993
Medical Equipment	63,098	2,465,533
Hearing Aid Supplier	16,252	601,417
Independent Lab	47,281	315,366
Medical Transportation	109,340	4,177,986
Recipient Adjustments	7,828	(7,090,343)
Total Medical	6,073,709	$373,757,222[a]
HMO Payments	51,651	$ 2,371,779
Nursing Home Payments	947,055	466,910,475
Medicare Buy-In	183,401	2,283,763
GRAND TOTAL	7,255,816	$845,323,239[b]

Source: DPW Invoice Processing Section.

[a]Does not total due to rounding.

[b]The total differs from the $839,378,000 reported by DPW to the federal government and the $866,883,081 recorded on the Statewide Accounting system because of provider adjustments and accrual timing differences.

1. MINNESOTA MEDICAID MANAGEMENT INFORMATION SYSTEM

The claims processing system consists of an integrated set of computerized and manual procedures necessary to intake, approve or disapprove, and make payment for all submitted claims. A major support for the claims payment process is the Medicaid Management Information System (MMIS).

In 1973, the Minnesota Legislature directed the Department of Public Welfare to develop an automated payments system for Medicaid. The federal government encouraged the development of automated systems by paying for 90 percent of the development and 75 percent of the operating costs of approved systems. Systems development was accomplished jointly by the DPW systems office, the Department of Administration's Information Services Bureau, and a consultant. The MMIS was an adaptation of existing systems of other states. The principal components were the eligibility subsystem from Oklahoma, and five other subsystems from Ohio. Each of these systems is briefly described below. The Medicaid Management Information System was completed in 1975 when it was approved by the federal government as meeting the requirements for 75 percent funding.

Minnesota's MMIS consists of six interrelated subsystems: Recipient, Reference File, Provider Eligibility, Invoice Processing, Management and Administrative Reporting (MARS), and Surveillance and Utilization Review (S/URS). The first four of these systems are primarily concerned with prompt payment of claims to eligible recipients and providers. The latter two systems provide management information to DPW and the Legislature as well as monitoring the system on a postpayment basis to detect and deter fraud and abuse. The principal functions of each subsystem are described below:

a. Recipient Subsystem

This system maintains all information for recipient eligibility, Medicare Part B buy-in processing, and control of data for nursing home and health maintenance organization invoice generation. The system generates monthly recipient eligibility notifications and explanation of Medicaid benefit notices. This subsystem also generates reports for counties and data used as inputs to other subsystems.

b. Reference File Subsystem

The major function of the reference file subsystem is to maintain the various computer reference data files on procedures, drugs, supplies, and diagnoses for use in the claims processing subsystem.

c. Provider Subsystem

This system processes provider enrollment applications, and maintains a file of eligible providers for each type of service for use in claims processing and other applications.

d. Claims Processing Subsystem

This subsystem is the major system for processing invoices. Claims are input into the system and edited to ensure that they are valid claims for payment to eligible providers for services rendered to eligible recipients.

e. Management and Administrative Reporting Subsystem (MARS)

The purpose of this subsystem is to provide data for federal reports, and to provide adequate statistical and financial data to monitor and control the claims processing system and to support program management.

f. Surveillance and Utilization Review Subsystem (S/URS)

The functions of S/URS are: to develop a comprehensive statistical profile of health care and utilization patterns; to isolate suspected cases of fraud, abuse, or misutilization of services by both providers and recipients; and to provide information on possible defects in the level of care or quality of service.

2. CLAIMS PROCESSING ORGANIZATION

Effective July 1, 1983 the Health Care Programs Division reorganized. The current organization chart of the division is shown as Figure 3.1. The Invoice Processing Section was also reorganized along functional lines. Figure 3.2 shows the current organization of the invoice processing section.

Before July 1, claims analysts were organized into seven units that handled all questions and processing for a particular type of claim. The new organization will segregate the process of claims review from answering provider questions and from handling time-consuming unusual claims. In addition, management plans to conduct more quality control checking within the division. The effect of the reorganization is to both generalize the handling of normal claims and to specialize the handling of other functions.

3. FLOW OF INVOICES THROUGH SYSTEM

Invoices are prepared by the provider on the appropriate DPW form and must be submitted correctly within one year from the date of service. Invoices are received in DPW and run through an optical character reader. The optical character reader scans the submitted invoices and stores the information on magnetic tape for later processing. Approximately 90 percent of paper invoices are submitted in scannable form. Of these claims, approximately 55.6 percent are scanned without any errors. Another 40.8 percent are partially read by the system, and 3.6 percent are totally rejected by the scanner. Data entry personnel manually enter claims totally or partially rejected by the scanner. DPW is not concerned with upgrading the capabilities of the optical scanner at this time, rather it is encouraging the process of direct provider "tape-to-tape" billing.

FIGURE 3.1

INCOME MAINTENANCE BUREAU, HEALTH CARE PROGRAMS DIVISION
ORGANIZATION CHART
December 1983

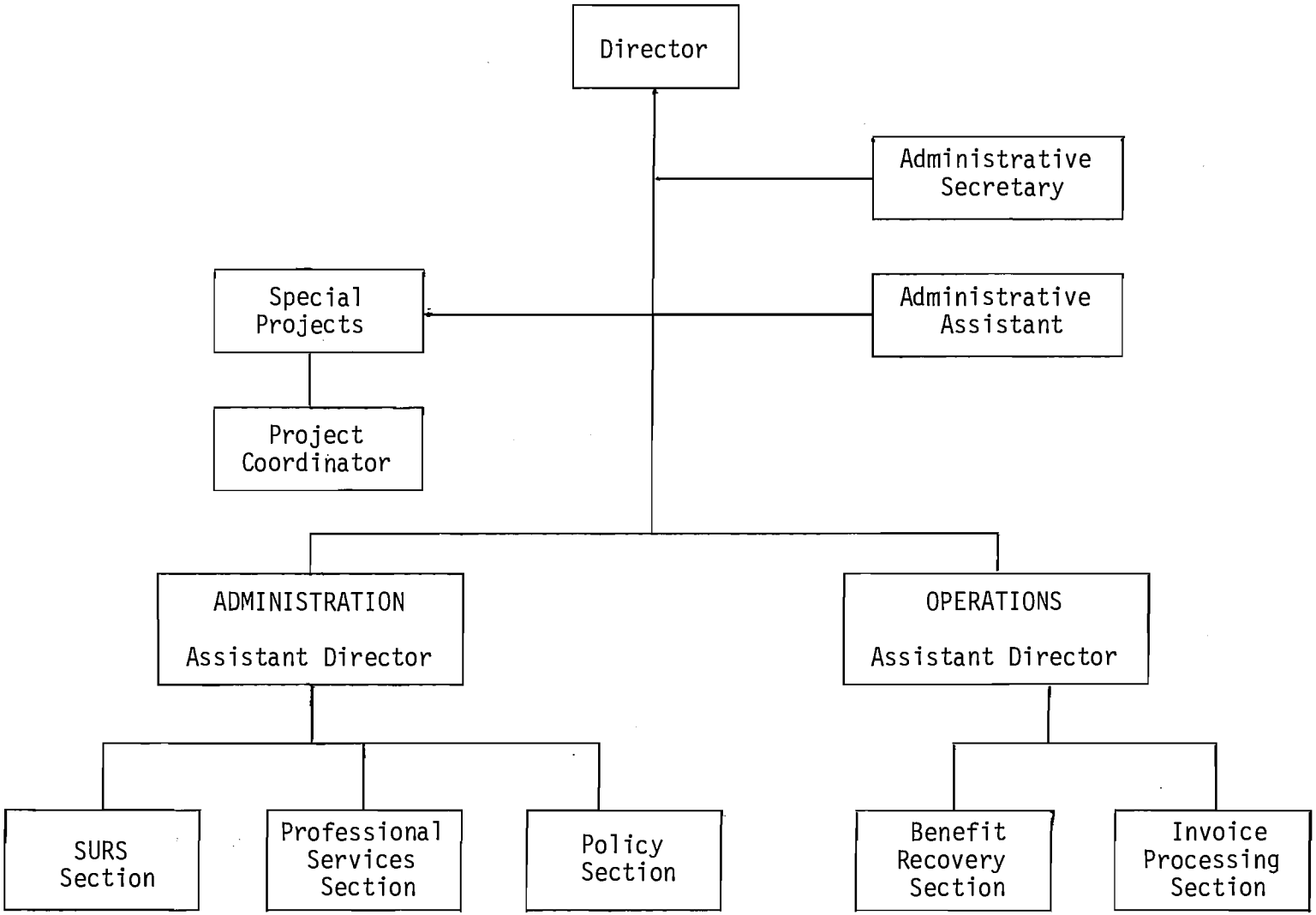
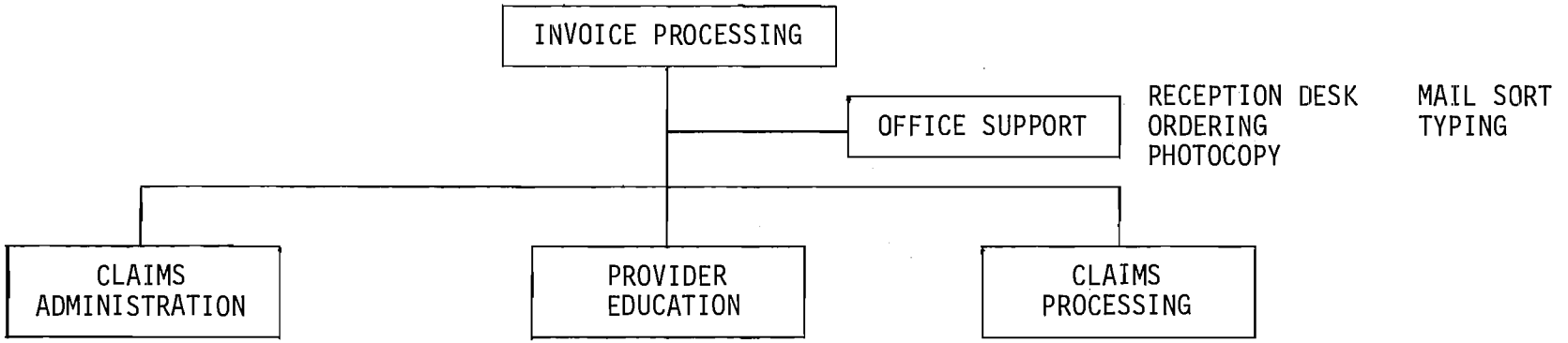


FIGURE 3.2

HEALTH CARE PROGRAMS DIVISION
INVOICE PROCESSING SECTION
ORGANIZATION CHART



1. Pharmacy
   - Physician Drug
   - Pharmacy
   - Medical Supply
   - Hearing Aid
   - Med. Trans.
   - By-Reports

2. Physician
   - Physician
   - Mental Health
   - Psychologists
   - Public Health
   - Podiatrist
   - Labs
   - Crippled Children
   - By-Reports

3. Practitioner
   - Dental
   - Vision
   - Chiropractor
   - Family Planning
   - Crossovers
   - Inpatient
   - Outpatient
   - By-Reports

TRAINING
MANUALS
BULLETINS

1. Claims Control

2. Long Term Care
   - State Institutions
   - HMO
   - Long Term Care
   - Day Activity Ctrs.
   - EPSDT
   - Rehab. Centers
   - Home Health
   - Audiologist
   - Physical Therapy
   - Occupational Ther.
   - Speech Therapy

3. Miscellaneous Transactions
   - Reference File
   - Adjustments
     - checks
     - invoices
   - Correspondence
   - Provider Phones
   - Personal Care Attend.
   - Quality Control
   - Out-of-State
   - Eligibility Phones

Provider groups or provider service bureaus generate magnetic tapes in the format of the DPW invoice and submit the tapes directly to DPW. Approximately 40 percent of claims currently are submitted on a direct billing basis.

Claims entered by DPW are processed each evening by the Department of Administration, Information Services Bureau (ISB). ISB runs the invoices through a series of computer edits, the so-called "daily" edits. These edits check the submitted invoices for completeness and logical consistency. Daily edits should also pick up any previously undetected scanning errors. Claims failing the edits are examined by a medical claims analyst. The medical claims analyst compares the actual invoice with the computer record and decides on the resolution of the claim according to a set of predetermined procedures. The medical claims analysts may reject the claim, or they may manually override the edit that suspended the claim from the processing stream. If the analyst rejects the claim, notice is sent to the provider on the next remittance advice that the claim failed for an indicated reason. If the error that suspended processing is correctible, or if the claim was suspended for examination and is found to be correct, the analyst will "force" or override the error code and return the claim to the processing stream. If a claim is not suspended by the daily edits, it is held until the end of the week and then submitted for a second series of edits, the "weekly" edits.

The weekly edits are a series of computer checks that compare the submitted invoices to the eligibility and history files, determine that the recipient was eligible on the date the service was provided, and run a series of checks for duplicate or conflicting payments. If a claim fails the weekly edits it is again examined by the medical claims analysts. If the claim is processed without error, it is held until the warrant writing system is run every two weeks. Figure 3.3 illustrates the flow of claims through the system.

The system currently does not check for recipient eligibility until the claim passes all of the daily and weekly edits. As a result, many times automated and manual processing efforts are expended on claims for ineligible recipients. A more efficient process would be to check recipient eligibility as a first step in processing.

Federal regulations require that consistency checks be made to see that the number of visits and services claimed on the invoice are logically consistent with the recipient's characteristics and circumstances, such as illness type, age, sex, location where the service was provided, etc.[2] The majority of the edits in the Minnesota Claims Processing system are consistency checks.

A second type of MMIS edit is designed to limit payment for services that are not medically necessary or duplicate in some unacceptable fashion a previous or concurrent service. Edits also identify payment requests higher than allowed. An example of this latter type of edit is one that detects whether MA is being billed separately for a

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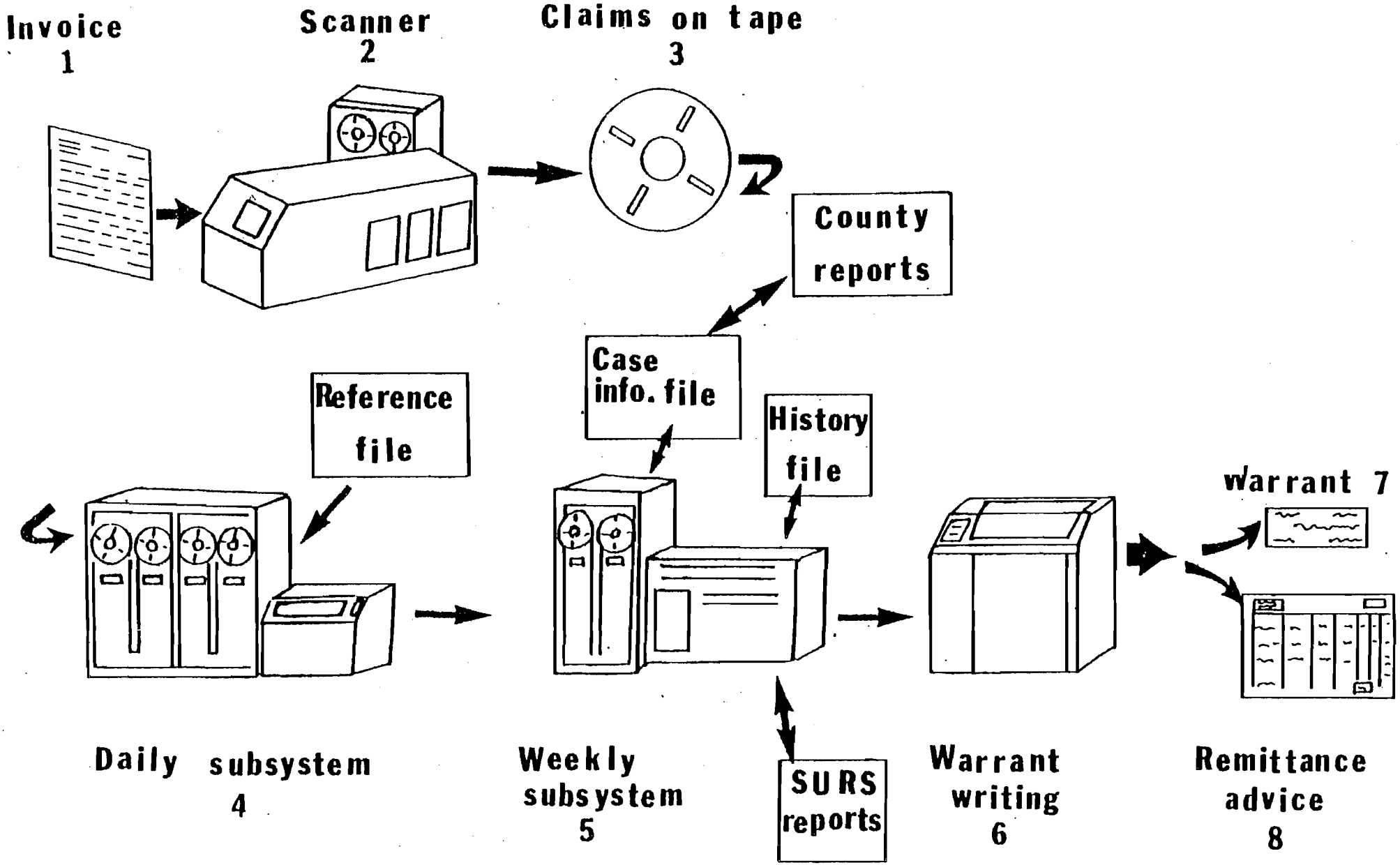
[2] 42 CFR 447.45(F)(ii).

FIGURE 3.3

FLOW OF MEDICAID INVOICES



battery of lab tests. Since DPW pays a lower rate for a patient profile of lab tests than for the total of each of the tests if they were billed separately, DPW collapses the separate tests and just pays for the patient profile.

We examined claims processed during 1983 to determine the makeup of the invoice processing section's workload. We found that the majority of medical claim analyst workload relates to the manual examination of claims screened out by the system and the correction of scanner errors. Table 3.2 shows the average number of claims suspended for the most frequent error conditions during the last six months of fiscal 1983. Each invoice could have more than one error condition so these numbers are representative of, but not directly translatable into the number of invoices suspended. Table 3.2 also illustrates the types of edits that are included in the claims processing system.

As one can see from examining Table 3.2, the most frequent type of suspension deals with ensuring that the service, recipient, and the provider were eligible for payment under the program on the date the service was provided. In addition, the system contains a number of screens or edits to ensure that the payment is for the right procedure, and at the correct amount of reimbursement. Examples of this type of edit include one that suspends claims where the amount allowed is less than one-half the submitted amount. These claims are suspended because they may be billing for the wrong procedure code or they may have used the wrong number of units of service provided.

By far the greatest number of claims suspended for review are the "by-report" procedures. These are procedures that by their nature, or because of system limitations, cannot be handled automatically. Examples of by-report procedures include the pricing of surgical procedures where a report of the surgery must be examined to determine the allowable charge. Some items, such as injectable drugs, could be priced by the system, but currently are not. With the advent of a new coding system for medical procedures, injectable drugs will soon be priced by the computer and will not require manual review.

We examined the makeup of the edits in the claims processing system to determine whether the basic edits necessary for detection of errors in claims and correct payment of claims were present.

We found:

- DPW has instituted a set of edits that is sufficient to meet the processing needs of the system. However, there are additional edits that could be added to strengthen claims review.

Many of these edits are a part of the systems and programming backlog of the systems division that we discuss in the section on claims processing performance.

TABLE 3.2

MOST FREQUENT INVOICE SUSPENSION REASONS
January to June 1983

Suspension Reason	Average
Procedure "By-Report" - Manual Review Required	25,665.7
Allowed Price Less than One-Half Submitted	10,441.3
Recipient Ineligible on Date of Service	5,198.0
Service Date Over 11 Months Old--Manual Review	4,789.8
Line Item Charges More Than $1 Different from Total	4,612.2
Provider Review Before Payment	3,433.3
Recipient Birthday Does Not Match CI File	3,246.0
Drug Code Format Invalid	3,141.7
Medicare Crossover Non-Covered Charge	2,885.8
Recipient Not Found on CI File	2,776.5
More than Two Units of Service Billed Per Line	2,699.2
Inpatient Hospital Miscellaneous Charges More Than $50	2,548.0
Drug/Supply Code Not on File and Charge More Than $8	2,154.0
Provider Not Eligible on First or Only Service Date	2,058.8
Procedure Code Not Numeric	1,993.7
Billing Date Precedes Service Date	1,813.0
Procedure Code/Service Date Conflict	1,744.3
Place of Service Conflict with Procedure	1,659.5
Type 8 Pend for Review	1,620.7
Group Member Provider Number Error	1,563.8
Recipient Birthday Invalid	1,505.5
Procedure Code Conflicts with Surgery	1,456.3
Prescribing ID Not on File	1,444.2
Provider Number Fails Check Number Test	1,436.2
Sum of Procedure Charges Not Equal Total Charge	1,415.0
Service Date Precedes Authorized Eligibility	1,364.7
Medicare Crossover Recipient Ineligible	1,292.2
Wholesale Cost $0, Submitted Charge More Than $3.50	1,165.7
Excess of One Medicine Charge Per Service Date	1,158.8
Procedure/Service Code Conflict within Transaction	1,155.2
Prior Authorization Number Non-Numeric	1,140.5
First/Second Procedure Code Invalid	1,067.8
Procedure Code Not Current	1,061.2
Billing Date After Current Date	1,050.5
Claim Must be Split Billed	1,027.0
Recipient ID Number Missing	1,023.3

Source: Office of Legislative Auditor calculations.

4. RECENT CHANGES IN CLAIMS PROCESSING

The claims processing function has recently undergone several changes in operation. First, as discussed above, the function was reorganized on July 1, 1983. In addition to the reorganization there have been several changes in the way the computer system processes payments. On October 1, Minnesota adopted the Health Care Financing Administration's Common Procedure Coding System (HCPCS). HCPCS was required for use with Medicare beginning on October 1, and within the next few years will also be required for Medicaid. HCPCS allows the coding for more detailed procedures than the previous system. As a result, once the edits are changed, fewer claims will have to be examined manually because the system will be able to price the exact service rendered. Minnesota adopted this system now to coordinate with the conversion of Medicare payors.

Another recent change is the conversion of outpatient hospital billing procedures to a system similar to the practitioner system. The 1983 Legislature authorized restrictions on outpatient hospital billing after DPW was prevented by a lawsuit from implementing the changes on their own. DPW was sued because Rule 47 did not specifically allow the review of individual items on outpatient bills. Before this change was instituted, billings did not have to be itemized, and as a result most of the time whatever was billed by the hospital was paid by Medicaid. Outpatient billings are now subject to a set of edits similar to those performed on practitioner invoices.

Invoice processing is also instituting a change to on-line error resolution. Instead of the data entry group rekeypunching changes to suspended invoices, Medical claims analysts will be able to directly enter the resolution of suspended claims onto a tape that will be transported to ISB daily. DPW has been experimenting with on-line resolution for dental claims and has found it cost-effective.

The change to on-line error resolution is part of a broader office automation effort by DPW. By July 1984 approximately 26 terminals will be installed for a variety of office automation tasks including on-line resolution, word processing, and spreadsheet analysis. These efforts will significantly improve the department's ability to process and organize the amount of information that they deal with daily. DPW also has plans to have more Medicaid information on-line or on microfiche. Having current information on-line or readily available on microfiche would make the process of pre and post-payment review more effective.

5. CLAIMS PROCESSING PERFORMANCE

We examined several measures of claims processing performance:

- Prompt payment of valid claims, to eligible providers, for eligible recipients.

- Limitation of payments to correctly determined reasonable amounts.

- Adequate controls to ensure the above objectives.

a. Prompt Payment of Claims

Federal standards require that 90 percent of claims be paid within 30 days of correct submission. We found that DPW has done a good job in paying claims promptly. The average time for payment of non-nursing home claims was 15.5 days in fiscal year 1983. Over 95 percent of claims were paid within 30 days of receipt. Minnesota has consistently met the federal requirements for prompt payment of claims.

b. Correct Payment of Claims

Another measure of performance is whether the claims are paid correctly. That is, were payments of the correct amount made for covered services, actually provided by enrolled providers to eligible recipients. A federally mandated quality control group in DPW monitors claims processing performance in correctly paying claims. The paid claims are sampled and thoroughly examined by the quality control staff. The dollar amount of Medicaid payments found to have been made in error as a percentage of total Medicaid payments during the periods tested are shown in Table 3.3. These rates compare favorably to the error rates of other states' claims processing systems, although they are not directly comparable because of inter-state differences in Medicaid programs. Table 3.4 shows claims processing case error rates for two review periods. Minnesota ranked fourteenth lowest of 41 states reporting in the 1981 period and four-teenth of 48 states reporting in the 1980 period.

TABLE 3.3

CLAIMS PROCESSING ERROR RATES
1978-1982

Review Period	Percentage of Benefit Dollars in Error
July-September 1978	.632
October 1978 - March 1979	5.856
April-September 1979	.173
October 1979 - March 1980	.678
April-September 1980	.543
October 1980 - March 1981	.388
April-September 1981	.269
October 1980 - March 1982	.125
April-September 1982	.139

Source: Medical Assistance Corrective Action Plan, October 1981 - March 1982, Minnesota Department of Public Welfare, March 1983.

TABLE 3.4

CLAIMS PROCESSING CASE ERROR RATES[a]

	March 1981	September 1980
National Average[b/c]	3.1%	3.2%
Region I		
Connecticut	3.6	3.8
Maine	2.8	3.8
Massachusetts	3.9	1.1
New Hampshire	2.9	2.6
Rhode Island	.3	1.0
Vermont	.7	2.2
Region II		
New Jersey	.9	1.1
New York	3.1	1.9
Puerto Rico	--	--
Virgin Islands	--	--
Region III		
Delaware	1.0	0.0
D.C.	24.5	19.1
Maryland	1.2	2.8
Pennsylvania	--	4.3
Virginia	.8	.3
West Virginia	1.4	.4
Region IV		
Alabama	1.5	2.8
Florida	5.6	7.5
Georgia	2.8	2.5
Kentucky	3.2	1.5
Mississippi	.1	.2
North Carolina	4.2	5.4
South Carolina	--	5.9
Tennessee	2.4	1.3
Region V		
Illinois	.7	.9
Indiana	4.5	3.0
Michigan	4.4	4.9
MINNESOTA	1.8	1.5
Ohio	.3	1.0
Wisconsin	--	--

	March 1981	September 1980
Region VI		
Arkansas	2.6%	6.1%
Louisiana	--	1.0
New Mexico	3.4	3.9
Oklahoma	1.8	1.7
Texas	0.0	0.0*
Region VII		
Iowa	11.0	7.6
Kansas	1.9	3.0
Missouri	0.0	7.1
Nebraska	13.1	16.0
Region VIII		
Colorado	14.3	10.0
Montana	--	7.6
North Dakota	4.9	7.1
South Dakota	--	25.8
Utah	14.4	10.6
Wyoming	--	4.5
Region IX		
Guam	--	--
California	--	--
Hawaii	--	10.2
Nevada	--	16.1
Region X		
Alaska	7.3	9.8
Idaho	.6	.5
Oregon	7.6	6.1
Washington	9.6	11.5

Source: Department of Health and Human Services, Health Care Financing Administration, Bureau of Quality Control, Medical Assistance Quality Control Report, March 8, 1982, Page 12.

*Rate is greater than "0" but less than .05 percent.

[a]Claims processing case error rates include only those cases with non-zero CP dollar errors. Cases having only non-dollar CP errors were excluded.

[b]Louisiana was excluded from national rate due to incomplete data.

[c]Tennessee, Kansas, and Missouri conducted only three months of reviews in the 1981 period. Their results excluded from national average.

In addition to quality control efforts, HCFA also conducts a system performance review of the Medicaid Management Information System (MMIS) each year. In each of the last two years Minnesota has met or exceeded the federal performance requirements. Although in our view the federal review is somewhat mechanistic, it does establish that Minnesota has met the minimum standards of the federal government for claims processing and MMIS performance. Federal administrators that we spoke with reaffirmed the view that Minnesota's Medicaid system is well regarded.

Although we compare favorably to other states, there is no room for complacency regarding the status of claims processing. A number of improvements are possible to the edit structure that we currently employ to screen out invoices with questionable claims. Some of these improvements are discussed below.

6. MMIS SUPPORT AND CONTROL OVER CLAIMS PAYMENT

Another measure of the claims processing function is whether or not adequate controls over the process exist. We found that controls over production and computer processing of claims were lacking. Several times in the last year duplicate checks have been written and in one case mailed to providers. Previous financial audits have also noted similar problems with the production control procedures. The claims processing section has instituted some manual procedures to check record and claim counts, balance daily totals to weekly totals, and weekly totals to the warrants written. Unfortunately, because the manual checks are performed after the data processing has occurred, DPW has no way of detecting problems before or as they occur. In fact, in some cases the soonest DPW can detect duplicate payments is several days after warrants are mailed.

Lack of adequate production and audit controls is categorized as a "serious" problem by the systems division, and as "potentially very serious" by the invoice processing division, but it has yet to be remedied. The systems division has proposed to add a staff person for audits and controls, whose function would be to establish both manual and computerized controls to monitor the system for proper updating and payment. We feel that this function is necessary and that if ISB does not provide it, DPW must.

We recommend:

- The Sytems and Data Flow Division and the Invoice Processing Section should update the audit control and security provisions of the claims processing subsystem of the MMIS. This should include an examination of ISB's restart procedures, as well as the addition of computerized checking and verification of the programs that make up the claims processing system. The checks should establish that all tapes are run, that the proper totals are passed between programs, and generally that the warrants are written for the proper amount of payment. If necessary, DPW should engage a consulting firm to review and update the processing controls.

A second area of general concern with the MMIS is the age of the system. Minnesota's system was put in place in 1975. Since that time there have been thousands of programming changes made to the system. We identified over 300 new edits and the replacement or removal of over 100 edits. Many of these changes have been necessitated by legislative changes in the coverage of the MA program. Other changes were made to prevent inaccurate or ineligible claims from being automatically paid by the system. There is no systematic documentation of these changes to the programs within the MMIS, indeed some of the changes are not documented anywhere except in the thousands of lines of computer code. As a result, no one knows all of the effects of changes that are made in the programs. This results in problems because legislative deadlines and other time pressures have not allowed programs to be tested as thoroughly as would be desirable before they are implemented. Also, many times requests for new edits have not been implemented because of the complexity involved in changing large programs that already have been changed many times and interact with other large frequently changed programs. There has not been a formal review of the edit structure since the system's inception. Such a review would be designed to evaluate the edit structure as a whole to determine what additional edits are needed to meet the screening needs of the current MA system.

We recommend:

- DPW should undertake a systematic review of the edits in the MMIS. The current edit structure should be updated and coordinated with the current legislative and policy requirements of the department. The MMIS should be evaluated to ensure that the various programs forming the system work together in a consistent manner.

- DPW should take steps to improve the documentation of the changes made to the claims processing and other subsystems of the MMIS.

Despite the many changes to the system over the years, until recently there has been little coordination or priority setting within the department for new edits or changes in existing edits. As a result, changes to the system were prioritized by the systems division without an appreciation of what was most important. This has been largely remedied by a more formalized process of meetings and coordination instituted in the summer of 1983 between the invoice processing section, systems, and departmental policy-makers. We applaud DPW's efforts in this direction.

Another problem area is the ability of the systems group to respond to requests for changes. Many of the users of the edits and other programming efforts of the systems group expressed frustration about the slowness in implementing new edits. In some cases, new edits are delayed for years because the systems group does not have sufficient resources to get to all the requests made of them. As a result, a large backlog of programming projects currently exists. The DPW systems division currently estimates a one year backlog of design work.

System enhancements and new systems work also has been delayed because of the large backlog of maintenance programming. For example, a new long-term care processing system has been proposed for several years. In fact, we are told the long-term care system instituted in 1974 was meant to be a temporary system. The current long-term care subsystem consists of a limited series of edits that inadequately control the large dollar volume of claims processed. One example of weakness is the long-term care system's lack of duplicate payment edits. The SURS unit has recently found over $215,000 in overpayments made because there was no duplicate payment edit. Changes in the long-term care payment system have been delayed by the large amount of more pressing systems and programming projects.

DPW relies on ISB for much of the actual programming done on the system. Unfortunately, ISB has not dedicated sufficient analysis resources to the MMIS series of programs. Because of the complexity of the interaction between programs, familiarity with them is necessary for effective modifications to be made. DPW has offered to contract with ISB for additional system analysts and programmers for a set period of time, but to date no agreement has been reached.

We found that other comparable claims processing operations devote considerably more resources to systems work than the state does in the Minnesota Medicaid system. Minnesota has devoted between 8-10 positions to maintaining the MMIS. Several of these are devoted full time to supporting the counties' eligibility systems. In contrast, the State of Michigan has approximately 40 systems staff supporting their MMIS. Minnesota Blue Cross/Blue Shield also has a larger systems staff to support their processing of Medicare claims. When one considers that the payment of claims is largely an automated process, it is reasonable to expect a major emphasis on systems work. Many of the problem areas that we identified above are the result of an inadequate level of resources and emphasis on systems work.

We recommend:

- DPW should devote more emphasis and personnel to the systems function. Either additional resources need to be added in the DPW systems and data flow division, or ISB should dedicate personnel to work on Medicaid systems.

- DPW should undertake a significant enhancement or replacement of the long-term care payment system.

There has also been insufficient resources devoted to the generation of management information for DPW, the Legislature, and other outside parties. Management needs have been inadequately met by the Management and Administrative Reporting Subsystem (MARS) of the MMIS. Interviews with departmental managers revealed a uniform opinion that MARS reports were of limited utility and were sometimes inaccurate. Some managers have designed and put in place needed reports, but many MARS reports that are unused continue to be produced. The MARS subsystem was one of the last implemented in Minnesota and there was an emphasis at the time on getting the system installed in order to qualify for increased federal matching funds. As a result, the MARS module was not tailored specifically to Minnesota's needs.

The federal government has recently taken steps to "reduce the burden" of MARS by providing that states can implement their own systems and demonstrate "conceptual equivalence" with the federal General Systems Design. While discontinuing unneeded reports should provide some savings, an evaluation to ensure managers have access to the information needed to effectively manage is also necessary.

We recommend:

- DPW evaluate their management information needs, design and implement needed reports, and discontinue unused MARS reports.

Responding to requests for Medicaid management information is difficult for DPW because they have not organized their information system in a way that is amenable to ad hoc requests. Requests generally require individual programs to be written, limiting DPW's ability to respond in a timely manner. Recent changes in the payment for hospital services, and the general move toward per capita payments for a variety of Medicaid services, make the availability of information regarding services and costs increasingly important.

We recommend:

- DPW should provide a capability to readily respond to ad hoc requests for management information.

In summary, the systems group appears to do a good job with the resources that they have, but there are many opportunities for improvement in the information processing function at DPW. Since the MA program is largely dependent on an automated processing system to handle the vast volume of claims it receives, we feel that DPW should devote more resources to the maintenance and improvement of this function.

Overall, we find that the claims processing component of prepayment review is functionally acceptable. However, the automated system the state uses is now old and somewhat patched together. DPW has significant opportunities for improvement in its management of Medicaid information.

In the next section we review DPW's process of prior authorization and medical review.

D. MEDICAL REVIEW

The second component of prepayment review of Medicaid claims is the review of prior authorization requests and the medical necessity of services. This is accomplished by a group of medical professionals in the Professional Services Section. This function was significantly enhanced by the 1983 Legislature. Funding was provided for seven new professional staff, and several new functions

were added. Figure 3.4 shows the current organization chart of the Professional Services Section. This section is now responsible for the review and coordination of prior authorizations, provision of medical consultations to the rest of DPW, inpatient hospital prospective payment, drug utilization reviews, and other medical utilization reviews.

1. PRIOR AUTHORIZATION

Minnesota has adopted a system of prior authorization for certain Medicaid covered services. Prior authorization is not required by Title XIX, but is allowed as one method a state may employ "to safeguard against unnecessary utilization . . . of care and services." Prior authorization is conducted in over one-half of the state Title XIX programs. Minnesota began a prior authorization program in 1974, and over the years we have added to the number of services that require prior authorization. The 1983 Legislature then mandated that the Commissioner of DPW promulgate temporary and permanent rules to establish standards and criteria for deciding which medical assistance services require prior authorization. Figure 3.5 shows the list of services that currently require prior authorization.

Rule 47 provides that, in conducting prior authorization reviews, DPW will:

a. Safeguard against the unnecessary or inappropriate utilization of care and services;

b. Safeguard against excess payments;

c. Assess the quality and timeliness of such services;

d. Determine if less expensive alternative medical care, services or supplies are available;

e. Promote the most effective and appropriate use of available services; and

f. Attempt to rectify misutilization practices of providers, recipients, and institutions.

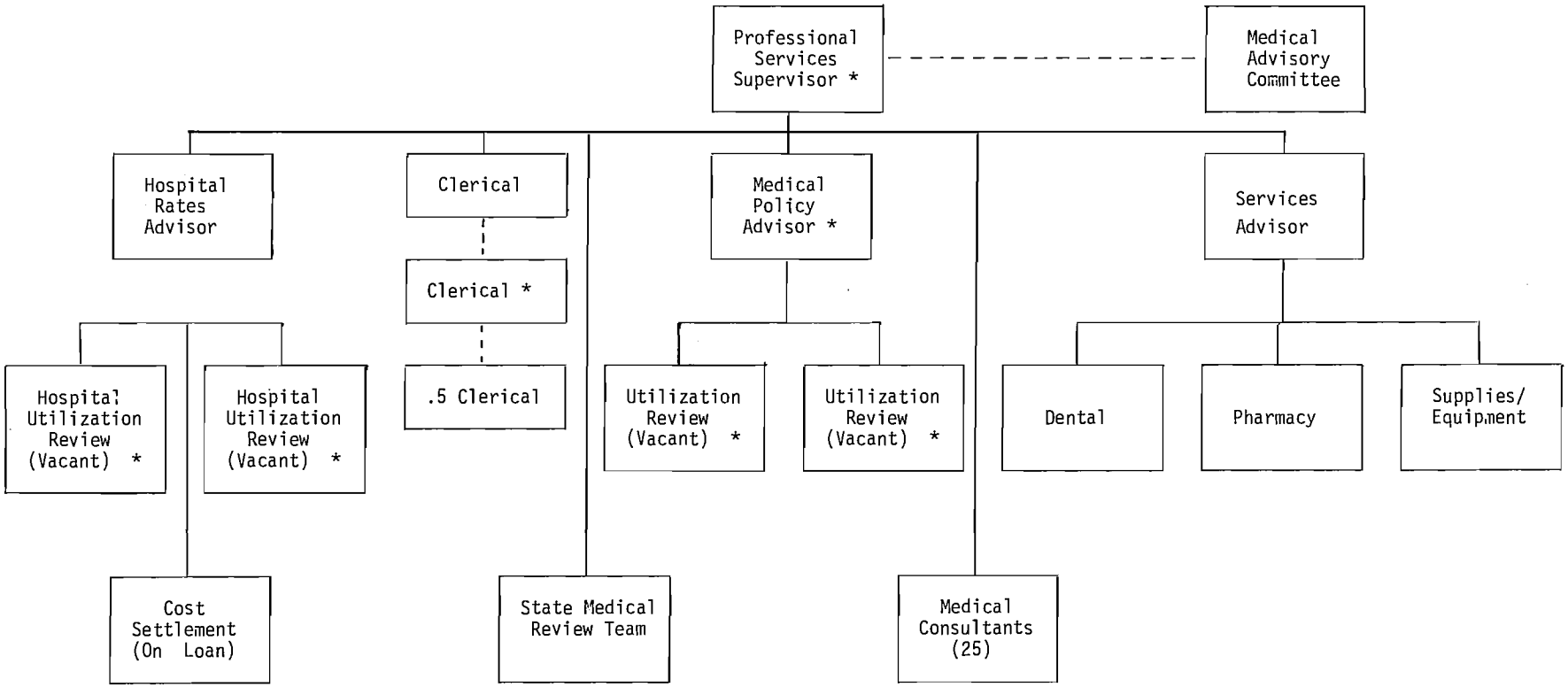
In practice, DPW medical consultants and staff use three tests to review prior authorization requests:

1. Is the procedure appropriate given the condition of the patient? An example of a request that might be denied because it was inappropriate, given the condition of the patient, is a cardiac rehabilitation program for a patient physically unable to participate.

2. Is the procedure medically necessary? Procedures commonly reviewed for medical necessity include gastric bypass operations, breast implants, and other plastic and cosmetic surgery.

FIGURE 3.4

ORGANIZATION CHART
DEPARTMENT OF PUBLIC WELFARE
HEALTH CARE PROGRAMS DIVISION
PROFESSIONAL SERVICES SECTION



Source: Department of Public Welfare, 1-16-84

* Position established by 1983 Legilsature for utilization review

FIGURE 3.5

SERVICES REQUIRING PRIOR AUTHORIZATION

1. Inpatient hospital services

   a. Medical care of "marginal medical necessity"
   b. Private rooms must be certified as medically necessary

2. Physician services

   a. All medical, surgical, or behavioral modification services aimed specifically at weight reduction
   b. Surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment
   c. Removal of tattoo
   d. Payment of physician's services exceeding 30 days of inpatient psychiatric treatment per year
   e. Individual hourly sessions with psychiatrist exceeding ten per calendar year

3. Chiropractors

   a. Payments in excess of maximum must have prior approval
   b. Maximum of 6 treatments per month and 24 treatments per calendar year

4. Podiatrist

   a. Treatment is excess of maximum must be approved
   b. Maximum of 3 visits per month and 12 visits per year

5. Vision care

   a. Contact lenses
   b. Custom fit prosthetic eyes
   c. Amblyopia therapy
   d. Strabismus therapy
   e. Vision therapy - supplemental evaluation and report
   f. More than one pair of eyeglasses in a twelve month period
   g. Photochromatic lenses
   h. Sunglasses
   i. Lenses coating surface or edge

6. Psychologists

   a. Services in excess of maximum of ten hourly sessions per year, or
   b. Up to 26 additional hours if three or more family members seen together, and, sessions extend over greater than six months, and at least one family member is under 18

7. Outpatient hospital services

   a. Kidney dialysis not covered by medicare
   b. Oral surgery (except emergencies)
   c. Hemodialysis back-up service
   d. Supplemental and tube feedings of patients with special nutritional needs
   e. All physician services (above) that must receive prior authorization

8. Medical supplies

   a. Oxygen and equipment for administering oxygen
   b. Non-durable medical supplies when the price exceeds the performance agreements
   c. Durable medical equipment, prostheses and orthoses, indwelling catheter, and hearing aids when the cost, projected rental, repair or maintenance exceeds the performance agreement

9. Dental

   a. Orthodontics
   b. Hospitalization for dental treatment
   c. Root canal therapy
   d. Periodontics
   e. Most oral surgery

10. Mental health centers

   a. Centers are subject to the same prior authorization restrictions as the practitioner under whose supervision the services are rendered

3. Is the procedure medically accepted? DPW does not approve procedures that are either outmoded or experimental in nature.

In reviewing dentistry prior authorizations, the criteria are basically the same. There are many options for care in dentistry; DPW trys to approve the level of treatment necessary to maintain a healthy normal life.

The goal of prior authorization in the psychiatric area is to avoid hospitalization. The state rarely approves intensive psychoanalysis or personality reorientation as treatment modes, focusing instead on crisis intervention. Psychiatric prior authorization reviews rarely result in cutoffs of service, but do result in fewer visits and shorter treatment sessions.

We asked DPW to provide us with the number of prior authorization requests reviewed, by provider type. DPW estimated the following number of reviewed were conducted:

Medical/Psychiatric/Chiropractic	450/week
Dental	300/week
Vision Care	50/week
Medical Supplies	250/week
Medical Equipment	70/week
	1,120/week
DPW Estimated Total	60,000/year

Since we desired more detailed information than the department could provide us, we conducted a computer review of the prior authorization files since January 1, 1983. Prior to January 1983, prior authorizations denied by the department were not entered into the computer system. We found that the department had reviewed 29,999 requests for prior authorization in the nine month period between January and October 1983. Of the 29,999 requests reviewed, 13 percent or 3,907 were denied. Table 3.5 shows the breakdown of requests and denials by provider type.

Based on this nine month sample, approximately 40,000 requests are reviewed each year. Professional Services personnel report that the number of prior authorization requests has been rising in recent months because of an increased number of requests from hospitals.

TABLE 3.5

PRIOR AUTHORIZATION REQUESTS AND DENIALS
BY PROVIDER TYPE
January-September 1983

Provider Type	Approvals	Denials
Nursing Homes	315	13
Mental Health	2,174	41
Rehab Centers	0	2
Physician-Individual	741	110
Physician-Group	1,064	115
Dentist-Individual	4,256	1,531
Dentist-Group	2,335	974
Optometrist	3,323	140
Chiropracter	577	47
Psychologist	1,181	48
Public Health	8	3
Dentistry-PreSchool	63	27
Pharmacy	666	131
Optician	2,149	94
Medical Equipment	5,388	632
Hearing Aids	1,852	1
TOTAL	26,092	3,907

a. Effectiveness of Prior Authorization

One of the primary goals of operating a prior authorization program is to avoid making excess payments for Medicaid services. Despite the length of time the program has been in operation in Minnesota, there has been no reliable information on the cost savings from prior authorization. Program managers are unaware of the number of prior authorization requests they review, how many are denied, how many are partially approved, and approximately what dollar savings are associated with the program. The nature of the program makes exact calculations of cost/benefit relationships difficult to achieve. The exact savings may never be known because requests that are denied may be resubmitted and later approved, and because there is a certain deterrent effect associated with the review. Federal guidelines for prior authorization programs say:

> The state agency should systematically study the effects of prior authorization in terms of improved utilization of care. The number of rejected or modified requests is but one of the indicators. Nearly equally important is a professional assessment of the extent to which the system has contributed to a greater emphasis on diagnosis and treatment of disease rather than on alleviation of symptoms. A comparison of Medicaid utilization of selected types of care with available information on the general population may also

provide a basis for judgment, although the comparison should be weighted by the correlation between poverty and ill health. The administrative cost of the system needs to be measured against the achievements (including an estimate of the deterrent value) in order to assess the cost effectiveness.

In order to make sound decisions about what services and procedures should be subject to prior authorization, DPW needs to develop information about the nature, frequency, and cost of services delivered. DPW currently does not have even the rudiments of such a system in place.

We recommend:

- DPW should initiate a system for tracking the cost savings of prior authorization reviews, by type of review. Careful consideration should be given to the cost effectiveness of maintaining prior authorizations for all services where they are currently required, and to the potential for positive benefits from review of additional services.

Despite the fact that adequate information on the benefits of doing prior authorization does not exist, we are convinced on the basis of the limited information available that prior authorizations, on the whole, do save the state money. We estimate that approximately $250,000 of state personnel costs are assignable to prior authorization activities. The department also has contracts with over 20 medical practitioners in various specialities to review prior authorizations. In fiscal year 1984 the department had contracts with medical practitioners for prior authorizations totaling $175,304. As a result of our review of the prior authorization files for nine months, we could readily identify over $400,000 in expenditures foregone because of prior authorization denials. We could not identify a price for some of the services denied because they are unpriced services reviewed on a case by case basis. However, as an example, the medical advisory group denied over 30 requests for gastric bypasses in the last year, each of which would have cost approximately $3,500-$6,000 for the operation and post-operative care. Many of the prior authorization requests are not denied but are partially approved, or approved at a lower level of service. So, although we cannot provide an exact dollar figure because of limited management information, we conclude that:

- Overall, the prior authorization activities of the department are cost-effective.

2. OTHER FUNCTIONS

The Professional Services Section also serves as the medical advisory unit for the Income Maintenance Bureau. Medical professionals consult with claims processing staff about the pricing of services, the medical necessity of services, recipient restriction, and other medical issues in utilization review.

DPW has formed a medical advisory committee that reviews DPW medical policy and recommends new policies. For example, the committee recommends changes in the price of services and reviews difficult questions of medical necessity. The medical advisory committee appears to have worked well as an advisory body for DPW medical policy.

The professional services section, medical consultants, and the medical advisory committee serve in many cases to make policy regarding prior authorizations and provider reimbursement. These policies are not gathered together in any one place. Informality regarding policy on these matters is understandable in the early years of program administration. However, after over 10 years of state administration, a more formal process of recording and controlling prices for services and precedents for prior authorization is needed.

We recommend:

- DPW should establish a precedence file for prior authorizations. Policies and criteria for consideration of prior authorization should be formalized. In addition, prices recommended by individual medical consultants and by the medical advisory committee should be recorded in one place and officially transmitted to appropriate claims payment personnel.

DPW's new medical policy section is the logical place to coordinate and control price setting and other policy matters.

The Drug Utilization Review Program is another responsibility of the professional services section. Drug utilization review is a program initiated by DPW under the general authorization of utilization review. Drug claims represent the largest number of invoices paid by Medicaid, over 3.3 million in fiscal year 1983. On a periodic basis, claims for certain drugs are examined by a computer edit designed to detect possible cases of inappropriate utilization. Those cases that fail the edit are then examined by regional drug utilization committees made up of practitioners from several medical disciplines. In cases where misutilization seems borne out after examination of patient records, the medical practitioner involved is sent a letter suggesting that they reconsider the use of the drug for the situations involved. Several studies have shown this effort by the department to be successful in cutting down on the usage of the drugs examined, and also suggest that hospitalization as the result of drug misutilization is decreased.

The 1983 Legislature mandated several new functions for the Professional Services Section. The Professional Services Section is responsible for implementing rules governing:

1. Inpatient Hospital Prospective Payment (Rule 54)

2. Utilization Review (Rule 48)

3. Prior Authorization

4. Second Opinions on Elective Surgery

Each of these new initiatives is discussed briefly below.

a. Inpatient Hospital Prospective Payment

Chapter 312 of the 1983 Laws of Minnesota mandates that the department develop a system of prospective payment for in-patient hospitals. The Professional Services Section is responsible for the development of a rule to implement this major change in the manner of payment for hospitals. In addition, the section will monitor in-patient hospitals for changes in utilization that might be brought about because of the changed incentives of the new payment plan.

In response to this mandate the department implemented a temporary rule governing the reimbursement method to be used for in-patient hospitals on October 24, 1983 (12 MCAR 2.054). Rule 54 provides for the hospitals' reimbursement to be based on the average cost of their past Medicaid patients, adjusted annually by a hospital cost index. DPW is working on promulgating a permanent rule that will more discreetly reimburse for different types of hospital admissions. A committee is examining how Minnesota can piggyback on the federal Medicare required use of diagnosis related groups (DRGs).

The change to a prospective payment system for Medicaid hospital admissions fundamentally changes the incentives for hospitals billing under Medicaid. The incentives are to discharge patients as quickly as possible because the reimbursement is a set amount per admission. As a result, provision for the review of hospital utilization is necessary.

b. Utilization Review

The 1983 Legislature also amended Minnesota Statutes, Section 256B.04 to provide for a new statewide program for utilization review, for the following purposes:

> to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or length of stay, and against underutilization of services in prepaid health plans, long-term care facilities or any health care delivery system subject to fixed rate reimbursements.

DPW received 14 new positions for utilization review. The Professional Services Section received seven of these new positions.[3] The SURS Section received the other seven positions. SURS is discussed in Chapter 4. DPW has allocated several of the Professional Services Section positions to review hospitals utilization of services to ensure against unnecessary or inappropriate admissions and against underutilization of services. DPW has also modified its agreement

[3]See Professional Services organization chart, Figure 3-4.

with two professional standards review organizations (PRSOs) that formerly reviewed inpatient hospital utilization. The PSROs will continue to review utilization for hospitals reimbursed on a per diem basis. In addition, they will administer the Certificate of Admission program. All non-emergency Medicaid hospital admissions will have to be approved before admission. Physicians will call the medical review agent and after giving the appropriate clinical information, the admission will be approved or denied. Rule 48, a temporary rule promulgated by the department, sets forth the criteria that govern the Certificate of Admission process.

c. Prior Authorization and Second Opinions on Elective Surgery

The department has not yet made significant progress on drafting a new prior authorization rule. DPW has hired a medical policy supervisor who will be responsible for writing the rule, but work on the rule has not begun. DPW plans to begin work on the rule in February 1984 and hopes to publish a rule by July 1, 1984.

At this time, DPW plans to include the rule on second opinions for elective surgery as part of the prior authorization rule. A draft of the second opinion rule has been prepared. The rule will set forth criteria for elective surgical procedures that second medical opinions will be required on.

3. SUMMARY

In summary, DPW conducts the prior authorization and medical review functions acceptably well. However, major responsibilities have been added by the 1983 Legislature. It is too early to say how effectively DPW will perform in examining hospital utilization and in implementing new medical policy functions.

IV. POST-PAYMENT REVIEW OF MEDICAID CLAIMS

The Department of Public Welfare conducts a substantial program of post-payment review of Medicaid claims. Federal regulations require post-payment review as a condition of federal financing. This program is carried out by the Surveillance and Utilization Review Section (SURS) in the Health Care Programs Division of DPW's Income Maintenance Bureau. The purposes of post-payment review are several:

- To detect and deter abuse and fraud by Medicaid vendors and recipients;
- To recover overpayments that have slipped past pre-payment 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.

Annual Medicaid payments now total $840 million per year. The state needs to be assured that Medicaid payments go for only medically necessary services, and that claims are paid only to legitimate Medicaid vendors who actually provide the services for which they submit bills.

Abuse of the Medicaid program by providers and recipients is defined by DPW Rule 64 (12 MCAR 2.064). In essence, abuse by providers involves submission of claims that are incomplete or inaccurate, failure to keep proper records, submission of claims that are contrary to accepted standards of practice, or repeated submission of claims that have been previously denied. Abuse by recipients includes permitting the use of a medical assistance identification card by an unauthorized person, selling pharmaceuticals or supplies provided through the program, and obtaining duplicate services for the same health condition.

Medicaid fraud has its statutory basis in the laws against theft. The abusive practices described above are considered to be fraud if criminal intent is present. In practice, the difference between fraud, abuse, and improper utilization depends in large measure on the perspective chosen by DPW or the Attorney General's Office in viewing the facts of a particular case. This in turn, rests on an assessment of how easily criminal intent can be demonstrated or how much it would cost to do so in light of the benefits to be obtained.

A. RESEARCH OBJECTIVES AND MAJOR FINDINGS

The previous chapter describes and evaluates DPW's pre-payment review of Medicaid claims. Prevention of erroneous payments as well as fraud or abuse is most effectively implemented prior to paying claims because once paid, erroneously paid money may be difficult to recover. Also, a comprehensive set of pre-payment consistency checks, price checks, and other edits leaves minimal room for inaccurate or illegal claims.

Nevertheless, there is an obvious need for post-payment review of claims. No claims processing system can detect all instances of illegitimate claims before payment. Also, post-payment review allows the examination of patterns of claims payment that can reveal abusive patterns not discernible when reviewing an individual claim. This chapter discusses:

- The organization of post-payment review and whether the organization and staffing of this function is appropriate and effective;
- How effectively post-payment review of providers and recipients is being accomplished, including an examination of cost-effectiveness; and
- The management of post-payment review, and whether the work load is effectively managed and controlled.

Our major findings are:

- Overall, the tangible results of provider surveillance are disappointing.
- Post-payment review, especially provider surveillance, has been impeded by staff turnover and problems in recruiting qualified investigators.
- There are significant problems with record keeping and statistical reporting that affect the accuracy of required reports on provider investigations. Poor record keeping practices also impede the proper management of the investigative caseload.
- Money recovered as a result of post-payment review of providers does not begin to cover the cost of conducting the reviews. However, it is unreasonable to expect actual collections to finance the cost of post-payment reviews, since part of the purpose of post-payment reviews is to prevent fraud and abuse.
- The Recipient Restriction Program which is the focus of post-payment investigation of recipients appears to be cost-effective and should be expanded. Expansion of the program should be accompanied by automation of claims review for restricted recipients.

- Post-payment review of inpatient hospitals expenditures are contracted out by SURS to the two Professional Standards Review Organizations (PSROs) in Minnesota. SURS Does not monitor these contracts adequately nor pay much attention to utilization review activities carried out under the contracts.

- Data processing support for the surveillance and utilization review function needs to be strengthened.

B. ORGANIZATION OF POST-PAYMENT REVIEW

The organization of SURS is described by Figure 4.1. Altogether there are 29 positions in SURS. The main functions of SURS are provider surveillance, recipient surveillance, utilization review of long-term care and inpatient hospital providers, and support services.

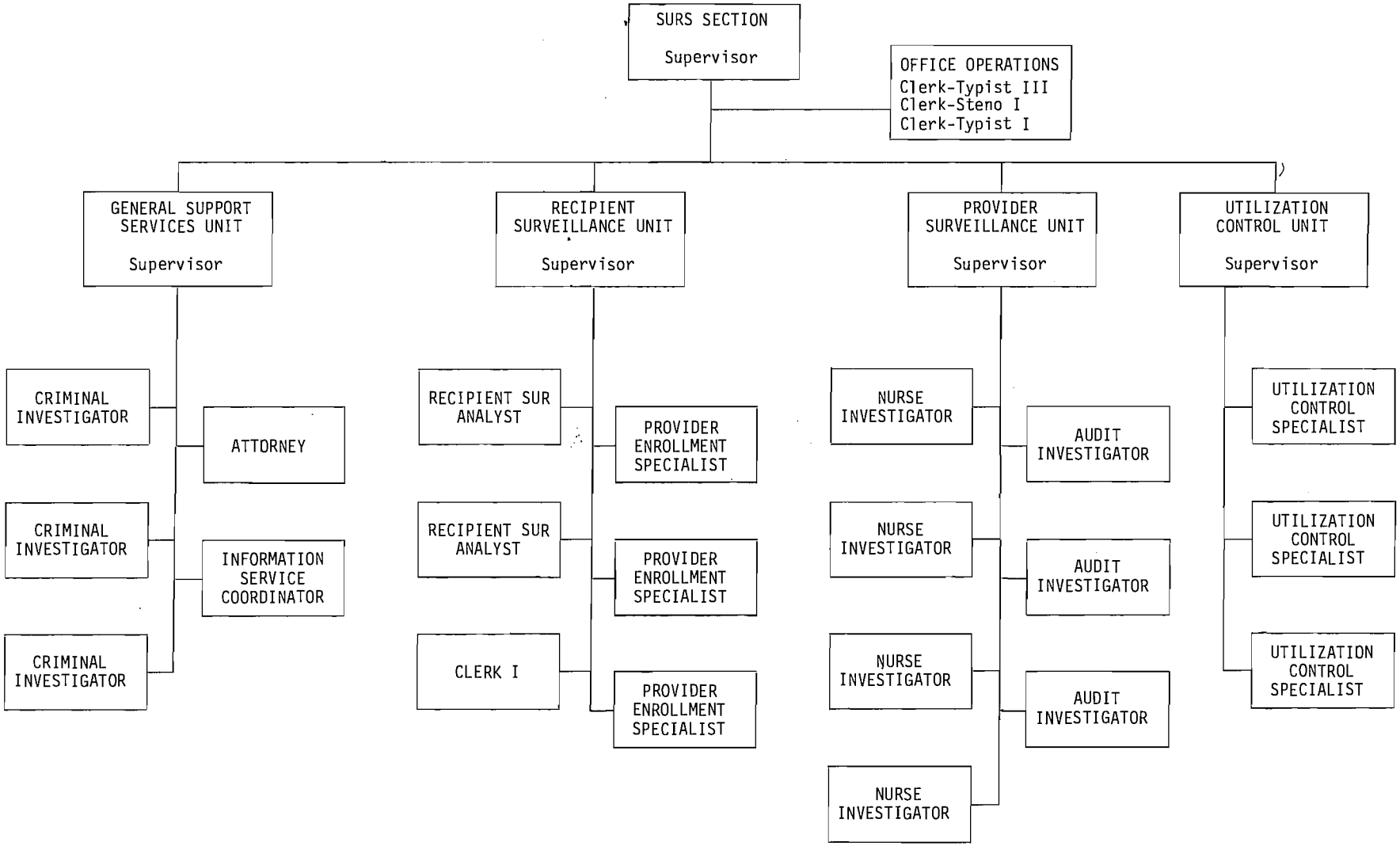
The Provider Surveillance Unit is responsible for the greatest part of what is known as Medicaid fraud and abuse investigation. This unit receives allegations of fraud and abuse from several sources, investigates these and either settles the cases with or without a monetary recovery or other sanctions, or refers the cases to the Attorney General's Office of other agencies. The Provider Surveillance Unit now consists of a supervisor and seven investigators, three of whom have auditing backgrounds and four of whom have nursing or other health professions backgrounds.

As Figure 4.1 shows, the Recipient Surveillance and Utilization Review Section contains two analysts plus a supervisor whose primary role is to prevent, detect, and correct fraud or abuse by Medicaid recipients. Its primary tool is the power to restrict Medicaid recipients suspected of abusive practices to a single physician or pharmacy so that their use of health services and pharmaceuticals can be closely monitored and controlled. The recipient unit has also recently taken on the responsibility of provider enrollment, a straightforward clerical function by which providers become certified as Medicaid vendors. This function had previously been located in the Invoice Processing Section during which time provider enrollment had not been kept up-to-date.

The General Support Services Division is also involved in investigation of providers suspected of fraud and abuse, as well as in providing certain support services to all of SURS. Three investigators in this section work on provider investigations and have come to specialize in pharmacy and dental investigations. In addition, the investigators assist on other provider investigations. These investigators have law enforcement rather than health or auditing backgrounds (outside of the expertise they have developed on the job in dental and pharmacy claims investigation). Thus, support services investigators operate parallel to the provider section in specialized areas of provider surveillance as well as supporting the work of the

FIGURE 4.1

SURVEILLANCE AND UTILIZATION REVIEW SECTION
ORGANIZATION CHART



provider unit. This organizational arrangement works all right except for problems in coordinating record keeping and statistical reporting, a problem which is discussed later in this chapter.

The final SURS unit shown in Figure 4.1 is Utilization Control which monitors utilization of long-term care and inpatient hospital services principally by contracting with outside agencies. This section consists of three clerical workers plus a supervisor. The performance of this section along with provider and recipient surveillance are discussed in later sections of this chapter.

The 1983 Legislature established a new unit in the Attorney General's Office dedicated to prosecution of Medicaid fraud and this unit has been staffed up in recent months.[1] At present, the Minnesota fraud unit consists of two attorneys, two investigators (one of whom moved from the DPW provider surveillance unit to take the position), and one clerical worker. The Attorney General is working on 15 to 20 cases and plans eventually to employ three attorneys, six investigators, and two clerical workers.

Since this Medicaid Fraud Control Unit has only recently begun operations, we cannot discuss its performance in connection with this study. There is no question, however, that the prosecution of Medicaid fraud has not been emphasized in Minnesota in recent years. Prior to establishment of the fraud unit in the Attorney General's Office, fraud investigation and prosecution was not well-organized in Minnesota. DPW investigators were faced with a choice of whether to go for a negotiated settlement with a provider or to pursue prosecution of a criminal charge. According to DPW investigators, there was a reluctance by the Attorney General's Office and local prosecutors to take on Medicaid fraud cases because they were often technically complex and unpopular. DPW lacks legal staff as well as the authority to develop cases for prosecution and faced with the past reluctance of the Attorney General's Office to pursue a criminal case and the unwillingness of county attorneys to prosecute fraud cases, DPW chose most often to negotiate the best deal it could even where it felt it had developed a strong case for prosecution.

It remains to be seen if the new fraud unit in the Attorney General's Office will succeed in materially increasing the number of successful Medicaid fraud prosecutions carried out each year, but if it is successful at all, the existence of this unit ought to improve Medicaid fraud and abuse control all along the line, since it will strengthen DPW's position in negotiating voluntary settlements with Medicaid providers.

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[1] In 1977, the federal government strongly encouraged the establishment of Medicaid fraud units in the states by providing 90 percent funding for the establishment and operation of such units. About 29 states have active Medicaid Fraud Control Units. Funding was authorized by Section 17 of Public Law 95-142 and the Medicaid fraud units established under this law are known informally as Section 17 units.

C. EFFECTIVENESS OF POST-PAYMENT REVIEW

An effective post-payment review system should both detect and prevent fraud and abuse. Overpayments should be identified and recovered, and flaws or loopholes in the prepayment review of claims that permit improper claims to be paid should be corrected.

To a substantial degree, all of these things are taking place as a result of DPW's post-payment review of claims. This study asks: Is the state doing as well as it could with the resources it has committed to post-payment review? Would committing additional resources save money or improve the Medicaid program?

We have addressed these issues by examining the following questions:

- What is the post-payment review workload of SURS and is it reasonable in light of the staff resources committed to the task?
- Is the work well-managed?
- Do the direct, measurable results of post-payment review justify the committment of people and money?
- Can sizeable indirect or unmeasurable benefits be safely assumed to exist?

Post payment review of Medicaid claims begins with allegations or complaints about providers or recipients that originate from several sources:

- Health care providers concerned about a recipient or another provider;
- Exception reports (produced by a computerized information system) that show an unusual pattern of practice or utilization by a provider or recipient;
- Referrals from medical claims analysts within DPW who suspect a problem; and
- Questions raised by Medicaid recipients who receive a monthly itemization of benefits and are encouraged to call DPW if they think they did not receive all the indicated services.

When an allegation or referral is received from one of these sources it is handled by either the provider or recipient surveillance units, or by the investigators in the General Support Unit of SURS. The greatest part of post-payment review is focussed on providers. While there is a popular view that "welfare chiselers" are responsible for costly overpayments in income maintenance programs, in the case of medical assistance at least, it is providers, not recipients, who are

responsible for most fraud, abuse, or improper utilization. In fact, many kinds of recipient abuse would not be possible if providers carried out their responsibilities completely. Even where a recipient is caught red-handed, the possibility for monetary recovery from a Medicaid recipient (most of whom are close to indigent) is remote. Therefore, it is appropriate that DPW's emphasis in post-payment review is on providers and not recipients.

1. PROVIDER SURVEILLANCE

Surveillance and investigation of non-institutional providers is carried out by the Provider Surveillance and Support Services Sections of SURS. Allegations of provider fraud or abuse from any source are given a preliminary screening for validity and merit. Those that are dropped at this point are not formally counted or reported. Many complaints in this category turn out to be requests for information rather than allegations or are allegations based on a misconception of Medicaid policy or benefits.

Cases that are not dropped become "Integrity Reviews." These cases are formally entered into a log and a case file is established. Integrity reviews merit at least a desk audit including a review of exception reports, claims histories, and in-depth review of the original complaint or allegation. Integrity reviews may also require a field audit or involvement by the health professionals DPW uses as expert consultants. If a monetary recovery of more than $1,000 is involved or criminal intent is seen as an important factor, the case is classified as a full-scale investigation.

Full-scale investigations either involve fraud or a recovery greater than $1,000 or otherwise are the most important or time-consuming cases handled in SURS. These cases still may be closed without a monetary recovery, referral to the Attorney General, or the imposition of another administrative sanction, so it is the potential of a case and its complexity rather than the outcome which determines how it is classified.

SURS is required to report on the post-payment reviews it conducts, as well as the operation and use of its provider and recipient exception reporting system, to the Health Care Finance Administration (HCFA), the federal agency that regulates state administration of Medicaid. In addition, the department is required to report to the Office of the Legislative Auditor each quarter on its investigations of suspected Medicaid fraud or abuse.[2] These statistical reports of SURS are the best available source of information on the provider investigations conducted by DPW, although, as we will see, these reports are not an altogether reliable source of information on DPW's post-payment review workload.

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[2]Minn. Stat. 1982, 256B.04, Subd. 11.

a. Allegations of Provider Fraud and Abuse

According to DPW reports assembled for the Legislative Auditor, about 200-300 allegations of fraud or abuse are received each quarter. For each of the four quarters ending September 1983, between 274 and 332 allegations against providers were received and recorded. Approximately 200 per quarter come from recipients reacting to something they do not agree with or understand on the Explanation of Medical Benefits (EOMB) form they receive each month with their renewed Medicaid ID cards. About 70 allegations are exceptional cases identified by the SURS exception reporting system. And a smaller number of cases (although often the most significant ones) come from DPW claims analysts and the other sources identified earlier.

b. Investigations

Table 4.1 shows the number of initial investigations active at the beginning and end of each quarter as well as the number of each type of case opened and closed. Table 4.2 shows the same information for full-scale investigations. Until recently, the terms "initial investigation," "initial review," and "integrity review" were used somewhat loosely to refer to either a preliminary investigation leading up to a full-scale investigation or a completed investigation of limited scope or complexity. Furthermore, the provider surveillance unit and general support services unit have and continue to use different criteria in classifying post-payment reviews for reporting purposes, so the statistics presented in Tables 4.1 and 4.2 are presented only to give a general idea of the caseload. A better appreciation of what this caseload yields is given by information reviewed later in this section on monetary recoveries and other outcomes of these investigations.

Table 4.1 shows that the ongoing inventory of initial investigations totals about 80 to 100 cases each quarter. During the last four quarters, between 67 and 115 cases were initiated and about the same number were closed. According to these figures most cases were closed in a way that resulted either in corrective action or in promoting the case to a full-scale investigation.

Table 4.2 shows that there were between 36 and 47 full-scale investigations underway at the beginning of each of the last four quarters. Between three and 14 cases were initiated each quarter and a similar number closed. Over the 11 quarters shown in Tables 4.1 and 4.2, the caseload of initial investigations and full-scale investigations has remained fairly stable. The inventory of open cases has not grown over time due to the fact that it is completely up to DPW to decide what is or is not a case, and to decide how much effort should go into a particular case, although the department must investigate a certain number of cases of specified kinds each quarter in order to meet federal requirements.

TABLE 4.1

INITIAL INVESTIGATIONS OF MEDICAID PROVIDERS

Date	Continued from Previous Quarter	Initiated this Quarter	Closed this Quarter		Continued to Next Quarter
			Unsubstantiated	Passed on for Corrective Action or Full-Scale Investigation	
1981					
January - March	66	135	75	42	84
April - June	84	2	-	23	63
July - September	63	132	27	26	142
October - December	142	100	53	79	110
1982					
January - March	110	156	1	89	176
April - June	176	88	1	132	131
July - September	131	107	29	116	93
October - December	93	88	-	93	88
1983					
January - March	88	115	-	103	100
April - June	100	67	14	73	80
July - September	80	74	10	49	92

Source: DPW records.

TABLE 4.2

FULL-SCALE INVESTIGATIONS OF MEDICAL PROVIDERS

Date	Continued from Previous Quarter	Initiated this Quarter	Closed this Quarter		Continued to Next Quarter
			Unsubstantiated	Passed on for Corrective Action or Full-Scale Investigation	
1981					
January - March	24	1	-	4	21
April - June	21	1	-	-	22
July - September	22	-	-	-	19
October - December	19	38	-	2	55
1982					
January - March	55	4	-	2	57
April - June	57	6	-	8	55
July - September	55	6	-	14	47
October - December	47	5	-	14	38
1983					
January - March	38	3	-	5	36
April - June	36	10	-	6	40
July - September	40	14	-	14	40

Source: DPW records.

c. Results of Post-Payment Review

This section examines the yield of DPW's post-payment review and investigation of non-institutional Medicaid providers.

The major question we asked is:

- What are the measurable, tangible results of post-payment review of providers in terms of administrative or legal actions, and money recovered?

In short, the answer is:

- Only a handful of investigations each year result in a referral to the Attorney General's Office, signifying a serious case where probable cause of criminal intent has been found. There have been 13 such referrals between January 1981 and September 1983.

- Only a few providers have been suspended from the Medicaid program during the same period. It is not DPW's practice to terminate providers from the program.

- About $418,000 has been recovered from providers between January 1981 and September 1983. This sum is far less than the cost of conducting post-payment review of providers, although a program of fraud and abuse investigation undoubtedly deters abuse from happening in the first place and prevents providers from repeating inappropriate practices once they have been caught.

- In general, we think that the results of provider investigations are less than what might reasonably be expected given the size of the state's investment in provider surveillance, although for reasons discussed below, we would like to base this conclusion on more extensive information.

Tables 4.3 and 4.4 present information on the results of investigation of providers. Among other things, Table 4.3 presents a count of referrals to the Attorney General of providers suspected of Medicaid fraud. Altogether over nearly a three-year period, there were only 13 such cases. During this time, five providers were suspended from the program, and 10 providers were subjected to a pre-payment review of claims because they were under investigation.

Table 4.4 shows that an additional handful of cases have been referred to other agencies for action. For example, a total of four cases were referred to other law enforcement agencies, four cases were referred to licensing boards or the Minnesota Department of Health, and four cases were referred to provider peer review organizations.

By far the greatest emphasis over the last few years in the investigation of providers has not been on criminal investigation leading either to prosecution or administrative sanctions, but on negotiated settlements with providers that results in recovery of inappropriate payments and in some cases penalty payments.

TABLE 4.3

DIRECT ADMINISTRATIVE ACTION AS A RESULT OF PROVIDER INVESTIGATIONS

	Referrals to the Attorney General's Office	Providers Suspended	Providers Placed on Pre-Payment Review	Monetary Recoveries
1981				
January - March	3	2	5	$ 22,603
April - June	1	-	-	12,514
July-Sept	2	1	-	13,973
October December	-	1	-	33,202
1982				
January - March	3	-	-	$ 47,379
April - June	-	-	-	56,023
July - September	3	-	-	43,883
October - December	-	-	-	47,046
1983				
January - March	-	-	-	$ 52,960
April - June	-	-	-	35,124
July - September	1	1	5	53,217
TOTAL January 1981 through September 1983	13	5	10	$417,924

Source: DPW records.

Table 4.3 presents data on monetary recoveries for each quarter between January 1981 and September 1983. In general, the level of monetary recoveries has been higher in the last two years than earlier. The cost of the provider surveillance program far exceeds the monetary recoveries it produces, although it is difficult to precisely estimate the cost of provider surveillance due to the way the DPW budget is organized and the absence of an internal provider surveillance budget.

Over the eleven quarters ending in September 1983, about seven full-time staff have been working on provider surveillance. As Figure 4.1 shows, about 11 people are now working full time in provider surveillance including investigators in the Provider Surveillance and Support Services Sections. For fiscal year 1984, provider surveillance costs total about $265,000 not including computer services, according to DPW. For fiscal year 1983 DPW estimates the cost at $179,000. Data processing support for both provider and recipient surveillance totals around $400,000 per year.

Table 4.3 shows that provider surveillance has yielded monetary recoveries totalling about $418,000 over nearly a three year period. We figure that the cost of provider surveillance, although hard to pin down, is several times as large as this amount.

To be absolutely clear, we are not suggesting that actual monetary recoveries need to cover the full cost of provider investigations in order to justify the program. DPW estimates that it has identified over $1.3 million in overpayments and that whether or not these funds are recovered, the post-payment review program has served to identify problems and prevent their reoccurrence.

But, it is clear that committing additional resources to provider surveillance will not, in a narrow sense, "pay for itself." The 1983 Legislature took a couple of important steps to improve both pre and post-payment review of Medicaid claims. It provided resources for 14 new positions in the area of utilization review, and SURS was allocated seven of these positions and recently filled several new positions in the provider surveillance and support services units.

TABLE 4.4

REFERRALS FOR ACTION BY OTHER AGENCIES AS A RESULT OF PROVIDER INVESTIGATIONS

	County Attorneys/ Other Law Enforcement Agencies	Licensing Boards MDH	Peer Review Organizations	Other DPW Units
1981				
January - March	1	-	-	-
April - June	-	-	-	-
July - September	-	4	-	1
Ocobert - December	-	-	-	1
1982				
January - March	3	-	2	-
April - June	-	-	-	-
July - September	-	-	-	2
October - December	-	-	2	-
1983				
January - March	-	-	-	-
April - June	-	-	-	-
July - September	-	-	-	-

Source: DPW records.

There is no expectation at DPW that these new positions will result in a major change in DPW's approach to post-payment review. A larger caseload will be undertaken and it is hoped that it will now be possible to get out from under federal requirements to follow up exception reports in order to pursue more promising leads. The question of whether there are high-potential investigative leads to keep additional investigators busy will become clearer in the next year, according to the Provider Surveillance Section.

Since the actual monetary recoveries attributable to provider investigations does not cover the cost of conducting those investigations, it is necessary to assume a sizeable preventive effect of post-payment surveillance and review in order to conclude that the program is cost-effective.

DPW has not attempted to quantify the benefits of this deterrent effect, and in our judgement there is no obvious way of doing this. Comparisons of Minnesota and its level of post-payment surveillance and recoveries to that of other states are highly tentative and do not support useful conclusions, although many other states report higher recoveries. In part the question of whether Minnesota's post-payment review program is cost-effective is not the appropriate one to ask. It is a federal requirement that a certain number and type of post-payment reviews be conducted and the federal government pays for 75 percent of the cost of post-payment reviews.

Given these facts, we think that the post-payment review program should aim more effectively to present itself as a visible impediment to providers who might be tempted to abuse the system. An effective deterrent should include:

- At least a few highly publicized criminal investigations each year;
- Notification that an audit program is in place that subjects every provider to a definite chance of being reviewed;
- Better use of the computer system to identify providers who are high-potential candidates for investigation; and
- Improved case management practices that will permit an improved basis for allocating resources within SURS.

d. Case Management, Record Keeping, and Statistical Reporting

Our examination of provider surveillance was impeded by the fact that provider surveillance record keeping and statistical reporting practices are deficient. Our major concern is not with the question of whether federal or state requirements have been met but with the question of whether statistical reporting, record keeping, and case management practices are being carried out in a way that is consistent with good management practices, and especially, whether the conduct of these functions is interfering with the basic function of SURS to conduct post-payment reviews of Medicaid providers. We found significant problems that interfere with the provider surveillance and review function:

- Statistical reports produced in SURS are inconsistent and inaccurate. Inconsistent definitions of what constitutes an integrity review or full-scale investigation are used, the numbers reported in quarterly reports do not correspond to cases identified in unit logs, and cases are filed in a way that impede management's ability to track cases and report on the results of its investigative workload.

Two sections within SURS conduct investigations of providers. However, consolidated reporting of provider reviews are required by state and federal authorities. Therefore, a common classification terminology has to be used by both the support and provider surveillance sections in SURS if the reports are to make sense. A common terminology is not used, and therefore the reports do not add up.

The caseload of provider investigations is large enough to require an orderly approach to case tracking and case management. Management needs to know how many cases are opened over various periods of time, who the cases are assigned to, what their status is, how and when the cases are closed, and with what result. Periodically, management needs to review the payoff of its decisions regarding selection of cases to pursue and staff assignments so that it can evaluate the productivity of the unit and individual staff.

Periodically the Legislature wants to know the yield of provider fraud and abuse investigations. With the present filing and record keeping system, it is awkward or impossible for SURS to answer questions such as the following for itself or others:

- Of the cases opened in 1982 (or any given period) how many have been resolved?

- How much money has been identified in overpayments, how many providers have been suspended or subjected to other administrative discipline?

- How long has it taken to resolve cases by type?

- Which cases opened in 1982 resulted in provider suspensions? Assessment of damages in addition to recovery of money overpaid?

SURS has been asked questions of this kind from time to time and has provided some information in response, but such reports have been assembled by polling staff members who report data from memory or individually kept notes and records. Inevitably, there are limits to the accuracy of such reports. Even if it was possible for DPW management to rely on these methods in the past, the recent expansion of the provider surveillance function makes a continuation of this practice unworkable.

In the preceding section we reported the available information on the results of provider investigations and conclude that these results are disappointingly meager in light of the committment of

resources. DPW takes issue with this viewpoint and argues that it is impossible to adequately measure the results of its provider surveillance and review activities. We acknowledge that there is no unambiguous way to quantify the results of provider investigations, but believe that SURS can and should do a lot more to assess the results of its activities in provider surveillance. In fact, the manager of the provider surveillance function must be more interested in assessing the results of DPW's activities in this area than the Legislature, because he is charged with making decisions aimed at making the most of the department's resources in this area. The argument that because it is impossible to definitely and unambiguously evaluate the results of provider surveillance, it is therefore appropriate to do almost nothing is untenable.

Since SURS management had not done the appropriate studies of program effectiveness, we set out to do it and our study of provider investigations proceeded as follows. We examined reports indicating how many investigations were opened and closed each quarter. We then compared these numbers to the unit log which records cases as they are opened and closed. We planned then to sample cases opened in a given period of time to see what happened to a representative sample of cases and ultimately reach conclusions whether the investigative activities of the provider and support sections was reasonable in light of staff resources committed to the job.

It proved impossible to reconcile the numbers reported in the quarterly reports (and summarized in Tables 4.1 and 4.2) to log entries. Also because cases are filed by provider number rather than by date opened, or log entry number, it was not possible to pull the case files for a representative sample. All we could do was examine in the aggregate, case outcomes reported quarterly to HCFA and the Legislative Auditor.

Again, it is not the errors in statistical reporting that are most significant (although these should be corrected). The biggest problem is the absence of management information needed to run the provider investigative function properly. The current record keeping and statistical reporting system is not only inadequate, it is also awkward and time-consuming. In our judgement, once a proper system is set up, it would take less staff time to operate than the present system.

We recommend that:

- The present record keeping, statistical reporting, and case management approach be scrapped in favor of a simple, logical, and reliable system. The new system should use classification criteria and definitions that are shared between the support and provider units, a common log, and a key that ties together log entries and case records.

2. RECIPIENT SURVEILLANCE

The recipient surveillance function is carried out in a unit of the same name in the Surveillance and Utilization Review Section. Until recently, recipient surveillance activities were carried out by the Recipient Surveillance Unit Supervisor plus one Recipient SUR Analyst (see the organizational chart presented in Figure 4.1). As a result of action taken in the 1983 session, a second analyst has been added.

The principal emphasis of the recipient surveillance program is a recipient "lock-in" program where recipients suspected of abuse are locked into using a single pharmacy or primary physician for a period of time, usually a year. Criminal prosecution and monetary recovery are rarely sought in cases of suspected Medicaid abuse by recipients, although a few such cases have been reported over the years.

Medicaid recipients suspected of fraud or abuse are identified from several sources. These include exception reports, county welfare departments, and providers. Exception reports can identify recipients who appear to be "shopping" for physicians or pharmacies. Such recipients are identified because they appear to use a lot of different physicians or pharmacies, or different pharmacies for the same drugs.

The investigation of recipients usually starts with an examination of a claims history that shows all services received by the recipient that were paid by Medicaid. The county welfare department or physician involved in the case is contacted as well as DPW's medical consultants.

If abuse is still suspected at this point, DPW sends a memo to the county, and the county calls the recipient in to explain the restriction program and the recipient's right to select a provider or to appeal the action. When a recipient is placed on restriction, he no longer receives a regular Medicaid ID card. Recipients are usually kept on restriction for 12 months, then their cases are reviewed. Although recipients have the right to appeal the decision to restrict their access to providers, DPW reports very few appeals, only 25 or so since 1976.

a. Recipient Investigations

Table 4.5 presents some descriptive information on the number of allegations or complaints on recipients received each quarter, the number of cases reviewed, the number placed on restriction, and the restricted recipient caseload.

As Table 4.5 shows, between 151 and 342 allegations or complaints are received each quarter by the Recipient Surveillance Unit. As noted, some of these come from exception reports produced by the SURS subsystem of the Medicaid Management Information System. This computer program compares recipients and identifies

those whose use of services or drugs is atypical. Other Income Maintenance division staff are also a source of leads as are county welfare departments, federal audits, and providers. According to DPW, the exception reports are a less productive source of information than other sources. The federal government requires investigations based on 25 exception reports each quarter and meeting this requirement has not been a problem.

TABLE 4.5

RECIPIENT INVESTIGATIONS AND RESTRICTIONS

	Allegations	Cases Reviewed	Recipients Placed on Restriction	Restricted Recipient Caseload
1981				
January - March	342	63	34	98
April - June	317	56	46	-
July - September	234	43	27	113
October - December	198	64	62	136
1982				
January - March	191	66	42	143
April - June	290	58	51	152
July - September	176	37	23	145
October - December	151	45	21	126
1983				
January - March	286	56	38	117
April - June	188	43	34	106
July - September	193	66	34	113

Source: DPW records.

Of the hundreds of allegations received each quarter, all but 37-66 each quarter (over the 11 quarters we reviewed) turned out to be unsubstantiated on the basis of an initial screening. For substantiated cases the next step is to set up a case file and analyze the claims history along with other system information, such as invoices, for signs of misutilization. As appropriate, the recipient, medical providers or county welfare staff are contacted for information. In addition, the case is usually reviewed by the DPW Restriction Review Committee consisting of recipient unit staff, DPW medical consultants, and other DPW staff as appropriate. As a result, each case surviving to this point may be closed, held in suspension, determined to be a provider problem and referred to the provider surveillance unit, or a recipient may be placed on restriction. Rarely will additional investigative work be done for possible legal action or monetary recovery.

As Table 4.5 shows, one-half or more of the cases reviewed result in recipients being placed on restriction. For example, 34 of 66 cases reviewed in the July-September 1983 quarter were placed on restriction bringing the restricted recipient caseload to 113.

A good deal of paperwork is required both at DPW and the county when a recipient is placed on restriction. Most important for DPW is the fact that all claims for Medicaid payments for restricted recipients need to be manually reviewed within the recipient surveillance unit. Since one percent of claims are, in fact, rejected, this review is necessary, but it should be done automatically with only exceptional claims reviewed manually.

As Table 4.5 shows, the restricted recipient caseload is currently 113, down from around 150 in mid-1982. Recipient surveillance staff say that the caseload has fallen off because the unit has been engaged in additional work not related to recipient surveillance. These new responsibilities include enrollment of Medicaid providers and acting as the employer of personal care attendants for the purposes of workers' and unemployment compensation insurance.

b. Cost-Effectiveness of the Recipient Restriction Program

A 1980 study[3] of the cost-effectiveness of the recipient restriction program suggests, but does not conclusively demonstrate that the program is cost-effective. This study reviewed utilization and expenditure data on 40 recipients who were assigned to the program during an 18-month period between August 1976 and January 1978. Recipients' use of services was examined before, during, and after the period of restriction.

The study looked at recipients' use of prescription drugs, ambulatory services, and hospital services and found that by all measures of service utilization, recipients on restriction used fewer services costing less money, on average, than the same group used prior to being placed on restriction. Furthermore, these recipients continued to use fewer and less expensive services after their period of restriction was over, although expenditure reductions were eroded once recipients left the restriction program.

Compared to a comparable prerestriction period, per recipient savings were $2,790 during restriction and $1,833 following restriction compared to a comparable pre-restriction period. This amounts to a 46.4 percent reduction during restriction and a 30.5 percent reduction following restriction. Depending on how the costs of running the restriction program are figured, this amounts to a savings of $1.38 to $2.59 per dollar invested in the recipient restriction program.

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[3] "Case Study and Analysis of the Minnesota Medical Assistance Recipient Restriction Program." PRACON Inc., Fairfax, VA. September 1980.

There are several issues to be settled in deciding whether these study findings can be generalized to all Medicaid recipients participating in the restriction program. The study group differs from all restricted recipients in that recipients in the study group were enrolled for at least 8 of 12 months during three 12-month periods before, during, and after restriction. Other restricted recipients experienced longer gaps in Medicaid participation during the three year study period. But even if there is some loss in program effectiveness for recipients who drop in and out of the program, it is reasonable in the absence of any contradictory data to assume the program would be cost-effective in these cases as well.

A more serious question is whether the restriction program would continue to be cost-effective if participation in it were significantly increased. There are about 200,000 persons eligible for Medicaid in Minnesota, of whom 135,000 receive services in a given month. Given that all evidence points to the cost-effectiveness of the recipient restriction program, and given that a restricted recipient caseload of 113 is less than one-tenth of one percent of all Medicaid recipients, and given any reasonable estimate of the prevalence of drug abuse and other causes of misutilization of drugs or health services, we conclude:

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

An expanded recipient restriction program promises to save the state more money than it takes to operate the program, as well as improve the health care of the recipients involved.

We asked SURS staff what they thought was an appropriate restricted recipient caseload given their experience with the program. their answer is that the program can and should be expanded, although staff did not want to speculate on how large the restriction program should grow. It is clear that a larger caseload will require some improvements in the review of restricted recipients' claims. Now all Medicaid claims for restricted clients are manually reviewed. This function can be automated, with only exceptional claims reviewed.

DPW now plans to increase the period of restriction from one to two years. Data from the PRACON study (reviewed above) suggest there is a marked tendency for recipients removed from the program to return to a level of use closer to their pre-restriction level. This suggests that a longer period of restriction would be beneficial to the health of clients as well as beneficial in terms of its impact on the paperwork faced by DPW and county welfare departments.

The recipient restriction program is objected to by some as interfering with clients' freedom of choice in arranging for their health care. It restricts free choice of health care provider only to a limited degree, however. Recipients still retain free choice of a primary physician or pharmacist and are free to change providers although they must notify welfare authorities if they do this.

In conclusion, we recommend that:

- The recipient restriction program be expanded until additions to the program cease to contribute to cost savings.

- DPW should monitor the cost-effectiveness of the program as it expands the program in order to know where to stop.

- DPW should refine and improve its exception reporting system so that this is a more productive source of referrals to the restriction program. Now 85 percent of restricted recipients are suspected of overutilization of prescription drugs. Other areas of overutilization also need to be identified.

- If staffing and clerical support is preventing expansion of the program, DPW should take steps to increase the staff of the Recipient Surveillance Unit or reduce its other responsibilities.

3. UTILIZATION CONTROL

The Utilization Control (UC) Unit within SURS is responsible for monitoring and preventing unnecessary or inappropriate delivery of care and services to Medicaid recipients in inpatient hospital and long-term care facilities. The UC unit carries out this function by:

- Contracting with two Professional Standards Review Organizations (PSROs) in Minnesota to review and make recommendations concerning the medical necessity, appropriateness, and quality of inpatient hospital services provided to Medicaid recipients.

- Contracting with the Minnesota Department of Health (MDH) to survey and certify long-term care facilities, and inspect the quality of services provided to Medicaid recipients residing in those facilities.

- Conducting limited on-site reviews of approximately 770 long-term care facilities, eight state hospitals, and two state-run nursing homes to ensure compliance with federal law and regulations, and to monitor the MDH contract.

A large percentage of the Utilization Control activities in the state are performed outside of DPW. Since 1982, DPW has chosen to contract out Utilization Control responsibilities for inpatient hospital services to the two PSRO's operating in the state.[4] In addition, Minnesota Statutes (Chapter 144) authorizes the Minnesota Department of Health to conduct quality assurance reviews and certifications of long-term care facilities under the supervision of DPW.

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[4]Prior to 1982, the Health Care Finance Administration (HCFA) contracted directly with the PSROs.

The present Utilization Control system is a product of detailed federal Medicaid requirements. Federal regulations require each state Medicaid agency to set up and monitor a utilization control system which includes physician certification and recertification of the medical necessity of inpatient services, review of recipients' plan of care, review of the utilization, and inspection of quality of services provided in each facility. The regulations include detailed time-frame and monitoring requirements under which DPW and its contractors must operate. Severe federal sanctions, in the form of reduced financial participation, can be imposed by the Department of Health and Human Services if the Minnesota system does not meet minimum requirements.

a. Monitoring of PSRO Contracts

As noted, the Utilization Control unit currently contracts with two PSROs to perform utilization control functions for inpatient hospitals. The primary responsibilities of the PSROs are to:

- Determine the medical necessity and appropriateness of services for Medicaid recipients including the pre-admission screening of inpatient admissions.

- Identify problem areas in utilization and quality of care for inpatient facilities.

- Develop and monitor implementation of utilization and quality of care goals for inpatient facilities.

Contracts for PSRO Medicaid services in fiscal year 1982 totaled over $480,000. The Utilization Control unit has the primary responsibility for monitoring performance and effectiveness of these contracts. Our review found that monitoring of PSRO contracts by the Utilization Control unit has been inadequate.

DPW has not undertaken a comprehensive evaluation of PSRO contract performance. Monitoring activities of the Utilization Control unit consist of little more than receiving quarterly and yearly data report forms from each PSRO. The Utilization Control unit does not systematically use this information to monitor PSRO performance. For example, a major PSRO responsibility is to formulate and monitor implementation of utilization and quality goals for each hospital. DPW's contracts with the PSROs stipulate that these goals are the contract performance objectives. These goals include reducing utilization of certain high use medical procedures. However, the Utilization Control unit has never evaluated PSRO performance in terms of these goals, nor evaluated the effectiveness of this goal development system in reducing unnecessary or inappropriate Medicaid services in inpatient hospitals.

Evaluation of PSRO contract performance and effectiveness should be an essential component of Minnesota's Utilization Control system. The significant resources devoted to PSRO contracts alone requires that DPW monitor the contract effectively.

We recommend that:

- DPW initiate an ongoing and systematic evaluation of PSRO contract performance and effectiveness.

b. Coordination of Data Collection and Monitoring Activities

Both Utilization Control staff and Minnesota Department of Health (MDH) staff (under contract to DPW) conduct annual on-site visits of long-term care facilities in the state. MDH staff conduct certification compliance and inspection of care reviews of all Medicaid facilities. These reviews include an examination of the appropriateness and quality of care provided by each facility as a whole and to individual recipients.

The Utilization Control unit visits these same facilities to conduct additional compliance reviews and to perform relatively minor data collection activities for the other units within SURS. These additional reviews consist of examining a small sample of utilization control records in each facility to assure that federal reporting and time-frame requirements are being met.

In our opinion, this dual data collection effort is poorly coordinated. Economies of effort could be achieved by MDH staff assuming responsibility for all or most on-site reviews. Monitoring of MDH performance could be integrated into the present contractual arrangement between DPW and MDH.

We recommend:

- The on-site review activities now carried out by the Utiliziatiion Control unit of DPW should be carried out by MDH as part of its broader quality assurance function.

In addition, DPW and MDH should evaluate the potential for conducting additional monitoring activities in long-term care facilities as part of a streamlined review system. One example would be to monitor the distribution of Explanation of Medical Benefit statements (EOMBs) to Medicaid recipients in long-term care facilities. Presently, there is no check of whether EOMBs have been properly distributed to residents who are capable of reviewing the records or to a responsible relative. EOMBs are a key component of the fraud and abuse detection system operated by DPW, but are only effective if properly distributed.

c. Deficiencies in the Utilization Control System for Long-Term Care

As mentioned earlier, the Utilization Control system in Minnesota is a product of detailed federal laws and regulations. The present system, while meeting minimum federal requirements, appears to have many deficiencies, particularly in the area of long-term care.

Within the Utilization Control unit itself, much staff time is spent performing perfunctory paper compliance reviews of long-term care facilities. The reviews serve very little purpose other than to

meet minimum federal reporting requirements and thus avoid federal fiscal sanctions. Data collected by the Utilization Control unit is used very little for analytical or planning purposes.

Looking at the larger Utilization Control system for long-term care, other deficiencies can be found. These include:

- A quality assurance and review system (operated by MDH under contract to DPW) that has little authority to make binding recommendations concerning proper level of care for long-term care residents.

  Federal regulations require each long-term care facility to set up and operate a Utilization Review Committee (composed of physicians and other health professionals) to examine the appropriateness and quality of care provided to inpatient residents. MDH's Quality Assurance and Review Section makes recommendations to these Utilization Review Committees on appropriate level and plans of care based on its own review of individual patient needs. However, because Quality Assurance and Review recommendations are not binding, the Utilization Review Committees often reject the recommendations, reducing the effectiveness of this utilization control function.

- An uncoordinated and unintegrated long-term care data base (both between and within DPW and MDH) which prevents adequate system-wide analysis.

- A medical care evaluation system, designed to examine and improve the care delivery system within each facility, which is required by federal regulations but rarely utilized.

In general, we conclude that the effectiveness and appropriateness of Minnesota's Utilization Control system for long-term care need to be closely examined. The problems with the present system go beyond the Utilization Control unit within DPW. It can be argued that the basic cause of deficiencies in the system are cumbersome and poorly conceived federal regulations. While we agree that the federal regulations in this area may present a barrier to development of an effective control system, DPW (and MDH) have a responsibility to examine and consider alternative systems which will more effectively meet the needs of the state.

We recommend that:

- DPW and MDH should examine and consider alternative systems to accomplish the utilization control function.

We believe that a coordinated interdepartmental evaluation of Utilization Control is an important first step in designing a more effective and appropriate system.

- DPW should work closely with MDH to develop an integrated and cross-referenced long-term care data base, including facility certification, quality assurance review, and nursing home cost data sources. This system will allow the state to develop and examine comprehensive facility profiles of utilization, quality of care, and cost indicators.

4. DISCUSSION OF PERFORMANCE PROBLEMS IN POST-PAYMENT REVIEW

In summary, we found:

- The results of provider surveillance are disappointing in light of the resources devoted to this function.

- A necessary step in improving provider surveillance is strengthening management information on the results of provider investigations and making basic improvements in record keeping and statistical reports.

- The recipient surveillance program appears to be cost-effective, but can and should be expanded and should receive improved data processing support.

- The Utilization Control Section is primarily engaged in activities that comprise perfunctory paper compliance with federal regulations rather than an effective program of oversight of hospital and nursing home utilization.

DPW acknowledges that there is at least a measure of truth to these points and offers the following reasons:

- In the area of provider surveillance, DPW has had trouble recruiting and retaining investigators. The department has suffered delays in recruiting new staff authorized by the 1983 Legislature and only in January 1984 had it finally filled all the vacancies in the provider surveillance unit.

- There are improvements in data processing support that would enhance operations in provider and recipient surveillance and utilization review.

- In provider surveillance as well as utilization control, federal requirements and regulations force SURS to spend time unproductively.

In the following sections we comment on the performance problems discussed in this chapter and offer our perspective on DPW's analysis of the source of the problems.

a. Staff Recruitment Problems

SURS has had staff recruitment and turnover problems in several positions. Part of the problem, according to SURS and Health

Care Programs Division management is delays induced by DPW's personnel section, a job evaluation study conducted by DPW personnel that didn't reach the right conclusions about salaries, and delays in classification and certification decisions by the Department of Employee Relations (DOER).

In our view there is at least some basis to conclude that the DPW personnel section and the Department of Employee Relations are not adequately serving the needs of SURS operations. But it is difficult to sort out the responsibility of SURS, DPW personnel, and DOER, expecially when each of these actors contributes something to unsatisfactory personnel transactions.

A major difference in perspective by the DPW personnel section and DPW's operating divisions need not and should not continue to exist. Therefore, we recommend that:

- The Commissioner of DPW take action to see if staff turnover and recruitment problems in SURS can be resolved through changing job descriptions, salary schedules, recruitment practices, or performance standards for the affected positions.

Once this situation is cleared up it will be easier to solve any remaining problem between DPW and DOER. Because there is some difference between the DPW personnel section and SURS on recruitment and classification issues, it is hard at this point to hold DOER responsible.

b. Data Processing Support

The Surveillance and Utilization Review Subsystem of the Medicaid Management Information System provides data processing support for the DPW section of the same name.

According to DPW and our own analysis, there are several important problems with data processing support in SURS that need attention:

- The SURS system is expensive to run.
- It is difficult to change the system to meet changing needs for statistical information.
- Data processing problems have caused federal auditors to conclude that system performance requirements have not been met in the past, and meeting quarterly reporting requirements continues to be a problem.
- Both provider and recipient surveillance staff report historical problems with the usefulness of SURS system reports. Modification of the system on a timely basis could make provider and recipient profiles, exception reports and special analyses more timely and useful.

The SURS system will be expensive to run in any case since the file of claims that needs to be read to generate provider and recipient profiles is huge. As a rough guide, it costs about $400,000 a year in computer costs to run the system, $175,000 at ISB and $225,000 at the University Computer Center.

A control file is prepared at ISB and sent to the University. SURS staff complains that Medicaid invoice processing commands priority attention from the welfare systems office, and that poor documentation leaves the SURS system vulnerable to staff turnover.

The system has been error prone. According to staff, this has had a negative impact on the ability of SURS to do its work. For example, requested categories of service have been omitted from reports and column totals have not added up properly. The private consultants who helped develop the system have been called in to see if they can find the problem.

In the past, system performance requirements for SURS set by the Health Care Financing Administration have not been fully met. For example, the fiscal year 1981 review standards pertaining to timely production of SURS profiles and responding to user requests for special profiles or reports were not met. The fiscal year 1983 systems performance review still shows a problem with the production of profiles, but overall the judgment of the HCFA review is that the system is being effectively utilized.

Part of the problem with data processing support is due to turnover in the position of the research analyst responsible for coordinating data processing support for SURS. The fact that this job has been held by several different people and was vacant for a significant time over the last three years has had, in our view, a tangible negative effect on the effectiveness of SURS. A new person has just been hired to fill the position. The following problems will command his attention and none of them will be easy to solve:

- identifying the source of errors in the system;
- cleaning up the disarray that exists in the statistical reporting required by HCFA and Minnesota law;
- shopping around for cheaper data processing services; and
- designing special studies of utilization and in general using the SURS system in a more creative fashion.

It is possible that this job is too much for one research analyst and that additional resources within DPW should be committed to the job of straightening out the existing problems.

c. Federal Requirements

Federal requirements are blamed in part for the inefficiency of the Utilization Control and Provider Surveillance Sections. In the first case, we have concluded that DPW can negotiate a better arrangement with the federal authorities, and should continue to press

for a better solution because the present Utilization Control program is largely a waste of time and money. There is no question that the federal agencies have presented difficult obstacles to accomplishing reforms in this area in the past.

In the area of provider surveillance, the federal requirement that causes the most problem in terms of effectiveness, according to DPW, is the requirement to investigate a quota of cases involving specified provider types identified by the SURS exception reporting system rather than cases that became identified from other sources.

This problem may now be moot since the resources committed to provider surveillance have been materially increased and should permit SURS to "get out from under" the federal requirements. But it seems to us that the exception reporting system is an essential element of a post-payment review program and is based on absolutely sound principles that ought to be strongly communicated to providers, viz., providers whose pattern of practice is remarkably different than normal will be audited.

A better solution to the problem of the present exception reporting system therefore is to improve it by:

- selecting parameters that more selectively identify cases of high potential; and

- streamlining investigative procedures so that low potential cases can be closed quickly.

A final observation seems appropriate. Post-payment review of Medicaid claims historically has received lower priority than invoice processing and other "front-end" aspects of Medicaid administration. Even now SURS managers and staff are engaged to some extent with other responsibilities such as provider enrollment and rule-writing that have nothing to do with post-payment review, at the same time that unfinished business relating to post-payment review remains to be completed. We believe that the priority of post-payment review ought to be elevated so that the data processing, personnel, and intergovernmental relations issues discussed in this section can be resolved. This seems appropriate in light of current concern with Medicaid cost containment.

APPENDIX I

STATUS REPORT

During the 1983 legislative session significant changes were enacted which affected the Medicaid program administered through the Department of Public Welfare. The changes focussed on improving the use of state funds for providing health and social service benefits. This appendix discusses the following items:

a. Services for the Mentally Retarded (Minn. Laws 1983, Ch. 312, Art. 9.)

b. Prepayment Demonstration Project (Minn. Laws 1983, Ch. 312, Art. 5.)

c. Preadmission Screening and Alternative Care Grants (Minn. Laws 1983, Ch. 199, Sec. 6-9.)

d. Interagency Board for Quality Assurance (Minn. Laws 1983, Ch. 199, Sec. 5.)

e. Nursing Home Rates Determination (Minn. Laws 1983, Ch. 199, Sec.10.)

Several other 1983 legislative initiatives affecting prepayment and postpayment review are discussed in Chaper III and Chapter IV of this report.[1]

A. SERVICES FOR THE MENTALLY RETARDED

1. BACKGROUND

This legislation encourages the deinstitutionalization of mentally retarded persons by increasing the availability of non-institutional services and limiting institutional capacity. These actions were taken in response to two previous findings that Minnesota has an overreliance on ICF-MR placements. The Welsch v. Levine consent decree[2] mandated that mentally retarded persons be placed in the

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[1] Chapter III discusses initiatives dealing with inpatient hospital prospective payment, utilization review, prior authorization, and second opinions on elective surgery. Chapter IV discusses the new utilization review functions in the SURS section.

[2] Welsch v. Levine, United States District Court, District of Minnesota, No. 4-72-Civ. 451. (The name of the case was originally Welsch v. Likens, changed to Welsch v. Dirkswager in 1977, and to Welsch v. Noot in 1979 to reflect changes in the administration of DPW.

least restrictive setting, and established a timetable for decreasing institutional placement. The Legislative Auditor's report, Evaluation of Community Residential Programs for Mentally Retarded Persons[3] concluded that the state relies too heavily on Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) for residential care for retarded persons and recommended that the department pursue appropriate alternatives. In addition, expenditures for ICF-MR services have been one of the fastest growing expenses in the Medicaid program.[4]

2. DEPARTMENT PROGRESS

The 1983 legislation authorized DPW to apply for a Home and Community-based Services Medicaid waiver.[5] This federal waiver will allow for development of a system of alternative community services for mentally retarded persons funded through Medicaid. The waiver application was submitted to HCFA in mid-January 1984. The department's timeline for implementing this project is July 1, 1984, assuming approval of the waiver by HCFA.

In addition to the waiver, the Legislature enacted two changes to control institutional expansion. A moratorium was placed on licensing and certification of Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) and beds, with certain exceptions. Also, the Legislature placed a cap on the total number of certified intermediate care beds in state hospitals and community facilities at 7,500 as of July 1, 1983, and 7,000 on July 1, 1986. These two measures will be repealed if the waiver is disapproved by HCFA. The 7,500 bed requirement was met by decertifying 200 state hospital beds, bringing the number of certified ICF-MR beds in the state to 7,453. At this point no plan has been developed for further reductions. No formal work has begun on the administrative rule required to govern the decertification process.

The Legislature was also concerned about per diem rates in ICFs-MR. Chapter 312, Art. 9, limits annual rate increases to five percent. Temporary Rule 53, effective January 1, 1984, establishes a new rate-setting system for ICFs-MR.

3. DISCUSSION

The department's progress in implementing the legislative mandates for providing new Medicaid services for mentally retarded persons is satisfactory. State expenditures should be closely monitored to assure that the effects of the program do not shift costs to

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[3]Office of the Legislative Auditor, Program Evaluation Division, Evaluation of Community Residential Programs for Mentally Retarded Persons February 11, 1983.

[4]Expenditures for ICF-MR services rose 445 percent from fiscal year 1976 to fiscal year 1982, while total Medicaid expenditures rose 133 percent over the same time period.

[5]42 CFR 440.180.

other state funded programs. Also, total expenses for residential costs and services should be considered in determining the cost effectiveness of this program.

B. PREPAYMENT DEMONSTRATION PROJECT

1. BACKGROUND

This provision authorizes DPW to establish a demonstration project to determine whether prepaid medical care is a cost effective approach to providing Medicaid benefits. The three year project will be conducted in three counties which contain a mix of urban and suburban health consumers and providers. This project is the only prepaid demonstration project in the country that will enroll Medicaid recipients who reside in long-term care facilities.

Increased utilization of services and the high rate of inflation in health costs are primary causes of the recent growth in the Medicaid budget. The prepayment approach to health care delivery is intended to control the rate of utilization, as well as introduce incentives for providers to minimize costs through efficient case management. Results of the program will influence the way health care benefits will be provided to Medicaid recipients in the future. Arrangements are currently being made with national evaluators for ongoing monitoring of the project.

The legislation requires that all eligible individuals in the county must have continuing access to the full range of services agreed on in the contract. Persons who are eligible for Medicaid benefits through the spend down provision will be exempt from the program. These individuals will receive care as in the past because high medical costs at the time of eligibility determination would exceed the prepayment rate. Nursing home rates for Medicaid residents will be bound by Rule 50 limitations.

2. DEPARTMENT PROGRESS

One of the primary efforts of the project to date has been to obtain county participation. Counties are to be designated by the Commissioner of DPW and must include one urban, one suburban, and one rural county. The main obstacle to county participation has been that health care providers resist changes in the traditional method of Medicaid reimbursement. Also, county officials are concerned about administrative expenses of the program. Counties currently being considered are Anoka, Hennepin, and Itasca. The department is conducting final negotiations with these counties. Selection will be made in early March 1984.

The legislation authorized the department to seek waivers of certain statutory provisions in order to implement the project. The waiver proposal is nearing completion and will be submitted for federal review in mid-February, with approval anticipated during March 1984.

3. DISCUSSION

The department has had continual involvement with this project since June 1981. Since the 1983 legislation, department efforts have focussed on recruiting counties, developing the waiver request, and establishing necessary agreements and protocols. Department efforts on the Prepayment Demonstration Project are progressing very well.

C. PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS

1. BACKGROUND

The preadmission screening program was established by the Legislature in 1980. The law required county screening teams to determine whether nursing home applicants who would be eligible for Medicaid within 90 days could be cared for as well in a non-institutional setting.

The alternative care grant program was enacted in 1981 to provide counties with funds for services to persons remaining in the community. The services include homemaker, home health aide, personal care, adult day care (health related) respite care, foster care and case management.

A federal waiver allowing Medicaid funds to cover home and community based services was approved July 23, 1982. The waiver program will continue for three years providing that cost of services with the waiver is not greater than it would have been without the waiver. Reports are required 45 days after implementation and semi-annually for the remainder of the waiver period.

2. DEPARTMENT PROGRESS

All counties are now participating in the screening program. The program was expanded by the Legislature in 1982 to cover persons being discharged from a hospital to a nursing home. In 1983, additional legislation was passed to include:

- a fee schedule for persons screened and receiving alternative care funding but not Medicaid eligible;
- nursing home applicants who would be eligible for Medicaid in 180 days;
- boarding care (ICF-II) applicants; and also
- a mechanism by which counties will share 50 percent of costs when persons are hospitalized longer than necessary pending a screening team determination.

These provisions will be incorporated into DPW Rule 65 in 1984.

Technical assistance is critical to success of the program. Staff have made site visits, conducted regional workshops, and distributed an instructional manual. The addition of staff authorized by the 1983 Legislature should expand technical assistance and monitoring efforts.

3. DISCUSSION

Records show that through December 1983, about 4,800 persons have been screened and about 50 percent of persons screened determined to be able to remain in the community. Alternative services for persons not institutionalized are $200.00 to $400.00 per month compared to average costs of $1,500.00 for nursing home care. The department reports that more people are being cared for without additional expenditures.

An evaluation contract is being arranged by the department. The evaluation will analyze existing data collected from counties for a status report to the 1985 Legislature. A more comprehensive study of six counties is also being contracted for by the department. This evaluation will determine whether there have been changes in county spending patterns, and how effectively the county grants have been expended.

Possible legislative concerns are:

- cost-effectiveness as it relates to total service expenses beyond those provided through the program;
- consumer satisfaction and whether health of the elderly is maintained at previous levels;
- that the quality of care received by the elderly through home care and other service providers is monitored and regulated as necessary; and
- that the county grant approach currently in place is the most effective means of reimbursement.

D. INTERAGENCY BOARD FOR QUALITY ASSURANCE

1. BACKGROUND

The Interagency Board for Quality Assurance was established to develop recommendations for state agency monitoring of recent nursing home legislation concerning long-term care facilities. Currently, nursing home standards for quality of care are inspected and recorded apart from cost factors. Lack of formal coordination between these functions limits analysis of quality care as it relates to reimbursement rates.

In order to assure that quality of care does not deteriorate as a result of changes in reimbursement policy, it is important to have a means of relating cost data to measures of the quality of care, as well as a means of enforcing certain standards. The Board is directed to address these issues and provide recommendations for improvements.

2. DEPARTMENT PROGRESS

The Interagency Board for Quality Assurance has made considerable progress toward achieving legislative directives. The statute directs the Board to make recommendations to the 1984 Legislature. The Board submitted its Progress Report to the Legislature February 15, 1984.

3. DISCUSSION

The Board's report to the Legislature makes recommendations for necessary changes, including the need for a computerized facility profile system which links cost report data to performance and case mix data from the Department of Health. Copies of the report can be requested at 296-0868.

E. NURSING HOME RATE DETERMINATION

1. BACKGROUND

The 1983 legislation directs the Commissioner of Public Welfare to establish a new procedure for setting Medicaid reimbursement rates for nursing homes. The legislation was established to allow DPW to project future costs, establish a formula linking direct care costs and reimbursement, and simplify administration of the rate-setting program.

The legislation specifies that rates are to be set in advance, and through July 1, 1985, established by grouping facilities with certain level of care characteristics and geographic location. After that date, rates will be based on the mix of residents using an established case-mix formula.

Per diem rates have traditionally been based on nursing home reports of previous year costs and projected cost increases for the following year. Under this method there was a clear incentive for providers to overproject and spend all available funds since any difference had to be returned to the state. This system was costly and prone to accounting manipulations. The legislation was an attempt by the state to increase control over the rate of increase in nursing home costs and to improve administration of the program.

In addition, the legislation provides that:

- Beginning July 1, 1985, property-related costs will be reimbursed by paying a rent for use of the facility.

- Rates for private pay residents are to be equal to rates for Medicaid residents. Nursing homes that violate this provision are liable for treble damages.

2. DEPARTMENT PROGRESS

Contract work on the case-mix reimbursement approach is to be completed in October 1984. Contract work on the rental concept has been completed and the department will make a determination on the concept in March.

Rule 50, the successor of Rule 49, will govern operating and property related costs. Rule 50 (temporary) was promulgated effective July 1, 1983. The department will begin permanent rule-making procedures on Rule 50 by March 1, 1984.

The equalization provision continues to be extremely controversial. However, the providers and the department have been moderately successful in addressing some of the major issues. At the present time, about half the facilities have equalized rates. The remainder continue to escrow the difference pending resolution of the nursing home industry's legal challenge.

3. DISCUSSION

The department is making progress on all aspects of the legislation including work on the case-mix formula which has been contracted out. The case-mix approach to reimbursement may bring about major changes in how the current long-term care reimbursement system is managed. Long-range plans and final resolution of potential problems cannot be proposed until more is known about how the case mix approach will affect financial incentives and quality of care.

STUDIES OF THE PROGRAM EVALUATION DIVISION

Final reports and staff papers from the following studies can be obtained from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-8315.

1977

1. Regulation and Control of Human Service Facilities
2. Minnesota Housing Finance Agency
3. Federal Aids Coordination

1978

4. Unemployment Compensation
5. State Board of Investment: Investment Performance
6. Department of Revenue: Assessment/Sales Ratio Studies
7. Department of Personnel

1979

8. State-sponsored Chemical Dependency Programs
9. Minnesota's Agricultural Commodities Promotion Councils
10. Liquor Control
11. Department of Public Service
12. Department of Economic Security, Preliminary Report
13. Nursing Home Rates
14. Department of Personnel, Follow-up Study

1980

15. Board of Electricity
16. Twin Cities Metropolitan Transit Commission
17. Information Services Bureau
18. Department of Economic Security
19. Statewide Bicycle Registration Program
20. State Arts Board: Individual Artists Grants Program

1981

21. Department of Human Rights
22. Hospital Regulation
23. Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill
24. State Designer Selection Board
25. Corporate Income Tax Processing
26. Computer Support for Tax Processing

27. State-sponsored Chemical Dependency Programs, Follow-up Study
28. Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights
29. Individual Income Tax Processing and Auditing
30. State Office Space Management and Leasing

1982

31. Procurement Set-Asides
32. State Timber Sales
33. Department of Education Information System
34. State Purchasing
35. Fire Safety in Residential Facilities for Disabled Persons
36. State Mineral Leasing

1983

37. Direct Property Tax Relief Programs
38. Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes
39. Community Residential Programs for Mentally Retarded Persons
40. State Land Acquisition and Disposal
41. The State Land Exchange Program
42. Department of Human Rights: Follow-up Study

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43. Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf
44. The Administration of Minnesota's Medical Assistance Program

In Progress

45. County Managed Tax-Forfeited Lands
46. Special Education
47. Sheltered Employment Programs
48. State Block Grants to Counties