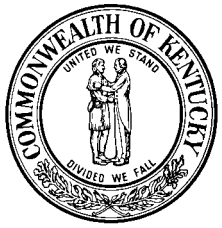
MEDICAID'S RECIPIENT LOCK-IN PROGRAM

DECEMBER 1997 - PERFORMANCE AUDIT



EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS

The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.

EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS

December 10, 1997

To the People of Kentucky
The Honorable Paul E. Patton, Governor
John Morse, Secretary, Cabinet for Health Services
Larry McCarthy, Deputy Commissioner, Department for Medicaid Services
Timothy Veno, Inspector General, Cabinet for Health Services

Re: Performance Audit on Medicaid's Recipient Lock-In Program

Ladies and Gentlemen:

We present our report on Medicaid's Recipient Lock-In Program. With approximately nineteen percent of the state's budget allocated to Medicaid expenditures, it is essential that savings be achieved whenever possible. The transition to managed care in two areas of the state is an attempt by Kentucky to fund medical services for more Kentuckians by realizing greater efficiencies in healthcare expenditures. Regardless of the speed of this transition, as long as the fee-for-service Medicaid program exists, opportunities to reduce unnecessary and sometimes harmful Medicaid services must be discovered and employed.

Our analysis of the Medicaid program concluded that Kentucky's Surveillance and Utilization Review Subsystem (SURS) does not effectively employ a principal control tool, recipient lock-in, to eliminate duplicate and unnecessary expenditures. By identifying more Medicaid recipients who overutilize and abuse Medicaid services, and by locking those recipients into a single physician and pharmacy, Kentucky could decrease Medicaid costs by $6,374 per identified recipient per year. We estimate that the Cabinet for Health Services could lock-in 820 additional recipients per year realizing annualized savings of $5.2 million. Conversely, we estimate that Kentucky's failure to effectively employ recipient lock-in unnecessarily cost taxpayers $12.4 million from 1994 through 1996. We therefore have made several recommendations to increase the number of reviews being conducted.

I would also like to point out the value added work being conducted by our performance audit division. The second chapter of this report discusses opportunities to increase the efficiency of the Medicaid SURS Branch and accordingly offers several recommendations to the Cabinet. As is the case with all of our performance audits, this audit serves not only to document practices that can be improved upon but offers real solutions and options to agency management. We intend for our performance audits to be a consulting service and management tool to cabinet leaders.

Once the Cabinet has advised us that the recommendations have been implemented, they will be considered closed. We will be happy to discuss with you at any time this audit or the services offered by our office. I appreciate the courtesies and cooperation offered to our staff during the audit.

Respectfully submitted,

Edward B. Hatchett, Jr.

cc: Tommy Richie, Director, CHS Division of Audits
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Executive Summary

The Surveillance and Utilization Review Subsystem (SURS) is a mandated component of Medicaid, a joint federal and state government program to provide medical care to certain qualified low-income citizens. Among other things, the staff of the SURS is responsible for identifying misuse, overuse, and abuse of Medicaid services. One of the principal control tools available to SURS is the Lock-In Program, in which the recipient is restricted to a single primary physician and a single pharmacy. Subjecting the recipient to a greater degree of professional supervision and control minimizes the use of duplicate and unnecessary services and prescription drugs that can be harmful to a recipient's health. Analysis of past Medicaid payments and interviews with physicians indicate that lock-in reduces both Medicaid costs and potentially detrimental service and drug use. For fiscal year 1997, approximately 664,454 Kentuckians benefited from Medicaid program expenditures totaling $2.6 billion. This has constituted approximately 19% of the state's budget over the past few fiscal years.

In furtherance of cost containment objectives, we determined that the Cabinet for Health Services (CHS) could annually assign approximately 820 additional Medicaid recipients to lock-in. Annualized savings could amount to 5.2 million taxpayer dollars. In the past few years, CHS has attempted to meet only the minimum federal requirements for the number of quarterly recipient case reviews which must be conducted (in recent quarters only 64 cases). Hundreds, if not thousands, of highly suspect cases have escaped review, resulting in the unnecessary expenditure of millions of taxpayer dollars. We estimated that over the past three years, CHS has foregone savings of approximately $12.4 million by not placing additional recipients in lock-in. In fact, CHS personnel have estimated that as many as 5,000 recipients could be misusing the system and be eligible for lock-in. Current problems with Medicaid data and reporting have limited our ability to specify the total number of additional Medicaid recipients who should be assigned to lock-in. Therefore we have confined our estimate of new lock-in recipients to those which would result if the SURS Branch simply completed reviews of the top 400 case files it requests for preliminary analysis each quarter. We analyzed the current processes used by SURS to review and identify candidates for the Lock-In Program. We recommended changes to streamline this process and allow CHS to review the entire Medicaid recipient population using automated systems.

Future savings from expanding the Lock-In Program may be reduced if the CHS is able to replace the current Medicaid fee-for-service program with managed care in the various partnership regions across the Commonwealth. The transition to managed care began in November 1997 with the 16 county area around Jefferson County and is scheduled to be completed in an estimated two years. However, until total implementation of managed care, the SURS Branch will continue to have an important role in identifying overuse and abuse of Medicaid services, ensuring quality of care to Medicaid recipients, and reducing unnecessary expenditures of taxpayer money. Even after managed care is fully in place, some recipient groups and Medicaid services will remain under the fee-for-service system, with the continuing need for an overutilization review process.

Our specific recommendations are for the Cabinet for Health Services to:

- Review for lock-in all of the first 400 recipients identified in the quarterly exception log as potentially overusing or abusing Medicaid services;
- Use existing computer technology to automate the current manual review and analysis process in order to increase the number of cases that can be reviewed with existing resources;
- Streamline and automate the process for communicating with lock-in candidates and their primary care physician and pharmacy; and
- Document the policies and procedures of the SURS Branch including those describing the branch's role both during the transition to managed care and, once implemented, under managed care.

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Abbreviations

CFR	**Code of Federal Regulation**
DMS	**Kentucky Department for Medicaid Services**
FFY	**Federal Fiscal Year; October 1 through September 30**
HCFA	**Health Care Financing Administration**
MMIS	**Medicaid Management Information System**
SFY	**State Fiscal Year; July 1 through June 30**
SURS	**Surveillance and Utilization Review subsystem or branch**

Definitions

Abuse	Recipient practices that result in unnecessary costs to the Medicaid Program and/or potentially unhealthy outcomes to the recipient.
Capitated Payment	A maximum per member, per month payment to the health maintenance organization or Medicaid partnership that is made regardless of the actual services provided. The health service provider is required to provide all necessary Medicaid services regardless of the payment level.
Fee-for-Service	A reimbursement method whereby providers are paid directly for each service or product they provide to Medicaid recipients.
Lock-In Program	The system whereby a recipient found to be overutilizing physician or pharmacy services is assigned, i.e., restricted, to one (1) physician and one (1) pharmacy for those services except on referral or in the event of an emergency.
Lock-in Provider	A physician or pharmacy that agrees to be the assigned provider of physician or pharmacy services for a recipient placed in lock-in status.
Managed Care (Partnership Program, Kentucky Health Care Partnership Program)	Kentucky's Medicaid managed care plan, approved by HCFA, under which almost all Medicaid recipients in the Commonwealth will be assigned to one of eight geographic areas and have medical services provided on a capitated basis by that area's partnership organization, acting under contract with DMS.
Medicaid	The state program of medical assistance as administered by DMS in compliance with 42 USC 1396, designed to provide for the medical care needs of Kentucky's medically indigent citizenry.
Overutilization or Overuse	Utilization of Medicaid services or items at a frequency or amount that is not medically necessary as determined in accordance with the utilization guidelines established by the state.
Participating Provider	A provider who takes part in the medical assistance program by agreeing to comply with program administrative regulations and provide services to eligible recipients.
Utilization Review	The process of monitoring and controlling, to the extent possible, the quantity and quality of Medicaid health care services.

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Introduction

Background

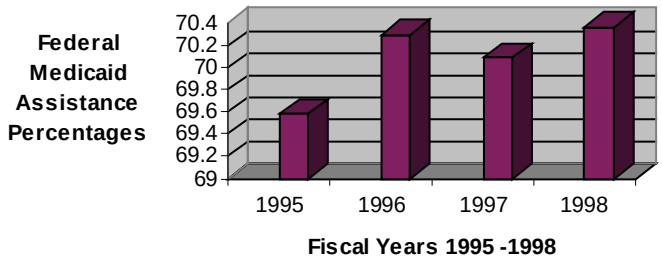
In 1965, the Medicaid Program was authorized by Title XIX of the Social Security Act to provide medical assistance to certain individuals with low incomes and resources. Medicaid is a jointly funded venture of the federal and state governments which is administered by agencies within each state.

Within broad guidelines, each of the states

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and,
- Administers its own program.

These guidelines are described in each state's Plan for Medicaid Services. The states may also place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, limits could be placed on the number of covered physicians, or authorization may be required to be obtained prior to service delivery.

Figure 1: **Kentucky's Title XIX Federal Medicaid Assistance Percentages**



Source: Health Care Financing Administration – March, 1997

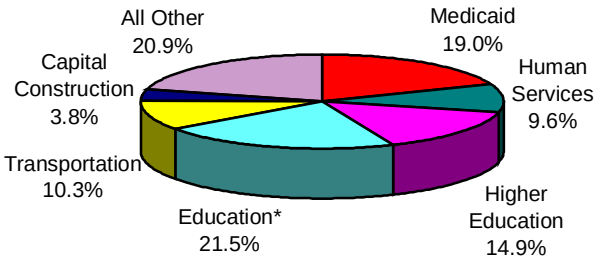
Kentucky's Medicaid Program

In Kentucky, the single state agency responsible for Medicaid is the Department for Medicaid Services in the Cabinet for Health Services. The Secretary for Health Services also serves as Commissioner of the Department for Medicaid Services. The Kentucky Medicaid benefit package has grown from six services in the mid-sixties to nearly 40 services today. Certain services are mandatory in order to receive federal matching funds; other services are optional. Nearly one-quarter of Kentucky's current Medicaid expenditures are for optional services as shown in Appendix II. In federal fiscal years 1996 and 1997 (October 1 through September 30), approximately 16% of Kentucky's population received Medicaid Services; 640,541 and 664,454 Kentuckians, respectively.

The portion of Medicaid expenses paid by the federal government is adjusted periodically based on a comparison of each state's per capita income and the national average per capita income. Wealthier states receive less federal assistance. The amount for general benefits ranges from 50% to 80%. From 1995 to 1998 Kentucky's federal assistance fluctuates around 70%, as shown in Figure 1. The remainder of funding used for Medicaid services is from the State's general and restricted agency funds.

Funds appropriated for Medicaid expenditures for State FY 96 were over $2.3 billion. Medicaid as a percentage of all state appropriations (SFY 97 and SFY 98 combined) is shown Figure 2. The sources for the funds include the federal government assistance.

Figure 2: **Distribution of All Fund Appropriations**
Commonwealth of Kentucky
Fiscal Years 1997 and 1998 Combined



Total = $27.5 Billion

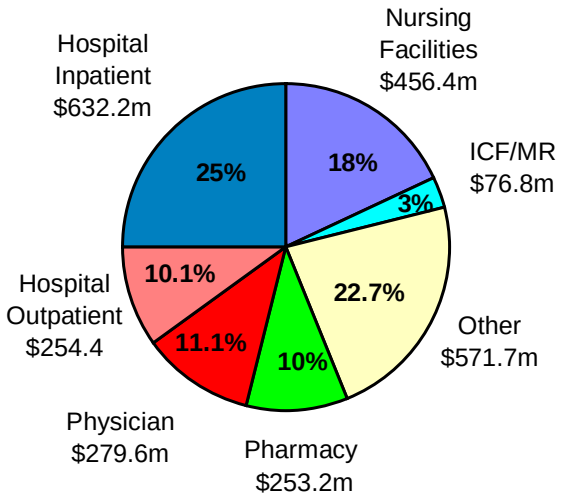
*Includes the Department of Education, Teacher's Retirement System, and the School Facilities Construction Commission.
Source: 1996-98 Budget of the Commonwealth

The Surveillance and Utilization Review Subsystem

To be eligible under the Social Security Act to receive federal Medicaid funds, the Department of Medicaid Services prepares a state plan describing the nature and scope of its Medicaid program. Amendments to the plan are approved by the Federal Health Care Financing Administration (HCFA). Within this plan, the State prescribes procedures to monitor and control the use of and the payment for care and services. The Code of Federal Regulations (CFR), Chapter 42 Section 456.22, requires procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services. Also, 42 CFR 456.23 requires a post-payment review process for recipient profiles, provider profiles, and exception criteria.

The state monitors and controls the use of Medicaid services with the assistance of several systems including the federally mandated Medicaid Management Information System (MMIS). The MMIS is an automated system used to process and pay Medicaid claims. A third-party administrator hired by the Cabinet, Unisys Corporation, maintains this system. The MMIS has subsystems that provide utilization control and management data. The data generated from the Surveillance and Utilization Review Subsystem (SURS) of the MMIS is used to monitor and control Medicaid recipient use of physician and pharmacy services. The following graph identifies the current size of the physician and pharmacy portions of Medicaid in relation to other Medicaid expenditures.

Figure 3: **Fiscal Year 97 Medicaid Expenditures $2.5 Billion***



*Administrative Expenses of $50 Million Per Year Not Included;
ICF/MR – Intermediate Care Facility for the Mentally Retarded.
Source: Cabinet for Health Services, Office of Communications

The SURS Branch is responsible for the surveillance and utilization review of Medicaid participants, including:

- conducting post-payment reviews of providers and recipients;
- establishing criteria and methods for identifying suspected fraud or abuse;
- investigating suspected or alleged fraud, abuse, or overutilization;
- locking in Medicaid clients who overutilize services;
- recommending recovery of monies as a result of overpayments;
- referring potential fraud cases to the Office of the Attorney General;
- coordinating with the Medicaid Fraud Control Unit;
- reviewing provider's Explanation of Medicaid Benefits (EOMB); and
- verifying services.

The SURS Branch had 11 employees as of June 16, 1997, and it currently has an estimated budget (Personnel and Operating Costs) of $446,300 for State FY 1997 and $497,167 for State FY 1998. The federal government generally funds fifty percent of these administrative costs.

For federal compliance, each quarter SURS must review a minimum of 0.01 percent of the total number of Medicaid active recipients on the HCFA-2082 report[1] from the previous federal fiscal year ended (64 cases per quarter in the

[1] The 2082 report is designed to provide information on State Medicaid activity to the Health Care Financing Administration.

most recent fiscal year quarters). If the review indicates that a recipient is overusing or abusing Medicaid services, the Branch may send warning or educational letters, inform the providers serving the recipient, or place the recipient in the Lock-In Program (restrict them to a single primary physician and a single pharmacy).

The Lock-In Program

42 CFR, 431.54 and 431.55 (see Table 1 below) authorize state Lock-In Programs. The overall goal of such programs is to ensure safe, quality delivery of medical care to eligible clients in the most cost efficient manner. In Kentucky, a pilot project was implemented in January 1971 to determine the feasibility of lock-in for Medicaid recipients who were identified as overusing services. The project determined that by restricting overusers to one physician and one pharmacy the use of Medicaid could be reduced by fifty percent.

The Lock-In Program provides the following two important benefits:

1. Saving taxpayer money by eliminating duplication of services, overuse, and abuse; and
2. Improving the quality of health care provided to a Medicaid recipient by assuring that a single professional coordinates every aspect of medical care he or she receives.

Table 1: **Regulatory Basis for Lock-in**

Assigning a recipient to the Lock-In Program is an exception to the "freedom of choice" of recipients. 42 CFR 431.54, Part (e), "Exceptions to certain State Plan requirements: Lock-in recipients who overutilize Medicaid services" states:

> If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met:
>
> (1) The agency gives the recipient notice and opportunity for a hearing (in accordance with procedures established by the agency before imposing the restrictions).
> (2) The agency ensures that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.
> (3) The restrictions do not apply to emergency services furnished to the recipient.

Kentucky Administrative Regulations, 907 Part 1:002 defines lock-in to mean: "…the system whereby a recipient found to be overutilizing physician or pharmacy services is assigned (i.e., restricted) to one (1) physician and one (1) pharmacy for those services except on referral or in the event of emergency." A restatement of the federal regulation can be found in Section 2103 of Kentucky's State Medicaid Manual.

The Transition to Managed Care

By the end of 1995, over half of the 50 states had begun managed care programs and over 25% of all Medicaid recipients (11.6 million across the United States) were placed in managed care. In Kentucky, managed care within Medicaid began in November of 1997 with the first of eight "partnership" regions. The rollout across the Commonwealth is expected to take approximately 24 months and cover the majority of Medicaid recipients. A small fee-for-service system will remain for those recipients not included in managed care, currently estimated to be 9.0 percent or approximately 53,117 of total Medicaid recipients eligible as of October 1996. The following categories of Medicaid recipients will not be included in managed care:

- individuals whose eligibility is dependent upon medical expenditures (Aid to Families with Dependent Children related medical assistance as well as aged, blind, and disabled assistance);
- individuals currently Medicaid eligible who have been in a nursing facility for more than thirty-one (31) days;
- individuals served under the alternate intermediate services mental retardation, home and community-based, or other Medicaid waivers;
- qualified Medicare beneficiaries, specified low income Medicare beneficiaries, or qualified disabled working individuals;
- individuals in an intermediate care facility for mentally retarded.

Under managed care, recipient monitoring will focus less on recipient overuse and more on potential under-treatment. A Decision Support System (DSS) will be used. This is a generic term describing a menu of hardware and software components which can be combined to facilitate access to data and data analysis for a wide range of end-users. The objective of the DSS is to provide managers with useful information rather than raw data for use in making decisions regarding implementation of the Medicaid program. Functions supported by the DSS include:

- benefit modeling,
- utilization management,
- provider/recipient/health plan/case manager profiling,
- program planning,
- forecasting,
- program assessment, and
- contractor performance evaluation.

Until the managed care program is fully implemented, the SURS Branch will continue to have an important role in identifying overuse and abuse of Medicaid services, ensuring quality of care to Medicaid recipients, and reducing unnecessary expenditures of taxpayer money. Even after managed care is fully in place, some recipient groups and Medicaid services will remain under the fee-for-service system, with the continuing need for the oversight of those Medicaid expenditures.

Audit Objectives

A preliminary survey conducted by the APA Division of Performance Audit identified potential opportunities for savings in Kentucky's Medicaid program through the elimination or reduction of unnecessary, harmful services. Upon review of the survey findings, the Auditor of Public Accounts directed that a full performance audit be conducted of CHS's Surveillance and Utilization Review Subsection.

Specifically, our audit was designed to answer the following questions:

- Is the Cabinet for Health Services effectively using the Surveillance and Utilization Review Subsystem to minimize Medicaid costs and the overuse and abuse of Medicaid services?

- Are the Surveillance and Utilization Review Processes of the Cabinet for Health Services efficient?

In order to answer these questions, we reviewed the processes being used within the SURS Branch, and the past financial savings of the Lock-In Program. Our audit was conducted in accordance with generally accepted government auditing standards. Accordingly, we reviewed compliance with applicable laws and regulations and management controls. We did not independently examine the reliability of computerized data; rather, we relied on the work of Coopers & Lybrand, LLP, and Ernst & Young, LLP. The scope and methodology of our work is an integral part of the audit and is included as Appendix I.

Chapter 1

Is the Cabinet for Health Services Effectively Using the Surveillance and Utilization Review Subsystem to Minimize Medicaid Costs and the Overuse and Abuse of Medicaid Services?

Summary

The Cabinet for Health Services is not effectively using the Surveillance and Utilization Review Subsystem to minimize Medicaid costs and the overuse and abuse of Medicaid services. The Cabinet has focused the SURS function on minimal compliance with federal requirements, thus not maximizing savings associated with the reduction of recipient overuse and abuse.

Overusers and abusers of Medicaid services can be placed in the state's Lock-In Program which restricts recipients to a single primary physician and a single pharmacy. The criteria used by the SURS Branch in evaluating potential overuse and abuse cases for assignment to the Lock-In Program seem to be reasonable and consistent with those used in other states. However, no more than 0.01% of the prior year's eligible Medicaid recipients are reviewed each quarter. That is currently 64 cases out of over 640,000 recipients. At the time of our analysis there were only 1,111 recipients in lock-in. The quarterly exception log, generated from Medicaid statistics, identifies some 15,000 potential overuse and abuse cases; SURS management and staff suggest that at least 5,000 of those are appropriate candidates for assignment to lock-in.

If additional quarterly reviews are conducted only on the top 400 cases selected by SURS from the exception log , our analysis indicates that:

- An additional 820 recipients could be assigned to lock-in each year;
- Savings of $6,374 per recipient would be realized (an aggregate annualized rate of savings of $5.2 million); and
- Improvements in health care would be achieved by the reduction in misuse, overuse, and abuse of medical services and drugs.

Current SURS Utilization Fails to Meet Minimum Federal Requirements

For each quarter, the State must review at least 0.01 percent of the total body of active Medicaid recipients on the HCFA-2082 Report (those that have incurred at least one paid service during the year ended). While the SURS Branch focuses only on meeting the Health Care Financing Administration's (HCFA) minimum requirement of reviewing 0.01 percent of active Medicaid recipients, we found that SURS has been out of compliance with even those minimal requirements for three of the last four state financial reviews (SFY 93, 94 and 96). For example, in SFY 96, the number required for review per quarter was 64. However, the SURS staff reviewed 60 in the quarter audited[2]. According to the 1993 Systems Performance Review by HCFA officials, the Agency was notified that it was out of compliance and was warned to begin using the HCFA-2082 to determine the number of necessary reviews to meet required standards.

[2] Further, at least 50% of the minimum number of quarterly reviews must be selected from recipients identified through the SURS quarterly exception process. This requirement was met.

SURS staff stated that they miscalculated the minimum number of reviews necessary to meet the Federal requirements because of a miscommunication between the SURS staff and the Department of Medicaid Services regarding the proper HCFA report used to determine the requirement. Furthermore, the limited number of adequate staff and the processes currently used are said to allow time for only the minimum number of reviews.

The Review Process Should Be Expanded

The requirement for a review system is included in the Code of Federal Regulations (CFR), Chapter 42, Section 456.22 which states "To promote the most effective and appropriate use of available services and facilities the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services." 42CFR 456.23 (b) goes on to require the agency to have a post-payment review process which "identifies exceptions so that the agency can correct misutilization practices of recipients and providers." Section (a) allows state personnel to develop and review "recipient utilization profiles, provider service profiles, and exception criteria."

We reviewed the exception criteria used by the SURS Branch in Kentucky to identify recipients who overutilize services. Management prioritized their most important exception criteria as indicated in Table 2 below. In our opinion, the SURS exception criteria appear reasonable when compared to criteria of other states. The Medicaid Management Information System produces a quarterly exception log based on these criteria, which identifies those recipients with an exceptionally high pattern of usage. After weighting is applied to each criterion, a listing of all Medicaid recipients is produced in order from the highest level to the lowest level user of services.

Table 2: **Exception Criteria Used by SURS Staff to Identify Overuse and Abuse of Medicaid Services**

For each of the criterion below, the Medicaid Management Information System scans the records of all Medicaid recipients to identify and list those recipients using the highest level of the services described:

1. number of narcotics (specifically codeine)
2. average drug items per recipient
3. total number of drug items
4. total number of pharmacies
5. total unduplicated physicians
6. number of office visits
7. total number of providers
8. number of outpatient services
9. number of emergency room visits

Source: SURS Staff

To begin the process, SURS Branch staff reviews, from a computer generated listing, the top 400 recipient profiles on the quarterly exception log. Approximately 20% of the profiles are immediately discarded because the recipients are in nursing homes, no longer eligible to receive Medicaid, or already in

lock-in leaving approximately 320 recipients. The staff then reviews the minimum number of cases required by HCFA (64 for the most recent quarter). Of the cases reviewed, approximately 80% of those recipients are assigned to the Lock-In Program while the remaining 20% are excluded from lock-in based on the recipients' medical condition or extenuating circumstances.

Currently the remaining 256 cases (320 less 64) are not reviewed. Given that the recipients are randomly selected for review,[3] we would expect an additional 80% of the 256 remaining recipients, or approximately 205, to be referred to the Lock-In Program if they were reviewed. These potential 205 lock-in candidates per quarter represent lost taxpayer savings. Table 3 illustrates the process for reviewing the top 400 users of Medicaid services.

Table 3: **SURS Review of Medicaid Recipients for Lock-in**

INITIAL REVIEW	**No. of Recipients**
Highest Ranked Recipients From Computer Generated Exception Log	400
Less: Recipients Excluded Because of Residency in a Nursing Facility, Ineligibility, or Already in Lock-in (20%)	80
Recipients Identified for Manual Review	320
MANUAL REVIEW	
Recipients Reviewed and Excluded From Lock-in (20%)	13
Add: Recipients Reviewed & Referred to Lock-in (80%)	51
Total Recipients Reviewed by SURS Branch	64
EXPECTED OUTCOME IF REMAINING RECIPIENTS REVIEWED	
Recipients Not Reviewed by SURS Branch	256
Less: Expected Additional Number of Recipients That Should Be Excluded From Lock-in (20%)	51
Expected Additional Number of Recipients That Should Be Locked In (80%)	**205**

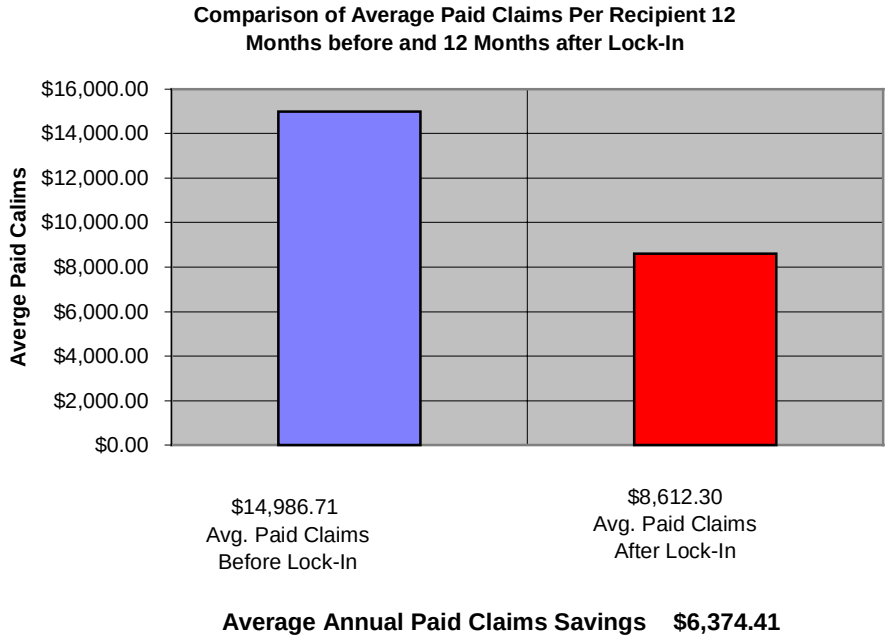
Source: Auditor Review of Actual Quarterly Results of Reviews for January 1, 1997, through March 31, 1997, and SURS Records

We analyzed the savings resulting from 170 randomly selected Medicaid recipients who were limited to a primary care physician and pharmacy. The savings occurred between January 1994 and March 1997. Our analysis reveals that an average of $6,374 of taxpayers' money is saved for each recipient placed in the Lock-In Program[4]. The analysis, see figure 4, demonstrated that the amount of paid claims dropped dramatically in the 12 months after placement in lock-in. The sample of recipients is included as Appendix III.

[3] The order of reviews is by Medicaid Assistance Identification number, which is assigned irrespective of the anticipated level of use of Medicaid services. For purposes of our analysis, we considered this a random review.

[4] The $6,374 represents a confidence level of 95% with a variance of plus or minus $1,458. Stated differently, we are 95% confident that the savings is $6,374 plus or minus $1,458. Amounts are in then year dollars and not adjusted for inflation. If indexed, the savings amount would be higher.

Figure 4: **Average Lock-in Savings Per Recipient (Sample of 170 Lock-In Recipients)**



Source: Auditors analysis of a sample of 170 recipients locked in between January 1994 and March 1996. We may expect a 95 percent confidence interval of plus or minus $1,458 for the savings above. Amounts are in then year dollars and not adjusted for inflation. Savings, if adjusted, would be larger.

Prior Savings Foregone

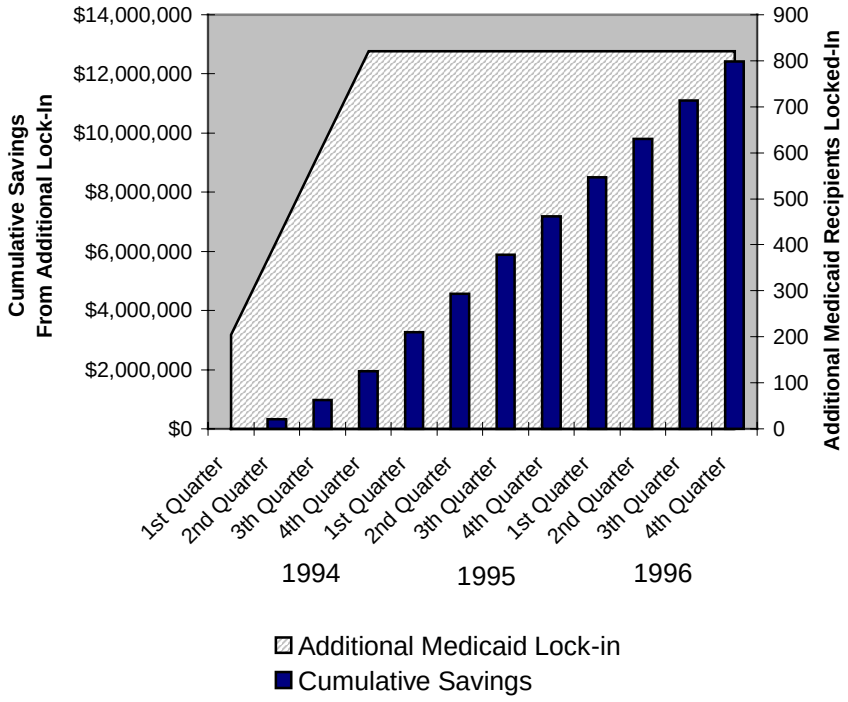
We determined that for the past three years from 1994 through 1996, the CHS could have saved approximately $12.4 million if the additional 205 recipients per quarter were locked in for one year each[5].

Given that approximately 205 additional Medicaid recipients could be placed in lock-in per quarter and that a $6,374 annual savings results on average for each lock-in, the State has foregone a material amount of Medicaid funding over the past few years. We determined that for the past three years from 1994 through 1996, the CHS could have saved approximately $12.4 million if the additional 205 recipients per quarter were locked in for one year each[5]. The $12.4 million represents the cumulative savings from identifying 205 recipients the first quarter, then 205 the second quarter, and so forth. The estimated savings accrue at approximately $1,593 per quarter per lock-in. Figure 5 illustrates the savings potential over time. The increasing diagonal line and the right vertical axis shows the number of additional lock-in candidates starting with 205 in the first quarter of 1994 cumulating in 820 from the fourth quarter of 1994 though the end of 1996. The bars and the left vertical axis show the cumulative savings estimate. This analysis assumes that the rate of savings is constant over the time period and that those recipients placed in lock-in would have remained in lock-in throughout the three-year period.

[5] Using the same confidence interval, the range of expected savings foregone would be between $9.6 and $15.2 million.

Our sampling methodology was limited to the savings generated per lock-in recipient for the one year after the individual was placed in lock-in. Given that many recipients remain in lock-in for several years, the amount of foregone savings is a conservative estimate of what the CHS could have saved if more Medicaid recipients were to have been placed in lock-in.

Figure 5: **Lock-in Savings Foregone For Calendar Years 1994 through 1996**



Source: Auditor Analysis and SURS Records
Cumulative Savings Are Not Adjusted For Inflation

Potential Future Savings

For each quarter a recipient is in lock-in, savings of $1,593 would accrue.

Carrying this analysis forward, we can estimate the potential future savings that will be enjoyed by the CHS if a review of all 400 of the highest users of Medicaid services, per the quarterly exception report, is completed. Over four quarters we would expect a total of 820 additional referrals to be locked in over and above the current number that is referred (205 per quarter). For each quarter a recipient is in lock-in, savings of $1,593 would accrue. Once 820 recipients are locked in, we estimate that annualized savings of approximately $5.2 million would be realized or 820 times the $6,374 savings per recipient[6].

[6] Each of the 820 recipients would have to be in lock-in for one year to realize the estimated $5,227,016 savings.

Table 4: **Calculation of Potential Future Savings**

If 820 Medicaid recipients (205 X 4 quarters) who overuse services are placed in lock-in in the next four quarters, average annualized savings from paid claims would be $5,227,016.20 or $6,374.41 X 820. Per quarter, each locked in Medicaid recipient would on average incur $1,593.60 less in expenditures of Medicaid services ($6,374.41 divided by 4).

Statistical Confidence of Estimate: The savings per year were estimated with a 95% confidence that the amount of annual savings will be between $4,916.58 and $7,832.24. Assuming that an additional 820 individuals are placed in lock-in, this would translate into a savings estimate of between $4,031,596 and $6,422,437.

Assumptions: Because of the difficulties in obtaining data on the Medicaid population, we were required to make several assumptions as noted below. The sample and methodology sections found in appendix I discuss these assumptions and the work done by auditors to decrease the bias they might cause.

- Because 80% of Medicaid recipients reviewed by the SURS Branch have been locked in to Medicaid during recent periods, we assumed that this rate of lock-in would remain constant for the rest of the sample of the top 400 users of Medicaid services on the quarterly exception report.
- Savings are in then year dollars and not adjusted for inflation.
- The annualized savings are based on the assumption that the 205 recipients locked in each quarter would remain in lock-in for at least one year. Given that some would remain longer while others would become ineligible or be placed in managed care, we believe the estimate provides an appropriate basis for quantifying the potential savings from identifying more recipients for lock-in.

While current full time staffing of the SURS Branch may not be sufficient for the increase in the number of reviews conducted, we believe the potential savings would justify temporary employment of nurses or professional staff to assist in conducting the reviews. Given that SURS staff currently spends at least two to four hours per review, the estimated savings of $6,374 per locked in recipient per year would be justified. Chapter 2 of this report discusses changes to the review process that may eliminate the need for increased staff to complete the additional reviews.

Lock-in Results in Better Health Care for Selected Recipients

The exception log identifies and ranks some 15,000 recipients each quarter whose service usage is above the norm of critical indicators. SURS management estimates that perhaps 5000 of these recipients, one third, are appropriate candidates for lock-in. We believe that this indicates that these recipients overuse and abuse Medicaid services to such a degree that their health is potentially damaged. The state, as a party to these harmful practices, has a moral, ethical, and perhaps legal obligation to act to remedy the situation. 42 CFR 456.3 requires the Medicaid agency to implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services.

The Cabinet disapproves practices considered to be improper, dangerous, and inconsistent with sound medicine, not medically necessary, inappropriate, or which fail to meet professionally recognized standards for health care. The professional management of an individual's health care helps ensure consistent, focused treatment, and helps to eliminate redundant, duplicative, or otherwise potentially harmful services that can occur when one provider is unaware of what another provider (or the recipient) is doing.

Each of the five professionals contacted stated that while the overall Lock-In Program could be improved, it did ensure better health care than when the recipients were allowed to choose physicians and pharmacies on their own.

As evidence of the impact of the Lock-In Program, we reviewed comments of physicians from recipient case files. Further, we interviewed by telephone physicians from eastern, southern, northern and central Kentucky, who have experience providing medical services to Medicaid recipients before and after lock-in. Each of the five professionals contacted stated that while the overall Lock-In Program could be improved, it did ensure better health care than when the recipients were allowed to choose physicians and pharmacies on their own. Listed are some of the comments from those medical professionals:

"The basic concept of lock-in is great. It improves the quality of health if used for its intended purpose, and it should be utilized more. A lot more people should be put in lock-in. This would save a lot of public money."

"The concept of lock-in (one physician and one pharmacy) is a great idea for medical care. The restriction improves the health care of individuals."

"The health care of those put into lock-in is improved. I think it is ridiculous for us to pay all these unnecessary medical claims. I don't know about you, but I don't like to see my taxpaying dollars wasted that way."

"Not only is it less expensive for the taxpayers once an abusive recipient is put in lock-in; more importantly, the quality of care that a patient receives is much better. I feel very strongly about the importance of using one physician and one pharmacy."

"I fully support the concept of lock-in 100 percent. I think it is ridiculous to let Medicaid recipients abuse the system. Lock-in is less expensive, but much more importantly is the quality of health care it provides."

Some of the physicians we interviewed said that recipients learn how to manipulate even the lock-in system at times, such as going to the emergency room and paying a private doctor to get additional prescriptions. The physicians felt that the Lock-In Program definitely improves the health of the majority of those individuals found to be overusers/abusers of the Medicaid system. They also felt that it reduces costs, benefiting all citizens.

Recommendation

By focusing on achieving only minimal compliance with Federal requirements for case review, SURS may be allowing thousands of Kentucky Medicaid recipients to continue to overuse or abuse Medicaid services, damaging their health with inappropriate medical care. While many identified recipients whose cases are reviewed are not put in lock-in because they are deceased, live in nursing homes, or have medical diagnoses which seem to explain adequately their high use of services, approximately 80% of those reviewed are placed in lock-in. SURS staff estimate that nearly 5,000 recipients are candidates for and could benefit from lock-in. Currently approximately 200 recipients are added to lock-in each year and only a total of 1,111 recipients were in the Lock-In Program as of April 16, 1997.

While managed care will dramatically decrease the need for the SURS branch, significant savings ($1,593 per quarter per lock-in) can be achieved in a cost-effective manner before that program's implementation, currently estimated to be over the next two years. Even then, some form of overutilization review of the 9% of Medicaid recipients who remain in a fee-for-service program will be necessary.

Recommendation 1: We recommend that the Cabinet for Health Services, Department of Medicaid Services, expand use of the Lock-In Program by reviewing at least the top 400 potential overuse and abuse cases at the top of the quarterly exception log.

Response to Agency Comments

CHS stated that the 1,111 recipients in lock-in at the time of our audit was a number consistent with lock-in programs in other states. They based this statement on comments by officials from the Health Care Financing Administration. CHS agreed with the recommendation. Agency comments are included as Appendix V.

Chapter 2

Are the Surveillance and Utilization Review Processes of the Cabinet for Health Services Efficient?

Summary

The surveillance and utilization review processes used by the Cabinet for Health Services are not efficient. Specifically, the processes used in reviewing recipient cases for possible assignment to the Lock-In Program are unnecessarily manual and time-consuming. Also, the Cabinet does not take advantage of available technology already present in the Department of Medicaid Services to automate many portions of the process.

Our testing verified that the current Medicaid Management Information System (MMIS) can facilitate the decision processes undertaken by the Surveillance and Utilization Review branch (SURS). Furthermore, MMIS can be used to streamline and automate the communications processes associated with SURS and the Lock-In Program. Currently a lock-in review can extend over several months, during which time patterns of overuse and abuse continue. Increased efficiencies would be realized if manual processes were eliminated. We also noted the lack of a SURS policy and procedures manual. Additionally, increased usage of automated systems could enhance savings and potentially improve the quality of care through increasing the number of reviews and lock-in assignments.

We recommend that the Cabinet for Health Services

- Use current technology to automate the manual SURS recipient review process,
- Streamline and automate the process for communicating with lock-in candidates,
- Create a policies and procedures manual for the SURS Branch.

CHS Should Automate Manual SURS Processes

The SURS Branch has established a decision process to help identify Medicaid recipients who should be placed in the Lock-In Program. The process begins with an exception report which identifies recipients whose Medicaid usage exceeds the norm on criteria established by SURS staff, e. g., numbers of physician visits, prescriptions or outpatient visits, or dollars spent on total Medicaid services or prescriptions.[7] Currently, the SURS function must review at least 64 recipients each quarter, a number equal to 0.01% of the total number of citizens who were active Medicaid recipients in the prior year.

The SURS Branch decision processes use criteria for recipient case evaluation which are consistent with those used in other states. However, in our opinion, productivity is low because the processes are inefficient, intensely manual, and time-consuming. For example, information from computer-generated reports is manually transcribed onto note pads, reordered, counted, summarized, etc. Table 5 below and Figure 6 later in this chapter describe the step by step processes.

[7] 907 KAR 1:677, Section 2(1)(e) indicates that recipients whose utilization "…exceeds a norm by at least a standard deviation…" may be reviewed, along with recipients selected by other means.

Table 5: **SURS Lock-in Elimination/Selection Processes**

- Establish exception criteria for production of an exception log (see Table 3). Request the exception log be processed and printed by the computerized Medicaid Management Information System (MMIS) based on those criteria. When the log is received, select the top 400 names on it.
- For each of the selected 400 recipients, request both an Exception Profile Report and a Claims Detail Report from MMIS. Manually match the two reports by recipient number for review.
- Manually eliminate from further consideration those lock-in recipients whose documentation indicates that they are no longer eligible for Medicaid, for whatever reason, or those that are living in nursing facilities and therefore already under supervision.
- Manually eliminate from further consideration those lock-in recipients whose documentation indicates a severe medical problem or a condition that appears to justify their exceptional levels of service.
- Manually transcribe recipient information from the Exception Profile Report and Claims Detail Report onto (1) recipient SURS activity form (2) SURS exception profile review form, (3) patient history form, (4) patient pharmacy history form (5) patient provider list, (6) recipient worksheet/rationale summary form, and (7) lock-in activity record form.
- Review the manually created forms and make a preliminary decision to place the recipient in lock-in status or to close the case.
- Prepare and send letters to each of the recipient's providers, including a case analysis summary and a response card, asking for confirmation of the lock-in decision. Evaluate responses.
- If any physician concurs with the lock-in assignment decision, send a letter notifying the recipient of his/her assignment and asking him/her to select a primary provider and pharmacy. If there is no response in 30 days, send another letter.
- Notify the provider and pharmacy selected by the recipient. If the recipient fails to make selections, select both for the recipient and make the notifications. Complete the lock-in worksheet form and enter the case into the computer.

Source: SURS Staff

SURS management estimates that the first stage elimination review for all 400 cases may take a half-day. SURS management stated that each of the approximately 64 remaining cases in the second and third stages of the quarterly review can take from two to four hours to complete. According to SURS management and staff, this

review proceeds through most of the quarter until the minimum number of cases required by HCFA is reviewed. Management estimates that approximately 80% of those cases (51) are assigned to lock-in; the remaining 20% (13) are closed without being put in lock-in. All cases from the original 400 are not reviewed, though their presence at the top of the exception log suggests that a similar percentage would be assigned to lock-in if they were. In fact, these numbers are consistent with our analysis of data from 1994 through 1996[8].

Although there is no regulatory requirement that a doctor confirm the recipient's placement in lock-in, the branch manager seeks such confirmation from at least one physician to enhance the credibility of the program. However, SURS Branch staff may place recipients into lock-in without a physician's recommendation. According to 42 CFR 431.54-55, the state can choose the primary physician and pharmacy without violating any freedom of choice requirements, provided that specified rights with respect to appeal and access to health care are maintained. Although recipients selected for lock-in may appeal and provide arguments and evidence against the lock-in assignment, SURS Branch management says that very few appeals are filed, and few of those result in overturning the decision to put the recipient in lock-in.

The Agency Should Apply an Automated Review Process to the Entire Medicaid Population

Resources (including personnel, training, and support) allocated by the Cabinet for Health Services to the SURS function have been based on the goal of minimal compliance. Using the Lock-In Program to ensure proper use of Medicaid services does not appear to be a high priority of the Cabinet. Accordingly, we believe there has been little attempt on the part of management to move from a labor-intensive system to a more efficient and productive technology-based system which would allow SURS to address Medicaid overuse and abuse.

We attempted to confirm whether the manual processes described by SURS management and staff could be replicated by the Cabinet's current MMIS system. We assumed that (1) if a recipient demonstrated a high probability of Medicaid service overuse or abuse, and (2) failed to meet the SURS lock-in exclusion criteria, that recipient would be placed in lock-in.

As a result of our test, we were able to conclude that the manual process can be largely replicated on an automated system using existing technology.

As a result of our test, we were able to conclude that the manual process can be replicated on an automated system using existing technology. We documented the decision rules we were given by SURS management and staff, and asked a CHS liaison to UNISYS to request a MMIS *ad hoc* report applying the model to the same 400 exception log recipients whose records were requested by SURS Branch staff at the end of the first quarter, 1997. The decision process model we documented during our interviews was provided to CHS and is included as appendix IV.

We found that the system could produce a report identifying those recipients who met the lock-in criteria (by being at the top of the exception log), and who failed to

[8] SURS analysis during the first three calendar quarters of 1996 was completed in a different manner because of problems with Claims Detail Reports and similar reports from the MMIS. The lock-in rate was consistent before and after this period. The percentages may vary with the number of case referrals (reviews based on allegations of overutilization rather than the quarterly exception log). Referrals are less likely to be put in lock-in than are cases taken from the top of the exception log.

meet any of the decision rule criteria to be excluded from assignment to lock-in. Using the specified decision rules, the model yielded 313 recipients who could have been assigned to lock-in and eliminated 87. SURS staff had not reviewed all 400 cases (just the minimum required) but their prior history of lock-in determination would suggest a lock-in yield of 256 out of the 400.

The difference between the 313 recipients identified by the model, and the 256 recipients who might have been expected to have resulted, may have been caused by differences in the documented decision rules we provided to CHS and the actual processes used by the individual analysts who review lock-in cases. The decision rules we provided represent an initial attempt to document and simplify a complex human thought process. For example, the decision rules, based on discussions with SURS management and staff, include the requirement that the same serious diagnosis be shown on the recipient's Claims Detail Report from two different providers. The analyst may consider the timing of the diagnosis, or a combination of diagnoses listed only once, as sufficient to eliminate a recipient from lock-in assignment. A single diagnosis of congestive heart failure, with extensive supportive treatment, or separate diagnoses of two or more cancers from a single physician, may be sufficient for an analyst to eliminate a recipient from further consideration for lock-in. Our model did not include these or perhaps other possibilities.

Because of the difficulties in obtaining reports and information from the UNISYS system, we were unable to continue refining the rules and automated processes to deal with these sorts of situations. However, we believe that SURS personnel could revise the simple model we applied and refine it to very nearly replicate the lock-in decisions made during the manual reviews. Such knowledge-based expert systems have been increasingly used in both business and government sectors to reduce cost and more efficiently complete tasks.

It is our belief that many more reviews and lock-in assignments could be completed by taking advantage of this automated support, resulting in greater savings and improved quality of care. The occasional selection inconsistencies and oversights that can result from human error or from multiple analysts with different training or perspectives could be minimized by the uniform application of explicit and open decision rules. We believe that the result, with periodic review of the model by SURS staff, would be a more accurate, thorough, and equitable program.

SURS Branch staff estimate that as many as 5,000 of the over 600,000 Medicaid recipients could be eligible for and would benefit from lock-in. If an automated analysis identified even 1,000 additional recipients for lock-in, at a savings rate of only $1,000 per year, the first year's savings would be $1,000,000. In order to be conservative with regard to our savings analysis, we looked only at first year spending reductions associated with lock-in. Our determination of the savings from lock-in was based on a sample of the 400 recipients at the top of the exception report, the recipients most likely to be overusing or abusing Medicaid services, who were assigned to lock-in during the nine quarters beginning in January 1994. We elected not to quantify savings for recipients beyond the first 400 or for time periods beyond the first year because of the lack of data and difficulty in predicting such outcomes. However, we believe that additional savings can be achieved at some rate beyond the first 400 recipients on the exception log, and that additional

savings will be realized, beyond the $6,374 estimate of first year savings, for those who remain in lock-in beyond one year. For example, if the rate of savings for the additional 205 lock-in recipients per quarter in our analysis were 50% lower in the second year, and 20% of the recipients were removed from lock-in after one year, the second year's savings for those individuals would be an additional $2 million.

CHS Should Streamline the Review, Analysis, and Recipient Communication Processes

Constant improvement of the efficiency and effectiveness of operations is an assumed goal of both private and public sector organizations. We believe that the current processes used by the SURS Branch staff to review and analyze Medicaid recipients and to communicate with their medical providers contain several inefficient, manually intensive, and time-consuming elements. For instance, Exception Profiles and Claims Detail Reports are matched by hand for all 400 of the Medicaid recipients identified by the quarterly exception report. However, approximately 20% will be discarded by a cursory review for eligibility and for nursing home residency and only another 64, under the current procedures, will be reviewed.

Review is manual even though the MMIS system is capable of sorting and analyzing Medicaid profiles using diagnostic and procedural codes. Detailed case information from the computer printouts is hand-transcribed onto forms to facilitate review and analysis. Assignments are delayed waiting for provider responses and physician responses. As a result, SURS Branch staff has only attempted to review the federally required minimum number of Medicaid recipients for lock-in, thus limiting the review of thousands of other recipients who, according to SURS staff, should be reviewed for lock-in.

Manual processes should be limited to the extent possible to those exceptional cases where the computer cannot appropriately conduct the analysis.

We recommend that the processes be revised to take advantage of technology available within the Cabinet. Manual processes should be limited to the extent possible to those exceptional cases where the computer cannot appropriately conduct the analysis. Consideration should be given to using the MMIS to automatically make initial lock-in determinations. Below is a list of potential changes to the current processes of the Branch and the corresponding increase in efficiency from such a change. Table 6 below and the accompanying flowcharts, Figure 6 and Figure 7 respectively, illustrate the current process and suggested alternative processes.

Implementing our recommended changes would increase SURS staff productivity, decrease taxpayer expenditures, deliver better medical care to at-risk recipients, and create a more consistent and equitable system. The recommended changes enhance the review process by capturing the SURS staff's knowledge base and expanding the use of the existing computerized system. An additional benefit is the ability to review multiple cases simultaneously.

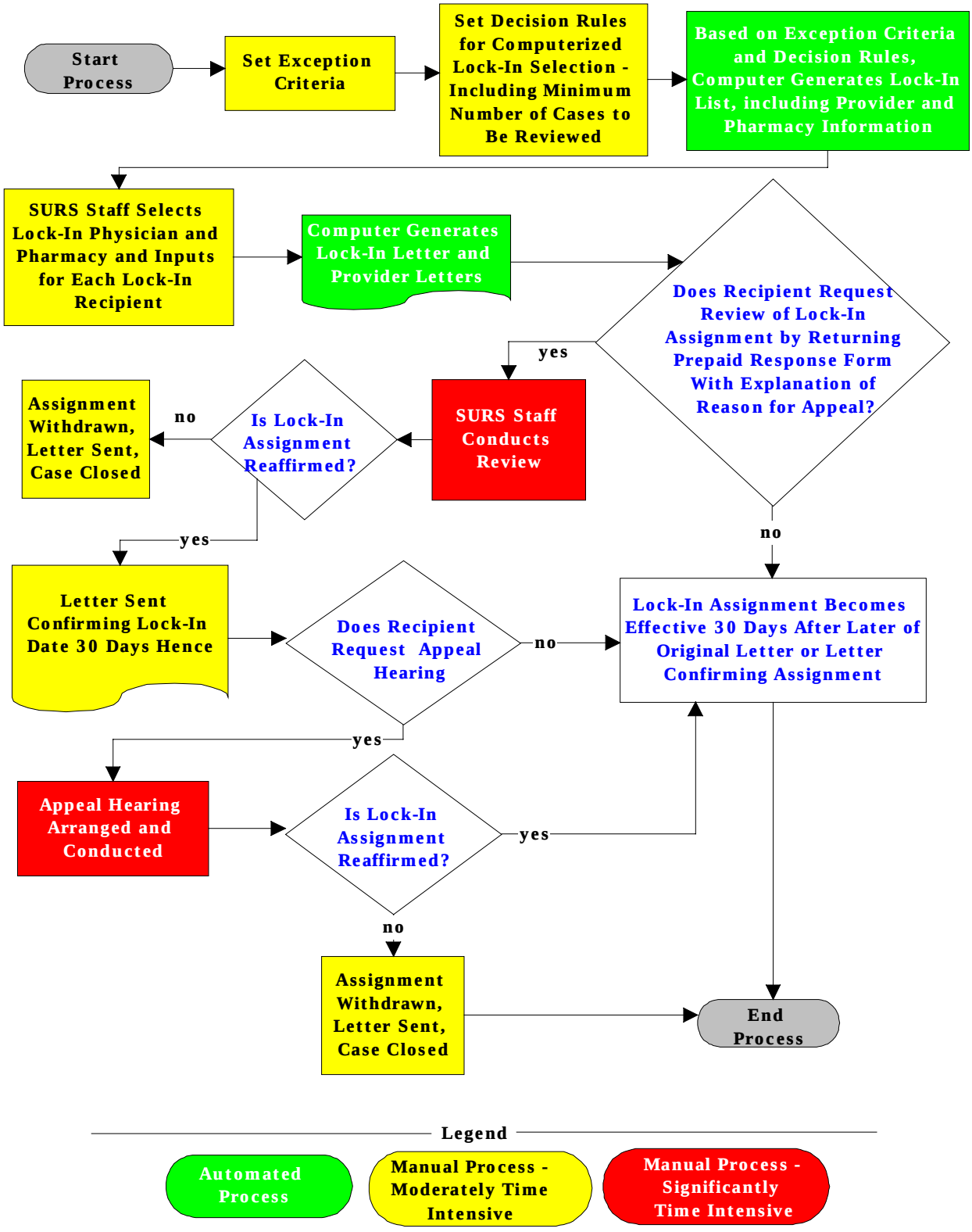
Table 6: **Potential Changes to the SURS Branch Recipient Lock-in Selection/Elimination Process**

Potential Process Change	Potential Impact
The computer system can generate the lock-in list automatically at the beginning of each quarter, going as far down the exception log as the Cabinet desires (ultimately, everyone deviating from the norm on any objective measure by as much as a standard deviation could be considered for lock-in). The list could contain the names of each recipient along with the names and provider numbers of physicians and pharmacies seen in the past year arranged like the manually transcribed sheets currently used in lock-in reviews.	Elimination of recipients who are ineligible, living in nursing facilities, or with chronic or severe medical problems could be done automatically thus ending the need for detailed manual case review. The computer automatically lists providers that SURS staff could identify as a lock-in physician or pharmacy. An overall increase in the number of reviews and a decrease in the time spent per review is anticipated.
The computer could then generate a lock-in letter to each recipient, notifying the recipient of the lock-in assignment, explaining the benefits and requirements of the program, and informing him/her of a 30-day deadline to file an initial appeal. It could also generate provider letters informing them of the pending lock-in decisions for their patients/customers. If desired, provider letters could be sent first with details of the case analysis (provided in summary form by the computer) and a request for comment or confirmation (thereby not delaying the assignment process).	At this point, staff has yet to perform any manual tasks (other than the tasks required to mail the letters). The computer automatically identifies the lock-in candidate and prepares letters to recipients and providers with copies of detail reports.
If no appeal request is received, the lock-in assignment could become effective at the end of the 30 days. If an appeal request is received, the lock-in assignment might or might not be effective 30 days after the original assignment, depending upon Cabinet preference. The initial appeal process can be simply a manual review as currently done by SURS Branch staff (with the notes now transcribed by hand generated instead by the computer).	The manual reviews are limited only to those who appeal the decision, instead of every recipient the branch wishes to place in lock-in. This would take much less time per review and require many fewer manual reviews. The MMIS has already produced the necessary detail reports and providers may have already responded with their recommendation. Formal and costly hearings are avoided when possible.
If the SURS staff agreed with the recipient after reviewing the case, the lock-in assignment could be withdrawn. If the SURS staff reaffirmed the lock-in assignment, a letter could be sent to the recipient advising of the formal hearing process, as is done now.	Staff will have placed in lock-in those who agree to the decision. Hearings are held as time allows.

Figure 6. Current SURS Recipient Lock-in Selection/Elimination Process

Figure 7.

Alternative SURS Recipient Lock-in Selection/Elimination Process



CHS Should Document the Policies and Procedures of the SURS Branch

We found that SURS Branch has not received the support, attention, or direction needed to pursue effectiveness or compliance. In 1994, the branch was moved from the Department for Medicaid Services (DMS) to the Office of Inspector General, Division of Audits, to improve branch efficiency. No changes were made within the Branch. Three years later, in 1997, it was moved back to DMS to improve coordination and data access. Throughout the changes in organizational structure and oversight, the internal Branch processes appear not to have been changed.

Currently, there is no policies and procedures manual for the SURS function. The only document available appears to be a 1988 program summary booklet prepared by a former Lock-In Program Coordinator. During our interviews, the SURS manager and staff stated that they did not feel adequately informed about issues affecting branch activities. A comprehensive policies and procedures manual is necessary to provide guidance on laws, regulations, standards, requirements, and policies, and to ensure that tasks are performed correctly, consistently, and equitably. The Branch Manager has developed mission and goals statements, and memoranda and other written information received from DMS appear to be promptly circulated to all branch personnel. Nonetheless, documented policies and procedures approved by the CHS might have served to emphasize the maximizing of overall cost containment and improvement of Medicaid recipient healthcare instead of minimal compliance with federal requirements.

Recommendations

The Cabinet for Health Services should ensure that the processes it uses are the most efficient and effective for the goals it is attempting to achieve. Cost containment and enhanced Medicaid oversight would result from improving the current processes used by the SURS branch to identify overuse and abuse of Medicaid services. These policies, and subsequent policies or changes to existing policies as managed care is implemented, should be documented. Accordingly, we recommend that that the CHS, Department of Medicaid Services:

Recommendation 2: **Use current MMIS technology to automate the manual SURS recipient review process, thus expanding from the minimum required number of reviews each quarter to the entire Medicaid recipient database.**

Recommendation 3: **Streamline and automate the process for communicating with lock-in candidates and their primary care physicians and pharmacies to further improve functional productivity.**

Recommendation 4: **Document the policies and procedures of the SURS Branch (including the unit's role under managed care) in a comprehensive manual to ensure accurate, thorough, consistent, and equitable administration of the function.**

Response to Agency Comments

CHS noted that the recommendations to streamline and automate processes would be very useful. SURS staff will simulate the process of automating the review of recipients and measure the results. Agency comments are included as appendix V.

Scope and Methodology

Appendix I

Scope

We performed our audit in accordance with generally accepted government auditing standards. The audit's purpose was to develop recommendations and information useful to the Cabinet for Health Services in administering an effective and efficient Surveillance and Utilization Review Subsystem (SURS) Program and assuring that recipients properly use Medicaid services. The fieldwork was conducted in the Division of Audits, Office of Inspector General, and the Department for Medicaid Services from April, 1997, through September, 1997.

We did not verify the accuracy of computer-generated data with regard to Medicaid. Unisys replaced Electronic Data Systems on December 1, 1995, as the fiscal agent for Kentucky's Medicaid Management Information System (MMIS). The fiscal agent's reliability was not included in the scope of our audit. During this period, the Health Care Financing Administration conducted a certification review of Kentucky's MMIS.

Methodology

In order to obtain an understanding of the Medicaid Program, the SURS function, and the Medicaid Management Information System, we reviewed the following information:

- Reports, audits, manuals and research literature from other states and the federal government relating to Surveillance and Utilization Review of Medicaid recipients;
- Information relating to Medicaid, Lock-In Programs, Medicaid Management Information Systems, and Surveillance and Utilization Review functions on the internet;
- Applicable federal and state laws, the HCFA Systems Performance Review (Factors 21 and 22), federal and state administrative regulations and policies, and executive and administrative orders affecting Kentucky's SURS function and Lock-In Program;
- The SURS portions of prior and current financial audits of the Medicaid Program;
- The Budget of the Commonwealth of Kentucky as it relates to Medicaid appropriations and expenditures;
- The Coopers & Lybrand, LLP "Agreed-Upon Procedures" review of CHS computer systems;
- Ernst & Young, LLP's SAS 70 audit of Unysis, the private sector firm acting as fiscal agent for the Department for Medicaid Services;
- Health Care Partnership legislation and materials;
- Selection criteria and lock-in procedures of other states;
- Interviews of personnel from CHS, HCFA, and other states with respect to operation of the SURS function;
- Interviews of physicians from northern, eastern, southern, and central Kentucky, and physician comments in the recipient case files;
- Results of legislative subcommittee meetings and hearings; and
- Contents of 225 case files selected randomly from the 1,111 recipients listed by the SURS Branch as being in the Lock-In Program as of 4-16-97, and scores of other case files of recipients being reviewed by SURS or whose cases had been closed.

Calculation of Savings Estimate for Each Additional Lock-in Recipient

We estimated the savings from each additional lock-in recipient by calculating a sample mean as described below.

- We selected a population of 438 Medicaid recipients who had been placed in lock-in between January, 1994, and March, 1996. We considered paid claims for both the twelve months before and the twelve months after lock-in assignments using data through March, 1997. Recipients placed in lock-in during the first quarter of 1996 were used in our sample, since they had been reviewed in early 1997 before we selected our sample. By selecting a recent and relatively short period, we minimized both the impact of medical inflation and the possible effects of attrition on our population. From that population we selected a random sample of 170 case files of active lock-in recipients who had been in the program at least twelve months.

- We used a 95% confidence interval (the degree of credibility that may be attached to the results of our mean estimate). We allowed for interval width (bound on estimation) and kept our estimates within the interval range (precision). As noted above, we attempted to minimize the possible effects of attrition bias by choosing our population and sample from the most recent appropriate time period. Also, we assessed possible attrition bias by comparing our sample to a sample of 96 cases chosen from 217 recipients who had been assigned to lock-in during calendar year 1995. We found that the difference between the two means was less than 2%, and the difference between the bound estimates was less than 25% (to be expected from the smaller sample size). Therefore, we concluded that attrition did not significantly bias our sample, and that our sample represents the population taken as a whole.

- We used paid claims data from the paid claim rationale sheet which is manually created by SURS analysts and included in the case history files of those recipients reviewed for the Lock-In Program. We also reviewed Claims Detail Reports, if available, and case summary letters from the SURS Branch to providers to verify recipient paid claims before and after lock-in.

The Lock-in Selection/Elimination Process

We reviewed the lock-in selection/elimination process with SURS management and staff and observed the process on a case by case basis for the quarter ended March 31, 1997. From those interviews and observations we attempted to document the decision rules being used. This included:

- Reviewing exception log criteria, the exception log, the Exception Profile, and the Claims Detail Reports for each of the 400 highest ranked potential abusers of Medicaid services;
- Reviewing the process of eliminating from consideration those recipients who were in nursing homes, deceased, ineligible, already in lock-in, or whose diagnosis so obviously justified their usage pattern that lock-in would clearly not be appropriate;
- Observing the manual transcription process and reviewing the resulting profiles and worksheets used by SURS management and staff to analyze each case; and

- Reviewing a 15-month Claims Detail Report for each recipient (15-months because claims from the most recent quarter may not have been filed yet).

We further reviewed the lock-in process for those recipients selected for lock-in, i.e., whose records were judged by SURS management and staff not to include adequate justification for their patterns of service overuse, including:

- Examining the SURS communications to physicians/providers, such as the activity summary and analysis supporting SURS lock-in recommendation;
- Reviewing physician/provider responses regarding the proposed lock-in assignment;
- Reviewing other communication with providers, recipients, and case workers regarding placement and other aspects of lock-in assignment; and
- Reviewing assignment follow-up and case evaluation processes.

Determination of Prior Year Savings Foregone and Possible Future Savings

Calculation of Annualized Rate of Aggregate Savings: If an additional 205 recipients per quarter, based on our process analysis, were placed in lock-in, and first year savings for each lock-in recipient were $6,374.41, as our savings analysis indicates, then the annualized rate of savings would be 205 X 4 = 820 additional recipients placed in lock-in each calendar year. (Average savings in paid claims of $6,374.41 X 820 = $5,227,015.20.) 205 X $1,593.60 = $326,688.51 or the estimated quarterly savings from locking in an additional 205 recipients.

Assumed in this calculation are 1) that only savings from the first twelve months after lock-in assignment for each recipient are included and 2) that those whose savings are no longer considered because they have been in lock-in for twelve months are replaced with new assignees each quarter, so that after three quarters there are always 820 of these additional lock-in recipients.

This analysis can be applied to past periods back to 1994, to indicate taxpayer money DMS could have saved, or to future periods to indicate money the agency can avoid spending (subject of course to limitations resulting from Managed Care implementation).

	Additional Recipients Put Into Lock-in	Recipients Reaching 12 Months Dropping From Savings Calculation	Cumulative Additional Lock-in Recipients in Savings Calculation	Quarterly Savings	Estimated Annual Rate of Savings Based on Cumulative Additional Lock-in Recipients
Base Quarter	205				
1st Quarter	205		205	$326,689	$1,306,754
2nd Quarter	205		410	$653,377	$2,613,508
3rd Quarter	205		615	$980,066	$3,920,262
4th Quarter	205		820	$1,306,754	$5,227,016
5th Quarter	205	205	820	$1,306,754	$5,227,016
6th Quarter	205	205	820	$1,306,754	$5,227,016
7th Quarter	205	205	820	$1,306,754	$5,227,016

All monetary amounts are shown in then-year dollars, not indexed, adjusted for inflation, or otherwise converted to any constant dollar equivalent.

COVERED MEDICAID SERVICES FOR KENTUCKY

Mandatory	Optional
Inpatient Hospital	Intermediate Care Home for the Mentally Retarded
Physicians Services	Pharmacy
Nursing Facilities	Community Mental Health
Outpatient Hospital	Mental Hospitals
Home Health	Renal Dialysis Services
Durable Medical	Podiatry
Family Planning	Community Residences for the Mentally Retarded Waiver Services
Screening	
Lab	Ambulatory Surgical Centers
Dental (under 21)	Home and Community Based Waiver Services
Transportation:	Adult Day Care
Non-Emergency	Nurse Anesthetist
Emergency	KenPAC (Primary Care Case Management)
Vision Care (under 21)	Hospice
Hearing Care (under 21)	Preventive
Primary Care/Rural Health	Handicapped Children
Medicare/Insurance Premiums	Emotionally Disturbed Children
QMB/Medicare Services	Case Management Mentally Ill
EPSDT Related Services	
Nurse Midwife/Practitioner	

Source: 1996-98 Budget of the Commonwealth
Based on current fee-for-service program

Sample of Medicaid Recipients

Appendix III

DATE PLACED IN LOCK-IN	CASE NO.	12 MONTHS PAID BEFORE LOCK-IN *Base Year	12 MONTHS PAID AFTER LOCK-IN	SAVINGS PER BASE YEAR	PERCENT CHANGE FROM BASE YR.
1/1/94	A9304060	$ 2,705.52	$ 1,518.86	$ 1,186.66	0.44
1/1/94	A9304058	11,542.44	4,366.54	7,175.90	0.62
2/1/94	A9304062	4,584.84	1,108.16	3,476.68	0.76
2/1/94	A9304051	14,407.44	3,788.55	10,618.89	0.74
3/1/94	A9304054	5,674.56	2,069.00	3,605.56	0.64
4/1/94	A9401008	18,415.87	6,569.22	11,846.65	0.64
4/1/94	A9401043	13,600.77	3,758.11	9,842.66	0.72
4/1/94	A9304059	20,395.49	11,432.62	8,962.87	0.44
4/1/94	A9401025	12,652.39	9,362.55	3,289.84	0.26
4/1/94	A9401045	3,268.70	18,531.65	-15,262.95	-4.67
4/1/94	A9304075	4,010.35	710.23	3,300.12	0.82
4/1/94	A9401003	8,731.32	506.73	8,224.59	0.94
4/1/94	A9401013	21,568.73	24,396.62	-2,827.89	-0.13
4/1/94	A9304039	3,005.28	13,831.58	-10,826.30	-3.60
4/1/94	A9401051	25,795.48	18,065.07	7,730.41	0.30
4/1/94	A9401024	26,304.89	3,945.92	22,358.97	0.85
4/1/94	A9304071	6,282.94	1,192.02	5,090.92	0.81
4/1/94	A9401035	22,638.72	9,606.10	13,032.62	0.58
6/1/94	A9402029	7,966.08	3,125.19	4,840.89	0.61
6/1/94	A9402024	11,392.92	2,939.76	8,453.16	0.74
6/1/94	A9402023	11,434.68	8,555.51	2,879.17	0.25
6/1/94	A9402016	12,325.08	12,810.75	-485.67	-0.04
6/1/94	A9402010	39,913.20	16,260.96	23,652.24	0.59
6/1/94	A9402008	15,448.08	10,560.89	4,887.19	0.32
6/1/94	A9402007	9,808.08	1,359.14	8,448.94	0.86
6/1/94	A9402006	10,494.24	7,958.56	2,535.68	0.24
6/1/94	A9402001	31,075.20	45,536.67	-14,461.47	-0.47
7/1/94	A9402056	8,575.44	1,709.68	6,865.76	0.80
7/1/94	A9402055	10,491.36	3,495.40	6,995.96	0.67
7/1/94	A9402039	10,812.48	9,141.61	1,670.87	0.15
7/1/94	A9402034	47,228.52	22,830.81	24,397.71	0.52
7/1/94	A9402031	6,471.12	2,792.41	3,678.71	0.57
7/1/94	A9402014	17,093.64	8,185.45	8,908.19	0.52
9/1/94	A9402057	20,719.20	6,818.79	13,900.41	0.67
9/1/94	A9402050	1,862.42	3,887.73	-2,025.31	-1.09
9/1/94	A9402036	5,345.52	8,112.05	-2,766.53	-0.52
9/1/94	A9402033	6,239.04	4,740.64	1,498.40	0.24
9/1/94	A9402020	1,432.86	2,035.41	-602.55	-0.42
10/1/94	A9403038	16,708.80	1,400.82	15,307.98	0.92
10/1/94	A9403037	2,073.36	1,321.41	751.95	0.36

DATE PLACED IN LOCK-IN	CASE NO.	12 MONTHS PAID BEFORE LOCK-IN *Base Year	12 MONTHS PAID AFTER LOCK-IN	SAVINGS PER BASE YEAR	PERCENT CHANGE FROM BASE YR.
10/1/94	A9403034	2,919.48	1,792.87	1,126.61	0.39
10/1/94	A9404033	3,873.00	1,593.73	2,279.27	0.59
10/1/94	A9403032	8,267.16	2,264.30	6,002.86	0.73
10/1/94	A9403029	13,162.44	3,330.93	9,831.51	0.75
10/1/94	A9402058	8,303.52	14,207.71	-5,904.19	-0.71
10/1/94	A9402049	19,006.68	6,234.85	12,771.83	0.67
10/1/94	A9403007	10,798.08	11,112.50	-314.42	-0.03
11/1/94	A9403065	6,060.12	3,551.71	2,508.41	0.41
11/1/94	A9403063	16,130.40	2,415.04	13,715.36	0.85
11/1/94	A9403061	18,280.68	1,613.59	16,667.09	0.91
11/1/94	A9403050	14,164.32	14,076.20	88.12	0.01
11/1/94	A9403048	4,592.16	1,910.96	2,681.20	0.58
11/1/94	A9403030	11,850.00	16,873.00	-5,023.00	-0.42
11/1/94	A9403013	3,019.80	348.84	2,670.96	0.88
11/1/94	A9403012	2,041.80	214.92	1,826.88	0.89
11/1/94	A9402041	11,379.36	2,476.57	8,902.79	0.78
12/1/94	A9404015	6,887.35	9,035.39	-2,148.04	-0.31
12/1/94	A9404034	6,786.71	10,694.15	-3,907.44	-0.58
12/1/94	A9403054	2,427.72	894.40	1,533.32	0.63
12/1/94	A9404003	12,443.61	9,309.90	3,133.71	0.25
1/1/95	A9404009	19,090.51	16,273.61	2,816.90	0.15
1/1/95	A9404014	23,001.74	2,880.02	20,121.72	0.87
1/1/95	A9404026	4,788.08	4,275.53	512.55	0.11
1/1/95	A9404038	2,985.97	2,341.57	644.40	0.22
1/1/95	A9403060	10,365.36	587.96	9,777.40	0.94
1/1/95	A9403055	22,979.52	37,847.22	-14,867.70	-0.65
1/1/95	A9403053	6,480.72	2,008.01	4,472.71	2.23
1/1/95	A9403051	10,638.60	5,313.84	5,324.76	0.50
1/1/95	A9403049	8,576.76	8,989.64	-412.88	-0.05
1/1/95	A9403047	14,396.04	3,697.75	10,698.29	0.74
1/1/95	A9403041	10,410.00	8,471.24	1,938.76	0.19
1/1/95	A9403006	6,471.84	2,386.06	4,085.78	0.63
1/1/95	A9403068	1,895.16	950.68	944.48	0.50
1/1/95	A9403067	5,386.68	4,037.69	1,348.99	0.25
2/1/95	A9404050	10,653.04	2,455.33	8,197.71	0.77
2/1/95	A9404063	11,871.45	10,361.12	1,510.33	0.13
2/1/95	A9404075	29,311.65	30,446.99	-1,135.34	-0.04
2/1/95	A9404011	20,653.03	13,733.63	6,919.40	0.34
2/1/95	A9404023	12,677.63	3,875.31	8,802.32	0.69
2/1/95	A9404029	4,589.00	39,830.75	-35,241.75	-7.68
3/1/95	A9404047	35,550.21	6,122.95	29,427.26	0.83
3/1/95	A9404048	30,779.16	9,066.99	21,712.17	0.71

DATE PLACED IN LOCK-IN	CASE NO.	12 MONTHS PAID BEFORE LOCK-IN *Base Year	12 MONTHS PAID AFTER LOCK-IN	SAVINGS PER BASE YEAR	PERCENT CHANGE FROM BASE YR.
3/1/95	A9404049	33,683.65	5,807.48	27,876.17	0.83
3/1/95	A9404069	23,649.79	4,481.77	19,168.02	0.81
3/1/95	A9404071	14,525.49	4,004.62	10,520.87	0.72
3/1/95	A9501006	19,690.39	18,451.21	1,239.18	0.06
3/1/95	A9404012	20,864.32	16,263.63	4,600.69	0.22
3/1/95	A9404017	6,806.04	2,925.11	3,880.93	0.57
3/1/95	A9404031	14,460.80	10,091.58	4,369.22	0.30
3/1/95	A9404040	55,650.66	28,061.44	27,589.22	0.50
4/1/95	A9403040	58,564.40	16,187.71	42,376.69	0.72
4/1/95	A9501049	3,431.74	14,026.41	-10,594.67	-3.09
4/1/95	A9501023	2,049.34	1,038.05	1,011.29	0.49
4/1/95	A9404052	12,836.14	12,317.14	519.00	0.04
4/1/95	A9501056	2,869.66	2,178.24	691.42	0.24
4/1/95	A9404008	22,809.68	9,597.81	13,211.87	0.58
4/1/95	A9501048	22,947.24	4,427.41	18,519.83	0.81
4/1/95	A9501016	26,923.34	6,282.37	20,640.97	0.77
4/1/95	A9501021	11,310.44	12,269.06	-958.62	-0.08
6/1/95	A9501064	7,968.37	44,543.96	-36,575.59	-4.59
6/1/95	A9501063	12,605.91	1,776.67	10,829.24	0.86
6/1/95	A9501060	31,706.42	3,338.42	28,368.00	0.89
6/1/95	A9501011	8,542.56	2,225.00	6,317.56	0.74
7/1/95	A9502030	3,866.52	1,401.29	2,465.23	0.64
7/1/95	A9502025	5,596.08	4,651.93	944.15	0.17
7/1/95	A9502023	15,588.04	9,046.35	6,541.69	0.42
7/1/95	A9502022	81,022.36	7,194.80	73,827.56	0.91
7/1/95	A9502014	7,305.40	4,490.96	2,814.44	0.39
7/1/95	A9502009	19,471.56	12,963.51	6,508.05	0.33
7/1/95	A9501004	39,520.20	27,854.29	11,665.91	0.30
8/1/95	A9502068	6,386.49	2,557.03	3,829.46	0.60
8/1/95	A9502050	5,842.76	2,351.49	3,491.27	0.60
8/1/95	A9502018	7,821.28	1,892.58	5,928.70	0.76
8/1/95	A9502016	2,473.52	8,353.69	-5,880.17	-0.70
8/1/95	A9502011	9,683.99	3,237.79	6,446.20	0.67
8/1/95	A9502005	5,460.12	2,783.15	2,676.97	0.96
8/1/95	A9501062	8,466.71	7,268.35	1,198.36	0.14
8/1/95	A9501061	5,255.04	79.06	5,175.98	0.98
9/1/95	A9503011	19,282.56	18,823.04	459.52	0.02
9/1/95	A9503010	3,922.79	708.91	3,213.88	0.82
9/1/95	A9503001	25,464.33	8,372.07	17,092.26	0.67
9/1/95	A9502064	2,434.75	3,120.43	-685.68	-0.28
9/1/95	A9502062	24,530.67	28,706.76	-4,176.09	-0.17

DATE PLACED IN LOCK-IN	CASE NO.	12 MONTHS PAID BEFORE LOCK-IN *Base Year	12 MONTHS PAID AFTER LOCK-IN	SAVINGS PER BASE YEAR	PERCENT CHANGE FROM BASE YR.
9/1/95	A9502044	7,812.88	2,591.03	5,221.85	0.67
9/1/95	A9502043	15,544.33	13,704.70	1,839.63	0.12
9/1/95	A9502042	7,107.52	4,646.70	2,460.82	0.35
9/1/95	A9502041	14,068.17	7,730.87	6,337.30	0.45
9/1/95	A9502029	16,282.87	14,479.15	1,803.72	0.11
9/1/95	A9502026	5,909.80	17,291.80	-11,382.00	-1.93
9/1/95	A9501050	6,314.04	987.16	5,326.88	0.84
9/1/95	A9501019	34,316.46	18,703.06	15,613.40	0.45
10/1/95	A9503095	19,998.19	10,675.52	9,322.67	0.47
10/1/95	A9502055	28,761.80	23,494.94	5,266.86	0.18
10/1/95	A9502054	10,788.13	22,487.76	-11,699.63	-1.08
10/1/95	A9502053	13,589.91	7,549.17	6,040.74	0.44
10/1/95	A9502048	5,277.29	6,430.51	-1,153.22	-0.22
11/1/95	A9504021	14,385.88	1,341.51	13,044.37	0.91
11/1/95	A9503019	11,908.47	6,718.27	5,190.20	0.44
11/1/95	A9502067	19,226.31	2,091.04	17,135.27	0.89
11/1/95	A9502065	3,091.93	1,112.38	1,979.55	0.64
11/1/95	A9502037	5,000.83	2,856.85	2,143.98	0.43
11/1/95	A9502039	15,079.37	4,192.83	10,886.54	0.72
11/1/95	A9502040	4,058.86	1,387.06	2,671.80	0.66
12/1/95	A9503049	11,076.34	7,150.41	3,925.93	0.35
12/1/95	A9504020	13,001.26	9,301.19	3,700.07	0.28
12/1/95	A9504030	11,103.15	2,069.17	9,033.98	0.81
12/1/95	A9504033	6,827.51	2,569.47	4,258.04	0.62
12/1/95	A9504039	44,885.06	23,278.03	21,607.03	0.48
12/1/95	A9504041	37,589.62	29,967.40	7,622.22	0.20
12/1/95	A9503021	7,608.35	7,271.16	337.19	0.04
12/1/95	A9503017	4,941.73	1,860.13	3,081.60	0.62
12/1/95	A9503016	5,654.42	5,123.99	530.43	0.09
12/1/95	A9503013	4,824.95	1,718.10	3,106.85	0.64
12/1/95	A9502027	27,055.87	13,462.31	13,593.56	0.50
12/1/95	A9503049	11,076.34	7,150.41	3,925.93	0.35
12/1/95	A9502032	19,173.55	2,403.23	16,770.32	0.87
1/1/96	A9504002	8,125.12	5,967.56	2,157.56	0.27
1/1/96	A9504003	15,250.50	12,961.56	2,288.94	0.15
1/1/96	A9504013	27,796.57	5,838.08	21,958.49	0.79
1/1/96	A9504015	43,284.76	34,761.91	8,522.85	0.20
1/1/96	A9504023	28,837.93	23,468.38	5,369.55	0.19
1/1/96	A9504027	41,263.24	5,734.92	35,528.32	0.86
1/1/96	A9504029	34,637.63	13,956.77	20,680.86	0.60
1/1/96	A9504050	9,936.42	6,226.72	3,709.70	0.37
2/1/96	A9504045	7,500.17	4,119.27	3,380.90	0.45

DATE PLACED IN LOCK-IN	CASE NO.	12 MONTHS PAID BEFORE LOCK-IN *Base Year	12 MONTHS PAID AFTER LOCK-IN	SAVINGS PER BASE YEAR	PERCENT CHANGE FROM BASE YR.
2/1/96	A9601004	6,410.52	5,677.72	732.80	0.11
3/1/96	A9503055	7,375.70	2,900.24	4,475.46	0.61
3/1/96	A9504025	88,102.41	12,670.07	75,432.34	0.86
3/1/96	A9504028	18,897.49	19,006.44	-108.95	-0.01
3/1/96	A9504043	17,245.94	607.26	16,638.68	0.96
Totals		$ 2,547,740.73	$1,464,091.40	$ 1,083,649.33	0.43
Averages		$ 14,986.71	$ 8,612.30	$ 6,374.41	

SURS EXCEPTION LOG ELIMINATION DECISION RULES

This criteria, or set of decision rules, is used by SURS staff to exclude Medicaid recipients identified by the exception log (those recipients with a high level of Medicaid expenditures) from assignment to lock-in. Source: Review of case files and interviews with SURS staff as of 6-2-97.

I. **Ineligible** {Input by local offices into eligibility subsystem, part of Kentucky Automated Medicaid Eligibility System (KAMES); available in MMIS (Medicaid Management Information System) through SURS screen; should therefore be available for computer processing…Eligibility dates are in Recipient Master File} **OR**

II. **In Nursing Home** {Listed as address on eligibility system, with name of nursing home; is supposed to be listed as indicator in Recipient Master File} **OR**

III. **Deceased** {In Recipient Master File…May not be matched with death certificate records in Vital Statistics} **OR**

IV. Diagnosis (Consistent throughout claim period, i. e., identified by **more than one provider, excluding labs, provider code 37**)

A. Terminal Illness or Condition
1. **AIDS** {HIV+ is not enough} [diagnostic code **042**] **OR**

B. Illness or Condition Requiring Extensive and/or Expensive Care
1. Cancer of Major Body Organ
   a) Leukemia [diagnostic code **204.0-208.9**] **OR**
   b) Lymphatic Cancer [diagnostic code **200.0-203.9**] **OR**
   c) Malignant Neoplasm of Digestive Organs and Peritoneum (Includes Cancer of the Liver, Stomach, Small Intestine, Colon, Pancreas) [diagnostic code **150.0-159.9**] **OR**
   d) Thyroid Cancer (includes all endocrine glands) [diagnostic code **194.0-194.9**]**OR**
   e) Lung Cancer (Includes Other Respiratory Cancer) [diagnostic code **160.0-165.9**] **OR**
   f) Malignant Neoplasm of Bone & Articular Cartilage [diagnostic code **170.0-171.6**] **OR**
   g) Kidney Cancer [diagnostic code **189.0-189.9**] **OR**
   h) Brain Cancer [diagnostic code **191.0-191.9**]**OR**

2. Severe Disease or Condition of Major Organ
   a) Heart Failure (Congestive and Other) [diagnostic code **428.0-428.9**] **OR**
   b) Heart Valve Disease [diagnostic code **424.0-424.99**] **OR**
   c) Acute Thyroid Disease [diagnostic code **245.0**] **OR**
   d) Severe Kidney Disease [diagnostic code **403.0-403.9, 584.0-589.9**] **OR**
   e) Severe Lung Disease [diagnostic code **513.0-518.8**] **OR**
   f) Severe Liver Disease [diagnostic code **571.0-572.0**] **OR**
   g) Severe Stomach/Intestinal Disease [diagnostic code **536.6-537.9**] **OR**
   h) Gangrene [diagnostic code **785.4, 250.7, 443.0**] **OR**
   i) Multiple Sclerosis [diagnostic code **340.0**] **OR**

3. Paraplegic Or Quadriplegic Condition [diagnostic code **344.0-344.9**] **OR**

4. Other Severe Spinal Injury or Condition [diagnostic code **334.0-334.9**] **OR**

C. Other
1. Accident Caused by Firearm [diagnostic code **E922.0-E922.9**] **OR**
2. Pregnancy/Childbirth [diagnostic code **640.0-648.99, V22.2**] **OR**
3. Other Serious Accident or One-Time Event [diagnostic code **800.0-999.999**]**OR**

V. Procedures

A. Cardiac Surgery (Excluding pacemakers) [procedure codes **33000-33199, 33262-33999**] **OR**

B. Cardiac Catheterization, Angioplasty, or Related Procedure [procedure **35450-35499, 36000-36299]** **AND** a Hospital Stay of 3 days or more (on billing form from **Admit Date to Discharge Date**) **OR**

VI. Usage Patterns

A. Physicians (provider type: **31** Primary Care, **35** Rural Health Clinic, **64** Physician, **65** Clinic)
1. Two or Fewer Total Physicians/Clinics **AND**

B. Pharmacies
1. No More Than Three Pharmacies (Provider Type 54) **AND**

C. Office Visits
1. 12 or Fewer Office Visits **AND**

D. Drugs
1. 18 or Fewer Prescriptions **AND**
2. 12 or Fewer Codeine and Analgesic Prescriptions [Therapeutic Drug Classes **280808 AND 280400-281000**] **AND**
3. Prescriptions from No More Than Two Physicians

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

November 3, 1997

Mr. James A. Rose, Director
Division of Performance Audits
Office of Auditor of Public Accounts
2439 U.S. Highway 127 South
Frankfort, Kentucky 40601

Dear Mr. Rose:

This is in response to the preliminary report presented by the Office of State Auditor concerning the Lock-In Program of the Department for Medicaid Services.

The performance audit provided a unique opportunity for a review of procedures by an outside agency. The report is thorough, detailed and objective. Its analysis and recommendations provide alternatives and mechanization of manual procedures. The report will be helpful because it forced SURS into analysis of the Lock-In function. The recommendations to streamline and automate processes are very useful. It is easy for an agency to become too consumed with getting a job done. In this case, completing the appropriate number of cases. The outcome of the audit produced directives in reducing man hours, making better use of time, and increasing productively.

The Cabinet had the opportunity to work with the State Auditor's staff to develop the automated system for Lock-In reviews. The "trial process" of the automated review worked well and appeared to be functioning appropriately and effectively. SURS staff will simulate the process for the next two quarters and measure the results.

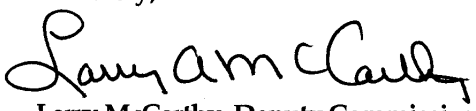
A Manual of Operation has already been developed for provider reviews. A manual for Lock-In will be completed in the near future.

Mr. James A. Rose
Page two
November 3, 1997

We are confident that the recommendations presented by your Office will enhance the manner in which services are delivered to the citizens of the Commonwealth by the Kentucky Medicaid Program.

Thank you very much for sharing the audit report and allowing the opportunity for comments.

Sincerely,



Larry McCarthy, Deputy Commissioner
Department for Medicaid Services

LM/md

c: Mr. John Morse, Commissioner
Ms. Cherilynn D. Reagan, SURS Manager

Auditor of Public Accounts Information

Appendix VI

Contributors To This Report

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Margaret Hurst, CPA, Performance Auditor
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Obtaining Audit Reports

Copies of this report or other previously issued reports can be obtained for a nominal fee by faxing the APA office at 502-564-2912. Alternatively, you may

order by mail:	Report Request Auditor of Public Accounts 144 Capitol Annex Frankfort, Kentucky 40601
visit :	8 AM to 4:30 PM weekdays
email:	Hatchett@apa1.aud.state.ky.us
browse our web site:	http://www.state.ky.us/agencies/apa

Services Offered By Our Office

Audit Services - The staff of the APA office performs a host of services for governmental entities across the state. Our primary concern is the protection of taxpayer funds and furtherance of good government by elected officials and their staffs. Our services include:

Performance Audits: The Division of Performance Audit conducts performance audits, performance measurement reviews, benchmarking studies, and risk assessments of government entities and programs at the state and local level in order to identify opportunities for increased efficiency and effectiveness.

Financial Audits: The Division of Financial Audit conducts financial statement and other financial-related engagements for both state and local government entities. Annually the division releases its opinion on the Commonwealth of Kentucky's financial statements and use of federal funds.

Investigations: Our fraud hotline, 1-800-KY-ALERT (592-5378), and referrals from various agencies and citizens produce numerous cases of suspected fraud and misuse of public funds. Staff conduct investigations in order to lay the foundation for possible referral of cases to prosecutorial offices.

Training: We annually conduct training sessions for county government officials across the state. These training events are designed to assist local officials in the accounting and compliance aspects of their positions.

General Questions

General questions should be directed to Donna Dixon, Intergovernmental Liaison, or Ed Lynch, Director of Communications, at (502) 564-5841 or the address above.