STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Medicaid: A Staff Study of Selected Programs

April 1996

Performance Audit Division

Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor

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Staff Study
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State of Louisiana

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April 24, 1996

The Honorable Randy L. Ewing,
President of the Senate
The Honorable H. B. "Hunt" Downer, Jr.,
Speaker of the House of Representatives
and
Members of the Legislative Audit Advisory Council

Dear Legislators:

This is our staff study titled "Medicaid: A Staff Study of Selected Programs." The study was conducted under provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended.

The report presents our findings, conclusions, and recommendations. We have also identified matters for legislative consideration. Included in Appendix F is the response of the Department of Health and Hospitals.

Sincerely,

Daniel G. Kyle, CPA, CFE
Legislative Auditor

DGK/jl

[MEDICAID]

Office of Legislative Auditor

Executive Summary

Medicaid: A Staff Study of Selected Programs

The Department of Health and Hospitals (DHH) administers the state's Medicaid program. The Medicaid program provides medical services to qualifying low-income people and others. Our study focuses on the physicians services and pharmacy programs and the post-payment review process. We found that:

- Spending in the physicians services program has nearly quadrupled between fiscal years 1988 and 1995. Furthermore, spending in the pharmacy program has more than doubled for the same time period.
- The department does not regularly review the rates it pays to physicians. As a result, some rates may be higher than needed to maintain access to care. In addition, an estimated $5 million could be saved if certain physicians services rates were lowered to the southern regional average.
- Approximately $2 million could be saved in the pharmacy program by lowering the dispensing fee to the southern regional average.
- The claims payment process lacks sufficient controls to detect erroneous or fraudulent claims before they are paid. Thus, DHH is relying on its post-payment review process to detect overpayments.
- According to DHH officials, only the worst cases of overpayments due to error or fraud are investigated because of limited staffing.
- Sanctions imposed on providers that have overbilled for Medicaid services may not be effective and also lack emphasis on enforcement.

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Study Initiation and Objectives

The Legislative Audit Advisory Council requested us to perform a study of Louisiana's Medicaid program. This study focuses primarily on two programs that serve a large portion of the state's Medicaid population: the physicians services and pharmacy programs. In addition, this staff study examines the Medicaid program's post-payment review process.

The primary objectives of this staff study were to:

- Review Louisiana's Medicaid reimbursement methodologies for pharmacy and physicians services.
- Compare Louisiana's Medicaid reimbursement rates for pharmacy and physicians services with those of 14 other southern states.
- Review the efforts of the Medicaid program to detect and investigate potential overpayments.

Physicians Services Program Costs Have Increased Significantly

Between fiscal years 1988 and 1995, the amount spent on physicians services in Louisiana rose from $62 million to $228.5 million. Although Medicaid pays for hundreds of services, the 20 most billed made up 42 percent of the amount spent in fiscal year 1995. During that fiscal year, Louisiana was reimbursing physicians at a rate higher than the southern regional average for seven of these services. Those seven services constituted nearly $54 million in Medicaid spending, about 23 percent of total physicians services spending. Louisiana spent $5 million more on these seven services than would have been spent if DHH had reimbursed at the regional average.

Louisiana's Medicaid state plan does not provide for regular review and adjustment of physicians' reimbursement rates. As a result, some rates may be higher than required to ensure recipient access to medical care. Five other southern states we surveyed report they adjust their physicians reimbursement rates annually or biannually. According to the physicians services program manager, DHH does not have the staff to review physicians service codes and, as necessary, adjust reimbursement rates.

When Louisiana has adjusted its physicians reimbursement rates, these changes have usually been in response to federal actions. The department raised some rates in 1990 when a federal law mandated expanded Medicaid services for pregnant women and children. However, in 1995, DHH experienced losses of funding from the federal disproportionate share program and lowered these rates and others that had not been increased since 1990.

Although Louisiana's state plan establishes how reimbursement rates are to be adjusted, it does not provide for regular review and adjustment of these rates. The state plan also advises providers to bill their usual and customary charges (their fees to the general public), so that DHH can use these fees to establish prevailing fees in Louisiana. However, the amount that providers bill for some physicians services has grown to more than twice the maximum fee. Using usual and customary charges to set future reimbursement rates could, therefore, cause the cost per service to grow considerably. Louisiana's Medicaid physicians reimbursement rates for certain services are higher than those of two states with similar reimbursement methodologies.

Pharmacy Program May Pay Too Much for Overhead

Expenditures in Louisiana's pharmacy program increased from $87 million in fiscal year 1987 to $234 million in fiscal year 1995. Since 1987, pharmacy program expenditures have risen an average of 13.2 percent each year with the exception of a decline in expenditures in 1989.

As part of their reimbursement, pharmacies participating in the Medicaid program receive a dispensing fee to cover their overhead costs. Since fiscal year 1987, the dispensing fee has grown by an average of 7.2 percent a year. The state's current average dispensing fee is 15 to 18 cents above the average for comparable southern states. Thus, the amount that Louisiana spent in fiscal year 1995 on the dispensing fee was $1.7 to $2.0 million more than what the state would have spent if the average dispensing fee had been equal to the regional average.

In July 1995, Louisiana instituted two money-saving emergency rules affecting the pharmacy program. One suspended the annual inflation adjustment to the dispensing fee, which DHH expects will save about $3.2 million in fiscal year 1996. The other establishes a co-payment requirement of from $0.50 to $3.00 per prescription on certain Medicaid recipients. DHH estimates this measure will save about $7 million in fiscal year 1996. We found that 11 southern states regularly use co-payments. Other states also use additional methods to reduce the costs of their pharmacy programs.

Overpayments Not Identified Until After Payments Have Been Made

The Medicaid fiscal intermediary has not implemented sufficient controls to detect overpayments before payment is made. Such controls might include checking frequency of services billed. As a result, no mechanism exists to ensure that the service provided was both received and necessary before payment is made. Thus, the department uses its post-payment review system to identify possible overpayments.

The manner in which providers are grouped for analysis may not be specific enough to ensure that providers are being compared to other providers with similar characteristics. Furthermore, the statistical methods used to analyze claims data will only detect the worst cases of overpayment due to fraud or abuse.

In fiscal year 1995, Louisiana's Medicaid program collected $2.3 million in overpayments to providers, out of a total of $4.2 billion in payments to providers. During this same time, less than 2 percent of providers were investigated for possibly being overpaid. However, of that group, more than 60 percent suffered sanctions. Furthermore, most of the investigations of providers as being overpaid were because of complaints and not from the post-payment review process.

Some sanctions may not be as effective as possible and also lack emphasis on enforcement. Providers can have overpayments recouped through credits made to the future billings of the erring providers. However, these providers are not monitored to make sure their future billings are valid. Therefore, providers could make up for the amounts being credited by submitting claims for more services they never rendered. Furthermore, no formal criteria exist for when cases should be referred to the Attorney General's Office for

investigation. A state law gives Medicaid providers the opportunity for an interview with DHH officials before they are referred to the Attorney General's Medicaid Fraud Control Unit. That law may inhibit the Attorney General's Office from investigating all potential cases of Medicaid fraud and abuse as soon as possible. Consequently, this law may put a suspect provider on notice before the start of a criminal investigation. Furthermore, the law also gives the provider an opportunity to conceal certain actions, to flee, or to otherwise impede any subsequent criminal investigation.

Recommendations

1. **DHH may wish to consider reviewing the rates paid for physicians services and setting these rates at the lowest possible level that will maintain adequate access to Medicaid services.**
2. **DHH should develop more specific provider grouping criteria to ensure better analysis of paid claims information.**
3. **Wherever possible, DHH should implement numerical limits based on medical standards to generate exception reports, to avoid weaknesses in the current statistical methodology.**
4. **Providers having moneys recouped for previous overpayments should have their subsequent billings monitored, to prevent providers from again overbilling Medicaid.**
5. **DHH should develop formal criteria for determining when a case warrants a referral to the Attorney General's Medicaid Fraud Control Unit for criminal prosecution.**

Matters for Legislative Consideration

1. **The legislature may wish to consider deleting the requirement for a personal interview contained in LSA-R.S. 46:442(C).**
2. **The legislature may wish to consider amending LSA-R.S. 46:442(C) so that referral to the Attorney General's Medicaid Fraud Control Unit is mandatory instead of discretionary.**

Glossary

Average Wholesale Price (AWP)	The price charged by wholesalers to pharmacies as reported in one or more national lists of cost information.
Dispensing Fee	Maximum amount pharmacies will be reimbursed over ingredient costs for the dispensing of prescriptions to Medicaid recipients.
Fee for Service	The traditional way of billing for health care services. Under this system, there is a separate charge for each patient visit and the service provided.
Formulary	A list of drugs approved for reimbursement under a benefit plan which reflects the name of the drug, the national drug code, the drug cost, and other information.
Health Care Financing Administration	The agency of the United States Department of Health and Human Services that operates the Medicaid program.
Medicaid	A state administered program that reimburses health care providers for medical treatment to low-income individuals and families. This program is jointly funded by the federal government and the states.
Multiple Source Drugs	Therapeutically-equivalent drugs marketed or sold by two or more manufacturers or labelers or drugs marketed or sold by the same manufacturer or labeler under two or more different proprietary names.
Single Source Drugs	Drugs produced or distributed under an original new drug application approved by the Food and Drug Administration.
Surveillance and Utilization Review Subsystem (SURS)	A system operated for the Louisiana Department of Health and Hospitals by UNISYS to identify fraud, abuse, and misutilization among the providers participating in and recipients being served by Medicaid.

UNISYS	A data processing company that since 1984 has had the DHH contract as the fiscal intermediary for Louisiana's Medicaid provider program.
Usual and Customary Charge	A provider's charge to the general public.
Wholesale Acquisition Cost (WAC)	The price wholesalers pay to manufacturers to acquire drugs.

Chapter One: Introduction

Study Initiation and Objectives

Recent federal government efforts to limit the amount of spending on Medicaid have brought increased attention to the issue of Medicaid expenditures and financing. As a result, Louisiana had to reduce its Medicaid spending for fiscal year 1996 and faces the prospect of further reductions in subsequent years. Consequently, the Legislative Audit Advisory Council, at its meeting on August 31, 1995, requested that the Legislative Auditor perform a study of Louisiana's Medicaid program.

The executive and legislative branches of the federal government are presently negotiating Medicaid's future. Regardless of federally mandated changes in Louisiana's Medicaid program, cost containment will continue to be critical. Therefore, the primary objectives of this staff study were as follows:

- Review Louisiana's Medicaid reimbursement methodologies for pharmacy and physician services.
- Compare Louisiana's Medicaid reimbursement rates for pharmacy and physicians services with those of 14 southern states.
- Review the efforts of the Medicaid program to detect and investigate potential overpayments.

Report Conclusions

Nationally and in Louisiana, the total cost of the Medicaid program has grown in the last seven years. However, losses in federal funding have made it critical that these costs be brought under control.

As with the total Medicaid program, Louisiana's physicians services program expenditures have grown significantly in recent years. Louisiana's Medicaid state plan lacks provisions for regular review of the rates paid for these services. Consequently, some rates may be at levels higher than necessary to assure patient access to care. Most changes to these rates have occurred in response to federal mandates.

In fiscal year 1995, Louisiana was reimbursing physicians for seven of this state's twenty most frequently billed services at rates above the Southern regional average. As a result, Louisiana spent $5 million more than what would have been spent if these services had been reimbursed at the Southern regional average. Some states in the Southern region review and/or adjust their rates either annually or biannually.

Louisiana's pharmacy program spending also has been climbing for several years. For fiscal year 1995, Louisiana's average dispensing fee per prescription was 15 to 18 cents above the Southern regional average. If the department reduced the average dispensing fee to the Southern regional average, from $1.7 million to $2.0 million in savings could be obtained. The department suspended a scheduled dispensing fee increase in fiscal year 1996, which will save an estimated $3.2 million.

To curb rising costs, most southern states have instituted cost-saving methods to lower the cost of their pharmacy programs. In an attempt to lower the cost of its pharmacy program, DHH instituted co-payments on certain Medicaid recipients for most prescription drugs. These co-payments are expected to save $7 million in fiscal year 1996.

Paying for services not rendered also increases costs. The department relies primarily on its post-payment review process to detect payments to providers due to errors or fraud. However, problems exist in the methodology used to detect, select, and recoup provider overpayments. Furthermore, only the very worst cases will be investigated.

For fiscal year 1995, DHH recouped approximately $2.3 million in overpayments of the total $4.2 billion paid to providers. Furthermore, less than 2 percent of providers were investigated as having been overpaid, but more than 60 percent of these ultimately suffered sanctions. As a result, the department took action on only the worst cases of abuse or fraud. According to department officials, they only have enough staff to investigate a small number of providers because these investigations are very labor intensive.

Some sanctions used by the department may not be as effective as possible. Providers can remain in the Medicaid program after a determination is made that they have overbilled so that overpayments can be recouped. However, their future billings are not monitored. In addition, a state law may prevent the state Attorney General's Medicaid Fraud Control Unit from investigating potential cases of fraud and abuse as quickly as possible. Another method of monitoring for fraud and abuse, recipient activity review, has not been effective because of low recipient response.

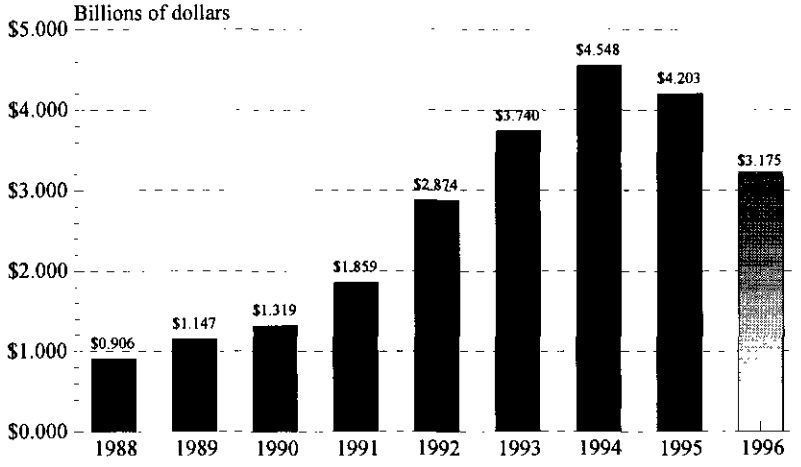
Cost of Medicaid Has Risen Significantly

Medicaid is a jointly funded federal-state entitlement program that provides medical assistance to qualifying low-income people, including pregnant women, children, elderly, and disabled persons. Presently, under broad federal guidelines, each state designs and administers its own Medicaid program. These programs must be approved by the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) for compliance with federal laws and regulations.

The federal government mandates that states provide certain Medicaid services. The states receive federal matching funds for the mandatory services, and for any optional services they choose to provide. Examples of mandatory programs are physicians services and inpatient hospital care, and examples of optional programs are chiropractic services and adult dentures. In Louisiana, DHH, through its Bureau of Health Services Financing, administers and monitors the state's Medicaid program.

Through most of the 1980s, Medicaid payments in Louisiana showed moderate growth. However, beginning in fiscal year 1989, Louisiana's Medicaid payments began growing rapidly. From fiscal years 1988 to 1994, Medicaid payments in Louisiana rose from $906 million to over $4.5 billion, a five-fold increase. The number of recipients increased by 80 percent from 433,000 in fiscal year 1988, to more than 778,000 in fiscal year 1995. Exhibit 1-1 on the following page shows the growth in Louisiana's Medicaid expenditures from fiscal year 1988 to fiscal year 1995, and also shows projected expenditures for fiscal year 1996.

Exhibit 1-1
Louisiana Medicaid Expenditures
for
Fiscal Years 1988-1996



Note: Fiscal year 1996 figures are projected by the Legislative Fiscal Office.

Source: Prepared by legislative auditor's staff from information obtained from the Legislative Fiscal Office.

Disproportionate Share Program Contributed to Rapid Spending Growth

The disproportionate share program is a federal funding program designed to provide financial assistance to hospitals treating a large proportion of poor patients. The growth of the disproportionate share program, both in Louisiana and in other states, resulted in the federal government capping disproportionate share payments. In 1993, disproportionate share payments in Louisiana equaled almost one-third of total Medicaid expenditures. However, capping disproportionate share payments has reduced funds available in Louisiana's Medicaid program. In July 1995, DHH issued emergency rules that lowered provider reimbursement rates and reduced services in an attempt to reduce program expenditures by more than $280 million.

The federal executive and legislative branches of government have negotiated the future of Medicaid during the past few months. Since these negotiations presently continue, the effect of federal legislation on Louisiana's Medicaid program is uncertain. The president vetoed the Budget Reconciliation bill agreed to by U.S. House and Senate conferees in November 1995. This Reconciliation bill would have changed present federal Medicaid funding for the states and instituted a block grant system. Louisiana's federal funding under the Reconciliation bill was set at $2.622 billion, per year, for fiscal years 1996 through 2000.

Scope and Methodology

This staff study was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. We followed generally accepted government auditing standards as promulgated by the Comptroller General of the United States, where applicable.

Scope

Our staff study began on September 1, 1995, and ended February 5, 1996, and covers fiscal years 1987 through 1995. When applicable, we have included some information from fiscal year 1996. This study focuses primarily on the physician services and pharmacy programs within Louisiana's Medicaid program because they are not only among the larger Medicaid programs, but they also serve a large portion of the Medicaid population. In addition, we examined the Surveillance and Utilization Review Subsystem (SURS), which serves to detect and to investigate fraud and abuse in the state's Medicaid program.

General Methodology

To obtain information on the development of the Medicaid program and its current status, we contacted state and federal government organizations and private associations, including the following:

- United States General Accounting Office;

- United States Health Care Financing Administration;
- Kaiser Commission on the Future of Medicaid;
- Louisiana Health Care Campaign; and
- National Conference of State Legislatures.

Furthermore, we reviewed applicable federal and state statutes and regulations, news accounts, and other relevant background data. In addition, we interviewed key staff members at the Louisiana Department of Health and Hospitals (DHH) that administer the physicians services and pharmacy programs.

In our study of the physician services programs, we performed the following:

- Reviewed reports previously issued by the legislative auditor concerning DHH and the Medicaid program.
- Identified Louisiana's 20 most frequently billed physicians services and obtained the corresponding reimbursement rates.
- Surveyed the Medicaid pharmacy and physician services programs of 14 southern states, particularly with regard to how other states reimburse their providers. We also obtained their reimbursement rates for the same 20 services that we obtained for Louisiana.
- Calculated the average reimbursement rate for the 20 services for the southern states and compared to Louisiana's reimbursement rate.

The states that we surveyed are as follows:

Alabama	Maryland	South Carolina
Arkansas	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

For the pharmacy program, we surveyed the same states and obtained similar information relating to the pharmacy program. We did not analyze ingredient costs as part of this study due to time and resource limitations. We also did not audit the responses and information furnished in these surveys.

In our examination of the post-payment review process, we interviewed staff of the Program Integrity and Claims Processing sections. We obtained and reviewed relevant manuals and reports. In addition, we interviewed the staff of the Medicaid Fraud Control Unit within the Office of the Attorney General.

Report Organization

The remainder of this report is organized into three additional chapters and six appendixes.

- **Chapter Two** contains a review of the rate-setting methodology and rates for certain physicians services.
- **Chapter Three** presents an analysis of the reimbursement methodology of the pharmacy program.
- **Chapter Four** discusses the post-payment review process.
- **Appendix A** contains a copy of the survey of Medicaid physicians services sent to other states.
- **Appendix B** contains reimbursement rates for 20 physicians services provided by 14 other states in response to the physicians survey.
- **Appendix C** contains a summary of other states' responses to the Medicaid pharmacy services survey.

- **Appendix D** contains definitions and an explanation of pharmacy reimbursement methodologies.
- **Appendix E** provides a flowchart of the claims processing function.
- **Appendix F** is the Department of Health and Hospitals' response.

Chapter Two: Physicians Services

Chapter Conclusions

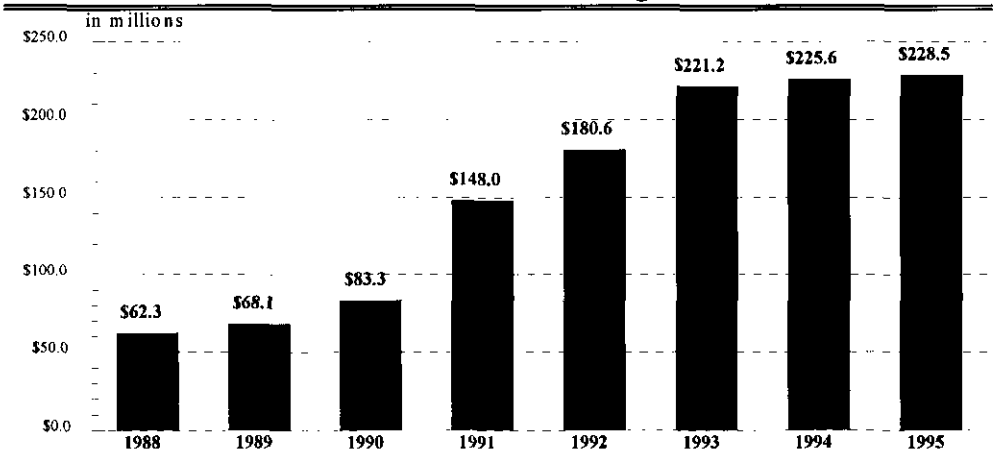
The cost of the physicians services program in Louisiana has grown significantly in recent years. A large amount of the cost of this program goes to physicians providing routine medical care such as office visits, hospital care, and emergency department care. In fiscal year 1995, Louisiana was reimbursing physicians for seven of this state's twenty most frequently billed services at rates above the Southern regional average. As a result, Louisiana spent $5 million more than what would have been spent if these services were reimbursed at the Southern regional average.

In addition, Louisiana's Medicaid state plan lacks provisions for regular review of the rates paid for these services. When rate changes are made, it is usually in response to federal mandates. Some states in the southern region review and/or adjust their rates either annually or biannually. In addition, two states that use methodologies similar to Louisiana's have lower reimbursement rates for certain physicians services.

Physicians Services Spending Has More Than Tripled in Eight Years

Louisiana has increased its annual spending on Medicaid physicians services from $62 million in fiscal year 1988 to almost $230 million for fiscal year 1995. Federal regulations mandate that each state provide physicians services to individuals enrolled in Medicaid. Among the services provided in Louisiana's physicians services program are office or outpatient visits, inpatient hospital care, emergency department services, nursing facility services, and custodial care. Exhibit 2-1 on the following page illustrates the growth in physicians services spending.

Exhibit 2-1
Physicians Services Expenditures
for Fiscal Years 1988 through 1995



Source: Prepared by legislative auditor's staff from data obtained from the Legislative Fiscal Office.

A Few Services Comprise Large Portion of Physicians Services Spending

Louisiana's 20 most frequently-billed physicians services together accounted for more than a third of all spending in this area during fiscal year 1995. These 20 services, which represent only a small fraction of the thousands of physicians services reimbursed by Medicaid, comprised more than $95 million, or 42 percent, of the $228.5 million spent for physicians services in fiscal year 1995.

We surveyed 14 other states to find out their reimbursement rates for these same 20 services. Appendix B shows the reimbursement rates for these 20 physicians services in Louisiana, the other 14 states, and the average rates for these 14 states.

Rates for One-Third of Louisiana's Most Used Services Above Southern Regional Average

In fiscal year 1995, Louisiana spent about $5 million more than most southern states on seven of its 20 most frequently billed physicians services. As illustrated in Exhibit 2-2 on the following page, rates for these seven services were above the Southern regional average. DHH spent nearly $54 million for

the seven services that were above the regional average in fiscal year 1995, or about 23 percent of the total amount paid for Medicaid physicians services.

Louisiana's rates are below the Southern regional average for the remaining 13 physicians services that we examined.

Exhibit 2-2
Comparison of Rates to Southern Regional Average for Seven of Louisiana's 20 Most Used Physicians Services

Service	Louisiana	Average
Routine finger stick	$ 3.00	$ 2.65
Outpatient visit - Established patient (May Not Require Physician's Presence)	14.00	9.24
Outpatient visit - Established patient (Straightforward)	23.00	18.91
Outpatient visit - Established patient (Low Complexity)	27.00	25.94
Subsequent Hospital Care (Low Complexity)	25.00	22.75
Subsequent Hospital Care (Moderate Complexity)	32.00	31.24
Subsequent Hospital Care (High Complexity)	50.00	42.60

Source: Prepared by legislative auditor's staff using data obtained from the Department of Health and Hospitals and calculations using survey data.

Based on the number of services provided in fiscal year 1995, the department saved nearly $10 million by reimbursing below the regional average for the remaining 13 services.

Physicians Rates Not Reviewed Regularly

While Louisiana's Medicaid state plan establishes how reimbursement rates are to be set and adjusted, it does not provide for regular review and adjustment of rates. Regularly reviewing rates could help to identify rates that may be too high and need to be reduced; rates that are too low and need to be increased; or rates that should be maintained at current levels. According to the Medicaid state plan, DHH makes rate changes when "found to be necessary," but it does not explain how the need to adjust rates is to be determined. Five southern states that we surveyed report that they adjust their physicians services rates annually or biannually. According to DHH's physicians services program manager, DHH does not have the staff to review physicians service codes and, as needed, adjust their reimbursement rates.

In 1987, DHH instituted a major change in the way it reimburses physicians service providers. Before 1987, DHH reimbursed physicians for Medicaid services at their usual and customary charge (their charge to the general public). On February 1, 1987, DHH implemented a statewide maximum fee-for-service methodology. According to department officials, DHH reduced all rates by 6 percent at the same time and then paid physicians the lesser of billed charges or the maximum fee.

For physicians services reimbursed at that time, DHH initially determined its maximum reimbursements by examining the rates paid by Medicare. DHH set rates for newly payable services at 70 percent of the Medicare statewide prevailing fees. Some services, such as services to children, did not have rates set by Medicare. DHH set the rates for these services based on a review of statewide billed charges for the service in comparison with rates already established for similar services. If there were no similar services, DHH set rates based on review and recommendations of reasonable charges by consultant physicians.

Presently, DHH sets reimbursement rates for new services based on:

- an analysis of the rates paid by Medicare;
- contacts DHH has made with neighboring states and with health insurance companies; and
- billings DHH has received from physicians for these services (usual and customary charge to the public).

Rates Set by Usual and Customary Charges May Increase Spending

By using usual and customary charges to adjust rates, DHH could increase the cost of the physicians services program. The Medicaid state plan advises providers to bill their usual and customary charges so that DHH can use these fees to establish prevailing fees in Louisiana.

For fiscal years 1992 through 1995, we compared the average physician services billings to the established maximum rate for the 20 most frequently billed services. Exhibit 2-3 below shows that the average amount physicians bill the Medicaid program has grown to more than twice the maximum fee for some services. If these billings are used to set future reimbursement rates, the cost per service in the physicians program could grow considerably.

Exhibit 2-3
Maximum Fee Compared to Average Amount Physicians Billed

	Maximum Fee	Average Amount Billed Per Service by Fiscal Year			
Service		**1992**	**1993**	**1994**	**1995**
Follow-Up Prenatal Visit	**$27.00**	$32.97	$34.04	$34.61	$34.55
Routine Finger Stick	**3.00**	6.11	6.11	5.92	5.36
Office Visit - New Patient (20 minutes)	**30.00**	40.42	42.21	43.11	44.21
Office Visit - New Patient (30 minutes)	**36.00**	48.53	51.88	54.28	57.74
Office Visit - New Patient (60 minutes)	**50.00**	60.00	67.21	70.20	77.29
Office Visit - Established Patient (5 minutes)	**14.00**	18.46	19.56	19.16	19.80
Office Visit - Established Patient (10 minutes)	**23.00**	27.59	28.39	29.83	31.15
Office Visit - Established Patient (15 minutes)	**27.00**	34.50	34.84	35.97	37.74
Office Visit - Established Patient (25 minutes)	**32.00**	41.38	44.43	45.99	48.68
Office Visit - Established Patient (40 minutes)	**45.00**	56.76	60.49	66.57	69.72
Initial Hospital Care (50 minutes)	**46.00**	105.32	116.43	122.78	131.62
Initial Hospital Care (70 minutes)	**60.00**	126.56	134.70	144.99	156.39
Subsequent Hospital Care (15 minutes)	**25.00**	51.51	54.06	52.76	53.90
Subsequent Hospital Care (25 minutes)	**32.00**	56.87	66.39	67.96	70.98
Subsequent Hospital Care (35 minutes)	**50.00**	79.25	102.47	98.90	97.12
Hospital Discharge Day Management	**32.00**	66.74	71.06	74.79	81.42
Emergency Department Visit (Low to Moderate Severity)	**22.00**	55.27	57.92	62.41	64.40
Emergency Department Visit (Moderate Severity)	**29.00**	78.07	84.31	85.86	91.69
Emergency Department Visit (High severity)	**43.00**	113.20	113.90	111.74	122.54
Subsequent Nursing Facility Care (15 minutes)	**18.00**	29.96	32.18	32.76	33.87

Source: Prepared by legislative auditor's staff using data provided by the Department of Health and Hospitals' Physicians Services Program staff.

Changes in Physicians Rates Usually in Response to Federal Actions

Physicians reimbursement rate adjustments in Louisiana are not always the result of DHH initiatives. According to DHH officials, spending increases in the physicians services program were primarily in response to federal initiatives. The federal Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandated expanded services for children and pregnant women. To be in compliance with that law and to assure access to care, Louisiana increased its reimbursement rates for physicians' evaluation and management services to attract sufficient providers. DHH increased rates for 17 of Louisiana's 20 most-billed physicians services in March through July of 1990. These increases ranged from 23.9 percent to nearly triple the 1987 rate.

According to DHH's physicians program manager, OBRA '89 mandated expanded services to pregnant women and children. However, rates were increased for evaluation and management services that can be provided to any Medicaid recipient. For example, the procedure for hospital care subsequent to the day of admission was previously paid at $24.08 per day. However, in July 1990, this amount was increased to $50.00. Physicians received the higher fee for serving anyone, not just for services to pregnant women and children.

According to physicians program officials, because providers were dropping out of the Medicaid program, the department decided not to restrict rate increases to only physicians who provide services to women and children. Thus, most providers benefited from the rate increase. Furthermore, no rate increases for these services had been given in three years.

Conversely, losses of federal funding in the Medicaid program required substantial reductions in Louisiana's Medicaid spending. DHH issued an emergency rule in July 1995 that reduced the reimbursement for surgery, medicine, and physicians' evaluation and management services by 10 percent. According to DHH's physicians program manager, some of these services had not been adjusted since before 1987. Rates for radiology, pathology, and laboratory services were reduced by 15 percent. DHH estimated that these changes would save nearly $22 million in fiscal year 1996.

Assuming fiscal year 1995 services level, we estimate that the 10 percent rate reduction could save approximately $9.6 million in fiscal year 1996 for the 20 most frequently billed services. However, even with this rate reduction, rates for four of the physicians services are still above the regional average. If DHH reduced the rates for these four services to the regional average, an additional $1.5 million could be saved.

States With Similar Methodology But Lower Rates

Louisiana's reimbursement rates sometimes exceed those of states with similar reimbursement methodologies. While several states we surveyed establish their Medicaid reimbursement rates in a manner similar to Louisiana, two of these states, Maryland and Oklahoma, did not pay as much for certain services.

Like Louisiana, the states of Arkansas, Maryland, Virginia, and West Virginia have a maximum fee schedule. These states and Louisiana reimburse for physicians services according to this fee schedule or the provider's usual and customary charge, whichever is less. However, Maryland paid less for 13 of the 20 physicians services most frequently billed in Louisiana. Of these 13, nine were for hospital related charges. Exhibit 2-4 on the following page shows that in some cases Louisiana's rates were as much as two and one-half times more than Maryland's.

Similar to Louisiana, Oklahoma sets its Medicaid reimbursement rates in part on the basis of a percentage of what Medicare will pay. Even with a similar methodology, Oklahoma paid less for 12 of the 20 physicians services most frequently billed in Louisiana. The differences between Oklahoma's and Louisiana's rates for these services are illustrated in Exhibit 2-5 on page 17.

Exhibit 2-4
Comparison of Louisiana's and Maryland's Rates for Louisiana's 20 Most Frequently Used Physicians Services

Service	Louisiana	Maryland	Difference
Follow-Up Prenatal Visit	$27.00	N/A	N/A
Routine Finger Stick	3.00	$1.50	$1.50
Office Visit - New Patient (20 minutes)	30.00	33.00	-3.00
Office Visit - New Patient (30 minutes)	36.00	37.00	-1.00
Office Visit - New Patient (60 minutes)	50.00	50.00	0.00
Office Visit - Established Patient (5 minutes)	14.00	10.00	4.00
Office Visit - Established Patient (10 minutes)	23.00	20.00	3.00
Office Visit - Established Patient (15 minutes)	27.00	31.00	-4.00
Office Visit - Established Patient (25 minutes)	32.00	38.00	-6.00
Office Visit - Established Patient (40 minutes)	45.00	45.00	0.00
Initial Hospital Care (50 minutes)	46.00	24.50	21.50
Initial Hospital Care (70 minutes)	60.00	25.00	35.00
Subsequent Hospital Care (15 minutes)	25.00	14.50	10.50
Subsequent Hospital Care (25 minutes)	32.00	16.00	16.00
Subsequent Hospital Care (35 minutes)	50.00	20.00	30.00
Hospital Discharge Day Management	32.00	20.00	12.00
Emergency Department Visit (Low to Moderate Complexity)	22.00	14.50	7.50
Emergency Department Visit (Moderate Complexity)	29.00	18.50	10.50
Emergency Department Visit (High Complexity)	43.00	22.50	20.50
Subsequent Nursing Facility Care (15 minutes)	18.00	10.50	7.50

Source: Prepared by legislative auditor's staff using data obtained by survey and from Department of Health and Hospitals.

Exhibit 2-5
Comparison of Louisiana's and Oklahoma's Rates for Louisiana's 20 Most Frequently Used Physicians Services

Service	Louisiana	Oklahoma	Difference
Follow-Up Prenatal Visit	$27.00	$ 25.00	$2.00
Routine Finger Stick	3.00	2.85	0.15
Office Visit - New Patient (20 minutes)	30.00	28.33	1.67
Office Visit - New Patient (30 minutes)	36.00	34.97	1.03
Office Visit - New Patient (60 minutes)	50.00	64.19	-14.19
Office Visit - Established Patient (5 minutes)	14.00	9.21	4.79
Office Visit - Established Patient (10 minutes)	23.00	14.46	8.54
Office Visit - Established Patient (15 minutes)	27.00	20.91	6.09
Office Visit - Established Patient (25 minutes)	32.00	30.70	1.30
Office Visit - Established Patient (40 minutes)	45.00	50.89	-4.11
Initial Hospital Care (50 minutes)	46.00	56.36	-10.36
Initial Hospital Care (70 minutes)	60.00	69.22	-9.22
Subsequent Hospital Care (15 minutes)	25.00	21.90	3.10
Subsequent Hospital Care (25 minutes)	32.00	27.09	4.91
Subsequent Hospital Visit (35 minutes)	50.00	29.78	20.22
Hospital Discharge Day Management	32.00	26.09	5.91
Emergency Department Visit (Low to Moderate Complexity)	22.00	24.15	-2.15
Emergency Department Visit (Moderate Complexity)	29.00	32.43	-3.43
Emergency Department Visit (High Complexity)	43.00	56.93	-13.93
Subsequent Nursing Facility Care (15 minutes)	18.00	18.29	-0.29

Source: Prepared by legislative auditor's staff using data obtained by survey and from Department of Health and Hospitals.

Recommendation

The legislature and DHH may wish to consider reviewing the rates paid for physicians services and setting these rates at the lowest possible level that will maintain adequate access to Medicaid services.

Chapter Three: Pharmacy Program

Chapter Conclusions

Louisiana's pharmacy program spending has been climbing steadily for several years. For fiscal year 1995, Louisiana's average dispensing fee per prescription was 15 to 18 cents above the Southern regional average. If DHH reduced the average dispensing fee to the Southern regional average, from $1.7 million to $2.0 million in savings could be obtained. DHH suspended the dispensing fee increase scheduled for fiscal year 1996, which will save an estimated $3.2 million.

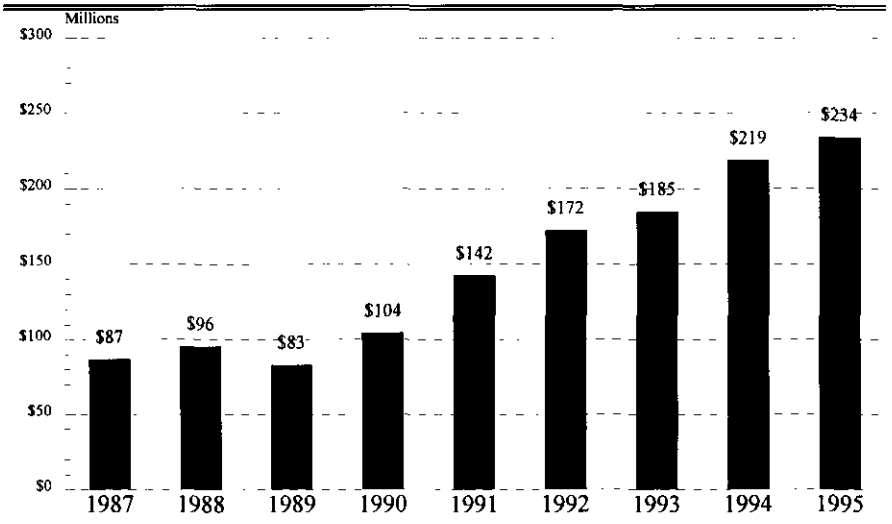
Most southern states have instituted methods of lowering the costs of their pharmacy programs such as reducing the dispensing fee or limiting the number of times the dispensing fee is paid. In an attempt to lower the cost of Louisiana's pharmacy program, DHH imposed co-payments on certain Medicaid recipients for most prescription drugs. These co-payments are expected to save $7 million in fiscal year 1996.

Pharmacy Expenditures Increase *Significantly* Every Year

In fiscal year 1995, Louisiana's Medicaid pharmacy program paid over $234 million for more than 11 million prescriptions. The Medicaid pharmacy program reimburses participating pharmacies for prescription drugs dispensed to Medicaid patients. In fiscal year 1995, there were a total of 1,223 providers participating in the program including independent pharmacies, chain stores, and physicians dispensing drugs out of their offices. Except for a decline in fiscal year 1989, this program's expenditures have grown an average of 13.2 percent annually since fiscal year 1987. Program spending for the last nine fiscal years is shown in Exhibit 3-1 on page 20.

Federal laws mandate pharmaceutical coverage for children and the institutionalized elderly who are classified as categorically needy. Coverage of other categories of eligibles is optional. According to DHH's pharmacy program manager, Louisiana presently enrolls all of its Medicaid eligibles in the pharmacy program except for Qualified Medicare Beneficiaries, who are a group of individuals qualifying for both Medicaid and Medicare. This group constitutes 2.4 percent of total Medicaid eligibles.

Exhibit 3-1
Medicaid Pharmacy Expenditures in Louisiana
for Fiscal Years 1987-1995



Source: Prepared by legislative auditor's staff from information provided by the Legislative Fiscal Office.

Closed Formulary Once Saved Millions

In previous years, Louisiana excluded certain drugs from its pharmacy program and achieved significant savings. A Medicaid drug formulary is a list of drugs that will be reimbursed under the program. An "open" formulary permits Medicaid recipients to receive any medication a physician prescribes, whereas a closed formulary limits the prescription drugs for which Medicaid will pay.

In 1988, Louisiana implemented a closed formulary for almost a year. Pharmacy program expenditures dropped approximately 13 percent and the number of recipients grew about 3.5 percent for that year. This translated into approximately a 16 percent savings per recipient. According to a DHH official, the closed formulary was difficult to manage because of requests for drugs not contained in the formulary, and it also increased costs in other Medicaid programs through increased physician and hospital visits.

In 1989, LSA-R.S. 46:153.3 was amended and reenacted to prohibit a closed formulary. The following year, the federal *Omnibus Budget Reconciliation Act of 1990 established the* Medicaid outpatient prescription drug rebate program. This program was to reduce the cost of prescription drugs by requiring drug manufacturers to pay a rebate directly to the state Medicaid programs. The legislation also stipulated that if a drug manufacturer participates in the rebate program, all of its Food and Drug Administration-approved drugs must be reimbursable under Medicaid. Since Louisiana participates in the rebate program, its formulary is currently open to almost all drugs. As a result, the state received $57.3 million in rebates in fiscal year 1995.

Some see a closed formulary as a way to reduce the cost of Louisiana's $234 million Medicaid pharmacy program. This expenditure level includes the $57.3 million rebate program (i.e., actual spending excluding rebates is approximately $290 million). If the 16 percent savings per recipient achieved *in fiscal year 1989 were again realized, pharmacy costs could* decrease by approximately $46.4 million.

Pharmacy Payments Have Two Components

Under Louisiana's Medicaid state plan, for each prescription, DHH reimburses a pharmacy the lesser of:

- DHH's estimate of the cost of the drug (ingredient costs) plus a dispensing fee; or
- the pharmacy's usual and customary charge to the general public.

Ingredient Costs. DHH estimates the ingredient cost based on price information available from a national data service. For single source drugs (those produced by only one manufacturer), DHH uses the average wholesale price minus 10.5 percent as its estimate of the price the pharmacy paid for the drug. Wholesalers regularly offer drugs for less than the average wholesale price. The 10.5 percent discount is an estimate of the average size of wholesalers' discounts to pharmacies.

For multiple source drugs (those produced by more than one manufacturer and also called generics), DHH has three different methods for estimating the price the pharmacy paid for the drug. If more than one method is applicable to a drug, DHH uses the least expensive estimate.

1. **Federal Upper Limits method** is based on a list of wholesale drug prices from the federal government.
2. **Louisiana Maximum Allowable Cost method** is based on a list of wholesale drug prices developed by DHH.
3. **Estimated Acquisition Cost method,** like the single source drug method, uses average wholesale price minus 10.5 percent.

Dispensing Fee. DHH pays a dispensing fee on each prescription to cover the pharmacy's overhead costs. According to the state's Medicaid plan, the dispensing fee is determined using the results of a pharmacy cost survey. Every three years, Medicaid pharmacy providers complete surveys of allowable costs. The results of the survey are combined to develop values for cost components in the typical pharmacy and to set the maximum allowable dispensing fee. A cost survey was conducted in 1991 and another in 1994. Each year since 1991, the cost components have been adjusted based on appropriate price indexes and the dispensing fee has increased.

Presently, Louisiana's maximum dispensing fee is $5.77 per prescription. The actual dispensing fee amount paid could be less than the maximum if the ingredient costs plus the dispensing fee exceed the pharmacist's usual and customary charge.

The dispensing fee amounts have grown an average of 7.2 percent annually since fiscal year 1987. The fees for the last nine years are shown in Exhibit 3-2 on the following page.

Exhibit 3-2
History of Louisiana's
Dispensing Fee Amounts

Effective Date	Dispensing Fee
July 1, 1986	$3.30
August 1, 1987	3.51
July 1, 1989	4.00
April 1, 1990	4.41
September 1, 1990	4.68
October 1, 1991	5.00
July 1, 1992	5.30
July 1, 1993*	5.54
July 1, 1994*	5.77

* Fee includes 10 cents provider fee mandated under state law for every prescription filled by a pharmacy or dispensing physician.

Source: Prepared by legislative auditor's staff using data provided by Department of Health and Hospitals' pharmacy program manager.

Lowering Dispensing Fee Could Produce Savings

By reducing its average dispensing fee to the southern regional average, Louisiana could have saved approximately $1.7 million to $2.0 million in fiscal year 1995. To compare Louisiana's and other states' pharmacy reimbursements, it is necessary to consider both the ingredient costs and the dispensing fee because a state may have a relatively generous dispensing fee reimbursement but a less generous ingredient cost reimbursement or vice versa.

We surveyed 14 southern states and found that 10 states in our survey had comparable ingredient cost reimbursement methods for single source drugs. Comparable states are those that use average wholesale price minus 10 percent or more as an estimate of the price pharmacies pay for drugs like Louisiana. These states have an average dispensing fee of $4.74.

We computed the average dispensing fee by dividing the amount paid for the dispensing fee by the number of prescriptions paid. If the necessary data were not provided, we used the maximum dispensing fee. Exhibit 3-3 below illustrates these states and their average dispensing fees.

Exhibit 3-3
Average Dispensing Fees for States with Similar Single Source Drug Reimbursement Methodology

State	Average Dispensing Fee
Texas	$6.34
Arkansas	5.54
Maryland	5.07
Kentucky	5.00
Mississippi #	4.91
Georgia #	4.41
Oklahoma	4.22
Missouri #	4.09
South Carolina #	4.05
North Carolina	3.78
Average	**4.74**
Louisiana	**4.92**

= Maximum dispensing fee used.

Source: Prepared by legislative auditor's staff based on calculations performed using data taken from surveys of other states.

For multiple source drugs, states with comparable ingredient reimbursement methods to Louisiana have an average dispensing fee of $4.77. Comparable states are those with maximum allowable cost (MAC) programs. In our survey, eight states had MAC programs. Exhibit 3-4 on page 25 compares these states and their average dispensing fees.

Exhibit 3-4
Average Dispensing Fees for States with Similar Multiple Source Drug Reimbursement Methodology

State	Average Dispensing Fee
Texas	$6.34
Arkansas	5.54
Maryland	5.07
Georgia #	4.41
Virginia #	4.40
Oklahoma	4.22
Missouri #	4.09
South Carolina #	4.05
Average	**4.77**
Louisiana	**4.92**

= Maximum dispensing fee used.

Source: Prepared by legislative auditor's staff based on calculations performed using data taken from surveys of other states.

We computed Louisiana's average dispensing fee at $4.92 for fiscal year 1995. Based on this average along with the total number of prescriptions reimbursed in fiscal year 1995, Louisiana could have saved between $1.7 million and $2.0 million by actually reimbursing at either of the regional averages of the comparable states.

Most States Seeking to Lower Cost of Pharmacy Program

In our survey of southern states, we found that other states were using various methods to reduce the cost of their pharmacy programs. Appendix C contains more information on survey responses.

For example, Alabama, Kentucky, and South Carolina pay different dispensing fees to institutional pharmacies and to dispensing physicians. This could possibly be because costs of these organizations are generally different than free-standing pharmacies.

To encourage pharmacies to dispense at least a 30-day supply on maintenance drugs, North Carolina pays the dispensing fee only once a month for a given prescription. According to the National Pharmaceutical Council, Virginia also only pays the dispensing fee once per month.

Two states are attempting to base their reimbursements on "market prices." Texas and Georgia are currently trying to align their reimbursement rates with those of other third party reimbursement organizations within their respective states. These states have found that HMOs and insurance companies often reimburse considerably less for both ingredient costs and dispensing fees. Rather than base their reimbursement methodology on costs, these states are attempting to base their reimbursements on "market prices."

Two states have recently lowered their dispensing fees. Oklahoma reduced its fee from $5.10 to $4.15 on October 1, 1995, and Virginia reduced its fee from $4.40 to $4.25 on July 1, 1995. Texas informed us it plans to lower its maximum dispensing fee to $3.00 for urban areas and $4.00 for rural areas from a present average fee of $6.34.

In July 1995, DHH instituted an emergency rule suspending the annual inflation adjustment to the dispensing fee. According to DHH, this rule is expected to save approximately $3.2 million for fiscal year 1996.

Co-Payments Used in Most Southern States

DHH expects to save approximately $7 million in fiscal year 1996 through a co-payment, according to DHH's pharmacy program manager. In July 1995, DHH instituted an emergency rule imposing co-payments on certain Medicaid recipients for most prescription drugs. Co-payments are used in 11 of the 13 states in our survey. Louisiana's co-payment ranges from $0.50 to $3.00, depending on the price of the prescription. Federal regulations exempt certain Medicaid recipients from co-payments. These include individuals under 21 years of age, pregnant women, and inpatients in medical institutions. In addition, the co-payment does not apply to family planning services and supplies or emergency services.

The co-payment has encouraged recipients to lengthen the amount of time between prescription refills. So far, DHH officials say there has been a slight decline in the number of prescription claims filed.

In addition to co-payments, six of the states surveyed limit the number of prescriptions per recipient that can be filled. The limits range from a low of three per month to a high of six per month. There are some exceptions to the limits and some states require prior authorization to exceed the limits.

Chapter Four: Post-Payment Review

Chapter Conclusions

The Department of Health and Hospitals' claims processing section could pay claims for services never rendered without detection. The department relies on its post-payment review process to detect overpayments to providers due to errors or fraud.

The methodology used by the fiscal intermediary to detect and select provider overpayments reveals the very worst cases. For fiscal year 1995, DHH collected about $2.3 million in overpayments of the $4.2 billion paid to providers. While less than 2 percent of the providers were examined as possibly being overpaid, more than 60 percent of these received some type of penalty. According to DHH officials, limited staffing prevents them from investigating more of the providers who have been identified as possibly being over paid.

Since providers can remain in the Medicaid program after it has been determined that they have overbilled, some sanctions against the provider may not always curtail overbillings. In addition, a state law may prevent the state Attorney General's Medicaid Fraud Control Unit from investigating potential cases of Medicaid fraud and abuse fully and timely.

In addition to reviewing provider activity, reviews of recipient activity could be increased. This procedure may help find abuse of services or charges for services that were never received.

Payment of Erroneous or Fraudulent Claims Possible

DHH's claims verification process can fail to detect erroneous or fraudulent claims. This is due, in part, to insufficient controls to identify these types of claims before they are paid. Although the fiscal intermediary checks the validity of some information on providers claims, the section does not check other information that could more effectively identify claims that are for services not rendered before payment is made.

The Claims Processing Section within DHH's Bureau of Health Services Financing oversees claims processing by UNISYS, the state's Medicaid fiscal intermediary. During the screening phase, the fiscal intermediary performs preliminary checks ("edit checks") to ensure claims were properly completed.

Claims that have missing or invalid information are returned to the provider. Based on the extent of missing or invalid information, UNISYS can either send claims back to the provider for resubmittal or deny them. After processing, UNISYS denies, pends, or pays the claims. Appendix E illustrates the claims payment process.

Claims for Services Not Rendered Could Be Paid Without Detection

It is possible for providers to submit claims for services never rendered and for DHH to pay the claims without detection. Claims processing compares incoming claims to paid claims processed within the past two years to determine if the claim is a duplicate. If so, the claim will be denied before being paid.

According to the claims processing manager, although hundreds of edits exist to identify duplicate payments, providers can still be paid for erroneous or fraudulent claims. A claim could contain similar information and yet be different in one area, for instance with the date of service being different by two days. Such claims would get paid as long as the claim information is valid (i.e., recipient eligible at date of service or provider is certified to provide such a service). In addition, the only opportunity for detecting this type of error or fraud occurs after payment, during the post-payment review process.

Limited Controls Exist to Detect Overpayments Before They Occur

The fiscal intermediary maintains a large amount of claims information, and sufficient controls have not been implemented that will detect erroneous or fraudulent billings before they are paid. An overpayment, in this staff study, refers to amounts paid to providers that were not due to them because of errors or fraud. For fiscal year 1995, UNISYS processed more than 40 million claims submitted by over 17,000 providers and made payments on more than 34 million of the claims.

Louisiana allows Medicaid providers up to one year to submit claims for reimbursement. Thus, DHH must maintain two years of information on file, or up to 80 million claims, to check for duplicate billings. Similarly, federal regulations allow state's Medicaid providers no more than one year to submit claims for reimbursement from the date that services are rendered.

If the time allowed for submitting claims was reduced, for example to 90 days, DHH could reduce the volume of information maintained and redirect those resources to efforts aimed at detecting overpayments before they occur. According to an official with the Health Care Financing Administration, the state of Texas allows providers up to 95 days to submit claims. However, certain services that have special billing cycles are exempt from this time frame.

Overpayments Identified After Claim Is Paid

DHH conducts its primary efforts to detect fraud and abuse after payment has been made. Even so, these efforts only assure that the providers with the most fraudulent or abusive activity will be detected and examined. As a result, a small percentage of providers are investigated. However, of those investigated in fiscal year 1995, more than one half were sanctioned.

Through a post-payment review process, DHH is able to identify some instances of fraud and abuse. DHH sends paid claim information to the Surveillance and Utilization Review Subsystem (SURS) for further analysis. SURS is operated by employees of both DHH and UNISYS. Federal regulations require that all state Medicaid agencies have a post-payment review process. The regulations state that the program should:

- safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments;
- assess the quality of those services; and
- provide for the control of utilization of all services provided.

Recommendation

DHH should shorten the time frame allowed providers to submit claims to reduce the number of claims kept on file. Any resources made available should then be used to increase efforts to identify potential overpayments before they occur.

Only Worst Cases Investigated and Acted On

The methods used to segregate and to analyze paid claims do not ensure that overpayments will be identified. Although less than 2 percent of providers are selected for review for potential overpayments, most of those reviewed received some type of sanction. However, these sanctions are not always as effective as they could be.

Provider Groupings Not Specific Enough to Identify Overpayments

Because providers are grouped so broadly, overpayments may not always be identified. UNISYS established criteria for grouping of providers' paid claims called peer groups. For example, physicians are divided by area of specialty and some are further subdivided into urban or rural so that comparisons of claims can be made against group norms. However, some providers such as pharmacists are not subdivided at all. Peer groupings play an important role in defining criteria (called exception criteria or upper and lower exception limits) to detect potential overpayments. Exhibit 4-1 on page 33 shows how Medicaid pharmacists and physicians are grouped for analysis.

A 1990 Joint State Audit Project on Medicaid SURS programs in 11 other states found that peer groups should permit comparisons of claim information between provider types that share similar characteristics. Well-defined peer groupings will set narrower upper and lower exception limits, which, in turn, will detect more instances of divergent paid claims.

For example, although there are different types and sizes of pharmacies in the Medicaid program, all pharmacists are analyzed as one group. In addition, physicians are grouped by specialty and then into rural or urban. However, these classifications do not take into account the volume of Medicaid recipients served or the number of physicians in the practice.

Exhibit 4-1
Peer Groupings of Pharmacists and Physicians

Pharmacists - ALL	Internal Medicine - RURAL
General Practice - URBAN	OB-GYN - URBAN
General Practice - RURAL	OB-GYN - RURAL
Surgeons - URBAN	Radiologist - STATEWIDE
Surgeons - RURAL	Psychiatry - STATEWIDE
Eye, Ear, Nose, Throat - URBAN	Pathologists - STATEWIDE
Eye, Ear, Nose, Throat - RURAL	Multi-Special Practice - URBAN
Pediatric Specialist - URBAN	Multi-Special Practice - RURAL
Pediatric Specialist - RURAL	Radiation Centers - ALL
Anesthesiology - STATEWIDE	Out of State Physicians - ALL
Internal Medicine - URBAN	

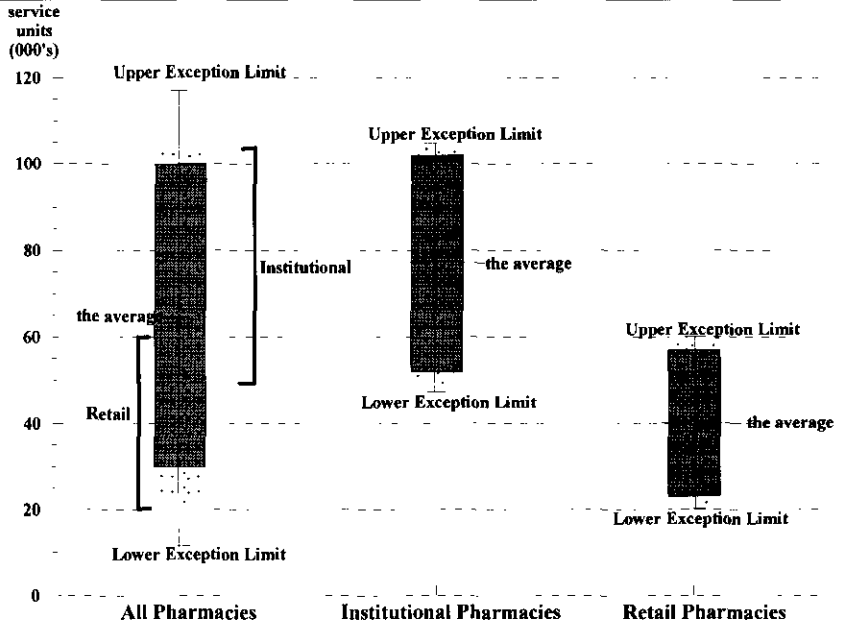
Source: Prepared by legislative auditor's staff from information provided by Department of Health and Hospitals' Program Integrity section.

Exhibit 4-2 on page 34 shows an example of how peer groupings affect the probability of detecting an overpayment. This exhibit depicts an example analysis done for the average number of claims billed for retail and institutional pharmacies. Institutional pharmacies are those that serve nursing homes. The column on the left shows what can occur when both types of pharmacies are grouped together. In this example, retail pharmacies might submit between 20,000 and 60,000 claims and institutional pharmacies might submit between 50,000 and 100,000 claims in the period being reviewed.

In this analysis, retail pharmacies could submit claims for prescriptions not filled and escape detection by "flying" under the upper limit set by institutional pharmacies. By segregating these two pharmacies types into retail and institutional groupings, the upper and lower limits become better defined as shown in the middle and right columns.

According to DHH officials, pharmacists are subject to audit at least once every three years. Many of the cases selected to be reviewed by SURS are a result of these audits. Furthermore, DHH is considering segregating pharmacies based on volume.

Exhibit 4-2
Illustration of How Peer Groupings
Could Affect Detection of Potential Overpayments



Source: Prepared by legislative auditor's staff based on assumptions developed to illustrate deficiencies in peer groupings.

Ineffective Method Used to Analyze Claims Data

The statistical methods used to examine claims data will only identify the worst cases of fraud or abuse. SURS analyzes claims within peer groups against each other to find the average, which sets the upper and lower limits to detect the most divergent paid claims. The end result of this statistical process is known as the standard deviation.

In addition, SURS analyzes more than 300 variables of each provider's paid claims information. Each provider having one or more exceptional items is reported by the computer system with the exceptions ranked by a weighting system on a report referred to as an exception report. Only providers that submit claims with characteristics such as a high number of units of service that deviate from the group average, or norm, would be detected. For example, under the current system, if many providers within a peer group submit claims for services not rendered that are an average of 10 percent above the norm, none of the overbillings will be detected.

A 1990 Joint State Audit Project on Medicaid SURS in other states found that supplementing the standard deviation method with numerical limits in generating exception criteria may be more practical. Furthermore, that audit suggests that medical professionals, or other sources, could be used to determine the numerical limits. Using numerical limits would decrease the chances of inflated claims escaping detection and would also decrease the workload of the computer system used to generate exception reports. These resources could be reallocated to implement measures that would allow for additional analyses before payment is made. UNISYS currently has the capability to use numerical limits.

Limited Resources Affect Number of Providers Reviewed

Of the more than 17,000 providers participating in Louisiana's Medicaid program, the SURS unit reviewed 236 providers, or about 1.4 percent, that were possibly being overpaid. More of these cases were detected as a result of complaints (139) than through the post-payment review process (97). According to SURS officials, over 960 cases were identified for potential review by the post-payment review process during one quarter in 1995, but, due to limited resources, not all could be investigated.

However, of the 236 cases opened, 144, or over 60 percent, of the providers involved suffered some sort of sanction. Furthermore of the 144 sanctions issued, over 93, or 65 percent, received such serious sanctions as suspension from the Medicaid program, referral to the attorney general, and recoupment of funds. DHH recovered approximately $2.3 million, which represents one half of one-tenth of one percent of the $4.2 billion Medicaid program. Exhibit 4-3 below shows SURS Provider Case Activity for fiscal year 1995.

Exhibit 4-3
Surveillance Utilization Review
Provider Case Activity
for Fiscal Year 1995

Total Provider Cases Opened	236
Total Provider Cases Closed	235
Exception Cases Opened	97
Exception Cases Closed	88
Complaint Cases Opened	139
Complaint Cases Closed	147
Total Dollars Recovered	$2,253,436
Suspensions	12
Recoupments	66
Attorney General Referrals	15
Other (Education, Pre-Pay Review, etc.)	51
Total Sanctions Issued	**144**

Source: Prepared by legislative auditor's staff from information received from the Department of Health and Hospitals' SURS staff.

According to SURS officials, information on the amount of overpayments identified was not available. Consequently, we could not evaluate the effectiveness of SURS in recovering overpayments. Furthermore, they said that Louisiana's post-payment review system is approved by HCFA. However, HCFA officials informed us that SURS must only examine a certain number of cases yearly. HCFA used to do in-depth reviews of SURS to ensure that the system was adequate to detect potential overpayments, but in-depth reviews have not been done since DHH contracted with UNISYS in 1986 to conduct SURS-related activities.

Exhibit 4-4 below represents data compiled by DHH's SURS Unit. These data were compiled by them from surveys that they conducted of SURS units in other states. As illustrated in this exhibit, for fiscal year 1995, Louisiana has a comparable number of staff, and cases reviewed. However, differences exist between the number of providers enrolled in each state's Medicaid program and dollars recovered.

Exhibit 4-4
Comparison of Louisiana's Surveillance Utilization Activity to Other States for Fiscal Year 1995

State	Staff Size	Number of Provider Cases Reviewed	Enrolled Providers (Approximate)	Dollars Recovered (Approximate)
Georgia	13[a]	400	41,000	$2 million
Kentucky	12	240	12,000	$1 million
Louisiana	**16**[b]	**236**	**34,000**	**$2.3 million**
Oklahoma	8	300	6,000	$1.5 million
South Carolina	20	201	8,000	$0.5 million

[a] Georgia contracts this function out.
[b] Louisiana employs six staff members and the remaining ten are UNISYS employees.

Source: Prepared by legislative auditor's staff using information obtained from Department of Health and Hospitals' Program Integrity section. These data have not been audited.

Some Sanctions Could Allow Continued Abuse

If a provider's billings cannot be justified after an investigation, action must be taken to correct the situation. However, some of these actions either do not ensure that more overpayments will not occur or lack emphasis on enforcement.

SURS uses education and persuasion for voluntary compliance as a first course of action. If such measures fail to produce results, SURS may apply a variety of administrative and legal sanctions, depending upon specific circumstances.

Administrative Sanctions Used When Provider Has Been Overpaid

1. Require education in program policies and billing procedures;
2. Require prior authorization of service;
3. Place claims on manual review before payment is made;
4. Give warning through written notice or consultation;
5. Suspend or withhold payments;
6. Recover moneys improperly or erroneously paid by either arranging credits against future billings or by requiring direct payment;
7. Refer to the appropriate state licensing authority for investigation;
8. Refer for review by appropriate professional authority;
9. Refer to the Attorney General's Medicaid Fraud Control Unit for fraud investigation;
10. Suspend participation in Medicaid of Louisiana; and/or
11. Refuse to allow participation in Medicaid of Louisiana.

Source: Prepared by legislative auditor's staff from list of sanctions provided by Department of Health and Hospitals' staff.

Eleven different administrative sanctions can be taken against a provider which has been overpaid Medicaid funds. One sanction that may not achieve the desired results allows overpaid providers to remain in the Medicaid program and have future billings credited to recoup overpayments. However, DHH does not monitor all billings to ensure that they are correct. Consequently, providers could submit more claims for services never rendered to make up for the amounts being credited and escape detection. When informed of this, SURS officials replied that such overbillings would be detected in the next quarterly post-payment review process. However, given the weaknesses of the process to detect provider overbillings initially, again only the most severe cases would be detected.

Another sanction contains requirements that may impede necessary criminal investigations. Referral to the state Attorney General's Medicaid Fraud Control Unit for investigation is one of the most severe actions DHH takes against providers who have been overpaid because of fraud or abuse. However, according to SURS officials, no formal written criteria exist for determining when a provider warrants a referral to the fraud control unit. The decision is based upon the personal judgment of SURS officials.

In addition, a state law may not allow cases to be referred as quickly as possible. LSA-R.S. 46:442(C) requires that if the preliminary investigation indicates fraud, then DHH must conduct a personal interview with the suspected provider before making a referral to the fraud control unit. At this interview, the provider can present documentation in support of his or her position. In a letter dated June 23, 1986, to the President of the Louisiana Senate and its members, the attorney general expressed concern that these interviews forewarn providers suspected of fraud that they are under review and compromises the investigation of them.

Federal regulations require that when SURS suspects fraud, it must conduct a preliminary investigation. However, the federal regulations do not define the term "preliminary investigation." Moreover, federal officials have opined that the personal interview may damage investigations in the following ways:

- give the suspect provider an opportunity to conceal certain actions.
- obscure evidence or manipulate witness attitudes and willingness to cooperate.
- allow suspect provider to flee before charges are filed and bail set.

Recommendations

1. **DHH should develop more specific provider grouping criteria to ensure better analysis of paid claims information.**
2. **Wherever possible, DHH should implement numerical limits based on medical standards to generate exception reports, to avoid weaknesses in the current statistical methodology.**
3. **All providers having moneys recouped for previous overpayments should have their subsequent billings monitored, to prevent providers from again overbilling Medicaid.**
4. **DHH should develop formal criteria for determining when a case warrants a referral to the Attorney General's Medicaid Fraud Control Unit for criminal prosecution.**

Matters for Legislative Consideration

1. **The legislature may wish to consider deleting the requirement for a personal interview contained in LSA-R.S. 46:442(C).**
2. **The legislature may wish to consider amending LSA-R.S. 46:442(C) so that referral to the Attorney General's Medicaid Fraud Control Unit is mandatory instead of discretionary.**

More Recipient Reviews Could Identify Abuses

Increased recipient reviews could allow SURS to detect instances of abuse by checking for excessive use of medical services or medically unnecessary services. For example, providers could share recipient identification numbers and submit claims for services never rendered.

The 1990 Joint State Audit Project on SURS in other states recommended increased recipient reviews as a means to detect fraud and abuse. During fiscal year 1995, SURS sent requests for information to over 51,000 of the approximately 800,000 Medicaid recipients of which only 792 were returned (less than 2 percent). If recipient claims data were more closely reviewed, SURS could detect overutilization or misutilization of services. Exhibit 4-5 below shows SURS recipient case activity for fiscal year 1995.

Exhibit 4-5
Surveillance Utilization Review Recipient
Case Activity for Fiscal Year 1995

Cases Opened	339
Exception Cases Opened	224
Complaint Cases Opened	115
Cases Closed	383
Sanctions*	186

* Referral to Louisiana Drug Utilization Review for Lock-In Consideration or Education Letter.

Source: Prepared by legislative auditor's staff from information provided by UNISYS.

For example, recipients who are found to have abused Medicaid pharmacy services can be referred to DHH's Lock-In program for prescription drugs. Recipients who are "locked-in" are assigned to one pharmacy and are monitored to ensure that they do not further abuse prescription drug services.

Recommendation

DHH should review its Surveillance Utilization Review Subsystem in its entirety. As part of this review, the department should increase recipient reviews to improve the chances of detecting potential overpayments to providers or abuse by recipients.

Appendix A

Physicians Services
Survey Questionnaire

STATE OF LOUISIANA
OFFICE OF LEGISLATIVE AUDITOR
MEDICAID PHYSICIAN SERVICES SURVEY

Name of Person Completing Questionnaire _____ State: _____
Title: _____ Phone: _____
Date: _____

The following questionnaire is designed to obtain information on the physician services component of your state's Medicaid program. We appreciate the assistance you will provide us by responding to these questions.

1. What formula or methodology does your state use for setting reimbursement rates for physician services to Medicaid recipients? (If possible, please send a copy of the part of your state's *Medicaid plan which sets forth the reimbursement methodology for physician services.*)

_____
_____
_____
_____

How often are these rates adjusted? Annually ____ Biannually ____ As Needed ____

Other _____ (Please describe) _____

_____

2. Listed below are twenty (20) of the most frequently used Medicaid physician services in Louisiana and their CPT codes. Please give the rate your state presently reimburses for the same service. In the final column on the right, indicate if this service is frequently used in your state--"Yes" if the service is frequently used or "No" if not frequently used.

OV=Office or Other Outpatient Visit

CPT Code	Service	Rate Paid	Frequently Used?
Z9005	*Follow-Up Prenatal Visit*		
36415	Routine Venipuncture or Finger Stick For Collection of Specimen		
99202	OV: New Patient-Straightforward Decision Making		
99203	OV: New Patient-Low Complexity Decision Making		
99205	OV: New Patient-High Complexity Decision Making		
99211	OV: Established Patient-May Not Require Doctor's Presence		
99212	OV: Established Patient-Straightforward Decision Making		
99213	OV: Established Patient-Low Complexity Medical Decision Making		

CPT Code	Service	Rate Paid	Frequently Used?
99214	OV: Established Patient-Moderate Complexity Decision Making		
99215	OV: Established Patient-High Complexity Decision Making		
99222	Initial Hospital Care-Moderate Complexity Decision Making		
99223	Initial Hospital Care-High Complexity Decision Making		
99231	Subsequent Hospital Care-Low Complexity Decision Making		
99232	Subsequent Hospital Care- Moderate Complexity Decision		
99233	Subsequent Hospital Care-High Complexity Decision Making		
99238	Hospital Discharge Day Management		
99282	Emergency Department Visit-Low Complexity Decision Making		
99283	Emergency Department Visit-Moderate Complexity Decision		
99284	Emergency Department Visit-Moderate Complexity Decision		
99311	Subsequent Nursing Facility Care-Low Complexity Decision Making		

Return Survey to: Office of the Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana, 70804-9397
Attention: Donald Austern
Telephone: (504) 339-3940; Fax: (504) 339-3988

Appendix B

Medicaid Physicians Reimbursement Rates

Appendix B: Medicaid Physicians Reimbursement Rates

State	Follow-Up Prenatal Visit	Routine Finger Stick To Collect Specimen	Outpatient Visit - New Patient - Straight-forward Decision-Making	Outpatient Visit - New Patient-Low Complexity	Outpatient Visit - New Patient- High Complexity	Outpatient Visit - Established Patient (May not require physician's presence)	Outpatient Visit - Established Patient-Straight-forward
Alabama	$ 42.18	$ 2.00	$ 37.00	$ 50.00	$ 95.00	$ 12.00	$ 21.00
Arkansas	26.00	-	41.00	59.00	125.00	13.00	25.00
Florida	50.00		31.77	43.39	81.35	12.00	21.00
Georgia	N/A	-	45.34	61.08	113.99	13.82	24.75
Kentucky	N/A	7.64	32.77	44.90	84.12	9.81	17.55
Louisiana	**27.00**	**3.00**	**30.00**	**36.00**	**50.00**	**14.00**	**23.00**
Maryland	N/A	1.50	33.00	37.00	50.00	10.00	20.00
Mississippi	20.16	5.16	24.50	31.33	63.77	9.49	15.39
Missouri	N/A	-	15.00	20.00	27.00	5.00	10.00
North Carolina	N/A	3.67	36.97	50.70	94.39	11.04	19.95
Oklahoma	25.00	2.85	28.33	34.97	64.19	9.21	14.46
South Carolina	25.00	3.00	30.00	30.00	50.00	5.50	21.50
Texas	22.80	*	35.20	47.57	86.53	11.56	19.35
Virginia	N/A	3.00	28.66	34.50	55.38	6.98	16.52
West Virginia	51.28	3.00	33.98	46.59	87.26	-	18.28
Average	**32.80**	**2.65**	**32.39**	**42.22**	**77.00**	**9.24**	**18.91**

* This service is grouped, or bundled, with other services for payment purposes.

N/A - These states reimburse for the service using a methodology that prevents their comparison to the other states.

Note: Louisiana's rates are not included in computation of the averages.

State	Outpatient Visit-Established Patient - Low Complexity	Outpatient Visit-Established Patient - Moderate Complexity	Outpatient Visit-Established Patient-High Complexity	Initial Hospital Care - Moderate Complexity	Initial Hospital Care - High Complexity	Subsequent Hospital Care - Low Complexity	Subsequent Hospital Care - Moderate Complexity
Alabama	$ 30.00	$ 44.00	$ 71.00	$ 47.80	$ 49.50	$ 20.25	$ 24.39
Arkansas	33.00	64.00	106.00	84.00	129.00	33.00	46.00
Florida	25.00	37.45	59.14	63.03	80.48	19.41	29.01
Georgia	34.82	51.22	84.92	102.63	130.59	31.85	47.38
Kentucky	25.03	38.71	61.16	77.41	98.57	24.00	35.61
Louisiana	**27.00**	**32.00**	**45.00**	**46.00**	**60.00**	**25.00**	**32.00**
Maryland	31.00	38.00	45.00	24.50	25.00	14.50	16.00
Mississippi	20.16	28.93	58.64	60.59	68.20	23.82	28.74
Missouri	17.00	20.00	25.00	25.00	28.00	12.00	15.00
North Carolina	28.12	43.79	68.58	86.22	110.91	27.52	40.67
Oklahoma	20.91	30.70	50.89	56.36	69.22	21.90	27.09
South Carolina	21.50	35.00	35.00	38.00	50.00	11.40	16.15
Texas	26.87	40.85	62.88	81.43	102.92	27.14	38.97
Virginia	23.81	32.86	46.94	75.20	87.83	26.70	35.34
West Virginia	26.00	40.15	63.58	80.31	102.45	24.97	37.07
Average	**25.94**	**38.98**	**59.91**	**64.46**	**80.91**	**22.75**	**31.24**

State	Subsequent Hospital Care - High Complexity	Hospital Discharge Day Management	Emergency Department Visit - Low Complexity	Emergency Department Visit - Moderate Complexity	Emergency Department Visit - Detailed Examination - Moderate Complexity	Subsequent Nursing Facility Care - Low Complexity
Alabama	$ 34.65	$ 25.30	$ 17.92	$ 21.81	$ 26.69	$ 26.00
Arkansas	62.00	34.00	35.00	49.00	65.00	26.00
Florida	40.35	34.24	19.50	34.02	52.13	19.41
Georgia	64.89	50.15	32.27	55.10	82.27	31.89
Kentucky	49.55	42.06	22.97	41.80	63.74	23.74
Louisiana	**50.00**	**32.00**	**22.00**	**29.00**	**43.00**	**18.00**
Maryland	20.00	20.00	14.50	18.50	22.50	10.50
Mississippi	41.75	30.56	22.28	34.95	48.33	18.82
Missouri	16.50	12.00	15.00	15.00	15.00	10.00
North Carolina	55.75	46.15	26.06	47.31	71.76	26.13
Oklahoma	29.78	26.09	24.15	32.43	56.93	18.29
South Carolina	26.60	24.70	29.45	29.45	39.90	11.40
Texas	52.40	46.76	35.20	47.57	69.60	23.92
Virginia	50.67	37.23	26.41	38.61	51.07	22.06
West Virginia	51.48	43.76	23.94	43.50	66.15	24.71
Average	**42.60**	**33.79**	**24.62**	**36.36**	**52.22**	**20.92**

Appendix C

Summary of Responses
to
Pharmacy Program Survey

Appendix C: Pharmacy Survey Responses

We sent surveys to 14 states to gather information on their Medicaid pharmacy programs. In this appendix, we summarize the responses received from 13 states.

1. How often are ingredient costs adjusted?

State	Annually	Bi-annually	As Needed	Other
Alabama			X	
Arkansas				No schedule
Georgia				Monthly if changed
Kentucky			X	
Maryland				Updated weekly
Mississippi			X	
Missouri			X	
North Carolina			X	
Oklahoma			X	
South Carolina				Monthly
Texas			X	
Virginia				Monthly
West Virginia				Weekly

2. What is the basis for ingredient cost adjustments?

State	Basis
Alabama	
Arkansas	HCFA approval and survey
Georgia	monthly updates from First Data Bank
Kentucky	cost fluctuations
Maryland	price increases
Mississippi	when AWP (Average Wholesale Price) changes
Missouri	First Data Bank and Federal Upper Limit updates from HCFA
North Carolina	when manufacturers change prices
Oklahoma	AWP (Average Wholesale Price) - 10.5%
South Carolina	product price increase
Texas	calls from providers; pricing information from drug companies
Virginia	updates from First Data Bank; revised MAC lists
West Virginia	First Data Bank updates

3. Dispensing Fee: What is the present amount? How often is it adjusted and what is the basis for the adjustment?

State	Dispensing Fee	Adjusted	Basis for Adjustment
Alabama	$5.40 retail $2.77 institutional	As Needed	
Arkansas	$4.51+.103 (AWP-10.5%); $20 cap	No Schedule	Survey and department finances
Georgia	$4.41	As Needed	Survey of pharmacies adjusted for inflation and availability of program funds
Kentucky	$4.75 out-patient $5.75 nursing facility		Statewide survey
Maryland	$4.66	As Needed	Surveys
Mississippi	$4.91	As Needed	
Missouri	$4.09	As Needed	Legislative budget appropriations
North Carolina	$5.60	As Needed	Cost-studies and CPI
Oklahoma	$4.15	As Needed	Average of states using AWP (Average Wholesale Price) - 10.5%
South Carolina	$4.05 ($2.55 + $1.50 copay where applicable)	Annually (reviewed)	Only if supported by review and legislative appropriation
Texas		As Needed	Cost reports
Virginia	$4.25	As Needed by General Assembly	Market place comparisons and fiscal constraints
West Virginia	$2.75		No adjustment since early 1980's

Note: Oklahoma reduced its rate from $5.10 to $4.15 effective October 1, 1995, and Virginia reduced its rate from $4.40 to $4.25 effective July 1, 1995.

4. For fiscal year 1995, what was the total amount expended on ingredient costs and dispensing fees?

State	Ingredient Costs	Dispensing Fee	Total Costs
Alabama (Fiscal Year 1994)	$125,321,610	$37,719,449	$163,041,059
Arkansas	74,380,362	19,916,211	94,296,573
Georgia			283,512,096
Kentucky	187,211,731	49,890,325	237,102,056
Maryland	116,363,000	22,962,000	139,325,000
Mississippi			165,204,840
Missouri			246,260,205
North Carolina	224,978,075	33,905,665	258,883,740
Oklahoma	83,051,656	14,656,175	97,707,831
South Carolina			137,097,674
Texas	430,300,000	147,800,000	578,100,000
Virginia			217,353,611
West Virginia	117,208,435	13,242,924	130,451,359

5. Type of drug formulary: Open or Closed?

State	Open	Closed
Alabama	X	
Arkansas	X	
Georgia	X (with some restrictions)	
Kentucky		X
Maryland	X	
Mississippi	X	
Missouri	X (with few exclusions)	
North Carolina	X	
Oklahoma	X	
South Carolina	X	
Texas	X	
Virginia	X	
West Virginia	X	

6. Is there any type of prior authorization required for drug dispensing?

State	Prior Authorization	
	Yes	No
Alabama	X	
Arkansas	X	
Georgia	X	
Kentucky	X	
Maryland	X	
Mississippi	X	
Missouri	X	
North Carolina		X
Oklahoma	X	
South Carolina	X	
Texas	X	
Virginia	X	
West Virginia	X	

7. What percentage of your state's Medicaid prescription drug expenditures would you estimate to be comprised of generic drugs? Does your state have any regulations or procedures promoting the use of generic as opposed to brand name drugs?

State	Percent Generic	Promote Generic vs. Brand		
		Yes	No	If yes, describe procedure.
Alabama		X		Educational program - not mandatory
Arkansas	50%			Recommend that generics be used when possible
Georgia	45%	X		MACs placed on multiple source drugs
Kentucky		X		Brand of Pharmacy Drug Law
Maryland	25%	X		Generic must be used unless otherwise prescribed. Also, brand reimbursed at MAC rate without override.
Mississippi	63%			Policy to dispense generic when available.
Missouri		X		If generic reimbursement rates exist and not used, prior authorization required.

State	Percent Generic	Promote Generic vs Brand (Cont.) Yes	No	If yes, describe procedure
North Carolina	50%-52%	X		Generic unless brand prescribed
Oklahoma	75%	X		Use HCFA upper limits to set prices on multi source drugs, unless physician prescribes brand
South Carolina		X		Federal and state upper limits programs
Texas	33%	X		MAC programs (federal and state)
Virginia		X		Generic use when available
West Virginia	51%	X		Generic use unless otherwise prescribed

8. Profile of usage.

Categorically Needy Profile of Pharmacy Usage Fiscal Year 1995				
State	Categorically Needy	Limits on Usage	Average Number Prescriptions Per Recipient Per Year	Average Cost Per Recipient Per Year
Alabama	410,487	none	17.02	$397.00
Arkansas	243,769	Unlimited if under 21 or Long-Term Care; Otherwise - 3/month	19.2	503.43
Georgia		5/adults; 6/child		325.94
Kentucky	360,494	none		
Maryland	27,314	none		301.00
Mississippi	378,562		12.96	333.44
Missouri	591,650		45.6	97.92

Categorically Needy Profile of Pharmacy Usage Fiscal Year 1995 (Cont.)				
State	Categorically Needy	Limits on Usage	Average Number Prescriptions Per Recipient Per Year	Average Cost Per Recipient Per Year
North Carolina	1,138,786	6/month		
Oklahoma	288,886	3/month	10.38	$309.49
South Carolina	364,999	3/month	26.64	375.61
Texas	2,100,000	Unlimited if under 21 or nursing home; Otherwise - 3/month	33.6	$822.60
Virginia				
West Virginia	223,317		18	519.00

9. What measures are being taken to lower the cost of your state's pharmacy programs?

State	Cost Containment Measure(s)
Alabama	• Prospective Drug Utilization Review • Preferred Drug List (educational)
Arkansas	• Prior authorization of certain drugs • Anti-ulcer program with an on-line computer system. 60 days of maximum dosage is allowed in a 12-month period. Continued dosage through prior authorization. • Medically necessary prescriptions override prior authorization requirements.
Georgia	**Proposed:** • closed drug formulary • prior authorization for brand necessary drugs • capitation fee for nursing home providers • disallow duplicative therapy for certain drug categories • deny fee for more than one dispensing per month • reducing the dispensing fee to "market place" rates
Kentucky	
Maryland	
Mississippi	Prior authorization of growth hormones, sanelimmune, clozaril, single source NSAIDs, and nutritional products
Missouri	

State	Cost Containment Measure(s)
North Carolina	• No dispensing fee for refills of same drug within same month • Lock-in of recipients to one pharmacy per month
Oklahoma	• Reduction in dispensing fee • Requiring generic drugs • Prior authorization for Benzodiazepines, antihistamines, and anti-ulcer medications • Establishing a Drug Utilization Review Board
South Carolina	• Increase in AWP (Average Wholesale Price) discount from 9.5% to 10% • Alternate reimbursement policy for nursing home prescriptions
Texas	
Virginia	• Drug utilization review • Participation in VA Health Outcomes Partnership (VHOP) program based on disease state management and provider education • Drug rebate program • Proposed OTC initiative for the outpatient population
West Virginia	• Limiting number of prescriptions to 10 per month • Increasing co-payment $0-$10 = $.50, $10.01-$25.00 = $1, and >$25.01 = $2.00 • Looking at discounting to AWP (Average Wholesale Price) -10% or -12% + $3.90 • Looking at a formulary

Appendix D

Pharmacy Reimbursement Methodologies

Appendix D: Pharmacy Reimbursement Methodologies

We surveyed 14 states in the Southern Legislative Conference to determine their methodologies for reimbursing pharmacies for drugs provided to Medicaid recipients. Except for Florida, which did not respond, every state reimburses for dispensing drugs using the same basic methodology. For drugs other than multiple source drugs, each state pays the lesser of usual and customary charges or the state's estimate of the cost of the drug. Each state's drug cost estimate divides the reimbursement amount into ingredient costs and a dispensing fee. Differences occur at the detail level. For example, some states use different discount amounts from average wholesale price in estimating ingredient costs of single source drugs.

Single Source Drugs. The chart on page D.2 shows the different approaches used by states to estimate drug acquisition costs to pharmacies for single source drugs. Some states use Wholesale Acquisition Cost (WAC) instead of, or in addition to, Average Wholesale Price (AWP). The wholesale acquisition cost is the price paid by wholesalers to acquire drugs from manufacturers. The states that use the wholesale acquisition cost add a mark-up that they determine is typical of wholesalers.

Dispensing Fees. The third column of the chart shows the dispensing fees for these states as of June 30, 1995. Arkansas and Texas use dispensing fees that are composed of a set base amount plus a percentage of the ingredient costs (EAC). Three states, Alabama; Kentucky; and South Carolina, use different rates, depending on the type of provider (outpatient or institutional).

All of these rates, including Louisiana's, are the maximum that is paid for a dispensing fee. If a provider's usual and customary charge for a prescription is less than the estimated ingredient cost plus the dispensing fee, the dispensing fee actually reimbursed will be less than the maximum.

Reimbursement Methodology for Single Source Drugs

State	Ingredient Reimbursement	Dispensing Fee
Alabama	WAC + 9.2%	$5.40 outpatient $2.77 institutional
Arkansas	AWP - 10.5%	$4.51 + .103 EAC(up to $20)
Georgia	AWP - 10%	$4.41
Kentucky	AWP - 10%	$4.75 outpatient $5.75 institutional
Louisiana	**AWP - 10.5%**	**$5.77**
Maryland	WAC + 10% or Direct + 10% or Distributors + 10% or AWP - 10% *	$4.66
Mississippi	AWP - 10%	$4.91
Missouri	AWP - 10.43%	$4.09
North Carolina	AWP - 10%	$5.60
Oklahoma	AWP - 10.5%	$5.10
South Carolina	AWP - 10%	$4.05 outpatient $3.15 institutional
Texas	AWP - 10.49% or WAC + 12% **	$4.89 + .075 EAC
Virginia	AWP - 9%	$4.40
West Virginia	AWP	$2.75

* listed in order of preference

** whichever is lower

AWP = Average Wholesale Price

WAC = Wholesale Acquisition Cost

EAC = Estimated Acquisition Cost

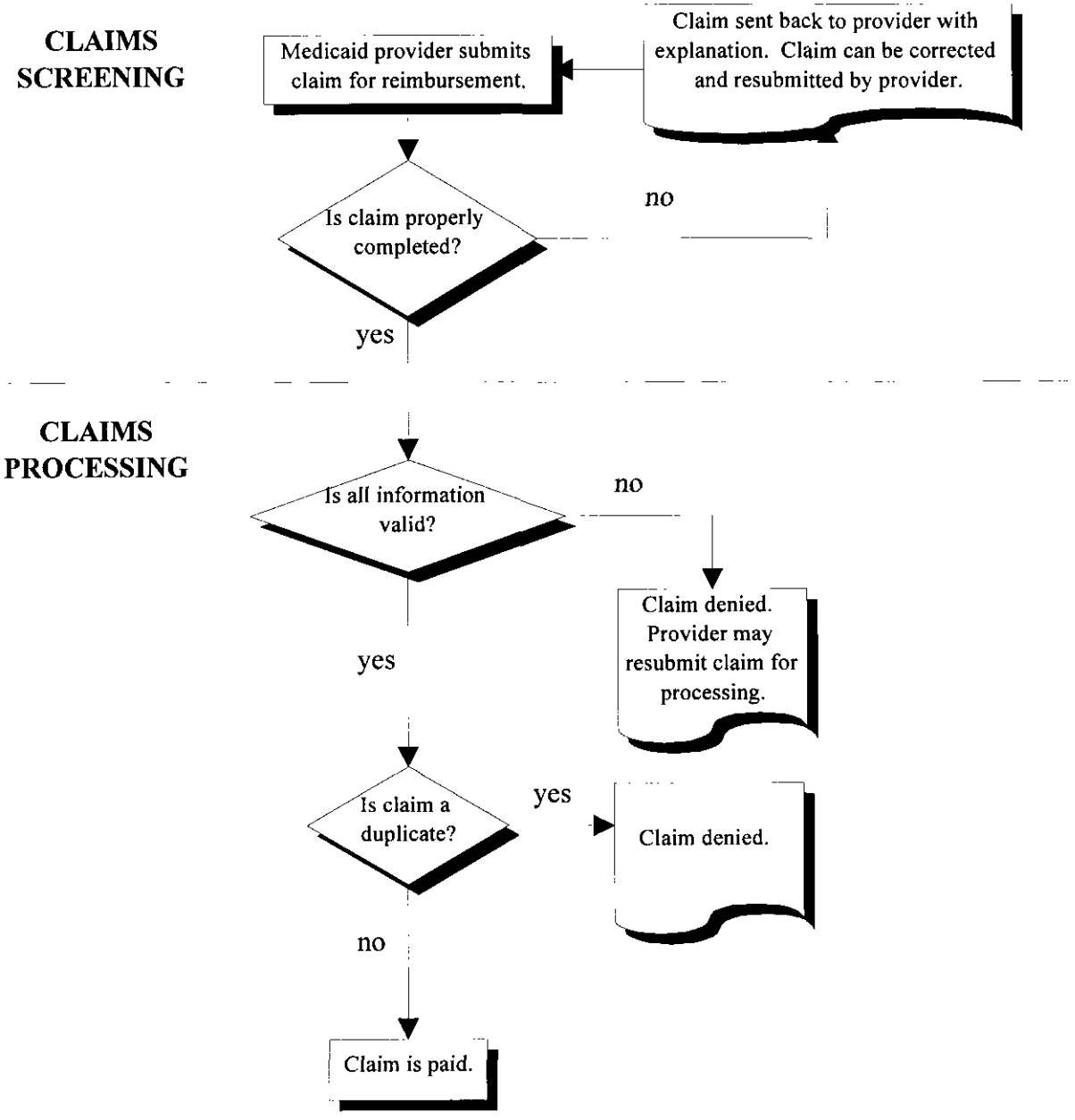
Source: Prepared by legislative auditor's staff using data taken from surveys of other states and data obtained from the Department of Health and Hospitals.

Appendix E

Processing of Provider Claims

Appendix E: Processing of Claims

The chart below illustrates how Medicaid provider claims are screened and processed by UNISYS, the state Medicaid fiscal intermediary.



Source: Prepared by legislative auditor's staff from information provided by the Department of Health and Hospitals.

Appendix F

Department of Health and Hospitals' Response

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Bobby P. Jindal
SECRETARY

April 8, 1996

Dr. Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor
1600 North Third Street
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

RE: Preliminary Draft
Medicaid: A Staff Study of Selected Programs

Dear Dr. Kyle:

This is in response to Ms. Sharon B. Robinson's correspondence of March 25, 1996 requesting our comments on the above referenced report. Please find listed below those comments.

Chapter Four: Post-Payment Review

Pg 33 "DHH is considering segregating pharmacies based on volume."

Effective June 1996, pharmacies on the Control File will be divided into four groups, urban and rural, as well as, over and under $60,000 in claims. The mean payment per pharmacy per year is approximately $60,000.

Pg 34 "Unisys currently has the capability to use numerical limits."

The Control File does not establish overpayments! It only identifies "potential" fraud and abuse. It is only a tool to help select which providers are reviewed. Overpayments can only be established by investigation.

The standard deviation of the Control File can and is adjusted and weighted by SURS. The Control File and other resources are used to best target providers for review.

Pg 36 "could not evaluate the effectiveness of SURS in recovering overpayments."

SURS can only recoup overpayments from a provider's current billing. Once a provider stops billing Medicaid, the overpayment can only be recovered by civil action, which is handled by DHH legal.

Of the 20 states on which information is available for last year, only Idaho suspended more providers (16), and only Connecticut collected more money.

Pg 39 "no formal written criteria exists for determining when a provider warrants a referral *to the fraud control unit.*"

DHH's responsibility to, "Refer all cases of suspected provider fraud to the [MFCU] unit," is found in 42 CFR 455.21. Complicating our MFCU referrals is a "special" state law, LSA-R.S. 46:442(C), which requires us to notify the provider of the criminal investigatory referral, before we refer the case! We must conduct a personal interview with the provider, in which we share our evidence, usually with the provider and his criminal defense attorney, only then may we sent the case to the MFCU or Federal agencies for them to begin a criminal investigation.

According to 42 CFR 455.2: "Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

We follow 42 CFR 455.2, 42 CFR 455.21, and LSA-R.S. 46:442(C) to the letter, in referring cases to the Attorney General. We do not refer providers which we know the Attorney General's Medicaid Fraud Control Unit is already investigating.

Pg 39 LSA-R.S. 46:442(C)

A DHH sponsored bill (Senate Bill 53) is pending in the current special session to repeal the personal interview requirement of this law.

Response to the "Recommendations"

The report recommends changes for exception profiling (Control File) which could change its purpose. The Control File is mandated and designed by HCFA. While we can change some aspects of the system we can not change its nature. It is correct that the Control File is designed to identify the worse cases of "potential" fraud and abuse.

1. DHH has a formal Control File management process with regular meetings by which changes are recommended and made to the Control File. We can and do constantly strive to refine the Control File and will gladly review our provider grouping criteria.

2. The control file does not establish overpayments! It is only a tool to help select which providers are reviewed. Overpayments can only be established by investigation. This routinely requires extensive review of provider records.

   We will test numerical limits to see if this aids our selection of providers to review.

3. We move to exclude providers that we have reason to believe should not be allowed to participate in the Medicaid program. We frequently flag rehabilitated providers for periodic pre-payment or post-payment review. SURS will establish a formal system to flag rehabilitated providers for periodic review.

4. We follow 42 CFR 455.2, 42 CFR 455.21, and LSA-R.S. 46:442(C) to the letter, in referring cases to the Attorney General. We do not refer providers which we know the Attorney General's Medicaid Fraud Control Unit is already investigating.

"Matters for Legislative Consideration"

1. A DHH sponsored bill (Senate Bill 53) is pending in the current special session to repeal the personal interview requirement of this law.

2. We would strongly oppose #2, unless the personal interview requirement above is repealed. We do not refer providers which we know the Attorney General's Medicaid Fraud Control Unit is already investigating. To do so would only alert the provider to the criminal investigation being conducted by the Attorney General!

"Increased recipient reviews"

Our recipient review standard is comparable to the SURS units of other southern states. With more resources, we certainly could do more recipient reviews.

General Comments Regarding Chapter Four:

Bob Patience, SURS Manager:

This chapter mixes pre-payment and post-payment activity as if they were one and the same. It confuses exception reporting with recoupment of overpayments. It ignores elements that are in place and recommends including these items.

The report recommends changing the system of post payment review from the federally mandated one that is now in use and approved by HCFA. HCFA specifies that the system will report "...suspected misutilizers...who deviate significantly from their group norm." The report repeatedly condemns the system because it will "only detect the very worst case" -- exactly as HCFA intends it to do.

The report is critical of provider groupings and methods used to analyze claim data. Both are done in accordance with the General System Design for Medicaid and function effectively. On page 36 the report confuses what HCFA requires and what it does not.

Susan Taskin, Assistant Manager, Medicaid Management Information System:

Corrections were made as to some details as to who does what, but we still have a problem with the way the erroneous/fraudulent payment issue is presented, and the absence of any concrete suggestions for pre-pay editing.

Perhaps it would help if the Post Payment Review Section would read as follows:

First Paragraph:

The Department of Health and Hospitals relies on its post-payment review process to detect overpayments to providers due to fraud. The claims processing section could pay claims for services never rendered without detection.

Fifth Paragraph:

The claims processing system is set up to put claims through a series of edits which can and do detect erroneous billing; some claims pend for further review. However, the extent of editing and review done is a compilation over the years of an effort to combat known and anticipated types of erroneous/fraudulent billing. It is still possible for a provider to "game" the system and receive payments for services not rendered or overpayments for services given but billed at higher levels than actually provided. Appendix E illustrates the claims payment process.

Appendix E needs a correction - it says a denied claim cannot be resubmitted for processing. This is not true. It can, and would deny again for the same error condition.

Please contact me should you have any questions.

Sincerely,

Thomas D. Collins
Acting BHSF Director

c: David W. Hood
Stan Mead
Dexa Alexander